

The Indian Healthcare System

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After gaining independence in 1947, India adopted the welfare state approach, which was dominant worldwide at that time. India's leaders envisaged a national health system in which the state would play a leading role in determining priorities and financing and would provide services to the population. Set up by the

Indian government in 1943 to investigate and recommend improvements to the Indian Public Health System, Bhore Committee noted in 1946 that "If it were possible to evaluate the loss which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency

through malnutrition and preventable morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about."

This statement has, unfortunately, not been heeded by India's leaders, which has

been reflected in three significant facts: the low level of investment and allocation of resources to the health sector over the years – about one percent of GDP with clear declining trends over the last decade; the uncontrolled and incredibly rapid development of an unregulated private health sector in the recent past; and, as a result of the first two facts, the undermining of roles and responsibility such as stewardship and governance. A healthcare policy statement only came about after the Alma Ata Declaration of the World Health Assembly in 1978, which advocated “Health for All” by the year 2000.

The inequity in the access to and distribution of public health services has been a concern because of the extent of impoverishment that many Indian households face due to ill health. According to a national survey, 61 percent of India’s poor use public facilities for health services, compared to 33 percent who reported to be non-poor¹. The poor benefit from centrally funded vertical programs such as immunization, antenatal care, tuberculosis, malaria, and leprosy.

The single most vital component of healthcare is pharmaceutical drugs, as they account for a substantial part of household health expenditures. The market for drugs, particularly in the allopathic category, has been growing rapidly in India in terms of production, trade, investment, and employment. However, the industry is characterized by supplier-induced demand, uncertain demand from the patients, oligopoly elements, monopoly profit, and other factors. This has far-reaching implications on the healthcare of the masses, whose essential problem lies in lack of purchasing power, lack of access, and lack of knowledge regarding modern medicine. Estimates from the above-mentioned survey revealed that three-fourths of the total out-of-pocket health expenditure are spent on drugs.

However, the component of drugs and medicines in the overall budget of both the central and state governments is only a minor share. In all, roughly ten percent of the national health budget goes into procuring drugs.

Enacted in 1948, the Employees’ State Insurance (ESI) Act was the first major legislation on social security in India. The scheme applies to power-using factories

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employing ten persons or more, and non-power and other specified establishments employing 20 persons or more, with employees earning up to US\$150 per month being covered, along with their dependents. The current coverage stands at 84 million employees and 353 million beneficiaries across 22 states and union territories. The benefit package goes beyond the cost of medical care to include cash benefits (sickness, maternity, and permanent disablement of self and dependent) as well as other benefits such as funeral expenses and rehabilitation allowance.

The Central Government Health Scheme (CGHS), established in 1954, covers employees and retirees of the central government and of certain autonomous, semi-autonomous, and semi-government organizations. It also covers members of parliament, governors, accredited journalists, and members of the general public in some specified areas. The families

¹ National Sample Survey, 52nd round

Facts & Figures

The central government, through the main council of the Ministry of Health and Family Welfare and various committee recommendations, has shaped health policy and planning in India. It is being implemented through one of India's five-year plans with a programmatic approach. The central government designs national programs and the states' governments are required to implement them. However, there is a clear demarcation between the central and state governments' provision of health services. The states fully finance hospital services and primary healthcare facilities. Meanwhile, family welfare programs are fully financed by the central government. And national disease control programs are funded on a 50:50 sharing arrangement. However, in many cases, the states' contribution turns out to be about 75 percent, and the states have to bear all administrative costs, including staff salaries. Out of the total expenditure on medical education and research, the central government's share is a little over 40 percent. Thus, by and large, the states fully finance all curative care services.


Regarding private spending on healthcare, the National Health Accounts matrix reveals that 71 percent of the health budget is contributed by the private sector, of which households alone spend 68.8 percent. This is because the government's health sector policies encourage the growth of the private healthcare sector, especially for curative services, by investing resources in medical education, providing subsidies and tax exemptions, and offering soft loans to set up hospitals. So even though public sector spending on healthcare is less, it has a major role in terms of planning, regulating, and shaping the delivery of health services in the country. Such public provisioning is considered essential to achieve equity and to reduce the gaps associated with health. As a result, the public health system has grown over time across the country with 137,311 sub-centers (mainly dispensaries manned by paramedics), 22,842 PHCs (Primary Health Centers), 3,043 CHCs

(Community Health Centers), 4,048 hospitals, and a workforce of 345,514 (statistics from 2001-02). There is a strong case to markedly increase public sector spending on health, as stated in the National Health Policy 2002 and the National Common Minimum Program (CMP) 2004.

