Health Care Financing: Conceptual Study of Health Care Financing in India

ROHIT MATHUR

The principal focus of this article is on critically evaluating the current status of the health care financing system - its organisational structure, financing mechanisms, etc. Such analysis has highlighted and reiterated several shortcomings in the country's health system which are well known and have been recognized for long. What was also emerged is that the solutions for many of the issues have been known for long, but routinely ignored and not acted upon. It was impossible not to conclude that if only timely attention to the large number of recommendations already available had been accorded, the health system need not have been so inefficient, insensitive, dysfunctional and in such a crises as we find it today. The main purpose has been to stimulate greater debate and research that would be useful for the policy formulation.

Introduction

Universal Coverage

For continuous economic and social development, promotion and protection of health is supreme. The same has been recognized by the Alma-Ata Declaration signatories, it was also acknowledged that good health for everyone contributes in better quality of life, security and global peace (WHO report 2010). As cited by WHO report 2010, in 2005 Member States of WHO committed to frame a financial system in which all people have access to health care services and do not face any financial adversity paying for them (WHO 2005).

This objective was defined as universal coverage or universal health coverage. For achieving this objective, governments all over the world face three essential questions. 1. What would be the mechanism for financing of such a health system? 2. How to save people from financial burden due to ill-health and financing of health services? 3. How to ensure full utilization of the resources available? The World Health Assembly resolution 58.33 from 2005 states that:-

Rohit Mathur is an Assistant Professor, Educosm Technical Campus, Jaipur, rm.educosm@gmail.com, rohit.9894@gmail.com, (O)+91(141)6542428 (M) +919549547779, www.educosm.org

1) Access to health services for everyone. 2) No financial hardship in accessing health services. And on both the fronts, the world is still very far from achieving the universal coverage (WHO report 2010).

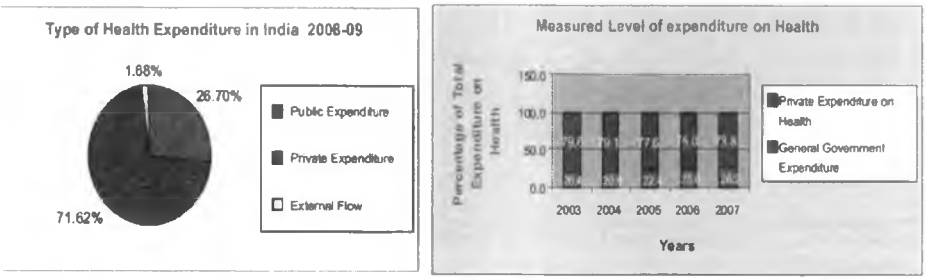
Health care financing

Health financing is by a number of sources: (i) Tax based Central Governments, State and local public sector and various other autonomous public sector bodies; (ii) the private sector as well as the not-for-profit sector, organising and financing, directly or through insurance, the health care of their employees and target populations; (iii) households by out-of-pocket expenditures, which includes user fees paid in public facilities; (iv) other insurance-social and community- based; and (v) external financing (through grants and loans) (Rao, Selvaraju, Nagpal, Sakthivel 2005).

Health care financing in India

As per WHO- 1) 65% of the Indian population lacks regular access to essential medicines. 2) The expenditure on health is the second most common cause for rural indebtedness. 3) Expenditure on health is responsible for 3% shift from APL to BPL every year. 4) Over 23% of the sick don't seek treatment because they do not have enough money to spend. 5) Expenditure on drugs constitute about 50-80% of the health care cost. 6) Over 40% of the hospitalized patients have to borrow money or sell their assets to get them treated. 7) A study by World Bank shows that as a result of single hospitalization 24% of people fall below poverty line in India.

Figure 1 & 2



As a percentage of total expenditure on health, Govt. share in expenditure on health is 25% and private expenditure is 75% in the year 2006 & 2007.

