



ACHIEVING HEALTHCARE FOR ALL

The stakes of the current debate around Universal Health Coverage in India are high.¹ The coming months will decide whether the government takes a proactive role in ensuring access to healthcare for all, or whether the status quo will prevail. The debate has polarised positions on a number of fundamental questions. How should healthcare be funded? What should be the role of public and private providers? How should the latter be regulated? The choices made, could determine whether healthcare becomes a reality for all, or whether a majority of citizens will continue to pay an unbearable price for poor quality services.

Summary

All citizens should be provided “affordable, accountable and appropriate health services of assured quality [...], with the government being the guarantor and enabler of such services”.² More specifically, it should ensure access to a package of essential health services that covers high-impact, cost-effective treatments for major diseases.³

Since the idea of UHC has gained momentum among decision makers, the positions of influential stakeholders have clashed on its implementation. Should the government be the primary provider of care, or should its role be limited to managing private providers? Will the country move towards a tax-funded system of delivery or an insurance model? The Planning Commission and the High Level Expert Group it set up, the Ministry of Health and Family Welfare, private lobbies and civil society groups have taken divergent positions on these policy orientations. The choices made in the coming months could determine whether the promise of achieving quality healthcare for all will materialise.

India’s health indicators show what is at stake. Life expectancy, at 65 years, is lower than in neighbouring Sri Lanka, at 75, Bangladesh and Nepal at 69,⁴ and further away from countries with similar economic development. Health indicators among lower socio-economic groups are distressing: the life expectancy of Scheduled Tribes who fall under the poverty line is eight years less than the national average, and has decreased slightly over the past 20 years.⁵ Under-five and maternal mortality, at 50 per 1,000 and 212 per 100,000 live births, remains high compared to other countries,⁶ and the gap between the poorest 20 per cent and the richest is stark, with infant mortality rates more than twice as high for the former.

These indicators point at major weaknesses in India’s health policy. The public system carries the symptoms of its neglect: health infrastructure is decaying; shortage of staff is severe; drugs are rarely available. Poorly regulated private providers have spread in this vacuum, and sell services of often dubious quality at prices that are unaffordable for the poor. This scenario plays into patterns of exclusion: groups that are left behind by the country’s economic development are not only in poorer health condition, health hazards are also a major cause of vulnerability for them.

All stakeholders involved in the current debate agree that a change of policy is needed. Over recent years, the

government initiated a number of schemes aimed at strengthening its ailing public health system – the National Rural Health Mission and the recently approved National Urban Health Mission, as well as subsidised insurance schemes and cash incentives for the poor. While these programmes are part of a positive momentum, they fall short of providing the unified framework required. The Planning Commission took up the issue by creating a High Level Expert Group on UHC. The group’s report proposes a number of far-reaching reforms: it emphasises the central role of public providers, and recommends strengthening the public health system accordingly; it calls for tax-based government funding; recommends abolishing user fees; and suggests defining a national health package covering all basic health requirements.

The policy orientation since taken by the government contrasts with these recommendations. Its model emphasises partnerships with private providers, with targeted interventions aimed at improving access for the poor. It does not abolish user fees. Public spending on health, which stood at 1 per cent of GDP in 2010-2011,⁷ sets the government on track to fail its financial commitment one more time – it is below the 2 per cent pledged in the 11th Five Year Plan and further away from the 2.5 target for the 12th Five Year Plan. This falls very short of the share needed for any meaningful improvement of the country’s neglected public health system.

As the country’s health policy is being debated, Oxfam India wishes to stress three principles of inclusive health coverage, which find strong empirical backing from existing health scenarios in India and worldwide. Only by placing those at the heart of a coherent system will the promise of access to healthcare become a reality for all.

Recommendations

1. The government should be the primary provider of essential healthcare.
2. Public tax-based funding should cover all essential health expenditure.
3. The social accountability of health providers should be strengthened by placing patients’ rights at the heart of comprehensive regulations, associated with systems of monitoring and grievance redress.

1. The government should be the primary provider of essential healthcare.

The pitiful situation of India's public health system is a ready-made argument for defenders of public-private partnerships: they claim that the success of private providers, who account for 82 per cent of patient care,⁸ proves the failure of the public health system; only by drawing on the strength of the private sector will the government solve the country's health problem effectively. However, there are at least three powerful arguments against this claim.

