HEALTH SYSTEM IN TRANSITION IN INDIA

Journey from State Provisioning to Privatization

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Abstract: This paper highlights how privatization in healthcare is being promoted and its further growth facilitated through the adoption of neoliberal policies in India. The approach to financing healthcare has been shifting from public provisioning to tax-funded health insurance merely to achieve health coverage. The idea of the strategic purchasing of care from private providers promoted through insurance seems likely to aggravate the crisis in access and healthcare delivery. Such a crisis will escalate costs and promote concentration and monopolies in the healthcare market. Under the recently promoted neoliberal policy, India is compromising the goal of comprehensive provision of public health services, which is essential for creating a healthier society.

Keywords: neoliberalism in health; health system transition; privatization; health insurance

1. Introduction

As an important commodity for individuals and nations as a whole, healthcare has been on the political agenda of every government across the world. Historically, there have been different ideological and practical approaches to designing healthcare systems in different countries. The healthcare system in Western industrial states and societies places emphasis largely on curative aspects, and is limited to hospital-provided health services, medical practice, and pharmacies. Preventive care (prevention of diseases) has occupied a relatively small place in these health systems. However, at the first World Health Assembly organized by the World

Health Organization (WHO) in Alma Ata in 1978, it was increasingly realized that health services in the so-called developing countries could not share the same orientation as Western industrial states and societies (WHO 1978; Fisk 2000).[1] The consensus was that the majority of disease cases in developing countries can be prevented easily under a primary healthcare system. The primary health care (PHC) approach emerged as a central concept for attaining the goal of Health for All (HFA) by 2000. This concept was heavily concerned with people, with the principles of social justice, accessibility, appropriateness, and acceptance of medical services, with consideration of the needs of people in the communities, their participation, and their orientation to the concept of health services. This strongly reaffirmed the position 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 prime responsibility for fulfilling this goal.

The consensus that was reached on how to design the healthcare system in India after independence was almost the same as that expressed in the Alma Ata declaration. The recommendations of the 1946 report of the Health Survey and Development Committee (Bhore Committee), India's foremost committee on health, enunciated the principle that "nobody should be denied access to health services for his inability to pay," and that the state should take the prime responsibility for delivering healthcare (Bhore Committee 1946). Several other committees on health (the Sokhey Sub-Committee in 1948, the Mudaliar Committee in 1962, the Chaddha Committee in 1963, the Kartar Singh Committee in 1974, the Srivastava Committee in 1975, and the Joint Panel of the Indian Council of Medical Research–Indian Council of Social Science Research ICMR-ICSSR in 1980) also supported the concept of a comprehensive (primary) healthcare system in the public sector (for details about these committees see Sen 2012; Hooda 2017). India in its first National Health Policy (NHP) in 1983 embraced most of the tenets of Alma Ata in the health policy agenda (GOI 1983). This agenda called for a more integrated and comprehensive health system comprising a three-tier structure in the areas of primary, secondary, and tertiary care services. At that time, it was felt that under a pure market system healthcare would typically be allocated inefficiently, and that in the absence of a reasonably well-organized system of public healthcare people would be distressed by the cost of private healthcare. The ideas and dynamics of health system development, however, changed over time. Especially since the 1990s, neoliberal thinking has argued consistently in support of privatization, and has exerted a strong influence on health system design and financing. This paper aims to highlight the changes that neoliberal thinking and policies have brought to the Indian healthcare sector, and to list the implications. Specifically, we aim to understand and describe health in the context of neoliberalism. This includes how, as a result

of neoliberal initiatives in the health sector, healthcare financing approaches are shifting from tax-funded provisioning to tax-funded insurance protection merely in order to achieve health coverage. Lastly, the implications of the current financing approaches and policy initiatives that promote privatization for the Indian healthcare sector are highlighted.

To understand healthcare in the era of neoliberalism, various policy documents and academic writings are reviewed. These date from the time of independence to the announcement of the third National Health Policy 2017 (GOI 2017). The major developments in the health sector are explained, with the discussion organized around the following themes: the first 35 years of independence—designing the healthcare system; the liberalization phase of the 1990s, an era that saw a reduced role for the state in healthcare provision; liberalization within the health sector since 2000; and the new financing approach under which public funds support private insurance and healthcare. Several data sets are adduced to strengthen the arguments, and reference is made to these at the relevant places.

2. Justifying Public Underfunding and Privatization

It took India almost 35 years of independence before announcing its first National Health Policy in 1983 that largely focused on designing the healthcare system. With the announcement of the first NHP in 1983, a rise in public investment in the health sector was observed (Figure 1). Government investment in health increased as a share of total budgetary allocations. The phenomenon of rising public investment in health was, however, short-lived. It began in the early 1980s and ended even before the start of the 1990s, the liberalization phase in the Indian economy. In the early 1990s, India was experiencing liberalization and macroeconomic policy restructuring. One outcome of this restructuring was the implementation of structural adjustment programs (SAPs) enforced by international lending agencies. The fiscal stringency induced by the structural adjustment measures affected central as well as state finances in a big way. The SAPs forced the central and state governments to restructure their expenditure patterns. The thrust of the SAPs was to reduce the budgetary deficit either by increasing the revenue resources or by curtailing expenditure, or both. Because of the limited base of the tax structure and the stagnant revenue/GDP ratio, the central and several state governments went through a process of expenditure curtailment. In the restructuring process, a squeeze in social sector spending, largely in the healthcare area, was observed at the national and state levels. It was not only the period of fiscal crisis around 1991 that affected public spending on health adversely; later, other macroeconomic developments, such as the international financial crisis of 2008–2009 and the implementation of the Pay Commissions, Fiscal Responsibility and Budget Management Act 2003, also influenced central and state finances in a big way.

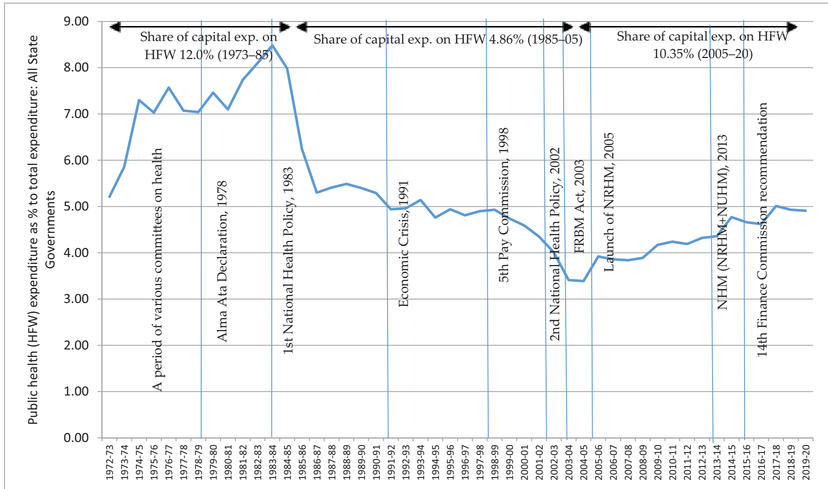

Figure 1 Time-Line: Health Expenditure Under Macroeconomics and Health Policy Changes Scenarios

Source: Author's design, data from http://www.epwrfits.in/.

