

Financing Strategies for Universal Access to Healthcare

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Introduction

Access to healthcare is critically dependent on how healthcare provision is financed. Countries that have universal or near universal access to healthcare have health financing mechanisms which are single-payer systems in which either a single autonomous public agency or a few coordinated agencies pool resources to finance healthcare. All OECD countries, excluding the USA, have such a financing mechanism. In these countries, excluding USA, 85% of financing comes from public resources like taxes, social insurance or national insurance which insure healthcare to over 90% of the population – even in the USA public finance (Medicare and Medicaid) constitutes 44% of total health expenditure but one-third of the population in the US is either uninsured or under insured. In fact the USA and Canada stand out in sharp contrast even though they are neighbours and strong capitalist economies. Canada gives healthcare access to 100% of its population free of direct payments at 40% of the cost that USA spends and has health outcomes better than the USA.

Outside the OECD group a number of developing countries in Latin America, Asia and Africa like Costa Rica, Cuba, Argentina, Brazil, South Africa, Kenya, South Korea, Iraq, Iran, Thailand, Sri Lanka etc. too have evolved some form of single-payer mechanisms to facilitate near universal access to healthcare. It is only in countries like India and a number of developing countries, which still rely mostly on out-of-pocket payments, where universal access to healthcare is elusive. In such countries those who have the capacity to buy healthcare from the market most often get healthcare without having to pay for it directly, and those who suffer a hand-to-mouth existence are forced to make direct payments, often with a heavy burden of debt, to access healthcare from the market.

India is the most privatised health economy in the world and this despite the fact that three-fourths of the country's population is either below the poverty line or at the subsistence level. Given the political economy of India one would have expected the State to be the dominant player in both financing and providing healthcare for considerations of establishing equity in access to healthcare. But this has not happened.

Historically, the Indian State has always been an insignificant player in provision and/or financing of ambulatory healthcare. Private providers, both modern and traditional, as well as informal providers, have been dominant players in the healthcare market. While pre-colonial healthcare was still largely within the *jajmani* realm of transactions, the establishment of modern medicine during the colonial period gradually moved in the direction of commodification. Today the healthcare system is completely characterised by modern medicine, and healthcare being a commodity. Even the traditional and non-formal providers, often practitioners of quackery, use modern medicine in their practice and operate within the market context.

In case of hospital care the transition has been very different. Right from pre-colonial times, through the colonial period and the post-Independence period upto mid-seventies, the State and its agencies were the main providers of hospital care. There were also significant non-state players who set up large charitable hospitals. By 1970's medical education made a

major transition; post-graduation, specialisation and super-specialisation became sought after and the character of medical practice changed. Specialists on one hand began setting up private nursing homes and the corporate sector on the other hand began to show interests in entering the hospital sector. Also major changes in medical technology, which hastened the process of commodification of healthcare, made for-profit hospitals a lucrative proposition. By 1980's the State was already decelerating investments in the hospital sector and this was a clarion call for the private sector to increase its presence. By the turn of the millennium the for-profit hospital sector had not only become dominant but also within the state sector privatisation via user-charges, as well as through contracting out or leasing had become the order of the day.

It is apparent from the above discussion that the largest source of financing healthcare in India is out-of-pocket or *self-financing*. Out-of-pocket spending on healthcare as a mode of financing is both regressive and iniquitous. Latest estimates from National Accounts Statistics indicate that private expenditures on healthcare in India are over Rs. 1300 billion and 90% of this is out-of-pocket. Public expenditures on healthcare are about Rs. 250 billion additionally. Together this adds up to nearly 6% of GDP with out-of-pocket expenses accounting for 72% of the share in total health expenditures or 4.3% of GDP. This is a substantial burden, especially for the poorer households, the bottom three quintiles, which are either below poverty line or at the threshold of subsistence, and when illness strikes such households just collapse. In fact, for the poorer quintiles the ratio of their income financing health expenditures is 2 to 4 times more than the average mentioned above. Further, while this burden is largely self-financed by households a very large proportion of this does not come from current incomes. A very large proportion, especially for hospitalisations comes from debt and sale of assets.

