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Government Funded Health Insurance Schemes in India: Obstacles to Public Sector Accountability

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Abstract

Health sector is one of the crucial sectors in any economy. The issue of financing health care has assumed greater significance particularly in the developing world, mainly because of the inability of the government in providing the service. It is well known that health expenditure in India is dominated by private spending. In view of the fact that currently India's government spends just 1.4 percent of the country's GDP on health, while household health expenditure is estimated to be 2.72 percent of the GDP, a critical gap is found to be existing in the health sector of the country. Despite of large positive externalities associated with health spending, which make it a clear merit good, public spending on the health sector has been quite inadequate. Greater reliance on private delivery of health infrastructure and health services means under provision by private agents as there will be denial of adequate access by the poor thereby affecting social welfare.The identification of India's health care crisis due to lack of accessibility by the people has proven to be a major burden for the government.Recognizing this, considerations have been made by the government in providing the servicethrough government provided health insurance schemes.Thus, the strategy being set for the country's health care is in the form of state provided insurance-based mechanism which has led to the inception of public funding for the purchase of private health care, implemented through insurance. Here, in this paper, an attempthas been made to give insights on the different issues and obstacles of the government while providing health care through insurance-based system.

Keywords: Health care, Financing, Insurance.

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Introduction

The social welfare consideration, particularly in the developing world, calls for the government's obligation to provide access to health care, but the flourishing for-profit private health care providers in India has brought the health care market in the country at a critical juncture. In view of the fact that currently India's government spends just 1.4 percent of the country's GDP on health, while household health expenditure is estimated to be 2.72 percent of the GDP (Ministry of Health and Family Welfare, 2016); an unfavourable gap is found to be existing in the health sector of the country. While government expenditure on health as a percentage of total expenditure on health has been 30.04 percent in the year 2014, private expenditure stands at 69.96 percent for the same year (Global Health Observatory, WHO, 1995-2014).The shortage of health service providers and infrastructure has proved to be the acute cause of crisis for the public health sector in the country, where data shows that in order to treat 1.3 billion people, only 10 percent of more than 1 million doctors are working in public health sector (National Health Profile, 2017).This paper aims togive insights on the different issues and obstacles of the government while providing health care through insurance-based system.

Approach Towards Providing Health Care in India: Detaching Public Health from Public Health Care Service

Looking at India's health care landscape,high Out of Pocket expenditure is found to be a very important affair. Subsidised and free public health services are what people aspires for particularly in a developing country. But with the rising health care costs, people are forced to adjust and cope up financially with health care contingencies. Affordability to health care services has become an issue of utmost concern, particularly in this era of privatization.In a country like India, having one third of the world's poor population and 42 percent of the country's total population living below the poverty line (BPL) (World Bank Policy Research Working Paper, 2008), health improvement requires the implementation of a comprehensive health policy having a robust primary health care system. Nevertheless, the approach towards providing the service in India has found to be tracing a clear transition from the development of a public health system to a service captured by private system. All the three health policies (National Health Policies of 1983, 2002 and 2017, India)completely omitted the concept of comprehensive and universal primary health care. This negligence in providing the services has made space for the private sector to occupy. Looking at the investment on health as a

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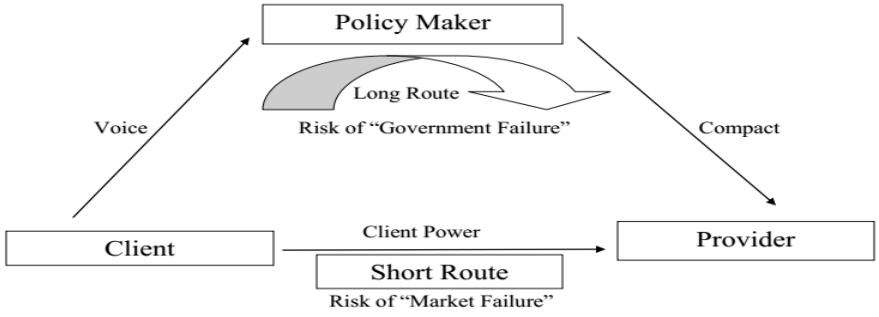
percentage of total investment outlay in all heads of development, it is found to be decreasing from 3.3 percent (Rs. 65.2 crore) in the first plan (1951-56) to 3.15 percent (Rs. 102254.6 crore) in the eleventh plan (2007-2012) (Reports of Planning Commission, Government of India).Thus,due to the country's health care delivery system failing to interact effectively with the components of the public health system,health care crisis in terms ofprovisioning and managing has proven to be a major burden for the government of the country, both central as well as the states.

