Review Article

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METAMORPHOSIS IN FINANCIAL STRATEGY- AN UNTAPPED POTENTIAL OF HEALTH CARE IN INDIA

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ABSTRACT

The way in which healthcare is financed is critical for equity in access to healthcare. At present the proportion of public resources committed to healthcare in India is one of the lowest in the world, with less than one-fifth of health expenditure being publicly financed. India has large-scale poverty and yet the main source of financing healthcare is out-of-pocket expenditure. This is a cause of the huge inequities we see in access to healthcare. The article argues for strengthening public investment and expenditure in the health sector and suggests possible options for doing this. It also calls for a reform of the existing healthcare system by restructuring it to create a universal access mechanism which also factors in the private health sector. The article concludes that it is important to over-emphasize the fact that health is a public or social good and so cannot be left to the vagaries of the market.

KEYWORDS: Financial strategy; Health care; Health insurance; Equity

INTRODUCTION

Access to healthcare is critically dependent on how healthcare provision is financed. Countries that have universal or near universal access to health- care have health-financing mechanisms in which either a single autonomous public agency or a few coordinated agencies pool resources to finance healthcare.[1] All Organization for Economic Co-operation and Development countries, excluding the United States of America, have such a financing mechanism.[2] In these countries, 85% of financing comes from public resources like taxes, social insurance or national insurance, which ensure healthcare reaches over 90% of the population.[3] The health financing system in United States of America has resulted in poor access to healthcare compared to other Organisation for Economic Co-operation and Development countries such as Canada. India is the most privatized health economy in the world and this is despite the fact that three-quarters of the country's population is either living below the poverty line or at subsistence level.[4] Given the political economy of India one might have expected the state to be the dominant player in both financing and providing healthcare as, for example, in Sri Lanka, out of a concern to establish equity in access to healthcare.[5]

HEALTH INSURANCE FOR THE POOR

In the current debate on health security for the poor, health insurance is made out to be panacea for all the ills facing the poor. Health insurance, no doubt, has emerged as an important financing tool as it promises to mobilize some resources from the people themselves i.e., those who buy insurance.[6] But health insurance, which strengthens demand side, makes sense only when the supply of health care is reasonably well

developed. Where this is not so, health insurance is meaningless.[7] The supply of health care in the rural and remote areas of country is far from satisfactory. Although public health care centers are pervasive, these centers have degraded overtime in most states due to lack of funds, accountability and so forth. Any attempt at introducing health insurance for the poor must also be accompanied by revival of health care facilities at these centers. The need for stepping up public health spending is endorsed by many expert studies.[8] Unfortunately, the launch of the scheme is not accompanied by either an increase in public health expenditure or any commitment to reorient the public health system, and this seems to suggest lack of seriousness in providing health security to the poor.[9] Finally, both the provision and access to health care services should be a part of a bigger health strategy which includes other public health programs such as safe drinking water, sanitation, family planning etc. as each of these are important determinants of health outcomes.[10] In other words a comprehensive approach is needed.

TOWARDS A NEW FINANCING STRATEGY

As already mentioned, India's health-financing mechanism is largely based on out-of-pocket expenditure, with the role of public finance actually in decline. It is quite evident from that the public finance of healthcare is weakening and that private expenditures are becoming even larger. But this can be changed, using mechanisms listed below.[11]

1) Within the existing public finance of healthcare, macro policy changes in the way funds are allocated could bring about a substantial improvement in equity by reducing the inequalities between rural and urban areas. This would be a major gain for rural healthcare of over twice more money, which could help fill the gaps, in both human and material terms, in rural healthcare systems. The urban areas have municipal resources in addition, though they have to generate more resources to maintain their existing healthcare systems that, at least in terms of numbers (such as hospital bed: population and doctor: population ratios) have been adequately provided for. Such global budgeting could also mean autonomy over how resources are used at the local level.[12] Doing away with the current highly centralized system of planning and programming in the public health sector would result in greater faith being placed in local capacities.
2) The public exchequer even today contributes substantially to medical education, to the extent that nearly 80% of medical graduates are from public medical schools. This major resource is not fully being utilized. Since medical education is virtually free in public medical schools, the state should demand compulsory public service for at least three years from graduates from them as a return for the social investment (today only about 15% of such medical graduates are actually absorbed into the public health system).[13] Furthermore, a spell of public service should also be made mandatory for those wishing to undertake post-graduate studies, which currently attract as many as 50% of public medical school graduates.[14]
3) Governments could raise additional resources by imposing health cesses (levies) and taxes on health-degrading products, if they cannot be banned, such as cigarettes, beedis (small Indian cigarettes), alcohol, paan masalas (betel nut mixture) and guthka (tobacco), personal vehicles and so on. The same logic could also be applied to personal transportation vehicles, both at point of purchase as well as each year, through a health cess on road tax and insurance to be paid by owners.[15] Land revenues and property taxes could also attract a health cess (i.e. a tax earmarked for public health, just as municipal taxes already have an education cess component).
4) Social insurance could be strengthened by making a contributory system similar to the Employee State Insurance Scheme (ESIS) compulsory across the entire organized labour market sector and integrating ESIS, the central government health scheme and other such social insurance schemes with the general public health system. In addition, social insurance will need gradually to be extended to other sectors of employment, using models drawn from experiments elsewhere in collective financing (as with