In addition to this, the Ministry of Health and Family Welfare implements certain schemes itself, such as the Central Government Health Scheme (CGHS) and national disease-control programs, through the states' governments. A large part of the Ministry's budget is passed on as grants-in-aid to states for implementing various national health programs. Even though the size of the central health budget has grown considerably, transfers to states as a proportion of the total budget of the Ministry has declined from nearly 57 percent to 44 percent. This shows the increasing role that the central government has been assuming in the delivery of health services.

To overcome the country's inequity, inequality, and budget deficits, the government has initiated a mix of mandatory social health insurances, voluntary private health insurances, and community-based health insurances. However, social security for medical emergencies is not new to India. It is a common practice for villagers to take a *piruvu* (collection) to support a household with a sick patient. Health insurance as we know it today was revised in 1972, when the insurance industry was nationalized. Private and foreign entrepreneurs were allowed to enter the market with the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999. The penetration of health insurance in India has been low. It is estimated that only about four to six percent of all Indian citizens are covered under any form of health insurance. In terms of the market share, the size of the commercial insurance market is barely two percent of the total health expenditures in the country. Thus, health insurance is really a minor player in the health ecosystem.

All data taken from *India Medical Device Market Intelligence Report*,
Epicom Business Intelligence 2009. Numbers refer to 2009
unless otherwise indicated.

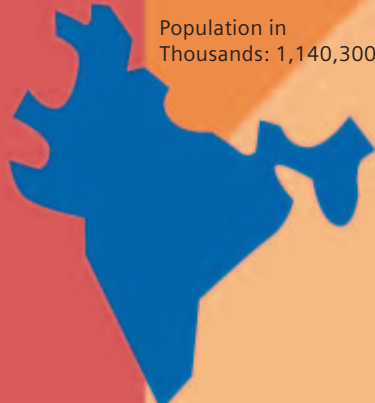


Total Expenditure on Healthcare / Capita (US\$): 55



Total Expenditure in Healthcare as % of GDP: 5.0

Public Expenditures on Healthcare as % of Total Expenditures on Health: 22.6



Population in Thousands: 1,140,300



Men: 68.1

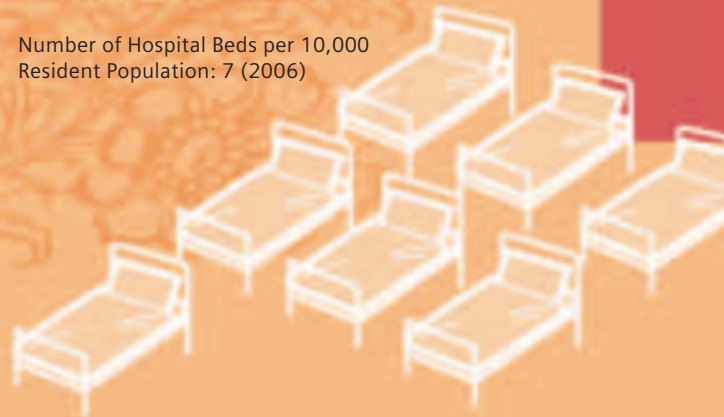
Women: 65.8

Life Expectancy at Birth (2006)

Number of Physicians per 10,000 Resident Population: 6 (2006)



Number of Hospital Beds per 10,000 Resident Population: 7 (2006)



Number of Dentists per 10,000 Resident Population: 0.7 (2006)



Number of Nurses per 10,000 Resident Population: 8 (2006)



of the employees are also covered under this scheme. Benefits under the plan include medical care at all levels and home visits/care as well as free medicines and diagnostic services.

In providing financial risk protection to the poor, the Indian government announced a revised Universal Health Insurance Scheme (UHS) in 2004 for BPL (Below Poverty Line) families. Under this scheme, for a premium of US\$7.5 per year per person, US\$12 for a family of five, and US\$15 for a family of seven, healthcare for an assured sum of US\$650 is provided. To make the scheme more saleable, the insurance companies provided for a floater clause that made any member of the family eligible for the Medclaim Policy. Yet, in the last few years of its implementation, the coverage has been minimal. The reasons are many: Public sector insurance companies required to implement this scheme find it unprofitable and do not promote it; to meet their targets, many field officers pay premiums under fictitious names; identifying eligible families is problematic; the poor find it difficult to pay the entire