Until 1984–1985, spending on water supply and sanitation was included under the expenditure headings of medical and public health and family welfare (HFW). Expenditure on these components during that time shows an increasing trend from 5.2% of the total budget to 8.5% (Figure 1). Budget expenditure since 1985–1986 shows a sharp decline in spending on HFW. The share of health spending in the total budgetary spending of all-state governments dropped by at least one percentage point between 1985–1986 and 1990–1991. During the years until the second National Health Policy announcement in 2002 it again dropped by more than one percentage point. Around the time of the implementation of the 5th Pay Commission in 1998, the spending increased slightly, which can be attributed largely to an increase in the salary bill, while in all states the share represented by capital expenditure during the period was particularly low (Figure 1).

The second National Health Policy 2002 insisted that the states should raise their budget spending on health to 8% by 2010 (GOI 2002). However, no sign of an increment in state health expenditure was observed after the policy announcement. Soon after the second NHP announcement, the Government of India in 2003 implemented the Fiscal Responsibility and Budget Management (FRBM) Act. The purpose of the FRBM Act was to force the central and state governments to reduce fiscal and revenue deficits, either by increasing their revenue resources or by restructuring/curtailing overall public expenditure. Since the federal nature of the country means that most of the revenue-generating capacities lie with the

central government, the state governments followed the route of expenditure curtailment, with the health sector bearing the brunt of the cutbacks. At that particular time the all-state average health spending fell significantly, to around 3.4% of total budget outlays (Figure 1). The year 2005 brought a landmark reform in the health sector when the central government implemented its National Rural Health Mission. The share of state health expenditure in total budget spending increased thereafter, with a small setback around the time of the 2008–2009 international financial crisis. Even in the recent period, spending by the states on health, which in India is a state responsibility, has remained lower than what the states were able to allocate in 1986–1987.

Analysis of the priority given by individual states to the health sector reveals that between two particular points in health policy (second-2002 and third-2017 NHP), most states showed an increasing trend, with health spending rising as a share of total state budgets (Figure 2). West Bengal and Jharkhand showed no increment in the share of health budget. The low-income states (generally termed

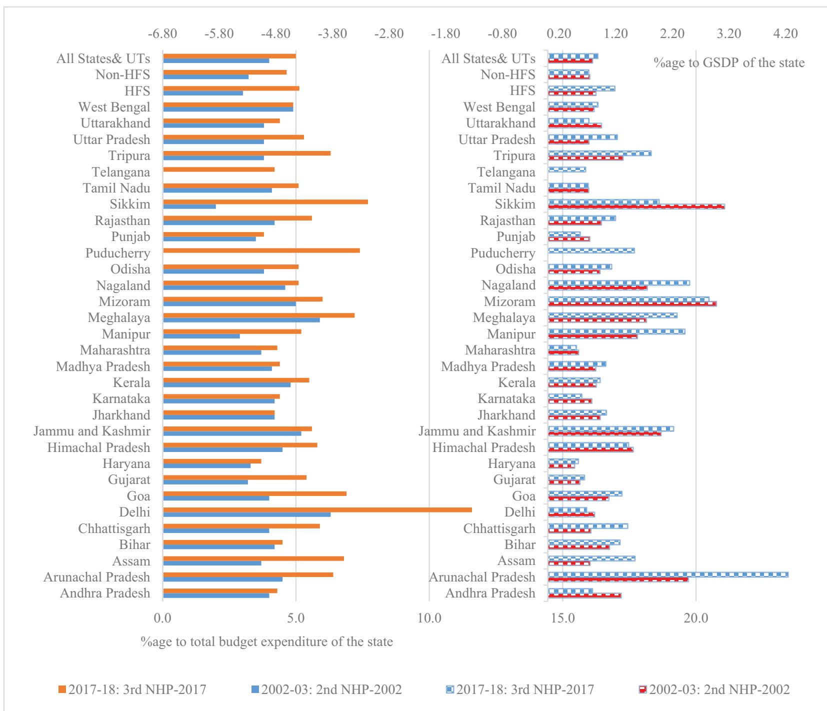

Figure 2 Trends in State-Level Health Spending at Two Recent Health Policy Points

Source: Author’s estimate and design, data from http://www.epwrfits.in/.

high focused states—HFS in government terminology) recorded higher increments in their allocation of public funds to the health sector than non-HFS. Some of the high-income states like Punjab, Maharashtra, and Haryana showed only marginal increments in their health budgets. However, state health spending as a ratio of GSDP (Gross State Domestic Product) reveals an interesting picture. The share of state health spending as a ratio of GSDP increased between these two points in the HFS (in India, low-income states with poor health outcomes are described as high focused states in government terminology), while no increment was recorded in the case of the non-HFS; rather, their expenditure declined marginally. Increments in health expenditure as a ratio of GSDP occurred in Uttar Pradesh, Rajasthan, Orissa, Chhattisgarh, Bihar, Assam, and Madhya Pradesh, while a decline was observed in Uttrakhand. Most of the north-eastern states (NE-states) recorded a higher increment. Among the non-HFS, states like Tamil Nadu, Maharashtra, Karnataka, Andhra Pradesh, and Delhi experienced a decline in health expenditure as a percentage of GSDP. The state of Delhi observed the highest increment in health expenditure as a proportion of its total budget, though health spending declined as a percentage of GSDP (Figure 2). Total public expenditure on health in India currently hovers around 1.23% of GDP. The recommended resource requirements for providing basic health facilities would, however, require raising public health spending to 2–3% of GDP (GOI 2017). The government health sector has not received the kind of investment it needs. A fundamental question that emerges is why the government health sector always bears the brunt of expenditure curtailment, as well as suffering from a generally low level of spending.

As discussed, different macroeconomic conditions have affected state finances and thereby expenditure on health differently. The pattern of public expenditure on health must, however, be linked with the neoliberal thinking that has emerged from a number of publications of the World Bank and other international agencies. The World Bank published a report on "Investing in Health" in 1993, followed in 2001 by an India-specific report entitled "India: Raising the Sights: Better Health Systems for India's Poor." The first report, while acknowledging the role of government efforts in improving health outcomes, argued that the public healthcare system in developing nations is confronting with several challenges in the areas of efficiency and equity (World Bank 1993). It insisted that government involvement in the healthcare and health insurance sectors had only a limited role to play, and that the government should restrict its role in these areas. The report rejected the idea of healthcare as a public good, insisting that healthcare provisions are a matter that individuals and families, with their strikingly different health needs, should be able to choose freely (Fisk 2000). Viewing healthcare as a private good, the report proposed a quite consistent strategy for spreading both private insurance and private delivery. This gave a rise to arguments calling for privatization in the health sector.

