Health Financing in India: Taking Stock and Moving Forward

Report of the Expert Group Meeting

On 30th November and 1st December 2007
At the Taramati Baradari Cultural Complex, Hyderabad

Prepared by: C.K. George on behalf of the Expert Group

Institute of Health Systems, Hyderabad

In collaboration with: World Health Organization, India Office

Table of Contents

No.	Contents	Page
I	Background	3
II	Financing of public health sector with special emphasis on National Rural Health Mission	4
III	Out of pocket expenditure and private sector financing	7
IV	Health insurance	9
V	Health Financing India Network	12
Annex-1: Agenda of the Expert Group Meeting		13
Annex-11: List of Participants		14

I. Background

Wide ranging reforms is underway in the Indian health sector under the National Rural Health Mission. Several States are implementing or planning state specific reforms. Sustainability of these reforms is linked to financing options available. A clear priority for national and state governments is establishing financing mechanisms which will help alleviate the high burden of out of pocket expenditure on health which falls disproportionately on the poor. Generating evidence to support decision making in this endeavor is a critical need.

Researchers based in institutions in different parts of the country have contributed greatly in improving our understanding regarding contribution of various financing sources, flow of funds within the health sector, expenditure on drugs, costing of services and different financing models including health insurance. However, there have not been many opportunities to pool this varied expertise. It was in this context that an idea for bringing together people working on health sector financing took shape. Mr. Sunil Nandraj from the WHO, India country office, took the initiative to moot the idea of an expert group on health financing in India among professionals working in this field. There was an overwhelmingly favorable response. The Institute of Health Systems, Hyderabad offered to host a two day meeting of the expert group. Financial support for the expert group meeting was provided by the WHO India office.

The broad contours of the agenda and setting of the expert group meeting emerged through the informal discussions among the health financing professionals. The following objectives were set for the meeting:

1. facilitate information sharing and pooling of evidence on health financing in India
2. identify priority areas in health financing of the country which requires more rigorous study
3. provide the government with actionable recommendations on health financing priorities, policy options and models
4. explore setting up a common platform for pooling expertise within the country and ways of working together

There was a consensus that setting of the meeting would be informal to facilitate more intensive discussions in a small group. The workshop would have 3 sessions, facilitated by a

member of the group. Though the broad agenda (Annex-1) had been set, the sessions were not structured but left to the participants to initiate discussions on issues they felt relevant.

The Expert Group Meeting was held on 30th November and 1st December 2007 at Taramati Baramati Cultural Complex, Hyderabad. Twenty professionals participated. List of participants is provided in Annex-2.

The discussions in the first session brought forth a number of issues related to health financing in India. A consensus emerged that the group would focus on the following three major issues in the subsequent sessions:

1. Financing of public health sector with special emphasis on National Rural Health Mission
2. Out of pocket expenditure and private sector financing
3. Health insurance

II. Financing of Public Health Sector

The group noted that in recent years there has been a greater focus on health in recent years resulting in larger allocation to the sector especially in the context of the National Rural Health Mission. The provision of flexible funds to State governments under NRHM Flexi-Pool has provided an opportunity for States to develop and implement innovative programmes. Other NRHM financing strategies such as untied funds to institutions, financing of NGO sector for public health goals and risk pooling where money follows patient, has the potential to strengthen and widen the reach of public health care services. Key concerns voiced by the group members with regard to financing of the public sector include:

1. Budget formulation by and large continues to be incremental and normative, even though current policy favors outcome budgeting and need based allocation, Mechanisms for using decentralized planning as tool for identifying local requirements and involving communities in developing need based programmes as envisaged under NRHM are yet to be institutionalized.
2. Budget documents are complex and not user friendly. They are technical documents and it is difficult for the average person to identify key fiscal trends or expenditure

priorities. Complexity of budget on account of multiplicity of central and state schemes and multiple provisions to the same entity arises from a complex budget classification system that is followed in the government. While, the 19 digit classification system currently followed by the government meets the needs of legislative sanction and oversight, it is quite dysfunctional when it comes to the requirements of the administrator as the budget is prepared neither by function nor by the provider. A particular function is provided under many providers as also a provider serves many functions. As a result, if one wants to get an idea of budget by a function or provider, it will have to be obtained by going through the entire budget, a task that is complex and confusing even for trained finance specialist.

3. NRHM is often seen as an entirely new programme bringing with it fresh allocation of funds. However, NRHM funds also subsume existing allocation for RCH and other disease control programmes. There is need for better clarity on the resource envelope for NRHM, pooling of resources and the process of budgeting under NRHM.

