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Health Financing Model in India- A Universal Health Coverage Perspective.

Date: February 6, 2021

Dr. Monika Chaudhary is a postgraduate in Economics, MBA in Finance and Ph.D in International Trade and Finance from University of Rajasthan. She is a National Scholarship holder and was selected for Rajasthan State Administrative Services, but she found her true call in research and academics. After having taught Investment Banking in a regular business school for six years, she decided to switch to development studies. Her early research work is in capital markets, exchange rates and financial modeling. She presented research papers in National and International conferences and won awards. She had done Corporate Consultancy in the areas of Capital Financial Restructuring and Profitability Analysis. For the last five years she has been involved in research pertaining to various areas of health economics viz Water Economics, Water Financing, Hospital Finance, Integrated Water Resource Management, Monitoring and Evaluation of health programs, Health Financing and Health economics. She has worked closely with government, funding agencies and NGOs. Her consistent endeavor is to develop sustainable models, particularly in the health sector, which may contribute in the growth and development of the economy.

Health Financing Model in India- A Universal Health Coverage Perspective.

- ***Healthcare lies at a confluence of inelastic demand, political sensitivity, economic consequences, and ethical governance that makes the state's role crucial. Alongside an increase in the quantum of funding, there is a need to improve the policy design and quality of spending to ensure closer alignment with health outcomes.***

The definition of UHC embodies three related objectives:

- Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;
- The quality of health services should be good enough to improve the health of those receiving services; and
- People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

affordable access to health services is ensured to all

Key facts

- At least half of the world's population still do not have full coverage of essential health services.
- About 100 million people are still being pushed into extreme poverty (defined as living on 1.90 USD or less a day) because they have to pay for health care.
- Over 800 million people (almost 12% of the world's population) spent at least 10% of their household budgets to pay for health care.

Health Management models

- Beveridge Model - healthcare is provided to all the citizens by government and is financed through taxes. Britain, Spain, Norway, Sweden, Finland, New Zealand and Cuba
- Bismarck Model - covers everyone in the country under various health insurance plans, financed by a risk pool where the insurer does not make a profit. Germany, Japan, Belgium, Netherlands, France and Switzerland
- National Health Insurance Model - a government run insurance program uses private healthcare providers, financed through public expenditure. Canada, Taiwan and South Korea
- Hybrid model-separate systems for separate classes of people - for veterans – Beveridge, for workforce – Bismarck, and for poor out of pocket.
- Out of Pocket – Large part of Health Expenditure is Out of Pocket - Africa, India, Rural China and South America.

Some facts about India

- Public Spending on Health continues to hover around 1% of GDP
- 32 million people being pushed into poverty, out of them 22 million are rural poor
- A fifth of the ill in both urban and rural areas deny themselves treatment
- 3.5% of India's population becomes impoverished and 5% faces catastrophic expenditures
- Only 44% of the people in India have health insurance, 56% of the people are uninsured. - 2018.
- Across all the states, the proportion of households with health insurance increased by 54 per cent for the states that implemented PM-JAY while falling by 10 per cent in states that did not.

Health financing in India

- Is largely private
- According to NHA (2013-14) estimates public spending is 28.06%, and household spending is 67.74%, including premium for Health Insurance
- Medicines, diagnostic and ambulatory care accounts for 70% of this expenditure
- 13.68% of households face catastrophic expenditures
- Poor households finance catastrophic expenditures by borrowing, at 24% to 60% interest rates, that pushes them to inter-generational poverty

Can we do something about it?

- If all out-patient treatment, could be provided for free, only .05% will sink into poverty due to Health Expenditures.

