



Review article

Health Care in India: Critical Analysis

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ABSTRACT

The objective of this paper is to critically analyse the Indian health care system, and illuminate the key challenges to the overall attainment of better health status for Indians. Such an analysis is timely because health care restructuring is high on the Indian political agenda and policy options are being continuously debated. This paper is expected to inform the health debate by offering useful insights and recommendations. This critical analysis focuses mainly on three dimensions of the Indian health care system, which are: structural parameters, intermediate outcome and ultimate outcome. The author recommends several policy and organizational changes in the system including; considering both public and private insurance models and their adapted versions rather than leaning toward greater role of private sector, considering separating drug prescription and dispensation adopting alternative reimbursement mechanisms, spending more resources on building primary health care facilities, improving horizontal and vertical coordination between various government branches and finally making quality assessment and evaluation an integral part of its health system.

KEY WORDS: Health Care, India, Analysis.

INTRODUCTION

Health is a major global concern, especially for the developing countries such as India, with an extremely large population, limited health resources, and with wide gaps in knowledge to actions. Over the past few decades, India has made substantial gains in health, including increased life expectancy, reduced infant mortality, and the eradication of several diseases. Despite these gains and India's amazing recent economic performance, the health status of Indian residents still lags behind that of other populations, while the health gains in India continue to be uneven across subpopulations.

This raises an important question: How can overall health status in this country be improved? One starting point in this regard is to critically analyse the Indian health care system, which can illuminate the key challenges to the overall attainment of better health status for Indians. Such an analysis is also timely because health care restructuring is high on the Indian political agenda and policy options are being continuously debated. Against this backdrop, this

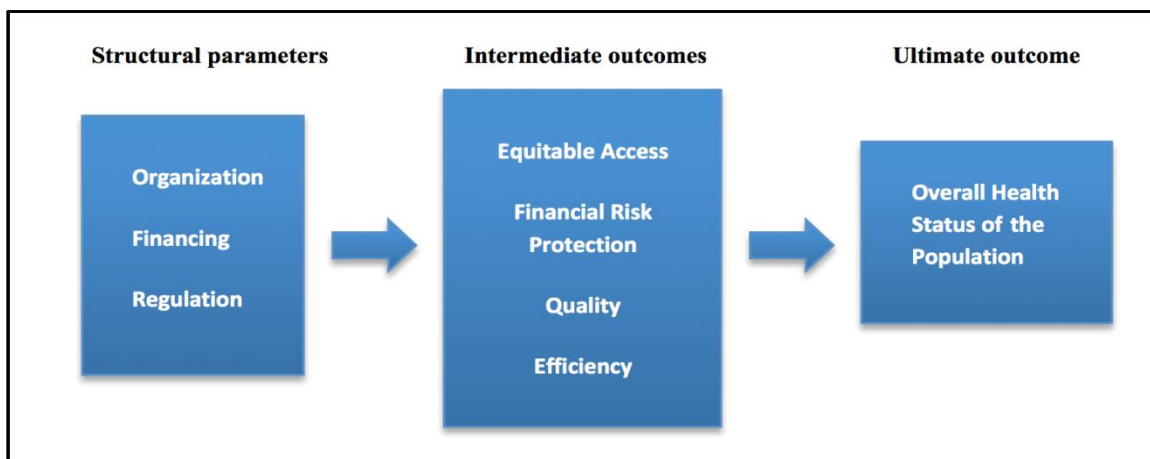
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CRITICAL ANALYSIS FRAMEWORK

In order to review the Indian health system, I am applying Hsiao's definition of health care system, which is: "A health system is defined by those principal causal components that can explain the system's outcomes. These components can be utilized as policy instruments to alter the outcomes"[1]. Given that this definition answers why and how a particular health system produces a set of outcomes, it provides a meaningful analytical framework for critical analysis and review of a health care system.

This critical analysis focuses mainly on three dimensions of the Indian health care system, which are: structural parameters, intermediate outcome and ultimate outcome. The figure below is a modified version of the analytical framework used by Dataret al. demonstrates each dimension along with its critical components[2].

