A NOTE ON HEALTH CARE & FINANCING STRATEGIES FOR THE NINTH FIVE YEAR PLAN

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PREAMBLE

Health care access and availability in India has a peculiar public-private mix, which generates a political economy that makes the health sector purchasing-power-dependant. This is a contradiction given the fact that the large majority do not have purchasing capacities even to sustain adequate nutritional requirements. In a country where nearly half the population struggles under severe poverty conditions and another one-half of the remaining manages at the subsistence level it is a sad state of affairs that social needs like health and education have to be more often than not bought in the market place. Thus, when we discuss issues in health financing we must not restrict ourselves to money-matters but bring to centrestage in our discussions macro issues like poverty, poor availability of public services and the strong market penetration of the private sector in provision of health care, etc.., that is issues of distributive justice.

Today there are about 12,000 hospitals (60% private) and 700,000 hospital beds (45% private) in the country and a total of 1,200,000 qualified practitioners (89% private) of all systems of medicine. The skewed rural/urban availability of public health services is well known - 70% hospitals and 85% of hospital beds under public domain are located in urban/metropolitan areas when 70% of the population lives in the rural and backward areas of the country. The pattern of distribution of the private health sector is not very different, they too tending to concentrate in urban/metropolitan areas - 60% hospitals, 75% of hospital beds and 70% of allopathic doctors are found in urban areas. However, the private health sector is not confined to just the allopathic qualified practitioners. There are nearly twice as many practitioners qualified in homoeopathy and various Indian systems of medicine and a larger proportion of them (60%) are located in the rural and backward areas, 90% of them also practising modern medicine.

Hence, the private sector definitely has a better penetration in areas where the majority live. Further, because of a complete lack of regulation and control there is another large chunk of practitioners, estimated at about half as many as the qualified, who practice modern medicine without having any qualifications in any system of medicine - again a larger majority of them are in rural and backward areas. This entire private health sector operates on a for-profit basis within the context of a supply-induced-demand economy. And estimates based on various studies show that the private health sector is as much as 4 to 6% of the GDP, in sharp contrast to less than one percent of the GDP which the governments spend.

Therefore when we look at issues in health financing we must begin with this reality of general impoverishment on the one hand and the market led for-profit private health sector on the other. While the public health sector, accounting for less than one-fifth of the overall health expenditures, is financed almost wholly through tax revenues, the dominant private health sector is financed by people directly through fee-for-services. Insurance and employer supported financing, as yet, accounts for a very small proportion of the total funding of the health sector.

STRATEGY FOR THE NINTH PLAN

In the new scenario of liberalisation and globalisation the pressures for reduced State participation in the health sector is going to be difficult to fight. Hence, the fight has to be

fought at another level, both to strengthen the State's role in the health sector as well as to make the private sector more accountable. Over the last eight plan periods the Planning Commission or for that matter the Ministries of Health have not paid much heed to the way in which the private health sector has grown or operated. Infact the State has subsidised the growth of the private health sector by various means - subsidised medical education even for those who ultimately go into private practice or worse still migrate abroad; concessions, subsidies and tax reliefs to private practitioners and hospitals - infact many private hospitals function as trust hospitals whose incomes are exempt from tax; public sector units have supplied bulk drugs and raw materials at subsidised prices to the private pharmaceutical industry and in the process have earned the label of "being in the red" and "inefficient"; import duty concessions for importing the expensive new medical technology which largely benefits the richer sections; etc..

Thus, during the Ninth Plan a lot of rethinking needs to be done. The new strategy should focus both on strengthening the state-sector and at the same time also plan for a regulated growth and involvement of the private health sector. There is a need to recognise that the private health sector is huge and has cast its nets, irrespective of quality, far wider than the state-sector health services. Through regulation and involvement of the private health sector an organised public-private mix could be set up which can be used to provide universal and comprehensive care to all. What we are trying to say is that the need of the hour is to look at the entire health care system in unison to evolve some sort of a national system. The private and public health care services need to be organised under a common umbrella to serve one and all. A framework for basic minimum level of care needs to be spelt out in clear terms and this should be accessible to all without direct cost to the patient at the time of receiving care.

Thus, the Ninth Five Year Plan should adopt a strategy of firstly, setting in a process of reorganising the public and private health sectors into a single regulated system which functions in the context of a universalised system to provide equitable and basic care to all, irrespective of the capacity to pay. And secondly, it must undertake definitive action towards changes in the existing system which are both feasible and desirable.

