Universal Health Coverage
Reform of the Government System Better Than Quality Health Insurance

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For India to improve the existing government health system is far less complex than expanding health insurance. International experience shows the difficulties of regulating an insurance-based system to keep costs down and assure quality.

India has a "single-payer" health system (at least in principle) that was intended to be financed by tax revenues and available free for all at government facilities. In large parts of the country, due to underfunding and poor management, this system has functioned poorly, as indicated by low facility utilisation rates. Meanwhile, the private health sector has mushroomed with little public oversight. The national health accounts estimated that private expenditures constituted 78% of total health expenditures in 2004-05 (Ministry of Health and Family Welfare 2009).

One of the policy responses to this has been to expand insurance coverage, to protect people against the high costs of healthcare that can push people into debt and poverty. This article argues that improving the existing government health system is far less complex than expanding health insurance coverage. There are two parts to this argument: (a) international experience shows the difficulty of regulating an insurance-based health system (whether publicly or privately financed) to keep costs down and assure service quality, even under conditions much more amenable to regulation than those in India, and (b) the government healthcare system works well in some areas, and can be made highly competitive with some relatively simple changes. We summarise some of the information on this for the new Bharatiya Janata Party government.

International Experience

International experience shows unambiguously that shifting from a "single-payer" to a health insurance model would be a very dangerous path for India to take because of obstacles to regulating the system. This is because a health insurance system can only work well if the government tightly regulates the insurers and health providers, both in the fees they charge and in the services they provide (Reinhardt 2004, 2011). Where this was not done, as in the US, there ensued a free-for-all whereby people have been at the mercy of insurance companies that could refuse coverage (or charge very high premiums) to all but the healthy, and find pretexts for refusing to reimburse an insured person who needed care. Meanwhile, costs are further inflated by doctors' financial incentives to increase the number of tests and procedures. Fees for the same service also vary widely between providers. About 16% of the population was not insured in 2011 according to the Census Bureau (Todd and Sommers 2012).

Since at least the 1930s, successive governments in the US have sought to introduce a "single-payer" system, but have been thwarted by powerful opposition from the American Medical Association, private health insurance companies, and other groups that would lose large profits (Palmer 1999; Derickson 2005). The government was permitted to provide coverage only to categories such as the poor and the old who are bad for companies' profit margins. Some important changes to the system were finally introduced in 2010, but their scope was heavily diluted by lobbying. The new system is a long way from finding its feet, and the government will face stiff opposition in regulating the services and the fees of insurers and health providers. If even these partial reforms succeed, it will be after nearly a century of effort.

As a result, the US spent as much as 17.7% of its GDP on healthcare in 2011 (WHO India 2013), nearly double that of the average in the member countries of the Organisation for Economic Co-operation and Development (OECD). Measured in US $ PPP,[1] both private and public outlays in the US in 2011 were higher than the OECD's average *total* per capita expenditure – despite the US' relatively young population (Table 1, p 30). All other OECD countries have far lower health costs per capita, and significantly better mortality indicators than the US. Infant mortality rates are especially sensitive to the quality of health services,

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and that for the US is 50% higher than the OECD average.

Most developed countries have universal health coverage financed by tax revenues (Thomson et al 2013), achieving good results despite the demands of their ageing populations (Table 1). Japan is especially striking, with excellent mortality indicators with expenditures slightly below the OECD average, despite nearly a third of its population being above age 60 years.

One exception is the Swiss health insurance system where people have to purchase personal health insurance and pay for a significant share of the costs of care (Reinhardt 2004). The Swiss system delivers good outcomes because it is tightly regulated, but it costs 70% more than the OECD average (Table 1).

