PRINT: ISSN 0976-6634 ONLINE: ISSN 2456-6764
J Sociology Soc Anth, 11(1-2): 100-109 (2020)
DOI: 10.31901/24566764.2020/11.1-2.347

Current State of Healthcare in India: A Critical Appraisal of the National Health Protection Scheme and Way Forward

Anil Kumar[1], Aswini Kumar Mishra[2] and Debasis Patnaik[3]

Department of Economics, BITS, Pilani – K. K. Birla Goa Campus, Zuarinagar 403 726, Goa, India
E-mail: [1]<kumaranil1414@gmail.com>, [2]<aswini@goa.bits-pilani.ac.in>, [3]<marikesh@goa.bits-pilani.ac.in>

KEYWORDS Health Disparity. Public Health Expenditure. Public Provision of Health Insurance. Out of Pocket (OOP). Private Health Providers

ABSTRACT In most emerging economies, the key healthcare issues are its access and delivery. Further, there is double burden of care arising out of communicable and growing chronic diseases. The prevailing healthcare systems in these economies are one of complete dominance of the private healthcare providers. These provisions, however, have been found to be inequitable and inefficient. In India, most government health insurance schemes have made limited impact in spite of their grandness, for the same reason. It is found that wherever there are adequate public healthcare provisions, the outcomes are much better. The new healthcare scheme of Ayushman Bharat Health Insurance in India has attempted to address this dilemma in policy wordings. In order to make the public health insurance schemes effective, the healthcare industry needs total restructuring based on re-strengthening of the public healthcare system.

INTRODUCTION

In most emerging economies, the insufficient public healthcare provision is driving the growth of private healthcare providers, with adverse outcomes. Healthcare services in South Asia are characterised by low public investment, overly dependent on the private providers and very high rate of out of pocket expenses as the principal source of health financing. Analysis of coverage with reproductive and maternal interventions in some South Asian countries (Guo et al. 2019) reveal that the private health providers play a substantial role in delivering maternal, new born and child health (MNCH) interventions, but the outcome is more inequitable. On the other hand, wherever, the care was sourced through public provisions, the distribution of services across wealth quintiles tended to be more equitable.

The World Health Organisation (WHO Fact Sheet 2018) report shows domestic private health expenditure in 2015 was very high in some South Asian countries, corresponding to seventy-eight percent of total health expenditure in Afghanistan, seventy-four percent in Bangladesh, seventy-one percent in India and in Nepal and sixty-nine percent in Pakistan. Furthermore, among domestic private health expenditure, more than ninety percent are out-of-pocket expenditure in these countries, which has exposed individuals to financial hardship. Since the private health providers tend to be more unequal and inefficient than the public sector providers, in policy perspective, greater involvement of the private sector may exacerbate inequalities unless they are regulated and monitored strictly.

Countries where the public health insurance schemes are also supported by the public provisions, the results have been excellent. The examples are China, Thailand, and some Latin American countries like Brazil, Chile, Colombia, Uruguay, Peru, and Argentina, Mexico and Cuba. They all exhibit similar results coming out of similar efforts. In India, in most public healthcare schemes at the central and state levels the healthcare provisions are left to the private players as the public investments in healthcare has been declining. In addition, because of the growing market cost of health care, it has become increasingly difficult for poor people to get adequate care. Many of them do not have the ability to pay for medical services. Moreover, there is the rapid increase in inequality in the distribution of income and wealth (Mishra 2007; Mishra and Kar 2017; Mishra and Parmar 2017; Mishra 2018;

Mishra and Kumar 2018; Mishra et al. 2019). Such changes can have major health consequences.

Most Indian healthcare schemes have produced unsatisfactory results. The new healthcare scheme, the Ayusman Bharat - New Health Policy (AB-NHP), launched recently in India, theoretically is different but in practice it may have the same outcomes unless some of the suggestions enumerated below are seriously incorporated.

Extensive literature review findings on India's biggest health insurance scheme, the Rashtriya Swasthya Bima Yojna (RSBY) launched in 2007, is now available. Exhaustive cross-country experiences in such experiment of Universal Health Care (UHC) highlight the achievements and shortcomings in the Indian healthcare scheme. The RSBY forms the main subject of this paper and the critical review and analysis are done to bring out the shortcomings of the Indian health insurance scheme in terms of coverage, access, utilisation, financial protection and impoverishment amongst the health seekers in India. The lessons learnt have important implications for Indian planners and policymakers.