Figure 3. **Health Expenditure in India**

(Rs. in 000)

S.No.	Type of Expenditure	2005-06	2006-07	2007-08	2008-09
	1	2	3	4	5
1	Public Expenditure	344,461,727	405,788,591	480,852,110	586,813,788
2	Private Expenditure	1,150,005,214	1,378,805,733	1,426,902,392	1,573,935,382
3	External Flow	21,448,597	22,402,612	26,538,964	37,015,853
	Total Health Expenditure	1,515,915,533	1,707,596,936	1,940,293,466	2,197,765,023
4	Gross Domestic Product (Rs. 000)	35,803,440,000	41,458,100,000	47,234,000,000	53,217,530,000
5	Health Expenditure as share of GDP %	4.23	4.12	4.11	4.13
6	Public Expenditure as share of GDP %	0.96	0.98	1.02	1.10

Source: Table No 1.5 of National Health Accounts Report 2004-05 of MOHFW/GOI. (Latest)

Household Out-of-Pocket Expenditure on Health in India

Just like many other developing countries, India's household also spend unequal share of consumption expenditure on the health related services, with the Government's contribution being minimal. Household consumer expenditure data of various rounds of the National Sample Survey Organisation (NSSO) suggest that households spend about 5%-6% of their total consumption expenditure on health and nearly 11% of all non-food consumption expenditure. Since 1995-96, household expenditure on health has been growing at the present rate of approximately 14% overall. Indian households spent around Rs. 33,253 crores in 1995-96 at nominal prices which is then expected to have increased to Rs 72,759 crore in 2001-02. Household spending is probably to be around Rs. 100,000 crores in nominal terms with the growth rate of 14% in the year 2003-04. Except the category of childbirth/delivery, all other categories registered a current growth rate in double digits. The growth in inpatient expenditure has been the highest, in the range of 16%-18% during 1995-96 to 2003-04. In per capita terms, household expenditure measured in nominal prices has almost tripled from Rs 364 in 1995-96 to Rs 905 in 2003-04, while the real per capita household expenditure is expected to only marginally increase from Rs 265 to Rs 347, respectively (Rao, Selvaraju, Nagpal, Sakthivel 2005). It is disquieting to note that nearly 70% of the total health expenditure in India comes from households, while around 25% is financed by the Central, State and local Governments.

Figure 4

Household health expenditure by different source of care in India, 1995-96 to 2003-04

(Rs in crore)

Type of service	1995-96	2001-02	2003-04	Growth rate
Outpatient-rural	16,692.96	34,290.99	43,590.87	12.75
Outpatient-urban	7251.45	16,904.82	22,415.01	15.15
Inpatient-rural	3030.04	8536.86	12,057.25	18.84
Inpatient-urban	2092.90	5150.72	6954.10	16.19
Childbirth	1654.22	2258.14	2504.97	5.32
Antenatal care (ANC)	1053.90	2383.27	3128.22	14.57
Postnatal care (PNC)	390.85	1028.10	1419.21	17.49
Immunization	241.02	535.61	698.95	14.23
Contraceptives	207.14	422.74	536.22	12.62
Self-care	638.83	1247.47	1559.23	11.80
Total	33,253.31	72,758.71	94,457.19	13.94

Source: Estimated from the 52nd Round of the NSS, using 2001 Population Census and applying growth rates worked out from the 50th and 55th rounds of the NSS.

Trends in public spending on health in India

Public spending on health in India gradually accelerated from 0.22% in 1950-51 to 1.05% during the mid-1980s, and hover around 0.9% of the GDP during the later years (ie. spending by only Central and State health departments), of this, recurring expenditures, such as salaries and wages, drugs, consumables, etc. constitute for more than 90% and is growing in the recent years. In terms of per capita spending, it grows considerably from less than Re 1 in 1950-51 to about Rs 215 in 2003-04. However, in real terms, for 2003-2004 this is around Rs 120 (Rao, Selvaraju, Nagpal, Sakthivel 2005).

Figure 5. **Trends in Health Expenditure in India 1950-51 to 2003-04**

S. No.	Year	Health Expenditure as % of GDP			Per Capita Public Expen Health (Rs)
		Revenue	Capital	Total	
	1	2	3	4	5
1	1950-51	0.22	NA	0.22	0.61
2	1955-56	0.49	NA	0.49	1.36
3	1960-61	0.63	NA	0.63	2.48
4	1965-66	0.61	NA	0.61	3.47
5	1970-71	0.74	NA	0.74	6.32
6	1975-76	0.73	0.08	0.81	11.15
7	1980-81	0.82	0.09	0.91	19.47
8	1985-86	0.96	0.09	1.05	38.63
9	1990-91	0.89	0.06	0.96	84.83
10	1995-96	0.82	0.06	0.88	112.21
11	2000-01	0.86	0.04	0.9	184.56
12	2001-02	0.79	0.04	0.83	183.56
13	2002-03	0.82	0.04	0.86	202.22
14	2003-04	0.86	0.06	0.91	214.62