Understanding Government Failure in Fixing Market Failure While Providing Public Health Services

Health care service having a public good character and also characterised by asymmetric information makes the case for government intervention a must. But in most of the developing countries, the government having different constraints and problems fails to carry out its functions properly and failure of accountability is crucial amongst them (Hammer et. al., 2007). Hammer et al. (2007) has made an attempt to explain the accountability relationship and its applicability to the health sector through a framework developed in the WDR 2004. In an institutional arrangement, there is a connection between the accountability and the incentives provided. The essence of the transaction lies in the fact that the provider (seller) has complete accountability to the desires and preferences of the buyers and has every incentive to fulfil those desires. The government (the policymaker), while acting as an intermediary between the patients (buyer) and the health worker (seller), firstly has to have a clear understanding of the requirements of the people and secondly to transmit these demands to the actual provider of service. The accountability framework of the WDR 2004 is shown in the following figure where the two-step process of the government provision is compared with the market provision.

Figure: Accountability Framework



Source: Hammer et al. (2007)

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In the figure, the services delivered from the provider to the citizens (clients) are shown with two lines of accountability. For ensuring the delivery of the services, accountability mechanism can be either directly to the provider through the market (short route of accountability) or through the government (policymaker in the diagram) (long route of accountability). Market failure is the problem with short route of accountability and government failure is the risk with long route. The government failure may be either because of the policy makers not taking cognisance of people's wants (voice in the diagram) or due to inability of the government to create incentives to the clients (failure of compact). This framework is very essential since it sets priorities for government intervention. Hammer et. al. emphasises the need to weigh the advantages in case of both the failures. According to them, there is low priority for government intervention if the market failure is not too bad. Again, if market failure seriously outweighs government failure, then there is an urgent need for intervention.

Gupta et al. (1999) made the view that the rural health services run by the government in most of the developing countries are highly centralised which leads to certain problems like unresponsive services to local demands, excess infrastructural capacity ignoring the supply side, assignment of unequipped or ill-trained staff, failing of the working of referral system etc. But the services provided privately or through NGOs are almost completely decentralised. This is the reason that they are preferred most and clients feel satisfied by using them despite higher fees than in the public sector. The authors have identified two major reforms that have affected the public sector health services in UDCs mostly in rural areas. Firstly, it is the increase in the user fees for local control, i.e., having some amount of local autonomy for non-salary expenditures and the second reform is the devolution of responsibilities of the central government to lower levels of governments.

Mazumdar (2015) has identified that pilferage of government funds by private empanelled hospitals because of lack of standard guidelines and auditing, "abnormal" economics of induced demand in clinical services, quality of health care providers, lack of infrastructural facilities etc. are responsible for growing private services. According to him, the central issues in the health economics literature are moral hazard problem and supplier induced demand which have ensured reckless system of privatisation characterised by fragmented, unregulated market that lack institutional sophistication but a few badly mauled normative assumptions.

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Neglected Public Health Priorities

The health system in a country should be designed and health policies should be implemented in such a way so as to address the healthcare requirements of the people, particularly of the poor and under-privileged. But currently, the healthcare landscape of India displays a very disturbing picture of providing health services, where there is continuous withdrawal of the service by the government on the one hand and encouraging private provisioning on the other. The gaps in the service delivery, shortage of manpower and infrastructure, lack of attention to the comprehensiveness of healthcare service by neglecting issues like sanitation and water supply provisions etc. have very much undermined the public health priorities and dilapidates the affordable accessibility to the service.