While reorganisation of the health sector into a universalised public-private mix will take time, certain positive changes are possible within the existing setup through macro policy initiatives the medical councils should be directed at putting their house in order by being strict and vigilant about assuring that only those qualified and registered should practice medicine, continuing medical education (CME) should be compulsory and renewal of registration must be linked to it, medical graduates passing out of public medical schools must put in compulsory public service of atleast five years of which three years must be at PHCs and rural hospitals (this should be assured not through bonds or payments but by providing only a provisional license to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies only to those who have completed their three years of rural medical service), regulating the spread of private clinics and hospitals through a strict locational policy whereby the local authority should be given the right to determine how many doctors or how many hospital beds they need in their area (norms for family practice, practitioner : population and bed : population ratios, fiscal incentives for remote and undeserved areas and strong disincentives and higher taxes for urban and overserved areas etc.. can be used), regulating the quality of care provided by hospitals and practitioners by setting up minimum standards to be followed, putting in place compulsory health insurance for the organised sector employees (restructuring the existing ESIS and merging it with the common national health care system where each employee has equal rights and cover but contributes as per earning capacity, for example if each employee contributes 2% of their earnings and the employer adds another 3% then nearly Rs.100 billion could be raised through

this alone), special taxes and ceases for health can be charged to generate additional resources (alcohol, cigarettes, property owners, vehicle owners etc.. are well known targets and something like one percent of sales turnover for the products and a value tax on the asset could bring in substantial resources), allocation of existing resources can be rationalised better through preserving acceptable ratios of salary : nonsalary spending and setting up a referral system for secondary and tertiary care. These are only some examples of what can be done through macro policy initiatives.

SPECIFIC ACTIONS FOR STRENGTHENING PUBLIC HEALTH CARE – A FEW SUGGESTIONS

1. *The urgent need to strengthen, restructure and reorient public health services:* The urban bias in medical care provision by the State needs to be removed. The Primary Health Centres (PHCs) and Subcentres (SCs) need to be thoroughly reoriented to meet peoples' needs of medical care and not be obsessed with family planning alone. Facilities for medical care need to be substantially enhanced at the PHCs both in terms of personnel and supplies. While supplies can be increased through larger budgetary allocations the difficulty would be in getting personnel to work in the public system. Since private individual practice is the norm it becomes necessary to involve such practitioners to join a public sponsored health care program on a pre-defined payment system, for instance, a fixed capitation fee per family registered with the practitioner. Such a system needs to be evolved both in the rural and urban areas. This would mean a five-fold increase in primary care costs, which would be partly financed from within the existing resources and the remaining from the organised sectors of the economy, including insurance, and special health related taxes. Ofcourse, this would mean a lot of restructuring, including stronger regulations and control and a mechanism for regular audit of the system's functioning. This is the only way of guaranteeing universal access to health care and achieving 'health for all'. The bottom line would be no direct payments by patients at the time of receiving care. All payments would be made through a statutory authority which would be the monopoly buyer. People having the capacity to pay should be charged indirectly through taxes, insurance premia, levies etc.. Such restructuring would not disturb the autonomy of the individual practitioner or the private hospitals except that it would strive to eliminate irrational and unnecessary practices, demand some amount of relocation of practitioners, standardise and rationalise costs and incomes, eliminate quackery and demand accountability from the providers. The Ninth Plan must endeavour to set in processes which would make all this possible.

2. *Making the public health sector efficient, cost-effective and socially accountable:* The response to the malaise of the public health services should not be 'privatisation'. We already have a large, exploitative and unsustainable private health sector. What makes the private health sector 'popular' in usage is its better access (irrespective of quality), a personalised interface, availability at convenience, and its non-bureaucratic nature. The public health services by contrast are bureaucratic, having poor access - especially in rural areas, have often inconvenient timings, are generally impersonal, often don't have requisite supplies like drugs etc.. and are plagued by nepotism and corruption. There is a lot of scope for improvement of public health services with better planning, reallocation of existing resources as well as pumping in additional resources - especially for non-salary expenditures, reducing wastage and improving efficiency by better management practices and separation of primary, secondary and tertiary care through setting up of referral systems, improving working conditions of employees etc.. One good example of enhancing the value, efficiency and effectiveness of the existing system using the available resources is to assure that all medical graduates who pass out of public medical schools (80% of all graduates every year) serve in the public system for say atleast five years without which they should be denied the licence to practice as well as

admission for postgraduate studies. After all the State is spending Rs.800,000 per medical graduate ! This measure if enacted by law will itself make available 14,000 doctors of modern medicine alone every year for the public health care system. There can be many such macro decisions which can help in making the existing resources more effective and useful. Further, public health services must be made accountable to local communities they serve and the latter must perform both the role of social audit as well as take responsibility of seeing that the system works properly for the benefit of patients. As regards the private health sector, as mentioned above, there is an urgent need to regulate it, implement minimum standards of care, standardise charges, have policies for location and distribution etc.. All these are feasible possibilities which can be undertaken irrespective of the structural changes suggested in point (1) above.