Note:
* GDP is at market price, with base year 1993-94

Sources: Report on Currency & Finance, RBI, Various Issues; Statistical Abstract of India, Government of India, various issues; Handbook of Statistics of India, RBI, various issues quoted in Financing and Delivery of Health care services in India, NCMH, 2005 (latest)

Health Expenditure by the Central Government:-

The Union Ministry of Health and Family Welfare consists of three departments. The department-wise break-up of the Health Ministry's budget suggests that over one-third of the budget is spent by the Department of Health, while roughly two-thirds goes to the Department of Family Welfare. The Indian Systems of Medicine and Homeopathy (ISM&H) (AYUSH) Department receives a paltry 2%-3% of the total budget of the Ministry.

CGHS - a mandatory social health insurance scheme for the Central Government Employees:-

Six per cent of the combined budget of the department or 18% of the budget of the Department of Health was spent on 44 lakh beneficiaries or 0.5% of the country's population under the Central Government Health Scheme (CGHS).

Low priority for preventive health care:-

An important public health function that governments are expected to perform is expanding access to public goods by focusing on the preventive and promotive education. Under the NHP, the amount spent on preventive care aimed at

prevention and behaviour change during the financial year is an estimated 21%. Out of this a large amount was for vaccines under the universal immunization programme (UIP). In terms of the use of mass media and interpersonal communication, the expenditure under this head in the National Programmes is a mere 2% of the overall budget.

Centrally sponsored schemes-National Health Programmes (1991-2003):-

Of the total combined central budget, 70% is spent on the National Health Programmes related to the disease control programmes and family welfare (Rao, Selvaraju, Nagpal, Sakthivel 2005).

Health expenditure by State Governments:-

General tax and non tax revenue is the source for financing public health at the State level, as cost recovery is less than 2% from the services delivered. (Selvaraju 2001). As a result, resource allocation to this sector is subjective to the general fiscal condition of the State Governments.

Structure of health sector spending:-

Analysis of the structure of spending on health by State Governments shows that spending on salaries and wages account for more than 70% of health budgets. Of the remaining budget, nearly 12% is allocated for drugs, medicines, supplies and consumables; purchase of machinery and equipment account for 8%, and nearly 5% is allocated for maintenance of equipments, buildings, electricity, rent, taxes, etc. The remaining 5% is spent on other routine expenditures. (Rao, Selvaraju, Nagpal, Sakthivel 2005).

Figure 6. **Scheme-wise plan outlay and actual expenditure for Health during 11th plan (2007-2012)**

Figure 7. **Scheme-wise plan outlay & expenditure for National Rural Health Mission (NRHM) during 11th plan (2007-2012)**

Health Insurance in India:

The penetration of health insurance in India has been low. It is estimated that only about 3% to 5% of Indians are covered under any form of health insurance. The size of the commercial insurance is barely 1% of the total health spending in the nation. The health insurance in India is a blend of mandatory social health insurance (SHI), voluntary private health insurance and community- based health insurance (CBHI).

Social Health Insurance: -

The SHI is based on income-determined contributions from mandatory membership of, in principle, the entire population with the government subsidizing the financially vulnerable sections. While the SHI is an effective risk-pooling mechanism that allocates services according to the need and distributes the financial burden according to the ability to pay (thereby ensuring equity in access), In India such schemes are difficult and expensive to implement where a majority of the workforce is unemployed or employed in the informal sector.

The existing mandatory health insurance schemes in India are as follows:-

Employees' State Insurance Scheme (ESIS) - ESIS, started in 1948 is for employees of the factory using power, where total number of employees is 10 or more, and no power using factories and other specified establishments employing 20 persons or more.

Central Government Health Scheme:-

This scheme started in 1954, it is for the central government employees & retirees, and some autonomous, semiautonomous and semi-government organisations. (Rao 2005).