Contemplating health inequality as an important driver of health policy making, so as to reduce the socio-economic disparity in healthcare delivery, it should be provided by the government. But unfortunately, in India, gradually the service is being privatised where data shows that 76 percent of healthcare is provided by the private sector with 67 percent being out of pocket expenditure (National Health Accounts Estimates of India).India's dismal performance in terms of expenditure on public healthcare very well reflected from the fact that India ranks far below than the BRICS countries like Brazil, China, Russia, South Africa; OECD countries like USA, UK, Germany, France, Norway, Sweden, Denmark, Japan and even below countries like Thailand and Sri Lanka in terms of total health expenditure per capita, total health expenditure as percentage of GDP and government health expenditure as percentage of total health expenditure (Source: Situation Analysis: Backdrop to the National Health Policy, 2017;Ministry of Health and Family Welfare, Government of India).Such insubstantial public spending forces the people to approach private providers thereby increasing the catastrophic health care spending.Looking at the conditionsof the rural areas of the country, the situation is even worse where shortage of health care personnel and health infrastructure in the Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) are contributing to the already dilapidated services. Data shows that against the requirement of 25650 doctors at PHCs, 5624 physicians at CHCs and 31274 pharmacists at PHCs and CHCs, there is the availability of 27124, 864 and 25193 respectively; thereby having a shortfall of 3027, 4760 and 7092. Out of total 25650 PHCs functioning, 1974 are functioning without doctors, 9183 without laboratory technicians and 4744 without pharmacists. Out of total 156231 SCs functioning in the country, 6371 are

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without female health workers (ANMs), 78569 without male health worker and 4243 operating without both. Out of 5624 CHCs functioning, 5170 CHCs are running without having all the four specialists (Surgeons, Physician, Gynaecologist and Paediatricians) at the same time, 928 are lacking operation theatres and 438 are not even having the labour room (Source: *Data.Gov.in*, Rural Health Statistics, Ministry of Health and Family Welfare, Government of India). Although many reform initiatives are being introduced in the name of achieving universal healthcare, yet in actual practise the deteriorated public health sector deprives the poor and needy that ultimately trivialises the healthcare achievement.

Tackling the Health Crisis Through a System of Insurance: A Critical Evaluation

As a solution to the growing burden of diseases because of inaccessibility of the people to the health care serviceand in order to eliminate the Out of Pockethealth care expenses of the people, the mechanism isset toprovidecare through health insurance in the country. Increasing insurance coverage is claimed to be associated with an increase in healthcare coverage and financial protection which would ultimately improve the health status of the population.Even if insurance has been conceded to be the way forward for improving access to health care, yet the success of embarking on that path would require reorientation and restructuring of the public health care system. Considering the dismal health infrastructure and the distressing primary health care in the government health services in India, the country needs investment not in insurance, but in health infrastructure. In the absence of a strong public health system,such insurance-based mechanismswould displace the resources, as can be seen in the contemporary landscape in India where the services are increasingly delivered through private institutions. Apart from the issues like using the public money to finance for private sector augmentation and its profiteering, another troublesome aspect of such insurance-based mechanism is the generation of financial resources for making payments to the providers of the service. With the already under-funded public health sector because of fiscal compression, further instigating such schemes is bound to put strains on the fiscal solvency of the government. Without any scrutiny about how the payments will be made for such a broad allocation, the entire provision will raise question about its affordability and long-term viability. India, currently having the most privatized health sector dovetailing the collapse of the public health sector, the success of insurance-based mechanism for managing the health care crisis appears to be far away from becoming the reality. Thus, while in the attempt of moving towards universal health coverage, greater emphasis is required on the supply side of

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the service by the government, with the insurance-based mechanism, the entire focus got shifted to the demand side, where the preferences of the people have been shifted towards the private sector providers and with insufficient government investment, the private providers would also falter which would create a huge health care crisis altogether.If the service providers are not paid for the reimbursable expenses they occur, the institutions will be penalized and such reform initiatives would exacerbate the entire health situation.