premium in one payment for a future benefit, foregoing current needs; the paperwork required for enrollment and claims is cumbersome and time-consuming; there is a limited supply of service providers, particularly because government

hospitals are not permitted to treat patients insured under this scheme; and lastly, there have been setbacks due to health insurance companies refusing to renew the previous year's policies. For the majority of Indian citizens, the public health system is out of reach due to distance, lack of money, or lack of confidence in the system. The organizational structure requires a villager to travel an average distance of 2.2 kilometers (km; ca. 1.4 miles) to reach the first health post for getting a common pain reliever, over 6 km (ca. 3.7 miles) for a blood test, and nearly 20 km (ca. 12.4 miles) for hospital care. Given the poor road connectivity in rural India, the unreliability of finding the provider at the health center, and the indirect costs for transport and lost wages, many of the poor opt for local, self-proclaimed "physicians." Furthermore, even when initial care is accessed, continuity of care is not guaranteed. This has resulted in the dilution of the concept of the integral nature of health where curative services are a continuum of preventive and promotive healthcare.

The shortage of funds has been primarily responsible for the unavailability of facilities that are in accordance with the norms set by the government. Likewise, there is inadequate provisioning of critical inputs like drugs, equipment, and facilities such as operation rooms. Due to the lack of budgets and the pressure to achieve targets, several states have upgraded the two-room sub-centers to primary health centers. But with no space for a laboratory, examination room, or pharmacy, most of these are nonfunctional. This shows that there is a combination of factors that influence health-seeking behavior and determine outcomes.

The Indian government's policy governing the National Health Programs (NHP) is that services being provided under them are free for all. Theoretically, therefore, regardless of income, all citizens are eligible to avail themselves of services free of charge, including treatment for

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premium in one payment for a future benefit, foregoing current needs; the paperwork required for enrollment and claims is cumbersome and time-consuming; there is a limited supply of service providers, particularly because government

vector-borne diseases, tuberculosis, leprosy, cataract blindness, and HIV/AIDS, among others. However, the suboptimal functioning of the delivery system due to gross underfunding has led to huge out-of-pocket expenditures being incurred by individual households in seeking services “guaranteed” to them under the NHP.

There are four obvious flaws in the Indian healthcare system as it exists today: First, by and large, it offers traditional indemnity, under which the insured first pay the amount and then seek reimbursement. Under indemnity, all known diseases or health conditions are excluded; therefore, such policies typically turn away large numbers of care seekers, and those most in need of insurance, that is, the sick, are ineligible for any financial risk protection against the diseases from which they are suffering. Second, the system is fee-for-service-based. This is advantageous for the provider, since he bears no risk for the prices he charges for services rendered by him. Such a system usually entails increased costs. Third, the system is based on risk-rated premiums. This again puts the risk on the insured. Under such a system, women in the reproductive age group, the old, the poor, and the ill pay higher amounts and are thus, victims of discrimination. Last but not least, the system is voluntary, making it difficult to form viable risk pools for keeping premiums low.

An important public health function that governments are expected to perform is expanding access to preventive and pro-

motive education. This does not mean simply disseminating disease-specific messages to raise awareness among people for behavior change, but includes a range of other aspects, such as laws for the use of helmets to prevent road accident injuries or providing nutritional information to consumers regarding food products or raising awareness of risky behaviors and exhorting people to adopt healthy lifestyles. In India, the interventionist role of the state in this case is negligible, although some information, education, and communication activities are carried out under the NHP. This is a serious omission given the huge treatment costs that will be required to cope with the increases in noncommunicable diseases. Moreover, as most people are unaware of the free services under the National Health Programs, a large number of them continue to go to the private sector for treatment.

In developing countries like India, healthcare has been a neglected issue in the overall policy framework. With low public budgets, providing universal social security to the population is difficult. At the same time, households spend a significant portion of their income on food, leaving little for healthcare. 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 in order to take corrective measures in time, and flexible enough to have the capacity to respond to local needs. Unless such restructuring takes place, the challenge of meeting

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healthcare needs in India will continue to be difficult.

Providing healthcare to all Indian citizens at their doorsteps has been a “mantra” in India for the last 60 years, but the words have yet to be translated into actions. Unfortunately, health education seems to be lacking at both the supply and demand side. This has resulted in high morbidity and mortality. The service delivery mechanism is always on war footing, fighting health problems due to this lack of preventive vision, which makes the system more costly. Therefore, there is a strong need for capacity building in improving community health with preventive perspectives, which would yield better health all around.

The opinions expressed in this article do not necessarily reflect those of Siemens Healthcare.



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