HEALTH IN THE ERA OF NEOLIBERALISM:
Journey from State Provisioning to Financialization

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Shailender Kumar Hooda*

[***Abstract***: *This paper brings out the evidence that India has been compromising the goal of providing comprehensive public health services in the post liberalisation phase. Over the years, privatisation in healthcare has not only been promoted, but also facilitated to expand and grow further, especially with the adoption of financialisation approach in the healthcare sector. The country's approach to finance healthcare is gradually shifting from tax-funded provisioning of services for achieving universal healthcare access to tax-funded health insurance, merely to achieve health coverage. Insurance based financing mechanism, however, has largely been unsuccessful to deliver either on health outcomes or financial protection grounds. Though the comprehensive healthcare provision ensures equitable, accessible and affordable healthcare services and protects households from the devastating consequences of out-of-pocket payments, the idea of "strategic purchasing" as outlined in the National Health Policy of 2017 for promoting privatisation is neither based on adequate empirical evidence nor is sustainable. As a result, instead of addressing the current challenges, it will further aggravate the crisis in the healthcare sector.*]

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1. Introduction

The aim of this study is to understand and describe health in the context of neoliberalism. This also explains how healthcare financing approaches are shifting from tax-funded provisioning to tax-funded insurance protection merely to achieve health coverage, due to neoliberal initiatives in the healthcare sector. Lastly, the implications of current financing approaches and policy initiatives promoting privatisation in the Indian healthcare sector are highlighted. In order to understand health in the era of neoliberalism, several policy documents and academic writings are reviewed since independence and up to the announcement of third National Health Policy (NHP) 2017.

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The major developments in healthcare sector are explained and classified in several periods, namely (i) first thirty-five years of independence: designing the healthcare system; (ii) early 1980s to pre-liberalisation: rise in public investment to achieve *health for all*; (iii) liberalisation phase 1990s: beginning an era of reduced role of state in provision; (iv) liberalisation in healthcare sector since 2000: justifying underfunding and privatisation; (v) financialisation in healthcare sector: public-fund supporting private insurance and care. Further, the effectiveness of current healthcare financing strategies and *strategic purchasing* ideas are analysed in greater detail.

2. First Thirty-five Years of Independence: Designing the Healthcare System

Health is an important commodity not only at the individual level, but also at microeconomic and macroeconomic scales of a country. Improvement of health status is therefore on the political agenda of every government. In India, health has been a major policy issue since independence. India is amongst those countries that have tried to build a healthcare system on the premises that health is a public good. India's foremost committee on health (called Bhore Committee, 1946) was announced on the principles that 'nobody should be denied access to health services for his inability to pay' and that the provision of healthcare services should be the government's responsibility. Considering the burden of diseases and mortality pattern during the time, the Committee suggested a comprehensive primary healthcare system in the country. After independence, India constituted several committees on health to review the health conditions of the population and seek recommendations to design a better health system to serve the general population. Like Bhore Committee, several other committees [Sokhey Subcommittee 1948, Mudaliar Committee 1962, Chaddha Committee 1963, Kartar Singh Committee 1974, Srivastava Committee 1975 and Joint Panel of Indian Council of Medical Research-Indian Council of Social Science Research (ICMR-ICSSR) 1980] also felt the need for a more integrated and comprehensive health provisioning based on a three-tier (primary, secondary and tertiary) structure in the public sector (for details on these committees, see Sen, 2012 and Hooda, 2017). A state interventionist approach was advocated in the healthcare sector. The major consideration during the time was that the provision of healthcare services requires extensive intervention by the state. The principles of non-excludability (one cannot exclude or prevent other people from obtaining it because of inability to pay, as benefits of goods are freely available to all) and non-rival in consumption (quantity available for other people does not fall when someone consumes it) were proposed for healthcare. That is, health was considered a public good, which, typically, was inefficiently allocated in a pure market system because it was felt that in the absence of a reasonably well-organised system of public healthcare for all, people may be distressed by costly private healthcare.

Overall, in a broader sense, these committees advocated an integrated and comprehensive three-tier healthcare provisioning structure, i.e. primary, secondary and

tertiary. Given the patterns of disease during the time, such a health system design was highly appreciated. India was not the only country that was in the process of designing a healthcare system; rather, this was a period when most of the developing countries were also facing prevalence of several diseases like diarrhoea, lung inflammation, tuberculosis and malaria, and were therefore in the process of reforming and designing their healthcare systems.

There were different ideological and practical notions to design/reform the healthcare system. One notion was to follow a healthcare system that is prevalent in the western industrial states and societies. The healthcare system in these economies laid emphasis on the curative aspect of healthcare but limited it to healthcare services in hospitals, medical practice, and pharmacies based on medicine technology. Preventive care (prevention of diseases) had relatively little value in these economies. But, during the time, there was a growing notion amongst scholars, academicians and civil society actors that more than 80 per cent of the diseases that are prevalent, particularly in the developing countries, could be protected easily under the preventive healthcare system. As a response to the problems of health in developing countries, the World Health Organisation (WHO) called its members and other nations to an international conference held in Alma Ata, Kazakhstan, in 1978. In the conference, it was increasingly realised that health services in the so-called developing countries could not be perceived or oriented according to the western industrial states and societies. The adoption of a western style healthcare system was opposed on several counts. First, the western system was one-sided, especially oriented towards curative dimensions, while neglecting preventive and social medicine aspects. Second, the curative system was too expensive and because of low fiscal capacity, the developing nations were not in a position to allocate the required amount of funds to replicate such a system. Third, the medicine apparatus from the industrial states were unaffordable and unfavourable in the developing countries in terms of price and utility because the disease prevalence pattern in these countries was different than that of the developed nations. Fourth, their system did not fit well in developing nations because of a lack of specialists (health personal) who could handle the high-technical medicine. And fifth, the natural and scientific understanding of medicine in the West does not consider the traditional views concerning experiences about diseases and health that has spiritual background of the inhabitants, but were prevalent in the developing countries (WHO, 1978; Medical Mission Support, undated).

The common consensus that emerged at the conference held in Alma Ata was that majority of the diseases prevalent in developing countries can be protected easily under the primary healthcare system. Achieving Health for All (HFA) through Primary Health Care (PHC) approach emerged as a central concept of Alma Ata Declaration 1978. That is, the PHC approach emerged as the key for attaining the goal of HFA by 2000. This concept was heavily concerned with people, especially with the principles of social justice, accessibility, appropriateness and acceptance of medical services keeping in mind the needs of people in the communities, their participation and orientation to the concept

of health services. This strongly reaffirms that health, which is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, is a fundamental human right and that the state should take the prime responsibility for meeting this goal. The Declaration was considered a major milestone of the twentieth century in the field of public health, as it adopted a holistic framework of comprehensive healthcare provision to achieve HFA through state intervention. Most of the nations that participated in this conference supported the HFA vision and became signatories to it.

India also became a signatory to the HFA vision in 1978 and encompassed most of its tenets (like equity, universalism, comprehensiveness, government responsibility and community participation) in its first NHP which was announced in 1983 (Sen, 2012). India took a long time, almost three and a half decades after independence, to announce its first NHP in which a holistic (primary health care) approach was adopted to ensure HFA through provisioning of community health centres (CHCs), primary health centres (PHCs) and health sub-centres (SCs) in the remotest areas of the country. So, the first 35 years of the healthcare sector in the post-independence era can be described as a period when the healthcare system was being shaped with the help of the recommendations of several committees and the introduction of the first NHP that sought more public investment for promoting primary healthcare.

