Educational Research (ISSN: 2141-5161) Vol. 3(2) pp. 118-125 February 2012
Available online@ http://www.interesjournals.org/ER


*Review*

# Health sector reforms: Concepts, market based reforms and health inequity in India

**Hemant Deepak Shewade[1]* and Arun Kumar Aggarwal[2]**

[1]Senior Resident, School of Public Health, Postgraduate Institute of Medical Education and Research, Chandigarh, India. (At present working as Assistant Professor, Community Medicine, Indira Gandhi Medical College and Research Institute, Puducherry, India)
[2]Professor, School of Public Health, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Accepted 15 February, 2012

**Health sector reform is defined as sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector. Any change is not reform. Changes that affect at least two of the elements namely; health financing, expenditure, organization regulation and consumer behavior justify to be called as health sector reforms. Suggested reforms before introduction must undergo a feasibility and implementation analysis which includes the following components: implementability, political feasibility and political controllability. Health sector reforms in India were a direct outcome of the economic reforms post 1991. Economic reforms sought to achieve rapid economic development. It was thought that this effect would trickle down to health sector, which did not happen. Opening up of markets resulted in expansion of private health sector in India which largely remains unregulated. Even though evidence was available that market based health sector reforms were not able to achieve equity, it was pursued. Many states in India went for loan under the structural adjustment programme of the World Bank. User fee was introduced and free medical care was revoked. These changes in health financing only or donor driven changes that were non purposive are not health sector reforms in true sense. Decreased health spending, with decreased public health spending, inefficient expenditure of public spending, poor primary and secondary health care, high out of pocket expenditure, user fees, unregulated private sector and low financial protection all have led to failure of primary health care which has been replaced by market based health sector reforms. Market based health sector reforms need a human face to them. Changes in financing methods coupled with changes in health system organization and management with ongoing public sector reforms are effective health sector reforms.**

**Keywords:** Health sector reforms, inequity, health financing, privatization.

## Introduction: Health Sector Reforms

Reforms are inevitable part of a developing and progressive sector. The same applies to the health sector with the prevailing fiscal crunch forcing the health sector to reform in order to deliver in an effective, efficient and equitable manner. Cassels in 1997 defined reforms as 'Fundamental rather than an incremental change, which is sustained rather than one off and also purposive'. Hence, any change is not reform.

According to Berman, health sector reform is defined as a 'sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector'. It is also defined by Cassels as 'defining priorities, refining policies, reforming institutions through which policies are implemented'(Health Sector Reforms in India).The types of reforms can also be divided into those that are based on changes in financing methods, changes in health system organization and management, public sector reform (Health Sector Reforms in India) (Table 1). Another way of classifying reforms is: structural, programmatic, organizational and institutional reforms (Block et al., 2009).

*Corresponding Author E-mail: hemantjipmer@gmail.com

**Table 1.** Type of Reforms

| | |
|---|---|
| Changes in financing methods | User charges<br>Community financing schemes<br>Insurance<br>Stimulating private sector growth<br>Increased resources to health sector |
| Changes in health system organization and management | Decentralization<br>Contracting out of services<br>Reviewing the public-private mix |
| Public sector reforms | Downsizing the public sector<br>Productivity improvement<br>Introduction of competition<br>Improving geographic coverage<br>Increasing role of local government<br>Targeting role of public sector through packages of essential services |

## The Control Knobs in Health Reforms

In order to achieve the population level performance goals, five control knobs have been identified namely; financing, payment, organization, regulation and behavior (Roberts et al.,2004). Increase in efficiency, quality and access can be achieved by altering these control knobs leading to the ultimate population target of good health status, consumer satisfaction and risk protection. According to Hsiao, changes that affect at least two of these element namely; health financing, expenditure, organization regulation and consumer behavior justify to be called as health sector reforms. Health financing refers to the mechanisms for raising the money that funds the activities in the sector. Payment or Expenditure refers to the methods of transferring this money to the health care providers. This includes budgets, fees and capitations. Organization refers to the mechanisms affecting the mix of health care providers, their roles and how they operate within and among themselves. These mechanisms include measures leading to alteration in competition, decentralization and direct control of providers making up government service delivery. Regulation includes the use of coercive measures affecting the providers, insurance companies and patients. Behavior includes the efforts to influence the individual to act in relation to health and health care, including both patients and providers.