Table 1: Health Expenditures and Mortality Indicators in Selected OECD and Non-OECD Countries (2011)

	Total Per Capita Expenditure on Health, US$ PPP	Public Expenditure as % of Total Expenditure Per Capita, US$ PPP	Life Expectancy at Birth (m+f)	Infant Mortality Rate	% Aged 60 + Years
OECD countries					
Japan	3,213	82	82.7	2.3	31
OECD average	3,322	73	80.1	4.1	
Canada	4,522	70	81.4	4.4	20
Switzerland	5,643	65	82.8	3.8	23
The United States of America	8,508	48	78.7	6.1	19
Non-OECD countries					
Thailand	372	72	74.3	9.9	13
India	146	30	66.3	43.8	8

(1) The OECD and non-OECD countries are not directly comparable, since the OECD countries have more aged populations that require higher health expenditures per capita. They also differ in other ways from the non-OECD countries, such as higher wages and costs of service delivery.
(2) US$ PPP means the expenditure of each country is standardised in terms of the domestic purchasing power of its currency (purchasing power parity), denominated in US dollars.
(3) While life expectancy can be affected by many factors other than the quality of health services, the infant mortality rate is more directly influenced by health service quality.
Sources: (1) Source for OECD countries: OECD Health Statistics 2013. All data refer to 2011 or nearest year.
(2) Source for non-OECD countries: data on health expenditures from the World Health Organisation Global Health Observatory Data Repository. The data on life expectancy and infant mortality are estimates for the period 2010-15, while those for the percentage above age 60 are for 2010. All these data are from United Nations (2013).

Amongst developing countries, Thailand illustrates the efficiencies that can be achieved with public financing of healthcare (Table 1) – having rejected donor advice to the contrary (Yates and Dhillon 2014).

Difficulties of Regulation

India faces a far more daunting task than the US in providing the necessary regulation of private sector health insurers and providers. The US government could provide such regulation if the political system permitted it to do so, as its health facilities and doctors are accredited and registered. India's the Clinical Establishments (Registration and Regulation) Act 2010 can be used to improve quality through regulation and registration of health facilities, but as the health secretary to the Government of India pointed out, the task is enormous (WHO India 2013).

The Indian Medical Association is also quick to protect its interests. For example, a nationwide doctors' strike ensued when the central government sought to make reforms in response to corruption in the implementation of regulations by the Medical Council of India (Bhaumik 2012). There is also a very large number of non-registered medical practitioners, whose numbers are difficult to estimate (Ministry of Health and Family Welfare nd), let alone regulate their services.

The government has had difficulty even with the relatively simple task of ensuring that large private sector hospital groups offer a certain proportion of their services free to poor people, as promised in exchange for paying very low rates for substantial tracts of prime urban land to construct their hospitals (JSA 2006). Private sector health services have grown with little proactive public policy with regard to their size, service quality and costs of care.

Clients face much difficulty in effective health seeking. People anywhere, however well-educated, have difficulty evaluating their doctor. But this problem is hugely compounded when poor people are faced with the entire spectrum of service providers ranging from world class to witch doctors, with little to help them distinguish where in this spectrum a particular health provider lies. And even if there was proper accreditation of doctors accompanied by some kind of stamp of quality that could be displayed to patients, it would be very hard to prevent health providers from putting up counterfeit signboards. What chance would poor patients face in ensuring that health insurers provide them the coverage they are supposed to receive?

Another important consideration is that the private sector has no incentive to provide services aimed primarily at reducing population exposure to disease, as opposed to treating a patient. Two examples that are highly pertinent for India are measures to reduce the spread of communicable diseases, and offering technical and other assistance to rural panchayats in meeting their mandated sanitary and health responsibilities. These services are provided by the government health system to different degrees in different states, with Tamil Nadu offering a useful model (Das Gupta et al 2010). Such services are critically important anywhere, but especially in countries like India where the burden of communicable diseases is still very high.

Improving Government Health Services

Are the government health services beyond repair? Certainly there are innumerable studies showing dissatisfaction with long waiting times, staff absenteeism, lack of drugs, and many other problems. India performed nearly at the bottom of 39 low and low-middle income countries in the share of use of government health facilities in 2003 (Saksena et al 2010).

There are many reasons for this, stemming from government policy. Only two major reasons are mentioned here. First, government financing of health is extremely low. In 2012, government expenditure on health was only 1.3% of GDP (equivalent to $19 per capita), one of the lowest allocations of national income in the world, compared, for example,

with 3% in Thailand (equivalent to $164 per capita).[2] Adding to this is the policy trend towards collecting at least partial "user charges" for many services while also promoting the concept of health insurance, both policies undercutting the concept of free publicly financed healthcare. Second, central government policy has been to use its fiscal power to have states' health facilities focus on specific targeted programmes (vertical programmes) – and tightly monitor progress on these programmes rather than their overall functioning as health facilities (JSA 2006, Das Gupta et al 2010). It is left to the states to monitor overall functioning as part of state rights, so the results are very variable (Table 2).

Table 2: Per Cent Reporting Government Facilities as the Source of Healthcare that Household Members Generally Use when they Get Sick, by Wealth Quintile

	India	West Bengal	Maharashtra	Gujarat	Tamil Nadu	Himachal Pradesh
Wealth quintile:						
Lowest	39	33	47	50	74	(90)*
Second	37	34	40	43	69	92
Middle	39	29	37	35	63	83
Fourth	34	28	30	24	47	81
Highest	23	14	14	14	19	82
Total	34	21	30	28	53	83

* indicates that the numbers in the lowest wealth quintile in the Himachal Pradesh sample were very low, the estimate is based on 25-49 unweighted cases.

Despite all this, the data indicate that the public sector is still of benefit in many states, especially to poorer people. When asked what source of healthcare is generally used when household members are ill, high proportions of those in the lower wealth quintiles report that they seek care from government facilities. The differences between the states indicate that many would benefit from learning from the higher-performing states such as Tamil Nadu and Himachal Pradesh. In the major metropolitan cities, high proportions of slum dwellers (except in Delhi) go to government facilities to deliver their babies (Table 3). And significant proportions of users report receiving free in-patient care in government facilities in both rural and urban areas – despite the policies introducing user charges for services, with a complex system of exemptions for the poor that is not always accurately applied. By contrast, almost no one reported receiving free care in private facilities (Table 4).

Table 3: Per Cent Reporting Giving Birth in Government Facilities, Major Metropolitan Cities

	Delhi	Mumbai	Kolkata	Chennai
Slum residents	20	45	61	74
Non-slum residents	33	38	53	55
Total	30	43	56	60

Table 4: In-patient Services Received Free in Hospital (% of Cases), India

	Public Sector	Private Sector	Public Sector	Private Sector
	(Rural)		(Urban)	
Surgery	70	6	66	3
Medicine	19	1	24	1
X-ray/ECG/EEG/scan	29	1	39	2
Other diagnostic tests	38	1	44	2

Sources: For Table 2: National Family Health Survey 2005-06, India Table 13.12, State Tables 37 and 67). For Table 4: National Sample Survey 2006, Table 27.

Efforts to improve the system need to encompass several things. Staff performance needs to be monitored, and their living and working conditions improved. Facility infrastructure needs upgrading, and drug supplies need to be available.

Some efforts to achieve at least some of these improvements appear to have had some success. For example, the National Rural Health Mission (NRHM) provided some funds for flexible spending by facilities. Prasad et al (2013) found that the introduction of the NRHM in states with poor health indicators accelerated the reduction of infant mortality and fertility, as well as raising the proportion of institutional deliveries. The Tamil Nadu Medical Services Corporation offers an effective model for streamlining drug supply (Singh et al 2012). The state also ensures relatively good infrastructure in its facilities (Rao and Choudhury 2012).

Conclusions

The dangers for India of moving towards a system of (at best) lightly-regulated health insurance coverage are clear from the international experience. Adequately regulating a system of private insurers and providers can be managed by tiny tightly-run states such as Switzerland. Nor can India manage a system like Canada's, where publicly-financed health insurance pays private providers to deliver healthcare under tight government regulation of provider fees and services.

If India is to replace its "single-payer" model with one based on health insurance, the task of providing the needed regulation is beyond daunting, and could well plunge the country into the kind of morass that the US has experienced for nearly a century. It is far easier for the government to improve the functioning of health services that are directly under its control.

NOTES

1 US$ PPP means the expenditure of each country is standardised in terms of the domestic purchasing power of its currency (purchasing power parity), denominated in US dollars.

2 Source: World Bank, World Development Indicators http://data.worldbank.org/indicator/NY. GDP.PCAP.CD and http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS, accessed on 8 June 2014.

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