First, private hospitals have focused on geographic areas and types of treatments that yield high profit. Investments in health infrastructure have focused on urban areas. Primary healthcare has been neglected; instead investments have gone to more costly secondary and tertiary care. Two figures summarise the trend: between 1986 and 2006, the estimated ratio of government doctors to population in rural areas has fallen from 0.6 for every 10,000 people to 0.3, against 23 for every 10,000 people recommended by the WHO;⁹ with 0.2 hospital beds per 1,000 people, against 2.5 recommended by the WHO, physical access to hospitals and doctors has become a major obstacle in rural India.¹⁰

Second, public health policies work when they are applied systematically at very large scale.¹¹ For instance, a vaccination programme should cover a majority of the population to be successful, and the same will eventually hold for numerous other communicable diseases such as malaria and tuberculosis. Fragmenting healthcare services across a number of private practitioners therefore risks reducing overall health outcomes.

Third, relying on the private sector in a context where the government lacks the capacity or will to regulate it raises obvious issues of accountability, as is exemplified by the range of malpractices mentioned in the next section.

By highlighting the limitations of private coverage, the three arguments above make a clear case for prioritising the development of public health infrastructure and staff. The focus of financial engagements and policy attention should be directed accordingly. More pragmatically, given available resources and healthcare needs, the government should focus on providing a core set of quality preventive, curative and rehabilitative services that cover common diseases and high-impact, cost-effective interventions.¹²

Procurement too requires special attention. Buying drugs is a major burden for poor patients since medicines for free are rarely available.¹³ Publicly provided drugs are scarce to start with, and widespread embezzled by service providers further exacerbates the problem. This

calls for a focused intervention. The government should outline a basic package of health services falling under UHC, and design a procurement policy to curb the costs of the package: prices should be controlled; the use of generic drugs made mandatory; and the government's international stance defend the country's generic drug producing industry.

2. Public tax-based funding should cover all essential health expenditure.

At 1 per cent of GDP, India's public spending on health is one of the lowest worldwide, comparable only to a few lower income countries in Sub Saharan Africa, as well as Afghanistan, Haiti, Azerbaijan and Georgia.¹⁴ In contrast, the WHO estimates the average costs of providing essential healthcare in lower-middle income countries at around 6 per cent of GDP.¹⁵ Private funds complete the country's total expenditure on health, at 4.5 per cent of GDP. Direct payments during treatment constitute more than 70 per cent of expenditure, nearly 80 per cent of which are for outpatient treatments, notably on drugs.¹⁶

The consequences on individual lives are dramatic. The percentage of India's population falling below the poverty line because of health expenditure has been increasing steadily in recent years. The latest estimate, which dates back to 2005, is at 6.2 per cent per year.¹⁷ More than 40 per cent of the population has to borrow or sell assets for treatments, according to the 2004 National Sample Survey Organisation. Recent research shows a disturbing link between farmer suicides and incidence of chronic illness in the family: nearly one in two farmers who committed suicide had seen cases of serious illness within the family.¹⁸

The estimated costs of UHC range between 4 and 6 per cent of GDP.¹⁹ Though considerable, this financial commitment is achievable: India's public spending on health is not only one of the lowest worldwide, the country's total tax-GDP ratio, at 15.5 per cent, is also the second lowest among G20 countries, just after Mexico.²⁰ In contrast, the average ration for OECD countries is at 33.8 per cent.²¹ Revenue foregone, due to exemptions on direct and indirect tax, account for an estimated 6 per cent of GDP – ²² enough to cover the costs of UHC.

Alternative measures of health financing, such as user fees, need to be assessed critically based on the country's social reality. User fees are presented as an innovative mechanism to generate autonomous revenue for public service providers, reduce frivolous demand, and subsidise poor people. However, the reality is more sobering. Most patients who visit public health facilities are poor. This significantly reduces the financial interest of the measure. In a context where accountability remains a major issue, targeted

exemptions of the poor pave the way to corruption and discrimination. Other below poverty line schemes show that the government does not have the institutional capacity to keep abuses in check. These observations make a strong case for abolishing user fees.