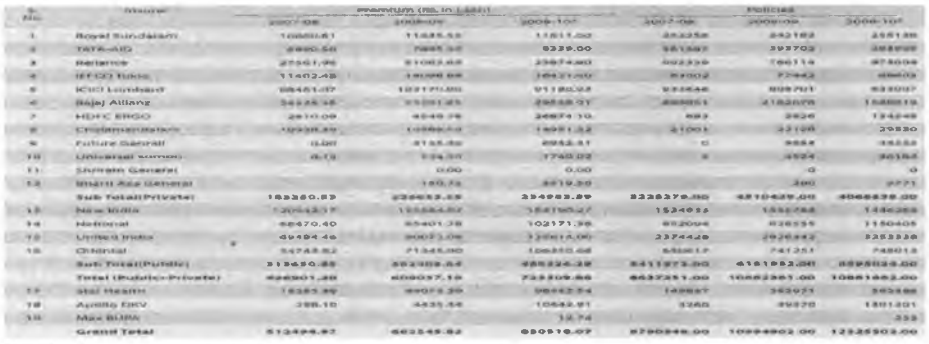
Figure 8: **Mandatory Social Insurance Schemes**

Types of beneficiaries	Factory sector employees (and dependants) with income less than Rs 7500 per month	Employees (and dependants) of Central Government-current and retired, some autonomous and semi-government organizations, Members of Parliament judges, freedom fighters, journalists
Coverage	About 353 lakh beneficiaries in 1998	About lakh beneficiaries in 1998
Types of benefits	Medical and other health-related provided through ESIS facilities and partnerships	Medical care through public facilities and restricted private care
Premiums (financing of scheme)	4.75% of employees' wages by employers; 1.75% of their wages by employees; 12.5% of the total expenses by the State Governments	Varies from Rs 15 to Rs 150 per month based on salaries of the employeesMainly financed by the Central Government funds
Provider payments	Mainly salaries for physicians in dispensaries and referral hospitals. Hospitals have global budget financed by ESIC through State Governments.	Salaries for doctors. Treatment in private hospitals is reimbursed on case basis, subject to actual expenditure and prescribed ceilings
Administrative costs	About 21% of the revenue expenditure. For paying wages for corporation employees, and administering cash benefits, revenue recovery and implementation in new area.	Direct administrative costs including travel expenditure, office expenses. RRT 5% of the total expenditure. Part of salaries can also be charged to administrative costs.
Status of finances	Contributions more than 80% of the ESIS income double the expenditure on benefits.	Contributions about 15% of the CGHS income half of the salary expenditures.

Private Health Insurance

Five features that characterize the health insurance system in India emerge: 1. By and large, the system offers traditional indemnity, all known diseases or health conditions are excluded and therefore such policies typically have a large number of exclusions. 2. It is a fee-for-service-based payment system. Such a system of payment is advantageous for the provider since he bears no risk for the prices he can charge for services rendered by him. Combined with the asymmetry in information, such a system usually entails increased costs. 3. Policies provide a ceiling of the assured sum. Such a system, and that too within a fee-for-service payment system, results in short changing the insured as he gets less value for money, as the provider and the insurer have no obligations to provide quality care and/or over provide/over charge services so long as the amounts are within the assured amount of the insurance policy. 4. The system is based on the risk-rated premiums. This again puts the risk on the insured as the premium is fixed in accordance with the health status and age. Under such a system, women in the reproductive age group, the old, the poor and the ill get to pay higher amounts and are discriminated against. 5. The system is voluntary, making it difficult to form viable risk pools for keeping premiums low.

Figure 9. **Coverage under Health Insurance in India 2007-08 to 2009-10**



Universal Health Insurance Scheme (UHIS)

For providing protection against the financial risk to the poor, the Government announced a UHIS in 2003. The scheme was redesigned in May 2004 with higher subsidy and restricting eligibility to BPL families only. The subsidy was increased to Rs 200, Rs 300 and Rs 400 to individuals, families of five and seven, respectively. In the last two years of its implementation, the coverage has been around 10,000 BPL families in the first year and 34,000 in the second year till 31 January 2005. There are various reasons because of which the scheme failed to attract the rural poor:- 1) The public sector companies, who were entrusted to execute this scheme discovered it is not profitable, hence they do not publicize it, resulting in very low levels of awareness, reflected in the low enrolment and very poor claim ratios. 2) A major problem has been the identification of the eligible families. 3) The procedures are cumbersome and difficult for the poor. 4) In most places there is a deficit in the supply or availability of service providers, particularly because government hospitals are not eligible.