3. *Modes of Financing, Payments etc.* : While the public sector is funded through tax revenues the private sector relies mostly on fee-for-services. There is a growing trend of thought favouring atleast partial user-charges or fee-for-services for public health services. This trend must be countered since in the given socio-economic conditions such a policy would hit the majority very hard. WHO has been firm about nations spending 5% of GDP on health care. In India the State doesn't even spend one percent. So the first effort must be at getting the State to commit a much larger share for the health sector from existing resources. Additional revenues specifically for health budgets may be collected on the lines of profession tax in some states which funds employment programs, levies and cesses for health could be collected by local bodies, employers in the organised sector must be made to contribute for health care services, those with capacity to pay like organised sector employees, the middle and rich peasantry (so far completely untaxed), and other self-employed, must do so through insurance and other pre-payment programs. In a vast and varied country like India no single system can work. What we would need is a combination of social insurance for the poor (premia paid by the state), employment related insurance for the organised sector employees, voluntary insurance for other categories who can afford to pay and ofcourse tax and related revenues. Further, payments of any kind at the point of provision of care must not exist as they usually are unfavourable to patients. Payments must be made to providers by a monopoly buyer/s of health services who can also command certain standard practices and maintain a minimum quality of care - payments could be made in a variety of ways such as capitation or fixed charges for a standard regimen of services, fee-for-service as per standardised rates, etc.. The move towards monopoly purchase of health services through insurance or other means and payment to providers through this single channel is a logical and growing global trend. To achieve universal access to health care and relative equity this is perhaps the only alternative available at present, but this of necessity implies the setting up of an organised system and for this the State has to play the lead role and involve the large private sector within this universal health care paradigm if it must be successful.

It is well documented today that public health expenditures have been declining rapidly, and especially so during the Eighth Plan which roughly coincides with the liberalisation phase. Medical care and capital expenditures are the worst affected and the declining trend in such expenditures can be seen right across states as is evident from Tables 1 and 2.

With these trends in health care spending the new thrust discussed above cannot be put into practice. The State must reverse these trends. The target for the Ninth Plan must be a minimum of quadrupling of spending at constant prices (reaching a level of about 2.5% of GDP). Capital expenditures and medical care expenditures, especially in rural areas, expenditure on drugs and medical equipment, expenditure on mobility (especially ambulances for referral care), expenditure on immunisation services, spending on maternity care and services, and expenditure on communicable diseases like tuberculosis, malaria etc.. must get

much larger shares of the health care budget. What would such increased spending mean? During the Ninth Plan period the ministries of health and family welfare must spend an average of Rs.350 billion per year (or Rs.350 per capita) on public health services of which 50% must be for rural health services. The Plan must contribute about half this expenditure, that is the Ninth Plan allocation must be around Rs.800-900 billion.

NEW STRATEGY FOR PUBLIC HEALTH SPENDING

As discussed above, certain fundamental changes in funding and expenditure strategies is called for. Some basic principles have to be laid down and strictly adhered to. These suggestions are based on experiences of various countries with near universal systems of health care delivery as also with varying approaches. A WHO technical report titled 'Evaluation of Recent Changes in the Financing of Health Services' done by an international team of experts (Tecnical Report Series, WHO 1993) is a good reference that shares various such experiences. Further, it must be emphasised that the suggestions given below and others need to be looked into carefully and a research exercise may have to be undertaken to operationalise them.

1> Basic or primary care, which includes OPD medical care, day care surgeries and treatment, immunisations, maternal services, basic diagnostics, opthalmic and dental services etc.., must be allocated 50% of the budget. The rationale for using such a proportion is experience from countries which have near universal health care systems. This budget should be distributed on global budgeting lines, that is, on a percapita basis. Thus every primary care unit, whether rural, urban or metropolitan, should get equitable allocations as per the population it supports (ofcourse special provisions for low density, and reduced ratios for very high density populations will be necessary). The net effect of this will be larger fund flows for primary care services, more resources for rural areas and less for urban and metropolitan areas (who also have municipal resources available). Canada is probably the best example of such use of budgetary allocations and there is no denying that it also has the most successful, effective and qualitatively most satisfactory health care system in the world.

