Healthcare Policy in India- Challenges and Remedies

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By:

Shivani Garg (PGP16319)

Indian Healthcare Sector

With the Indian population adding over 450 million people over the last 25 years, with changing demographics and socio-economic mix, and with the economy growing at above 7%, there have been significant changes in the healthcare requirements of the country. The Indian healthcare sector has grown at a nearly 16.5 percent CAGR since 2008 to become a $110 billion industry in 2016 and is expected to touch $280 billion by 2020. Over the years, Indian Healthcare scenario has shown great progress on several health indicators like life expectancy and maternal and child mortality. The year 2014 marked a remarkable moment in the Indian Public Healthcare system with the World Health Organization (WHO) declaring India a polio-free nation. India was only the fourth such region in the world after the Americas (1994), the Western Pacific Region (2000) and the European Region (2002). The Infant Mortality Rate (IMR) has significantly come down from 57 deaths per thousand live births in 2004 to 34 deaths in 2016. Life expectancy at birth during the same period increased from 63.80 years to 68.35 years. The significant progress made by the healthcare system in India is attributed to the combined efforts of the public and the private sector.

Despite the rosy picture painted by these numbers, the current healthcare system in India faces major challenges owing to several social, economic and political factors. Broadly speaking, the healthcare system faces the triple challenge of raising service quality and providing equitable access while addressing and tackling the changing disease incidence profiles.

Challenges faced by Indian Healthcare Sector

Demographics

India, today, faces the so-called "dual disease burden" as the share of non-communicable diseases (NCDs), better known as "lifestyle" disease, increases over the years along with a continuing rise in communicable diseases (FirstPost, 2018). With the growing middle-class and working-age population, there is increased incidence of lifestyle diseases like diabetes and cardiac ailments. The NCDs accounted for more than 50 percent of all deaths in 2015, up from 42 percent in 2001-2003 (Upadhyay, 2012). Another staggering fact about the occurrence of NCDs in India is that while in most western countries NCDs are likely to occur in old age, the peak occurrence in India is a decade earlier, majorly affecting the age group of 30-59 years (Maya, 2017). This nature of the problem has socioeconomic consequences as it directly affects the working-age population and, hence, calls for stronger secondary and tertiary healthcare system.

Public vs. Private Sector

The contributions of public and private sectors in the Indian healthcare system also show a worrisome picture. As per the National Sample Survey Office (NSSO), between January and June 2014, 243 people out of 1,000 sought medical treatment within the public healthcare system, whereas 756 people out of 1,000 opted to visit a private doctor or private hospital (Lakshman, 2016). Astonishingly, the public sector accounts for only about 20 percent of the total healthcare expenditure with 80 percent contribution coming from the private sector which is one of the highest in the world. Equally astonishing is the fact that between 1995 and 2014 India's public expenditure on healthcare rose only from 1.1 percent of GDP to 1.4 percent. This, when compared to other BRICS countries (Brazil: 3.8 percent, China: 3.1 percent, Russia: 3.7 percent, South Africa: 4.2 percent), shows how under-funded and small in size the public healthcare system in India is to meet the health needs of the country. Of

the total private expenditure on healthcare, 94 percent is the out of pocket expenditure which is one of the highest in the world. During the period 1991-2003, private out of pocket expenditure on health grew at 10.9 percent per annum in real terms, while per capita income grew only at 3.8 percent during the same period. This poses a huge burden not only on poor families but also the middle class who slide into indebtedness to meet their healthcare needs while some may let go the need for medical care completely. On average, the poorest 20 percent of Indian population is 2.6 times more likely than the richest population to forgo medical treatment when ill, due to financial reasons.

Health Infrastructure

Infrastructure is another pain point in the Indian healthcare sector. The country faces severe resource shortage on both capital invested and manpower. India faces an acute shortage of hospital beds with a ratio 0.5 per 1000 population for India as compared to 2.3 for China, 2.6 for Brazil and 3.2 for the US (Sinha, 2011). Huge regional variations exist with some of the more prosperous states with excess capacity while others with a huge shortage. This ratio is much lower than the requirement of 1 bed per 1000 population as defined for the low-income countries by WHO. Providing for quality healthcare services is highly capital intensive where the cost of building a secondary care and a tertiary care hospital could be as high as 25 lakhs and 40 lakhs per installed bed, respectively. This means that in order to meet the WHO standards of 1 bed per 1000 population would require an investment of INR 1,62,500 crores.