Figure 1: Analytic Framework

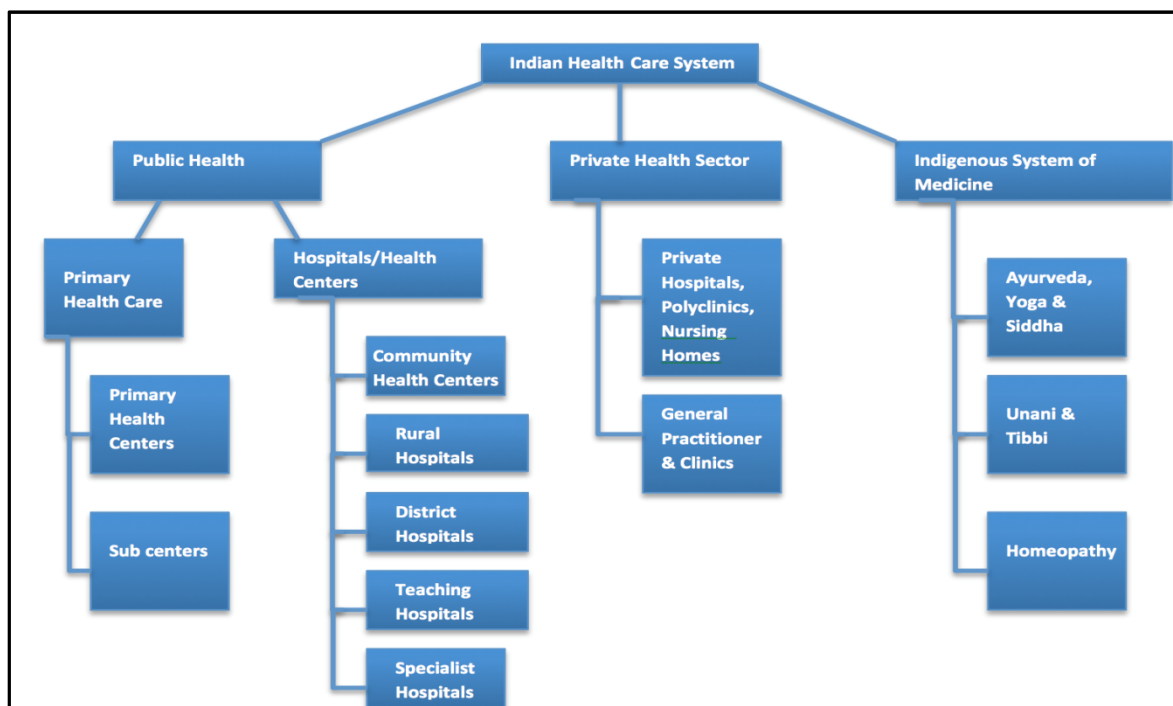


ORGANIZATION

Described as "policy levers" by Datar et al. [2], the structural parameters listed above directly or indirectly affect the health status and health care. As for intermediate outcomes, the important among them are: equitable access to health care, level of financial risk protection against health risk between different population subgroups (the employed, unemployed, those with limited financial means and those with higher needs), efficiency of the system in addressing needs, and the quality of care. Finally, I will analyze how completely the health system achieves its ultimate end, which is improving the overall health status of the population.

The quality and the efficiency of health services depend on the organization and management of the health care system. According to Hsiao, organization refers to "the broad structure that organizes health care provision, including ownership, market competition, decentralization, and vertical integration"[1]. India has a mixed health care system consisting of both public and private health care systems. In the public domain, India has developed a three-tiered system: Central Ministries of Health and Family Welfare, State Ministries of Health and Family Welfare and the District Health Teams. The figure below provides a comprehensive picture of various health sectors in India.

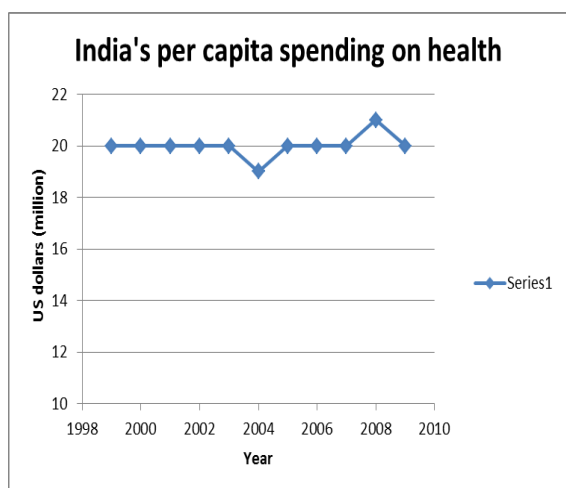
Figure 2: Indian health care system



Initially, public health care system (PHCs) was designed to provide basic medical care, disease prevention services, and health education[2]. However, since the early 1990s, PHCs have witnessed a decline in funding for infectious-disease control programs. There was a 16% funding decline for the control of communicable diseases between 1980 and 1997. Therefore, PHCs have fundamentally shifted their focus to family planning services[3]. In light of this trend, there are rising concerns about the disruptions in general health care services due to the effect of vertical health programs such as family planning and polio eradication [4].