4. Funds flow to the district from the state budget which also comprises of central funds for national programmes and through off-budget mechanisms under NRHM and NACP. Funds under NRHM are provided under different programmes through different mechanisms at the level of district and below. The variety of funds flow mechanisms makes lower level budgets confusing. There is need for greater clarity regarding allocation for districts and who provides for it.

5. There is need to systematically track and study flow of funds from the centre to state and then to district and below, right up to the level of the beneficiary. In the absence of which, an assessment of impact and efficiency of health spending cannot be done. In the context of NRHM it would be particularly useful to have an idea of the impact of NRHM financing strategies such as provision of flexible funds.

6. The central government is committed to increasing budget allocation by about 30% annually in moving towards the National Health Policy goal of increasing public spending on health to around 2-3% of the GDP. However, there is lack of an evidence based resource envelope for health. A key constraint has been the lack of data on financial costs. The National Commission of Macroeconomics and Health has made a

key contribution in providing estimates of unit costs of facilities and costing of programmes at the national level. However, there is requirement for more disaggregate data on financial costs for managing diseases and conditions and prevalence rates at district level for arriving at a more meaningful resource envelope. There is a need to develop methodologies for collecting such financial data on a regular basis.

7. While working towards developing methodologies for collecting disaggregate data on financial costs, it would be useful to study data that is currently available. Costing studies have been carried out in the country and sharing of reports on a website could be a good option for pooling of such data. Care should be taken to see that the data is used properly, including acknowledgement of data source.

8. Most states have not been able to satisfactorily utilize funds allocated under NRHM. Given the available evidence to justify significant allocation of public funds to the health sector, the inability to spend allocated funds is a matter of deep concern especially for the poorly performing states.

9. Weak absorption capacity in the public sector is linked to systemic and institutional issues as well as poor designing of expenditure items. Lack of stability and flexibility in the budgetary processes has been a major reason for the government to adopt the society mode of funding the health sector, as in the case of NRHM. Potential areas which could have an impact on under spending of NRHM funds and requires studying were identified by the group. They include:

    - NRHM financing is linked to strategies such as decentralized planning and implementation; integration of health programmes with the general health services; inter-sectoral convergence; central role of Panchayati Raj Institutions (PRIs) in planning, managing and monitoring public health services; and promotion of nonprofit sector in health service delivery. Efforts towards operationalizing these strategies are still in rudimentary stages in many States.

    - Capacity for planning and programme management has been generally weak in the health services. Further, the NRHM framework requires development of capacities in health departments for effectively managing coordination within

the health services, collaboration with departments having complementary functions and building partnerships.

- Lack of clear guidelines in managing flexible funds. While flexible funds are meant for use as per local requirements, key personnel and oversight committees are not yet empowered with capacities to prioritize and plan for requirements.
- Weak financial capabilities within health services. Capacity in budgeting and accounting functions is deficient not only in numbers but also in quality. At the State level, financial management is generally vested with few officers and support staff. In the district offices the accounts are being maintained mostly by junior assistants and senior assistants who do not have relevant educational qualification or formal training in maintaining accounts. In health facilities, the departmental personnel manage the finance functions as drawing & disbursing officers (DDOs) and are often vested with accounting functions also. They are in many instances medical officers with no training in management of financial systems.
- Use of information technology in maintenance of accounts and monitoring of spending is generally weak

III. Out of Pocket Expenditure and Private Sector Financing

Private sector is the major provider of health care in the country which according to latest NSSO survey on health care (60^{th} Round) accounts for about 80% of the outpatient treatment and 60% of hospitalizations. Out of pocket expenditure by households is the major source of funds for health care which according to NHA estimates for 2001-02 accounted for about 72% of the total health expenditure. A system dominated by out-of-pocket expenditures by households is considered the most inequitable as the poor who have a greater probability of falling ill due to poor nutrition and unhealthy living conditions pay disproportionately more on health than the rich and access to health care is dependent on ability to pay. The key concern that emerged from the discussions was the need to provide financial protection to the poor. Some of the issues related to health insurance and financial protection schemes are covered in the next section. Other issues include the following:

1. Currently the primary source of data on out of pocket health expenditure comes from household surveys conducted by the NSSO. The NSSO 60th Round indicates that on an average about 18% of spells of ailment in rural areas and 10% in urban areas were untreated. Untreated ailments are higher in lower income categories. While about 32% and 50% of spells of ailment in rural and urban areas respectively were untreated because they were not serious, in remainder of cases ailments were left untreated due to health sector access and responsiveness issues of which financial issues was the major one. Developing financing strategies for health care coverage of this segment of population is a key priority.