The supporters of neoliberal ideas made a further attempt to justify public sector underfunding and privatization in the India-specific report of 2001. This report noted that India's healthcare system was at a crossroads. Its ability to combat infant mortality, communicable diseases, and malnutrition was being stretched. At the same time, the system faced emerging demands for better services, and for more attention to be paid to 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 the country's health problems will only become more severe. The 2001 World Bank report contended that the country needed to promote its private health sector, and in this way, to take better advantage of the supposed capacity of the private sector to deliver better service and outcomes for all regions and socioeconomic groups (World Bank 2001).

Both these reports argued that underfunding and privatization were actually defensible in the sense that the Indian economy had the potential to grow at a faster rate, leading to an increase in the paying capacity of the masses. Since the public system was largely inefficient in meeting the healthcare needs of the population, marketizing the healthcare sector would not cause harm. The neoliberal argument that cuts in public investment were essential was vigorously propagandized. In line with the neoliberal priority of opening up investment opportunities for the private sector, India threw open the health insurance sector to private players in 1999, setting the foreign direct investment (FDI) cap in health insurance at 26%. Generally, the private insurance funds access to hospitalization services from private providers. Another impact of the reform urged by the World Bank was the introduction of user fees at public facilities, with the change implemented in most of the states between 1992 and 1997. Then 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). Although the user fees were waived for people living below the poverty line, the definition of poverty was arbitrary, meaning that most poor people received only limited relief. Another major development in the health sector was the introduction of a new Drug Price Control Order (DPCO) in 1994. Initially, 166 bulk drugs and their formulations were under price control, and the DPCO1995 brought down the number of essential bulk drugs to 74 (Ghosh 2010). The pharmaceutical sector was further liberalized in 2002. The impact of these drug policy changes could be seen in the spiraling increase in drug prices during the period 1994–2004 (Ghosh 2010). The overall reforms in the health sector during this period were piecemeal but incremental, which led to extensive changes in the organizational structure, financing, and delivery of health care services. The SAPs and World-Bank-supported health system reforms became

the guiding instruments for reducing the role of the state in health care provision. The underfunding of public healthcare was a step in the realization of an overall neoliberal strategy, and the sector became the victim of low political priority followed by privatization.

In order to realize the neoliberal strategy still more broadly, India opened its hospital sector to foreign players. In 2000 the government approved 100% FDI in the hospital sector through an automatic route. Other initiatives aimed at encouraging private (domestic and foreign) provider enterprises, especially the large and corporate-run, to exploit the Indian hospital market included the relaxation in 2000 of import duties on the importing of medical equipment and technology, the granting of cheap long-term loans to private healthcare institutions, and the confirmation in the 2003–2004 budget of industry status for the hospital sector. According to the Ministry of Commerce and Industry, foreign investment in the hospital sector increased hundreds-fold between 2000 and 2014, from Rs. 31 crores in 2001 to Rs. 3995 crores in 2014 and Rs. 70,289 crores in 2018 (GOI 2020). The decade of the 2000s was seen as an era of support for the private sector through subsidies, credits and public–private partnerships (PPPs), as well as through insurance.

The liberalization and privatization policies introduced on the macroeconomic front in the health sector during the early 1990s and again around 2000—policies that provided a range of tax benefits and other incentives for setting up private hospitals/clinics—resulted in a mass presence of private healthcare providers in the country. This growth of the private health sector, however, remained very heterogeneous, as discussed in the following section.

3. The Private Sector in Healthcare: Its Distribution and Implications

Estimates from Economic Survey 2016 reveal that around four-fifths of the total number (983,018) of health enterprises are private (Table 1). Private partnerships and private companies, as well as cooperative enterprises, are large relative to others in terms of the number of health workers they employ. This indicates that the majority of large hospitals are of a private corporate/company nature. The share of government health enterprises in 2016 was found to be only 20% (Table 1).

According to a Services Sector Enterprises Survey by the NSS (The National Sample Survey), the private sector consisted of 10.67 lakhs private providers, ranging from informal to large formal and corporate entities, as opposed to a low 1.96 lakhs public hospitals/centers. The growth pattern of the private sector reveals that the private sector grew at a much faster rate during the liberalization and privatization policy reforms (Figure 3), a period that saw a number of tax benefits and other incentives provided for setting up private hospitals/clinics.

Table 1 Total Number of Health Enterprises and Persons Employed by Ownership

Ownership categories	*Total Establishments/ enterprises*		*Total persons employed*		*Number of persons employed per establishment*
	In numbers	*Distribution (%)*	*In numbers*	*Distribution (%)*	
Govt /PSU	195,650	19.90	931,474	26.63	4.76
Private: Proprietary	673,131	68.48	1,789,320	51.16	2.66
Private: Partnership	9,428	0.96	130,008	3.72	13.79
Private: Company	4,280	0.44	97,159	2.78	22.70
Private: Self Help Group	4,167	0.42	33,846	0.97	8.12
Private: Cooperative	2,392	0.24	32,414	0.93	13.55
Private: Non-profit Institute	25,440	2.59	138,604	3.96	5.45
Private: Others	68,530	6.97	344,729	9.86	5.03
Total	983,018	100.0	3,497,554	100.0	3.56

Source: GOI (2016).

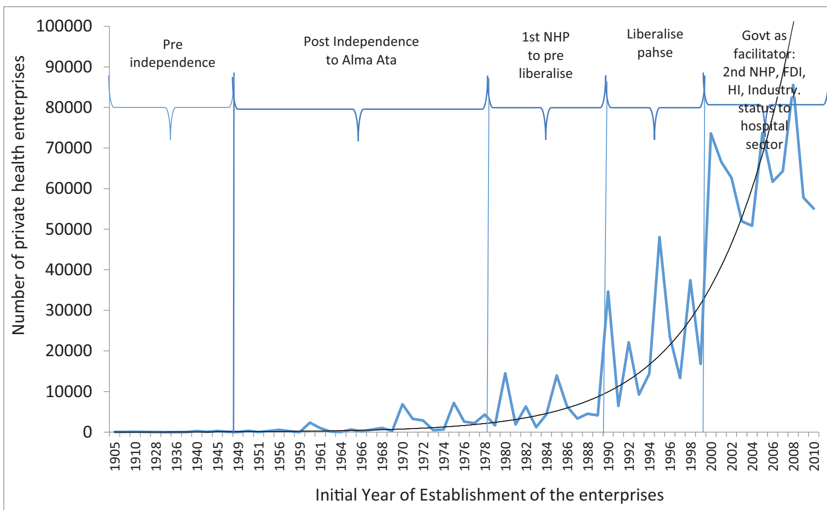

Figure 3 Growth of Private Healthcare Providers in India

Source: Author's estimate and design, data from GOI (2010–2011).