3. Early 1980s to Pre-liberalisation: Rise in Public Investment to Achieve *Health for All*

With the announcement of the first NHP, several developments took place in the Indian healthcare sector. For instance, a rise in government spending in health was noticed after the announcement of the first NHP. The rise in public investment in healthcare sector was observed to build a comprehensive three-tier healthcare system/structure in the country. This includes SCs, PHCs, CHCs, sub-divisional hospitals and district/civil hospitals and medical institutions. The SC is the first and the most peripheral point of contact between the primary healthcare system and the community. According to the proposed guidelines, one SC is to cover a population of 3,000 in hilly/tribal/difficult areas and 5,000 in the plains. Each SC is required to have at least one female health worker/auxiliary nurse midwife (ANM) and one male health worker. Sub-centres have been assigned the task of conducting interpersonal communication in order to bring about behavioural change and provide services in relation to maternal and child health, family welfare, nutrition, immunisation, diarrhoea control and control of communicable diseases programmes. Also, the sub-centres are provided with basic drugs for treating minor ailments and taking care of essential health needs of men, women and children. The PHC, on the other side, is the first point of contact between the village community and the medical officer. The PHCs were envisaged to provide integrated curative and preventive healthcare to the rural population with emphasis on preventive and promotive aspects of healthcare. One PHC is to cover a population of 20,000 in

hilly/tribal/difficult areas and 30,000 in the plains. One PHC, as per minimum requirement, is required to have one medical officer supported by fourteen paramedical and other staff. The PHC generally acts as a referral unit for about six sub-centres and has four to six beds for patients. The activities of a PHC include curative, preventive, promotive and family welfare services. One CHC is to cover a population of 80000 in hilly/tribal/difficult areas and 1,20,000 in the plains. The CHC is required to have four medical specialists which include a surgeon, a physician, a gynaecologist and a paediatrician supported by paramedical and other staff. It is proposed to have 30 in-door beds with one operation theatre, X-ray facility, labour room and a laboratory. It serves as a referral centre for four PHCs and also provides facilities for obstetric care and specialist consultations. The sub-divisional and district/civil hospitals—at least one each in a district—are to provide secondary and tertiary care (GoI, 1983).

In order to establish such health infrastructure and achieve the goal of HFA by the year 2000, government investment in the healthcare sector also increased both as a share of total budgetary allocation as well as the percentage to Gross Domestic Product (GDP). The rise in public investment in health was seen both at the national level and the state level. However, with the amount that was allocated to the healthcare sector, the prescribed infrastructural strength in healthcare, both physical and human, could not be achieved (Hooda, 2015a). Healthcare facilities could not achieve a satisfactory level of provision and therefore were confronted with several problems. However, it is also true that the health services, even if of low quality and uneven in reach, were available to the poor. In respect of the public healthcare system, its performance was observed to be quite effective till the mid-1980s. This is simply because the phenomena of rise in public investment in health was short-lived—it started in early 80s and ended by the late 80s (a period which is called a rise in public investment in healthcare sector), leading to a failure in achieving the HFA target. The rise in public expenditure for providing adequate healthcare services could not be sustained in most of the Indian states. The decline in public health expenditure was observed even before the starting of liberalisation phase of 1990s (Hooda, 2015a).

4. Liberalisation Phase of 1990s: Ushering in an Era of Reduced Role of State in Provision of Healthcare Services

The liberalisation phase in India began in the early 1990s. The early 90's was a period when India was going through macroeconomic policy restructuring. One outcome of this restructuring was the implementation of the Structural Adjustment Programme (SAP) enforced by the international agencies. The fiscal stringency induced by the structural adjustment measures affected the central and state finances in a big way. The SAP enforced the central and state governments to restructure their expenditure pattern. The thrust of the SAP was on reducing the budgetary deficit either by increasing revenue resources or curtailing expenditure or both. Because of the limited base of tax structure, the revenue of both central and state governments did not show any increase, as the

trend in revenue/GDP ratio was stagnant. During the period, central and several state governments went through the process of expenditure curtailment. In the restructuring process, a squeeze in the health and social sectors' spending was observed at the national and state levels. A study on expenditure pattern across Indian states reflected that between 1987 and 1992, a period of fiscal stress and expenditure restructuring, none of the Indian states recorded a positively significant growth in health expenditure. Even for some of the middle- and high-income states like Andhra Pradesh, Assam, Karnataka, Kerala, Gujarat and Punjab, the growth rate turned out to be significantly negative during this period (Hooda, 2015a).

In addition, there were several other developments in the healthcare sector, largely promoted by international agencies. For instance, in the early 1990s, the World Bank (hereafter the Bank) brought out a report titled *Investing in Health*. While highlighting the performance of the healthcare sector, the report stated that in the past forty years (from 1950 to 1990), life expectancy of the world has improved more than ever, especially considering the entire span of human history. In 1950, life expectancy in developing countries was forty years; by 1990 it increased to sixty-three years. In 1950, 28 of every 100 children died before their fifth birthday; by 1990 the number had fallen to ten. Smallpox, which killed more than 5 million annually in the early 1950s, has been eradicated entirely. Vaccines have drastically reduced the occurrence of measles and polio. Not only do these improvements translate into direct and significant gains in well-being, but also they reduce the economic burden imposed by unhealthy workers and sick or absent school children. These successes have come about in part because of growing incomes and increasing education around the globe and in part because of governments' efforts to expand health services, which, moreover, have been enriched by technological progress (World Bank, 1993).

Though the *Investing in Health* report mentioned the efforts made by the government towards improving the health outcome, it also argued that the public healthcare system in developing nations is confronted with several challenges on grounds of **e**fficiency and equity. The report, therefore, insisted upon the limited role of government involvement in healthcare and insurance sector. That is, government should limit its role in healthcare and insurance. The report rejects the idea of a healthcare system as a public good, insisting that healthcare is a matter of choice for individuals and families, considering their strikingly different health needs (Fisk, 2000). Viewing healthcare as a private good, the report quite consistently proposed a strategy for promoting both private insurance and private delivery. It argued that when a country develops, a section of its population becomes able and willing to spend its own money on healthcare. At such a point, the state, according to the Bank, should not retain sole responsibility for a field like health. It should be shared with the private sector. The public sector will continue to be responsible for providing healthcare services to the low-income groups and for matters concerning public health. Beyond that, it will use its resources not to deliver healthcare but to make it possible for individuals to buy private insurance and care. It could return

its obligatory fees for healthcare to individuals and add subsidies to those fees if they are insufficient for buying private insurance. As affluence spreads among citizens, such public-sector stimulation of private insurance would create demand sufficient to call forth a brisk supply of private healthcare (World Bank, 1993; Fisk, 2000).

Along with the declining share of public expenditure on health, another important development was the introduction of user fees during the Eighth Five-year Plan (1992–1997), which was implemented in most of the states at different points of time during the decade. From the late 1990s to the early 2000s, many states initiated World Bank-sponsored health system reforms that further increased user fees in government hospitals (Ghosh, 2010). The study mentions that although user fees was waived for people living below poverty line, the definition of "poor" was arbitrary, leading to limited relief for most poor people. During the period, though reforms in healthcare sector were piecemeal but incremental, it led to extensive changes in the organisational structure, financing, and delivery of healthcare services. The SAPs and bank-supported health system reforms have largely been the guiding instrument in the reduced role of state in healthcare provisioning, leading to government failure in meeting public healthcare needs. This can be corroborated with the point that a certain number of primary health centres (CHCs, PHCs and SCs) and human infrastructure which were proposed to be achieved under the "Health for All by 2000" goal of the first NHP, but by 2000 the prescribed minimum numbers of human and physical infrastructure in the healthcare sector could not be achieved. The actual number of CHCs (about 3043 CHCs as against the required 7415 by the end of 2000), PHCs (about 22842 PHCs as against the required 24717 by the end of 2000) and SCs (about 137311 SCs as against the required 148303 by the end of 2000), which were considered as the basic pillars of primary healthcare approach, were lagging behind the required number of health centres/infrastructure (Hooda, 2015a). The lack in health service provision resulted in inaccessibility of health services for the general population. The inability of the public sector to meet the healthcare needs resulted in dependency on private providers. The general population, especially those working in the informal sector, look forward to receiving services from private healthcare providers— mainly small clinics, medical centres, nursing homes and other informal healthcare providers. Due to these reasons, a sharp rise in the number of informal healthcare providers during the period was observed (Hooda, 2015b).

Another reform measure suggested by the Bank was to open up and promote the health insurance sector for private players. No doubt, India's tryst with health insurance schemes dates back to the early 1950s, when the employer-mandated social security schemes [the Central Government Health Scheme (CGHS) in 1954 and Employees State Insurance Scheme (ESIS) in 1952] were launched. These were mandated for civil servants and formal sector workers through a contributory mechanism but were highly subsidised. Considering the status of self-employment and the emergence of the corporate and service sectors, it is argued that since the middle-income population is growing, the insurance sector should be opened up for private players. Thus, India

opened up its health insurance sector for private players in 1999 with the foreign direct investment (FDI) cap in health insurance set at 26 per cent. The insurance generally covers hospital services; as a result, the growth in the private formal healthcare providers can also be observed thereafter (Hooda, 2015b).

