

Financing of universal health care coverage: The case of India

**Presentation by
A.K. Shiva Kumar, PhD**

Research Dialogue on Emerging Economy Perspectives and
Priorities in the New Multi-polar World:

Food, Energy and Health Security: What Roles for Technological
and Institutional Innovations?

November 15, 2011

Structure of the Presentation

1. Six key features of health financing in India
2. The vision of UHC
3. Ten key recommendations on health financing plan:

Proposal of the

High Level Expert Group on Universal Health Coverage
[set up by the Planning Commission, India]

Six key features of India's health financing

1. Low levels of health spending

2009	Total expenditure on health as % of GDP	Per capita total expenditure on health (PPP\$)
Sri Lanka	4.0	193
India	4.2	132
Thailand	4.3	345
China	4.6	309

Source: WHO database, 2009

2. Low levels of public expenditure on health

2009	Public expenditure on health as % of GDP	Per capita public expenditure on health (PPP\$)
Sri Lanka	1.8	87
India	1.2	43
Thailand	3.3	261
China	2.3	155

Source: WHO database, 2009

LOW PRIORITY TO PUBLIC SPENDING ON HEALTH – INDIA AND COMPARATOR COUNTRIES, 2009

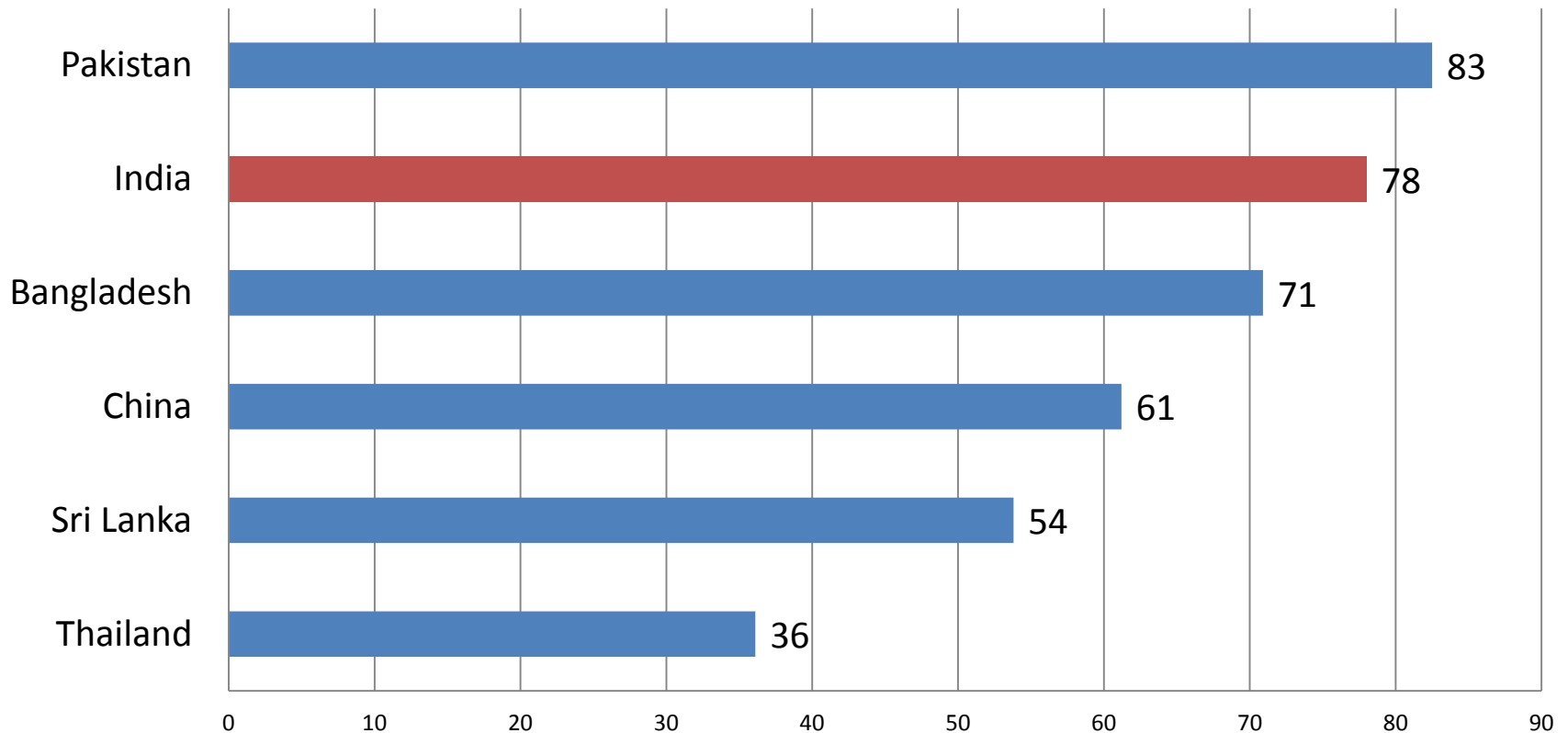
	Total public spending as % GDP (fiscal capacity)	Public spending on health as % of total public spending	Public spending on health as % of GDP
India	33.6	4.1	1.2
Sri Lanka	24.5	7.3	1.8
China	22.3	10.3	2.3
Thailand	23.3	14.0	3.3

