# HEALTH FINANCING: PROTECTING THE POOR

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## Introduction

Today as the world stresses on economic growth, globalisation and privatisation; a silent section of the society seems to slip through all safety nets. In India, one is talking about at least 26% of the population who fit into this category[1]. The percentage varies from state to state. In most of the northern states poverty seems to be increasing and if you further disaggregate from urban to rural, you will find that 40% of the rural population in 10 states in India are below the poverty line. If one further disaggregates the figures into schedule caste, schedule tribes, the marginalised etc.[2], the percentages just keep on rising. So we have to accept the fact that there is a segment in our society, and we are talking about 260 million Indians, who are surviving on less than 2,400 calories everyday.

## Why protect the poor?

The next question is, why do we need to protect the poor? If one looks historically, the government of India, right from the time of independence has said, "yes, the health of the Indians is our responsibility." Article 47 of the Constitution states very clearly – "*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.*[3]" Even in the national health policy 2002, the government acknowledges that it has a very key role in providing and financing health[4]. So while the government has taken the responsibility of health care, in reality things are different. While life expectancy has increased and mortality rates have fallen, India is still a host to many communicable diseases. We have the highest number of TB cases and will soon have the highest number of HIV cases in the world. Malaria is still a problem in many parts of the country and many states still battle with polio, measles and tetanus. On the other hand, lifestyle diseases like hypertension, diabetes mellitus and road traffic accidents are on the increase. One of the reason for this could be the low budgetary allocations. The national health budgets allocations are steadily decreasing, it is currently about 0.9 percent of the GDP (Fig 1). This is one of the lowest in the world. Countries like Bangladesh and Sub-Saharan Africa spend about 3% of their GDP on health.

If one further disaggregates this data, one realises that 33% of this budget goes to the richest 20 percent of the population, whereas the poorest quintal gets only 10 percent of the money[5]. This results in under staffed health centers, with no or minimal medicines, poorly maintained equipment and poor quality of care. This pushes people into the private sector and there they have to spend their meagre income on health care. Studies show that about 80% of OP care and about 40 – 60% of IP care is provided by the private sector[5]. Patients end up paying out of their pocket for health care, one of the basic needs of any population. This naturally affects access to health care, especially for the poor. For example, the hospitalisation rate for the poorest quintile is only about 5 per thousand

population, whereas for the richest quintal it is about 35 that is practically seven times more (Fig 2). So people especially in rural areas have two options, either they spend their valuable money going to the private sector or they quietly sit at home and die. They sell their land, they sell their assets, they become indebted, all to pay the doctors' and the hospitals' bills. One can call it iatrogenic poverty[6].

