Health Care Financing Reforms in India

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The Background

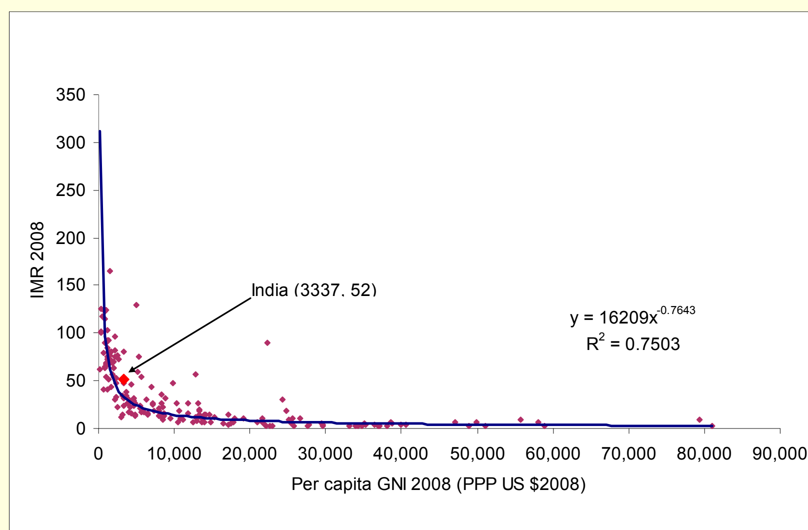
- 'Health' – a primary component of human development -- provides freedom to live a healthy life – has an instrumental role in enhancing labor productivity, human capital and economic growth
- Government intervention in health required due to high degree of asymmetric information
- Public spending on health care in most low and middle income countries below what is required, despite poor health indicators.
- Achieving universal health coverage in many low and middle income countries remains a major challenge due to required increases in public spending in an environment of resource crunch.

The Indian Health System

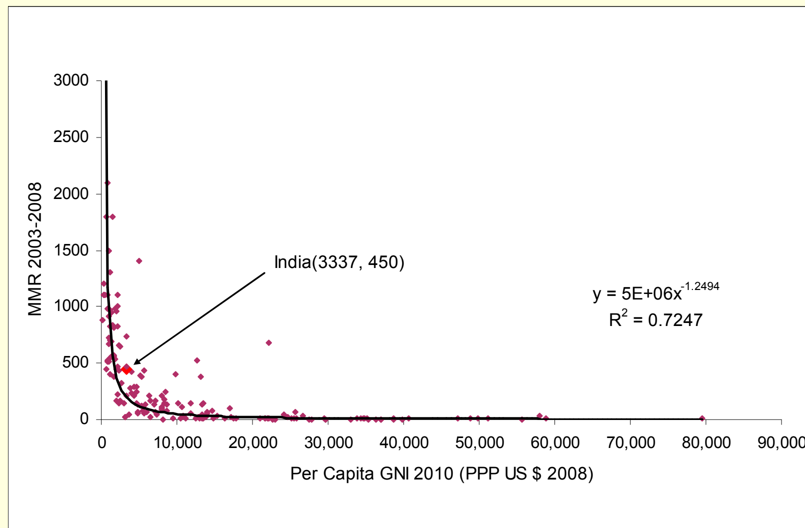
- The India, health care is primarily a responsibility of the State governments, -- the Indian constitution assigns the predominant responsibility for the provision of social services to States.

- In the rural areas, public health service delivery is characterized by a three tier system
  - Sub-centres (lowest-level) covering 5000 population in plains (3000 in hilly and difficult terrain) – staffed only with para-medical staff
  - Primary health centres (second tier) covering 30000 population in plains (20000 in hilly and difficult terrain)
  - Community health centres (third tier) covering 120000 population in plains (80000 in hilly and difficult terrain)
- In urban areas, there are sub-divisional hospitals, district hospitals and tertiary health care facilities – acting as referral centers.

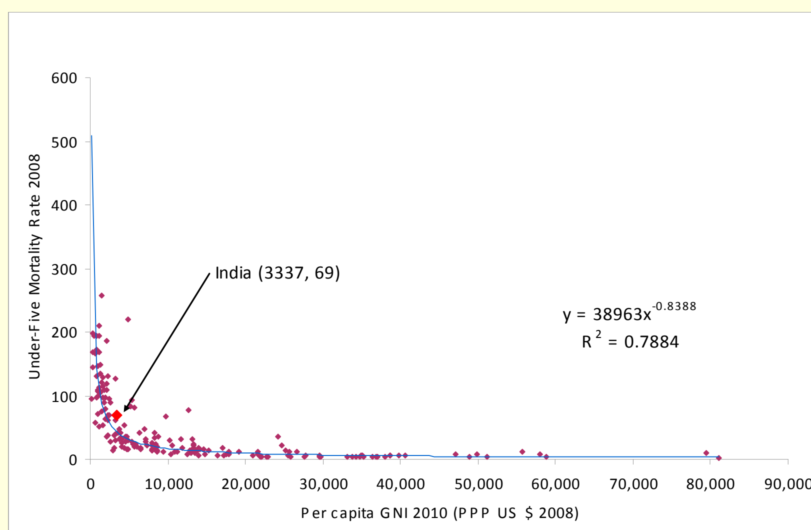
Health Status in India – Low Achievement in Comparison to Income -- IMR



