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HEALTH FINANCING IN INDIA: CHALLENGES AND OPPORTUNITIES

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Abstract: *India's healthcare financing system is a cause of and an exacerbating factor in the challenges of the health inequity, inadequate availability and reach, unequal access and poor quality and costly health care services. Low per capita on health and insufficient public expenditure results in very high private out-of-pocket expenditure. Citizens receive low value for money in the public and private sectors. Financial protection against medical expenditure is negligible. Large inefficiency in public and private sectors and unregulated private sector reduce efficiency, effectiveness and accountability of health expenditure. The government of India has made a commitment in recently released National Health Policy, 2017 to increase public health care spending from 1.15 percent of the GDP in 2014 to 2.5 percent of the GDP in 2025, whereas, it could only increase public health spending from 0.9 percent to 1.15 percent from 2004-05 to 2013-14, which appears to be a herculean task. Health in India is a state subject and its implementation lies with subnational. The National Health Policy 2017 has also assured to increase state sector health spending to more than 8 percent of their budget by 2020 and decrease in proportion of households facing catastrophic health expenditure from the current level of 64 percent to 48 percent (25 percent) by 2025. In addition to increase in public spending on health which would mean reprioritization which may further mean curtailment of funds in other social sectors which are already in constraints of resources in India, the government of India needs to review its taxes and subsidies not only to generate additional resources but to promote health. The paper deals with the weaknesses of health care financing in India, out of pocket expenditure vis-à-vis other countries and its addresal, need to increase government spending on health care and innovative means of generating resources to address the unfinished agenda of MDGs carried forwarded to be achieved during the era of SDG since India is undergoing a demographic, epidemiological and nutritional transition.*

Keywords: Health, Financing System, Health Priorities, Diseases

Introduction

Improving health care and increasing the number of people who are healthy is the development goal of any country. In case of fast developing economies, like India external aid is drastically getting reduced and there is a little capacity to increase per capita spending on health as India has limited capacity to raise tax revenue. The health priorities are changing as maternal and child mortality have rapidly declined but there is growing burden of non-communicable diseases and some infectious diseases. Due to rising economic growth which enables to enhance physical capacity; India is experiencing an emergence of robust health care industry estimated to be growing a double digit but is also facing growing incidences of catastrophic due to healthcare cost which are presently estimated to be one of the major contributor to poverty. Healthcare spending in India for 2014 is about 4.7 percent of its GDP, which is 75 USD per capita[1]. Of this Government Health Expenditure (GHE) is 30 percent and a majority, more than 60 percent of healthcare expenditure is household out of pocket expenditure (OOPE). Prepayments towards risk pooling arrangements or health insurance are very low. Household premiums to private health insurance are 3 percent of Total Health Expenditure and Social health insurance expenditures[2] (which are included under government health expenditures) are about 6 percent. The National Health Accounts, 2013-14 reports that Government Health Expenditure is 3.8 percent of the general government

[1]Health financing indicators for select countries 2014; Global Health Expenditure Data Base (GHED), World Health Organization
[2]Social Health Insurance includes Central Government Health Scheme (CGHS), Employee State Insurance Scheme (ESIS), Ex-servicemen Contributory Health Scheme (ECHS), and Government Financed Health Insurance Schemes such as RSBY and State specific health insurance schemes. Medical Reimbursements to Union/State Government employees are also included.

expenditures. Considering India's federal structure, share of State governments in government health expenditure is 66 percent and about 7 percent of Government healthcare expenditures in India are capital investments. Of the current health expenditures, government spending is 51 percent on primary healthcare, 23 percent on secondary 13 percent on tertiary care[3] and others. Government spending on health is primarily focused on primary healthcare covering family planning, immunization, disease control programs for both communicable and non-communicable diseases provided by health facilities and outreach programs. In 2013-14, Household expenditures on health were majorly OOPE (64 percent of THE) and Health insurance contributions were very low of THE. OOPE on healthcare is largely spent on curative care services as 55 percent was on outpatient care, 32 percent on inpatient care, 6 percent on patient's transportation, and 4 percent on preventive care and the rest on other services. Overall, majority of OOPE is on drugs and diagnostics i.e. 53 percent and 10 percent respectively. India's position on OOPE vis-à-vis other countries is alarming, therefore, there is need to enhance efficiency and look into innovative ways of raising finance.