## Implementation of Health Reforms

Reform is a cyclical process. It does not end with itself. The cycle of problem definition, diagnosis, implementation, policy development, political decision, evaluation and problem definition is repetitive in nature (health reform cycle / policy cycle) (Roberts et al., 2004). Any reform is not a one-time solution. Problem definition and availability of resources change with time. Yesterdays reform can be today's problem based on current scenario, priorities and resources at hand. One must understand the role of politics in reforms. Politics has to be embraced and reforms have to be decided considering the political situation and the possible repercussions. Hence, the need for the suggested reforms to undergo a 'feasibility and implementation analysis'. These are also called as the 'Screening tests for health sector reforms'. The components of this analysis are; implementability, political feasibility and political controllability (Roberts et al., 2004).

Implementability includes the social and institutional prerequisites to support a proposed intervention. Smart reformers will not presume that an idea of a country will work in another country. Often, the most radical reforms are in the least equipped countries (Bjorkman, 2004). The concept of 'window of opportunity' should be kept in mind by the reformers. Anticipation of the political decision making and the mood in the ruling party, combined with effective advocacy gives any reform a good chance of being implemented, yet the outcome is not always certain. Reformers, hence, need to embrace politics, not shun it. A final consideration in reforms is political controllability. This includes whether the new arrangement or institutions will be under effective political control. The general argument is that political controllability must be there. The reasons being current efforts into reforms can also become an obstacle sometime later. Consumers through a democratic system should have the right to demand and get better performance form the system. On the other hand, lack of political controllability, in the long run can be undesirable. Lack of political controllability, obviously gives the reformers a chance for reforms to remain sustained; it also decreases the influence of special interest groups. This can be of use in short run and a risky long term strategy. The decision on political controllability also depends on the local situation (Roberts et al., 2004)

**Table 2.** Performance problems being addressed by reforms

| Performance Problem | Health Sector Reform |
|---|---|
| Failure of Pay clinics and auto finance schemes | Medical relief Societies, Community Health Centers (CHC), Rajasthan |
| BPL patients not receiving benefits | BPL cards in Uttarakhand |
| Frequent stock out of drugs | Streamlining drug procurement, Tamil Nadu Medical Services Corporation (TNMSC) |