Source: WHO database, 2009

Indian governments devote very low per cent of public spending to health – 3-4% - amongst the lowest of any country in the world.

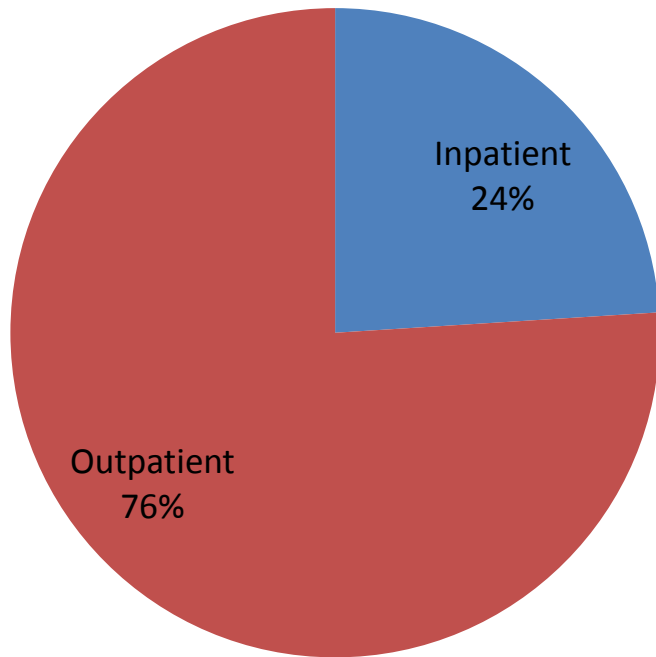
3. High burden of private out-of-pocket expenditures

Proportion on private out-of-pocket expenditures (%)

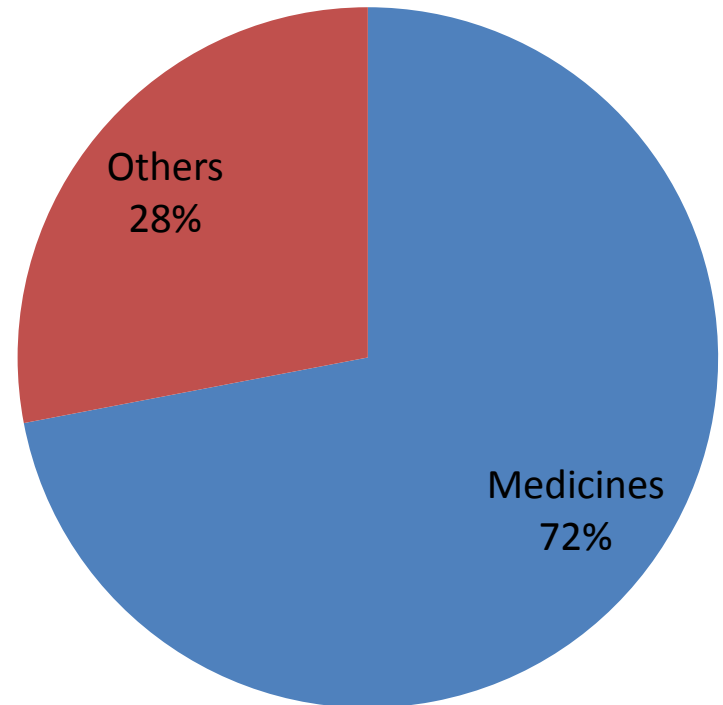


4. High costs of out-patient and medicine costs

Breakdown of private out-of-pocket expenditures (%)



Medicines and other expenses



5. Centre-State financing issues

- State governments are primarily responsible for the funding and delivery of health services
 - State governments bear close to two-thirds (64%) of the total government health expenditure.
 - The Centre accounts for the remaining third.
- Though the Centre's financial contribution is relatively small, its influence is substantial.
 - National Rural Health Mission
 - Rashtriya Swasthya Bima Yojana (RSBY) strongly motivate increased contributions to health from State governments.