Data from the 52nd Round NSS of 1995-96 (Table 1) reveals that over 40% households borrow or sell assets to finance hospitalisation expenditures, and there are very clear class gradients to this – nearly half the bottom two quintiles get into debt and/or sell assets in contrast to one-third of the top quintile; in fact in the top quintile this difference is supported by employer reimbursements and insurance. When we combine this data with the ratio of “not seeking care when ill” in case of acute ailments by the bottom three quintiles in contrast to the top quintile – a difference of 2.5 times, and the reason for not seeking such care being mostly the cost factor, it becomes amply evident that self-financing has drastic limits and in itself is the prime cause of most ill health, especially amongst the large majority for whom out-of-pocket mode of financing strains their basic survival.

Thus in countries where near universal access to healthcare is available with relative equity the major mechanism of financing is usually a single-payer system like tax revenues, social insurance or some such combination administered by an autonomous health authority which is mandated by law and provided through a public-private mix organised under a regulated system. Canada, Sweden, United Kingdom, Germany, Costa Rica, South Korea, Australia, Japan are a few examples.

Experience from these countries shows that the key factor in establishing equity in access and healthcare outcomes is the proportion of public finance in total health expenditures. Most of these countries have public expenditures averaging over 80% of total health expenditures. The greater the proportion of public finance the better the access and healthcare outcomes. Thus India where public finance accounts for only 17% of total health expenditures has poor

equity in access to healthcare and health outcomes in comparison to China, Malaysia, South Korea, Sri Lanka where public finance accounts for between 30% and 60% of total health expenditures.

In India public health expenditures had peaked around mid nineteen-eighties and thereafter there was a declining trend, especially post-structural adjustment period. The decade of eighties was a critical period in India's health development because during this period not only did the public health infrastructure, especially rural, expand substantially but also major improvements in health outcomes were recorded. After that public investment in health declined sharply and public expenditures showed a declining trend both as a proportion to GDP as well as in total government spending. This has also impacted health outcomes, which are showing a slower improvement if not stagnation. At the same time private health sector expansion got accelerated and utilisation data from the two NSS Rounds 42nd and 52nd Round, a decade apart, provides ample evidence of this change. (Table 2 and 3)

Thus, if India has to improve healthcare outcomes and equity in access then increasing public health expenditures will be critical. Apart from this the healthcare system will need to be organised and regulated in the framework of universal access, similar to countries like Canada or Costa Rica. Ofcourse, India has its own peculiarities and the system that will be designed will have to keep this in mind. We cannot transplant say the Canadian or Costa Rican system into India as it is, but we can definitely learn from their experience and adapt useful elements.

Prescription

Currently India's health financing mechanism as mentioned earlier is largely out-of-pocket and one sees a declining trend in public finance. Table 4 provides a profile of the current financing mechanism in India and Table 5 trends in health expenditures. It is quite evident from the data that public finance of healthcare is weakening and private expenditures becoming even larger.

First, within the existing public finance of healthcare macro policy changes in the way funds are allocated can bring about substantial equity in reducing geographical inequities between rural and urban areas. Presently, the central and state governments together spend Rs. 250 per capita at the national level, but this is inequitably allocated between urban and rural areas. The rural healthcare system gets only Rs. 80 per capita and urban areas get Rs. 540 per capita, a difference of over six times. If allocations are made using the mechanism of global budgeting, as done in Canada, that is on a per capita basis then rural and urban areas will both get Rs. 250 per capita. This will be a major gain, over three times, for rural healthcare and this can help fill gaps in both human and material resources in the rural healthcare system. The urban areas in addition have municipal resources, and ofcourse will have to generate more resources to maintain their healthcare systems which atleast in terms of numbers (like hospital bed:population ratios and doctor : population ratios) are adequately provided for. Global budgeting also means autonomy in how resources are used at the local level. The highly centralised planning and programming in the public health sector will have to be done away with and greater faith will have to be placed in local capacities.

Second, the public exchequer even today contributes substantially to medical education to the extent that 70% of medical graduates are from public medical schools. This is a major resource that is not fully utilised. Since medical education is virtually free in public medical

schools the state must demand compulsory public service for atleast three years from those who graduate from public medical schools as a return for the social investment. Today only about 15% of such medical graduates are absorbed in the public system. Infact, public service should be made mandatory also for those who want to do post-graduate studies (as many as 55% of MBBS doctors opt for post-graduate studies).