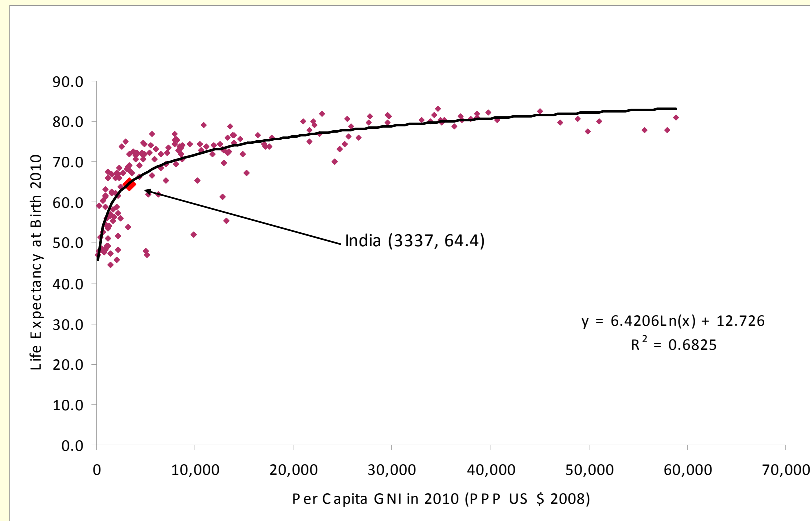
Health Status in India – Low Achievement in Comparison to Income -- MMR



Health Status in India – Low Achievement in Comparison to Income – U5M



Health Status in India – Low Achievement in Comparison to Income – Life Expectancy



Low Achievement Coupled with Large Intra-country Variations in Health Status

- The rate of improvement in many of the health indicators in recent past (between 1990 and 2008) has been lower than some of other South Asian countries like Maldives and Bangladesh
- Poor access to primary and preventive health care services.
- Large intra-country variations in health indicators across States – the difference in IMR between the best State (Kerala) and the worst State (Madhya Pradesh is nearly 6 times – 70 as against 12)
- Improvement indices as measured by Kakwani index (1993) and Sen index (1981) indicate that in the period 1988 and 2008, the average improvement index in IMR in the top four States was markedly higher than the average improvement index in the bottom four States.

Health Spending in India – Salient Features

- Public spending on health in India is one of the lowest in the world
  - As per WHO, India ranked 184th among 191 countries in 2007, in terms of public expenditure on health as a per cent of GDP.
  - In per capita terms, India ranked 164th – at about $ (PPP) 29 – which was about a third of that of Sri Lanka, 30 per cent of that of China and 14 per cent of that of Thailand (WHO 2010).
- Consequently, high out of pocket expenditure by households – the share of out-of-pocket expenditure in total health spending in the country is one of the highest in Asia (Van Doorslaer *et. al.* 2007)
- Skewed composition of public spending further reduces its effectiveness – high share of public spending incurred towards curative and tertiary health care. Also, overwhelming portion towards wages and salaries.
- High inter-state differentials in health spending – the difference between the top and the bottom State in terms of per capita public spending is nearly 3 times.

Recent Reforms in Health Financing – (1) National Rural Health Mission (NRHM)

- Realizing the low allocation and large differential in inter-state public spending on health and health infrastructure, the Central government initiated the National Rural Health Mission (NRHM) in 2005.
  - Intends to increase public spending on health to about 2 to 3 per cent of GDP and focuses on improving health infrastructure in lagging States.
  - Funds allocated to States on a per capita basis with a higher weight age to lagging States -- 100 per cent centrally funded in the first two years – since 2007-08 Centre State share funding in the ratio 85:15.
  - Formidable implementation problems –
    - Pattern of actual expenditure different from original allocation -- although 'high focus' States have higher allocation, actual expenditure in 'high focus' states has been lower than the actual expenditure in 'non-high focus' States.
    - Public expenditure has also not increased as proposed, due to lack of fiscal space both at the Central and the State-level

Recent Reforms in Health Financing – (2) Rashtriya Swasthya Bima Yojana (RSBY)

- To provide financial protection against high out-of-pocket expenditure, the Government of India in 2007, introduced a health insurance scheme –the Rashtriya Swasthya Bima Yojana (RSBY)
  - Provides insurance coverage for selected hospitalization and day care procedures to the BPL population
  - Annual limit Rs. 30,000 (for a maximum of five members in a family) along with a transportation allowance of Rs. 1000
  - Scheme is implemented by insurance companies, selected through bids at the State-level – smart cards provided to each BPL family
  - Premium shared between the Centre and State in the ratio of 75:25 in most States (90:10 in a few)
  - Beneficiary does not pay any premium (Rs. 30 registration fee)
  - As of July 2011, the scheme covered 27 per cent of the BPL population (and less than 50 per cent of the BPL population of the districts where the scheme was operational.
  - In 2010-11, public expenditure on RSBY was about Rs. 445.9 Crore (R.E.)