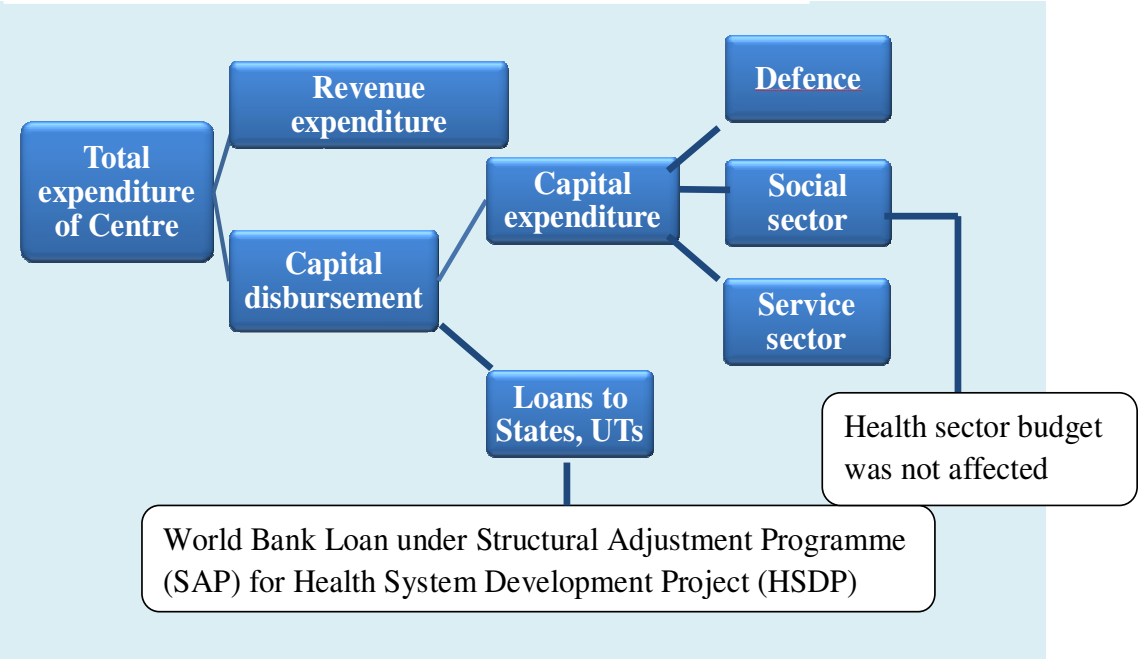



**Figure 1:** Distribution of Total Expenditure by Centre

## The Concept of 'Performance Problems

In health sector, certain targets might not be achieved despite having a system in place for the same. The performance of the system is hampered because of a certain problem. Health sector reforms address these performance problems (Table 2). In addition, reforms must be addressed to solve those performance problems for which a politically feasible and effective policy exists. To summarize: 'Start with what one want to accomplish and then see if there is a technically feasible and politically acceptable way of doing it' (Roberts et al., 2004).

## Origin of Reforms in India

Health Sector reforms in India were a direct outcome of economic reforms post 1991. Before this, the Indian economy was committed to socialism with slack foreign exchange flow. India followed planned economic development with a strong import substitute orientation. There was no balance of payment crisis till 1980s owing to the gulf boom and large worker remittances. With the oil crisis and an import dependent growth strategy there was a balance of payment crisis post gulf war in 1991. During this period, the social indicators too were poor. India had to go for loan under the Structural Adjustment Programme (SAP) of the World Bank (Narayana, 2008). The period also coincided with many other developing countries going for the World Bank loan. In the mean time there were two significant documents which later became the basis for reforms in many developing countries. One such document was 'Financing Health Services in Developing Countries' in 1987 by the World Bank. This document was a paradigm shift with respect to the role of government in health care provision. It called for introduction of user fee, insurance or other risk coverage, effective use of non government resources and decentralization. The World Development Report in 1993, 'Investing in Health' advocated the development of ideal environment for health, increased government spending and promoting diversity and promotion (Health Sector Reforms in India). With the fiscal deficit, the centre had to cut its total expenditure which fell more on the capital disbursement and the revenue expenditure remained unaltered (Figure 1). This led to a decrease in the

capital expenditure and decrease in the loans given to the States and the Union Territories (Narayana, 2008).

In the meantime, there were policy shifts in the five year plans. The eighth five year plan proposed revoking of free medical care and encouraged initiatives with private sector. The ninth five year plan emphasized the need to increase the involvement of voluntary, private organizations and the self-help groups and ensure inter-sectoral coordination. It also placed the need to enable Panchayati Raj Institutions (PRI) in planning and monitoring of health programmes. The tenth plan, in addition to the above points, recognized the need to address the issue of equity and the need to devise a targeting mechanism by which the population below the poverty line will have access to subsidized health care (Health Sector Reforms in India).