The estimates from the NSS show that in the year 2010–2011 around 82% of the health enterprises with one or more hired employees were located in urban areas, with only 18% in the countryside (Figure 4). Of the total, the share of Own Account health Enterprises (OAEs—generally run by an individual) in rural areas was 61%, reflecting the fact that healthcare needs in rural areas were mainly being provided by small/individual practitioners. The rural healthcare sector suffers from a lack of formal/large private health facilities. A sharp dichotomy thus emerges: the growth of the private sector has been concentrated in urban centers and metropolitan cities, while rural areas remain dominated by individual practitioners in the unorganized sector (Figure 4).

As of 2012, the distribution of private health enterprises (in absolute numbers and per 100,000 population) at the state level was higher in such states as Himachal Pradesh, Gujarat, Pondicherry, Chhattisgarh, Karnataka, Kerala, Maharashtra, Andhra Pradesh, Chandigarh, West Bengal, Uttaranchal, Uttar Pradesh, Punjab, Haryana, and Delhi (Table 2). Except in a few cases, particularly large numbers of private allopathic enterprises were located in economically prosperous states, and relatively few in poorer ones.

One important caveat for understanding the growth of the private healthcare sector is its high concentration in a few regions/districts. A district-level analysis across Indian states, compiled by the NSS in 2010–2011, records that out of a total of 568 districts that were studied only 29% (166 in number) were covered by large (having more than ten workers) private allopathic healthcare providers/enterprises (Table 3). The coverage of districts with large private allopathic healthcare enterprises was reported to be higher in states like Himachal Pradesh, Tamil Nadu, Andhra Pradesh, and Kerala (around 50%, 60%, 70%, and 86% of

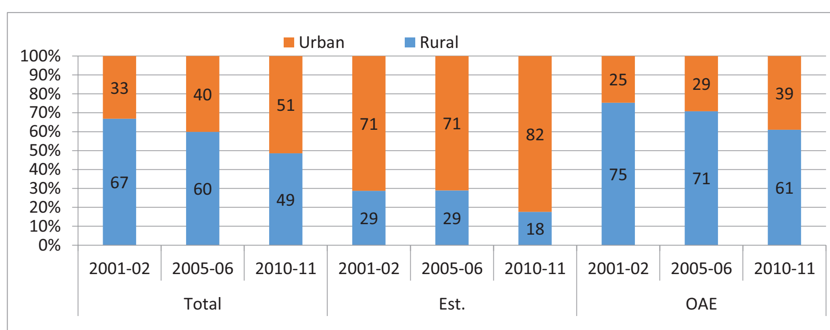

Figure 4 Distribution of Private Health Enterprises: Rural–Urban (in %)

Source: Author's estimate and design, data from GOI (2001–2002, 2005–2006, 2010–2011).

Table 2 Public and Private Health Enterprises: State-Level Analysis.

States	*Govt hospitals and private health enterprises (in No)#*			*Per 100,000 Population (in No)##*		
	Private health enterprises (PHE in No)	*Private allopathic enterprises (PAE in No)*	*Govt allopathic hospital (GAH in No)*	*PHE*	*PAE*	*GAH*
Manipur	139	34	725	5	1	27
Nagaland	34	31	575	2	2	29
Arunachal Pradesh	66	41	767	5	3	55
Sikkim	18	18	204	3	3	34
Assam	7,109	2,010	6,599	23	6	21
Meghalaya	1,058	239	546	36	8	18
Mizoram	128	128	449	12	12	41
A & N Islands	66	62	173	17	16	46
Daman & Diu	50	38	33	21	16	14
Tripura	4,155	713	837	113	19	23
Orissa	19,782	8,819	9,664	47	21	23
D & N Haveli	89	89	58	26	26	17
Bihar	59,937	33,164	12,230	58	32	12
Goa	483	483	235	33	33	16
Jammu & Kashmir	4,953	4,283	4,272	39	34	34
Jharkhand	19,385	12,267	4,837	59	37	15
Tamil Nadu	43,605	29,812	11,928	60	41	17
Rajasthan	40,490	31,853	15,527	59	46	23
Madhya Pradesh	48,740	34,799	11,564	67	48	16
Himachal Pradesh	4,302	3,411	2,688	63	50	39
Gujarat	46,111	31,328	9,985	76	52	17
Pondicherry	822	652	125	66	52	10
Chhattisgarh	17,039	13,861	7,889	67	54	31
Karnataka	48,178	36,069	11,946	79	59	20
Kerala	34,846	21,577	6,639	104	65	20
Maharashtra	95,684	73,505	13,564	85	65	12
Andhra Pradesh	74,603	57,300	14,606	88	68	17

(continued)

Table 2 (continued)

States	*Govt hospitals and private health enterprises (in No)#*			*Per 100,000 Population (in No)##*		
	Private health enterprises (PHE in No)	*Private allopathic enterprises (PAE in No)*	*Govt allopathic hospital (GAH in No)*	*PHE*	*PAE*	*GAH*
Chandigarh	951	790	21	90	75	2
West Bengal	112,470	73,245	12,831	123	80	14
Uttaranchal	11,836	9,083	2,966	117	90	29
Uttar Pradesh	233,826	189,168	24,908	117	95	12
Punjab	40,489	28,163	3,643	146	102	13
Haryana	36,312	26,311	3,121	143	104	12
Delhi	27,741	21,121	155	166	126	1
Total/Average	**1,035,497**	**744,467**	**196,331**	**86**	**62**	**16**

Notes: PHEs include all types of private health enterprises; PAEs are private allopathic enterprises, which include private hospitals, medical and dental hospitals, diagnostic center/labs and blood banks; GAHs—total number of all types of government allopathic hospitals including sub-centers (SCs), primary health centers (PHCs), community health centers (CHCs) as of March 2012.

Source: Author's estimate and design, data from GOI (2010–2011).

districts, respectively) compared to other low as well as highly-developed states of India. Interestingly, the coverage of districts with large private allopathic enterprises in high-income states like Gujarat, Haryana, Punjab, and Maharashtra was found to be lower than in the above-mentioned states. The NSS researchers found that large (having more than ten workers) non-profit (registered under charitable/trust/society acts) private allopathic healthcare providers/enterprises were located in only 81 of the 568 districts.

Similarly, the National Hospital Directory data of the Ministry of Health and Family Welfare, listing large formal hospital service providers, reported that there were 1,048 large public and private hospitals in the country in 2015. Of these, 175 were public and 873 large private hospitals, including medical institutions. The district-level analysis of these large private hospitals found that of the total hospital list, around 77% were located in 15 states, and within these 15 states such hospitals were located in only 33 of India's total of 640 districts (Table 3).