Another major development in the healthcare sector during the period was the introduction of the Drug Price Control Order (DPCO) in 1994. According to the DPCO (1995), only 74 out of 500 commonly used bulk drugs were to be kept under statutory price control. The pharmaceutical sector was further liberalised in 2002. The impact of these drug policy changes could be seen in the spiralling increase in drug prices during the period from 1994 to 2004 (Ghosh, 2010). These developments as well as inadequate provisioning, decline in investment and introduction of user fees in the public healthcare sector provided an opportunity to the private sector to exploit the healthcare market (Hooda, 2015b).

5. Liberalisation in Healthcare Sector since 2000: Justifying Underfunding and Privatisation

In the beginning of 2000s, two major developments in healthcare sector were noticeable. The first one, basically, tried to justify public sector underfunding and privatisation and the second related to the announcement of the not-so-effective second NHP of India in 2002. Amongst others, the neoliberal understanding can be recognised as one of the major factors that tried to justify public sector underfunding and privatisation. This narration comes out from another influential report of the World Bank specifically for India titled *Better Health Systems for India's Poor*, published in 2002 (Peters *et al*., 2002). This report mentioned that India's healthcare system is at a crossroads. Its ability to fight with infant mortality, communicable disease, and malnutrition is being stretched. At the same time, it faces an emerging demand for better services and for paying greater attention to the chronic diseases of adulthood. India's underfunded public sector and extensive, but largely unaccountable, private sector cannot hope to meet the country's enormous, growing, and shifting healthcare needs. If India continues on its present path, the mismatch between its health system and its health problems will only become more severe. The present moment is a decisive one because the Government of India is now seeking to define a better health system for the country through the draft report (2001) of the second NHP. The Bank report highlights that the country needs to promote its private sector because then it can take better advantage of the capacity of the private sector and deliver better service and outcomes for all regions and socioeconomic groups.

The Bank report also stressed that underfunding and privatisation are actually defensible in a sense that the Indian economy has the potential to grow to a higher level and at faster rate, leading to increase in the paying capacity of masses. Since public system has largely been inefficient in meeting the population healthcare needs, therefore it would not be harmful to marketise the healthcare sector. Such neoliberal arguments were made

familiar to everyone who made cuts in public investment necessary. We believe that this was a neoliberal priority of opening up investment opportunities for private sector. One can say that this was the beginning of a crisis in Indian public healthcare—its underfunding followed by its privatisation.

Now the question that emerges is: Has the public healthcare system really been wasteful/inefficient? In order to understand this point, we reviewed public health expenditure as well infrastructure and made some assertions. The review reveals a growth in the number of basic healthcare facilities (measured in terms of different tiers of health centres) over a period of time, but this growth was not enough to meet the required number of health centres. This lead to an uneven spread of public health facilities; some areas/regions had deficiency of healthcare facilities. What is more worrisome is that many of the existing health centres/hospitals were also not properly functional, particularly because of lack of medical equipment, medicine, health professionals and other basic amenities. In other words, a perfect combination of required health infrastructure within the existing facility was missing. This happened simply because capital expenditure—which is essential for providing physical infrastructure and purchasing of new medical equipment—on health has seen a declining trend both at the centre and the state levels (Hooda, 2015a). The declining share of capital expenditure, however, will not be problematic if state(s) fulfil the prescribed norms of basic health facilities. But, as reported earlier, most of the Indian states were facing a shortfall in achieving the prescribed norms of health standard. The low as well as declining share of capital expenditure further forced/pushed-back the recurring (revenue) expenditure from growing. As a result, the total public expenditure on health saw a declining trend. In terms of its share in GDP, it reveals that public expenditure on health hovered around only 1 per cent of GDP; however, the resource requirement to provide basic healthcare facility was recommended/argued to raise public expenditure to 2–3 per cent of GDP. Lack of investment in the public healthcare sector resulted in an inability to expand and modernise health services. This resulted in ineffectiveness of the public healthcare system simply because the services that are supposedly assumed to be there in public healthcare system were not available. With this connotation, one would not agree with the phrase that 'public healthcare system is wasteful/inefficient,' as, we believe, this is a problem of underfunding and not inefficiency. If one can ensure a perfect combination of physical and human infrastructure by spending adequate amount of money in health, the result will be different. It can be said that the public healthcare sector has never been given a chance to do better; the sector has always been lacking from flow of meagre funds. We believe that underfunding public healthcare was a step in realising neoliberal strategy and the sector became the victim of low political priority.

India also rolled out considerable amount of liberalisation policies to privatise the healthcare sector during the decade. One of the key factors in realising neoliberal strategy was the opening up of the hospital sector for foreign players. In this context, as a policy initiative, the Government of India approved 100 per cent FDI through automatic route

in 2000 in hospital sector. Furthermore, the relaxation in import duty for importing medical equipment and technology in the year 2000, granting of long-term and cheap loans to private healthcare institutions, according industry status to the hospital sector in the 2003–04 budget were other initiatives for encouraging private providers/enterprises (domestic as well as foreign), especially the large and corporate-run, to exploit the Indian hospital market. In this decade, the state was largely seen as a facilitator of the private sector. Overall, the consensus that emerged was to invest in health, but support the private sector through subsidies, credits and PPPs as well as through insurance.

In addition, in the beginning of this decade, India also announced its second NHP in 2002. This policy provided a good review on achievement and failure of the Indian healthcare system, but did not clearly specify the guidelines/recommendations to reform the healthcare sector. For instance, in the introductory section, the policy document acknowledged that the public health system showed only a limited success 'in meeting the preventive and curative requirements of the general population.' The performance of the Indian healthcare system is not satisfactory as 13 of the total 17 goals of the previous health policy have not been met even across a span of almost twenty years (Sen, 2012). There was a huge difference in rural-urban as well as state level outcomes. While justifying the dismal performance of the healthcare sector, the policy document mentioned that the responsibility for the health system in India lies in the hands of the federal states. The responsibility of setting priorities and making decisions with regard to healthcare spending lies with the state governments. It is not surprising that huge differences in health system performance and quality exist between the states. Within the states, the health system is also characterised by an urban-rural dichotomy, specifically the concentration of public and private healthcare facilities in urban areas and missing facilities in remote rural areas. The low income states are also characterised by low level of health spending. This is a common feature of the Indian healthcare system, amongst other factors, which has resulted in a dismal performance.

It is also true that the burden of disease is disproportionately placed on the poor. Mortality rates, fertility rates and undernourishment level have doubled for the poorest quintile of the population. They receive fewer subsidies and have to spend a higher share of their household incomes for health services (Misra *et al*., 2003). The report mentioned that while success in controlling the spread of communicable diseases is noticeable and mortality rates have declined, inequality in respect of access to quality healthcare has not decreased. The gap in health services access and outcomes between rural and urban areas and between the richer and the poorer segments of society has widened (Peters *et al*., 2002). It can be said that several factors contributed to this dismal state of the healthcare system. The limitations of current system centred on vertical programmes, rural-urban disparities in health infrastructure, shortage of medical personnel at health centres and doctors at hospitals, lack of legislation on minimum standards for private medical establishment, the inclusion of more than 300 drugs in price control list in 1970s to

around 30 in mid-1980s for ensuring affordable medicine, etc., were more prominent for the limited performance of Indian healthcare sector (GoI, 2002; Sen, 2012).

The policy document reported that another important factor of low performance is the lack of implementation of decentralisation mechanism for service delivery which was discussed in the first NHP. Therefore, as a reform strategy, the second policy emphasised decentralisation and community participation as measures to improve the quality of healthcare, to improve equity in the healthcare system and to achieve comprehensive primary health care. The policy, however, considered decentralisation and community participation as leading strategies to reform the healthcare sector. An in-depth review of the policy reveals that it failed to identify and specify: What constitutes decentralisation? What are the components of decentralisation? To what extent can decentralisation be incorporated? How much (funds, functions and functionaries) power needs to be devolved to decentralised institutions? How and where to involve the community in the design and making of the health policy? Overall, the second health policy document, however, provides a comprehensive review on the achievement and failure of the first NHP, but failed to identify and specify how to reform the healthcare sector. The second NHP (along with the National Population Policy 2000), no doubt, complemented the primary healthcare approach followed in the first NHP and also sought for more public investment in the healthcare sector. The policy document, however, did not negate the role of the private sector.