Aims and Objectives

The main and objectives of the research study are as under:

- To study health care financing in India.
- To study Out of Pocket expenditure and its addressal.
- To focus on need to increase government spending on health care.
- To suggest the innovative ways to raise health care financing.

Research Methodology

The present research paper is based on secondary data information sources and publication of Ministry of Health and Family Welfare, Ministry of Finance, World Health Organization, Economic Surveys and budget documents. Statistical methods and diagrams like percentages, growth, bar diagrams and pie charts have been used to display change.

Study Area

The study is focused on India but the parameters like low public spending, out of pocket expenditure and per capita health spending is compared with neighboring and developed countries.

Out-of-Pocket Expenditure in Selective Countries

Health expenditure in 2014 shows that India has the highest out-of-pocket expenditure (62.4 percent) on health except Bangladesh (67 percent). The countries like Thailand (12 percent), UK (9.7 percent), China (32 percent), USA (11% percent), South Africa (6.5 percent) and Brazil (25.5 percent) have shown more public spending on health which are the reasons for better health parameters. The government spending in India is lower than Nepal (40 percent), Sri Lanka (56 percent), Thailand (78 percent) and China (56 percent). This shows that the countries spending more towards public health care face no catastrophic expenditure.

Table 01: Health Expenditure in 2014

Countries	OOPE as % o	GHE as % o	Others * as %
India	62.4	30.0	8.0
Bangladesh	67.0	27.9	5.0
Nepal	47.7	40.3	12.0
Sri Lanka	42.1	56.1	2.0
Thailand	11.9	77.8	10.0
Brazil	25.5	46.0	28.0
South Africa	6.5	48.2	45.0
Russia	45.8	52.2	2.0
China	32.0	55.8	12.0
United Kingdom	9.7	83.1	7.0
United States of America	11.0	48.3	41.0

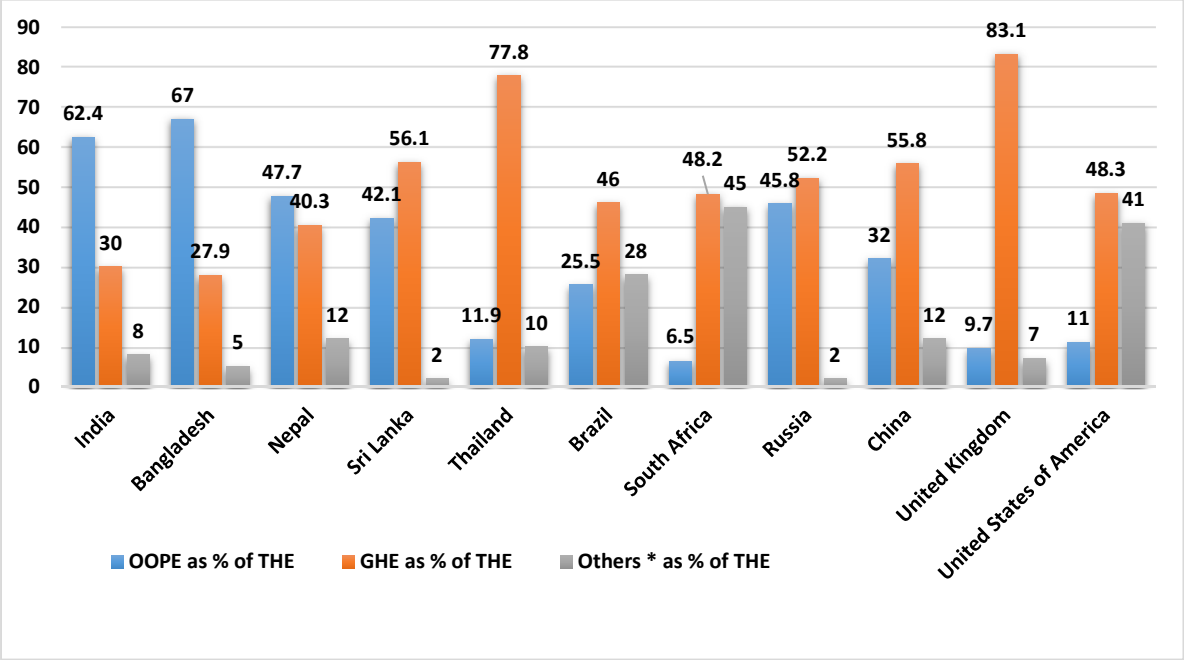
Source: WHO, Global Health Expenditure, 2014

