HEALTHCARE IN INDIA

A CALL FOR INNOVATIVE REFORM

As India seeks to become a global power, there is perhaps nothing more important than the health and well-being of its citizens. This is ensured in part through an effective, comprehensive health system. However, assessments about India’s healthcare—ranging from access and capacity to spending—are often bleak. Yet there has been renewed attention within India to health reform and universal health coverage in particular. New Delhi has pledged to increase public spending from 1.0% to 2.5% of GDP, and Prime Minister Manmohan Singh announced a specific emphasis on health in the country’s twelfth five-year plan covering 2012–17.

For insight into the reforms needed to improve India’s healthcare, NBR spoke with Victoria Fan, a research fellow at the Center for Global Development. Dr. Fan provides an assessment of India’s health system, the potential for universal health coverage, and the impact of the changing nature of disease in India on public health functions, among other key issues.

What is the state of healthcare in India?

Today, most Indians seek healthcare in private facilities. Owing to many years of neglect, lower-level public healthcare facilities often suffer from a variety of problems, including worker absenteeism and dual public-private practice, low demand for their use, and shortages of supplies and staff. In contrast, private healthcare varies greatly in quality of care, being unregulated and financed largely through out-of-pocket payments. In the private sector, there are a large number of health workers who have only a high-school education or do not have a medical degree.

There are at least two major healthcare programs in India. The first is the National Rural Health Mission (NRHM), which is the central government’s attempt to improve delivery of services in public facilities as well as public-health and preventive interventions, led by the Ministry of Health and Family Welfare. The second is the Rashtriya Swasthya Bima Yojana (RSBY), which is a health insurance program led by the Ministry of Labour and Employment. In most states RSBY covers people “below the poverty line” for a selected set of tertiary care services. While NRHM, launched in 2006, has had some success in improving access to certain services, such as maternal healthcare (under the Janani Suraksha Yojana...
program), it is not clear what effects NRHM has had on most other services. In contrast, there is early evidence that RSBY has been somewhat effective in reducing out-of-pocket payments for tertiary care, although it is not clear whether this program improves population health.

The Indian government has pledged to provide “universal health coverage” of its citizens. Can you explain what this means in the Indian context?

Universal health coverage (UHC) means different things to different people. If we accept the World Health Organization’s definition of UHC—a definition not without controversy—then UHC means that everybody receives access to needed healthcare and that people do not suffer major financial risk when seeking services. This definition of “universal” usually refers to the population accessing healthcare, and sometimes it also refers to the “comprehensiveness” of services provided. However, the scope of healthcare services varies among countries.

It is not clear what the Indian government is proposing for the package of healthcare services. China, for example, has defined “universal health coverage” as “universal coverage to essential healthcare services.” India will need to be more proactive and explicit in defining what package of benefits its citizens are entitled to, perhaps by creating appropriate priority-setting institutions.

India’s prime minister Manmohan Singh and other high-level officials have pledged to encourage public support for health by increasing GDP spending from roughly 1.0% to 2.5% between 2012 and 2017. What might this increase in public investment accomplish?

India has one of the world’s lowest levels of health spending as a proportion of GDP, and there is little disagreement that the pledged increase in spending is important for improving the country’s healthcare. There is cross-country evidence that shows that increased government spending on health in turn is associated with lower out-of-pocket health spending.

However, it is not yet clear how this new money will be invested—whether it will continue to fund NRHM or whether it will use RSBY as a platform to expand services, or some combination thereof. Money alone will obviously not resolve the challenges that any healthcare system faces.

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Victoria Fan
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Victoria Fan is a research fellow at the Center for Global Development. Her research focuses on the design and evaluation of health policies and programs. Dr. Fan joined the Center after completing her doctorate at Harvard School of Public Health where she wrote her dissertation on health systems in India. Dr. Fan has worked at various nongovernmental organizations in Asia and different units at Harvard University and has served as a consultant for the World Bank and WHO. Dr. Fan is investigating health insurance for tertiary care in Andhra Pradesh, conditional cash transfers to improve maternal health, the health workforce in India, and value for money for global-health funding agencies.
How that money is invested is critical, and I have not yet seen the Indian government’s detailed policy proposals to invest such money. The so-called high-level expert group report offered some suggestions, but I think many of the final details still need to be worked out.

Indians reportedly pay about 70% of health costs out-of-pocket, and of this, the majority of expenditures are on drugs. What measures is the Indian government taking to reduce this financial burden?

I think the figures that you have may be slightly out of date. It is true that a large proportion of healthcare spending is paid out-of-pocket, but I believe in recent years this percentage has decreased slightly. I don’t think it is as high as 70% today. Moreover, there is some disagreement about whether drugs account for a majority of health spending or simply a large fraction, depending on which survey one uses. Nevertheless, we can agree that drugs account for a large (though not necessarily a majority) share of health spending.

I understand that the government has recently announced a program to provide free drugs for all. The program seems to be modeled on the success of one state, Tamil Nadu, which has a central drug-procurement system; other states will attempt to follow Tamil Nadu. However, it is very much unknown whether this program will work as intended, whether people will benefit as expected, and how much leakage and corruption there will be. Tamil Nadu is a southern state, and its performance in health is among the best. But Tamil Nadu’s success is not limited to this sector. More generally, it seems to have slightly higher government capability and capacity to deliver services to its population. So it is unclear how other states will be able to fully replicate the successes seen in Tamil Nadu.

Moreover, if India’s public distribution system for selected grains and food is any indication of the central government’s capabilities in procurement and supply-chain management, I am not very optimistic about the program to provide free drugs for all. We also know that free drugs without appropriate prescribing can lead to overuse and increase the chances for drug resistance. If healthcare delivery is problematic, merely making drugs free will not solve India’s problems.

What can India learn from other countries that have undergone significant healthcare reforms?

There is much that India can learn from other countries. One country that India has yet to learn from, in my view, is one of its neighbors, Bangladesh. Despite being a very poor country, Bangladesh has achieved great health outcomes by focusing on selected core child-health interventions, including vaccinations, family planning, oral rehydration therapy, and other maternal and child health services. For example, India needs to improve its vaccination coverage for children, which is one of the most cost-effective health interventions. As many as a third or more of the country’s children still do not receive the full set of immunizations. India has very low coverage with regard to other key health interventions, including oral rehydration therapy and appropriate antibiotic treatment for childhood pneumonia. Bangladesh’s success at mobilizing community efforts and health workers to improve child health offers important lessons for India to address its burden of disease among women and children.

One common lesson from a variety of international experiences is that healthcare reform is a long, ongoing process that requires significant experimentation and innovation.

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to determine what works in one’s own country. Healthcare systems are very complex. Not surprisingly, then, countries have achieved universal health coverage through a variety of pathways, and there are many policy variables that can be adjusted and tweaked.

India will thus need to experiment with different tools for reforming its healthcare system, including how the central government pays state governments and the incentives on those payments, as well as how state governments can improve the delivery of healthcare services through changing payment systems, improving regulation and accreditation of facilities, increasing autonomy in public facilities, and using demand-side incentives such as cash transfers or insurance to stimulate the supply of services. This is just a short list of the various tools that can be deployed. Both NRHM and RSBY each have many moving parts and components. State governments will need to take the lead with support from the central government to find out what works for them.

While much of India’s population suffers from illness and disease associated with high rates of poverty, such as fatal diarrhea, TB, and malnutrition, the country has an increasing rate of noncommunicable disease associated with a growing middle class. How is the Indian health system set up to deal with this dual challenge?

India today faces this dual burden of infectious disease and chronic disease. While both public and private facilities can support the treatment of these diseases, their prevention is a priority for the government. NRHM has several components focusing mainly on infectious diseases, but with much less emphasis, if any, on the prevention of chronic diseases. RSBY is one initiative to support the treatment of certain chronic diseases, but not their prevention.

In my view, the prevention and public-health functions have been somewhat neglected by the government and somewhat crowded out by a focus on and financing for clinical and facility-based care. Education on improved hygiene, hand-washing, and sanitation, for example, is a severely neglected area in the country. Vaccinations are also a key neglected area, as I mentioned earlier. History has shown that the burden of infectious disease will not go down by treatment alone; prevention through government actions is critical. The same could also be said of chronic disease. Yet we know that current government policies, both nationa and at the state level, have varied greatly in their success in controlling infectious diseases. Again, states need to experiment and figure out what works best for them.

What else is important to understand?

There has been much criticism of healthcare services in the public sector in India, not without good reason. Some researchers, such as Banerjee and Duflo, have gone so far as to call tweaks to public facility delivery like “putting a band-aid on a corpse.” There is some truth to that, and I think it is fair to say that there has been little or limited attention to improving the public provision of healthcare
services. That said, since most people demand healthcare in the private sector, improving the quality of private care is crucial. Debates on public vs. private healthcare delivery in India are often very vitriolic, and I think policymakers need to take a pragmatic, rather than ideological, position on the two sectors. India will never have a ubiquitous national health service like the United Kingdom, which is what its public facilities were modeled on decades ago. For India to improve the quality and affordability of healthcare services in both the public and private sectors, the country will need to intervene in each sector appropriately.

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