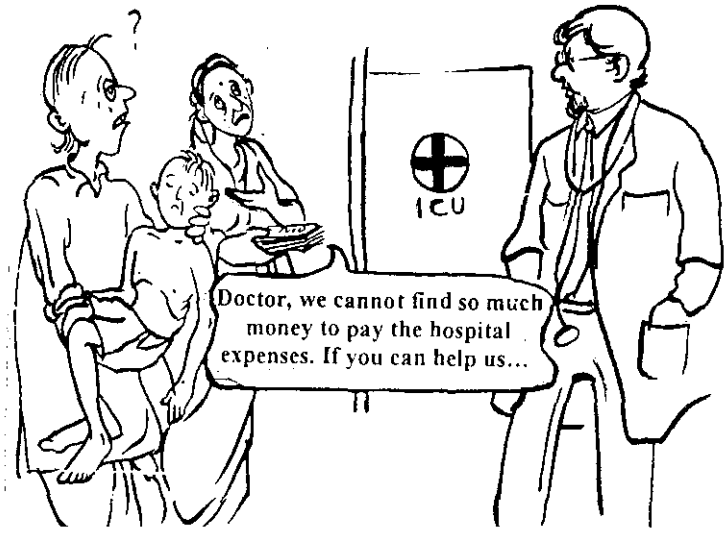
COVER STORY

# Reducing Inequities in Financing Health care: *From Self-Financing to Single-Payer Mechanisms*




***In India, as elsewhere, those who have the capacity to buy health care from the market most often get it without having to pay for it directly, and those who live a hand-to-mouth existence are forced to make direct payments, often with a heavy burden of debt, to access health care from the market.***

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**Background**

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 health care for considerations of establishing equity in access to health care. But this has not happened.

Historically, the Indian State has always been an insignificant player in the provision and/or financing of ambulatory health care. Private providers, both modern and traditional, as well as informal providers, have been dominant players in the health care market. While pre-colonial health care 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 health care system is completely characterized by modern medicine, and health care has become 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 1970s, medical education underwent a major transition; post-graduation, specialization and super-specialization became sought after and the character of medical practice changed. Specialists on the 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 health care, made for-profit hospitals a lucrative proposition. By 1980s, 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.

**Financing health care**

It is apparent from the above discussion that the largest source of financing health care in India is out-of-pocket or

self-financing. Out-of-pocket spending on health care as a mode of financing is both regressive and iniquitous. Latest estimates from National Accounts Statistics indicate that private expenditures on health care in India are over Rs. 1000 billion and 90% of this is out-of-pocket. Public expenditures on health care 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 they just collapse. In fact, for the poorer quintiles the ratio of their income financing health expenditures is bound to be much higher 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 hospitalization, comes from debt and sale of assets.

Data from the 52nd Round of NSS, 1995-96, (Table 1) reveals that over 40% households borrow or sell assets to finance hospitalization 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.

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

*Source : Compiled from NSS 52nd Round data files*

Thus in countries where near universal access to health care 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 organized under a regulated system. Canada, Sweden, United Kingdom, Germany, Costa Rica are a few examples.

Experience from these countries shows that the key factor in establishing, equity in access and health care 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 health care outcomes. Thus, India, where public finance accounts for only 20% of total health expenditures, has poor equity in access and health care 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- nine-

teen-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 utilization data from the two NSS Rounds, 42nd and 52nd, a decade apart, provides ample evidence of this change. (Table 2 and 2a)

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

The following suggestions can help India move in the direction of greater equity in access and health care outcomes.

First, within the existing public finance of health care macro-policy changes in the way funds are allocated can bring about substantial equity in reducing geographical inequities between rural and urban ar-

**Table- 2a**

**Percentage distribution of non-hospitalized 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 dispensary | 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 institution | 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*

**Thus, if India has to improve health care 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. Of course, India has its own peculiarities and the system that will be needed will have to keep this in mind. We cannot transplant say the Canadian system into India as it is, but we can definitely learn from its experience and adapt useful elements.**

**Table 2:**

**Per 1000 distribution of hospitalized treatments by type of facility during 1986-87 and 1995-96, India – NSSO**

| Types of Hospitals | Rural | | Urban | |
|---|---|---|---|---|
| | 1995-96 *(52nd Rd.)* | 1986-87 *(42nd Rd.)* | 1995-96 *(52nd Rd.)* | 1986-87 *42nd 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*

eas. Presently, the central and state governments together spend Rs. 220 per capita at the national level, but this is inequitably allocated between urban and rural areas. The rural health care 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. 220 per capita. This will be a major gain, nearly three times, for rural health care and this can help fill gaps in both human and material resources in the rural health care system. The urban areas in addition have municipal resources, and of course will have to generate more resources to maintain their health care systems which at least 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 centralized 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.

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 which is not fully utilized. Since medical education is virtually free in public medical schools the state must demand compulsory public service for at least 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. In fact, 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).

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, pan masalas and gutkha, and personal vehicles. Social insurance can be strengthened by making contributions similar to

**Ultimately, if we have to assure universal access with equity, then we have to think in terms of restructuring and reorganizing the health care 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 reorganizing the entire health care system, especially the private health sector.**

ESIS compulsory across the entire organized 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. For example, the sugar-cane farmers in South Maharashtra paid Re 1 per tonne of cane as a health cess and their entire family was assured health care 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.

The above-mentioned are just a 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 attempted. Ultimately, if we have to assure universal access with equity, then we have to think in terms of restructuring and reorganizing the health care system using the rights-based approach. This requires a multi-pronged strategy of building awareness and consensus in civil society, advocating right to health care at the political level, demanding legislative and constitutional changes, and regulating and reorganizing the entire health care system, especially the private health sector.

To conclude, we have to stem the growing out-of-pocket financing of the health care system and replace it with a combination of public finance and various collective financing options like social insurance, collectives/common interest groups organizing collective funds or insurance. At another level, the health care system needs to be organized into a regulated system which 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 health care to all with equity. ■

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