*Others include private health insurance, enterprises, NGOs and Donors.

[3]The combined (public and private) spending on primary, secondary and tertiary care is 45.5%, 34.8% and 16.1% respectively.

The per capita total health expenditure in India is much lower than Sri Lanka, Thailand, Brazil, South Africa and China. The government health expenditure is also lower than other countries except Bangladesh and Nepal. The out-of-pocket expenditure is also very high as compared to Thailand and China. India ranks 183 among 192 countries in terms of out-of-pocket healthcare expenditure as a percent of total health expenditure and is just above Bangladesh (187) and Afghanistan (184).

Figure 01: Health Expenditure in 2014



Per Capita Total Health Expenditure, Per Capita Government Health Expenditure and Per Capita Out-of-pocket Expenditure in Selective Countries

Table 02: Per Capita THE (USD), Per Capita GHE (USD), Per Capita OOPE (USD) and Per Capita Others (USD)

Countries	Per Capita THE (USD)	Per Capita GHE (USD)	Per Capita OOPE (USD)	Per Capita Others (USD)
India	75	23	47	5
Bangladesh	31	9	21	1
Nepal	40	16	19	5
Sri Lanka	127	71	54	2
Thailand	360	310	29	21
Brazil	947	436	241	270
South Africa	570	275	37	258
Russia	893	466	409	18
China	420	234	134	52
United Kingdom	3935	3272	383	280
United States of America	9403	4541	1039	3823

The squeeze of public finances in India has resulted in the appalling state of health care system and given birth to impoverishing out-of-pocket health care expenditure which is as high as 62 percent of total health expenditure, which pushes 7 percent population below poverty threshold every year.

Addressing High Out-of-Pocket Expenditure

High OOPE coupled with low government spending (1.15 percent of GDP) has made India's healthcare financing highly inequitable. Since OOPE is the most inefficient way of spending which leads to catastrophic health expenditure and pushing households into impoverishment, Government