Objectives

This paper aims to bring out the in-depth finer points of the debate related to public versus private provision of the healthcare in a developing country set up. The paper also aims to provide suggestions for incorporating them in the new health insurance scheme of India, the Ayushman Bharat Health Insurance Scheme.

METHODOLOGY

With these objectives in mind, data from publications of Insurance Regulatory and Development Authority of India (IRDAI 2017) and National Family Health Survey (NFHS rounds 3 and 4), conducted by the Indian Institute of Population Science, New Delhi, are used and presented in tabular forms with the outcomes in terms of equality in access, utilisation and financial protection achieved by various healthcare schemes, especially the RSBY, in India. The data from the World Health Organisation's publications are used to differentiate the Indian healthcare experience in comparison to its peer group of countries and some south Asian countries to highlight the objective points.

The paper is organised in the following manner. After a brief introduction, the third section provides methodology used for the study. The fourth section on observation and discussions provides exhaustive international and cross-country experiences of the healthcare schemes. Its sub sections provide the Indian experiences in terms of coverage, accessibility, financial protection and impoverishment of the population. The fifth section presents interstate impoverishment due to healthcare schemes in India. The sixth section concludes the study. The paper ends with suggestions and recommendations for the new national health policy in India. This is enumerated in the seventh section.

OBSERVATIONS AND DISCUSSION

Healthcare System Reforms in Developing Countries

Countries where the direct intervention in healthcare is complemented with adequate public investment in healthcare and the public provisions of the care, results have been excellent. Where the public healthcare provision is lacking and is dependent upon private providers, the government has provided more budgetary allocation to this sector. In Table 1, one can notice that India's per capita public expenditure on health is one of the lowest at USD 60, and is more only to the poorest, Pakistan and Bangladesh, in the group.

In most emerging economies, where the public intervention model has been adopted, the results have been encouraging. The former Soviet Union and most Eastern European countries have transitioned to a centralised public supported social health insurance scheme. By 2010, in China, state-run health insurance schemes supported by public provisions, successfully brought close to ninety percent of its population (which was less than 25% in 2004), under the scheme. Thailand has successfully instituted universal coverage in 2014-2015. People receive full-public health care coverage (WHO 2017). Ninety-eight percent of Thailand's citizens are covered by the state health insurance

scheme (CGD 2017). The Thailand government spends only slightly higher percentage of GDP on healthcare compared to India, yet it offers the entire range of healthcare services to all citizens for free. Not only does Thailand have better health outcomes, it also offers almost complete financial protection to its citizens. In Thailand, the government has put the citizens at the centre of the focus and introduced health schemes. Every citizen is fully covered by paying nominal amount of 30 Baht (roughly INR 60 in Indian currency) and the government pays the rest. The government spends as much as USD 500 per capita compared to only USD 60 in India.

In Brazil, only twenty-five percent of the population is covered by private insurance. Brazil made healthcare a justiciable right in 1988, making the state responsible for providing it. According to the World Health Report (WHO 2008), seventy-five percent of the population 'relies exclusively on it for their healthcare coverage'. Brazil spends 9.7 percent of their GDP on healthcare. Today, Brazil's health indicators are considered very good. Some Latin American emerging economies, which have embarked upon public provided healthcare schemes with good results are Chile, Colombia and Peru. In Mexico and Cuba as well their respective governments guarantee free universal health coverage.

Some neighbouring south Asian countries provide greater insight and are more comparable since most began their development journey at the same time and in similar economic situations. Healthcare services in most South Asian countries are characterised by low public investment, and overly dependent on the private providers and have a very high rate of out of pocket expenses as the principal source of health financing. India is actually an exception within this group, in many important ways. The public investment in healthcare in India is amongst the lowest at 3.8 percent of GDP. The public health expenditure per capita of USD 60 is higher only to poorer countries of Pakistan and Bangladesh. The out-of-pocket expense (OOP) of 87.2 percent is one of the highest in the group. Higher OOP is not the problem as other countries in the group also exhibit higher OOP but they also show better health outcomes. This could be only due to availability of accessible and efficient public healthcare or more regulated and controlled private provisions in these countries. The problem with the Indian health system is, on the one hand there is very low public investment in healthcare in creating infrastructure, and on the other hand it is dependent upon the largely unregulated and inefficient and substandard private providers. This situation has led to inaccessibility of care, lack of financial protection and ultimately impoverishment amongst Indian health seekers.

Education, especially the female education, has a direct impact on health outcomes. It is very important for spreading and disseminating health awareness and healthcare responses. India is far behind in most of its peer group members. The mean year of schooling for females at 3.6 years is lowest in the group, excepting Pakistan. With respect to female literacy India lags behind at 74.4 percent. Even Bangladesh has a higher female literacy rate. While every country in the set has achieved universal or near-universal literacy in the younger age groups, India is still quite far from this elementary foundation of participatory development.