Community-Based Health Insurance

In community financing, the community is in control of the principal functions of collection and utilization, the membership of the scheme is voluntary and there is willingness to prepay the contributions (Hsaio 2001). Currently, there are about 22 voluntary CBHI programmes in India, initiated and administered by NGOs. Of these about 10 are active. In many schemes, the community is also involved in various activities such as creating awareness, collecting premiums, processing claims and reimbursements, and the management of the scheme (deciding the benefit package, the premiums, etc). The membership of these CHIs scheme varies from 1000 to more than 20 lakh. Most of the schemes operate in rural areas and cover people from the informal sector.

The annual premium ranges from Rs 20 to Rs 120 per individual. The unit of enrolment is an individual and the membership is voluntary in most of the schemes. All the schemes offer hospitalization; this ranges from the classical Mediclaim product to a very comprehensive cover including all conditions and no exclusions. (Rao 2005)

Issues of Concern:-

1) Financing of National Programmes-not as per need:-Analysis showed that in a number of instances budget allocations are not as per need and in consonance with the extent of the disease burden. For example, UP and MP together accounted for 37% of the total caseload under child morbidity but received only 24% of the total budget for RCH.
2) Gross underfunding of National Health Programmes: A mismatch between policy and practice:-Policy governing the National Health Programmes is that services being provided under them are free for all. Theoretically, therefore, regardless of income class, all citizens of the country are eligible for availing of services free of cost under the NHP that cover vector-borne diseases, TB, leprosy, Family Welfare, cataract blindness and HIV/AIDS. The huge out-of-pocket expenditures being incurred by individual households in seeking services 'guaranteed' to them under the NHP is due to huge underfunding of the programme.
3) Weak absorption capacity in the Government:-Even while there is mounting evidence to justify a quantum jump in public budgets for health, the Central Ministry routinely surrenders budgets allocated to it. Under World Bank projects also, there have been frequent expressions of concern at the slow pace of expenditure and poor withdrawals. There is shortage of funds and at the same time inability to spend that fund, what is the reason for such an anomaly? The reasons for the slow pace of expenditure can be at the systematic & institutional levels and at the same time bad designing and sequencing of expenditure items.

Lack of stability in budgetary processes:-

State Governments normally pass the budget between April and June every year. Several times during bad fiscal situation, budget authorizations are released but instructions are issued informally to treasury officers not to release money, disrupting ongoing activities and processes, such as finalizing a contract for procurement of drugs or equipment. The department does not only lose the 'unutilized' funds at the end of the fiscal year but these are also shown as 'surrender of funds' and the next year's allocations accordingly pegged onto the funds 'actually spent'. Secondly, expenditure items are also fixed and no discretion is given at any level to reallocate available funds

for meeting a need or an emergency. Thirdly, utilization of funds also does not take place as the first instalment could be inadequate for any meaningful activity necessitating the release of subsequent instalments. Finally, in the month of December, the expenditure levels are reviewed and revised estimates for the department fixed. At times of acute fiscal stress, budget cuts are arbitrarily imposed across the departments.

Dysfunctional system of financing:-

The budget process so developed over decades has resulted in fragmentation of the health sector budget into more than 4000 small heads. The funds allocated under those numerous budget heads are non-transferable and are surrendered to the State's general pool of funds if they remain unutilized at the end of the fiscal year. This is strictly followed to ensure that the funds budgeted for specific activities at the beginning of the year should be spent on those activities to fulfil the intended objective. The system, from the perspective of achieving health system goals, is archaic and needs to be changed.

Complex design: -

Complex design of the scheme is also a big factor behind non utilization of funds. Systems that involve participation from all stakeholders do provide, in the long run, greater sustainability to the programme. However, such approaches are time-intensive as different constituents of stakeholders have different and varied ideas, expectations and needs. Therefore, when any activity has to be implemented within a strict time-frame, then such processes get short-circuited and data are fudged or money not spent.