Despite the cut in central total expenditure in the form of capital expenditure, health sector remained relatively protected. There was increase in absolute spending on health post economic reforms, though the central health spending as a percent of GDP remained stagnant. The cut fell more on the service sector. As 50 % of the States' debt is to the Centre, total expenditure remained stagnant post 1991. The Interest of payment rose (as a percent of GDP); there was a decrease in discretionary spending. Spending on public health and water, sanitation decreased post economic reforms. Hence, the states had to go for loans form World Bank under the Structural Adjustment Programme. Seven states went for the Health System Development Project (HSDP) as a part of the structural adjustment between1994-97. Though the health system development project recognizes the need to increase the public spending on health, the public spending as a share of total spending decreased. The decline in spending on public health water and sanitation was milder in the reforming states. Fifteen percent of the cost of health system development project had to be borne by the states, which already had scarce resources. The loan came with a pre-condition that 65% of loan had to be used for strengthening of hospitals, institutions and purchasing equipment. Hence, the states couldn't use this money exclusively to improve primary health care.

Despite health being a state subject, tax resources are largely controlled by the centre. The planning and finance commission gives money to the states, but there is no mention in the constitution on the fixed proportional spending on health. The states with decreased central grant, submitted the most promising budget with the assurance of increasing health sector spending, privatization, introduction of user fee and decentralization. The HSDP was used by reforming states as a tool for leveraging external financing (Narayana, 2008). Structural adjustment pushed the states to cut health sector investments, opening up of medical care to private sector, introduction of user fee and private investments in public hospitals (Qadeer, 2000), therefore revoking free and affordable health care. Health sector spending remained stagnant with increase in health inequity.

Economic reforms sought to achieve rapid economic development, overall increase in productivity with free access to market, eliminate poverty and finally leading to improved standard of living (Health Sector Reforms in India). It was thought that this effect would trickle down to health sector, which did not happen (Qadeer, 2000). Even though evidence was available that market based health sector reforms were not able to achieve equity, it was pursued (Bennett et al 1994). These changes in health financing only or donor driven changes that were non purposive are not health sector reforms in true sense.

## Effect of Market based Health Sector Reform in India

### Market Oriented Pursuit of Equity

For perfect competition in the market there has to be no barrier to entry and exit; the goods must be homogenous throughout the market; and there must be large number of buyers and sellers with complete information across buyers and sellers. In this scenario, price of the goods tends to decrease as the producers become price takers. The opposite of perfect competition is monopoly, in which the producers become the price fixers. In the health sector there are barriers to entry and exit, goods are not homogenous throughout, there are limited number of sellers and there is lack of information among the buyers i.e., the patients. In such a scenario, perfect competition is difficult to achieve and it is not possible to attain health sector equity which is market driven. One can argue that opening up of market has increased competition among the private sector, but the counter point is that post economic reforms, corporate hospitals have blossomed who cater to a different set of people, leaving the general population to the private practitioner.

### Privatization

The private sector is the major provider of health care in India, but with a price. The decrease in public spending on health as a share of total spending (post structural adjustment) and opening up of the market was a fertile ground for private sector to invest in diagnostics and therapeutics. In the context of organization (one of the five control knobs), it is worth mentioning that private sector is largely unregulated in India. It came under the purview of Consumer Protection Act (COPRA) 1986. Of various regulations in place, this was the only one that included the patient perspective. The private sector was considered as 'contract service' unlike before where it was in the purview of 'personal service'. The const-