A survey (IMS-Health survey) of the spread of large, organized hospitals that was conducted in 62 Indian cities during 2012, and that covered 14,121 hospitals, found that of the total number of hospitals surveyed almost half (48%) of large private hospitals and two-thirds of the corporate hospitals were located in cities with populations greater than 5 million. Mumbai alone has 16% of all

Table 3 Large Hospitals: Analysis at the District Level

	No of districts covered with private allopathic enterprises (PAE) #					*List of hospitals reported under National Hospital Director MOHFW 2015##*			
	Total no of NSS districts	*Large PAE (>10 workers)*	*% of district have large PAE*	*PAE regd. In CT*	*PAE regd. In CTS*	*Public*	*Private*	*Total*	*Concentration of private hospitals across districts (reporting of ≥2digits hospitals in number)*
Andhra Pradesh	23	16	70	3	6	1	31	32	Hyderabad (27)
Assam	24	4	17	1	1	6	0	6	
Bihar	38	4	11	1	1	8	11	19	Patna (16)
Chhattisgarh	18	1	6			4	3	7	
Delhi	7	3	43	2	3	61	272	333	South (67), West (55), Central (42), South-West (41), North-West (39), New Delhi (34), East (32), North (15)
Gujarat	25	7	28	5	7	12	23	35	Vadodara (8), Surat (6)
Haryana	20	7	35	2	2	5	192	197	Gurgaon (58), Faridabad (29), Sirsa (16), Hisar (15), Ambala (11), Rohtak (11)
Himachal Pradesh	12	6	50	1	3	2	0	2	
Jammu and Kashmir	11	1	9			7	8	15	Jammu (13)
Jharkhand	22	2	9	1	1	3	0	3	
Karnataka	28	9	32	1	1	2	24	26	Bengaluru (22)

(continued)

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	No of districts covered with private allopathic enterprises (PAE) #					*List of hospitals reported under National Hospital Director MOHFW 2015##*			
	Total no of NSS districts	*Large PAE (>10 workers)*	*% of district have large PAE*	*PAE regd. In CT*	*PAE regd. In CTS*	*Public*	*Private*	*Total*	*Concentration of private hospitals across districts (reporting of ≥2digits hospitals in number)*
Kerala	14	12	86	3	9	26	6	32	Kollam (8), Kochi (7)
Madhya Pradesh	48	6	13	1	2	0	32	32	Indore (32)
Maharashtra	34	12	35	2	4	0	42	42	Mumbai (23), Pune (18)
NE-states	21	5	24		1	7	5	12	
Orissa	29	5	17	2	4	5	3	8	
Punjab	19	9	47	1	3	2	87	89	Ludhiana (41), Amritsar (25), Mohali (10)
Rajasthan	31	3	10	3	6	3	4	7	
Tamil Nadu	30	18	60	6	13	3	30	33	Chennai (20)
Uttar Pradesh	71	19	27	5	8	1	65	66	Kanpur (20), Noida (13), Ghaziabad (10)
Uttaranchal	14	5	36	2	2	3	4	7	
West Bengal	19	9	47	1	4	0	21	21	Kolkata (21)
Total/ Avg.	568	166	29	43	81	175	873	1048	806 (76.9%): covering only 33 districts

Notes: CPTs are hospitals registered under charitable and public trust acts; CPTSs are hospitals registered under charitable, public trust and societies acts; Large PHEs have more than ten workers; Total includes UTs (union territories) and Goa (a state in India) as well.

Sources: GOI (2010–2011) and Open Government Data (OGD) Platform India (https://data.gov.in/catalog/hospital-directory-national-health-portal).

hospitals in the organized healthcare sector (Mukhopadhyay et al. 2015). This indicates that the urban metropolitan areas have a concentration of organized private and corporate hospitals.

Estimates from a different round of NSS research reveal that large/corporate hospitals are growing/emerging rapidly, while small providers are vanishing over time—a phenomenon of big fish eating smaller fish (Table 4). That is, large healthcare providers are growing at a faster rate, indicating a rapid shift toward an organized form of healthcare delivery, particularly in urban areas. The present growth pattern seems to favor a kind of private healthcare market that is concentrated in fewer hands. Smaller providers and individual practitioners in these areas are getting sucked into large and corporate-run hospital networks that create further induced demand.

The growth of private health enterprises has resulted in a high presence of hospitals and hospital beds in the private sector. The share of private hospitals, only 18.5% in 1974, increased to 74.9% in 2000. Similarly, the share of private hospital beds increased to 50.7% in 2013 from its low share of 21.4% in 1974. Among the medical institutions that are very important for human resource development in the health sector, the share of private institutions at the time of independence was only 3.6%, whereas it reached 54.3% in 2014 (Figure 5). The share of government hospitals, hospital beds and medical institutions has been declining throughout this period.

Due to its high dominance in the area of service provision, the private sector also became dominant in service delivery both for inpatient as well as outpatient care services. In 2014, around two-thirds of inpatient and three-quarters of outpatient care treatments were received from the private sector. The outpatient care

Table 4 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)*	
2001–2002 (57th)	1,009,064 (76.3)	276,690 (20.9)	25,777 (1.9)	10,900 (0.8)	1,322,431 (100)
2005–2006 (63rd)	757,227 (69.5)	287,611 (26.4)	28,629 (2.6)	16,819 (1.5)	1,090,286 (100)
2010–2011 (67th)	659,475 (63.7)	327,344 (31.6)	30,246 (2.9)	18,432 (1.8)	1,035,497 (100)
CAGR (2001–2002 to 2010–2011)	**–0.046**	**0.019**	**0.018**	**0.060**	**–0.027**

Sources: Author’s estimate and design, data from GOI (2001–2002, 2005–2006, 2010–2011).

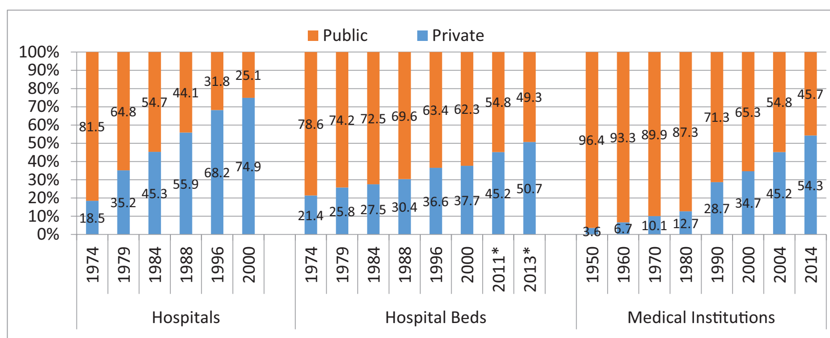

Figure 5 Private-Sector Dominance in Service Delivery

Notes: Data on hospital beds are not available after 2000. *The information for the years 2011 and 2013 represents hospital beds in medical institutions.

Sources: GOI (2005–2012).

treatment received from the private sector, however, is almost constant since 1986–1987, but in providing inpatient treatments its share increased to 68% in urban and 58% in rural in 2014 from a low share of 40% in 1986–1987 (Table 5).