Third, the governments can raise additional resources through charging health cesses and levies on health degrading products (if they cannot ban them) like cigarettes, beedis, alcohol, paan masalas and guthka, personal vehicles etc.. For instance tobacco, which kills 670,000 people in India each year, is a Rs. 35,000 crore industry and a 2% health cess would generate Rs. 700 crores annually for the public health budget. Similarly alcohol, which is much larger and presently generates Rs.25,000 crores in revenues can also bring in substantial resources if a 2% health cess is levied. The same logic can be applied to personal transportation vehicles both at point of purchase as well as each year through a health cess on road tax and insurance paid by owners. Land revenues and property taxes can also attract a health cess which is earmarked for public health (municipal taxes already have an education cess component).

Fourth, social insurance can be strengthened by making contributions similar to ESIS compulsory across the entire organised sector and integrating ESIS, CGHS etc.. with the general public health system. Also social insurance must be gradually extended to the other employment sectors using models from a number of experiments in collective financing like sugar-cane farmers in south Maharashtra paid Re 1 per tonne of cane as a health cess and their entire family was assured healthcare through the sugar cooperative. There are many NGO experiments in using micro-credit as a tool to factor in health financing for the members and their family. Large collectives, whether self-help groups facilitated by NGOs, or self-employed groups like headload workers in Kerala, can buy insurance cover as a collective and provide health protection to its members. Atleast 60% of the workforce in India has the potential to contribute to a social insurance program.

Fifth, other options to raise additional resources could be various forms of innovative direct taxes like a health tax similar to profession tax (which funds employment guarantee) deducted at source of income for employed and in trading transactions for self-employed. Using the Tobin tax route is a highly progressive form of taxation which in an increasingly service sector based economy can generate huge resources without being taxing on the individual as it is a very small amount of deduction at the point of transaction. What this basically means is that for every financial transaction, whether cheque, credit card, cash, stock market, forex etc. a very small proportion is deducted as tax and transferred to a fund earmarked for social sector. For example if 0.025% is the transaction tax then for every Rs. 100,000 the transaction tax would be a mere Rs. 25 or one paise per Rs. 40 transacted. This would not hurt anyone if it were made clear that it would be used for social sectors like health, education, public housing, social welfare etc..

The above are just few examples of what can be done within the existing system with small innovations. But this does not mean that radical or structural changes should not be done. Ultimately if we have to assure universal access with equity then we have to think in terms of restructuring and reorganising the healthcare system using the rights-based approach. This requires a multi-pronged strategy of building awareness and consensus in civil society, advocating right to healthcare at the political level, demanding legislative and constitutional

changes, and regulating and reorganising the entire healthcare system, especially the private health sector.

To conclude, we have to stem the growing out-of-pocket financing of the healthcare system and replace it with a combination of public finance and various collective financing options like social insurance, collectives/common interest groups organising collective funds or insurance. At another level the healthcare system needs to be organised into a regulated system that is ethical and accountable and is governed by a statutory mandate, which pools together the various collective resources and manages autonomously the working of the system towards the goal of providing comprehensive healthcare to all with equity.

Projection Of Resource Requirements

The projections we are making are for the fiscal year 2000-2001. The population base is one billion. There are over 1.3 million doctors (of which allopathic are 550,000, including over 180,000 specialists), 600,000 nurses, 950,000 hospital beds, 400,000 health workers and 25,000 PHCs with government and municipal health care spending at about Rs.250 billion (excluding water supply).

1. An Estimate of Providers and Facilities

What will be the requirements as per the suggested framework for a universal health care system?

- Family medical practitioners = 500,000 (one per 2000 population)
- Epidemiological stations = 35,000 (one per 30,000)
- Health workers = 500,000 (one per 2000)
- Health supervisors = 125,000
- Public health nurses = 35,000
- Basic hospitals = 20,000 (of 50 beds each per 50,000 population)
- Basic hospital beds = 1 million
- Basic hospital staff :
 - general duty doctor = 120,000
 - specialists = 100,000
 - dentists = 20,000
 - nurses = 360,000
- Other technical and non-technical support staff as per requirements (Please note that the basic hospital would address to about 75% of the inpatient and specialist care needs, the remaining will be catered to at the secondary/district level and teaching/tertiary hospitals)

One can see from the above that except for the hospitals and hospital beds the other requirements are not very difficult to achieve. Training of nurses, dentists, public health nurses would need additional investments. We have more than an adequate number of doctors, even after assuming that 80% of the registered doctors are active (as per census estimates). What will be needed are crash CME programs to facilitate integration of systems and reorganisation of medical education to produce a single cadre of basic doctors. The PHC health workers will have to be reoriented to fit into the epidemiological framework. And construction of hospitals in underserved areas either by the government or by the private sector (but only under the universal system) will have to be undertaken on a rapid scale to meet the requirements of such an organised system.