the sugarcane farmers of south Maharashtra, for instance, who pay Re 1 per tonne of cane as a health cess, for their entire families to be assured of healthcare through the sugar cooperative). There are many non-governmental organization experiments in using micro-credit as a tool for health financing for members and their families. Large collectives, whether they are self-help groups facilitated by non-governmental organizations or groups of self-employed people, such as the headload workers in Kerala, could buy insurance cover collectively, so as to provide health protection for their memberships. At least 60% of the workforce in India has the potential to contribute to such a social insurance programme.

7) Other options to raise additional resources could be various forms of innovative direct taxes like a health tax similar to the profession tax (a tax on employment, so that those who are earners contribute a fixed amount, depending on their level of earning, each month, which funds the employment guarantee) deducted at source of income for the employed and in trading transactions for the self-employed. Using the Tobin tax route is a highly progressive form of taxation that, in an increasingly finance and service-sector-based economy, can generate huge resources without bearing too heavily on the individual, since it is a very small deduction at the point of transaction.[16] What this basically means is that for every financial transaction, whether by cheque, credit card, cash, on the stock market, through foreign exchange, securities and so on, estimated to be Rs 1,000 billion daily, a very small proportion is deducted as tax and transferred to a fund earmarked for the social sector.[17] For example if 0.1 per cent is the transaction tax, then for every Rs 100,000 the transaction tax would be a mere Rs 100 and this would generate Rs 365 billion per annum.

8) The above are just a few examples of what can be done within the existing system, by making small innovations. But this does not mean that radical or structural changes should not also be considered.[18] Ultimately, if we wish to ensure universal access with equity, we need to think in terms of restructuring and reorganizing the healthcare system, using a rights-based approach. This would require a multi-pronged strategy: building awareness and consensus in civil society; advocating rights to healthcare at the political level; demanding legislative and constitutional changes and, finally, reorganizing the entire healthcare system, especially the private health sector.[19]

9) In short, we have to stem the growing out-of-pocket financing of the healthcare system and replace this with a combination of public finance and various collective financing options such as social insurance and other forms of collective fund-raising.[20] The healthcare system needs to be organized into a regulated system that is ethical and accountable, that is governed by a statutory mandate and that pools together the various collective resources and manages autonomously the workings of the system in the interests of providing comprehensive healthcare to all with equity.

CONCLUSION

Health sector in India suffers from gross inadequacy of public finance and therefore an immediate and significant scaling-up of resources is an imperative. The undue burden on households for spending on health cannot be wished away. Further, it is also clear that there is an urgent need to restructure the budgeting system 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.[21] Rules and procedures for actual release of funds, 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. In other words, decentralization can only be done after developing the requisite financial capability and laying down rules and procedures for accounting systems.[22] Unless such restructuring takes place, greater absorption of funds will continue be difficult. A good opportunity to innovate and experiment

with a restructured healthcare system will be affordable, but such restructuring will be possible only if certain conditions are met: The healthcare system, both public and private, is organized under a common umbrella/framework.

- The financing mechanism of healthcare is pooled and coordinated by some single-payer system.
- Access to healthcare is organized under a common system which everyone is able to access without any barriers.
- The providers of healthcare services have reasonable autonomy in man-aging the provision of services.
- The decision-making and planning of health services is decentralized within a local governance framework.
- The healthcare system is subject to continuous public/community monitoring and social audit, under a regulatory mechanism geared to ensuring the accountability of all the stakeholders involved.

The implementation of the above process would be critically dependent on the state and central government agreeing to changing the financing mechanism and giving complete autonomy to district panchayatand health institutions. With the financing mechanism in place, both panchayatand the health bureaucracy district authorities would require appropriate capacity building to manage the restructuring of the healthcare system. Private health providers and their associations will have to be brought on board at an early stage through discussions that explain to them the benefits of joining such a system. Those serving in public health institutions will have to be trained and appropriately informed to manage and run such a system. Above all, local governance bodies and civil society groups will have to be oriented and become skilled in planning, monitoring and auditing the functioning of the system.

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