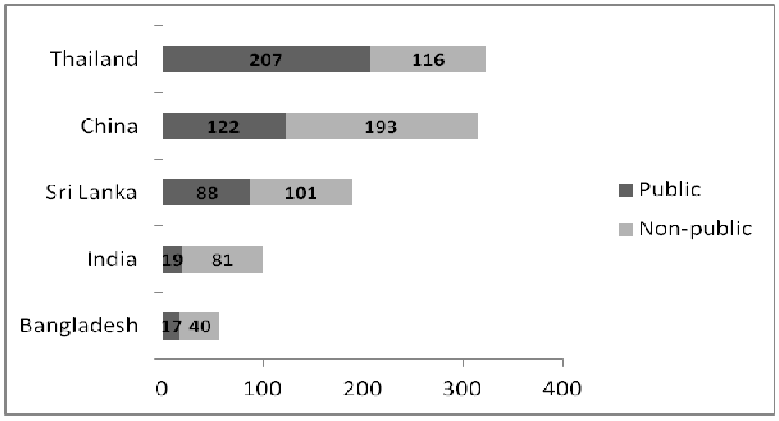



**Figure 2:** Health Expenditure (PPP$) in India and selected countries in 2005 (Kumar et al 2011)

raints for COPRA were that there was no data on providers, no standards in place. It was petitioner's responsibility to prove negligence and it being a highly technical field, there was a scope for subjectivity. COPRA while hearing cases in the consumer forum sought medical expert opinion. Those who were able to garner it, tended to win cases (especially doctors). There were certain desirable effects of COPRA 1986 which included increased awareness; increased concern for quality and information flow. The undesirable effects were increase of cost of care and diagnostics, as well as inappropriate care (Bhat, 1996). This made private health care unaffordable to majority of the population. 'Willingness to pay' has been taken as granted for 'ability to pay' via privatization. Privatization is not the only answer to strengthen health care delivery system in India (Aggarwal, 2008).

## Financing of Health Care in India

Health expenditure**:** Expenditure or payment is one of the five control knobs of health sector reforms. In India, the per person total expenditure in health, in purchasing power parity $ (2005) is 100$. It amounts to 6% of total expenditure. This is half of Sri Lanka's and one third of China and Thailand's total expenditure on health. Low overall health expenditure is further compounded with low public spending. This is despite the increase in income and tax collections. From 1993-94 to 2004-05 the per person increase (at 1993-94 prices) in income, tax collection and public health expenditure is 67%, 82% and 48% respectively (Kumar et al., 2011). The increase in public health expenditure is less than the increase in the financing. Public spending on health as a percentage of GDP in India, China and Sri Lanka is 0.95%, 1.82% and 1.89% respectively. In India, public health spending is 22% and out of pocket expenditure is 71% of the total health spending. India's public health expenditure (PPP$ 2005) is 22% of Srilanka, 16% of China and less than 10% of Thailand (World Health Statistics 2008) (Figure 2).

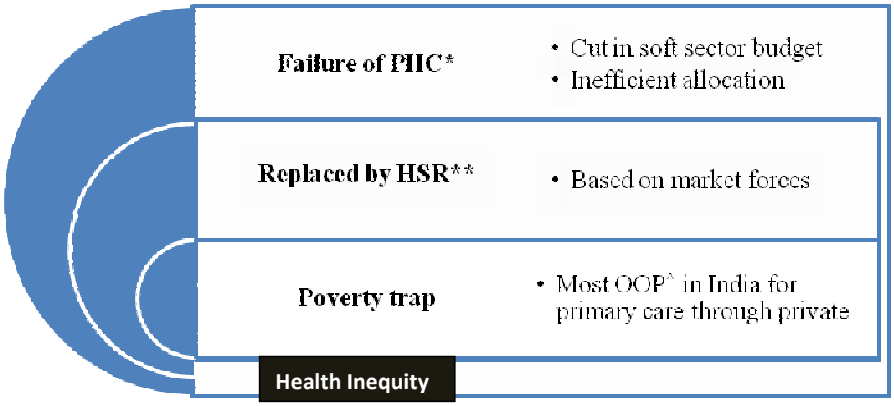
User fee**:** It is an alternate financing mechanism which is widely used in developing countries. Financing is one of the control knobs of health sector reforms. The maximum cost recovery that can be expected in health sector is not more than 15-20%. It is 3% for India. It has been used to increase revenue and supposedly decrease frivolous and costly use of health services (Creese and Kutzin, 1997). The problem with user fee is that it is not reviewed. There is weak administrative mechanism to manage user fee. Difficulty in targeting the poor for exemption and constraints to retention of funds at the facility are the other issues with user fees (A Comparative Review of Health Sector Reform in Four States: an Operational Perspective). Its overall effect has been decrease in resource utilization (Creese and Kutzin, 1997). Over a period of time, facilities tend to cater to those who can give user fee, with the being neglected. It must not be introduced with the narrow focus on revenue generation. In this context, mere reform in financing cannot be termed as health sector reform. User fee is an example of how reform is a cyclical process. After their introduction, it was realized that certain conditions must be met before cost recovery mechanisms are put in place.

