The rise of government-funded health insurance in India

Ila Patnaik, Ajay Shah and Shubho Roy

National Institute of Public Finance and Policy

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Overview

Phase I: Health care system during the British rule

Phase II: Evolution of health care system in independent India

Phase III: Failure of the health care system in India

Phase IV: Latest phase of reforms – Insurance

Questions for the way ahead

Section 1

Phase I: Health care system during the British rule

Colonial government not concerned with public health

Nature of colonialism was not pre-planned, and developed with increase in power

1600 Curative care medical officers on British ships

1764 Medical Service of Bengal formed to serve the British sailors

1785 Presidency Medical Departments, both army and civilians

Transfer to Crown rule

The Royal Commission of 1859

- Royal Commission report on troop losses, submitted in 1864
  - Europe loss was 10/1000
  - India loss was as high as 70/1000
  - Average loss in India hovered around 50/1000
- Quote from the commission report:

  > *Native hospitals are almost altogether wanting in means of personal cleanliness or bathing, in drainage or water-supply, in everything in short*, **except medicine**

Legal interventions in the British rule

There was an emphasis on prevention

1859 Sanitary commissioners introduced at central and provincial levels.

1864 Cantonments Act passed with most modern responsibilities in public health, laying drains, sanitary services, sanitary inspections/police government.

1874 Mortality number for troops in India reached 18/1000.

1897 The Epidemic Diseases Act with emergency powers of quarantine introduced as a response to international cholera epidemics.

Legal interventions in the British rule

There was an emphasis on prevention

1919 Government of India Act separated out central and provincial functions. Most health functions to provinces.

1920 Most municipal legislation were rewritten with emphasis on prevention.

1935 Government of India Act separated central, provincial and concurrent functions. Medical education, poisons & dangerous drugs shifted from provincial to concurrent, while lunacy and mental deficiency added in the concurrent list.

Section 2

Phase II: Evolution of health care system in independent India

Radical change in the Indian Constitution?

Not really

- The constitution maintained the same division as UK legislation on Indian governance.
- In 1977 population control and family planning would be introduced in Concurrent list.
- Created *Directive principles*
  - 39(1)(e) health of workers
  - 41 Social security
  - 47 *improve public health*

Directive principle on health

No mention of curative services

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of **public health** *as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health*

Bhore Committee 1946

Fundamentally shifted to health care

Recognition of difference	Recommendation
The health services may broadly be divided into (i) those which may collectively be termed public health activities and (ii) those which are concerned with the diagnosis and treatment of disease in general.	*Preventive and curative health work must be dovetailed into each other if the maximum results are to be obtained and it seems desirable, therefore, that our scheme should provide for combining the two functions in the* **same doctor** *in the primary units*, (emphasis added)

Laid down the structure of health care

- Killed para-practitioners
  - Continues with shortage of doctors in rural areas
- Suggested the famous 3 tier structure
  - Never financially feasible, but implemented anyways. PHCs have 70% vacancy
- Vertical health programmes
  - No general state capacity built, mission mode programmes
- Medical colleges
  - Indian taxpayers subsidise medical services in almost all English speaking first world

Bhore's legacy

Government established health system based on it

Bhore has become the basic document for government health policy

- The first three five-year plans endorsed it
- Other committee reports supported it, criticise government for non-implementation
- Government continues the model even after it failed

Section 3

Phase III: Failure of the health care system in India

It was not working

Government reports took time to acknowledge Bhore's flaws

- Some criticism in the 1960s
  - **Mudaliar Committee Report, 1961**: Re-evaluating the number of hospital beds required for the health centres as the targets set out by the Bhore Committee were unduly optimistic.
  - **Report of the Committee on Integration of Health Services 1967**: Slow and inconsistent implementation of Bhore Committee suggestions.
  - **Srivastava Committee Report, 1975**: Impracticable to increase Primary Health Centers (PHC) numbers as per Bhore Committee report because of financial constraints.
- By 1980s, more vocal criticism. **Health For All: An Alternative Strategy, 1981** criticised the basic structure of the Bhore Committee report, including too heavy emphasis on doctors leading to commodification of health services.