Weak financial capability:-

At almost every level-central, State or district, administrative directorates or hospital units-the staff dedicated for financial oversight functions are few and their capacity weak. In most cases, the staffs consist of one or two officers and a few clerks. Several times their knowledge of financial rules is superficial. Weak systems give room for discretion and scope for fraud and, more importantly, for delays due largely to raising meaningless and frivolous queries. This therefore calls for greater professionalism of the finance set-up and sharing of responsibility, making them equally responsible for poor expenditure. There is a need to change their mindset that we are here on a mission to achieve pre-defined goals and not mere for accounting. (Rao, Selvaraju, Nagpal, Sakthivel 2005).

CONCLUSION

Health sector in India suffers from gross insufficiency of public finance and therefore an urgent and significant scaling- up of resources is very crucial.

The undue burden on households for spending on health cannot be wished away. Further, it is also clear that budgeting system needs an overhaul to make it more functional, amenable to review of resource use to take corrective measures in time and be flexible enough to have the capacity to respond to an emergency or local need. Appointment of persons, labour laws, procurement systems all need a thorough review. Greater decentralization of funds, aligned with functional needs and responsibilities, is necessary. However, any decentralization and financial delegation needs to be carefully calibrated and sequenced. Unless such restructuring takes place, greater absorption of funds will continue be difficult. The present system of financing and payment systems raise several important concerns on the suitability of the structure to meet current day problems and future challenges. The large size of out of pocket expenditures provides an opportunity to pool these resources and facilitate spreading risk from households to government and employers on a shared basis which will be a more equitable financial arrangement. The dimension of equity is of particular concern as the in elasticity of demand for acute care, is resulting in over 33 lakh persons being pushed below poverty line, every year. In short the social benefits of instituting social insurance as a financial instrument to replace user fees, outweighs the possible risks of moral hazard and increased costs, typical outcomes of prepaid insurance. How to minimize these two market failures are of concern and need to be addressed by developing a well thought out strategy taking international evidence into account so that we build on existing knowledge and learn from others' experiences. In conclusion it is reiterated that given the fiscal constraints for government to provide universal access to free health care, insurance can be an important means of mobilizing resources, providing risk protection and achieving improved health outcomes. The critical need is to experiment with the wide range of financing instruments available in different scenarios and have adequate flexibility in the design features, the structures and processes, institutional mechanisms and regulatory frameworks, so that a viable balance can be achieved for minimizing market distortions so that the outcomes do not make the cure worse than the disease (Enthoven 1983, 1993). Unregulated markets are inefficient and inequitable, requiring governments to intervene to ensure no segmentation in the system (Bloom, 2001). For this, the burden of building partnerships and managing change is on the government, which in turn needs to base its strategy on sound research.

REFERENCES

1. Bloom Gerald, Equity in Health in Unequal Societies: Meeting Health Needs in contexts of Social Change, Health Policy, 2001.
2. Central bureau of health intelligence Director General of Health Services Ministry of Health & Family welfare.2010. 'National Health profile' .http://cbhidghs.nic.in/writereaddata/mainlinkFile/File1134.pdf as accessed on 30.01.2013
3. Enthoven A Managed Competition in Health Care and the Unfinished Agenda, Health Care Financing Review, 1986.
4. Enthoven A. Managed Competition of Alternative Delivery Systems, Journal Of Health Politics, Policy & Law, 1988.
5. Enthoven A. The History and Principles of Managed Competition, Health Affairs, 1993.
6. Hsaio W. Unmet health needs of 2 billion: Is community financing a solution. Working Paper for CMH, 2001.
7. Rao, KS. 2005. "Health Insurance in India", 275-293.
8. Rao,KS. Selvaraju,S. Nagpal,S. Sakthivel,S. 2005. 'Financing of Health in India', 239-254.
9. Selvaraju V. Budgetary subsidies to health sector among selected States in India. Journal of Health Management 2001;3.
10. World Bank. World Development Report 2004: Making services work for poor people. World Bank; 2003:256-7.
11. World Health Organisation.(2010). 'Health System Financing - the path to Universal Coverage'. The World Health Report, ISBN 978 92 4 068480 5.
12. World Health Organisation, (2008) "Closing the gap in a generation – health equity through action on the social determinants of health". Geneva.