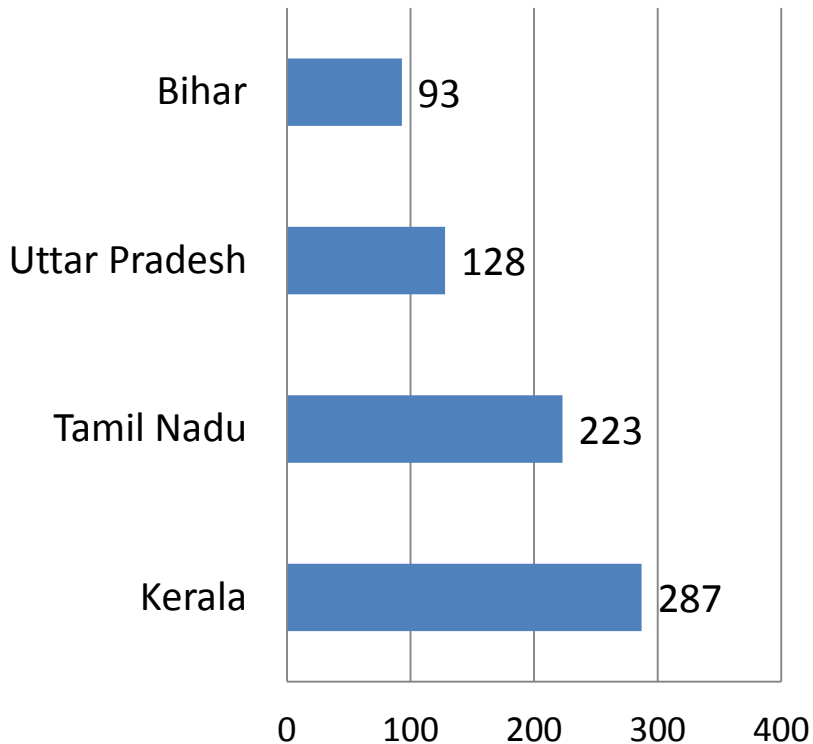
Fiscal constraints faced by States

Two factors fiscally constrain States with low public expenditure on health:

- The Centre's distribution of revenues across the states does not offset the fiscal disabilities of the poorer states.
- There is less fiscal space for development spending in the poorer states, which incur a large share of obligatory expenditures

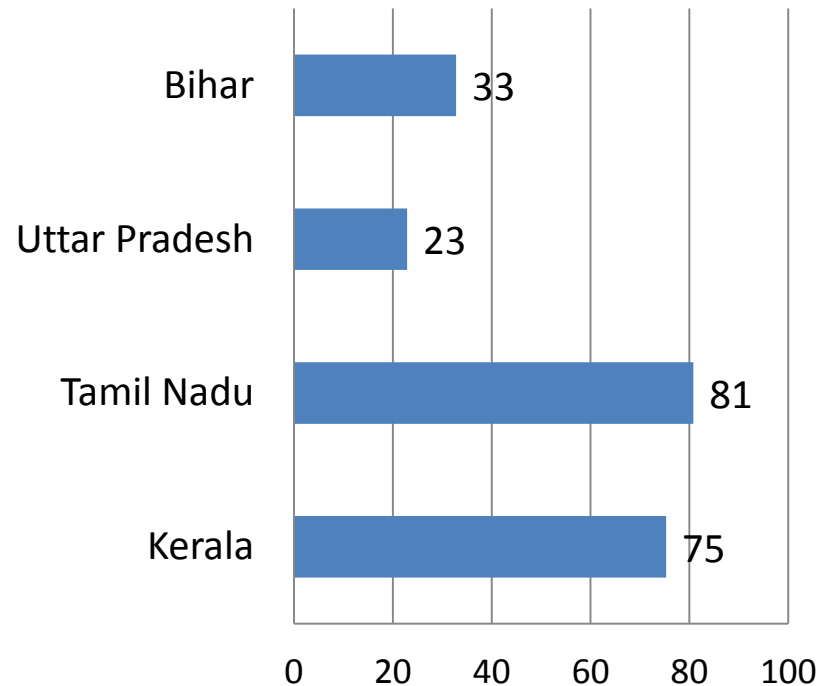
Large inter-state differentials in public spending