Fig 1: The National Health budget over time

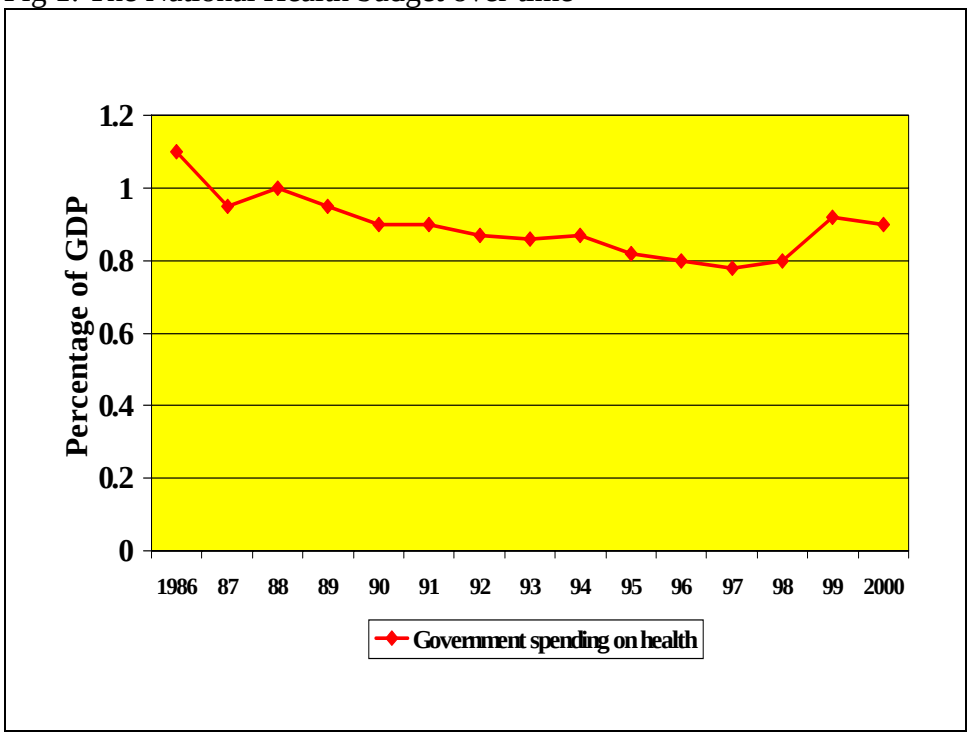



Fig 2: Hospitalisation