The dominance of service delivery by the private sector resulted in high and rapidly increasing care costs. Table 6 shows that in 1986–1987 the cost of hospitalization in private as compared to public facilities was around 2.3 times as great in rural areas and 3.1 times in urban areas, with the ratios increasing by 2017–2018 to 6.4 times in rural areas and 8.0 times in urban areas (Table 6). This indicates a sharp rise in the cost of care in private facilities. Along with the increasing dominance of the private sector, care costs also increased, with an inevitable impact on inflation.

NSS figures from 2014 and 2019 show that in private facilities treatment costs for particular categories of disease were between four and eight times higher than in

Table 5 Inpatient and Outpatient Care Treatments by Type of Facilities (in %)

		Inpatient		*Outpatient*	
		Public	*Private*	*Public*	*Private*
42nd: 1986–1987	Total	60.0	40.0	22.5	77.5
52nd: 1995–1996	Total	43.5	56.6	19.5	80.5
60th: 2004–2005	Total	40.0	60.1	20.5	79.5
71st: 2014	Rural	41.9	58.1	28.9	71.1
	Urban	32.0	68.0	21.2	78.8

Sources: GOI (1986–1987, 1995–1996, 2004–2005, 2014, 2017–2018).

Table 6 Cost per Hospitalization Case in Public/Private Facilities: A Comparison

Years/ Rounds		*Public (Rs.)*	*Private (Rs.)*	*Pvt/pub (ratio)*
42nd:1986–1987	Rural	1,120	2,566	2.3
	Urban	1,348	4,221	3.1
52nd: 1995–1996	Rural	3,307	5,091	1.5
	Urban	3,490	6,234	1.8
60th: 2004–2005	Rural	3,238	7,408	2.3
	Urban	3,877	11,553	3.0
71st: 2014	Total	6,120	25,850	4.2
75th: 2017–2018	Rural	4,290	27,347	6.37
	Urban	4,837	38,822	8.04
	Total	4,452	31,845	7.15

Sources: GOI (1986–1987, 1995–1996, 2004–2005, 2014, 2017–2018).

public facilities (Table 7). The costs of treating different types of ailments in private facilities also increased between these two rounds of NSS research (Table 7), indicating that the services concerned are becoming costlier over time due to the growing relative weight of private service delivery.

Table 7 Cost per Hospitalization Case by Ailment Category

	71st round of NSS: 2014			*75th round of NSS: 2017–2018*		
	In Public Hospital (in Rs.)	*In Private Hospital (in Rs.)*	*Pvt/Pub (Ratio/ times)*	*In Public Hospital (in Rs.)*	*In Private Hospital (in Rs.)*	*Pvt/Pub (Ratio/ times)*
cancers	24,526	78,050	3.18	22,520	93,305	4.14
cardio-vascular	11,549	43,262	3.75	6,635	54,970	8.28
genito-urinary	9,295	29,608	3.19	5,345	33,409	6.25
musculo-skeletal	8,165	28,396	3.48	5,716	46,365	8.11
psychiatric and neurological	7,482	34,561	4.62	7,235	41,239	5.70
gastro-intestinal	5,281	23,933	4.53	3,847	29,870	7.76
respiratory	4,811	18,705	3.89	3,346	24,049	7.19
infections	3,007	11,810	3.93	2,054	15,208	7.40
obstetric and neonatal	2,651	21,626	8.16			
Eye	1,778	13,374	7.52	2,605	18,767	7.20
All/Any ailment	**6,120**	**25,850**	**4.22**	**4,452**	**31,845**	**7.15**

Sources: GOI (2014, 2017–2018).

4. Toward Transition: Public-Fund Supporting Private Insurance and Care under New Financing Strategies

The growing costs of private-sector care, together with the increased dominance of the private sector in service delivery, have resulted in high out-of-pocket (OOP) costs to patients and their families. 70% of the healthcare spending in India is financed through OOP payment made by an individual from their pocket. This has made health services inaccessible to many people, especially the poor, simply because they cannot afford to pay for care when the need arises. People who make use of services often suffer financial hardship or even impoverishment, as they are forced to sell assets and/or borrow money (Hooda 2017). The economic gradients of inequality in access to healthcare in India have thus worsened sharply. Under the present system, rural residents and the poor are financially squeezed and experience difficulty in finding services they can afford (Sen 2012). To address the questions of equity, accessibility, and affordability, various financial innovation strategies have recently become more prevalent. One argument holds that the tax-funded public health care provisioning system should be rejuvenated, while a second calls for providing financial risk protection, at least to the poor, through health insurance schemes. As a part of rejuvenating the public health provision system, the Government of India in 2005 launched a flagship program called the National Rural Health Mission (NRHM). The Mission placed stress on improving service delivery in the public healthcare system and advocated increased public investment (2–3% of GDP) in the public health sector (GOI 2005–2012), especially to bridge rural–urban health outcome gaps and to achieve Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) for health. To strengthen primary healthcare in the public system, India's third National Health Policy 2017 announced Upgrade 1.5, which was to transform existing health sub-centers into health and wellness centers (HWC). This change was aimed especially at the prevention of communicable and non-communicable diseases (GOI 2017).

To address the issue of the inaccessibility of healthcare services, particularly among the poor, innovations have also been made in healthcare financing strategy. The general thrust of these changes has been to advocate for the financing of healthcare through health insurance. This new thinking on the financing of care through insurance is related to the debate on universal health coverage, and is tied partly to labor market outcomes. For instance, the dominant literature reveals that while seeking to open up new fields for investment and profit-making through privatization, the neoliberal regime argues for cheaper labor to attract foreign capital and to make the country's exports more competitive. This requires responding to labor's expectations of benefits from social programs or from employer-funded

social benefit packages. The cost of such programs varies according to the context. India's labor market may be compared with those of emerging-economy countries like China, Brazil, Chile, Thailand, and Malaysia where recently, along with public provisioning, social insurance schemes have been promoted for accessing services through accredited private and public facilities. The experience of these countries suggests that social insurance should pool resources from public sources along with contributions from employers and from beneficiaries/employees (Hooda 2020). The Indian labor market is highly fragmented, with a large proportion (about 93%) of the workforce employed in the informal sector. The incidence of informal employment is increasing, at the same time as ever-greater numbers of workers in the formal sector are being employed on a contract basis. The share of wages in value added within the formal sector has also declined over time, dropping from 19.1% in 1990/1991–1994/1995 to 9.9% in 2005/2006–2011/2012, while the share accruing to profits increased sharply from 21.4% to 49.6% over the same reference period (Roy 2016). This means that no or minimal provisions for social security are being made on the employer side for the majority of the workforce. For a large proportion of the workforce, therefore, there is no prospect, or little prospect, of receiving contributions from employers. Data from the National Health Account for 2016, on the sources of healthcare financing, indicate that the contribution to total health spending made by firms declined from 5.7% in 2004–2005 to 2.4% in 2013–2014 (GOI 2016), indicating that the funding of health benefits by employers has declined over time. This labor market outcome has forced the Ministry of Labour and Employment of the Government of India to implement a publicly funded insurance scheme (RSBY—Rashtriya Swasthya Bima Yojana [national health insurance scheme] 2008) for poor and informal community workers to protect them from the devastating consequences of a lack of health payments (GOI 2008). Consequently, the financing of healthcare through insurance in India occurs almost entirely from public sources. Such programs would cost the state more, and employers less, since the contributions made by beneficiaries under the scheme are minimal or negligible.