Thus, inadequate public investment and announcement of the nonvisionary second NHP on the one hand, and liberalisation and privatisation policy reforms at the macroeconomic front in the early 1990s and around 2000 in the healthcare sector—which gave several tax benefits and other incentives for setting up private hospitals/clinics—on the other hand resulted in (high) increase in the number of private healthcare providers. This resulted in dominant share of private service provision (consisting of 10.67 lakh private providers ranges from informal to large formal and corporate entities as against the low 1.96 lakh public hospital/centres) as well as service delivery which provides 3/4 of outpatient and 2/3 of inpatient care treatments (Hooda, 2015b). Costlier private cares resulted in high (around 70 per cent) Out-of-Pocket (OOP) health expenditure in the country. This made health service inaccessible, particularly to the poor, simply because they could not afford to pay in times of need and those who did use services suffered financial hardship or impoverishment, as they had to sell their assets and/or borrow money to meet their healthcare costs (Hooda, 2015b). That is, the economic gradients of inequality in access to healthcare worsened sharply in India. Under such a system, the rural poor felt financially squeezed and experienced difficulty in finding affordable services (Sen, 2012).

In order to address the questions of equity, accessibility and affordability, some financial (financing healthcare) innovation strategies were discussed in this decade. The most prominent was to rejuvenate the public healthcare provisioning system followed by the provision of financial risk protection, at least to the poor, through publicly-funded health

insurance schemes. As a part of the rejuvenation of the public healthcare provisioning system, the Government of India launched a flagship programme called the National Rural Health Mission (NRHM) in 2005. The Mission stressed on improving service delivery in the public healthcare system and advocated more public investment (2–3 per cent of GDP) in public healthcare sector, especially to bridge the gap in rural-urban health outcomes and to achieve the Millennium Development Goals for health. With the launch of NRHM, there was a visible rise in public investment, which, by the end of the decade, reached 1.2 per cent of GDP from the current expenditure of 1 per cent of GDP. In addition, it involved community and local agents/institutions in policy making/design and implementation through the introduction of VHSC (Village Health and Sanitation Committee) and ASHA (Accredited Social Health Activist, a community health worker). The NRHM made visible progress in improving child and maternal (immunisation, antenatal care, post natal care, institutional delivery, etc.) healthcare and health outcomes. However, due to shortage of physical and human healthcare infrastructure along with low availability/unavailability of medicines and equipment in hospitals/centres, even the services that are supposedly assumed to be provided in the public healthcare system were not available in practice. Healthcare services were still inaccessible for the poor owing to their inability to pay. In order to deal with the problem, the Government of India launched a nationally representative publicly-funded health insurance scheme for the poor in 2008 called the Rashtriya Swasthya Bima Yojana (RSBY), which is discussed in the following section.

6. Financialisation in Healthcare Sector: Public-fund Supporting Private Insurance and Care

In this section, the process of financialisation in the healthcare sector is understood through two dimensions: (i) labour market outcomes and (ii) universal health coverage debate. The financialisation process of the healthcare sector is largely related to labour. A brief review of literature reveals that in the process of opening up of new fields for investment and profit-making through privatisation, labour under the neoliberal regime became cheaper so as to attract foreign capital and to make the country's exports more competitive. In India, labour has become cheaper over the years. For instance, the share of wages in value added reduced significantly over the last three decades, i.e. between 1980–81 and 2011–12. In the post-liberalisation phase, its share declined from 19.1 per cent between 1990–91 and 1994–95 to 9.9 per cent between 2005–06 and 2011–12. On the other side, the share of profit in value added increased sharply from 21.4 per cent to 49.6 per cent during the same reference period (Roy, 2016). Cheap labour calls for labourers' expectations of benefits from social programmes. It is believed that part of the cost of labour is reduced when such programmes, including public healthcare, cost more to employers and less to state.

However, whether the social programmes cost employers more and/or less to the state, one needs to understand India's labour market as compared to other emerging

economies like China, Brazil, Chile, Thailand and Malaysia where currently, along with public provisioning, social insurance schemes are being promoted for assessing services through accredited private facilities. Social insurance schemes in these economies pool resources from public sources and from contributions made by employers and beneficiaries/employees. On the other side, the Indian labour market is highly fragmented. Not only is a large proportion (about 93 per cent) of the workforce engaged in the informal sector, but also informality is increasing in the formal sector as well. This reflects that a large proportion of the workforce leaves no/little room to receive contribution from employers. That is, the contribution from employers in India would be almost negligible owing to the informal nature of the economy. Moreover, for 93 per cent of informal workforce there will be no/minimal arrangement of social security system from the employer's side. The estimates of the latest National Health Account 2016 in respect of the sources of healthcare financing also suggest that firm contribution in total health expenditure has declined from 5.7 per cent in 2004–05 to 2.4 per cent in 2013–14 (GoI, 2016a). This trend reflects that the health security benefits from employers has declined over a period of time, may be because of the highly informal nature of the economy. In the highly informal scenario, it is very difficult to ask the informal workers to pay (high) premium, except for minimal contribution, to avail the benefits of social insurance schemes. Thus, the financing care though insurance-based model in India is expected to be almost entirely from public sources. That is, there will be a tax-funded insurance protection scheme/programme. Thus, in reality, any social programme or social insurance scheme in India would be costlier for the state and cheaper for the employer.

The other component of understanding the process of financialisation in health sector is the Universal Health Coverage (UHC) debate. Around 2010, a considerable amount of debate started on strategies to finance healthcare at global level to achieve UHC. The UHC debate largely advocates adoption of a social health insurance system or other publicly financed health insurance, where all citizens are insured and can utilize healthcare services regardless of whether or not they can afford it. The World Health Reports 2010 and 2013 suggested a road map for developing countries to adapt their financing systems to meet the requirements of UHC (WHO 2010 and 2013). The reports highlight that UHC is important for addressing the equity, accessibility and affordability issues in a developing country. The reports largely advocate an insurance-based health financing strategy to finance healthcare.

Government of India also set up a High Level Expert Group (HLEG) on UHC in 2010. The HLEG submitted its report to the then Planning Commission in 2011. While defining the UHC, the report upheld the principles of universality, equity and reflects that the state must be primarily and principally responsible for affordable, accountable and appropriate (promotive, preventive, curative and rehabilitative) health services for a UHC and recommended an increase in public investment in health between 2–3 per cent of GDP. The report, however, reflects that the government being the guarantor and

enabler, although not necessarily the only provider, of health and related services (GoI, 2011a: 3) indicates that services can be provided through other mechanisms, say from the private sector. Further, the Planning Commission Steering Committee for the Twelfth Plan, in its own assessment report to the Prime Minister, criticised the HLEG for ignoring the well-established private sector and made it clear that given the major share of personnel, beds and patients, "the private sector has to be partnered with for health care" (Qadeer, 2013). Thereafter, the draft report of the third NHP in 2015, however, specified the role of comprehensive primary care provision in the public sector, while simultaneously supplemented by strategic purchase of secondary and tertiary care services from both public and private sectors to assure universal healthcare. It is highlighted that the current publicly-financed (tax-based) national health insurance scheme would be aligned with this strategy and states would also be encouraged to do the same (GoI, 2015). In the beginning, the RSBY was a project of the Ministry of Labour but now it has been transferred to the Ministry of Health and Family Welfare from April 1, 2015, reflecting that the UHC debate is a more powerful instrument as compared to the labour market outcome.