Human Capital Crunch

Healthcare sector requires highly skilled human resources from doctors to other medical support staff like nurses, lab technicians, pharmacists, etc. The physicians ratio in India stands at 0.7 per 1000 population while this ratio for countries like China and OECD is at 1.9 and 3.2, respectively. Moreover, majority of the healthcare professionals happen to be concentrated in urban areas where consumers have higher paying power, leaving rural areas underserved. According to a KPMG report, although India meets the global average in terms of the number of physicians, 74 percent of its doctors cater to a third of urban population, or no more than 442 million people. As a consequence, India is 81 percent short of specialists at rural community health centres. The 25,308 primary health centres (PHCs) spread across India's rural areas are short of more than 3,000 doctors, with shortage up by 200 percent over the last 10 years (Salve, 2016).

Health Insurance

India's health insurance model excludes a large part of the population with over three quarters of the population having no health insurance. 24 percent of the population that has some kind of medical insurance includes both private and public sector insurance and the central scheme for weaker sections, the Rashtriya Swasthya Bima Yojana. Government contribution to insurance stands at roughly 32 percent, as opposed to 83.5 percent in the UK. India primarily relies on commercial health insurance now. Even as a copy of the U.S. model, commercial health insurance in India is seriously deficient. It almost entirely covers only catastrophic expenditure, such as the cost of highly restricted hospital treatments, which are offered without cost and quality regulation and external audits. Outpatient treatment and prescription medicines are not covered.

Healthcare Policies in India

With the above mentioned challenges in focus, the government has rolled out several policies and undertaken missions both in rural and urban space.

National Health Policy 2017

After the National Health Policy 1983 and National Health Policy 2002 served well in guiding the approach for the health sector in the Five-year plans, the Union Government approved the National Health Policy in March 2017. The 2017 policy aims to project an incremental assurance-based approach that expounds on the need for a new health policy to account for changing priorities in India's abysmal healthcare delivery system. This involves building a more 'robust health care industry', reducing 'catastrophic expenditure' in the form of out-of-pocket healthcare costs and enhancing 'fiscal capacity' to meet a widening healthcare financing deficit (Mohan, 2017). Some of the specific goals and objectives as laid out by the policy are:

- Increase **Life Expectancy** at birth from 67.5 to 70 by 2025.
- Reduce **infant mortality** rate to 28 by 2019.
- Increase **utilization of public health facilities** by 50% from current levels by 2025.
- Meet need of **family planning** above 90% at national and sub national level by 2025.
- Access to **safe water and sanitation** to all by 2020 (Swachh Bharat Mission).
- Increase **health expenditure by Government** as a percentage of GDP from the existing 1.15 percent to 2.5 percent by 2025.
- Increase **State sector health spending** to > 8% of their budget by 2020.
- Establish **primary and secondary care facility** as per norms in high priority districts (population as well as time to reach norms) by 2025.
- Ensure district-level **electronic database of information** on health system components by 2020.
- Strengthen the **health surveillance system** and establish registries for diseases of public health importance by 2020.
- Establish federated **integrated health information architecture**, Health Information Exchanges and National Health Information Network by 2025.

Under the organisation of public healthcare delivery, the policy thrust is on comprehensive care, system of referrals for regulating patient flows, output-based purchasing of private services to fill gaps, supply of free drugs, diagnostics and emergency services in all public facilities, scaling up urban health, strengthening of infrastructure and manpower in underserved areas, and integrating all national health programmes and making Ayush services an option (Vikaspedia, 2017).

Policy Critique

What this policy appears to be lacking is a cohesive, tangible action plan to address problems pertaining to any of the As (access, affordability and accountability) – especially given the challenges faced by the existing public healthcare machinery because of poor governance and deficient funding. The agency-capability critique applies well to the policy due to the restricted capability of public institutions to deliver on the identified objectives. The 2017 NHP policy identifies everything that needs to be done, without clearly illustrating who needs to do what and, more importantly, how it needs to be achieved.

Also, the feasibility of the policy is brought into question because of the limitations arising out of the funds allocated to the various schemes. The policy calls for major reforms in financing public healthcare facilities. But there is lack of clarity around how these financing reforms will be brought about and who will manage them, or how the need for a per capita medical insurance scheme will interplay with this. The proposal to increase public healthcare expenditure from 1.15 percent to 2.5 percent of GDP by 2025 seems inadequate to meet the ambitious goals laid out in the policy (Mohan, 2017).