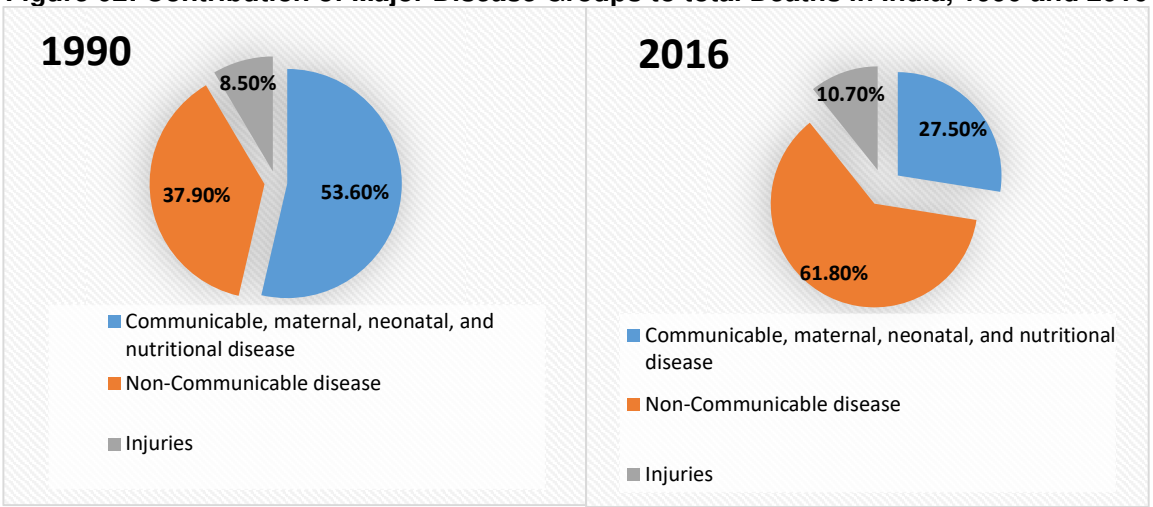
of India has assured through national health Policy, 2017 to increase Government healthcare expenditures to 2.5 percent of GDP and ensured a majority of government spending on comprehensive primary healthcare, drugs and diagnostics, screening of hypertension, diabetes and increase proportion of healthcare expenditures through risk pooling arrangements or health insurance. This can be done either through expanding population and service coverage through government on social health insurance schemes like employee state insurance and Rastriya Swasthya Bima Yojana (RSBY) that provides cashless healthcare services to population. Many states have already such insurance schemes under implementation such as Yeshasvini Scheme in Karnataka, kudumbasree in Kerala and Aryogyashree in Andhra Pradesh. The Government of India is also working on National Health Protection Scheme (NHPS) to provide health insurance to poor and marginalized. These measures can largely contribute towards reducing OOPE. Efforts are also made for incentivizing the large middle-income class population to purchase private health insurance so that majority of population with a 'capacity to pay' could be covered through this mechanism without any additional burden on the government finances.

Need to Increase Government Spending on Healthcare

Government spending on health is of utmost importance as this is central to efficiently mobilizing resources for the health sector. This key element underpins strong socio-economic solidarity among communities, which is essential to a health system. Without this, systems will be more dependent upon private funding sources, such as OOP spending and private health insurance which are associated with inequity and poor financial protection leading to iniquitous and unhealthy society. India is currently facing the problem of high Out-Of Pocket Expenditure (OOPE) which is over 60 percent (rank 183/192 countries) and over 7 percent population slip below poverty line due to catastrophic health expenditures and 27 percent of hospitalized patients had to sell assets or borrowed money to finance healthcare needs.

Further, large private sector and OOPE dependency leads to deleterious health outcomes due to issues of information asymmetry as majority of poor population are illiterate and do not have the understanding and are unable to make a decision about treatments largely depending on doctor's advice. There are several externalities (e.g. TB, vaccination) in healthcare where private markets fail to provide services such as disease prevention, health promotion and public health that will require government intervention to be able to achieve good health outcomes. India with its rapid social and economic development, undergoing a major epidemiological transition. Over the last 26 years the disease pattern has shifted as mortality due to communicable, maternal, neo-natal and nutritional diseases (CMNND) has declined substantially but non-communicable diseases and injuries are increasingly contributing to overall disease burden. India's health system therefore, faces a dual challenge. The burden from diseases such as diarrhea, respiratory infections, delivery complications, neo-natal disorders and tuberculosis are reduced but still a high burden. At the same time the contribution of NCDs such as cancer, heart disease, stroke and diabetes are rising which are largely life style diseases. The nature of this challenge varies across the country.