- If Inpatient Treatment and Hospitalisation is covered under insurance, 32% of out of pocket expenditures can be reduced

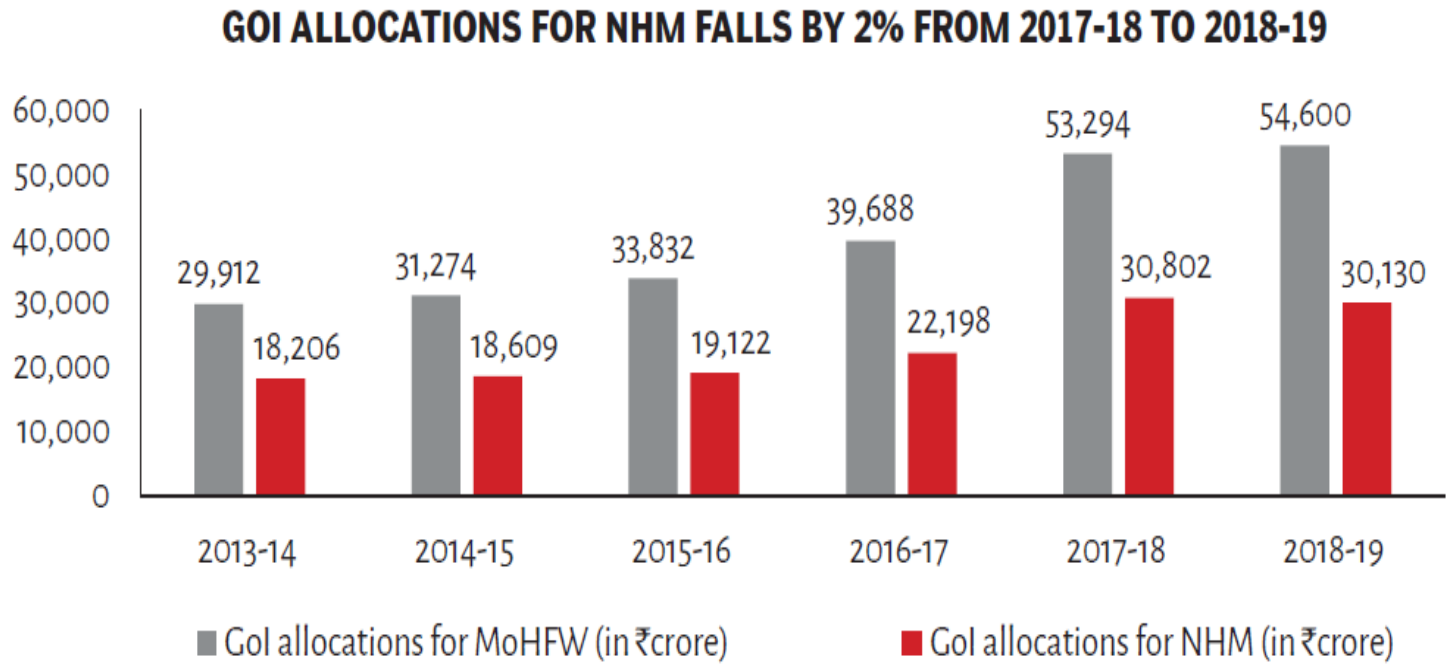
Does this look simple?

Health Financing system

- Is regressive and Inequitable
- Open unregulated marketplace, where individuals pay in accordance with their financial capacity
- And providers change in accordance with their choice
- Government allocations have remained stagnant for many years

Budget Allocations	Budgeted Amount – 2015-16 (Rs. Crores)	Actual Expenditure 2015-16 (Rs. Crores)	Budgeted Amount 2016-17
National Health Mission	18328.46	15318	19000
Department of Health and Family welfare	6254	7504	9100
National AIDS Control Society	1008	900	1050
Department of Ayush	600	657	750
Department of Health Research	1397	1615	1700

Government of India allocations on Health



Some more facts

- A part of allocations on healthcare largely remain unutilized, year after year.
- India is the Generic powerhouse of the world, and big enough to attain scale economies in diagnostics
- A large part of health expenditure is in curative care, rather than preventive and promotive care
- There is a normative gap of 3469 community health centers for a population of .1 million, 5887 primary health centers for every 30000 people and 27430 subcenters for every 5000 people.
- There is a gap in the number of doctors, nurses, paramedics, and frontline health workers required to run this system as well