- Retention at collecting facility and protocols in place for its use.
- Methods to revise fees
- System to identify below poverty line families so that they are not affected

Financial Protection**:** There has been a slow increase in financial protection in the form of insurance, be it social, community or private. According to NFHS 3, 10% of the Indian households are covered under any form of insurance. The reason for the slow increase being 93% of population is in unorganized sector and 77% of the population is poor and vulnerable (National Commission for Enterprises in the unorganised Sector). There are very few studies on Community based health insurance, in addition there is little information on impact (Devadasan et al., 2006).

**Table 3:** Proportion of Patients Quoting Poor Efficiency in India 2004-05

| | Rural (%) | Urban (%) |
|---|---|---|
| Not satisfied by Govt. doctor or facility | 41 | 45 |
| Large distance | 21 | 14 |
| Non availability of services / facilities | 30 | 26 |
| Private providers for OPD care | 78 | 81 |
| Private providers for in-patient care | 58 | 62 |




* Primary Health Care
**Health Sector Reforms
^ Out Of Pocket expenditure

**Figure 3.** Demise of Alma Ata Declaration (Hall et al 2003, Margaret et al 2001)

## Poor efficiency

It has been found that 28% of the ailments in rural area and 20% in urban went untreated. This has increased between 1994-95 and 2004-05 (Government of India. National Sample Survey Organization. Household consumption of various goods and services) At least half are not satisfied with government doctor or facility. Health facilities are not accessible especially in the rural areas. For OPD care, approximately 80% of the population goes to private providers. For in patient care, this figure is approximately 60%. There is no significant difference in rural and urban for both out-patient and in-patient care (Ministry of Health and Family Welfare, Government of India) (Table 3). Decreased health spending, with decreased public health spending, inefficient expenditure of public spending, poor primary and secondary health care, high out of pocket expenditure, user fees, unregulated private sector and low financial protection all have led to failure of primary health care which has been replaced by market based health sector reforms. In India, most of the out of pocket expenditure is on primary care through private sector (Hall and Taylor, 2003). Hence, the most affected is the poor, finally terminating into poverty trap and health inequity (Margaret et al., 2001) (Figure 3).

## Health Sector Reforms in India post Structural Adjustment

National Rural Health mission (2005-12) has been a paradigm shift in Indian health sector with a focus on improving health access, utility and coverage in rural areas. Of the total budget, the states have to contribute 15% which will increase to 25% after 2012. The target is to increase public spending on health to 2-3% of GDP. Financial reforms helped the states to efficiently spend the budget. Earlier states could not use the central grant for non salary recurring costs. Post-NRHM funds could be used in infrastructure to conform to IPHS standards. Funds are now directly issued to the State Health Missions. Flexi funds were created for every level of health care provision. Centrally Sponsored Innovational Health Cash Transfers was introduced to increase maternal health care utilization (World Health Statistics 2008). Governance related reforms were introduced into health sector. Decentralization in the form of 'devolution' upto district level led to development of District Action Plans according to the local needs. Panchayati Raj Institutions were involved in planning and monitoring. Indian Public Health Standards, standard treatment guidelines and quality assurance were additional governance related