The literature dealing with the universal health coverage (UHC) debate suggests that around 2010 a considerable amount of discussion took place on strategies for financing healthcare at a global level through achieving UHC. The UHC debate has largely advocated adopting a social health insurance system or other publicly financed health insurance scheme under which all citizens are insured and can utilize healthcare services regardless of whether they can afford it. The WHO's World Health Reports have suggested a roadmap for developing countries to adapt their financing systems to meet the requirements of universal health coverage (WHO 2010, 2013). The reports highlight the fact that UHC is important for addressing equity, accessibility and affordability issues in

developing countries. The reports largely advocate for an insurance-based health financing strategy to finance healthcare.

The Government of India also set up a High Level Expert Group (HLEG) on UHC in 2010, and this submitted its report to the then Planning Commission in 2011 (GOI 2011). The Planning Commission Steering Committee for the 12th Plan, in its own assessment report to the prime minister, made it clear that given its major share of personnel, beds and patients, "the private sector has to be partnered with for health care" (Qadeer 2013). Thereafter, the third National Health Policy 2017 report specified the role of comprehensive primary care provisions in the public sector, stating that the provisions should simultaneously be supplemented by strategic purchases of secondary and tertiary care services from both the public and private sectors to assure universal healthcare. The report stressed that current publicly (tax-based) financed national health insurance provisions (like the RSBY) would be aligned with this strategy and that the states would also be encouraged to do the same (GOI 2017).

Under the advanced UHC framework, the Government of India launched its Ayushman Bharat-National Health Protection Mission Scheme in 2018. Focused on the poor and on a section of the informal community, this was expected to cover more than 40% of India's population. The new national health protection scheme was expected to provide health cover of up to 5 lakh rupees per family (compared to only 30,000 rupees under the RSBY), with no charge to the beneficiaries. This brought about a major shift in the content of the policy dialogue, with the goal now to promote the purchase of services through a financial protection package provided via health insurance. These moves marked the beginning of an era of healthcare financing under which the state appears to ensure access to services, but not necessarily their provision, at public expense. Earlier, the public funds were allocated for service provision in the public system. Under the newly promoted insurance-based financing mechanism, the public funds are now to be utilized to support private insurance and care. This is simply because insured people generally prefer to avail themselves of private rather than public facilities and services. These trends were already apparent under such existing social insurance schemes as State Insurance Scheme (ESIS) and Central Government Health Scheme (CGHS) as well as in the case of the RSBY and other state-sponsored social health insurance schemes (Hooda 2015). Further, the opening of the health insurance sector to private insurers (with the FDI cap set at 49% in 2016) has represented a step toward replacing public with private insurance, with people/workers encouraged to buy private insurance on a premium-payment basis. Where health services are concerned, people who have private insurance vouchers generally get healthcare from private providers, thus replacing public with private provision.

Initially, the purpose of launching government-funded insurance (including the RSBY) was to ensure access and affordable services to the poor. Under the third National Health Policy 2017, this goal has changed to promoting the private sector. The NHP 2017 clearly reflects the intention to involve and promote the strategic purchasing of services from private care providers. The government acts as a single payer through health insurance (GOI 2017), indicating that the insurance-based financing strategy will be used to promote the private sector. While the policy document refers to the strategic aim of achieving universal health coverage, it reflects the need to ensure improved access and the affordability of quality secondary and tertiary care services through a combination of public hospitals and appropriate strategic purchasing, from private care providers, of services in healthcare deficit areas. The policy also advocates a positive and proactive engagement with the private sector in order to fill critical gaps and achieve national goals. The health policy recognizes that there are many critical gaps in public health services that strategic purchasing could potentially fill. This purchasing would play a stewardship role in directing private investment toward areas and services for which currently there are no or few providers. The policy advocates building synergies between not-for-profit organizations and the for-profit private sector, subject to the timely availability of quality services as per predefined norms for critical gap filling in the collaborating organization. Under the heading "align the growth of the private health care sector with public health goals," the report clearly mentions that India needs to influence the operation and growth of the private health care sector and medical technologies so as to ensure alignment with public health goals. The private-sector contribution is projected to make healthcare systems more effective, efficient, rational, safe, affordable, and ethical. Empirical evidence, however, suggests that such a strategy is not sustainable, since private healthcare providers have not shown any inclination to fill the gaps in critical areas (as can be seen from the analysis of the concentration of hospitals presented earlier), even after the implementation of the national/state-level tax-funded insurance scheme almost a decade ago.

An analysis of the relationship between enrolment of the population in publicly funded insurance (RSBY) and empanelment of private hospitals under the scheme in the year 2016 (that is, eight years after the RSBY was launched) showed a negative result, with a correlation coefficient of –0.3408 (Figure 6). The empanelment of private hospitals was found to be low in states where enrolment of families under the RSBY was high and vice versa, indicating that even if governments plan to enroll more families, the private hospitals are not inclined to fill the health facility gap, where it exists. The last eight years' experience of the relationship between RSBY enrolment and the empanelment status of private hospitals reveals that the idea of strategic purchasing put forward in the third National Health Policy 2017 is not based on strong empirical evidence.

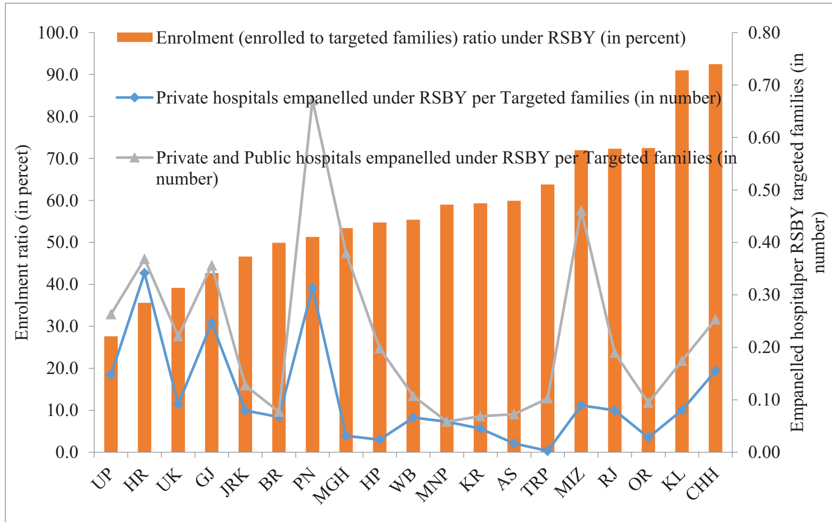

Figure 6 RSBY Enrolment and Private Hospitals Empanelment Status Relationship

Source: Author' design, data from http://www.rsby.gov.in.