Looking into the MDG's achievements, during 1990-2013, India's performance is not robust. In Bangladesh, the Life Expectancy at Birth (LEB) has risen more (18%) than India's (14%). Infant Mortality Rate (IMR) has fallen more in most other countries in the group, even compared to Bangladesh. In Under 5 Mortality Rate (U5MR) reduction, against the target of sixty-seven percent, only fifty-eight percent was achieved, which is one of the lowest in the group. Total Fertility Rate (TFR) for India is highest in the group. Against the MDG target of fifty percent in providing access to improved sanitation, India could achieve only twenty-two percent, which again is the lowest. Against the antenatal care, child immunisation against DPT and Measles, India's performance has been quite low in comparison.

An analysis of seven South Asian countries (Guo et al. 2019) confirm the important role of the private sector in providing preventive and curative interventions to women and children in this region. The domestic private health expenditure in 2015 was very high in some South Asian countries, corresponding to seventy-eight percent of total health expenditure in Afghanistan, seventy-four percent in Bangladesh, seventy-

Table 1: Healthcare achievements in health indicators (1990-2013)

Parameters/Countries	*India*	*China*	*Brazil*	*Russia*	*South Africa*	*Pakistan*	*Bangla-desh*	*Sri Lanka*	*Thailand*
GDP % on health expenditure	3.8	5.6	9.7	6.5	8.9	2.8	3.5	3.2	4.6
Govt. spending ($) at 2012 Const. per capita	60	323	659	779	528	45	27	105	500
Out Of Pocket (OOP) health expenses	87.2	78.8	57.8	87.9	13.8	86.8	93	83.0	56.7
Literacy rate 2005-2013 of adults aged 15 and above	62.8	95.1	91.3	99.6	93.7	54.7	58.8	91.2	96.4
Literacy rate 2005-2013 % female	74.4	99.6	99.0	99.8	99.3	77.5	81.9	98.6	96.6
LEB rise 1990-2013 %	14	9	14	0	-3	10	18	9	9
IMR 1990-2013	53	74	76	61	30	35	67	55	63
MMR (% Reduction MDG Target 75)	66	67	43	68	7	58	69	41	38
U5MR 2013 (% Reduction Target 67)	58	76	77	62	28	38	72	52	65
TFR 2013	2.5	1.7	1.8	1.5	2.4	3.2	2.2	2.3	1.4
Access to improved sanitation 2010-2012 % (50 Target)	22	54	42	-15	38	29	36	75	61
Antenatal care at least one visit % (Target 100)	75	95	96	NA	97	73	59	99	98
Child immunisation DPT3 %	72	99	96	97	65	72	97	99	99
Child immunisation measles (% Reduction) (Target 90)	74	99	66	98	66	61	93	99	99

Source: World Health Statistics, 2015 and UNDP (HDR 2015) Statistical Annex

one percent in India and in Nepal and sixty-nine percent in Pakistan (World Bank 2015). Furthermore, among domestic private health expenditure, more than ninety percent are out-of-pocket expenditure in these countries, which has exposed individuals to financial hardship. The finding suggests that the private health providers tend to be more unequal and inefficient than the public sector providers. From a policy perspective, greater involvement of the private sector may exacerbate inequalities and thus require regulation and monitoring strictly.

These changes over the last twenty years in the neighbourhood, mostly with lesser means, merit attention from Indian planners and the public. Notwithstanding its enormous size and rapid economic growth compared with its neighbours, India has much to learn from them.

Indian Experience in Healthcare Provision and Outcomes

In India, most public healthcare schemes, launched at state and central government level, follow a public-private mix of healthcare provisions where private providers completely dominate the healthcare space. The studies unequivocally indicate that any health insurance schemes dominated and delivered by private providers cannot be the means to achieve universal healthcare. Though the schemes have improved the access to healthcare, the effects on health outcomes are not known and the ûndings on ûnancial protection are mixed (Aggarwal 2010; Fan et al. 2012).

The Indian health system is characterised by substantial shortcomings relating to workforce, infrastructure, and the quality and availability of services (Angell et al. 2019). It also lacks strong control and regulatory mechanisms for the private providers. India, being a signatory of Alma Atta Declarations, of the Millennium Development goals (MDGs) and Sustainable Development Goals (SDGs), was obliged to initiate health policies and programmes to tackle the poor health stock of the population. India chose to respond to the situation by launching several tax based health insurance schemes at state and central government levels. Since the provision of the public care involved long term investments, the immediate choice of provision

rested on to the private health providers. Instead of investing in public health provision, the policies were enacted to promote, strengthen and develop the private health sector. Over the years private provisions rose and public provision dwindled. Most public health schemes now work under this healthcare environment where it has to depend upon private sources of care. Only now the new health policy tries to set a new balance in the private-public mix of healthcare provisions.