Murmurs of discontent

Literature started in late 1990s, asking for a new approach

- **Filmer, J. S. Hammer, and Pritchett, 1998**: Providing additional funds or increasing access to PHC like services do not enhance the health outcomes.
- **Berman, 1998**: Instead for hoping to achieve NHS like system where every health service is paid by taxes, India should acknowledge emergence of private health sector and its role in providing ambulatory services.
- **J. Hammer, Aiyar, and Samji, 2007**: Government failure in health due to accountability failure, among other reasons.
- **Selvaraj and Karan, 2009**: Utter neglect of public provision of health services caused rapidly increase in Out of Pocket (OOP) expenditure of households.

Murmurs of discontent

Literature started in late 1990s, asking for a new approach

- **Berman, Ahuja, and Bhandari, 2010**: Considerable burden of health care expenditure on households despite availability of free health care by the government.
- **Shahrawat and Rao, 2011**: Extensive network of government funded and managed health facilities which provide low-cost preventive and curative health services ineffective in reducing OOP expenditure.
- **Das Gupta et al., 2009**: Policies of the central government inadvertently weakened the capacity to deliver population-wide preventive health services in India since the 1950s due to amalgamation of the medical and public health services.

Failure at the highest level of the pyramid

Reports suggest failure of Public Hospitals even at the tertiary level

Report of the working group on Tertiary Care institutions for the Formulation of the Twelfth Five Year Plan (2012-2017) highlighted the failure of public hospitals at providing tertiary care

- **Tertiary care public hospitals number not expanding**: *Lack of funding* by both centre as well as state governments.
- **Geographical limitation**: Location of tertiary care public hospitals limited to *urban areas*.

Section 4

Phase IV: Latest phase of reforms – Insurance

A new approach?

Using private facilities

- Government recognised failure of government facilities
- How to use private facilities
- Insurance was a new innovation in India
- Government starts Universal Health Insurance Scheme (UHIS) in 2004

RSBY

Evolution of RSBY

- UHIS failed to take off, nobody signed up
- India had failed to organise labour: labour ministry had no constituents
- Organised labour services is for a small percentage of the population
- How to target unorganised labour which is vast and uncovered
- RSBY – UHIS health insurance with minimum fee (₹ 30 per month, for enrolling)
- RSBY is now operational in 15 states of India and has enrolled 36.33 million families in 267 districts.

New Development: Pradhan Mantri Jan Aarogya Yojana (PMJAY)

- PMJAY or Ayushman Bharat started in April 2018
- Need based health care to vulnerable families at primary, secondary and tertiary level
- Benefit of ₹ 500,000 per family per year with no cap on family size
- Adopted by 33 states and Union Territories
- Health and wellness centres along with insurance scheme

What is GFHIS

Using the insurance industry

Catastrophic health expenditure for some procedures

- Get a list of beneficiaries - ration card, etc
- Contract with insurer for a *list of procedures*
- Insurer contracts with hospitals (private and government)
- Beneficiaries (ought to get) cash-less procedures done

Expanding to states

1995 Maharashtra had started something similar

2017 Around 48 schemes (except for 3 states)

2018 Ayushman Bharat

Section 5

Questions for the way ahead

Management of disease burden

The initiatives are in the right direction

- Currently, GOI is using two pronged approach for our health system:
  - Secondary and tertiary care through Government-Funded Health Insurance Scheme (GFHIS).
  - Re-emphasising on public health through Swachh Bharat Mission, Mission Indradhanush.
- This is in line with the increasing burden of communicable and non-communicable diseases.

Concerns with this round

We need to remove the concerns

- Studies say that the insurance schemes do not help in reduce OOP expenditure at all.
- States like Andhra Pradesh sought financial assistance for their scheme from centre, puts questions on financial sustainability.

New Thinking is needed

Thinking for the way ahead

- India is entering into a new phase of health.
- We tried health care with doctors.
- We are now trying prevention of diseases and health care financing.
- This is absorbing huge resources.
- Need to base policy decisions on scientific cost-benefit analysis for best utilisation of limited resources.
- Need for continuing administration to prevent leakages.