Evidence also warns against a model that primarily relies on insurances. Private providers risk inflating costs, by favouring expensive treatments or claiming reimbursement for fictive treatments. The popularity of the Rashtriya Swasthya Bima Yojana for example, a subsidised health insurance for the poor, should not cover the fact that abuses have spread with the scheme.²³ The high percentage of out-of-pocket expenditure for out-patient care also means that insurance covering hospital expenditure cannot replace a system that delivers free basic health services across the country. In the short term, an insurance based model may be easier to implement, but the long term advantages of an accountable, functioning system of public delivery should rule against this quick-fix.

Despite these limitations, government-managed social insurances for the poor have a role to play in the shift towards UHC. Strengthening the public health system will take time and the struggle to spur political will at central and state level has a long way to go: social insurances will help accompany the transition and ensure that the poor access healthcare without delay. The final aim, however, should remain a tax-based publicly provided UHC, and social insurances be integrated with this system.

The increasing emphasis on cash incentives and cash transfers is another problematic trend. The experience of the Janani Suraksha Yojana, which provides cash to all women who give birth in health facilities, shows the ambivalence of such schemes: while delivery in health facilities has increased, positive impacts on pre- and ante-natal mortality rates are harder to establish.²⁴ At the same time, cases of malpractice associated with the scheme are widespread. In a context where accountability is weak, cash incentives and transfers need to be used cautiously. More insidiously, they risk moving attention away from the more meaningful task of strengthening public delivery across the country.

3. The social accountability of health providers should be strengthened by placing patients' rights at the heart of comprehensive regulations, associated with systems of monitoring and grievance redress.

India's health system is notoriously unaccountable. Excessive and irrational use of medication is widespread. The ratio of hospitals with at least one

qualified practitioner is less than one in two.²⁵ In rural areas, where the scarcity of medical staff is particularly severe, unqualified practitioners provide an overwhelming majority of services.

Regulation of the private sector is de facto inexistent: 16 out of 29 states do not have laws that make it mandatory for private clinics to register with authorities.²⁶ Resistance against the central Clinical Establishment Act 2010 or state-wise nursing homes regulations have been such that these laws have not been ratified in many states and are rarely applied even where they are ratified. Despite various public subventions, through tax deduction, transfers of funds, and attribution of heavily subsidised land, private hospitals rarely respect their obligations towards society – mandatory quotas of free beds for poor patients, for example, are commonly violated.²⁷ Public providers themselves lack accountability: doctor absenteeism, embezzlement of drugs, undue charges and discrimination against certain social groups are not exceptional practices.

Collusions of interest amongst health providers, drug producers and sellers are another source of widespread malpractices: hospitals – both private and public – tend to favour expensive patented drugs, despite guidelines by the Ministry of Health and Family Welfare prescribing the use of generic drugs in government hospitals.²⁸ This shift towards patented drugs comes at a time when numerous generic producing companies have merged with multinational corporations focusing on patented drugs. Private providers of services and drugs have become powerful lobbies. Their impact on policy decisions is also visible in economic policies that are progressively undermining India's generic drug industry. These different factors have resulted in a dramatic increase of prices.

The sensitivity of the sector and the unavoidable information asymmetry between patient and practitioner require a carefully designed set of measures. Regulations should be strengthened: clear guidelines should define standards of quality and rationality for government and private providers, as well as costs of treatments for the latter; existing laws, such as the Clinical Regulation Act, need to be implemented without delay.

Patients' rights should be at the heart of reliable mechanisms of accountability. Grievance redress procedures should be structured around such rights, rather than relying merely on consumers' rights. Community audits and monitoring have proven to be efficient tools to improve the quality and perception of services among patients:²⁹ they should be made an integral part of the effort to develop a health system that provides quality services for all.