Per capita public health spending, 2004-05 (Rupees)



Proportion of children fully immunized (%) 2005-06

Source: NFHS-3



6. Limited financial protection

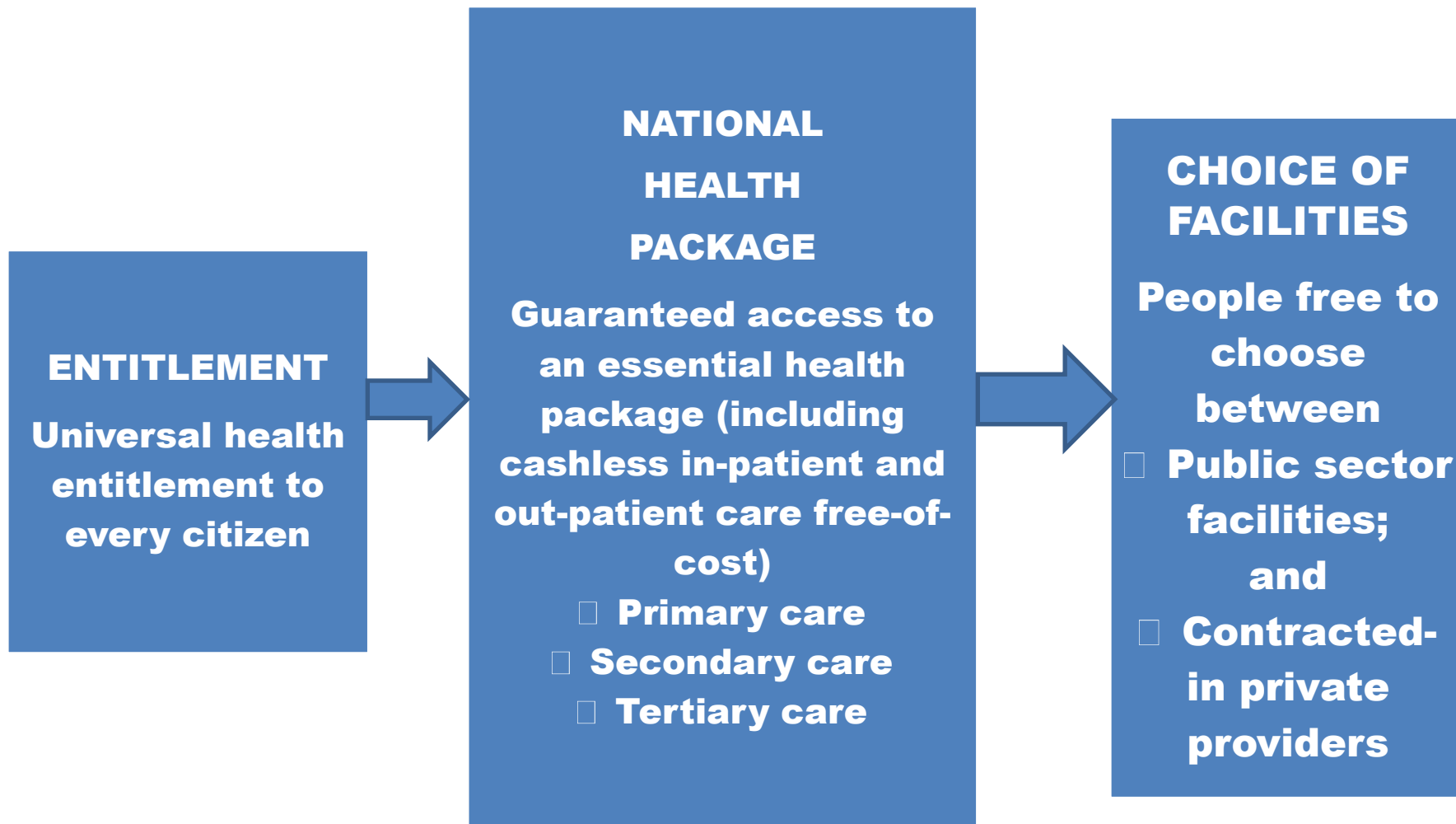
Insurance coverage remains low with financial protection available only for hospitalization, and not for outpatient care

India's medical insurance sector remains weak and fragmented

The benefits of traditional insurance coverage accrue only to a privileged few and mostly to those working in the organised sector.