rates by income quintiles.

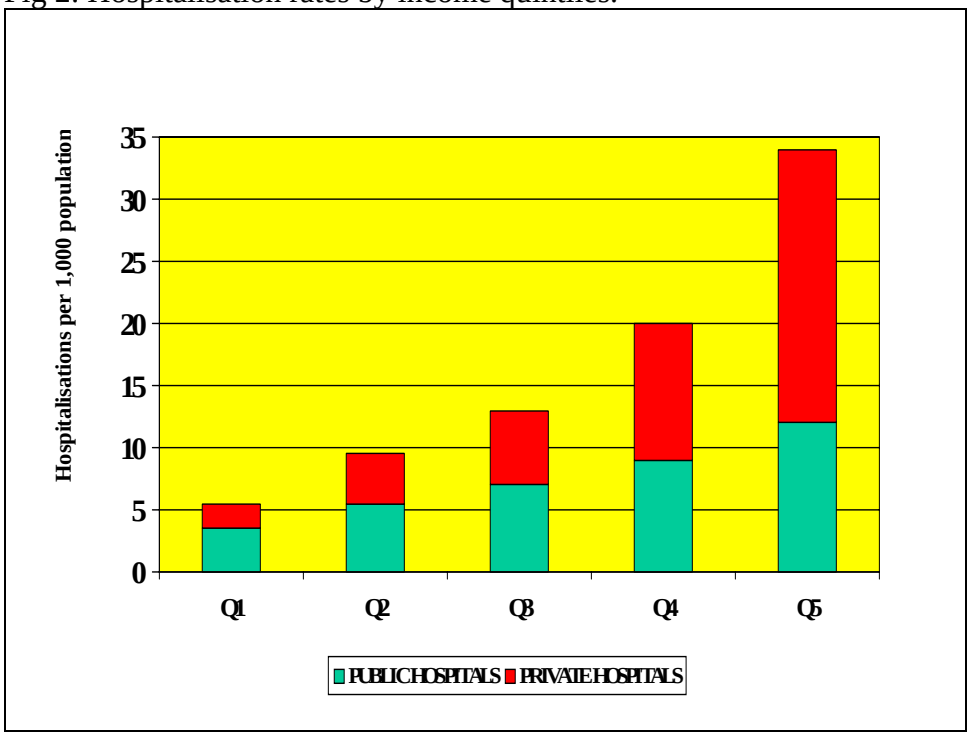
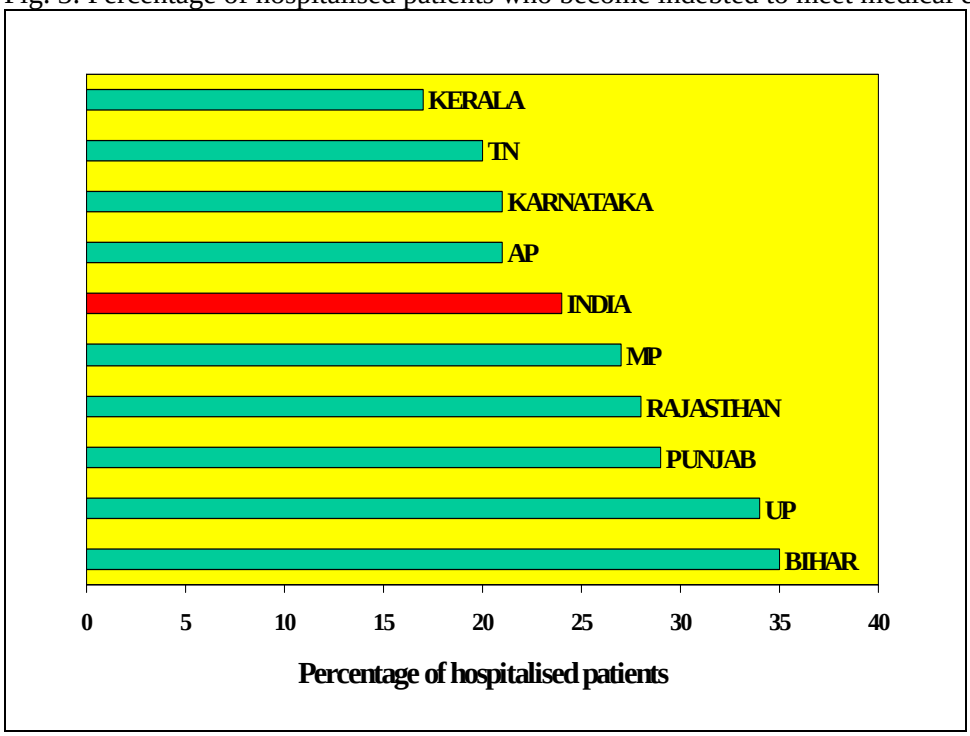