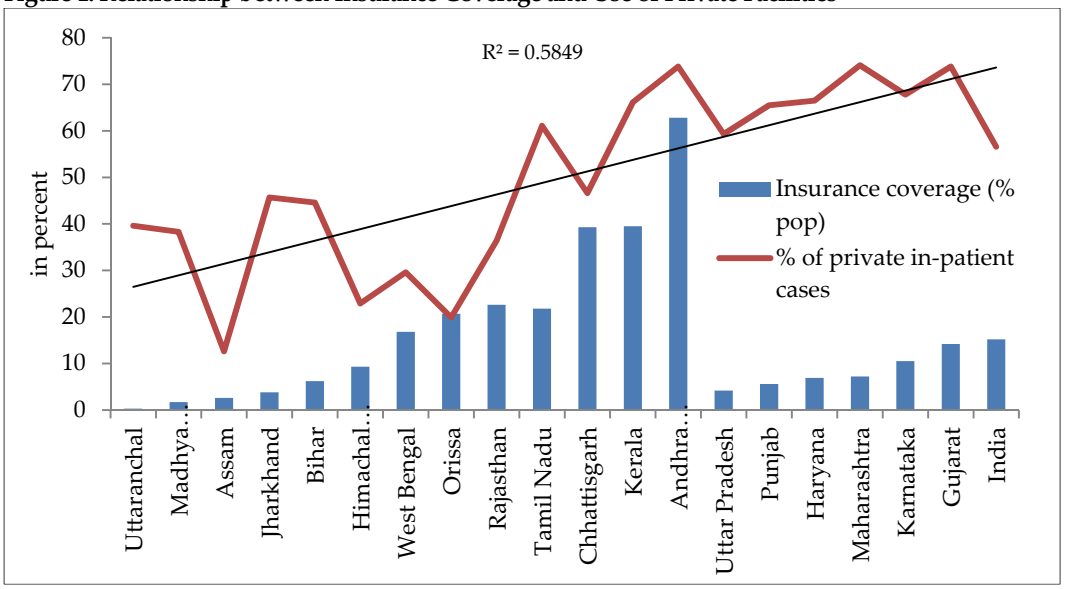
The Vajpayee Arogyasri in Karnataka, Rajiv Arogyasri in Andhra Pradesh and Kalaignar Insurance Scheme in Tamil Nadu are publicly-funded health insurance schemes currently being implemented at state level. The RSBY is a publicly-funded social health insurance scheme in India which is being implemented at national level since its launch in 2008. The RSBY has been recognised as one of the world's largest insurance schemes for the poor, which was later extended to the informal sector community/workers. These Social Health Insurance (SHI) schemes, sponsored by the central and state governments, enrol/cover those living below poverty line and the informal community at no/minimal charge (Rs 30/annum per household under RSBY). The coverage under the national health insurance (RSBY) is Rs 30,000/annum per household.

Under the advanced UHC framework, the recent national and state level social health insurance schemes, which were largely meant for the poor and a section of the informal community, are now expected to cover more than 80 per cent of India's population. The new national health protection scheme is expected to provide a health cover of up to rupees one lakh per family with an additional top-up package of up to Rs 30,000 to senior citizens of age 60 years and above (GoI, 2016b). The government will charge a minimum (only registration) fee from the people. This is a major shift in policy dialogue which gives an intention to promote the purchasing of services through a financial protection package provided through health insurance. One can say that this is the beginning an era of financialisation approach in the Indian healthcare sector, under which the state seems to ensure access to, but not necessarily provision of, services.

The insurance promoted health financing strategy would have larger implications for the healthcare sector simply because public funds can now be utilised to support private insurance and care. Earlier, public funds were meant for provisioning of public health services and now these funds will be utilised to promote/support private health care

providers. This is simply because insured people prefer private services over public services, as has happened in case of social insurance schemes like ESIS/CGHS (Hooda, 2015d). Similarly, in case of RSBY and state-sponsored SHI, a significant proportion of beneficiaries avail private health services instead of public services. Evidences from *Figure-1* also show that with the increase in coverage of population under pro-poor social health insurance schemes, more people tend to avail private facility for inpatient care, except for one low income (Uttar Pradesh) and four high income states, thus promoting the private sector. Furthermore, opening up of the health insurance sector for private insurers (with setting the FDI cap 49 per cent in 2016), which encourage people/workers to buy private insurance on premium-payment basis, is a step towards replacing public with private insurance.

Figure 1: Relationship between Insurance Coverage and Use of Private Facilities



Source: NSS 71st (2014) Round.

As regards the health services, those who have private insurance voucher generally receive healthcare from private providers, thus replacing public with private provision. When RSBY was implemented, the objective was to ensure access to affordable services for the poor. But, with the announcement of the NHP 2017 the intention has changed. The NHP 2017 clearly reflects the need for involving and promoting strategic purchasing of services from private care providers. The government funded insurance schemes will be used to promote privatisation. Strategic purchasing refers to the government acting as a single payer through health insurance (GoI 2017), indicating that insurance-based financing strategy will be used to promote private sector. These are going to have larger implications for the healthcare sector simply because public funds will now be utilised to support private insurance and care. That is, the strategic purchase idea has larger implications for the healthcare sector, as discussed in the next section.

7. Decoding the Strategic Purchasing Idea of National Health Policy 2017

The NHP 2017 advocates strategic purchasing of services. While referring to the strategy to achieve UHC, the policy document reflects the need for ensuring improved access and affordability of quality secondary and tertiary care services through a combination of public hospitals and well-measured strategic purchasing of services in healthcare deficit areas, from private care providers, especially from not-for profit providers. It indicates that the strategic purchase would be from public sector hospitals followed by not-for profit private sector and then commercial private sector in underserved areas, based on availability of services of acceptable and defined quality criteria. The policy repeatedly advocates free primary care provision by the public sector, supplemented by strategic purchase of secondary care hospitalisation and tertiary care services from both public and non-government sector to fill critical gaps as the main strategy of assuring healthcare services.

The policy reflects that the existing government-financed health insurance schemes shall be aligned to cover selected benefit package of secondary and tertiary care services purchased from public, not-for-profit and private sectors. The order of preference for strategic purchase would be public sector hospitals followed by not-for profit private sector and then commercial private sector in underserved areas. It is highlighted that the private not-for-profit and for-profit hospitals would be empanelled, for comparable quality and standards of care. The policy also advocates a positive and proactive engagement with the private sector for filling critical gap in order to achieve national goals. The health policy recognises that there are many critical gaps in public health services which would be filled by strategic purchasing. Such strategic purchasing would play a stewardship role in directing private investment towards those areas and those services for which currently there are no providers or few providers. The policy advocates building synergy with not-for-profit organisations and private sector, subject to availability of timely quality services as per predefined norms in the collaborating organisation for critical gap filling. Furthermore, the report, under the subheading 'Align the Growth of Private Healthcare Sector with Public Health Goals,' clearly mentioned that India needs to influence the operation and growth of the private health care sector and medical technologies to ensure alignment with public health goals. Also, measures must be taken as shall enable private sector contribution in making healthcare systems more effective, efficient, rational, safe, affordable and ethical.

The main strategic purchasing mechanisms are insurance and through trusts. Payments will be made by the trust/society on a reimbursement basis for services provided. The policy mentioned that schemes like Arogyasri and RSBY have been able to increase private participation significantly. Payment is by reimbursement on a fee-for-service basis and many private providers have benefited greatly from these schemes. The aim is to improve health outcomes and reduce OOP payments while minimising moral hazards;

in the long run these schemes can be scaled up and made more effective. The policy provides for preferential treatment to collaborating private hospitals/institutes for CGHS empanelment and in proposed strategic purchase by government, subject to other requirements being met. The new financing strategy and strategic purchasing ideology believed that by an abrupt introduction/scaling-up of national/state health insurance schemes the critical gap will be filled, impoverishment effect of high OOP expenditure will be addressed, and health and well-being of the citizens will be enhanced. We believe that the notion of adopting the new financing strategy and following the strategic purchasing ideology is hardly based on strong empirical evidences.

The evidences show that private healthcare market occupies a large share of hospitals (75 per cent), hospital beds (50.7 per cent) and medical institutions (54.3 per cent) largely located in urban areas. The growth of the private sector has been urban- and metro-centric (Hooda, 2015b). With regards to the spread of organised hospital care, the IMS-Health survey conducted in 62 Indian cities in the year 2012 covering 14121 hospitals reflects that out of the total hospitals surveyed, almost half (48 per cent) of the large private hospitals and two-thirds of the corporate hospitals are located in five million plus cities of India; Mumbai alone has 16 per cent of all hospitals in organised healthcare (Mukhopadhyay *et al*., 2015). This indicates that urban metropolitan areas have a concentration of organised private and corporate hospitals. The rural area is largely dominated by individual practitioners in the unorganised sector. As regards the unorganised healthcare providers, as per Services Sector Enterprises Survey of NSS, around 82 per cent of the health enterprises (of establishment nature) were located in urban areas and only 18 per cent in rural areas in the year 2010–11 (Hooda, 2015b). The share of Own Account Enterprises (OAEs) in rural areas, however, was higher—about 61 per cent in the same year, reflecting that rural areas have a higher number of small/individual practitioners but lacked formal organised and large private health facilities which can be part of empanelment under strategic purchase as per NHP 2017 classification.

The NSS 2010–11 data also recorded that out of the total 568 NSS districts, only 29 per cent (166 in number) of the districts in India are covered by large (having more than 10 workers) private allopathic healthcare providers/enterprises (*Table 1*). The coverage of districts with large private allopathic healthcare enterprises is reported to be high—around 50 per cent, 60 per cent, 70 per cent and 86 per cent districts in states like Himachal Pradesh, Tamil Nadu, Andhra Pradesh and Kerala respectively as compared to the other less as well as more developed states of India. Incidentally, health insurance penetration in these states also turned out to be higher than the national average and that of other Indian states (GoI, 2014). Interestingly, the coverage of districts with large private allopathic enterprises in high-income states like Gujarat, Haryana, Punjab and Maharashtra is noticed to be lower than the above-mentioned states. In one sense, it allows us to argue that instead of income, the paying capacity protected through health insurance probably plays a greater role in deciding the location of private sector. This

notion, however, does not hold true once we analyse data for formal and informal healthcare providers in greater detail at district level. The NSS 2010–11 data by registration status of health enterprises reveals that only 43 and 81 Indian districts (out of total 568 NSS districts) are covered by non-for-profit (registered under charitable/trust and charitable/trust/society Acts respectively) large (having more than 10 workers) private allopathic healthcare providers/enterprises. Even if the government tries to empanel the private not-for-profit hospitals through strategic purchasing, in majority of the districts such hospitals are not present.

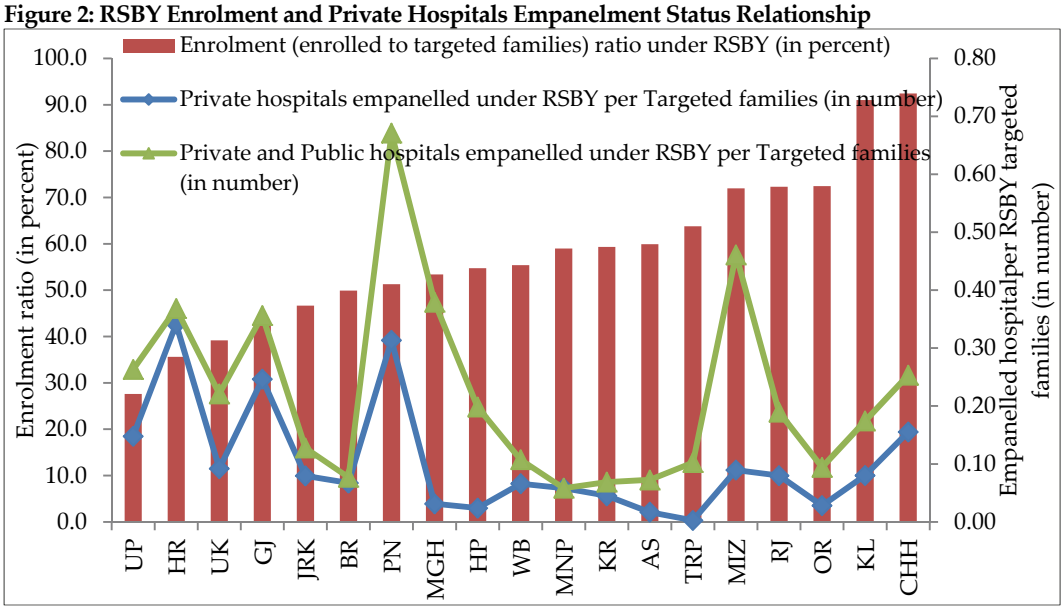
Table 1: District Level Status of Large/Charitable/Health Enterprises: 2010–11

	No of districts covered with private allopathic enterprises (PAE)				
	Total no of NSS districts	*Large PAE (>10 workers)*	*% of district covered with large PAE*	*PAE registered under charitable and trust*	*PAE regd. under charitable, trust & society Act*
Andhra Pradesh	23	16	70	3	6
Assam	24	4	17	1	1
Bihar	38	4	11	1	1
Chhattisgarh	18	1	6		
Delhi	7	3	43	2	3
Gujarat	25	7	28	5	7
Haryana	20	7	35	2	2
Himachal Pradesh	12	6	50	1	3
Jammu & Kashmir	11	1	9		
Jharkhand	22	2	9	1	1
Karnataka	28	9	32	1	1
Kerala	14	12	86	3	9
Madhya Pradesh	48	6	13	1	2
Maharashtra	34	12	35	2	4
NE states	21	5	24		1
Orissa	29	5	17	2	4
Punjab	19	9	47	1	3
Rajasthan	31	3	10	3	6
Tamil Nadu	30	18	60	6	13
Uttar Pradesh	71	19	27	5	8
Uttaranchal	14	5	36	2	2
West Bengal	19	9	47	1	4
Total/Average	**568**	**166**	**29**	**43**	**81**

Note: CPT: Hospitals registered under Charitable and Public Trust Acts; CPTS: Hospitals registered under Charitable, Public Trust and Societies Acts; Large PHE are having worker>10.

The strategic purchasing idea has not worked even in the current context of delivering health services through empanelled private hospitals under RSBY. For instance, one of the notions behind launching and further strengthening the publicly-funded health insurance scheme like RSBY is to provide access to health services at accredited private health facilities. For the purpose, private hospitals voluntarily asked to be empanelled under the RSBY empanelled hospitals list to serve the RSBY targeted families. The RSBY was implemented in 2008 and we have analysed the relationship between RSBY enrolment ratio and private hospital empanelment status in 2016, i.e. after eight years of implementation. For strategic purchase to be a success, the empanelment of private hospitals should have ideally been increased with the increasing level of enrolment of targeted families under the RSBY umbrella in order to facilitate access to health services for enrolled families. But, the analysis of such relationship turned negative with the correlation coefficient value -0.3408. A state-level analysis of such a relationship, presented in *Figure 2*, shows that the empanelment of private hospitals turned out to be low in states where enrolment of families under RSBY is high and *vice-versa*, indicating that even if the government plans to enrol more families (as government has a plan to cover 80 per cent of India's population) under the health insurance protection scheme, the private sector is not going to fill the health facility gap, if it exists. The experience of the past eight years in respect of the relationship between RSBY enrolment and private hospitals empanelment status reveals that the idea of strategic purchasing of the third NHP 2017 is not based on strong empirical evidences.

Figure 2: RSBY Enrolment and Private Hospitals Empanelment Status Relationship



Source: Author's design from http://www.rsby.gov.in, data accessed as on September 30, 2016.

Similarly, as per the National Hospital Directory data of the Ministry of Health and Family Welfare on large formal hospital service providers, there were around 1048 large public and private hospitals in the country in 2015. Of these, 175 are public and 873 are large private hospitals, including medical institutions. The district level analysis of these large private hospitals reflects that out of the total hospitals listed, around 77 per cent are located in 15 states and within these 15 states these hospitals are located in only 33 districts of the total 640 districts of India (*Table 2*). The concentration of these large private health facilities in only some districts and urban parts of India puts a serious limitation on the strategic purchase idea of the third NHP to involve the private sector in achieving the national health goals.

Table 2: Concentration of Large Public and Private Hospitals in India in 2015

	Public	*Private*	*Total*	*Concentration of private hospitals across districts (reporting of ≥2digits hospitals in number)*
Andhra Pradesh	1	31	32	Hyderabad(27)
Assam	6	0	6	
Bihar	8	11	19	Patna(16)
Chhattisgarh	4	3	7	
Delhi	61	272	333	South (67), West (55), Central (42), South West (41), North West(39), New Delhi(34), East(32), North (15)
Goa	1	5	6	
Gujarat	12	23	35	Vadodara (8), Surat (6)
Haryana	5	192	197	Gurgaon (58), Faridabad (29), Sirsa (16), Hisar (15), Ambala (11), Rohtak (11)
Himachal Pradesh	2	0	2	
Jammu & Kashmir	7	8	15	Jammu (13)
Jharkhand	3	0	3	
Karnataka	2	24	26	Bengaluru (22)
Kerala	26	6	32	Kollam (8), Kochi (7)
Madhya Pradesh	0	32	32	Indore (32)
Maharashtra	0	42	42	Mumbai (23), Pune (18)
Odisha	5	3	8	
Punjab	2	87	89	Ludhiana (41), Amritsar (25), Mohali (10)
Rajasthan	3	4	7	
Tamil Nadu	3	30	33	Chennai (20)
Uttar Pradesh	1	65	66	Kanpur (20), Noida (13), Ghaziabad (10)
Uttarakhand	3	4	7	
West Bengal	0	21	21	Kolkata (21)
NE states	7	5	12	
UTs	13	5	18	
Total	175	873	1048	806 (76.9%): covering only 33 districts

Source: https://data.gov.in/catalog/hospital-directory-national-health-portal, accessed as on 17 September 2015. Figures in parenthesis are the number of hospitals.