It was with the background of the overwhelming proportion of the health expenditure being privately financed in India, the insurance-based mechanism, RSBY was launched in early 2008.Sriram (2018) calls the health insurance system in India to be rudimentary on being available to only few groups of advantaged individuals, wherethe unmet need for healthcare is very high with the people having the highest need for health care. The author further reported some statistics which shows that IMR per 1000 live births is 82 for poorest wealth quintile and 34 for richest quintile. Similarly, women in the richest quintile are more than six times more likely to have institutional delivery as compared to the poorer women in the country (Balrajan et al., 2011).It has been found that access is not available to around 50% of the eligible people for the program as they are currently not enrolled in RSBY due to the lack of availability of full lists of the eligible participants, higher cost of enrolment and high migration rates (Wu, 2012).The Public Private Partnership (PPP) model followed by the health insurance schemes does not benefit the public health infrastructure and hinders the achievement of the National Public Health Goal to strengthen the government health infrastructure. Although there were some initial success stories like improved hospitalization and reduction in the out-of-pocket health care expenditures of the people, yet, issues like long run escalation of the costs, implying greater premium, threatened the sustainability of the scheme since there is the risk of rationing of essential health care having the government-imposed limit of 750 INR in the RSBY agenda (Balooni et al., 2012). Although the average cost of hospitalization increased by 10.1 percent in the rural areas and by 10.7 percent in the urban areas in the decade ending 2014, yet the RSBY insurance coverage remained unchanged since the scheme's existence (Salve, 2017). Karan et al. (2017), in a study, has not found any statistically significant effect of RSBY on the level of outpatient out-of-pocket expenditure, rather found 30 percent increase in the likelihood of incurring the expenditure. In the union budget of India, announced in the month of February, 2018, another flagship programme of government funded health insurance scheme was introduced under the 'Ayushman Bharat' initiative that subsumed the existing RSBY and accordingly National

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Health Protection Scheme has been launched. But, had its predecessor, the RSBY, been prospered, accessibility and financial risk protection would not have been counted as major issues even today. Although a good amount of money is being allotted through the insurance schemes, yet operationally the money is only for inpatient care treatment, thereby the system not being able to reduce the out-of-pocket expenditure for the people, most of it comprising outpatient care. Besides, the annual budget for the AB-NHPS being anticipated to rise to Rs. 10000 crores from an initial of Rs. 2000 crore in the coming years will just be petty cash for covering 10 crore population (Dreze, 2018). Various state governments in the country have also envisioned for providing health care to people by exploring the aberrant social mechanism of health insurance involving the private sector and it was pioneered by Andhra Pradesh through Rajiv Arogyasri Community Health Insurance Scheme. Reddy et al. (2013) held that after 18 months of the implementation of the scheme, the share of private hospitals was found to be Rs. 274 crores while only Rs. 34 crores went to government hospitals reflecting clearly the limping of public health care system by utter governmental negligence. Even the international experience, like the Patient Protection and Affordable Care Act (popularly known as Obamacare) in America reveals how such insurance schemes can prove to be economic disasters where the incapability of the government to rein the profit-oriented delivery mechanism made the entire system inherently inflationary due to spiralling health care costs, leading to financial collapse of the entire provision (Angell, 2013).

The crucial concern in all these cases of insurance-based intervention is the increasing market for private profit. This, as a public health strategy, is something which is running the risk where the private health sector is profiting from the public. Malhotra et al. (2018) made an analysis to obtain the claims ratio for measuring efficiency in the insurance market, claims close to but less than 100 percent indicating efficiency. The study showed the functioning of the Indian health insurance industry to be extremely undesirable and unsustainable, suffering from financial fragility having claims ratio more than 100 percent. The analysis also presumes that it will not be possible for the government to provide health insurance at the current prices for long being an issue related to insolvency. Thus, in the absence of an alternative of a well-functioning public health sector, insurance-based mechanism to provide health care service cannot work on its own.

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Practicability of Insurance-Based Intervention to Serve the Public Interest in a Resource Starved System

Health system providing Universal Health Coverage (UHC) should be one that provides access to the necessary and quality-oriented health services to all people needing them without any financial hardship (The World Health Report, 2010).But along with having plagued public health care system, even the national health insurance scheme of India has failed its poor as there is no reduction in out-of-pocket expenditure of the people. According to a study published in the Social Science Medicine in the year 2017, the probability of lowering the catastrophic outpatient out-of-pocket expenditure through Rashtriya Swasthya Bima Yojana (RSBY) having 150 million beneficiaries remained statistically insignificant (Karan et al., 2017). Thus, the insurance-based intervention further undermines the capacity of the government health care delivery system to provide the service effectively to the people. Thus, instead of concentrating on a health care system based on insurance, what is important on the part of the government is to develop a well-structured and well-funded health care system with no identified gaps of infrastructure and manpower.

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