The vision of UHC
proposed by the
High Level Expert Group
on
Universal Health Coverage

Universal Health Coverage by 2022: The Vision



Two options for contracted-in private providers:

Option 1:

Private providers opting for inclusion in the UHC system would have to ensure that at least

- 75 per cent of outpatient care and
 - 50 per cent of in-patient services
- are offered to citizens under the NHP.

For these services, they would be:

- reimbursed at standard rates as per levels of services offered
- appropriately regulated and monitored to ensure that services guaranteed under the NHP

For the remainder of the out-patient (25%) and in-patient (50%) coverage, service providers would be permitted to offer additional non-NHP services over and beyond the NHP package, for which they could accept additional payments from individuals or through privately purchased insurance policies.

Option 2:

Private providers would commit to provide only the cashless services related to the NHP and not provide any other services which would require private insurance coverage or out of pocket payment.

Citizens free to supplement free-of-cost services (both in-patient and out-patient care) offered under the UHC system by paying out-of-pocket or directly purchasing additional private voluntary medical insurance from regulated insurance companies.

How to finance UHC?

Ten Key Recommendations

Recommendation 1

Government (Central government and states combined) should increase public expenditures on health from

the current level of **1.2%** of GDP

to at least

2.5% by the end of the 12th plan, and

to at least **3%** of GDP by 2022.

Why increase public spending on health?

- Health care provision has a large number of public and merit good
- The financing for the provisioning of the proposed NHP (that offers essential services only) requires the level of public expenditures to increase to 2.5-3% of GDP.
- Prepayment and pooling provide a number of financial protection benefits.
- Spent wisely, enhancing public expenditures on health is likely to have a direct impact on poverty reduction

Recommendation 2:

Ensure availability of free essential medicines by increasing public spending on drug procurement.

An increase in the public procurement of medicines from around 0.1% to 0.5% of GDP would ensure universal access to essential drugs

Increased spending on drugs needs to be combined with a pooled public procurement system

Distribution and availability of quality medicines across the country could be ensured by contracting-in of private chemists.

Recommendation 3

Use general taxation as the principal source of health care financing –

complemented by

additional mandatory deductions for health care from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary.

Why general taxation?

The conditions necessary for other methods of financing are not present in India

Millions of self-employed and under-employed people work in the unorganised sector

Given that

- the organised sector base and the tax-payer base are likely to grow;
- the efficiency of tax collections is improving; and
- the goal is to offer cashless health care to all sections of the society,

India could complement general taxation with a specific surcharge on salaries or taxable income to pay for UHC.

Increase revenues through tax administration reform and, in particular, improved information system for taxes at both central and state levels.

Recommendation 4

Do not levy sector-specific taxes for financing.

- None of these options is likely to meet substantially the financial requirements of UHC.
- The practice of earmarking financial resources distorts the overall fiscal prioritisation. Given that most public revenues are fungible, earmarking from a specific tax may not actually add to the health budget if the increased funds from the earmark are offset by reductions from discretionary revenues.
- Higher taxes on tobacco and alcohol have the public health benefit of reducing consumption of these harmful products, while adding to the general revenue pool.

Recommendation 5

Do not levy fees of any kind for use of health care services under the UHC

Evidence suggests that user fees have:

- increased inequalities in access to healthcare.
- led to sharply negative impacts on the usage of health services even from those that need them.
- not proven to be an effective source of resource mobilization.
- pose practical challenges of means-testing and errors of inclusion and exclusion
- Out-of-pocket payment at the point of care is the most important reason why healthcare expenses turn catastrophic for all healthcare users.

How to generate additional resources?

- enhancing the overall tax-to-GDP ratio
- widening the tax base
- improving the efficiency of tax collections
- doing away with unnecessary tax incentives
- exploring possibilities of reallocating funds to health.

Recommendation 6

Introduce specific purpose transfers to equalize the levels of per capita public spending on health across different states

Recommendation 7

Accept flexible and differential norms for allocating finances so that states can respond better to the physical, socio-cultural and other differentials and diversities across districts.

Recommendation 8

Expenditures on primary health care should account for at least **70%** of all health care expenditures.

Recommendation 9

Do not use insurance companies or any other independent agents to purchase health care services on behalf of the government.

Purchases of all health care services under the UHC system should be undertaken either directly by the Central and state governments through their Departments of Health or by quasi-governmental autonomous agencies established for the purpose.

Recommendation 10

All government funded insurance schemes should, over time, be integrated with the UHC system.

Two final comments

Need for

Legislative frameworks, clear cut guidelines,
checks and balances

A common IT-enabled information gathering,
monitoring and networking system