A SIMPLE SOLUTION TO INCREASE PUBLIC EXPENDITURE IN HEALTH CARE

- Give it in the hands of the people, they are doing out of pocket expenditures, they will spend money for the betterment of their health
- Finance it with an increase of 1% in the special 'health' cess, or tax
- Resultantly overall Health Indicators will improve

Ayushman Bharat was born

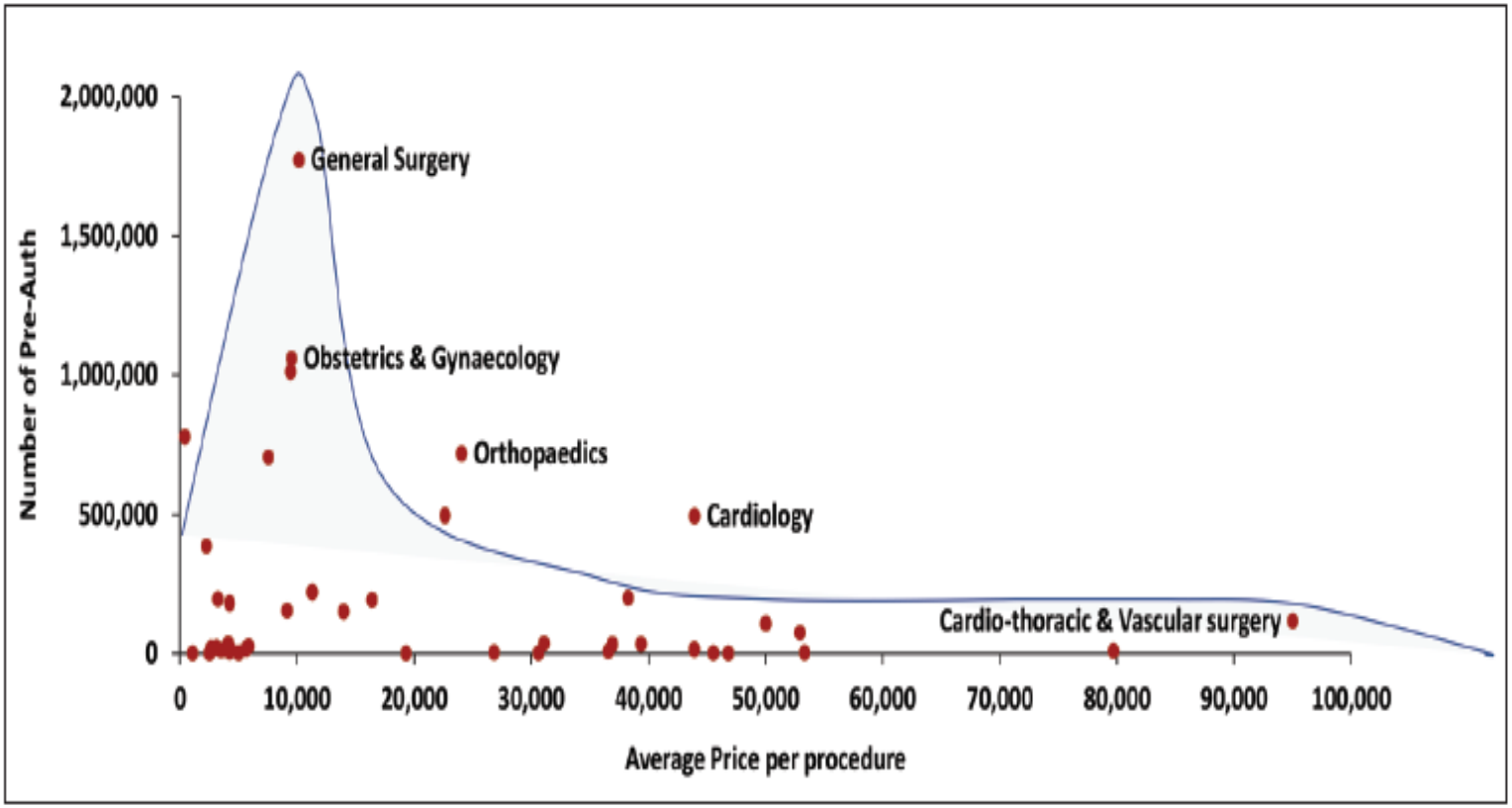
Pradhan Mantri Jan Arogya Yojana (PMJAY)