Figure 02: Contribution of Major Disease Groups to total Deaths in India, 1990 and 2016



The proportion of deaths in India due to CMNNDs has reduced from 53.6 percent to 27.5 percent during 1990 to 2016 whereas, those due to NCDs increased from 37.9 percent to 61.8 percent and those due to injuries increased from 8.5 percent to 10.7 percent. This shift in disease burden requires extra resources to address life style diseases. Therefore, the reason why health care system in India requires more funds are high out-of-pocket expenditure (OOPE), low health insurance coverage, weak public health facilities, dearth of infrastructure, shortage of skilled professionals and heavy burden of non-communicable diseases which is accounting for 62 percent of diseases. Though the National health Policy of India, 2017 assures availability of free comprehensive primary health care services for all aspects of reproductive, maternal, child, and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases and moving towards universal health coverage but as per past trends the total healthcare expenditure in India has increased from 0.9 percent of GDP in 2004-05 to 1.15 percent of GDP in 2013-14 and this 27.7 percent increase in expenditure could be achieved over constant efforts in a decade. However, as per the projections under National health policy, increase in healthcare expenditure from 1.2 percent in 2017-18 to 2.5 percent in 2025 means more than 100 percent over a period of 7 years will be a challenge for the government of India where health had never been a priority. The GDP calculations made assuming an annual increase of 7.2 percent with prices being constant show that to increase the health expenditure up to 2.5 percent of GDP, Government needs to increase health expenditure to 97.45 billion USD approximately with provision of 31.18 billion USD at central level.

Innovative Ways to Raise Health Financing

In India, additional funds for health would be reprioritisation which mean curtailment of funds in other social sectors which are already in constraints of resources. Innovative ways of health care financing to create more money for health and enhancing capacity, efficiency and accountability to get more health for money are the options to support developing economies to deal with unfinished agenda of Millennium Development Goals (MDG) and to create a roadmap for Sustainable Development Goals (SDG). Progress towards the MDGs, on the whole has been remarkable especially on front of poverty reduction, education improvements and increased access to safe drinking water. The progress on health goals and targets has also been considerable. Globally, the HIV, TB and malaria epidemics were addressed to an extent. Child mortality and maternal mortality decreased 53 percent and 44 percent respectively since 1990. In case of India, IMR reduced from 88 per 1000 live births in 1990 to 35 per 1000 live births in 2015 and Maternal Mortality Ratio (MMR) reduced from 556 per 100,000 live births in 1990 to 167 per 100,000 live births in 2015 but failed to achieve the target of reducing IMR by 2/3rd and MMR by 3/4th in 1990. Health care spending in India including public and the private sector was 4.7 percent of the country's GDP in 2014 which translates to about 75 USD per capita and three forth of this is from the private sector. The National Health Account for 2013-14 reports that Government health expenditure in India is 3.8 percent of the Total Government Expenditure (TGE) including State and Central government. Considering India's federal structure, share of State governments in government health expenditure is about 66 percent. National Health Policy 2017, has committed to increase health expenditure from the existing 1.15 percent to 2.5 percent of GDP by 2025.

In India, to generate more resources for health, there is need to consider review of taxes and subsidies which play a preventive role in controlling communicable and non-communicable diseases for example commodities that harm health, needs to be declared sin and heavily taxed and taxes generated to be earmarked for preventive and promotive health care whereas those beneficial need to be subsidised. In India, as per 2017-18 budget document, 10 percent of government spending are earmarked for subsidies for food, fertilizers and petroleum etc, which have direct and indirect health effects. The subsidies during 12th five-year plan were 1.74 times more than the central, State and local budget on health hence subsidies need to be reviewed periodically. Raised Taxes on harmful commodities may not only improve health but can generate more fiscal space for health. In case of India, taxes on alcohol, tobacco, salt and sugar will not only generate additional resources but would be preventing communicable and non-communicable diseases and contribute to easing burden on health system. At present, communicable and non-communicable diseases cause more than 65 percent deaths, the fiscal deficit created due to raised taxes would be impacting socio-economic and cultural factors in a low and middle-class society. The revenue generated through tobacco taxes may be earmarked for health sector

to deal with cancer and cardiovascular diseases and for agriculture sector to shift farmers from tobacco cultivation to other crops which yield high returns and are sustainable ecologically.