Fig 3 gives the percentage of the hospitalised patients who became indebted due to medical costs. In Kerala it is about 17 percent but in U.P, Punjab, Rajasthan, and Bihar, it is more than 30 percent. Direct and indirect medical costs together push the patients and their households into poverty. This is the reality, so to conclude people don't have access to care and those who access care are impoverished. So, these are the reasons why we need to protect the poor in this country.

Fig. 3: Percentage of hospitalised patients who become indebted to meet medical expenses

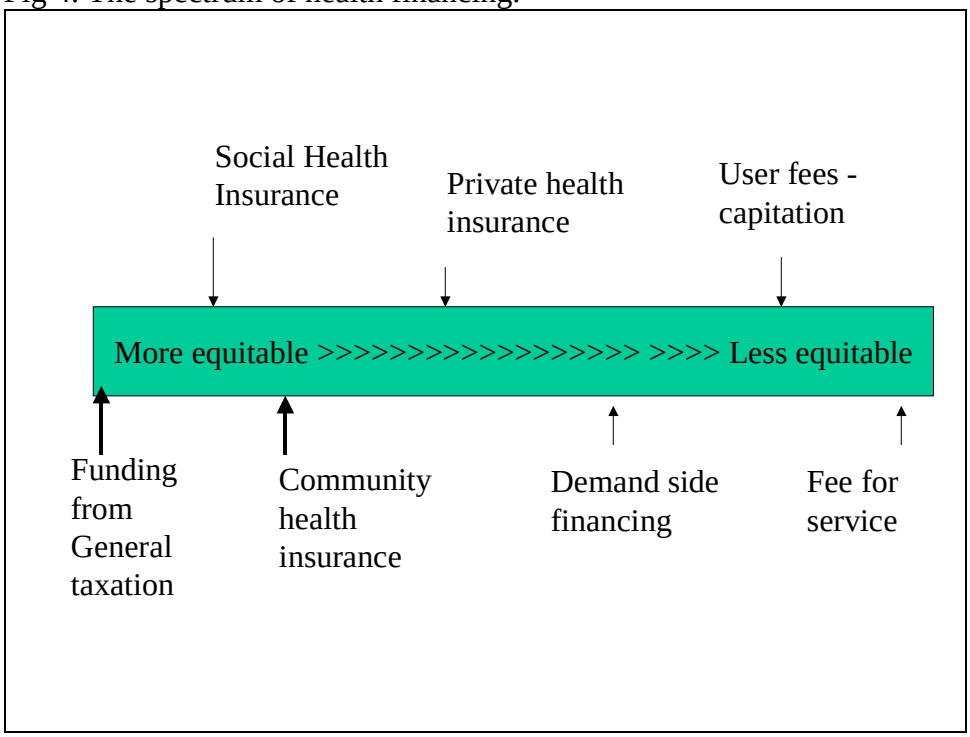



**Measures to protect the poor**

What are the measures that can be used to protect the poor? If one looks at health financing as a spectrum (Fig. 4), then we note that while government funding from taxation (as in the NHS of the UK) is the most equitable, fee for service (as in the Indian private sector) is the most inequitable. One measure is to increase the government allocation for health care. The national health policy hopes to increase it to 5 percent of the GDP. The Common Minimum Programme of the current government hopes to raise the government health spending to at least 2% of the GDP. If this succeeds, then it would be practically a 100% increase in funding. However, it is not enough just to give money to the health ministry; one also needs to target it. Currently, most of the money goes into medical colleges, into tertiary centers, and very little trickles down to the primary and secondary levels. That has to be reversed, and most of this money needs to be allocated to the primary and secondary health services, which are used by the poor.

Other than this, one needs to improve the efficiency of the health system. To give an example, in Orissa the government allocates about Rs 1:50 per person on medicines, which is very low by all standards. As getting more money was not possible, the then Health secretary changed the policy and shifted from branded drugs to generic drugs. Just this change doubled the amount of medicines that the government could buy[7].

Fig 4: The spectrum of health financing.




Yet another way of protecting the poor is by regulating the health sector. Such a regulation will improve the quality of care and this in turn will protect the patients including the poor. For example, just the use of standard treatment guidelines will provide 'rational' care, which will reduce unnecessary medications, procedures and investigations.

And finally let us discuss some financing mechanisms that can protect the poor. The two common measures are demand side financing and health insurance. Demand side financing[8] is a recently introduced measure where the money follows the patient. Traditionally, in most of the financing mechanisms money for health care is given to the provider (the supply side) like hospitals, health centers etc. and they provide the services. Thus they are in control. But in demand side financing, the money is handed over to the patient so that s/he can decide what to do. Thus the patient is in control of the care. In practise it is operationalised as follows:

- The government decides a target population e.g. BPL families who are the beneficiaries of the demand side financing
- They then hand over a certain amount of money to the district health & family welfare societies. In Cambodia, they gave the money over to NGOs at the district level[9].
- So when a BPL patient needs admission, s/he approaches the district society (or NGO) and s/he is given a voucher which can be encashed at the government or select private hospitals.
- The hospitals send the vouchers to the district society for reimbursement on a monthly basis.

So the patient doesn't have to pay money from his/her pocket when accessing care. One additional advantage is that the patients have a choice while seeking care. And finally if

organised properly, the district society / NGO can negotiate for better quality of care on behalf of the patients.