Moreover, because of India's public health system being continuously underfunded, the need for health care services has been filled by a large number of heterogeneous, private health care providers that operate on a fee for service basis. Thus, the private sector dominates India's health system. For example, in 2007, more than 80 percent of all health expenditures occurred in private health facilities

Figure: 3 Per capita spending (W.H.O.,2010)



India was ranked 42nd in having the highest average out of pocket payments (OOPE).[9] According to Gupta, OOPE accounts for an average increase in poverty by as much as 3.6 and 2.9 percent for rural and urban India respectively[10]. Therefore, a key drawback of OOPE consists in not pooling risk and in placing greater financial burden on the poor and the sick and their families. However, in recent years, policymakers in India have focused on the potential to use private or social health insurance and a variety of community-based health insurance schemes to pool risk, reduce the burden on the poor, and ensure equity [11].

In summary, Indian health care system's financing relies heavily on out-of-pocket payments and faces the challenge of reducing the burden of health care costs on the marginalized sections of society such as the poor.

REGULATION

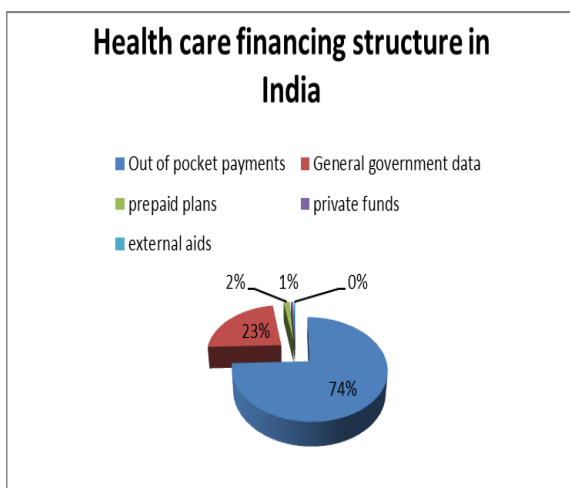
Regulation is fundamental to the success of a health system because "it reduces exposure to disease through enforcement

[5]. Approximately 70 percent of hospitals are private, and 60 to 79 percent of qualified doctors work in the private sector [6], [7].

FINANCING

Health care in India is normally financed through general revenue, social insurance, private insurance, community financing, and out-of-pocket payments. India spent 4.1 percent of its gross domestic product (GDP) on health care in 2010. Figure 1, depicts that India's per capita total spending on health between 1999 and 2009, has remained stable. Further, as shown in figure 2, the proportion of total medical spending paid out of pocket (OoPE) in India in 2011 was high at 74.4 percent. While the general government expenditure in India constituted the second largest financing source (23 percent), the remaining sources—prepaid plans, other private funds, and external aid—constituted nearly 2 percent of the total health spending in India[8].

Figure: 4 Health care financing (W.H.O.,2010)



of sanitary code, ensures the timely follow up of health hazards, and monitors the quality of medical services and

products"[10]. According to the Indian Constitution, three lists—the Union list, the State list, and the Concurrent list—specify health care responsibilities of the central government and the state government. The Concurrent list describes the responsibilities that are shared between central and state governments. Although public health is considered a state subject in India, the policy development and program design are centralized[10].

This regulatory structure has not been regarded as much effective. A World Bank survey report ranked the regulation and enforcement as the second worst among essential public health functions[10]. The survey participants expressed major concerns about the Ministry of Health and Family Welfare's capability for monitoring legislation, enforcing laws and regulations and partnering with state governments functions[10].

As for private health providers and insurers, the Indian government has adopted a "laissez-faire" policy. Lack of

public regulation, mandatory registration requirement, service evaluations and quality control measures raises questions about the quality of care provided by the public health sector[3], [7]. In addition, a large number of private practitioners and providers do not belong to professional bodies such as the Medical Council of India (MCI) that govern the medical profession by providing a code of conduct for practitioners; therefore, individual practitioners have freedom to practice as they choose[6]. This in turn makes it difficult for the MCI to monitor and ban the use of any harmful technology or drug by unaccountable practitioners[3].

In summary, India lacks a coherent regulatory framework. Regulation of the private sector is laissez-faire, laws are less stringent and are loosely enforced in both the private and public sectors.