2. An Estimate of the Cost

The costing worked out hereunder is based on known costs of public sector and NGO facilities. The FMP costs are projected on the basis of employed professional incomes. The actual figures are on the higher side to make the acceptance of the universal system attractive. Please note that the costs and payments are averages, the actuals will vary a lot depending on numerous factors. (Table A)

3. Distribution of Costs

The above costs from the point of view of the public exchequer might seem excessive to commit to the health sector given current level of public health spending. But this is less than 3% of GDP at Rs.600 per capita annually, including capital costs. The public exchequer's share, that is from tax and related revenues, would be about Rs.400 billion or two-thirds of the cost. This is well within the current resources of the governments and local governments put together. The remaining would come from other sources discussed earlier, mostly from employers and employees in the organised sector, and other innovative mechanisms of financing. As things progress the share of the state should stabilise at 50% and the balance half coming from other sources. Raising further resources will not be too difficult. Part of the organized sector today contributes to the ESIS 6.75% of the salary/wage bill. If the entire organized sector contributes even 5% of the employee compensation (2% by employee and 3% by employer) then that itself will raise close to Rs.250 billion. Infact, the employer share could be higher at 5%. Further resources through other mechanisms suggested above will add substantially to this, which infact may actually reduce the burden on the state exchequer and increase contributory share from those who can afford to pay. Table B gives the break down of how costs would be shared.

Table A: Projected Universal Health Care Costs (2000-2001 Rs. in millions)**Type of Costs**

➤ Capitation/salaries to FMPs (@ Rs.300 per family per year x 200 mi families) 50% of FMP services	60,000
➤ Overheads of FMP services	20,000
➤ Fees for specific services by FMPs	20,000
➤ Pharmaceutical Services	<u>35,000</u>
➤ Total FMP Costs	135,000
➤ Epidemiological Stations (@ Rs.3 mi per ES x 35,000)	105,000
➤ Basic Hospitals (@ Rs.10 mi per hospital x 20,000, including drugs, i.e.Rs.200,000 per bed per year)	<u>200,000</u>
➤ Total Primary Care Cost	440,000
➤ Per capita = Rs. 440; 2.09% of GDP	
➤ Secondary and Teaching Hospitals, including medical education and training of doctors/nurses/paramedics (@ Rs.2.5 lakh per bed x 3 lakh beds)	<u>75,000</u>
➤ Total health services costs	515,000
➤	
➤ Medical Research (2%)	10,300
➤ Audit/Info.Mgt/Social Res. (2%)	10,300
➤ Administrative costs (2%)	<u>10,300</u>
➤ TOTAL RECURRING COST	545,900
➤ Add capital Costs (10% of recurring)	<u>54,590</u>
➤ ALL HEALTH CARE COSTS	600,490
➤ Per Capita = Rs. 600.49; 2.86% of GDP	

(Calculations done on population base of 1 billion and GDP of Rs. 21,000 billion)

Table B: Projected Sharing of Health Care Costs (2000-2001 Rs. in millions)

	Type of Source				
	Central Govt.	State/ Muncp.	Organised Sector	Other Sources	
1. Epidemiological services	70,000	25,000	7,000	3,000	
2. FMP Services	10,000	75,000	45,000	5,000	
3. Basic Hospitals	--	100,000	85,000	15,000	
4. Secondary/Teaching Hospitals	20,000	30,000	20,000	5,000	
5. Medical Research	8,000	1,000	1,000	300	
6. Audit/ Info. Mgt./ Soc.Research		5,000	5,000	300	--
7. Administrative Costs		3,000	7,000	300	--
8. Capital Costs	25,000	25,000	4,000	590	
ALL COSTS	141,000	268,000	162,600	28,890	
	Rs.600,490 million				

Percentages

23

45

27

5

Table 1: Key Data pertaining to out-of-pocket expenditures, source of finance and for not seeking care across expenditure quintiles and social groups, NSS 52nd Round, 1995-96

	I Poorest	II	III	IV	V Richest	SC/ST	Other	All
<u>OPD</u>								
Rural								
Rs. per episode	77	94	124	130	174	92	138	128
Urban								
Rs. per episode	95	141	139	164	225	122	166	160
<u>IPD</u>								
Rural								
Rs. per Hosp.	1020	1197	1495	1931	4595	2789	3133	3102
Urban								
Rs. per Hosp.	835	1499	1964	2765	7470	2046	4303	3921
<u>Debt and sale of assets (%)</u>	47	45	42	42	32			43
<u>Did not seek care (%)</u>	24	21	18	18	9			17
<u>Cost as factor in not seeking care (%)</u>	33	23	21	22	15			24