The 'Situation Analysis' document, of the National Health Policy (NHP 2017), states that India is close to reaching the Millennium Development Goals (MDGs) with respect to major health indicators. The achievements are mostly through public healthcare programmes and policies whose services were sourced through the private providers. The Rashtriya Swasthya Bima Yojna (RSBY) of India, the most ambitious and widely implemented programme, represents one of the major health sector reforms in the Low and Middle Income Countries (LMIC). This scheme is also based on outsourcing of care from the private providers. Studies show that the RSBY scheme has achieved limited success. The analysis of the scheme suggests that greater involvement of the private providers have exacerbated the inequalities in health outcomes. The result could have been more equitable and efficient had the provisions been through the public healthcare systems (Kumar et al. 2019). Even if the involvement of the private sector was deemed essential, strong regulations could have prevented the potential negative impact on health inequalities. The experiences of RSBY indicate that targeted health insurance coupled with a healthcare delivery system dominated by "for profit" private providers have failed to address the issues of access and financial risk protection.

Coverage and Disparity

All health insurance schemes by the state and central government and commercial insurances together can be broadly classified into Government Sponsored Health Insurance, Commercial Group Health Insurance (other than Government Sponsored) and Commercial Individual Health Insurance. During 2016-2017, all the health insurances altogether covered an impressive 437.5 million persons, which is about one fourth of the Indian population. The main source of growth and provision was through various public sponsored health insurance schemes, which alone provided more than seventy-six percent of total health insurance coverage in 2016-2017 (See Table 2). Various public healthcare schemes, at the state and centre levels were launched in response to the Millennium Development Goals (MDG 2000) on health, since the year 2000.

Despite the impressive growth and overall coverage, inter-state disparity makes the achievement appear quite ordinary. According to National Family Health Survey (NFHS 4), published by International Institute for Population Sciences, New Delhi, only six states had more than forty percent of the households covered under all types of health insurance schemes and only four states had near and more than half of the households covered by insurance (Table 3). In the southern part of the country, Andhra Pradesh covered seventy-five percent of the households under state health insurance schemes of the Rajiv Arogyashree scheme. Tamil Nadu followed with 64 percent, under the Kalaignar health insurance scheme, Kerala covered 47.5 percent under the RSBY variants. New state of

Table 2: Number of persons covered under health insurance (in Lakhs)

Class of business	*2012-13*	*2013-14*	*2014-15*	*2015-16*	*2016-17*
Government Sponsored Schemes Including RSBY	1494 (72%)	1553 (72%)	2143 (74%)	273 (76%)	3350 (77%)
Group Business (Other than government, business)	343 (17%)	337 (15%)	483 (17%)	570 (16%)	705 (16%)
Individual Business	236 (11%)	272 (13%)	254 (9%)	287 (8%)	320 (7%)
Grand Total	2073	2162	2880	3590	4375

S*ource:* Insurance Regulatory and Development Authority of India (IRDAI) Annual Report 2017

Telangana also had 66.4 percent households covered. In the northern parts, Chhatisgarh with 68.5 percent and Odisha with 47.7 percent top the list. The four states having more than 50 percent household health insured are Andhra Pradesh, Tamil Nadu Telanganain south and only Chhatisgarh in north. In BIMARU and other lesser states, it is very minimal coverage, with the least being in Uttar Pradesh, with 6.1 percent households. In a majority of states less than twenty percent of households were health insured.

Table 3: Households with any usual members covered by a health scheme or health insurance (%): Inter State Analysis

S. No.	*State*	*NFHS 3 (2005-06)* Total	*NFHS 4 (2015-16)* Total
1	Andhra Pradesh ***	-	74.6
2	Bihar **	0.9	12.3
3	Goa	11.1	15.9
4	Harayana	6.7	12.2
5	Karnataka	10.3	28.1
6	Madhya Pradesh ****	4.8	17.7
7	Tamil Nadu	4.0	64.1
8	Telangana	-	66.4
9	Uttarakhand	6.6	19.5
10	W Bengal	6.0	33.4
11	Assam	2.3	10.4
12	Chhatisgarh	3.3	68.5
13	Delhi NCT	13.9	16.4
14	Gujarat	10.2	23.1
15	Jharkhand	4.6	13.3
16	Jammu & Kashmir	4.9	4.2
17	Kerala	8.9	47.7
18	Maharashtra	7.1	15.0
19	Odisha	1.6	47.7
20	Punjab	6.8	21.2
21	Rajasthan	4.5	18.7
22	Uttar Pradesh *	1.2	6.1
23	India	4.8	28.7