EQUITY IN ACCESS

Patients in India face access-to-care challenges. In 2007 there were significant deficits at each level of health facility. "There were 10 percent less secondary and primary health care centers than needed and 50 percent less community health centers than needed"[2]. One of the key reasons behind the access-to-care challenge is the inadequacy of transportation services. This is a serious barrier, particularly in rural and remote areas where public transportation is irregular and infrequent, while private transportation is very expensive [7]. According to Dataret al.[2], a poor rural resident, despite graver health problem, is six times less likely to access a hospital than a financially well-off urban resident. In light of these inequalities, the proportion of children living in villages with no health facility has increased from 43 to 47 percent[2]. However, in few areas, the gap appears to be becoming narrower. For example, in the case of child immunization in India, the gap between the proportion of rural children, compared with urban children who received at least one vaccine has narrowed, falling from 18 to 12 percent[2]. In addition to transportation-related barriers, out of pocket payments, which account for more than 75% of health care expenses, prevent both rural and the urban residents from seeking health care[7].

In summary, Indian residents have poor access to health care because of such reasons as the lack of transportation facilities and the inability to afford health care costs.

QUALITY AND EFFICIENCY

Though regular evaluation and assessment of quality is considered an important part of any health system, India lack national or regional structures for conducting routine quality assessments. However, there is evidence suggesting that India is plagued by the underuse of key public health services and the supply-induced overutilization of new technologies[2]. Bhatia and Cleland acknowledged that although private health care system provides better care in terms of thoroughness of diagnosis and superior doctor-patient communication, over prescription and unnecessary interventions are commonly observed in this sector[12].

Further, there is a disconnection between horizontal health services (i.e., regular health services) and vertical control programs (i.e., specific disease control programs such as polio eradication). Researchers argue that, on the one hand these vertical control programs are helpful in reducing the disease specific burden in short time, on the other hand these programs often lead to disruptions in routine primary health care provision[13].

In summary, care provided by the public sector in India is consistently described as poor, while the care provided by the private sector is often highly expensive and inequitable[12], [14].

FINANCIAL RISK PROTECTION

WHO argues that one of the "most important goals of health systems is to distribute and reduce risks throughout society"[15]. Unfortunately, the health systems in India provide little protection from financial risk. As discussed earlier in this paper, out of pocket medical expenses have become an important cause of transient poverty in India. Studies in this regard found that medical expenses were one of the three main factors pushing people into poverty[16].

In fact, numerous factors exacerbate health care costs in India, such as lack of well-developed health-insurance schemes, lack of access to affordable care means, turning people off from preventive and other necessary primary care. Consequently, people seek care mostly when they report a more serious medical condition[2]. In addition, overutilization of services and care (i.e. expensive and unnecessary diagnostic procedures) by the physicians further increases the financial burden of care.

ULTIMATE OUTCOME-HEALTH STATUS

According to WHO statistics, 2010[8], female and male life expectancies at birth are 67 years and 64 years respectively in India. This is far below the life expectancies of people living in Canada and other developed countries. Additionally, people in India have higher mortality rates in both childhood and adulthood than people in the developed world.

Further, other vital health indicators also reflect the poor health status of Indian residents. For example, the number of deaths due to communicable diseases is very high in India. In general, communicable and non-communicable diseases individually cause more than 40 percent of all deaths. India had the largest number of people living with HIV outside South Africa—2.4 million in 2009. However, with regard to malaria, 1124 cases per 100,000 of population were reported in 2010, which indicate approximately 50 percent reduction since 1997. Further, obesity and diabetes are fast-growing health concerns in India. Based on data from the 2007 National Family Health Survey[17], 12.1% male and 16% females in India are obese. Further, India ranks first in world with the largest number (over 50 million) of people diagnosed diabetic. Moreover, the number of diabetics in India is projected to reach over 80 million by 2030.

Moreover, there is evidence of widening inequalities in health status between rural and urban residents. For

example, a child in the 'Low standard of living' economic group is almost four times more likely to die in childhood than a child in a better off high standard living group. The infant mortality rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population[8].

CONCLUSION

In light of above-mentioned facts and key challenges faced by Indian health care system, the author recommends several policy and organizational changes in the system. First, in order to meet diverse needs and reduce out of pocket burden, Indian health care system should consider both public and private insurance models and their adapted versions rather than leaning toward greater role of private sector. Second, to reduce the overutilization of services, the system should move away from regulated prices and fee-for-service type contracts. India should consider separating drug prescription and dispensation and should adopt alternative reimbursement mechanisms (such as the prospective payment model adopted by Medicare in the United States).

Third, in order to increase access to health care, India needs to spend more resources on building primary health care facilities, especially those that provide preventive and basic curative care. Access to care in the rural areas can be improved through such measures as education, screening, immunization, and transportation assistance. Fourth, the existing health facilities require more resources/funding and better management, including improvements in horizontal and vertical coordination between various government branches. Finally, to ensure quality of care, India must make quality assessment and evaluation an integral part of its health system.

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