Pradhan Mantri Jeevan Jyoti Bima Yojana 2015

The government-backed life insurance scheme announced in 2015 aims to increase the proportion of the population in India that has some kind of life insurance. The scheme is available for people in the age group of 18-50 years who have their bank accounts opened under the Pradhan Mantri Jan Dhan Yojana scheme. The premium for the insurance amounts to Rs 330 per year, which is tax exempt, and provides a coverage of Rs 2 lakh in case of death due to any cause. Since its implementation, the scheme has benefitted over 5.22 crore families (Vishwanathan, 2015).

This provides a very good example of how the government can interlink its various schemes to have a more robust information system as well as to benefit the citizen in the most efficient way possible.

Healthcare in Union Budget 2018

Finance Minister Aruns Jaitley announced two major healthcare initiatives in the Union Budget 2018, indicating the move towards universal health coverage. The first initiative under the Ayushman Bharat Programme is a new flagship National Health Protection Scheme. The scheme aims to cover 10 crore vulnerable families with approximately 50 crore beneficiaries, providing a health insurance cover of Rs 5 lakh per family per year. This is a significant improvement over the previous coverage of Rs 30,000 per family per year under the Rashtriya Swasthya Bima Yojna (RSBY).

The other major initiative announced in the budget is the establishment of 1.5 lakh health and wellness centres across the country which will provide free essential drugs and diagnostic services. The government has allocated a budget of Rs 1,200 Crore for the scheme (NDTV, 2018).

Policy Critique

While the initiatives of the government sound extremely ambitious, it seems more like a "repackaged" version of the social security scheme of 2016. The major reasons why most of the healthcare policy commitments of the Indian Government have failed to translate into results have been inadequate budgetary allocation as well as lack of coordination between the centre and the states in the planning process, leading to inefficient spending. The budgetary allocation of Rs 52,800 Crores for healthcare in 2018-19 was only 5 percent higher than the revised estimate of Rs 50,079.6 Crores in 2017-18. This falls way short of a year-on-year increase of 20 percent needed to meet the target of government health spend at 2.5 percent of the GDP by the year 2025 (Matthew, 2018). In particular, Rs 2,000 Crore allocated for the RSBY scheme is woefully short of the required funds of at least Rs 10,000 Crores as per Dr Ravi Wankhedkar, President, Indian Medical Association (Anuj Gupta, 2018).

In the light of the shortfalls of healthcare policies in India, I will look into the various solutions that are feasible to combat the challenges that healthcare faces in India.

Remedying Indian Healthcare

Healthcare should not be restricted merely to medical care but cover aspects of pro-preventive care as well. Primary health care needs to be recognized as a public good which is non-excludable and non-rival consumption. Hence, its supply and demand cannot be left to be regulated by the invisible hand of the market. Elements of health like sanitation, vaccination, health education and primary healthcare have large positive and negative externalities and hence need public funding to be provided at socially optimal levels. Lately, a lot of public funding has been directed to improve our secondary and tertiary care systems that mostly provide private benefits. While there is a need to work at all the three levels of primary, secondary and tertiary healthcare, the main focus of the government today should be on improving the primary healthcare as a public good.

Governance

While more spending on public healthcare remains a central point of NHP 2017, it is important to realise that one of the key problems of the Indian healthcare system is its poor management, administration and the entire governance structure. The importance of management and governance structure can be observed through the variations in the health indicators as seen across the various states of India. It is seen that the states with better capacity and stronger management have utilized the National Rural Health Mission funds more effectively than the states with poor initial conditions. Years of misgovernance and neglect have vitiated our public management systems with perverse incentives. Chronic absenteeism, corruption and private practice have become very integral to our systems (Shamika Ravi, 2015).

The new governance structure needs to balance responsibility, accountability and flexibility. At best our systems today allocate responsibility but lack the flexibility and accountability of managers to build an effective system. One of the models that can be implemented in the country is the one pioneered by the **Tamil Nadu Medical Services Corporation**. It was set up by the Tamil Nadu Government to procure drugs for the public health system. An independent board of directors, including the health secretary, sits at the top of the corporation. Its managing director is an IAS officer and professionals and academics are hired on deputation as required. The model has proved extremely successful in improving drug supply in Tamil Nadu (Shamika Ravi, 2015). A recent report prepared by Niti Ayayog ranks Tamil Nadu on number three on its health index.

A similar model can be adopted by other states to suit their own governance structure to facilitate the expansion of public and preventive healthcare in India. Present government employees (health workers and doctors) can be absorbed on deputation, while new capacity is built and hiring is carried out by the corporation. Such a system will ensure that the employees are not restricted because of the government rules and the negative image surrounding short-term contracts does not affect the implementation of the programme.