Notes

1. The focus of this brief is on healthcare, in response to current policy debates. However, Oxfam India recognizes the crucial importance of adopting a holistic approach to health coverage, addressing factors such as nutrition and sanitation, and broader social determinants of health.
2. (HLEG) High Level Expert Group (2011), "Report on Universal Health Coverage for India", Government of India, Delhi, p. 8. Available at: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf, last accessed October 2012.
3. Ibid, p. 16.
4. World Bank Indicators, life expectancy at birth, available at: <http://data.worldbank.org/indicator/SP.DYN.LE00.IN>, accessed October 2012.
5. S.K. Mohanty, S. Ram (2010), "Life Expectancy at Birth Among Social and Economic Groups in India", Mumbai: International Institute for Population Science. Available at: <http://www.iipsindia.org/pdf/RB-13%20file%20for%20uploading.pdf>, accessed October 2012.
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7. CBGA (2012), "Response to the Union Budget", Delhi: Centre for Budget and Governance Accountability, p. 29. Available at: http://www.cbgaindia.org/publications_responses_to_union_budgets.php, accessed October 2012.
8. A. Marriott (2009), "Blind Optimism", Oxford: Oxfam International, p. 3. Available at: <http://www.oxfam.org/sites/www.oxfam.org/files/bp125-blind-optimism-0902.pdf>, accessed October 2012.
9. Based on data from the Government of India's Central Bureau of Health Intelligence; cited in: Meeta, Rajivlochan (2010), "Inequalities in Health, Agrarian Distress, and a Policy Avoidance", op., cit., p. 41. WHO (2012), "Measuring Service Availability and Readiness", Geneva: World Health Organisation. Available at: http://www.who.int/healthinfo/systems/SARA_ServiceAvailabilityIndicators.pdf, accessed October 2012.
10. K. Yadav, P. Jarhyan, V. Gupta, C. S. Pandav (2009), "Revitalizing Rural Healthcare Delivery: Can Rural Health Practitioners be the Answer?" *Indian Journal of Community Medicine* 34(1), pp. 3-5.
11. For this argument see: J. Sachs (2012), "Achieving Universal Health Coverage in Low-Income Settings", *The Lancet* (380), pp. 944-7.
12. This is in line with the National Health Package recommended by the High Level Expert Group. HLEG (2011), "Report on Universal Health Coverage for India", op. cit. p. 16.
13. Drugs account for 74 percent of private out of pocket expenditure. HLEG (2011), "Report on Universal Health Coverage for India", op. cit. p. 28.
14. World Bank data: public health expenditure. Available at: <http://data.worldbank.org/indicator/SH.XPD.PUBL/countries>, accessed October 2012.
15. D.B. Evans, R. Elovainio, G. Humphreys (2010), "Health System Financing, The Path to Universal Coverage", Geneva: World Health Organisation, p. xv. Available at: <http://www.who.int/whr/2010/en/index.html>, accessed October 2012.
16. Ibid.
17. P. Berman, R. Ahuja, L. Bhandari (2010), "The Impoverishing Effect of Healthcare Payments in India: New Evidence and Methodology", *Economic & Political Weekly* (XLV:16), pp. 65-71.
18. Meeta, Rajivlochan (2010), "Inequalities in Health, Agrarian Distress, and a Policy Avoidance", *Economic & Political Weekly* (XLVI: 43), pp. 41-47.
19. International averages for countries providing basic care range between 5 and 6 percent of the GDP. A study by Ernst and Young supported by the Federation of Indian Chambers of Commerce and Industry (FICCI) proposes a figure ranging between 3.5 to 4.5 percent GDP, but acknowledges that such public investment will reduce out of pocket expenditure by only 20-30 percent. D.B. Evans, R. Elovainio, G. Humphreys (2010), "Health System Financing, The Path to Universal Coverage", Geneva: World Health Organisation, op., cit., p. xv. Ernst and Young (2012), "Health Cover for India: Demystifying Financing Needs", New Delhi: FICCI.
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22. Based on data: Government of India (2012), "Budget 2012-2013, Statement of Revenue Foregone", Delhi: Ministry of Finance. Available at: <http://indiabudget.nic.in/ub2012-13/statrevfor/annex12.pdf>, accessed October 2012.
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25. In rural Rajasthan, about 40 percent of private providers did not have a medical degree, and almost 20 percent had not completed secondary school education. A. Banerjee, A. Deaton, E. Dufo (2003), "Healthcare delivery in rural Rajasthan", *Economic & Political Weekly* (39): pp. 944-49.
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29. A. Shukla, D. Kakade, K. Scott (2011), "Community Monitoring of Rural Health Services in Maharashtra", *Economic & Political Weekly* XLVI(30), pp 78-85.

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