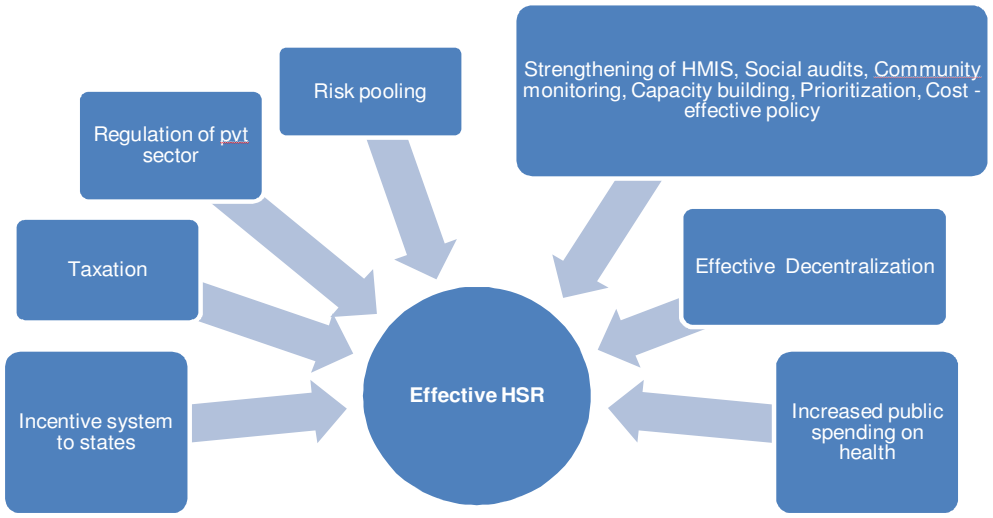



**Figure 4.** Way forward for effective health sector reforms (HSR)

reforms. Under structural and financial reforms, the focus was to strengthen primary health care. Horizontal integration of all health programmes, which will be under a common state health society, was introduced to decrease wasteful health expenditure. Strengthening of disease surveillance and capacity building were other structural and functional reforms. In addition, partnerships with NGOs and private sector were forged (Health Sector Reforms in India). Various state innovations in this period can be accessed through the Policy Reforms Option Database (PROD) website, being maintained by Central Bureau of Health Intelligence (CBHI).

Rashtriya Swasthya Bima Yojna (National Health Insurance Scheme) is the largest medical insurance scheme launched by the Ministry of Labor and Employment, in April 2008. The programme envisages covering all BPL families through smart cards. Upto five members in a family will be covered under this scheme. It covers present illness and age is not a restriction. Despite majority out of pocket payment being on primary health care in India, only hospital stay is covered upto Rs 30,000.

## Way Forward for Effective Health Sector Reforms

Changes in financing methods coupled with changes in health system organization and management with ongoing public sector reforms are effective health sector reforms. Market based health sector reforms need a human face to them. Creating open markets is not the only solution. Donor driven reforms are not reforms in true sense; rather they have increased the health inequity. It has been found that economic development does not always trickle down to health development.

Any health sector reform is senseless unless attention is paid to health system strengthening. The scenario would be similar to 'Playing Hockey without goal posts'. Health sector reforms, while trying to answer the 'performance problem', must not hide the underlying system deficit. Public health spending and quality must be increased with focus on primary and secondary health care along with regulation of private sector. Risk pooling mechanisms through single payer systems are necessary for universal financial protection. Decentralization in decision making must be accompanied with financial decentralization and capacity building. This effective decentralization is the way forward (Figure 4).

## REFERENCES

A Comparative Review of Health Sector Reform in Four States : an Operational Perspective. The World Bank Group [Internet]. [Accessed 2011 Jan 1]. Available from http://lnweb90.worldbank.org.

Aggarwal AK (2008). Strenghtening health care system in India: Is privatization the only answer ? Indian J. Community Med. 33(2):69-70.