Source: National Family Health survey 3 and 4 rounds, published by the International Institute for Population Sciences, Mumbai, under Ministry of Health and Family Welfare Government of India.
* Including Uttarakhand; ** Including Jharkhand; *** Including Telangana; **** Including Chattisgarh

Access and Utilisation

Various critical studies have been done on these schemes. The Rashtriya Swasthya Bima Yojna (RSBY) is the pan India public health insurance scheme and represents one of the major health sector reforms in the Lower and Middle Income countries (LMIC) and is quite attractive in the health policymaking circles around the globe. Several countries in South Asia and Africa showed interest in initiating such subsidised health insurance initiatives for their vulnerable population. Its impact and outcomes are now widely studied and its lessons are useful for the future Publically Financed Health Insurance (PFHI) schemes. Launched in 2007, it is meant for families who appear in the state's Below Poverty Line (BPL) list. The government purchases the services of insurance and healthcare from private or public providers, out of tax funds.

In spite of its universal appeal, several studies (Shivakumar 2013; Ghosh 2018) suggest that it has achieved limited success in terms of targeted population. The targeted population has not benefited as expected. The insurers have indulged in enrolling bogus beneficiaries to earn premium subsidies from the government (Shivakumar 2013). There is hardly any motivation for them to worry about the quality of enrolment (enrolling the intended beneficiaries). Ghosh (2015) found out that a large number of non-poor households whose names did not figure in the BPL list, colluded with the enrolling agents of insurance companies to get RSBY cards. In his latest studies, Ghosh (2018) found that the bulk of the targeted poor have not been covered. On the other hand, about 36.52 percent of households enrolled in RSBY were actually drawn from the richest forty percent of the sample households.

Across the states (Ghosh and Gupta 2017), findings suggest that only two less developed states had a high household enrolment rate, about forty percent, in Chhattisgarh and twenty-three percent in Rajasthan. One of the main reasons for the significant variation in coverage across the states is due to the variation in the state's functioning of the institutional systems, which ensure effective implementation of government schemes, including healthcare schemes. Kerala, and other southern states have better institutional capacity and thus RSBY in Kerala was more successfully implemented. Other states with their own state health insurance schemes were more successful for the same reasons. Thus, the important lesson for the new Public Financed Health Insurance (PFHI) is to first develop the administrative capabilities and

adequate provision of qualified healthcare professionals and infrastructure, especially in the rural areas.

Enrolment does not mean utilisation of the care. The outpatient care, the single largest contributor to OOP spending (Ghosh 2011), is excluded in most schemes. A study (Ghosh and Gupta 2017), confirms that the outpatient care utilisation was statistically insignificant. However, its impact on inpatient care utilisation was quite significant and admissions increased by fifty-nine percent compared to the mean inpatient care utilisation of uninsured families.

Financial Protection and Impoverishment

Another important acid test of the scheme is its ability to provide financial protection to the healthcare seekers. The existing literature has yielded conflicting results. Sakthivel and Karan's (2012) study results show that contrary to expectation, the poorer households reported an increase in out-of-pocket (OOP) expenditure for hospital care, and a corresponding rise in incidence of catastrophic expenditure. Ravi and Bergkvist (2015) using the same data of quinquennial rounds of the National Sample Survey Organisation (NSSO) on consumption expenditure and found that PFHI schemes had a favourable effect on financial protection. Johnson and Krishnaswamy (2012) also examined the effects of RSBY on OOP health expenditure. The results indicate that while the scheme led to a small decline in OOP payments for outpatient care, there is no evidence of its impact on inpatient expenditure. So it is found that there is no significant difference between RSBY insured and uninsured households in terms of OOP expenditure on outpatient, inpatient or on any type of care.

On the contrary, the OOP have risen due to the scheme implementation. Research shows that doctors and hospitals in the private sector often collude to perform unnecessary surgical procedures on patients to claim insurance money under the RSBY (Ghosh and Gupta 2017). Another reason is that most patients treated under the RSBY and other state-sponsored schemes in empanelled hospitals are often asked to buy medicines and diagnostics though they are actually included in the benefit package (Rent and Ghosh 2015). Besides, it is reported that the insurance coverage is very limited and a number of conditions are not covered under the RSBY, leading to patients incurring OOP payments for hospitalisations. Results indicate that the scheme has hardly had any effects on financial protection.