Source: Compiled from NSS 52nd Round data files

Table 2: Per 1000 distribution of hospitalised treatments by type of facility during 1986-87 and 1995-96, India – NSSO

Type of	Rural		Urban	
Hospital	1995-96 (52 nd Rd.)	1986-87 (42 nd Rd.)	1995-96 (52 nd Rd.)	1986-87 (42 nd Rd.)
Public hospital	399	554	418	595
PHC / CHC	48	43	9	8
Public Dispensary	5	-	4	-
All govt. sources	438	597	431	603
Private hospital	419	320	410	296
Nursing home	80	49	111	70
Charitable institution	40	17	42	19
Others	8	17	6	12
All non-govt. sources	562	403	569	397
all hospitals	1000	1000	1000	1000

Source: NSSO (1998); Report No 441 on Morbidity and Treatment of Ailments

Table 3: Percentage distribution of non-hospitalised treatments by source of treatment during 1986-87 and 1995-96, India – NSSO

Source of Treatment	Rural		Urban	
	1995-96 52nd Rd.	1986-87 42nd. Rd.	1995-96 52nd Rd.	1986-87 42nd. Rd.
Public hospital	11	18	15	23
P.H.C. / C.H.C.	6	5	1	1
Public dispen.	2	3	2	2
ESI doctor, etc.	0	0	1	2
All govt. sources	19	26	20	28
Private hospital	12	15	16	16
Nursing home	3	1	2	1
Charitable inst.	0	0	1	1
Private doctor	55	53	55	52
Others	10	5	7	3
All non-govt. sources	81	74	80	72
Total	100	100	100	100
Source: NSSO (1998): Report No 441 on Morbidity and Treatment of Ailments				

Table 4: Financing Healthcare in India c2003

	Estimated users in millions	Expenditure (Rs. Billions)
Public Sector	250@	252 (17)*
<i>Of which Social Insurance</i>	55	30 (2)
Private Sector	780@	1250 (83)**
<i>Of which social insurance</i>	30	24 (1.6)
<i>Private insurance\$</i>	11	11.5 (0.8)
<i>Out of Pocket</i>	739	1214.5 (80)
Total	1030	1552 (100)

@ Estimates based on National Sample Survey 52nd Round, and Labour Year Book

* Finance Accounts of Central and State Governments, and Labour Year Book, includes estimated Municipal health expenditures

** Private Final Consumption Expenditure from National Accounts Statistics

\$ 85% of private insurance is through public sector insurance companies

Figures in parentheses are percentages

Table 5: Health Expenditure Trends in India

Year	Total Public Health Expenditure (Rs.billions)	% of GDP	Private Health Expenditure (Rs.billions)	% of GDP	% Private to Total Health Expenditure
1975-76	6.78	0.90	24.66	3.26	78.43
1980-81	12.86	0.99	52.84	4.06	80.43
1985-86	29.66	1.19	90.54	3.61	75.32
1991-92	56.40	0.96	160.65	2.73	74.01
1992-93	64.64	0.74	175.57	2.61	73.09
1993-94	76.81	0.98	195.43	2.50	71.78
1994-95	85.65	0.93	278.59	3.04	76.48
1995-96	96.01	0.89	329.23	3.07	77.42
1996-97	109.35	0.88	373.41	3.00	77.35
1997-98	127.21	0.92	458.99	3.30	78.30
1998-99	151.13	0.94	653.40	4.04	81.21
1999-00	172.16	0.96	835.17	4.76	82.91
2000-01	186.13	0.98	981.68	5.18	84.06
2001-02	194.54	0.94	1100.00	5.32	84.90
2002-03	197.32	0.88	1250.00	5.60	86.36
2003-04 RE	235.06	0.98	1400.00*	5.83	85.62
2004-05 BE	249.28	0.96	1600.00*	6.15	86.52

* estimates by author for private expenditures; RE=revised estimate, BE=budget estimates

Source: Public: Finance Accounts of Central and State Governments and RBI's Finances of State Governments, various years; Private: CSO – GOI – Private Final Consumption Expenditures, National Accounts Statistics, 2003