The private enterprises are generally located in areas where public health facilities already exist in higher numbers, as they see health service clusters as an inducement to explore the market, rather than being inclined to fill health service deficiencies. The private sector cannot be relied on to fill the regional gaps in health infrastructure. As discussed above, private facilities are very much an urban-centric phenomenon found in a few districts of India, while many regions face a dearth of both public and private health facilities.

Strategic purchasing will promote an insurance-based system that will receive financing in the same way as the public health sector. The difference lies in the fact that the provisioning will be shifted almost entirely to the private sector. This can be expected to lead to another crisis in the public healthcare sector, especially with the emergence of private healthcare competitors. Private competitors will grow by capturing clients from the public healthcare system. The insurance-based system requires hospitals to come under empanelment, but by definition, only large hospitals can be empanelled, and the reality is that most large hospitals are of a private corporate/company nature. Effectively, therefore, a corporate system will emerge in the hospitals. Over time, this will produce monopolies in the health care market, as has happened in the United States of America. A 2016 post on *The American Interest* site (2016) observed that monopolists are taking over American healthcare, and concluded that for the general population, the current American

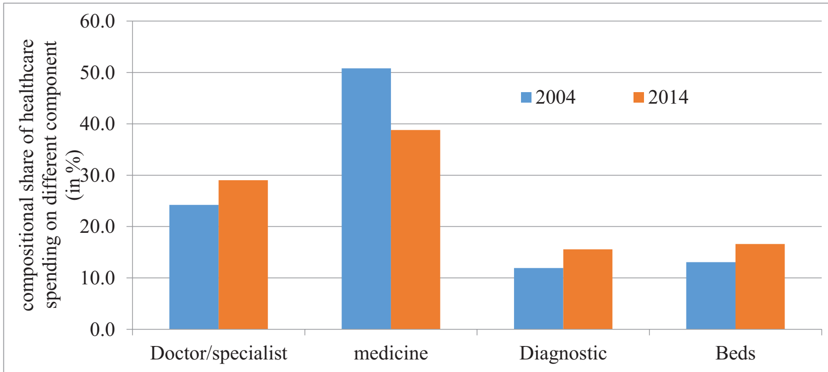

Figure 7 Health Insurance and Changing Healthcare Spending Pattern

Sources: Author's estimate and design, data from (GOI 2004–2005, 2014).

healthcare regime is not sustainable. The market in India can be predicted to evolve in a similar way in times to come.

Due to intrinsic market failures and information asymmetries in the health insurance and healthcare markets, providers, insurers, and patients are able to indulge in maximizing their individual gain. Insurance-promoted care has the potential to bring increased levels of inappropriate care, unwanted visits, unnecessary treatment, excessive laboratory tests, and overcharging. Evidence from before (2004) and after (2014) the advent of the insurance-based regime shows that the shift has resulted in high costs for specialists, beds and diagnostics (Figure 7). As discussed earlier, overall costs in the private sector have increased significantly since the implementation of an insurance-based financing mechanism. The question of how the change in the nature of financing is affecting the health sector, and whether it can help in achieving the national goal of a healthy India, thus requires close examination.

5. Conclusion and Discussion

This paper highlights the fact that, especially in the post-liberalization phase, India has compromised the goal of comprehensive provision of public health services, something essential for creating a healthier society. Over time, the privatization of healthcare has not only been promoted, but has also been enabled to expand and grow further. The country's approach to the financing of healthcare has been shifting from the tax-funded provisioning of services, with a view to achieving universal health access, to tax-funded health insurance aimed merely at achieving health coverage. The insurance-based financing mechanism, however, has largely failed to deliver either in the area of health outcomes or in that of financial protection.

The model currently promoted in India, of financing healthcare through an insurance-based model, is to be funded almost entirely from public sources. A tax-funded insurance scheme will oblige the poor and members of the informal community to access services from accredited private as well as 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, and was directed toward financing the provision of services through the public health system. The insurance-based system that is now being promoted will receive finance in the same way as the public health sector. The difference lies in the fact that the provisioning will be shifted almost entirely to the private sector. This will lead to a further crisis in the public healthcare sector, especially with the emergence of private competitors.

The idea of the strategic purchasing of healthcare services from private providers, with payments made from insurance, is not based on sound empirical evidence. The empirical evidence suggests that insurance-based financing has hardly been successful in providing financial protection against the costs of ill health and in reducing the burden imposed on beneficiaries by out-of-pocket health payments. Studies have reported that families enrolled under the existing nationally representative insurance scheme (RSBY) have continued to incur OOP charges (Rathi, Mukherji, and Sen 2012; Devadasan et al. 2013), with the insurance doing little to reduce the OOP burden (Hooda 2017; Karan, Yip, and Mahal 2017; Karan, Selvaraj, and Mahal 2014). There has been no statistically significant effect on the probability of incurring outpatient expenses, or on the level of outpatient OOP charges. On the contrary, the likelihood of incurring OOP expenses (inpatient and outpatient) rose by 30% due to the RSBY, and was statistically significant. Although OOP spending levels did not change, the RSBY raised household non-medical spending by 5%. Ghosh and Gupta (2017) report that the RSBY has had hardly any effect in terms of financial protection. Households have ended up with higher OOP expenditure, incurring catastrophic burdens and even suffering impoverishment in districts where the penetration of these schemes has been high. Since the allegedly progressive insurance-based financing strategies were implemented, OOP expenditures have increased among households, irrespective of their poverty status (poor or well-off) and geographical location (rural or urban).

The impact of Rajiv Aarogyasri in Andhra Pradesh had relatively small impacts on outpatient OOP charges and catastrophic payments (Fan, Karan, and Mahal 2012). Nor has the RSBY provided any significant financial protection for poor households (Das and Leino 2011; Rajasekhar et al. 2011). A study by Ghosh and Gupta (2017) on healthcare access found that the RSBY has increased the utilization of inpatient care (hospitalization rate) by 59%, though there has been no significant impact on the utilization rate for outpatient care.

In sum, promoting the role of the private sector through insurance does not seem a great idea for achieving the national goal of universal health coverage. The impact of changes to the nature of financing on the achievement of this goal needs in-depth examination. This study advocates in favor of comprehensive healthcare provisions that ensure equitable, accessible and affordable healthcare services, and that protect households from the potentially devastating consequences of out-of-pocket payments.

Note

1. See also http://www.mmh-mms.org.mmh-mms.com/gesundheitsversorgung/primary-health-care-strategie/index.php.

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