National Health Service (NHS) of United Kingdom is a successful implementation of such a model at a much larger scale. The corporation mostly acts as an independent entity even though the government sets its mandate and targets. Local health boards are made responsible for their finances. They 'purchase' or contract NHS primary care providers and hospitals on a services rendered basis, ensuring accountability at the local as well as the highest levels (Guardian, 2016).

Feasibility Analysis:

Any change in the governance structure of a system requires both time and the willingness of the people to change. Under the proposed solution, the various state governments would have to lay out the most effective structures for their respective states, hire the most competent individuals and lay out comprehensive rules and regulations for the functioning of the corporation. This could take several years' time but once the corporation is in place, the functioning of the same would bring in many improvements in the system. Also, this improvement would require only moderate government expenditure.

Information Management Systems

Another major problem plaguing the Indian healthcare system is the lack of information that is available about the patient's history. Take for instance a migrant worker who moves from Bihar to Delhi for work. He falls ill and consults a doctor in Delhi, gets the required treatment and moves to Mumbai in search for better work. There he falls ill again and consults another doctor but unfortunately, the doctor knows no medical history of the patient as there are no medical records other than what the patient can himself explain to the doctor of his past treatments based on his limited medical knowledge. Such is the case with more than 80 percent of our population.

Another important issue in the healthcare system is the **information asymmetry between the patients and the doctors**. While doctors know a lot about the condition of the patient, the patients have very little knowledge about their own medical condition or the quality of healthcare that they get from a doctor.

This kind of information management problem can be tackled through a **two-pronged approach**- one, **maintenance of electronic medical records** and two, **information sharing through internet** and other media about the quality of healthcare that one can get from a doctor. With the ever-growing use of smartphones and increasing internet penetration in the country, this could be a very effective solution going forward. The **medical records of a person can be linked to his Aadhaar number** and can be accessed by any doctor through this. The government needs to maintain single standard for Electronic Medical Records with can be accessed from any part of the country. The government should also support consumer's search for good healthcare by providing access to information about the various healthcare centres and the available services. They can also share the reviews of previous consumers in order to give an idea about the quality of healthcare services that can be availed from any centre. It can supplement the efforts of the already existing websites, like Practo, that help the consumers locate doctors round them, through its regulatory framework. The internet can be used as a very powerful tool to remove the problem of information asymmetry between the patients and doctors in India.

Feasibility Analysis:

The feasibility of maintaining such huge amounts of medical records is actually aided by the introduction of Aadhaar number. With a unique identification number in place for every citizen, it will be easier to link the medical records of a person with his other information and make it easy to access from anywhere by any doctor. Improvements in technology and mobile phone and internet penetration will play an important role in the pace of development and the effectiveness of such an information

management system. Integration of the same with bank accounts as done under Pradhan Mantri Jeevan Jyoti Bima Yojana will lead to a more efficient, self-sufficient system.

Healthcare Financing

Because of the uncertainty associated with healthcare needs, it is often not possible for people to plan their healthcare costs, which can be huge. Large uncertain expenditures are typically covered by insurance, but with over 70 percent of uninsured population, the burden of these expenditures on the pockets of common man is huge. The problem of adverse selection and moral hazard plagues health insurance throughout the world. One solution to these theoretical problems is **medical savings accounts (MSAs).** These are like the regular savings accounts, however, the savings here are tax exempt as long as the money is used only for healthcare expenditures arising for the individual or their immediate family (Shamika Ravi, 2015).

The evidence on the success of MSAs in cost containment in the healthcare system is mixed, either because of parallel introduction and implementation of several schemes or because of being tried on a small scale where significant impact cannot be observed. In India, financing for healthcare is still at a nascent stage and medical insurance is not as entrenched. Hence implementation of such a system will be non-distorting and more effective. Also, to address the issue of inequity, i.e., the poor may not be able to pay into these accounts, the government can intervene by making payments into these accounts, especially for the more vulnerable sections of the population.

Feasibility analysis

Medical Savings Accounts would be a combined effort of the government, the healthcare system and also the banking system. Because of the complexity of relationships involved this could be a rather more difficult solution to realise but through concerted efforts of the different stakeholders, once such a policy is mandated, the implementation of the same can be successfully done in a couple of years. This policy would be a high investment policy with the need for the government to allocate significant budget to it.