Inter-state Financial Protection and Impoverishment

The inter-state financial protection result is likely to be more adverse. Using NSSO 2004-2005 and 2011-2012 data, Hooda (2017) finds that insurance enrolments have led to higher health payments. Thus, households in higher insurance enrolment districts are more likely to be impoverished than the households living in the districts where enrolment is low. His study further suggests that this has led to more impoverishment amongst less provided people and in lesser states.

A field-based study conducted by Prayas-Oxfam in 2011 in five states of India also shows that in areas where the RSBY and other such state programmes were implemented, the out-of-pocket (inpatient as well as outpatient) expenses actually increased. The recent works by Singh and Kumar (2017) using the National Sample Survey Organisation's (NSSO) 71st round data also confirm the increased impoverishment, especially among Above Poverty Line (APL) and Below Poverty Line (BPL) families. Similar results were found between better and lesser states.

The findings across the state suggest that the impoverishing effect due to consumer and medical expenditure in Chhattisgarh is highest. The state of Bihar occupies the second highest position amongst all the states. Amongst the other states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh (BIMARU) states, only Rajasthan (24.4%) has a attained better position. The state of Madhya Pradesh and Uttar Pradesh is not far behind the worst performing state of Bihar. It is worth noting that the southern states where the pre-financing state health insurance scheme is available with better health and other institutional infrastructure, the poverty head count is one of the lowest and in single digits.

CONCLUSION

The present work highlights the lack of financial protection and resultant impoverishment of the people enrolled in public healthcare schemes in India. It has added clarity and provides serious policy implications for any new healthcare schemes. In India, despite many health insurance schemes, only about twenty-five percent people have been covered with disturbing regional disparity. The public provisions require huge investments, which due to lack of public resources, the provision is abdicated to the private providers. Thus, the private healthcare providers dominate in most of the developing countries including India. Private providers all over the world have been found to be inequitable and inefficient, resulting in sub-optimal outcomes of the health interventions. It is beset with the problems in access and utilisation and impoverishment among the health seekers. The poorer states in India are more impoverished. To make healthcare schemes work, as envisaged, public provision must be increased along with tight control over private providers.

The recognition that universal access to healthcare and to medicines has an impact on poverty and social inclusion, it has led to the formulation and implementation of diverse interventions to improve the provision, access and quality of health services and products in most emerging countries. In most emerging countries the dilemma is where from the provisions of care should be sourced. Decades of promoting private provisions have thrown up a situation where private provisions dominate over public provisions in most of these countries. Whenever the government initiates any healthcare schemes, it has to naturally fall back on the private providers for quick results. It is amply established that in provisions of care, the private providers are found to be substandard and inefficient. In spite of these shortcomings, the private sector is an important source of care in most developing countries including India.

The focus of health schemes should revolve around the provisions of cheap and quality public health infrastructure in rural areas and more provision for outpatient and primary care than the secondary and tertiary care. Government intervention should also focus on free medicines in revamped and improved public healthcare facilities, which considerably enhance access and utilisation and reduce OOP induced poverty, as the public facilities have been quite affordable and less impoverishing. Also public health system is far less complex than expanding health insurance, provided by private healthcare sector. To attain Universal Health Care (UHC) status, the public health system, needs structural reforms to restore competitiveness and facilitate efficient implementation of public health insurance schemes at the state and national level.

RECOMMENDATIONS

The experiences of PFHI indicate that targeted health insurance coupled with a healthcare delivery system dominated by private providers cannot be the means to achieve universal healthcare. The optimal design is in balancing the gains obtained from risk sharing, against the costs of moral hazard, adverse selection and supplier-induced demand, from the private providers. Instead of making efforts to further experiment with the same type of health insurance or healthcare model, it would be far less challenging to strengthen the existing government healthcare system. A publicly funded and delivered health system with universal access would be the ideal option to provide low-cost healthcare to all Indians.

Healthcare reforms in emerging economies are more challenging than they are in industrialised countries, due to not only the lesser resources but also the existence of profound social inequalities. Since expansion of the public sector may require long-term investments, immediate strategy should be to promote the use of private providers by poor and rural women and children, and to remove the monetary, geographic and cultural barriers that hamper their access. In parallel it is essential to invest in improving quality of care in both public and private sectors and build a responsive regulatory and control system. More specifically, any new scheme must focus on provisioning of free or low-cost healthcare, which calls for reduction in the inadequacies and inequalities in infrastructures especially in rural areas across districts. The focus should be in provisioning of low-cost or free medicines and diagnostics. Much of the

health issues are engrained in social norms, which if corrected, many health benefits can be derived quite cheaply.