- The scheme aims to provide a coverage of Rs. 5 lakhs per family, annually and will benefit 10 crore families.
- 1% cess, which is expected to collect an amount of Rs.11000 crore to the exchequer every year.
- Ayushman Bharat produced a bill of 7490 crores, provided 1.55 crore hospital admissions,
- There are 24215 hospitals empanelled with PMJAY
- 1.5 crore users have registered on the website, 13.48 crore e-cards have been issued. 32 states and UTs have implemented the scheme
- The Union government is providing 60 per cent funds, and the state governments are expected to pool in the remaining 40 per cent.
- All the other Insurance schemes at the state level will be merged with PMJAY

Problems with government sponsored insurance schemes

- RSBY, had misfired in targeting, covering only 12.7% of households among the poorest quintile at the national level.
- And while the scheme increased the number of admissions, it failed to significantly impact OOP expenditure or reduce health-related poverty for the former.
- At both the central and state levels, governments have lacked the capacity to regulate RSBY effectively.
- RSBY provides, Insurers find it more profitable to insure households less than five members, which is mandated
- Issue the registration cards halfway through the year.
- Effective targeting has not been a priority.
- Doctors and hospitals, recommend unnecessary procedures to claim reimbursements.

Figure 1: The distribution in utilization of various procedures



Source: NHA data secured from PMJAY

The distribution is a long tailed one peaking at Rs. 10000-150000

Some fallouts of PMJAY

- Putting too much of money in insurance, considering wide gaps in government infrastructure will transfer committed funds to private sector every year.
- Capital Expenditure on health will get a boost in the private sector, but it will also give rise to cost of care, drugs, and diagnostics.
- Very strict regulations and constant negotiations with the private sector to bring down the cost, will make this public private machinery work, otherwise it will give rise to various un-ethical practices.
- Privatization of a basic service like healthcare, brings up unique inequities, like it is in US, those who can pay have a better access to health.

UNIVERSAL HEALTH COVERAGE

- What are the health outcomes we want to achieve? It is not rocket science to figure that out.
- We want every citizen of India to have access to health and not merely an access to cure.
- Health outcomes are achieved not just by curative care but by many other factors too.
- Curative care providers, worldwide, have a strong lobby and great negotiating powers.
- Healthy environment, adequate nutrition, gender equality, low stress in society, road safety, absence of extreme poverty conditions, and healthy lifestyle.

Hospitals and insurance cover do not cover any of these.

Where are we spending?

- Health expenditure comprises of revenue and capital expenditures.
- Traditionally, capital expenditure on healthcare is low. It was on an average about 10% of the total health expenditures in the last ten years.
- Studies have shown that a large part of growing revenue expenditure goes is one head – Salaries.