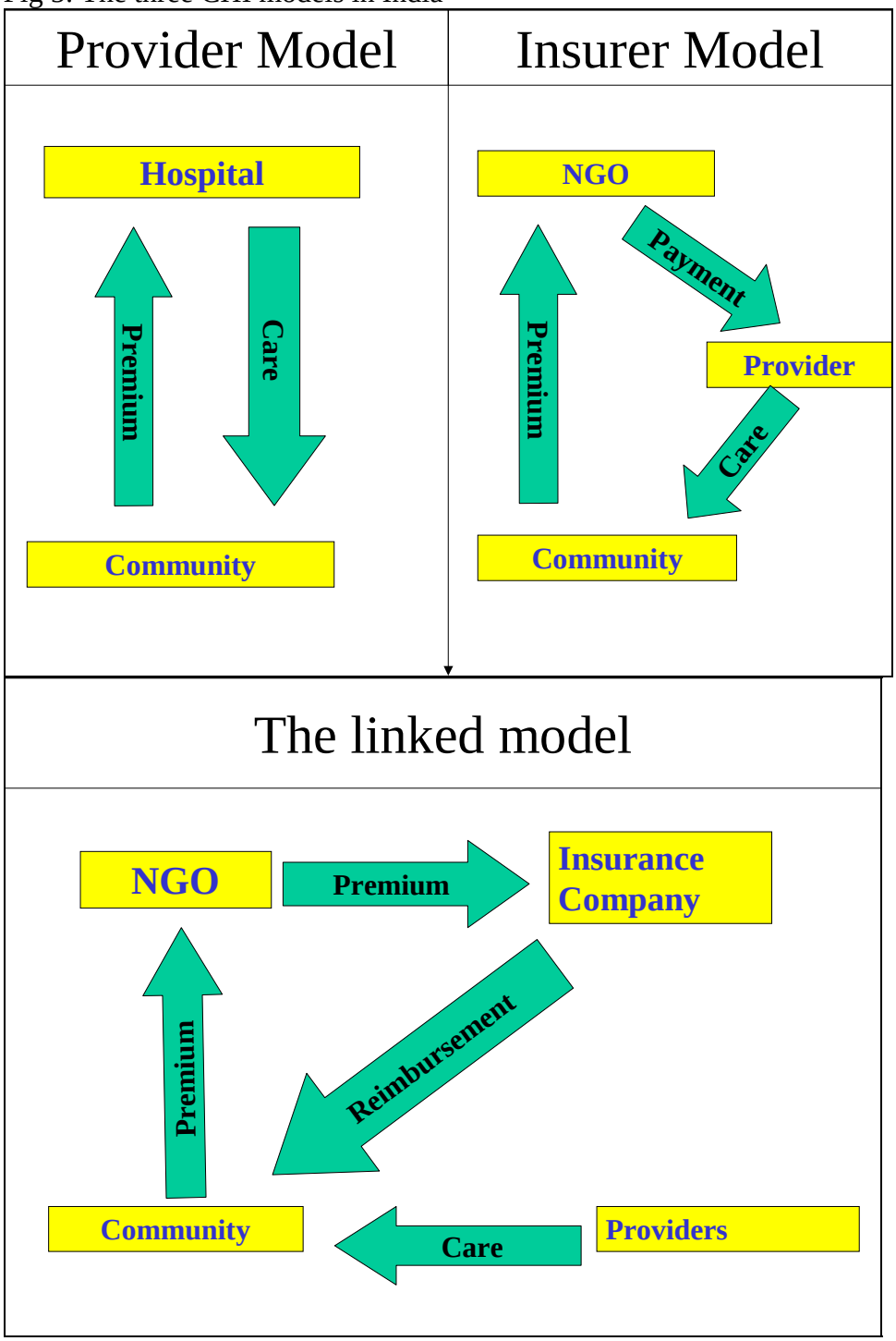
And finally let us discuss health insurance as a measure of protecting the poor. In our country the Central government health scheme (CGHS) and Employees State Insurance Scheme (ESI) are two health insurance schemes for the formal sector. They cover about 3% of the population. Moreover the quality of CGHS and ESIs leaves much to be desired[10]. Then is the standard Mediclaim policy – the only voluntary health insurance product for the rest of the population. It is costly and usually its subscribers are limited to the upper class in urban areas[11]. While private insurance companies have started operations in our country, very few of them are providing health insurance products in the rural areas[12].