The following suggestive measures are recommended to be incorporated in the existing and new health policy to make it more effective:

1. The existing health sub-centres in India should be upgraded and all primary health centres should be oriented towards providing a comprehensive set of preventive, promotive, curative and rehabilitative services. Strengthening public community health centres, sub-divisional and district hospitals is very important for sourcing cheaper secondary and tertiary healthcare services. So, bulk of the efforts should be geared towards strengthening and reorienting the existing public health system with built-in mechanisms of accountability, in India.
2. The present three-tier (primary, secondary and tertiary) public healthcare is inequitable and uneven across Indian districts and must be equalised in due course. The strategic purchase of services in healthcare in shortage areas from private care providers cannot fix this problem, as the private sector generally does not locate itself in short fall areas. On the contrary, it is observed that they have a higher presence in areas where public healthcare provisioning already exists in higher numbers.
3. Considering the high share of drugs spending (70%) in total OOP expenditure, it is important to bring essential and other life-saving drugs under price control. The study reveals that the present Drug Price Control covers only about eighteen percent of medicines, and the average reduction in prices has been only six percent. The drug pricing should be extended to more essential drugs. Also, the government should promote generic medicines. The drug price control has been implemented effectively in states like Tamil Nadu, Rajasthan and Kerala. The Tamil Nadu Medical Services Corporation currently supplies about 268-300 drugs or medicines across government hospitals, dispensaries and depots. At the national level, providing free generic medicines through the *Jan Aushadhi Store* (JAS), proposed in the new health scheme in India, is a welcome step to curb medicine expenditure. This should be complemented with the control over branded medicines, since most private providers prescribe branded drugs. Brazil, for example has experimented with the initiatives to make healthcare more affordable through the increasing use of generic drugs. The spending on public drugs procurement should also be increased in order to provide free essential medicines.
4. Till the public provisions achieve the desired presence, effective regulations are recommended for containing private healthcare costs, ensuring quality and preventing unethical practices. State authorities should create a grievance redress system at the local level, and raise public awareness of patients' rights. Given the importance of private providers in India, there is a need to strengthen the stewardship function of the government to monitor the provision of care from these providers. This could occur in a number of ways, such as through the development of robust referral pathways for patients, quality audits of providers, incentives to improve the efficiency and quality of care, strategic purchasing, and a general strengthening of the capacity of the public sector to effectively contract with and regulate the private sector.
5. Social movement is a long term but effective solution to social problems. The movement should be directed towards social practices like gender equality, education, cleanliness habits can produce direct health benefits at very lesser cost. The main challenge in such strategy is the long period of sustained efforts in the direction with capable and inclusive leadership to be in front to guide the movements. In a democratic set up, no leader in the government may have the luxury of extended time.

REFERENCES

Angell BJ, Prinja S, Gupt A, Jha V, Jan S 2019. The Ayushman Bharat Pradhan Mantri Jan Arogya Yoja-

na and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance. *PLoS Med*, 16(3): e1002759. https://doi.org/10.1371/journal. pmed.1002759

Aggarwal A 2010. Impact evaluation of India's 'Yeshasvini' community based health insurance programme. *Health Economics*, 19(S1): 5–35.

Fan V, Karan A, Mahal A 2012. State Health Insurance and Out-of-Pocket Health Expenditures in Andhra Pradesh, India. *Working Paper No. Id:* 5032, Centre for Global Development, US.

CGD 2017. Thailand's Universal Coverage Scheme. Millionssaved.cgdev.org. From <http://millionssaved.cgdev.org/case-studies/thailands-universal-coverage-scheme> (Retrieved on 10 May 2017).

Ghosh R 2015. Publicly Financed health insurance for the poor: A case study of RSBY. *Labour and Development*, 22(2): 97–117.

Ghosh S 2011. Catastrophic payments and impoverishment due to out-of-pocket health spending. *Economic and Political Weekly*, XLVI(47): 63-70.

Ghosh S 2018. Publicly financed health insurance schemes. *Economic and Political Weekly*, 53(23): 16-18.

Ghosh S, Gupta ND 2017. Targeting and effects of Rashtriya Swasthya Bima Yojana on access to care and financial protection. *Econ Polit Wkly*, 52: 61-70.