Where should we spend

- Infrastructure – Hospitals, Equipments, Technology
- Primary Health
- Nutrition
- Preventive and Promotive Care
- Health Education and Research – Medical and Public Health
- Health MIS
- Publicly operated not for profit Insurance
- Free Drugs and Diagnostics
- Public Health Workforce

Ministry of Health Expenditures

Component	2015-16	2016-17	2017-18 (BE)
Urban Health Services - Allopathy	38.74%	37.62 %	37.34
Rural Health services - Allopathy	25.13%	26.33	26.45
Urban Health Services - Other system of medicine	4.52%	4.30%	4.07
Rural Health Services - Other system of medicine	2.45%	2.45	2.77
Medical Education Training and Research	12.30%	12.42	13.06
Public Health	12.98%	13.18	12.13
General	3.89%	3.69%	4.18

How much money do we need

- Doubling the public health expenditure as a percentage of GDP, or taking it to 2.5% of GDP, as per Health Policy 2017, would mean an expenditure of about Rs.110000 crore by the Government.
- States need to Treble their current level of spending from about 3% to 9%.
- ***Every rupee spent on health has an opportunity cost in a developing economy, because there are many sectors such as education, infrastructure, which also claim the same resources.***

Where do we get money from?

- Increased Taxation
- CSR Expenditure
- Charity
- Pool in and Mitigate Risk
- Households

- Finance Minister Nirmala Sitharaman on Monday allocated a budget of Rs 2,23,846 crore in budget estimate of 2021-22, as against the 2020-2021 budget estimate of Rs 94,452 crore — a whopping overall increase of 137 per cent. It included Rs 35,000 crore for immunisation with Covid-19 vaccines.
- The Rs 2.23 lakh crore outlay for health and well-being will include expenditure on six components in varying proportions — Department of Health & Family Welfare (31.83 per cent) with finance commission grant (5.89 per cent), Department of Drinking Water & Sanitation (26.81 per cent) with finance commission grant (16.09 per cent), vaccination (15.63 per cent), health research (1.89 per cent), Ministry of AYUSH (1.32 per cent), and nutrition (1.20 per cent).
- Rs 64,180 crore would be allocated to the new scheme PM Atma Nirbhar Swastha Bharat Yojna with an outlay of six years. This implied that each year an additional Rs 10,000 crores will be pumped in the health sector. It will be implemented in addition to the National Health Mission