2. While bulk of the out of pocket expenditure directly flows to the private health sector, a not so insignificant proportion is also on account of expenditure incurred for availing care from government health services. While NSSO data is useful in understanding trends and making overall estimates of out of pocket expenditure, the format in which data is collected is not amenable for a more in-depth analysis of out of pocket expenditure on specific items such as that on drugs and consumables at specific levels of care. Given the one year recall period for expenditure on hospitalization, data is subject to recall bias and misclassification. Further such surveys do not provide much information on the volume of drugs and investigations purchased privately by patients seeking care at public hospitals. Given that cost of the same drug can vary significantly from manufacturer to manufacturer and the often unethical marketing and prescription practices, it is highly likely that patients may be actually spending more than what is required. Data for such expenditure is also not available. Such estimates will help generate evidence for appropriate allocation of resources for provision of drugs and investigations in public hospitals and framing of policies regarding prescription of drugs and diagnostic tests and procedures.

3. NSSO 60th Round also indicates that about 60% of hospitalized treatment in rural areas and 42% in urban areas were financed by borrowings and sale of assets. Current usage of using poverty line as the cut off for eligibility of public subsidies may not be adequate as an episode of hospitalization can bring households above poverty line below it. There is need for further research on impact of out of pocket expenditure on

health care on poverty and developing an income line for targeting public subsidies for health care.

4. The private health sector in the country is a heterogeneous. There is need to document and describe the growth and development of the private health sector in different States to understand their structure and dynamics, especially in the context of identifying potential areas for partnership to meet public health goals.
5. The private sector has been provided public subsidies in form of provision of land at nominal costs, tax exemptions etc., to provide subsidized treatment to the poor and/or to keep health care costs low. There is need for studying public subsidies to the private sector and assessing their impact.
6. The private health sector is largely unregulated in the country. Key requisites for regulation such as rate setting, standards of health care including standard treatment protocols and assurance of professional quality are generally lacking. These are important from the perspective of health insurance also. The group noted that there were some efforts in this direction. The Ministry of Health and Family Welfare in collaboration with WHO, India and AFMC had brought out standard treatment guidelines for some of the common diseases and conditions. Similarly rate setting mechanisms exist for some of the government schemes such as CGHS. There is further need to explore the feasibility of setting up a Rate Setting Commission in each State.
7. It was pointed out that the private medical colleges are highly underutilized. It would be useful to study the capacity and performance of a cross section of private hospitals in the country.

IV. Health Insurance

The group noted that health insurance as a financing mechanism had gained more importance in the recent years. In addition to GIC companies many new insurance companies are now offering health insurance. The NRHM seeks to promote risk pooling and social health insurance to provide health security to the poor. Some state governments had implemented health insurance programmes through insurance companies and third party administrators. Key concerns voiced by the group members with regard to health insurance include:

1. The term Health Insurance has been widely used to encompass a variety of risk pooling and financial protection mechanisms which is misleading. There is need to distinguish between private voluntary health insurance and social health insurance.

2. Many State governments have initiated health insurance programmes. There is a tendency to view health insurance as a magic wand to solve problems of the poor. However such schemes have been found not be practicable in states like Kerala, Punjab, Assam and Karnataka. Low utilization or unviable premium setting has been major factors in collapse of such government sponsored health insurance initiatives.

3. The current focus of government sponsored health insurance initiatives is to target vulnerable groups. Insuring the BPL and pensioners may lead to inefficiency and an alternative would be to open up schemes to rest of population with different sections paying premium along with graded subsidy by the government towards premium according to capacity to pay.

4. Private voluntary insurance schemes as well as government initiated health schemes are generally hospital based and ignores outpatient services. This may not provide adequate financial protection for the poor. While costs of outpatient treatment may not be catastrophic they are significant for the poor, especially in the context of increasing prevalence of chronic diseases. Further, newer technologies have made possible treatment for many conditions on outpatient basis. In many cases they are more cost effective than traditional procedures.

5. State governments may not have the requisite capacity to undertake health insurance schemes. The private health insurance schemes are also not doing well as they also have capacity issues. However, it was noted that premium and claims figures of insurance companies may not provide an actual picture regarding profitability of health insurance schemes to companies. This is because it is a known practice in the insurance industry to provide group health insurance schemes at very low premiums as a bonus for subscribing to other schemes such as fire insurance. Thus, while group health insurance schemes generally appear to be a loss making proposition for insurance companies; in reality they make their profits elsewhere by keeping health insurance premiums low.

6. Lack of credible morbidity and mortality data is a key constraint in determining the risk which has to be pooled. This affects setting of realistic premiums.