2> Under primary care allocative efficiency must be assured by pegging the salary : non-salary expenditures at 50 : 50. This means much higher allocations for commodities such as drugs, equipment, fuel etc.. and hence most drastice changes will be needed at the primry health centre level where these ratios are most skewed in favour of salary expenditures. Special attention needs to be paid to drug costs. The market is full of unnecessary and useless drugs. A National Formulary must be evolved based on the basic drug list of the WHO and other such rational drug lists, as also a shift must be made to using only generic names. Such an exercise cuts a lot of wasteful and unnecessary expenditures.

3> Capital expenditure should be enhanced substantially and must not be less than 10% of the budget. During the Ninth Plan capital expenditures should be restricted for rural and other underserved areas to improve its infrastructure to accomodate comprehensive primary care. The Planning Commissions role here will be most crucial.

4> Changes must be made in the functioning of the hospital structure where a lot of resources get wasted because specialist time and resources are spent on primary care services in OPDs. The general OPDs must be separated out from the hospital and specialist services. In cities they must be decentralised into primary units and dispensaries closer to where the populations live so that hospitals are not over-burdened with crowds. The allocations for these must be as indicated in point 2 above. The hospital and specialist services must be strictly on

referral basis from the primary care units and the follow-up treatment (not requiring hospitalisation) must be referred back to the primary care unit.

5> For the Ninth Plan the target for health expenditure (excluding water supply and sanitation) should be 2.5% of the GDP and the Plan must contribute about half this amount. This means additional resources will have to be raised. Firstly, allocations from the revenue account itself needs to be raised substantially. Further, resources should be raised as discussed in an earlier section, that is from the organised sector, special health cesses and taxes on health degrading products etc.. ESIS needs to be strengthened by merging it with general health services and making it compulsory for all employees, including management cadre, all of who should contribute 2% of their salary and the employers 3%. This itself will help to double the existing health budget (presently under ESIS the workers funds are being misused grossly; collections from employers are not regular and in many states there is a vast backlog and even what is collected is not fully used to provide quality services to the beneficiaries as a large part of the money is invested in securities etc.. and ESIS accounts even show large surpluses). Also, as stated earlier compulsory public service by graduates passing out of public medical schools for atleast five years and with conditionalities of holding back the license to practice and admissions for postgraduate studies etc. will add to existing resources considerably and facilitate better planning.

6> The policy of implementing user-charges in many states must be reversed because it is highly detrimental to the poorer sections and restricts their access and use of public health facilities. Data from district and other hospitals in Maharashtra from 1985 to 1994 shows this very clearly (Performance Budgets of the Ministry of Health, Maharashtra). Those who have the capacity to pay should pay indirectly (insurance, taxes etc..) or at the point of public service as a donation.

7> Finally it is important to regulate the private health sector if use of resources in the economy have to be rationalised and made more cost-effective.

PROJECTIONS FOR THE NINTH FIVE-YEAR PLAN

While provisions for universal health care would demand more comprehensive planning, restructuring and reorganisation of the entire health care system, positive reforms of the existing public health care services are feasible with little effort, planning and macro policy decisions. With such reforms resources for a substantially improved public health care system, which provides quality care can be generated with relative ease. As stated above allocations of about 2.5% of the GDP would strengthen primary care making it available more or less universally. Ofcourse, the restructuring of the health care system into a public-private mix suggested in a preceding section has to also gradually evolve to make these reforms effective in a long-term perspective. The following projections are made in the context of the preceding discussion:

1997-98	Rs.250 billion
1998-99	Rs.280 billion
1999-00	Rs.330 billion
2000-01	Rs.400 billion
2001-02	Rs.500 billion
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	Rs.1, 760 billion

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For the Ninth Plan period the requirement for health and family welfare services (excluding water supply and sanitation) would be Rs.1, 760 billion and the Plan should contribute about Rs.800 billion of this if the suggested improvements must be put in place. While overall between 50-60% of the budget should be reserved for primary care services, nearly 80% of Plan funds will have to be devoted to strengthening the primary care sector. Further, 50% of the primary care budget should be for non-salary demands so that allocative efficiencies are maintained and the services are effective as well as of a reasonably good quality. At the secondary and tertiary levels the non-salary component will have to be between 60-70%.

The above discussion is supported by a number of researched papers annexed to this note and hence this note should not be seen in isolation.

TABLE 1 : SELECTED PUBLIC HEALTH EXPENDITURE RATIOS, ALL INDIA, 1981-1995

YEAR →	1980-81	1985-86	1991-92	1992-93	1993-94	1994-95
HEALTH EXPENDITURE AS % TO TOTAL GOVT. EXPEND.	3.29	3.29	3.11	2.71	2.71	2.63
EXPD. ON MEDICAL CARE AS% TO TOTAL HEALTH EXPD(THE)	43.30	37.82	26.78	27.66	27.46	25.75
EXPD. ON DISEASE PROGRAM (AS % TO THE)	12.96	11.69	10.59	10.84	10.41	9.51
EXPD.ON MEDICAL EDU.& RESEARCH (AS % THE)	9.07	8.67	10.19	10.99	10.92	7.69
EXPD. ON FAMILY PLANNING (AS % TO THE)	11.94	17.94	19.39	16.54	16.88	17.27
EXPD. ON MCH SERVICES (AS % TO THE)	0.51	0.50	2.03	1.80	1.95	1.52
EXPD. ON HEALTH ADMIN. (AS % TO THE)	4.91	4.73	4.49	4.47	4.50	4.20
CAPITAL EXPENDITURE ON HEALTH (AS % TO THE)	7.54	8.45	7.78	4.03	4.47	4.27
TOTAL HEALTH EXPENDITURE (Rs.BILLION) - ONLY REVENUE	11.89	27.15	52.01	62.04	71.83	78.67
-INCLUDING CAPITAL EXPD.	12.86	29.66	56.39	64.64	75.18	82.17

Source: CEHAT Database; Original Source: upto 1985-86, Combined Finance and Revenue Accounts, Comptroller and Auditor General of India, respective years, other years, Demand for Grants, respective states, various years. The definition of health expenditure includes only what the ministries of health spend and thus excludes water supply and sanitation, which is normally included in total health expenditures. Please note that all percentages are calculated against the revenue expenditure total except capital expenditure, which is derived from the total including capital expenditure.

TABLE 2: REVENUE EXPENDITURE ON HEALTH BY STATES 1985-1996
(as percentage of total government revenue expenditure)

YEAR →	1985-86	1991-92	1992-93	1993-94 RE	1994-95 BE
UNION GOVERNMENT	0.52	0.45	0.42	0.45	0.42
MAJOR STATES					
ANDHRA PRADESH	6.61	5.82	5.87	5.75	5.63
ASSAM	6.75	5.23	5.57	5.14	6.00
BIHAR	5.68	5.66	5.87	6.24	6.89
GUJARAT	7.51	5.42	4.79	5.09	5.21
HARYANA	7.00	4.19	4.56	3.60	2.90
JAMMU & KASHMIR	7.61	6.37	6.87	7.71	6.20
KARNATAKA	6.60	5.96	6.44	6.56	6.39
KERALA	7.85	6.92	6.29	7.13	7.44
MADHYA PRADESH	6.69	5.78	5.48	5.65	5.55
MAHARASHTRA	5.97	5.25	5.33	5.34	4.67
ORISSA	7.38	5.94	5.63	6.00	5.00
PUNJAB	7.24	4.32	5.78	5.32	5.33
RAJASTHAN	8.11	6.85	6.64	6.34	6.97
TAMIL NADU	7.70	6.72	5.73	6.64	6.59
UTTAR PRADESH	9.75	6.00	5.81	5.48	5.38
WEST BENGAL	8.92	7.31	7.55	7.15	6.58
OTHER STATES					
ARUNACHAL PRADESH	5.85	6.28	6.37	5.64	6.39
GOA, DAMAN & DIU	8.22	8.33	8.10	7.87	7.52
MIZORAM	6.80	5.21	5.10	4.97	4.99
PONDICHERRY	9.11	8.91	7.93	8.07	8.03
HIMACHAL PRADESH	7.89	7.24	7.73	8.08	8.19
MANIPUR	6.15	5.74	6.01	5.24	4.54
MEGHALAYA	9.20	6.73	7.19	7.51	7.33
NAGALAND	6.96	4.17	*	5.39	4.78
SIKKIM	4.83	6.01	6.81	6.10	6.78
TRIPURA	6.53	5.54	4.90	5.16	5.10
ALL INDIA	3.29	3.11	2.71	2.71	2.63

*Notes : * = Not available, RE = Revised Estimate; BE = Budget Estimate*
Source : CEHAT Database; Original Source : Same as Table 1