Announcements made in the Budget

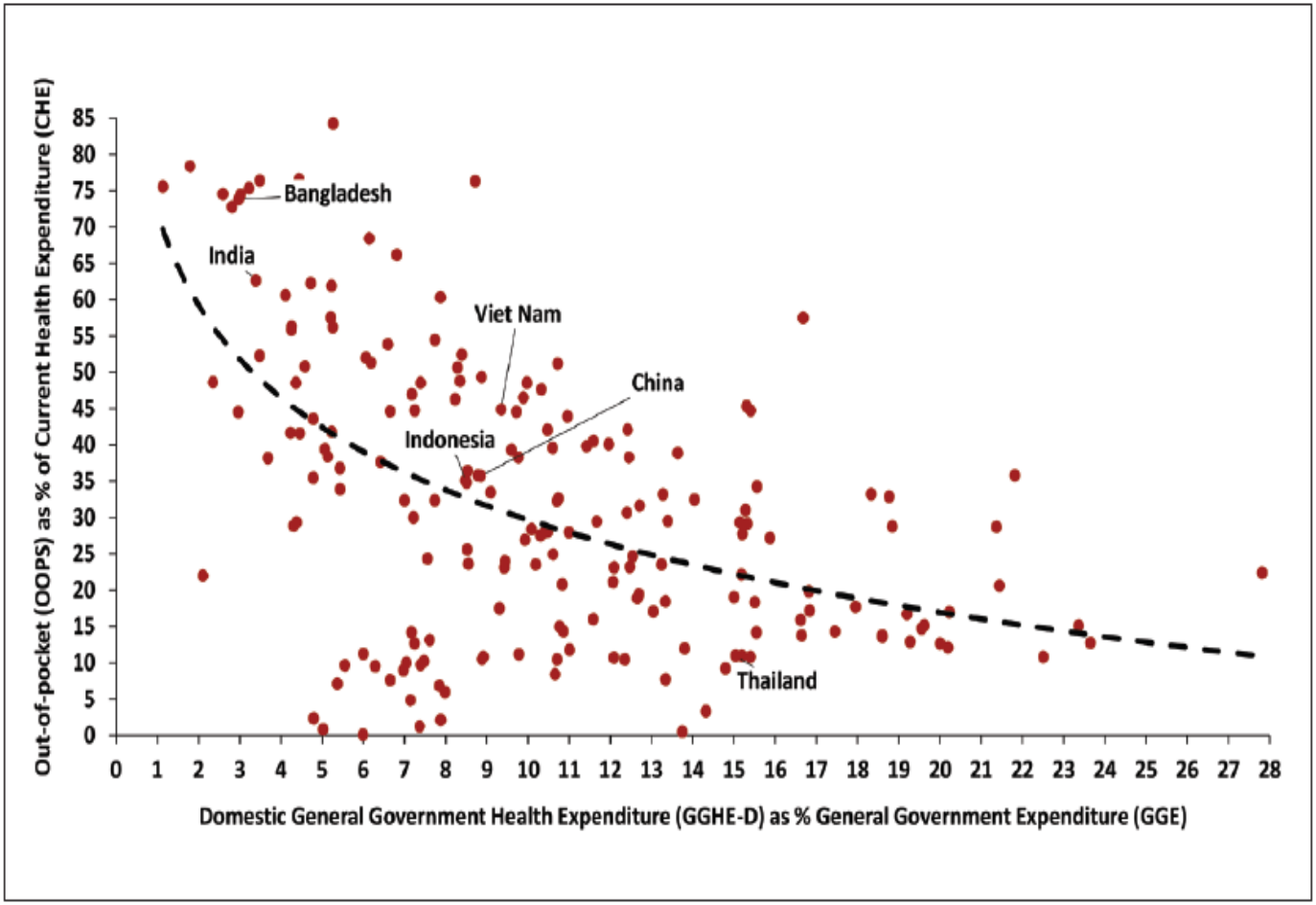
Health and Wellbeing – Expenditure

(In ₹ crores)

Ministry/Department	Actuals 2019-20	BE 2020-21	BE 2021-22
D/o Health & Family Welfare	62,397	65,012	71,269
D/o Health Research	1,934	2,100	2,663
M/o AYUSH	1,784	2,122	2,970
CoVID related Special Provisions			
Vaccination			35,000
D/o Drinking Water & Sanitation	18,264	21,518	60,030
Nutrition	1,880	3,700	2,700
FC Grants for Water and Sanitation			36,022
FC Grants for Health			13,192
TOTAL	**86,259**	**94,452**	**2,23,846**

Support for 17,788 rural and 11,024 urban Health and Wellness Centers;
b. Integrated public health labs in all districts and 3382 block public health units in 11 states;
c. Establishing critical care hospital blocks in 602 districts and 12 central institutions;
d. Strengthening of NCDC, its 5 regional branches and 20 metropolitan health surveillance units;
e. Expansion of the Integrated Health Information Portal with PHL
f. Operationalisation of Public Health Units at ports and land crossings
g. Setting up of 15 Health Emergency Operation Centers
h. Setting up of a national institution for One Health, 9 Bio-Safety Level III laboratories and 4 regional National Institutes for Virology.

Figure 3: Small increase in public health expenditure can drastically reduce OOP expenditure



Source: WHO (Global Health Expenditure Data Base)

Economic Survey - 2021

- Uncertainty, Variability of Demand, which is inelastic particularly for emergency care
- Information asymmetry - one party to an economic transaction possesses greater material knowledge than the other party
  - Related to cure
  - Related to medicine
  - Related to insurance
  - Related to quality of product and service
- Unregulated Private sector
- Hyperbolic Tendencies -

Mis-utilization of funds - management of hospitals.

- Are Government Hospitals poorly managed?
- Military hospitals in India are equally loaded, a doctor sitting in OPD, in a military hospital usually entertains, the same number of patients.
- OTs, wards and other services are also equally demanded for.
- Military hospitals are much more efficient.
- SOPs are followed, and monitoring and regulation is very strict.
- Could it be done for government hospitals too?

Mis-utilization of funds - Technology

- Major cost driver in healthcare is technology, as there is exponential price rise.
- Technical solutions for health are developed in such a way that they require high capital investment, push the user into a trap of updating latest technology at a higher cost
- Scientific Innovation leads to obsolete technology
- Health Technology Assessment helps in procurement of cost-effective technology.
- In a resource constraint economy, costly options for technology are pinching.

For Profit Insurance

The health insurance industry continued its tremendous growth trend as it experienced a significant increase in net earnings to $23.4 billion and an in- crease in the profit margin to 3.3% in 2018 compared to net earnings of $16.1 billion and a profit margin of 2.4% in 2017.

2018 Annual Health Insurance Industry Analysis Report US

Insurance Companies have a profit margin of about 4-5%.

Is there an Efficient fund utilization model ? – Some Government initiatives

- In July, 2018, Niti Aayog issued a document called 'National Health Stack' as a first step towards 'Ayushman Bharat'. ‘
- The National Health Stack (NHS) is a visionary digital framework usable by centre and state across public and private sectors.
- Through this platform, digital health records for all citizens by the year 2022 will be stored in a database'.
- National health electronic registries, a coverage and claims platform, a federated personal health records framework, and a national health analytics platform will be made possible.
- A strong and resilient digital backbone to the health system will bring transparency, and will enable the process of shifting from illness-focused to wellness-oriented approach and to ensure cost-effective healthcare.

Implications - Digital Health

- With the help of this kind of data, specific customized solutions can be developed for the people at local level.
- Technological innovations like telemedicine, gene mapping, large scale diagnostic labs etc. will enable health systems in the country to leapfrog to a more vibrant and sustainable health care delivery system.
- A large population is to be served, but it also gives opportunity in terms of scale economies, as per person cost of technology is bare minimum.
- Health and Wellness centre will be a pivotal point for Primary Health Care
- Availability of data will boost Health Research, Data Analytics and Innovative solutions

Health Financing and UHC – Final Take

- Government should increase capital expenditure and create infrastructure from the tax payer's funds.
- Government should increase its expenditure in preventive and promotive methods, as curative care would tackle just one part of the problem and preventive care solution are much more sustainable and cost effective.
- Health Insurance should be publicly provided and should be made a not for profit sector.
- Privatization of healthcare is not desirable. Private investment has a greater capital cost.
- Cost effective free drugs and diagnostic models be developed.
- Management of government hospitals should be improved. We should get back to the good old days of government hospitals.
- Make judicious use of technology to leapfrog to advanced care models. First step should be to have a robust MIS.
- Let the citizens pay their taxes and enjoy an equitable, universal basic health for all.

TAX

- Special Health Tax – 5% Health cess and a National Insurance scheme for all
- US spends 18.5% of GDP on Health and nearly half of it is public health expenditure
- Western Europe has Government Revenues at 45-50% of National Income, US and Japan 30-35%.
- Sub Saharan Africa and South Asia, especially India has Government Revenues at about 10% of GDP.

Capital by Thomas Piketty

Social state

- Chronic underfunding of Health is not accidental but the result of a development model adopted early on. K. Sujata Rao

- In all the developed countries in the world today, building a fiscal and social state has been an essential part of the process of modernisation and economic development. The historical evidence suggests that with only 10-15% of Tax Receipts it is impossible for a state to fulfill much more than traditional regalian responsibilities – Police and Judiciary. Thomas Piketty

Healthcare lies at a confluence of inelastic demand, political sensitivity, economic consequences, and ethical governance that makes the state's role crucial. Alongside an increase in the quantum of funding, there is a need to improve the policy design and quality of spending to ensure closer alignment with health outcomes.

I welcome your Ideas!

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