It is not that the private sector is located in the urban part of some of the states of India covering only a few districts; an index of public health facilities (estimated covering availability of SCs, PHC, CHCs, sub-divisional and district hospitals per 100,000 population) also shows high inequality in the provision of public health facilities across districts. For instance, the value of the above-measured index of public health provision turned out to be very high at 21.11 in one district and as low as 0.0000184 in another district, indicating presence of high inequality in public health provisioning across Indian districts (Hooda, 2017). Now, it would not have been a bad idea to involve the private sector to fill the critical health deficiency gap (specifically in areas/districts where public sector has low presence), but this is not the case in India. A simple correlation analysis between the availability of public (above-measured Index of the availability of public health facilities) and private healthcare providers (per 100,000 population) at district level shows a positive correlation coefficient, reflecting that private large allopathic enterprises locate themselves in those districts where public healthcare facilities already exist in high numbers. This may mean that the private sector is not for filling the health service deficiency gap; rather, they see health service cluster as an opportunity to explore the healthcare market. The private facility is a highly urban-centric phenomenon, covering a few districts of India. So, there is dearth of both public and private healthcare facilities in many of the districts. There is no one to serve people in many parts/areas/districts of India. Promoting the private sector through strategic purchasing therefore would not be a great idea to achieve national health goals, as the private sector is not for filling the regional gap in health infrastructure, but takes healthcare as a profit-making business.

As discussed, the currently promoted insurance-based system will also get finance in the same way as the public healthcare sector. The difference lies in the fact that the provisioning would now be shifted almost entirely to the private sector. In our understanding, this will lead to another crisis in public healthcare sector, especially the emergence of private healthcare competitors. Private competitors would grow through capturing clients from the public healthcare system. Moreover, SHI requires private providers to be on the list of empanelled hospitals. By definition, only large hospitals can be a part of the empanelment. This process, in our understanding, will produce monopolies in the healthcare market, as has happened in the US. Ten years ago, the US market was as fragmented as the one in India. But over the years, four major chains have emerged to control 90 per cent of the market in the US. The recent post from *The American Interest* (2016) also reflects that monopolists are taking over American healthcare and concluded that the current American healthcare regime is not sustainable for general population. The market in India will also evolve in a similar way. One can see a similar trend from the present growth pattern of private hospitals in India, which reflects that the large and corporate hospitals are emerging readily whereas small providers are vanishing—a phenomenon of big fish eating the small fish (*Table 3*). The Table also shows that large healthcare providers are growing at a much faster rate. This reflects a rapid transformation towards organised forms of healthcare delivery, particularly in urban areas of the country. The present growth pattern will soon lead to a kind of private

healthcare market concentrated in fewer hands. Small providers and individual practitioners in these areas are getting sucked into large and corporate-run hospital network which further creates induced demand. One of the bigger issues is: How does this kind of privatisation affect the possibility of having a public good based on public funding which supports privatisation?

Table 3: Changing Growth Pattern of Private Health Enterprises

	Size of health enterprises by number of workers				*Total no of enterprises*
	Single (1)	*Small (2–5)*	*Medium (6–10)*	*Large (>10)*	
2001–02 (57th)	1009064	276690	25777	10900	1322431
	(76.3)	(20.9)	(1.9)	(0.8)	(100)
2005–06 (63rd)	757227	287611	28629	16819	1090286
	(69.5)	(26.4)	(2.6)	(1.5)	(100)
2010–11 (67th)	659475	327344	30246	18432	1035497
	(63.7)	(31.6)	(2.9)	(1.8)	(100)
CAGR (2001–02 to 2010–11)	**-0.046**	**0.019**	**0.018**	**0.060**	**-0.027**

Source: Unit level records of 57th, 63rd and 67th Rounds of NSS. CAGR: Compound annual growth rate.

8. Decoding the Effectiveness of Financialisation Approach

One important belief relating to the effectiveness of financialisation (or insurance based financing) approach is that with the introduction and scaling-up of national/state health insurance schemes, the health and well-being of the citizens will be enhanced by addressing the impoverishing effects of OOP expenditure. That is, it is, precipitously, believed that the currently promoted insurance-based healthcare system would provide financial protection against the costs of ill health and reduce the OOP health payments burden of the beneficiaries. The recent literature on its effectiveness, however, reveals that families enrolled under the nationally representative insurance scheme called RSBY continued to incur OOP spending, particularly on drugs and diagnostics, during and/or following hospitalisation (Rathi *et al*., 2012; Devadasan *et al*., 2013). Selvaraj and Karan (2012), using pre- and post-intervention periods (2004–05 and 2009–10 respectively) data of NSSO, assessed the implications of national/state health insurance schemes for the poor. The study found no beneficial effects of health insurance schemes. Evidences suggest that households in national and state health insurance intervention districts have higher OOP expenditure as compared to households in non-intervention districts. Ghosh (2014) assessed the financial protection status for poor households covered under RSBY in Maharashtra and concluded that RSBY did not affect household catastrophic health expenditure. The study by Karan *et al*. (2017) did not find any statistically significant effect of RSBY on the level of outpatient OOP expenditure and the probability of incurring outpatient expenditure. In contrast, the likelihood of incurring any OOP spending (inpatient and outpatient) rose by 30 per cent due to RSBY and was statistically

significant. Although OOP spending levels did not change, RSBY raised household non-medical spending by 5 per cent. The overall results of the study suggest that RSBY has been ineffective in reducing the burden of OOP spending on poor households. Ghosh and Gupta (2017) reported that RSBY hardly had any effects on financial protection. Similarly, the study by Hooda (2017) has also shown that households in districts where penetration of national and state health insurance schemes is high, ended up having higher OOP expenditure, catastrophic burden and even impoverishment as compared to households in districts where penetration of these schemes was low or non-existent. The literature on the impact of health insurance programmes on household financial risk protection in low and middle income countries has also shown that the impact of health insurance on financial risk protection is less certain (Escobar *et al*., 2010; Acharya *et al*., 2012; Giedion *et al*., 2013).

The field survey based evidences from state-level insurance schemes shows that Rajiv Arogyasri scheme in Andhra Pradesh reduced inpatient OOP among the enrolled families but had relatively small impacts on outpatient OOP and catastrophic payments (Fan *et al*., 2012). The field-based studies (Das and Leino, 2011; Rajasekhar *et al*., 2011) show that RSBY has not provided any significant financial protection to poor households. Several plausible explanations have been flagged out for the ineffectiveness of RSBY (Karan *et al*., 2017). For instance, the enrolled households may have been persuaded by providers to utilise inpatient services not covered by RSBY, or members of enrolled households may have been denied care by empanelled hospitals. Studies have also reported that many hospitals refuse to admit RSBY enrolled patients because of administrative concerns such as delayed reimbursement by RSBY to hospitals, the relatively low coverage limit (Rs 30,000) of the scheme which may have led some households to utilise hospital services beyond the RSBY cap (Rajasekhar *et al*., 2011; Devadasan *et al*., 2013; Ghosh, 2014), or health service providers asking families to purchase expensive drugs and diagnostics (Devadasan *et al*., 2013) from elsewhere. In respect of access to healthcare, some studies found that RSBY insurance schemes have increased utilisation but are unable to reduce OOP expenditure. For instance, the study by Ghosh and Gupta (2017) found that RSBY has increased utilisation of inpatient care (hospitalisation rate) by 59 per cent, though there has not been any significant impact on outpatient care utilisation rate.

The literature also reveals that insurance-based financing strategy has largely been unsuccessful in reducing catastrophic expenditure and poverty prevalence and saving people from falling below poverty line due to healthcare payment. After the implementation of the so-called progressive healthcare financing (insurance) policy pronouncements, OOP expenditures have increased among households, irrespective of their poverty status (poor and rich) and geographical location (rural and urban). The increased OOP expenses have resulted in high poverty headcount ratio and poverty prevalence, especially among the poor, rural and the lowest APL (Above Poverty Line) quintile group households (Hooda, 2017). There are evidences that an insurance-based

strategy in fact undermines the effectiveness of the public healthcare provisioning system. It is simply because in districts with high level public healthcare provisioning, if government enrols more and more people/households under health insurance protection programmes, the household OOP spending is expected to go up, while OOP spending would be significantly low if India ensures adequate public healthcare provisioning with no/low level of health insurance coverage/enrolment. *Table 4* shows that the mean health spending of households in high health infrastructure districts (Rs 1391) is around Rs 222 lower than the mean health spending of households residing in low health infrastructure districts (Rs 1613), in conditions where there is no rollout of insurance scheme in the districts. At aggregate level, the mean health spending of households in high health infrastructure districts (Rs 1559) is around Rs 123 lower than the mean health spending of households residing in low health infrastructure districts (Rs 1682). With the increase in enrolment of families under health insurance protection programmes, the mean health spending increases. This reflects that availability of adequate health infrastructure matters more than the insurance coverage for reducing the OOP health spending burden of households.