7. There are a number of schemes offered by government, nonprofit sector and insurance companies. There is a need to document what's being done, evaluate the different schemes and need for meaningful debate by generating fresh evidence. Documentation of some of the schemes is currently underway under the aegis of WHO, India.

8. It is useful to study the impact of health insurance payments by the government on the health budgets- whether funds allocated to health insurance come from existing allocation to health departments or from fresh infusion of funds. There is also need to study non-financial impact of health insurance on government health services especially since bulk of the beneficiaries are treated in the private sector. For instance in AP, given current trends bulk of the Arogyasri funds of around Rs. 600 crore is poised to flow into the private sector which would require large number of specialist doctors to service this demand. There is apprehension that the already depleted pool of specialists within the public sector would be poached upon thereby depriving the poor of specialty services currently not covered by Arogyasri.

9. There is need for studying the evolution of health insurance mechanisms in other countries to make a reasonable forecast of the trajectory that health insurance as a financing mechanism will take in the country. Of particular interest are the potential impact of health insurance on the government health services and the potential roadblocks that the insurance and medical sector can create for public health goals of the country.

10. It is important to track what's happening in the health insurance sector, In addition to specific studies, there is need to collect data pertaining to health insurance in a routine manner. Given that health insurance still forms a miniscule part of insurance operations in the country, disaggregate health insurance data is not readily available. The group noted that IRDA is well placed to play a key role in making such data available and has been taking steps in this direction. The IRDA website could be a potential source of data on various health insurance schemes.

V. Health Financing India Network (HFIN)

The members of the expert group decided that it would be useful to form a network which could be a collective resource in studying and supporting health financing initiatives in the country. Accordingly a network –the Health Financing India Network (HFIN) was formed with all participants of the expert group. The network would initially be web based and the communication within the network will be through group email. The following members were identified as moderators of the group e-mail.

1) Nishant Jain
2) Selvaraju
3) CK George

The network is open to all those working on health financing issues in the country. Those wishing to join the network would communicate their request via email and any moderator may after reasonably satisfying himself/herself about the intent of the applicant admit the latter as a member of the network by providing access to the group e-mail.

It was suggested that the network would be a platform for sharing of information, reports and other data among members. The possibility of publishing a newsletter on behalf of the network could be explored. Members of the network could join hands as resource persons for teaching and enhancing research capacity in health financing. Members could also provide support in areas such as developing modules for Health Financing course, public expenditure and budget analysis, NSSO data analysis etc.

The meeting ended with the proposal that the HFIN could meet sometime after six months with a more specific agenda.

Annex -1: Agenda of the Expert Group Meeting

Friday, 30th November 2007

9.30-10.00	Registration
10.00-10.15	Setting the Context of the Workshop
10.15- 13.00	Introduction of Participants Self Introduction by Participants highlighting their major work on Health Financing issues in India
13.00- 14.00	Lunch
14.00-17.00	Taking Stock of Evidence: Discussion on evidence generated by research in India that could feed into policy making and identification of priority areas in health financing of the country which requires more rigorous study
19.30	Dinner

Saturday, 1st December 2007

9.30-12.00	Setting an Agenda for Health Financing Priorities for India Arrive at a set of recommendations on health financing priorities, policy options and models
12.00-1.00	Pooling Expertise and Moving Forward
1.00-2.00	Lunch

Annex-2: List of Participants

1 Annigeri VB, Professor, CMDR, Dharwad

2 Devadasan, Director, Institute of Public Health

3 Dilip T R, Faculty, CDS, Trivandrum

4 Gangamurthy, Economic Adviser, MoHFW, GoI

5 George C K, Director, IHS, Hyderabad

6 Manish Jain, Johnson and Johnson, Mumbai

7 Muraleedharan VR, Professor, IIT, Chennai

8 Nandraj Sunil, WHO, India

9 Nishant Jain, GTZ

10 Pattnaik GS, IHS, Hyderabad

11 Prasanta Mahapatra, President, IHS, Hyderabad

12 Rajeev Sadanandan, Secretary, Department of Power, Govt. of Kerala

13 Raman Kutty, Professor, AMCHSS, Trivandrum

14 Ramana GNV, World Bank

15 Ravi Duggal, Trustee - CEHAT, Mumbai

16 Selvaraju, Abt Associates

17 Shailaja Ramaiyer, Director, Strategic Planning & Innovation Unit, DoHMFW, GoAP

18 Shalini Rudra, Fellow, IHS, Hyderabad

19 Somil Nagpal, IRDA

20 Subodh Kandamuthan, Faculty, IHS, Hyderabad