Expenditure Needs and the Transfer System

- There is a strong positive correlation between performance in terms of health indicators and public spending in States.
- Low expenditure States are also low income States and have limited capacity in generating additional resources. There is a strong positive correlation between per capita health spending and income levels across States.
- Central transfers have not been able to offset the fiscal disabilities of States.
- A significant proportion of expenditure in States is towards committed liabilities leaving little room for reprioritization towards the health sector.
- Most low-income low expenditure States assign a relatively higher share of their GSDP or budgetary expenditure to the health sector – indicating a higher priority

Need for Additional Central Transfers

- To ensure a minimum standard of health services across States, additional central transfers need to be directed towards primary care and first level of secondary care.
- A preliminary estimation of expenditure based on National norms indicate that an additional amount of Rs. 3 billion (at 2008-09 prices) i.e. about 0.6 per cent of GDP will be required to be spent across 16 major States in India – Together with urban will be around 1 per cent of GDP
- About 65 per cent of these additional transfers will be required in just six States, which have the poorest health indicators in the country.
- Additional central transfers to these poorest States will reduce the coefficient of variation in per capita expenditure across the 16 major States from 0.3 in 2008-09 to about 0.15.
- These transfers need to be in the form of specific purpose matching transfers

Fiscal Space for Health care

- Sustainable fiscal policy calibration in India requires significant compression of consolidated fiscal deficit (of Centre and States)
- At the State-level there are competing demands on the resources of the States and additional fiscal space for mobilizing more resources and reprioritizing may not be large.
- The pattern of unconditional transfers from the Finance and Planning Commissions in the medium term is predictable and not likely to lead to substantial increase in health care spending
- Much of the increase therefore, will have to come from specific purpose transfers from the Centre to States.

Effects of Central grants on States' health expenditure -- Stimulation versus Substitution

The Model -- **(two way fixed effects panel data for 14 major States)**

$\Delta (PC_OHE)_{it} = \alpha + \beta\ \Delta (PC_CGH)_{it} + \gamma\ \Delta (PC_SOR)_{it} + \psi\ \Delta (SPH)_{it} + \tau\ \Delta (PC_GPGC)_{it} + \varphi$ (State Dummies) $+ \sigma$ (Year Dummies) $+ \varepsilon_{it}$

Where,

$\Delta (PC_OHE)_{it}$ = Changes in per capita own health expenditure (from the previous year) of State 'i' in year 't';

$\Delta (PC_CGH)_{it}$ = Changes in Per Capita Centre's grant (from the previous year) for health to State 'i' in year 't' ;

$\Delta (PC_SOR)_{it}$ = Changes in Per Capita own revenues (from the previous year) of State 'i' in year 't';

$\Delta (SPH)_{it}$ =Change in the ratio of public expenditure on health to total budget expenditure of the ith State in the year 't' over the previous year;

$\Delta (PC_GPGC)_{it}$ = Changes in Per Capita general purpose grant by the Centre's grant to State 'i' in year 't' = (Tax devolution + plan and non-plan grants)

Effects of Central grants on States' health expenditure – Results

	1991-2007	1991-2000	2001-2007
Center's Health Grant	– 0.952*** (0.074)	– 0.777*** (0.114)	– 1.059*** (0.109)
States' Own Revenues	0.012*** (0.003)	0.015*** (0.004)	0.0001 (0.006)
States' Priority to Health	17.649*** (1.828)	15.03*** (2.038)	19.487*** (4.231)
General (unconditional) Transfers	0.019*** (0.007)	0.014 (0.011)	0.013 (0.01)
Constant	18.252*** (3.561)	17.17*** (3.885)	3.552 (5.035)
No. of Observations	224	126	84
R-square	0.69	0.62	0.77

*****p < 0.01;**

Note: t-statistics are given in parentheses. The standard errors are robust to cross-sectional heteroskedasticity and within-panel serial correlation.

Concluding Remarks

- The Indian health care system is characterized by (i) low levels of public spending on health care (ii) large inter-state variation in public spending (iii) low public spending on primary and preventive health care and (ii) high out-of-pocket spending
- Levels of public spending across States is positively correlated with per capita income – pointing towards the need for additional Central transfers in the form of specific purpose transfers with matching contributions from States.
- Econometric estimates show significant substitution of central grants with States' spending from own resources – these findings underline the need to redesign the transfer system to increase the level of public spending in States, particularly those with low expenditure levels