To overcome these deficiencies, some NGOs have been experimenting with health insurance schemes for more than 10 to 15 years. Unfortunately these innovations have gone unnoticed in our country. These community health insurances (CHI) are meant for the informal sector and is a not for profit insurance scheme. In most schemes the members participate in its management. Historically, CHIs started in countries like Belgium, Netherlands, Germany etc. during the industrial revolution in the late 19$^{th}$ century. Lot of people migrated to the urban areas to work in the factories. But they did not have access to health care. So the workers pooled money every week to create a sickness fund. And this sickness fund was used to finance the treatment of any sick employee. Those sickness funds slowly merged and today we have the German Social Health Insurance, the Netherlands Social Health Insurance, the Belgian Social Health Insurance. So the community health insurances were the precursors to the current social health insurance. Today CHIs are common in Africa, in Japan, in Thailand, and China. In India also it started in the 1980's though there has not been much documentation. I share with you the relevant findings of a recent study of 10 CHIs in India.

There are basically three types of CHI in our country (Fig 5). One is a provider model where the CHI is started by hospital e.g. ACCORD, the MGIMS Wardha scheme. The hospital insures the community by collecting a premium from them. In return, the patients get free OP care and very subsidized IP care. So, anytime, any member is sick and needs admission they can come to the hospital and do not have to pay any fees.

The other type, which has started recently is the insurer model, where the community pays premium to the NGO. The members then seek health care from any hospital and the NGO in turn pays the hospital the patients' bills. The biggest example of this is in Karnataka, where the Yashaswani scheme insured 17 lakh farmers in the first year. The farmers, through the cooperative society, pay a premium of Rs 60 per person per year and in return they get surgical coverage for up to Rs 1 lakh per patient per year. This includes all types of surgeries, including CABGs.

Fig 5: The three CHI models in India




And the last model is the linked model where the NGO collects the premium and passes it on to insurance companies like the New India Insurance or the National Insurance Company. Patients go to private providers usually and get care. Unfortunately, here it is not a cashless system so they have to pay the provider at the time of illness. The patient then submits the bills to the insurance company via the NGO and receives the reimbursement (usually after a lag period of 1- 3 months). Advantage of this is that the

risk is taken by the insurance company and not by the NGO, so even small groups like 5000 people can get insured in this sort of model.

There are currently more than 20 CHIs all over the country of which the biggest one is in Karnataka. The average premium collected is about Rs 20 per person per year and ranges from Rs. 20 to Rs. 100. This is what the poor can afford, not the Rs. 356 as announced by the Prime Minister of India under the Universal Health Insurance Programme 2003. Usually the health care providers are NGOs or private providers. Unfortunately the Government has not been involved too much in these schemes. Usually the benefit package includes hospitalisation cover and the maximum limits range from Rs. 1200 to Rs. 1 lakh (average is about Rs 5000). The admission rates range from about 6-10 admissions per 1000 insured, which is higher than the national average for the poorest quintile of the population[13]. Administrative costs are low because usually the community and the NGO subsidise the administrative costs.

These CHIs have been effective in enrolling large numbers of members and in increasing access to health care for these members.[14] However, while in Africa there is evidence to show that CHIs are effective in protecting the members from catastrophic health expenditure[15], this is not yet clear in India. Also many of these CHIs depend on external resources to finance the scheme. This implies that there is a need for explicit subsidies to make it work.

**Conclusion**

To conclude, the poorer sections of the community can become further impoverished by health care costs. They need to be protected by various measures. Currently what is feasible is developing alternate financing mechanisms like demand side financing and community health insurance.

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