Table 4: Mean Households Health Spending by Level of Infrastructure and Insurance Coverage (in Rs)

	Mean households health spending in high health infrastructure districts	*Mean households health spending in low health infrastructure districts*
No insurance	1391	1613
Low insurance coverage	1551	1650
High insurance coverage	1615	1732
Total	1559	1682

Note: Low/High health infrastructure districts are identified on the basis of the availability of public health facilities consisting of SCs, PHCs, CHCs, sub-divisional and district hospitals per 100,000 population. No/low/high insurance coverage districts are identified based on RSBY enrolment ratio.

Source: Unit level records of NSS 68th Round 2011–12.

Empirical evidences on the relative impact of tax-funded public healthcare provision and tax-funded health insurance protection are also highly encouraging. The empirical evidences reveal that high public provisioning of healthcare facilities as well as high drug spending are highly significant in reducing the share of health payments in household's total consumption expenditure, share of health payments in household's non-food expenditure, and in reducing the catastrophic burden of health payments (measured if OOP health expenditure exceeded 10 per cent of the household's consumption expenditure) (*Table 5*). These factors also play a significant role in protecting people from falling below the poverty line because of health payments. The case, however, will reverse if India adopts the insurance-based health financing strategy. These evidences suggest that India needs to provide comprehensive healthcare provisioning through tax-

based financing mechanisms rather than insurance-based financing model for universal healthcare access. This system is important for ensuring equitable, accessible and affordable healthcare services and protecting households from the devastating consequences of OOP payment. Insurance-based financing model, which promotes private sector, seems unsustainable for India.

Table 5: Relative Strength of Provisioning over Insurance-based Financing Strategy: Heckman Selection Model Results

	Linear Regression Estimates				*Probit Estimates*	
	Log (health payment as % of household total exp.)		*Log (health payment as % of household non-food exp.)*		*Households affected by catastrophe-C1: (hh below & above C1)*	
	Coef.	*SE*	*Coef.*	*SE*	*Coef.*	*SE*
Insurance coverage (low)	0.1463***	0.0082	0.1604***	0.0078	0.1992***	0.0120
Infrastructure index (low)	-0.1045 ***	0.0079	-0.1006***	0.0075	-0.1298***	0.0117
Drugs spending (low)	-0.0295***	0.0086	-0.0619***	0.0082	-0.0584***	0.0126

Note: Results are estimated using several socio-economic/education/demographic/regional confounding factors, but because of their limited scope they are not described in this Table. *** -1% level of significance.
Source: Unit level records of NSS 68th Round 2011–12.

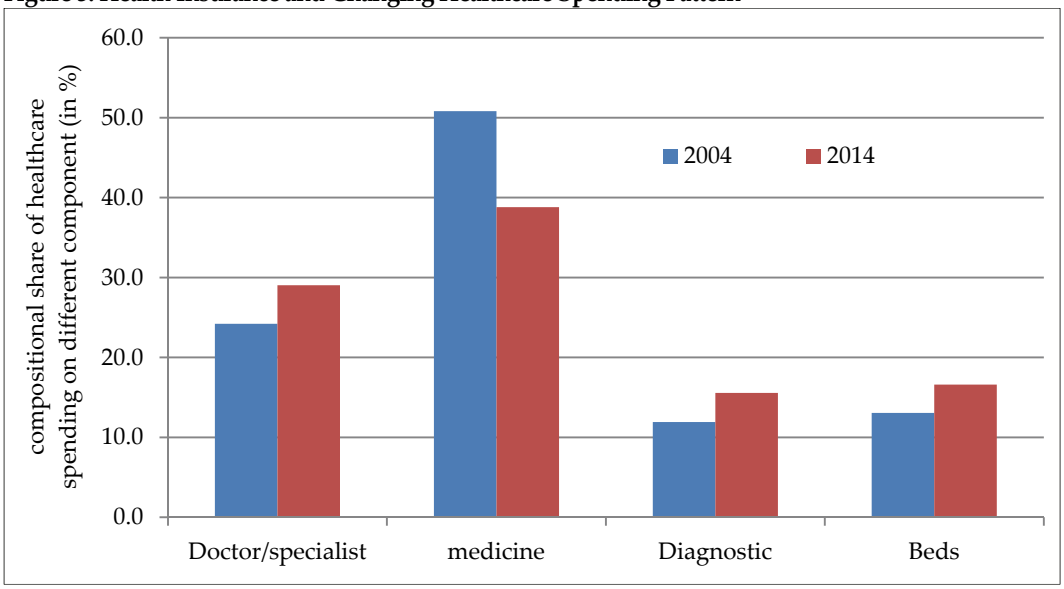
In addition, the insurance sector is characterised by intrinsic market failure due to supplier-induced demand and information asymmetries between the principal and the agent (GoI, 2011b). This provides an opportunity to patients, providers and insurers to maximise their individual gain. In the healthcare market, insured patients have the incentive to indulge in excess demand. Providers, on the other side, have a much bigger advantage over patients, given the mystification of healthcare and associated treatments. This may lead to increasing levels of inappropriate care, unwanted visits, unnecessary treatment, excessive laboratory tests or overcharging, and resultant high costs of specialists, beds and diagnostics, as can be seen between pre- and post insurance-based regime period from 2004 to 2014 (*Figure 3*). The cost of care in private sector is also an important factor responsible for increasing OOP spending, as over a period of time the cost of care in private sector has increased tenfold and is also significantly higher than the cost in public sector. The cost of care in private sector is more than four times higher than the cost in public sector in 2014. The cost of care in private sector as compared to the public sector has increased significantly after the implementation of insurance-based financing mechanism in India (*Table 6*).

Table 6: Unit Cost per Hospitalisation Case in Rupees

Years/ Rounds		*Public (Rs)*	*Private (Rs)*	*Increase in cost Pvt/pub ratio (times)*
42nd : 1986–87	R	1120	2566	2.3
	U	1348	4221	3.1
52nd : 1995–96	R	3307	5091	1.5
	U	3490	6234	1.8
60th : 2004–05	R	3238	7408	2.3
	U	3877	11553	3.0
71st : 2014	T	6120	25850	4.2
Increase in cost between 1987 to 2014		Around 5 times	Around 10 times	

Source: NSS Rounds reports, respective years.

Figure 3: Health Insurance and Changing Healthcare Spending Pattern



Sources: Unit level record of NSS 2004 and 2014 Rounds on health.

9. Conclusion

This paper highlights that India has been compromising the goal of providing comprehensive public health services, which are essential for building a healthier society, especially in the post-liberalisation phase. Over the years, privatisation in healthcare has not only been promoted, but also facilitated to expand and grow further, especially with the adoption of financialisation approach in the healthcare sector. The country's focussed approach to healthcare financing is gradually shifting from the tax-funded provisioning of services for achieving universal healthcare access to tax-funded health insurance merely to achieve health coverage. Insurance-based financing mechanism, however, has

largely been unsuccessful in delivering improved health outcomes and financial protection.

The currently promoted financing healthcare through insurance-based model in India is almost entirely from public sources. That is, a tax-funded insurance scheme will entail the poor and informal community people/workers for accessing services from accredited private and public facilities. This is an important shift in the fundamental nature of healthcare financing. Until recently, public investment in healthcare was almost entirely tax-based for financing public health system for service provisioning. The currently promoted insurance-based system will also get finance in the same way as the public healthcare sector. The difference lies in the fact that the provisioning would now be shifted almost entirely to the private sector. This will lead to another crisis in the public healthcare sector, especially the emergence of private healthcare competitors.

The idea of strategic purchasing as outlined in NHP 2017 is not based on adequate empirical evidences and therefore seems vague and unsustainable which may further aggravate the crises in the Indian healthcare sector. This study advocates that comprehensive healthcare provisioning is essential for ensuring equitable, accessible and affordable healthcare services and for protecting households from the devastating consequences of OOP payments.

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