Human Resources

The shortage of human capital in the public healthcare system in India is well documented. The problem is not only in terms of numbers but also the quality of education in medical schools. The distribution of medical staff across rural and urban areas is highly distorted, with rural areas facing severe shortages. This is due to many financial and non-financial disincentives to people in working in rural areas, like low salaries, poor working conditions etc.

The central government needs to focus on increasing the supply of doctors and medical staff, especially in the rural areas. It can be achieved through two means. One is through the **expansion of training of physicians and health workers under the current system**. Second is to expand the system itself to provide certification and training to new categories of paramedical staff focused on public health- primary and preventive care.

Under the second category, the idea is to **provide training to undergraduates in specifically primary and preventive healthcare**. This could be in a shorter period than the typical MBBS, say around three years. The government should get means to recognise some of the best brains from the rural areas, adequately train them with a revised curriculum focusing on primary care and incentivise them to

serve the CHCs and PHCs in the rural areas. Once they have worked here, gained enough experience and expertise, they can be encouraged to pursue further studies to augment their knowledge and serve as more qualified professionals. Since people from rural areas are more likely to be willing to stay in rural areas to render their services, this model could prove effective enough. These new categories could include both para-physicians-cum-public-health-managers that are trained (and licensed) to practice at the primary health centre level, and community health workers with more rigorous training and a more stable role than the current Accredited Social Health Activists (ASHAs).

An inspiring model for this is offered by Chhattisgarh which provided 3-year long medical training to the students from the State. Its graduates were hired as **Rural Medical Assistants** (RMAs) in government-run Primary Health Centers (PHCs) (Jain, 2010). A study by Public Health Foundation of India (PHFI) revealed that the PHCs run by RMAs were as good as those run by MBBS doctors in terms of provider competence, prescription practices and patient and community satisfaction. Three year degrees focusing on conditions that most commonly crop up at the PHC level (obviously, these may differ from state to state), on preventive healthcare and on public health management, would provide a group of qualified personnel willing and able to serve the cause of healthcare in rural areas in India (Krishna D. Rao, 2011).

Feasibility Analysis:
The RMA model has already proved its success not just abroad but also in India. However, the proposed training would require significant infrastructure investments in terms of personnel, institutes etc. Also, there would be a major challenge arising from the attitude of people towards working in rural areas which the government would have to alter through incentivising.

Preventive Healthcare

A robust preventive healthcare mechanism, finally, is an optimal solution to ease down the pressure building on the current healthcare system. Preventive healthcare in terms of proper sanitation, timely vaccination, avoidance of self-medication, increasing awareness through health education and regular health check-ups should be promoted through government policies. Sanitation is one of the key areas of preventive healthcare. People's hygiene has strong externalities and hence adopting schemes that promote hygiene can have impact on a large scale. Current government programmes like the Swachh Bharat Mission need to be emphasized and their outreach needs to be maximized. The government needs to focus more on implementation rather than just promotion of such programmes (Neutron, 2017). Adoption of medical devices to promote regular health monitoring can also be an effective step especially in tackling the increasing incidences of lifestyle diseases (Masuda, 2016). Health education, including health promotion, creating awareness about diseases as well as sharing information about appropriate treatment, needs to be disseminated both in urban and rural areas through healthcare centres as well as various forms of media.

Feasibility Analysis:
Any such preventive healthcare requires the adoption of certain practices by the public which calls first for a change in mindset and eventually a behavioural change. For example, large number of marketing campaigns have been undertaken by the government to alter people's attitude towards defecation in the open. Such changes are not easy to bring about and take their own time. However, what would be important are continued and renewed efforts of the government in this direction.

Conclusion

The healthcare sector in India is poised at a crossroads where the right policy action is extremely critical in determining the future course of the sector. The industry faces major challenges owing to the changing demographics of the country, the poor state of the public infrastructure, lack of financial resources, paucity of human capital and poor governance. The staggeringly low contribution of the public sector in the healthcare industry sits at the centre of all these problems. While the National Health Policy tries to address the majority of these challenges, it lacks significantly in terms of the feasibility of implementation and also inadequate finances. Through this paper, I have suggested multiple solutions to attack these problems from different directions through different approaches. Although the government realises the need to increase public spending in healthcare, it would be important to ensure that the spending is done in the right manner. Countries like Sri Lanka and Bangladesh which have much lower spending on healthcare when compared to India actually perform much better on several health indicators. This shows the importance of not just increasing the spending but also spending it more effectively.

All said and done, it may not be very accurate to directly compare the Indian situation with any of the other countries in the world given its huge population, unique demographics and democratic governance. We need our own solutions to our own problems which are best suited to our population and our systems.

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