Guo S, Carvajal-Aguirre L, Victora CG et al. 2019. Equitable coverage? The roles of the private and public sectors in providing maternal, newborn and child health interventions in South Asia. *BMJ Global Health*, 4: e001495. doi:10.1136/ bmjgh-2019-001495

Hooda SK 2017. Out-of-pocket payments for healthcare in India: Who have affected the most and why? *Journal of Health Management*, 19(1): 1-15.

International Institute for Population Sciences 2007. *India National Family Health Survey (NFHS-3), 2005-06*. Volume 1. International Institute for Population Sciences.

International Institute for Population Sciences (IIPS) and ICF 2017. *National Family Health Survey (NFHS-4), 2015–16*. India.

IRDA 2017. *Annual Report 2016-17*. Insurance Regulatory and Development Authority of India. Hyderabad: India.

Johnson Douglas, Karunakaran Krishnaswamy 2012. *The Impact of RSBY on Hospital Utilisation and Out-of-Pocket Health Expenditure*. Washington DC: World Bank Group.

Kumar A, Mishra AK, Patnaik D 2019. National Health Policy, 2017-A Milestone towards Health Security in India? Some Annotations. *J Soc Sci*, 60(1-3): 21-27.

Mishra AK 2007. Social security in the context of extreme poverty and vulnerability in India. *The Indian Economic Journal*, 55(3): 66-81.

Mishra AK 2018. Household income inequality and income mobility: implications towards equalizing longer-term incomes in India. *International Economic Journal*, 32(2): 271-290.

Mishra AK, Kar A 2017. Are targeted unconditional cash transfers effective? Evidence from a poor region in India. *Social Indicators Research*, 130(2): 819-843.

Mishra AK, Kumar A 2018. What lies behind income inequality and income mobility in India? Implications and the way forward. *International Journal of Social Economics*, 45(9): 1369-1384.

Mishra AK, Parmar VM 2017. Changing contours of income stratification and decomposition of income inequality: Evidence from recent longitudinal survey in India. *Journal of Quantitative Economics*, 15(2): 395-422.

Mishra AK, Kumar A, Sinha A 2019. The shape of income distribution and decomposition of the changes in income inequality in India 2005-2012. *Journal of Economic Studies*, 46(3): 760-776.

National Health Policy 2017. Ministry of Health and Family Welfare, Government of India. From <https://mohfw.gov.in/sites/default/files/914756294 14897 53121.pdf> (Retrieved on 16 March 2017).

Prayas-Oxfam 2011. Out of Pocket Spending in Health Care – Results of a Study in Five States of India. From <https://www.prayaschittor.org/> (Retrieved on 12 July 2018).

Rent P, Ghosh Soumitra 2015. Understanding the 'Cash-Less', nature of government-sponsored health insurance schemes: Evidence from Rajiv Gandhi Jeevandayee Aarogya Yojana in Mumbai. *SAGE Open*, 5(4): 1–10.

Sakthivel Selvaraj, Karan Anup 2012. Why publicly financed health insurance schemes are ineffective in providing financial risk protection? *Economic and Political Weekly*, XLVII(11): 60–68.

Shamika Ravi, Sofi Bergkvist 2015. Are publicly financed health insurance schemes working in India? *India Policy Forum*, 11(1): 158-192.

Shivakumar G 2013. Government Paid Private Insurer Crore in Premium for Ghost Beneû ciaries, 2 September, Hindu. From< http://www.thehindu.com/news/national/government-paid-private-insurer-crores-in-premium-for-ghost-beneûciaries/article5083382.ece> (Retrieved on 23 November 2019).

Singh P, Kumar V 2017. The rising burden of healthcare expenditure in India: A poverty nexus. *Social Indicators Research*, 133(2): 741-762.

UNDP 2015. *Human Development Report- Work for Human Development*. United Nations Development Programme, New York, USA.

United Nations 2000. United Nations Millennium Declaration. Resolution adopted by the General Assembly 55/2, New York. From <http://www.un.org/millennium/declaration/ares552e.htm> (Retrieved on 24 September 2019).

World Bank 2015. World Development Indicators. From <http://data.worldbank.org/data-catalog/world-development-indicators> (Retrieved on 22 May 2015).

World Health Organisation 2008. *The World Health Report 2008: Primary Health Care Now More Than Ever.* Geneva: WHO.

World Health Organisation. Universal Health Coverage (UHC) Factsheet 2018. From <http:// www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)> (Retrieved on 22 October 2018).

World Health Organisation 2015. *World Health Statistics 2015*. Geneva: WHO.

Paper received for publication in November, 2019
Paper accepted for publicatio in February, 2020