At policy level, marginal increase in taxes may not yield desired results and outcomes, thereby increase in taxes need to be substantial to achieve the desired changes in consumption and more towards phasing it out from life. In a country like India, inflation surpass small increases hence inflation need to be adjusted to avoid tax ineffectiveness. Planning of such taxation would yield outcomes if mechanism of strict adherence of regulation at centre and State is in place to avoid non-compliance on ground of loopholes and ground against smuggling and bootlegging as large tax collection allures pilferages. Formulation of policy on raised taxes may not achieve defined results unless its implementation and enforcement are monitored effectively and coordinated till it yields desired outcomes to transport and trade illegally. Raised taxes on tobacco, alcohol, salt, sugar and unhealthy products are justified not only to address the bad effects on society from the abuse of these substances but also to enhance collection of government revenue. Revenue raising on these products should be as high as the component that mitigate the bad effects of consumption/abuse. The design of taxes must take into account all products leading to obesity and further diabetes and cardiovascular diseases. Adolescents and adults respond most to price increases on unhealthy foods and beverages, tobacco and alcohol, therefore, for the productive utilization of tax resources, part of tax collection could be earmarked to preventive and promotive health care of these sections and remaining for improvement for air and water quality, nutrition and treatment of diabetes, Cardiovascular Diseases, Cancer and Chronic Obstructive Pulmonary Disease (COPD).

In a similar way, other front of resources mobilisation is review of subsidies which is a burden on growing economies and may provide some fiscal space. Food substances that contribute to obesity including refined grains such as wheat flour and white rice are highly subsidised and these subsidies need to be reviewed and reoriented towards improving the nutritional content of subsidised food. Production and consumption of pulses have stagnated in India while the output of food grains and sugar has increased. In India, under the National Food Security Act (NFSA), 2013, the government is projected to spend $25 billion a year to subsidize food grain, whereas this food subsidy can be used towards subsidies on pulses, fruits, vegetables and milk which will have a far beneficial impact on nutrition and help in addressing life style diseases. It is not only what consumers eat, drink or smoke that can harm health and whose effects can be modified by taxes or subsidies. India subsidises coal, gasoline and their fossil fuels which are the leading products of particulate matter which causes lower respiratory tract infections, Chronic obstructive pulmonary disease (COPDs), cancers, heart diseases and exacerbates the risk of tuberculosis.

According to a 2015 IMF report, government spent 6.5 percent of the world's GDP to subsidise energy and energy subsidies which is more than public spending on health and education. Re-allocating fuel subsidies towards clean fuels and eliminating subsidies on those items which have direct harmful effect on health to improve health and save scarce resources. Review of subsidies and later removal or reduction and imposition of heavy taxes may not favour political agenda but the health and economic burden of tobacco and alcohol use falls heaviest on the poor. Heart disease and stroke are the leading causes of catastrophic expenditure in India and the main reasons of families fall below poverty line trap into poverty. A second concern is that removal of agricultural subsidies would adversely affect farmers and small-scale manufacturers including those who make bidis and other tobacco products. Farmers of tobacco and sugarcane do well as these crops are cash crops in India but to assist them to switch over to such crops that are not harmful to human health and just a substitute of their livelihood. Allocating part of earmarked revenue collected through taxes for the orientation of these farmers for smooth transition from these cash crops to other crops without putting them into financial hardship. Policy makers need to document explicitly pros and cons of these reforms of reorienting tax revenue and subsidies and explain provisions how the losers from these changes would be compensated to ensure that their livelihoods are not compromised.

Conclusion

In nutshell, the need of the hour is an effective implementation of NHP for the improvement of healthcare service delivery and to reduce OOPE substantially. The policy ensures more resources by increasing government spending to 2.5 percent of the GDP by 2025 but the review of taxes and subsidies will further generate resources for health financing. Increase in government spending will also create millions of jobs through much needed expansion of the health workforce, which is 5th largest employer in India. This will help India converting a demographic surplus into demographic dividend. Further *"Sarvebhavantusukhinah, sarvesantuniramaya"* and Health is not only a Goal in itself, but also vital for improved developmental outcomes. Better Health Improves productivity and reduces economic losses due to premature death, prolonged disability & early retirement. Health and nutrition directly impact the scholastic achievements- bearing on productivity and income.

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