Bhat R (1996). Regulating the private health care sector: the case of the Indian Consumer Protection Act. Health Policy Plan. 11(3):265-79.

Bjorkman JW (2004). Health Sector Reforms - Measures, Muddles, and Mires. In Rosenbaum A, Nemec J, Tolo K, editors. Health Care Delivery Systems: Opportunities for Public Management Education in CEE. Bratislava: NISPAcee. Pp. 11 – 26.

Block MAG, Lucas A, Dantes OG, Frenk J (2009). Public health policies in developing countries. In: Detels R, Beaglehole R, Lansang MA, Gulliford M, editors. Oxford textbook of public health. 5th ed. vol 1. New York: Oxford University Press. Pp 303.

Creese A, Kutzin J. (1997). Lessons from Cost-Recovery in Health. In: Colclough C, editor. Marketizing Education and Health in Developing Countries. Oxford: Clarendon Press. Also available as Discussion Paper No.2. (1995), Forum on Health Sector Reform. Geneva: World Health Organization, Division of Analysis, Research and Assessment.

Devadasan N, Ranson K, Damme WV, Acharya A, Criel B. (2006). The landscape of community health insurance in India: an overview based on 10 case studies. Health Policy. 78(2-3):224-34.

Government of India. National Sample Survey Organization. Household consumption of various goods and services in India 2004–05. Vol I: major states and all-India [Internet]. 2007. [Accessed 2011 Jan 1]. Available from http://mospi.nic.in/rept%20_%20pubn/ftest.asp?rept_id=509_P1&type=NSSO.

Hall JJ, Taylor R (2003). Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. Med J Aust. Jan 6;178(1):17-20.

Health Sector Reforms in India. Initiatives from Nine States. Vol. 1. p. i-x. [Internet] 2004 Aug. [Accessed 2011 Jan 1]. Available from http://whoindia. org.

Kumar AK, Chen LC, Choudhury M, Ganju S, Mahajan V, Sinha A (2011). Financing health care for all: challenges and opportunities. The Lancet. Feb 19;377(9766):668-79.

Margaret W, Göran D, Timothy E. (2001). Equity and health sector reforms: can low-income countries escape the medical poverty trap? The Lancet. 358(9284):833-836.

Ministry of Health and Family Welfare, Government of India. Select health parameters: a comparative analysis across the National Sample Survey Organization 42nd, 52nd, and 60th Rounds. [Internet]. 2007. [Accessed 2011 Jan 1]. Available from http://www.whoindia.org/LinkFiles/Health_Finance_NSSO_Report.pdf.

Narayana D (2008). Adjustment and health sector reforms: the solution to low public spending on health care in India? In: Haddad S, Baris E, Narayana D, editors. Safeguarding the health sector in times of macroeconomic instability. New Jersey and Ottawa: Africa World Press and International Development Research Center.

National Commission for Enterprises in the unorganised Sector. Report on the conditions of work and promotion of livelihoods in the unorganised sector [Internet]. 2007 Aug. [Accessed 2011 Jan 1]. Available from http://nceus.gov.in.

Policy Reform Option Database website [Internet]. [Accessed 2011 Jan 1]. Available from http://hsprodindia.nic.in/info.htm.

Qadeer I (2000). Health Care Systems in Transition III. India, Part I. The Indian Experience. Journal of Public Health Medicine. 22(1):25-32.

Roberts MJ, Hsiao W, Berman P, Reich MR (2004). Getting health reforms right. New York: Oxford University Press. p. 142-144.

Roberts MJ, Hsiao W, Berman P, Reich MR. (2004). Getting health reforms right. New York: Oxford University Press. Pp 21-39.

Roberts MJ, Hsiao W, Berman P, Reich MR. (2004). Getting health reforms right. New York: Oxford University Press. Pp. 121-125.

WHO. World Health Statistics 2008 [Internet]. 2008 [Accessed 2011 Jan 1]. Available from http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf.