

India - Private Health Services for the Poor

Policy Note

Ismail Radwan

May 2005



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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

India - Private Health Services for the Poor A Policy Note

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Abstract: Despite India's great strides since Independence, fertility, mortality and morbidity remain unacceptably high. Although poverty and low levels of education are the root causes of poor health outcomes, poor stewardship over the health system bears some responsibility. Although India's states exhibit a wide variation in health outcomes, all but the best-performing states need to focus on improving both sexual and reproductive health care and child health care and on reducing communicable diseases for the poor. This paper examines the public and private responses to this situation detailing the reasons behind the failure of the public sector and ways in which the private sector can be encouraged to play a role in providing health care for the poor in India. The paper concludes that there are three promising areas for the private sector including; (i) contracting out the primary health centers, (ii) social franchising and (iii) demand-led financing. The study is focused on *what to* do to improve health care for the poor, while a series of separate background papers focus on *how to* do it and state specific issues in Andhra Pradesh, Bihar, Karnataka, and Punjab.

Keywords: private sector, health care, social franchising, contracting out, maternal and child health care, India, the poor.

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The mission team would like to take this opportunity to thank the government officials in all four states visited as well as Delhi for their interest, cooperation, and support throughout the study. They are mentioned by name in the individual state background papers that accompany this report. We hope that this policy note and the accompanying background papers will prove a valuable instrument to further the reform process across India with a view to securing improved health outcomes for India's poor.

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Preface

Why Are We Doing This Study?

Although India has made great strides since Independence, fertility, mortality, and morbidity remain unacceptably high compared to both countries in the region and those at similar income levels. Almost a third of the Indian population lives in poverty. The effect of poverty on health care—and vice versa—is significant.

Achieving National Health Targets and the related Millennium Development Goals will entail addressing challenges to the existing health system (see table 1).

Table 1. The Millennium Development Goals and How They Relate to India

| <i>Millennium Development Goal</i> | <i>1990</i> | <i>2000</i> | <i>2015</i> | <i>Reduction remaining</i> |
|---|-------------|-------------|-------------|----------------------------|
| Eradicate extreme poverty Population below poverty line (millions) | 347 | 296 | 174 | 122 |
| Reduce infant mortality Infant mortality rate (per 1,000 live births) | 80 | 69 | 27 | 61% |
| Improve maternal health Maternal mortality ratio (per 100,000 live births) ^a | >440 | 440 | ~110 | 75% |
| Combat diseases Incidence of tuberculosis (per 100,000 people) ^b | >185 | 185 | <185 | Disease halted and reduced |

^a Modeled estimates, 1990 numbers assumed to be greater than 2000 estimate.

^b Author's estimates.

Sources: Millennium Development Goal statistics and author's estimates.

Although the root causes of poor health outcomes are poverty and low levels of education, government stewardship of the health sector bears some responsibility. Since Independence, public financing and provision of health care services have been the main foundation of health care policy. Public sector health programs in India have faced well-recognized problems, such as inadequate access by the most vulnerable groups, poor quality and coverage of primary and secondary facilities, and—until recently—excessive focus on sterilization and inadequate focus on maternal and child health.

The private sector has filled this gap. At Independence, the private sector accounted for just 8 percent of health care facilities. That figure had risen to 60 percent by the early 1990s. Evidence is mounting that the private sector provides an increasing share of primary health care and that large segments of the poor use the private sector.

Until recently, governments have not explicitly recognized their responsibility for health policies outside the public sector. To date, private health care institutions in India have, therefore, grown in the absence of an explicit policy to define their role, which has raised questions regarding the quality and legality of care as well as the exploitation of the poor. Recently, the Indian government requested World Bank support in addressing these challenges. This study aims at presenting policymakers with suggestions for addressing this situation.

What Questions Will This Study Answer?

This study seeks to answer the following question:

Given the importance of the private health care financing and provision of services, how can the government of India better use the private sector in delivering health services to the poor?

Within that broad framework, three policy questions are of particular interest to the government of India-

- How to increase coverage for the poor, especially for essential health care priorities? The most important health goals both for the government of India and from the perspective of the poor are assumed to be those captured by the Millennium Development Goals.¹ Many states, especially the poorer ones, that have developed their own state health plans have indeed adopted these goals.
- How to improve the quality of care for the poor? A significant number of private health care providers in India (especially in the rural areas) are untrained practitioners. Although reliable data on their numbers are difficult to compile, it has been estimated that they number well over 1.25 million. The vast majority of these providers are not registered, qualified, or regulated. Evidence shows that the quality of care they provide is extremely low and can at times actually harm the health status of the patients. The Supreme Court has ruled their operations to be illegal and labeled them “quacks” (Peters and others 2002, 156). This highlights the need for a sensible government policy toward this sector.
- How to reduce expenses for the poor? Due to well-known asymmetries of information, the poor are especially vulnerable to exploitative charging practices. Without access to affordable health insurance, they face the largest health care bills as a proportion of their income. Moreover, they face the largest out-of-pocket expenses, which can often lead them into an unsustainable spiral of indebtedness and increasing poverty. Given this situation, how should the government respond?

What Should Be Done?

Within that broader context, this study seeks to provide some suggestions to policymakers on these important questions. This study presents high-level information on the issues at a national level, drawing on examples from various states in India.

How Can It Be Done?

Although this study points to what should be done, more in-depth case studies and manuals have been developed as background papers to this study. They present

- State-level assessments of Andhra Pradesh, Bihar, Karnataka, and Punjab. Those states were selected to give an overview of poor, intermediate, and richer states, as well as to feed into current World Bank–supported state health systems projects and other state-level initiatives.
- Guides to contracting for primary health care and social franchising.
- International case studies on the use of vouchers, health insurance, and self-help groups. It is hoped that these background documents will provide interested policymakers with concrete suggestions and a guide to how they can be implemented.

¹ These goals are reducing child mortality, reducing maternal mortality and improving reproductive health, combating communicable diseases (especially tuberculosis, malaria, and HIV/AIDS), and eradicating malnutrition.

Abbreviations and Acronyms

| | |
|--------|---|
| AIDS | Acquired immune deficiency syndrome |
| ANM | Auxiliary nurse midwife |
| BIMARU | Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh |
| BPL | Below poverty line |
| CBHI | Community-based health insurance |
| CHC | Community health center |
| DALY | Disability-adjusted life years |
| ESIS | Employees State Insurance Scheme |
| GDP | Gross domestic product |
| HIV | Human immunodeficiency virus |
| HMIS | Health management information system |
| IMR | Infant mortality rate |
| MDG | Millennium Development Goals |
| MMR | Maternal mortality rate |
| MSA | Medical savings account |
| NFHS | National Family and Health Survey |
| NFP | Not for profit |
| NGO | Nongovernmental organization |
| NIC | National Insurance Corporation |
| PHC | Primary health center |
| PHSC | Punjab Health Systems Corporation |
| PHU | Primary Health Unit |
| PSD | Private sector development |
| RMP | Rural medical provider |
| SC/ST | Scheduled caste/scheduled tribe |
| SHG | Self-help group |
| TPA | Third-party administrator |
| UHC | Urban health center |
| UHS | Universal Health Insurance Scheme |
| UNDP | United Nations Development Programme |

1 INTRODUCTION TO THE HEALTH CHARACTERISTICS OF THE POOR

Who Are the Poor?

It is estimated that approximately 29 percent of the Indian population lives below the poverty line (World Bank 2003). This figure accounts for more than 290 million people, or nearly 25 percent of the world's poor population. Although India has made significant progress in reducing poverty (down from an estimated 36 percent in 1993/94), a considerable challenge remains. To meet the Millennium Development Goals (MDGs), India will need to reduce the number of people living in poverty by an additional 123 million people by 2015.

The poor are concentrated in rural areas in the north, where they are predominantly engaged in agricultural activities. On average, the poor have lower levels of education than the general population and suffer from higher disease prevalence. Women are typically more disadvantaged than men in socioeconomic status. They are less literate and suffer from poor health care and a high rate of maternal mortality. The poor have less access to health facilities than the general population, and they have very low access to clean water and sanitation. Scheduled castes and tribes are overrepresented in below-poverty-line (BPL) households. More than 65 percent of scheduled caste/scheduled tribe (SC/ST) households live below the poverty line.²

The effect of poverty on health care—and vice versa—is significant. Studies have shown that the poor in India are disproportionately affected by disease and have limited access to adequate medical services. High illiteracy rates, limited access to safe water, and poor sanitation all contribute to the terrible state of health in which many of the poor live. Although India has made significant strides toward improving the overall health condition of its people, a substantial unmet demand for basic health services remains.

What Are the Health Characteristics of the Poor?

National Health Status

India has made considerable progress in reducing fertility, mortality, and morbidity since Independence. India's efforts to generate growth and reduce poverty have been rewarded with tremendous improvements in key health outcome indicators (see figure 1.1). However, key health indicators remain unacceptably high compared both with countries in the region and with those at similar income levels (see table 1.1).

Table 1.1. Burden of Disease: Disability-Adjusted Life Years (DALYs) per Thousand Population Lost to Mortality and Disability

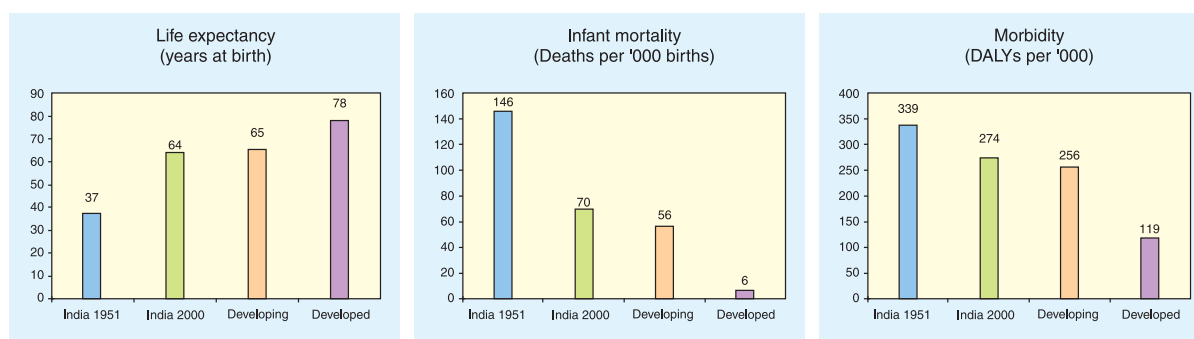
Lost DALYs per 1,000 population

| <i>Country or region</i> | <i>Mortality</i> | <i>Disability</i> | <i>Total</i> | <i>Percentage of total lost at ages 0–4</i> |
|--------------------------|------------------|-------------------|--------------|---|
| India | 235 | 103 | 339 | 45 |
| China | 104 | 80 | 184 | 24 |
| Other Asia | 168 | 92 | 260 | 38 |
| Middle East | 209 | 91 | 300 | 50 |

Sources: Murray and Lopez (1996). Also quoted in World Bank (1999).

² Appendix A presents a fuller analysis of poverty in India for those not familiar with the country situation.

Figure 1.1 : Health Improvements since Independence



Sources : ICRA Indian Health Care Industry (2003) and McKinsey : Health Care in India.

Subnational Health Status

Within India, wide disparities exist in health status among states (see table 1.2). A few states, such as Kerala, Maharashtra, and Tamil Nadu, are far above the country average and, in certain cases, close to the averages in industrial countries. Others, such as Bihar, Orissa, and Uttar Pradesh, lag far behind. High incomes and low poverty levels alone cannot secure the best health outcomes. Despite being the richest state and reducing poverty to just 6 percent, Punjab has health indicators that are only a little better than the national averages. This statistic implies that the health system does make a difference and that different states will have to focus on different health priorities.

Table 1.2. Key Health Indicators for India and Selected States

| State | Income (Rs per capita for 2001/02) | Poverty (headcount ratio for 1999/2000) | Infant mortality rate (per 1,000 births) | Maternal mortality rate (per 100,000 population) | Immunization (percent of population fully immunized) | Malnutrition (weight for age) |
|----------------|------------------------------------|---|--|--|--|-------------------------------|
| All India | 20,198 | 26.1 | 67.6 | 453 | 53.3 | 45.5 |
| Andhra Pradesh | 20,112 | 15.8 | 65.8 | 436 | 59.0 | 38.6 |
| Bihar | 6,006 | 42.6 | 72.9 | 452 | 11.18 | 54.3 |
| Karnataka | 22,816 | 20.0 | 51.5 | 450 | 60.0 | 36.6 |
| Kerala | 26,603 | 12.7 | 16.3 | 87 | 79.7 | 21.9 |
| Marahastra | 29,873 | 25.0 | 43.78 | 336 | 78.4 | 39.9 |
| Orissa | 11,093 | 47.2 | 90 | 367 | 44.0 | 54.1 |
| Punjab | 29,973 | 6.2 | 57.1 | 369 | 72.1 | 39.2 |
| Tamil Nadu | 23,414 | 21.1 | 48.2 | 376 | 88.8 | 29.4 |
| Uttar Pradesh | 12,038 | 33.0 | 82 | 707 | 44.0 | 51.7 |
| West Bengal | 20,039 | 27.0 | 48.7 | 389 | 43.8 | 41.5 |

Sources: State gross national product and poverty count: World Bank draft Punjab Economic Report; infant mortality rate: National Family Health Survey 1998/99; maternal mortality rate: UNICEF (1995).

Major Challenges: Communicable Diseases, Maternity, and Nutrition

India's states are at different stages of the epidemiological and demographic transition. However, a burden-of-disease analysis indicates that all states still need to focus on Group I diseases. Group I diseases include pretransition disorders such as communicable diseases and maternal and perinatal nutritional deficiency. Groups II and III include noncommunicable diseases plus injuries and accidents, respectively. Table 1.3 indicates the relative burden of disease caused by type of disease.

Table 1.3. DALYs Lost per Thousand Population, by Major Cause Groups in Rural and Urban Areas

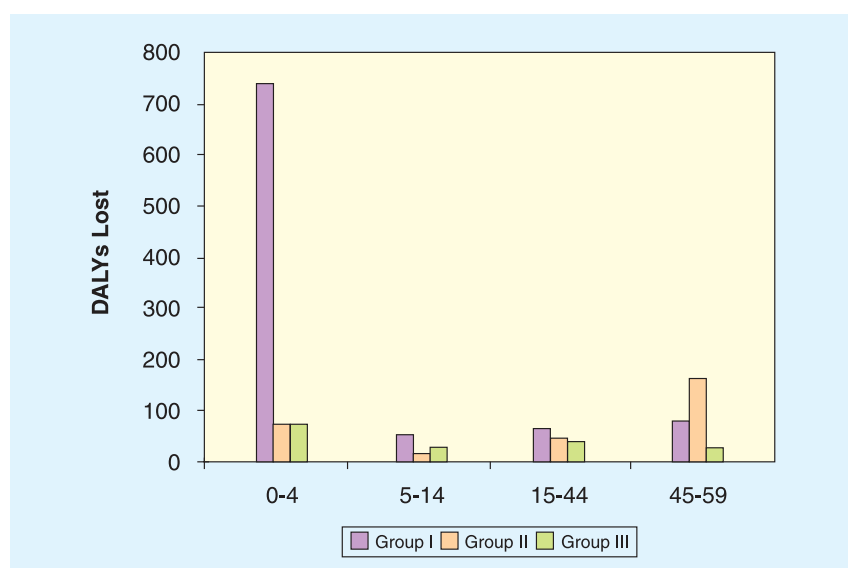
| State | Rural groups | | | Urban groups | | |
|----------------|--------------|----------|-----------|--------------|----------|-----------|
| | Group I | Group II | Group III | Group I | Group II | Group III |
| Andhra Pradesh | 160.04 | 81.46 | 47.23 | 97.67 | 74.25 | 30.45 |
| Karnataka | 165.56 | 72.78 | 43.24 | 109.90 | 50.27 | 22.13 |
| Maharashtra | 148.29 | 72.25 | 41.54 | 100.74 | 47.87 | 18.31 |
| Punjab | 134.41 | 73.51 | 43.86 | 114.39 | 56.15 | 32.08 |
| West Bengal | 164.60 | 69.14 | 44.03 | 96.66 | 53.84 | 20.29 |

Source: ASCI (2001).

The Need to Improve Maternal and Child Health Care

The highest incidence of lost disability-adjusted life years (DALYs) is among children ages 0 to 4 years who succumb to communicable diseases. Figure 1.2 presents data for Andhra Pradesh but is representative of the whole country. These data argue strongly for increased resource allocation to sexual, reproductive, and child health care; to immunization; and to improved nutrition. Future reforms and initiatives to strengthen the health care system must give priority to those areas and to the primary sector in general.

Figure 1.2 : Distribution of DALYs Lost by Age Group in Andhra Pradesh



Source: ASCI (2001).

India's Major Diseases

India has a disproportionately higher rate of acute respiratory infections and diarrheal disease per capita than the rest of the world has (table 1.4). Many diseases prevalent in India, such as tuberculosis, diarrhea, and measles, affect the poor more than the nonpoor, and the diseases are preventable with inexpensive and simple interventions. In many states, perinatal mortality causes account for about 20 percent of Group I DALYs; moreover, maternity and related conditions account for 10 percent of Group I DALYs in the female population. Tackling India's burden of disease will require a focus on primary health care and on efforts to improve maternal and child health care, including an increase in the proportion of children who are immunized and a reduction in communicable diseases. All those areas are targeted by the MDGs. Such improvements will require improvements in the current primary health care system, as well as a strengthening of emergency obstetric care at the secondary and tertiary levels.

Table 1.4. Top 10 Specific Causes of Lost DALYs in India, 1998

| <i>Causes of lost</i> | <i>Number of lost DALYs</i> | <i>Percentage of DALYs</i> | <i>India's percentage of the all causes world lost DALYs</i> |
|------------------------------------|-----------------------------|----------------------------|--|
| Acute lower respiratory infections | 24,806 | 9.2 | 30.1 |
| Diarrheal disease | 22,005 | 8.2 | 30.1 |
| Ischemic heart disease | 11,697 | 4.3 | 22.5 |
| Falls (injuries) | 10,898 | 4.1 | 40.3 |
| Unipolar major depression | 9,679 | 3.6 | 16.6 |
| Tuberculosis | 7,577 | 2.8 | 26.9 |
| Road traffic injuries | 7,204 | 2.7 | 18.5 |
| Measles | 6,474 | 2.4 | 21.4 |
| Anemia | 6,302 | 2.3 | 25.5 |
| Fire-related injuries | 5,723 | 2.1 | 47.8 |
| All causes | 268,953 | 100.0 | 19.5 |
| Population (thousands) | 982,223 | 100.0 | 16.7 |

Source: WHO (1999).

Although HIV/AIDS infection rates on a per capita basis in India are below the world average, in some states (such as Andhra Pradesh and Karnataka) the disease has begun to spread beyond the high-risk groups and into the general population. HIV/AIDS infections are concentrated primarily in the urban areas and are not yet a major health concern in rural communities. HIV/AIDS education, however, is critical to prevent the spread of the disease into those communities. Studies have shown that HIV/AIDS awareness is very low among poor communities.

What Are the Implications for Health Service Delivery?*The Need to Focus on Primary Health Care*

Given the situation described in the previous section, the primary health care system will clearly play the most important role in reducing the burden of disease through prevention, promotion,

and curative services, as appropriate. It is important that the primary health care system function efficiently, providing all children with all vaccines, providing all pregnant women with a full program of antenatal care and a location for safe institutional delivery, and meeting the demand for family planning services. The primary health care system should also provide a first port of call for the sick and an effective referral system. Within primary health care, governments should focus on sexual, reproductive, and child health. A sound and functioning primary system would then need to be supported with improved emergency obstetric care available at the secondary and tertiary levels.

The Need to Focus on Nutrition and Sexual, Reproductive, and Child Health

Providing health care for the poor means focusing on areas that most strongly affect the poor. Coverage levels diverge widely between the richest and poorest segments of society with respect to key interventions, such as antenatal care provision, contraceptive prevalence, and institutional deliveries. The poorest population quintile has fertility rates of 4.1 children per woman, and the richest quintile has fertility rates of 2.1 (World Bank 2003). Increased fertility only increases the level of poverty caused by the increased financial burdens that accompany larger family sizes.

Almost half the poor children in India are not immunized at all (World Bank 2002, p. 53). This statistic stands in stark contrast to the wealthiest segment, in which less than 8 percent of children were not immunized (see table 1.5). The BIMARU region (consisting of Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh) has the lowest rates of immunization in the country. Tuberculosis and measles—diseases that can be easily prevented provided that the adequate immunization is administered—are among the top 10 causes of lost DALYs in India (see table 1.4).

Table 1.5. Comparison of Health Status of Children in India (percent)

| <i>Condition</i> | <i>Poorest quintile</i> | <i>2nd quintile</i> | <i>3rd quintile</i> | <i>4th quintile</i> | <i>Wealthiest quintile</i> | <i>Total</i> |
|---------------------------|-------------------------|---------------------|---------------------|---------------------|----------------------------|--------------|
| Malnutrition ^a | 55.6 | 54.0 | 48.6 | 43.4 | 30.9 | 47.1 |
| No immunization | 48.4 | 40.8 | 27.5 | 18.0 | 7.9 | 30.0 |
| All immunizations | 17.1 | 21.7 | 34.7 | 48.2 | 65.0 | 35.4 |

^a As measured by stunting versus height for age.

Source: World Bank (2002, p. 53).

Almost half of Indian children suffer from some form of malnutrition, and diseases and symptoms resulting from malnutrition, such as stunting and wasting, are prevalent in the rural communities, especially in poorer areas. Malnutrition is a key risk factor for many childhood illnesses and affects the health status of the poorest women. Interventions to improve nutritional outcomes are vital in tackling the burden of disease and achieving the MDGs.

The Need for Public Health Surveillance

Given the high rate of communicable disease and the low rate of immunizations, the health system will need to provide for a large number of people suffering from tuberculosis, acute respiratory infections, measles, malaria, leprosy, and other common ailments, as well as HIV/AIDS. Such care and treatment require establishing an effective public health surveillance system, systematically collecting and analyzing timely and accurate health data, disseminating those results, and developing action plans to combat disease. Such a system will also monitor the effectiveness of disease control programs. Because many infected patients approach private facilities first, close links must be formed and information-sharing channels opened with the private sector and even informal providers (see later chapters), especially to combat outbreaks of infectious diseases.³ Such a system does not currently exist in most states.

³ For more practical information on this topic, see Garcia-Abreu and others (2002).

2 PUBLIC HEALTH CARE FOR THE POOR

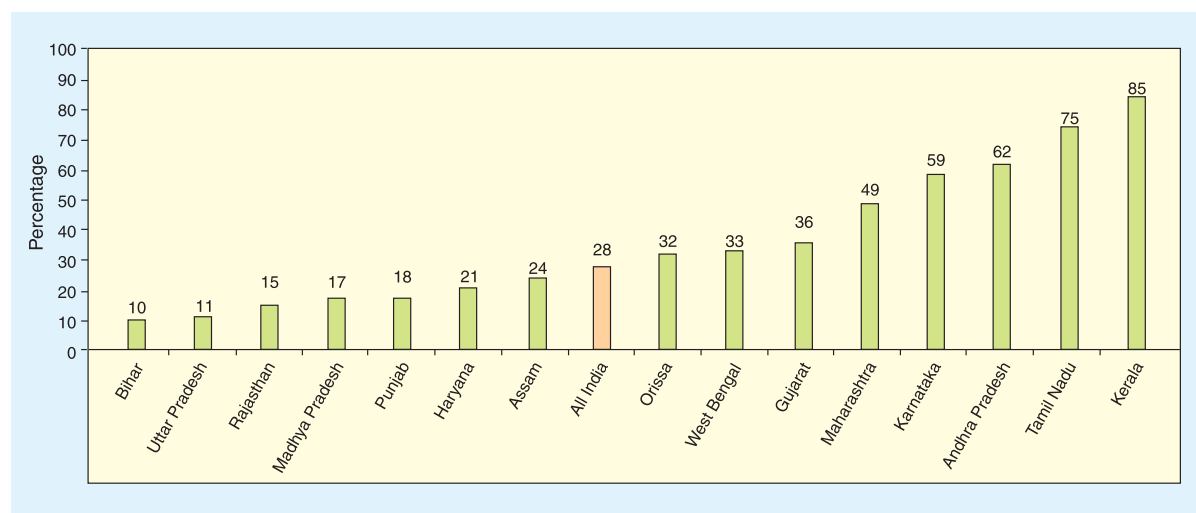
Public Primary Health Care

India's primary health care system is based on the primary health center (PHC) and its attached subcenters. Each PHC is targeted to cover a population of 30,000 (or 20,000 in remote or rural areas). The PHCs are hubs for five or six subcenters that each cover three or four villages. PHCs are operated by an auxiliary nurse midwife (ANM). They act as referral centers for the community health centers (CHCs), 30-bed hospitals, and higher-order public hospitals such as the *taluka* or district-level hospitals.⁴

The PHC is charged with providing promotive, preventive, curative and rehabilitative care. Thus, it should offer a wide range of services, such as health education, nutrition promotion, basic sanitation, mother and child family welfare services, immunization, disease control, and appropriate treatment for illness and injury. Unfortunately, PHCs are not currently fulfilling all these functions, many of which have a strong component serving the public good.

Although state governments throughout India are focused on reducing the infant mortality rate (IMR), maternal mortality rate (MMR), and communicable diseases, public health systems in only a few states have been able to meet this challenge. Figures 2.1 and 2.2 illustrate that even with support from the private sector, less than half the children are fully immunized and less than one-third of deliveries are institutional, which, in turn, contributes to high levels of disease and maternal and infant mortality. As the figures illustrate, there is large variation among the states. Unfortunately, the most populous states happen to be the poorest and are unable to reach even a quarter of the target population.

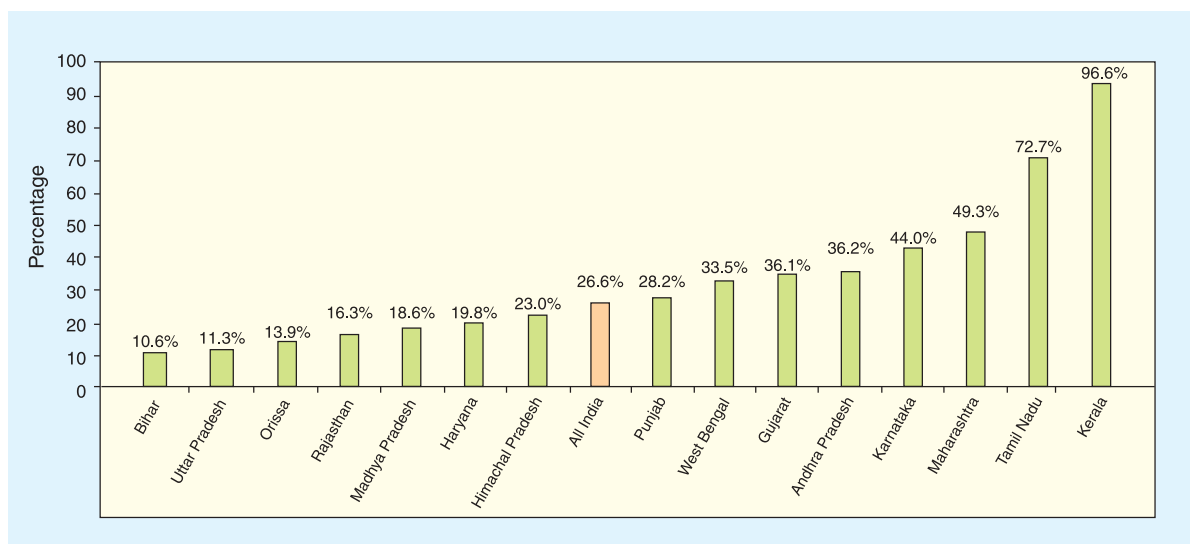
Figure 2.1 : Percentage of Population Receiving Full Antenatal Care



Source: National Family Health Survey-2 (1998/99).

⁴ A fuller picture of the primary health care system is presented in appendix B, using Karnataka as a case study.

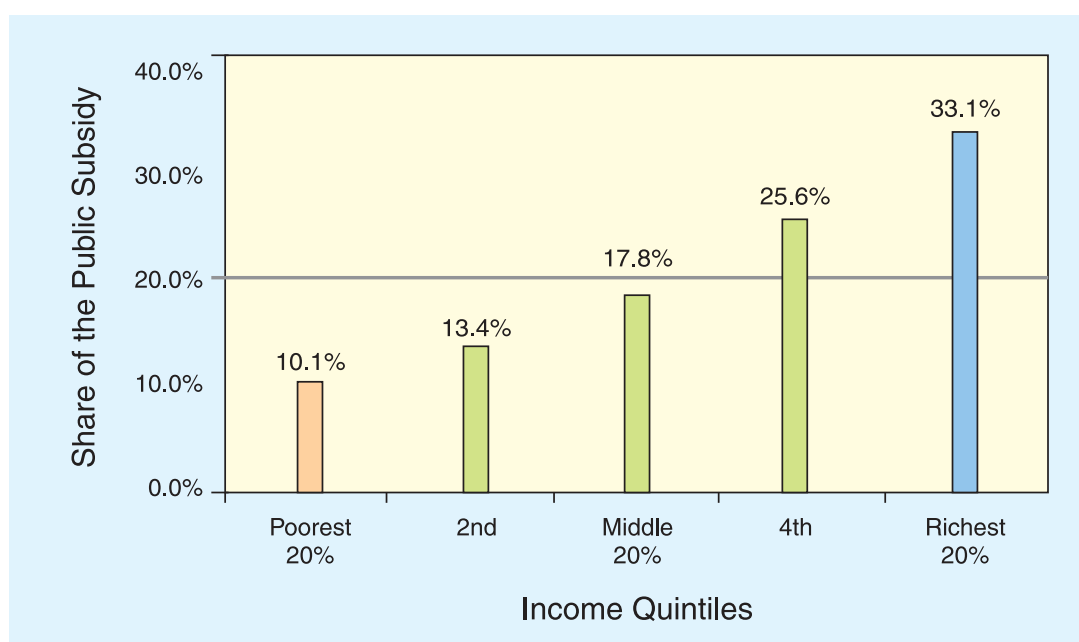
Figure 2.2 : Institutional Deliveries (percent per 1,000 live births)



Source: Mahal and others (2001).

Moreover, the public sector is not good at reaching the poor or those in remote areas. A recent assessment (Mahal and others 2001) of the public subsidy to the health sector has shown that the poorest 20 percent of the population captures only 10 percent of the subsidy, less than a third of that captured by the richest 20 percent (see figure 2.3).

Figure 2.3 : Distribution of Public Expenditures in India on Curative Care, 1995-96



Source: NCAER (2000).

Empirical studies have also shown that the quality of primary public services provided by the public sector did not improve significantly between 1987 and 1996. Moreover, income, education, and the overall quality of state administration are more important than specific public health interventions in explaining differences in demographic and health indicators during the period from 1981 to 1991.

Reasons for Poor Public Sector Performance

Although many reasons for poor public performance exist, almost all of them stem from weak stewardship of the sector. Three basic issues are highlighted here that together produce a poor incentive framework. Each of the following areas is discussed in detail:

1. A bureaucratic approach to health care provision
2. Lack of accountability and responsiveness to the general public
3. Incongruence between available funding and commitments

A Bureaucratic Approach

State governments approach the provision of health care from a bureaucratic paradigm, with the following results:

- *A rigid PHC structure.* The PHC structure is the same for every area and, therefore, unable to respond effectively to local realities and needs. PHCs exhibit very little differentiation despite serving markedly different populations and circumstances. For instance, the number of ANMs per PHC is the same throughout the country, even though some states have twice the fertility level as others. Rather than responding to local needs, public health officials are focused on and limited by the requirement to fill sanctioned posts. Moreover, political interference in the location of health facilities often results in an irrational distribution of PHCs and their subcenters.
- *A focus on inputs rather than outputs.* Government health departments are focused on implementing government norms, paying salaries, and ensuring that minimum facilities are available rather than on measuring health system performance or health outcomes. This focus results in a supply-driven approach. For instance, despite being completely underused, each PHC still has six beds.
- *Lack of public health management capacity.* In general, the public health care system is managed and overseen by the district health officers. Although they are qualified doctors, they have little or no training in public health management and are transferred frequently. Moreover, even if they had the training, they do not have the flexibility to reallocate financial capital and human resources to achieve better outcomes. Strengthening the capacity for public health management at the district and *taluk* level is crucial to improving public sector performance and nurturing partnerships with the private sector.
- *Vacancies in PHC posts for long periods.* A field visit to a PHC in Nelamangala Taluka (in Karnataka) revealed a sanctioned post complement of 25, of which only 18 positions were filled. Budgetary figures indicate that, on average, 25 percent of sanctioned PHC posts in Karnataka are unfilled. It is not clear whether this high percentage of vacancies is a deliberate strategy to reduce the budgetary burden or simply a result of administrative

inefficiencies. Moreover, when posts are filled, doctors are often absent (as discussed later in this chapter).

Lack of Accountability

The lack of accountability and responsiveness stems from the lack of a formal feedback mechanism, exacerbated by no tradition of and no incentive to treat citizens as clients. In every state visited, patients complain about rude or abrupt health workers who discriminate against women and minorities from scheduled castes or tribes and the poor in general. Patients understand that the incentives within the public sector cannot stimulate performance: “Anyhow they will get their money, so they don’t pay much attention,” says a patient in Andhra Pradesh (Probe Qualitative Research 2003a). As another patient remarks in Mumbai, “The same government doctor who was not easily or conveniently accessible, whose medication was not satisfactory, and whose manner was brusque and indifferent transformed into a perfectly nice and capable doctor when he was seeing a patient in his private practice” (Probe Qualitative Research 2003b). In general, the lack of accountability results in the following service deficiencies:

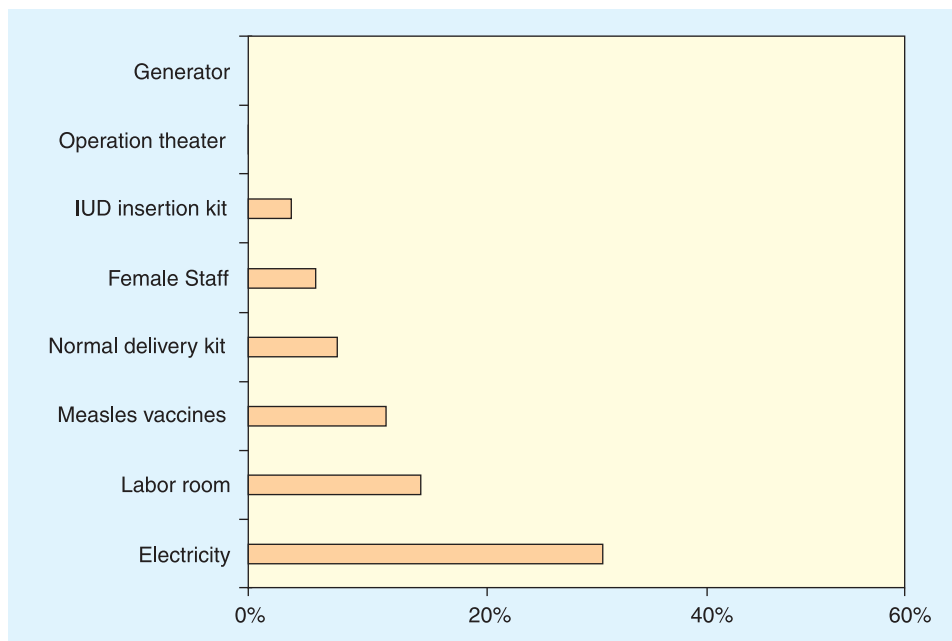
- *Absentee doctors.* It is difficult for the public sector to attract qualified doctors to the rural areas. Although in theory medical officers are required to be present at the practice, many medical officers visit the PHC infrequently, preferring to operate parallel private clinics in urban areas or to operate private practices from their residences after hours. A recent study has estimated that countrywide absenteeism rates in India are 43 percent in the public health sector (Chaudhury and others 2003). When doctors are present, their poor behavior discourages patients from approaching the PHC for health care.
- *Unresponsive ANMs.* In Karnataka, *dais*⁵ attend as many deliveries as ANMs, about 12 percent of total births. Villagers complain that ANMs are not available for deliveries at night, even if the mother is willing to come to the PHC. In addition, nearly a third of women who had planned to have an ANM assist at their deliveries finally had a *dai* or an experienced relative in attendance because the ANM was either unavailable or unwilling to attend if women went into labor at night.
- *Inconvenient opening times.* PHCs are very underused by outpatients for the reasons outlined in this section. The situation with respect to inpatients is even worse because PHCs have limited opening hours and no one is available to attend to the patients in the evenings or during the weekends.
- *Informal payments.* Although not officially sanctioned, most PHCs require patients to make small, informal payments before receiving treatment. After the costs of transportation and time taken to get to the PHC are factored in, this additional payment often makes the cost of public sector health care more expensive than low-cost private providers.
- *Little or no community participation.* The community is not involved in the operation of the PHC. In theory, the PHC is monitored by the Panchayati Raj system through a community health committee; however, in practice, villagers complain that they do not who is on the committee, resulting in a situation in which the PHC is not responsive to local needs such as opening times, range of services, and customer satisfaction.

⁵ *Dais* are informal midwives who operate in the rural areas. They have no formal training; the job is hereditary and passed down within certain lower castes.

Incongruent Budgets and Commitments

The lack of resources, which in some states is acute, is certainly a contributing factor to the poor performance of the primary health care system (see figure 2.4). In poor states, spending levels are extremely low, yet expectations for coverage remain high. This incongruence is a key factor in explaining poor use of public spending. Government officials are quick to blame inadequate budgetary provision for the breakdown in the system, however, without examining how government could improve its efficiency using current resources. The incongruence between resources and targets results in the following problem areas:

Figure 2.4 : Equipment and Facilities Available at PHCs in Bihar State



Source: National Family Health Survey-2 1998/99

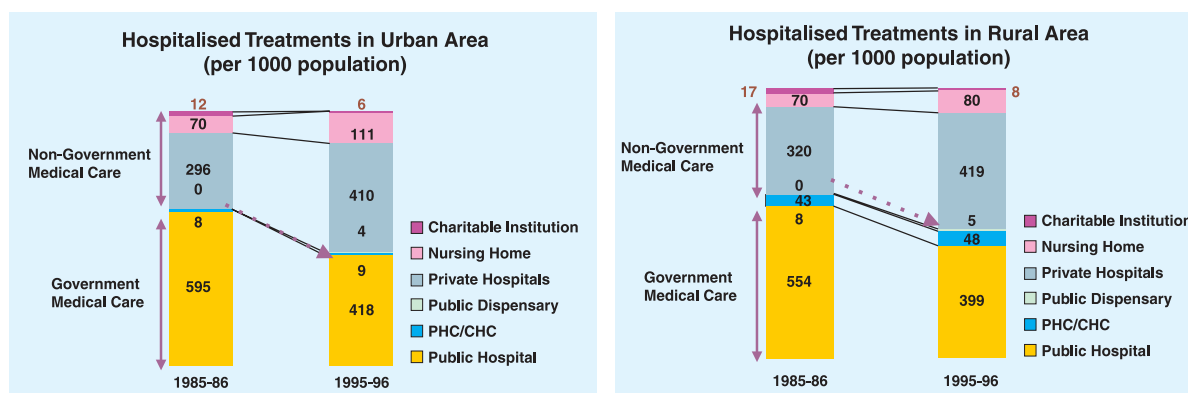
- *Lack of medicines.* The current annual budget for essential drugs at a PHC of Rs 75,000 is inadequate to ensure that sufficient drugs are available, especially if the PHC is staffed with dedicated health workers and able to attract a large number of patients.
- *Limited doctor salaries.* Low salaries are an obstacle to attracting qualified doctors to rural areas, especially given the high costs that many students will pay for their medical training.
- *Poor condition of PHC infrastructure.* When government budgets are under extreme pressure, the first area that is usually identified for cutbacks is the maintenance budget. PHCs across India are poorly maintained and are supplied only sporadically with electricity. Vehicles quickly fall into disrepair because spare parts are not forthcoming, and the process required to replace the simplest parts is so convoluted that even a flat tire can put a car out of action for more than a year. This situation deters patients from seeking care there. Within such a context, it is important to focus on system reforms before considering any potential budget increases.

3 PRIVATE HEALTH CARE FOR THE POOR

Growth of the Private Sector

At Independence, less than 8 percent of all medical institutions in the country were maintained by wholly private agencies (Bhore Committee 1946). By the early 1990s, this figure had reached close to 60 percent, and there are indications that it increased even further during the past decade. In large part, the private sector has emerged in response to the current health care situation as outlined in chapters 1 and 2.⁶ The decade to 1996 witnessed a steep decline in the market share of public health services (see figure 3.1). The proportion of patients seeking ambulatory care in the public sector fell from 32 percent to 26 percent in rural areas and from 30 percent to 17 percent in urban areas. Similarly, by 1996 the private sector accounted for 54 percent of rural hospitalization and 70 percent of urban hospitalization (National Sample Survey 1995/96). Strong evidence exists that such official statistics grossly underestimate the size of the private sector. Facility surveys in various states have recently estimated that the private sector includes as much as 93 percent of all hospitals and 64 percent of all beds nationwide (World Bank 2001). This remarkable growth in private sector health services has occurred largely by accident as the private sector has stepped in to meet needs that the public sector could not address.

Figure 3.1 : The Private Sector Captures Increasing Market Share from the Public Sector



Source: National Family Health Survey 1998/99; National Sample Survey 1995/96; and KPMG (2003).

Structure of the Private Sector

The private sector is a broad group that includes for-profit and not-for-profit providers, nongovernmental organizations (NGOs), missionary hospitals, private pharmacies, and blood banks plus unqualified informal providers, some of whom are registered and others who are not. For the purposes of this study, it is useful to divide private sector providers into the following three major groups, each of which is discussed in more detail:

⁶ For the purposes of this study, the private sector is defined as all nongovernmental health care, including NGOs, for-profit and not-for-profit institutions, private clinics and nursing homes, informal rural medical practitioners (whether registered or not), and donor-funded project facilities.

1. Rural medical providers (RMPs)⁷
2. Not-for-profit (NFP) sector, including NGOs and religious-based facilities
3. Corporate, or for-profit, sector

Rural Medical Providers

RMPs are unqualified medical practitioners. They operate on a for-profit basis, offering mainly curative services in the rural and semiurban areas. The vast majority are male solo practitioners in outpatient settings. A study in Punjab revealed that less than 1 percent of RMPs had inpatient beds. Responding to demand, the vast majority offer allopathic medicine, even though some RMPs are qualified in Indian systems of medicine. The majority (87 percent) are educated to the high school level. Those who have more education or training tend to operate in or around urban areas. Estimates of the number of informal providers nationwide vary widely from 500,000 (based on surveys in Andhra Pradesh and Uttar Pradesh) to 1.27 million (assuming that each village has, on average, two such informal providers).⁸

Each RMP sees 20–50 patients per day and receives anywhere between Rs 10 and Rs 50 per consultation, depending on the ailment and the state in which the RMP operates. Higher consultation fees are charged in richer states. Despite their lack of knowledge and frequent involvement in potentially harmful practices, RMPs continue to hold the public’s trust and earn a comfortable living from consultation fees and commissions for referrals to local private hospitals.

In the absence of regulation, such providers have been allowed to prosper, especially in rural areas, where they are often the only form of easily accessible care. Adapting flexibly to demand, some RMPs are peripatetic, visiting two or more villages during the week. Villagers stated that the reasons they used RMPs included that the practice is open at convenient times (usually 8:00 a.m.–1:00 p.m. and 6:00 p.m.–10:00 p.m.). Practices where the RMP lives on the premises are open at all hours. Moreover, RMPs are prepared to make house calls on elderly or incapacitated patients and often have a good standing within the community. They uniformly treat patients with kindness and respect. Another attractive feature is that RMPs will provide service on credit to those who cannot afford to pay immediately.

Not-for-Profit Sector

Although the NGO sector—and the NFP sector more broadly—is widely discussed in India, it provides a tiny proportion of health care services. In most states, the share of the NFP sector is less than 1 percent. NGOs, especially those funded internationally, tend to be more active in poorer states, whereas locally based religious organizations are able to attract more funding in richer states.

The NFP sector tends to mirror the facilities provided in the for-profit sector. However, NFP services are clustered in charitable clinics and larger hospitals. The small nursing home sector that characterizes the for-profit sector is almost entirely absent from the NFP sector.

⁷ More detailed information on RMPs is presented in appendix C.

⁸ The 2001 national census identified 638,365 villages in India.

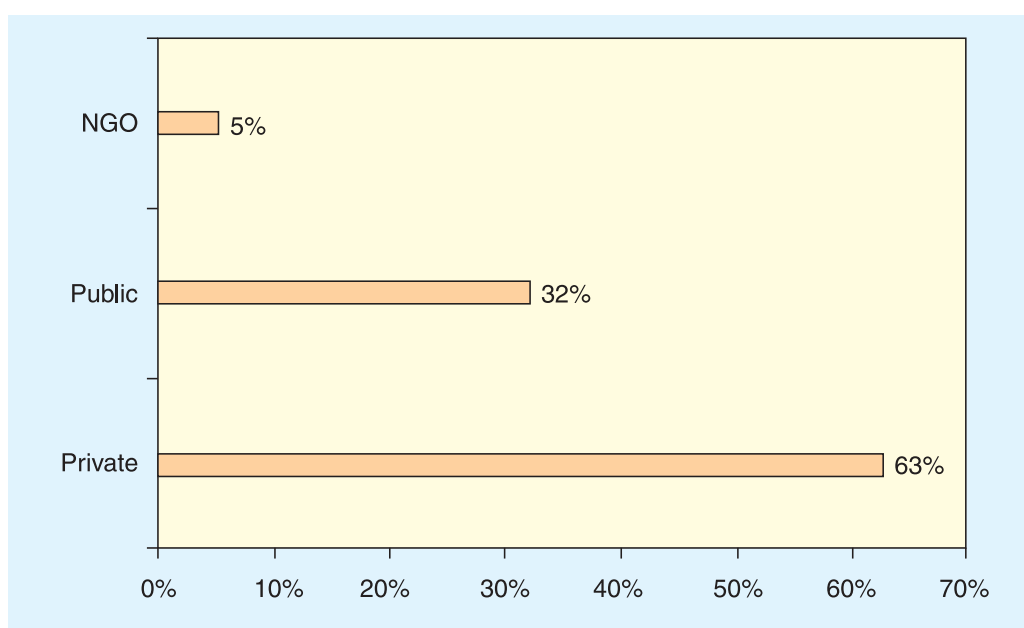
Some NFP facilities are established on a financially sustainable basis and are funded from user charges; however, most require the support of philanthropic donations. Because NFP institutions are not motivated by profit, these facilities often provide good-quality care, need little regulation or oversight from government, are able to attract dedicated workers at lower-than-market rates, and cater to the needs of the poor and those otherwise excluded from mainstream health care, often by charging lower rates. Moreover, they are also willing, budget permitting, to take on health care challenges that the for-profit sector is not willing or able to take on—for instance, running tuberculosis clinics, running HIV/AIDS voluntary counseling and testing centers, or adopting PHCs. Given these characteristics, governments have found it easy to create partnerships with the NFP sector for disease surveillance and control as well as to deliver and support the state or central government programs.

For-Profit Sector

Accurate and comprehensive data on the size and structure of the private sector are unavailable on a nationwide basis, and many state-level statistics underestimate the true size of the private sector. However, it is possible to piece together a general overview of the for-profit sector through good-quality facility surveys that have been undertaken recently in several states.

The picture that emerges is one in which the private sector is much larger than the public sector. A recent facility survey in Andhra Pradesh indicated that the private for-profit sector accounted for almost twice as many beds as the public sector (see figure 3.2). This finding matches utilization data from the National Family and Health Survey (NFHS) 2 (1998/99), National Sample Survey Organization, and other sources.

Figure 3.2 : Andhra Pradesh Health Facility Survey 2003: Beds Available



Source: Andhra Pradesh Health Institutions database.

The private for-profit sector is dominated by small, general facilities, such as clinics and nursing homes, that are individually owned. Facilities with fewer than 30 beds account for the vast majority of the private for-profit sector (83 percent in Karnataka). However, close to a third of private beds belong to large hospitals with more than 100 beds. Most for-profit facilities are general hospitals (71 percent), while those focused on maternal and child health account for 26 percent (Karnataka Facility Survey 1996).

Surveys have shown that the for-profit sector tends to charge more than the not-for-profit sector. Table 3.1 presents data from Bihar. Similar results were apparent in Punjab, where, after the cost of external medicines was added, the for-profit sector turned out to be cheaper than the government sector. Evidence from Karnataka illustrates that, although there are “market rates” for many procedures in the private sector, charges vary greatly among private hospitals. The survey showed that facilities operated by charitable institutions generally charged the lowest fees, closely followed by those owned by individuals and partnerships. Corporate facilities run by limited companies charged twice as much for the same service.

Table 3.1. Health Care Charges in Bihar (Rs)

| <i>Treatment</i> | <i>NGO</i> | <i>For profit</i> | <i>Informal</i> | <i>Government</i> |
|--|------------|-------------------|----------------------------|---------------------|
| Outpatient department and voluntary counseling and testing | 5–10 | 30–50 | 5–25 | Free |
| Vaccines | 100 | 150 | 110 (cost plus 10 percent) | Free (if available) |
| Ward bed | 400 | 500–550 | n.a. | 50 |
| Private bed | n.a. | 600 | n.a. | 250–350 |

n.a. = not applicable.

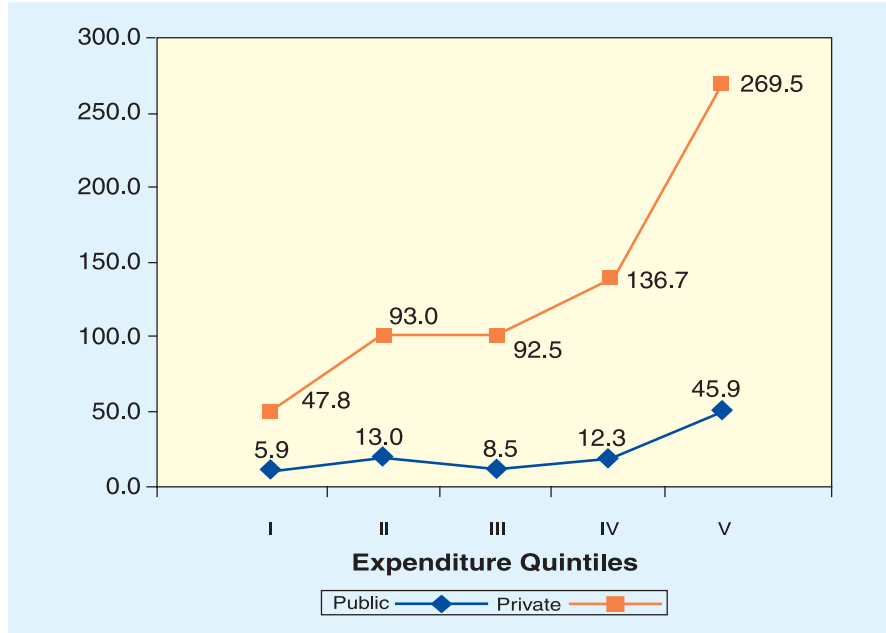
Source: Author’s field visit.

Private sector facilities tend to be clustered in a few urban centers. A review of the private sector in Punjab found two-thirds of the state’s 206 urban hospitals in just 2 of the 17 districts of Punjab. Only 7 percent of private beds are located in rural areas in Punjab (Foundation for Research and Development of Underprivileged Groups 2001). This situation does not seem to deter poorer patients from seeking care, but it adds to the total cost of treatment. Moreover, private hospitals tend to tailor their charges according to ability to pay much more than the public sector does (see figure 3.3). The highest rates are found in larger cities and the lowest in rural and remote areas. Most private for-profit hospitals are willing to offer concessionary or free services for the poor, especially for consultations.

Use of the Private Sector

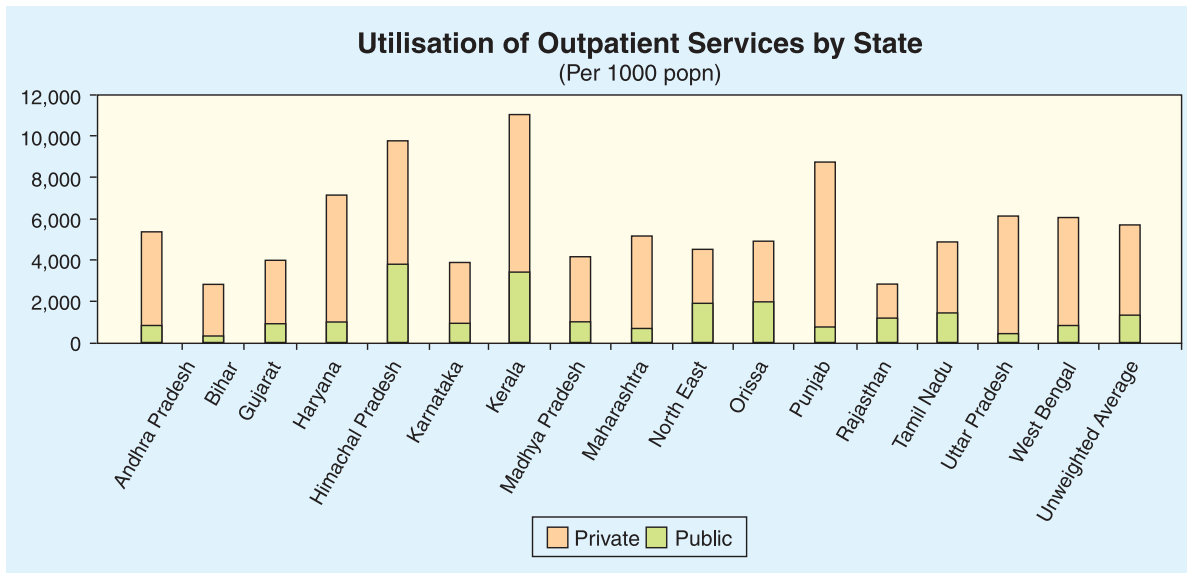
The private sector provides the majority of health care in India for both outpatients (more than 80 percent; see figure 3.4) and inpatients (close to 60 percent). In the poorest states, such as Bihar and Uttar Pradesh, the public sector is completely dysfunctional, and no effective alternatives to the private sector exist. At the other end of the spectrum, in the richest states, such as Punjab and Maharashtra, much of the population can afford and prefers private services even though government facilities do exist.

Figure 3.3 : Average Hospital Charges per Inpatient



Source: NCAER (2000).

Figure 3.4 : Use of Outpatient Services by State



Source: Mahal and others 2001, based on National Sample Survey (1995/96).

Increasingly, the poor use the services of private sector practitioners because the public sector fails to reach and service such vulnerable groups in India (see table 3.2). The majority of the population in rural areas uses the services of unregulated and often unqualified medical practitioners, such as “Jhola Chap” doctors and faith healers. Because almost 80 percent of the Indian population lives in rural areas, the informal private providers form an important health care option for the poor in India. The government-run PHCs and CHCs are increasingly irrelevant, despite receiving significant amounts from state budgets to continue their operations.

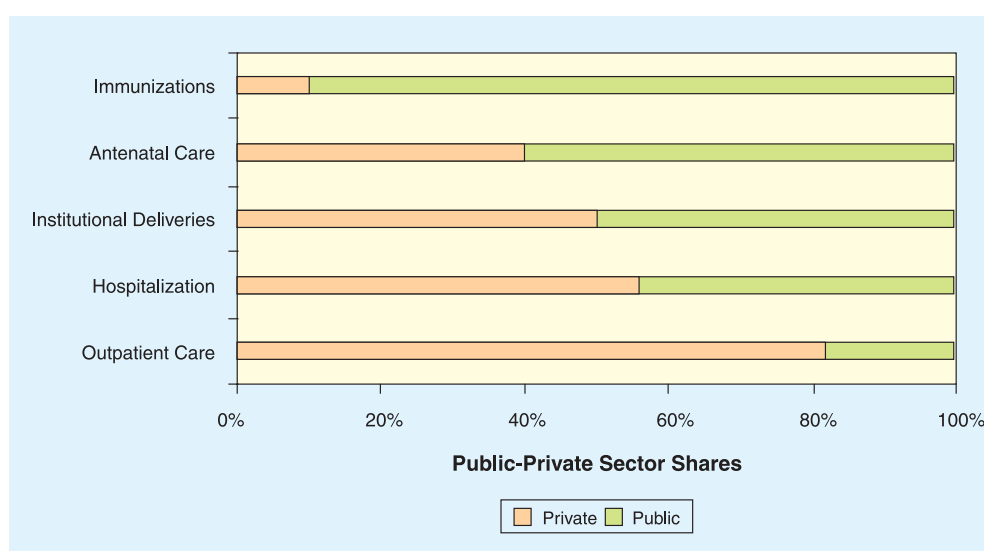
Table 3.2. Health Care Service Provider Preference (percent)

| <i>Medical practitioner/initial consultation</i> | <i>Poorest quintile</i> | <i>2nd quintile</i> | <i>3rd quintile</i> | <i>4th quintile</i> | <i>Wealthiest quintile</i> | <i>Total</i> |
|--|-------------------------|---------------------|---------------------|---------------------|----------------------------|--------------|
| Indigenous practitioner or faith healer | 8.6 | 11.7 | 7.8 | 8.4 | 5.3 | 8.3 |
| RMP | 53.2 | 52.6 | 49.6 | 42.9 | 43.1 | 48.3 |
| Chemist | 0.9 | 1.6 | 1.7 | 3.0 | 0.9 | 1.6 |
| Government doctor (PHC, CHC) | 5.1 | 4.0 | 5.2 | 6.4 | 5.5 | 5.2 |
| Government doctor (hospital, major facility) | 9.0 | 10.4 | 10.6 | 12.9 | 14.7 | 11.5 |
| Private doctor (clinic) | 23.0 | 19.4 | 24.7 | 24.7 | 30.5 | 24.5 |
| Charitable institution, NGO, or other | 0.2 | 0.3 | 0.5 | 1.8 | 0.1 | 0.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Note: Totals may not be exact because of rounding.

Source: World Bank (1998).

The private sector is increasingly involved in primary and even in preventive health care, especially maternal and child care. Such facilities provide the majority of institutional deliveries in many states and a high percentage of antenatal care (see figure 3.5). Rural women in Karnataka are twice as likely to visit a private doctor than to visit a public doctor when seeking antenatal care. When they do visit a government doctor, they are more likely to attend a higher-level hospital than the local PHC (Matthews and others 2001). Although the private sector provided only 10 percent of immunizations in 1995-96 (see figure 3.5), this figure is growing rapidly from a small base (Walsh n.d.).

Figure 3.5 : Public and Private Shares in Service Delivery, 1995-96

Source: Mahal and others 2001.

Challenges of Increased Private Sector Participation

Each part of the private sector is motivated by different objectives and, therefore, behaves in a unique way, producing a variety of outcomes. Each part of the system has its own pros and cons, as illustrated in table 3.3.

Table 3.3. Pros and Cons of Private Sector Health Care

| <i>Subsector</i> | <i>Pros</i> | <i>Cons</i> |
|----------------------------------|---|---|
| Informal | Is accessible Is client oriented Is low cost | Provides poor-quality care Is difficult to mainstream Has poorly educated practitioners |
| NGO | Is high quality Targets the poor Is low cost Involves the community | Has small coverage Lacks resources Cannot be scaled up Uses ad hoc interventions |
| For profit (small nursing homes) | Provides huge outreach and coverage | Is moderate cost Has variable quality Is clustered in cities |
| For profit (corporate) | Is of the highest quality Is innovative Is internationally regulated and accredited | Is at the highest cost Focuses on tertiary care Is located in urban centers |

Source: Author's illustration.

As explained previously, informal providers are available in every village. Offering credit, convenient opening times, and home visits, they are extremely accessible to the population. Unfortunately, they are not qualified to provide the type of services that almost all of them are offering, including prescribing and administering powerful drugs and injectable medicines. Given the low levels of education and poor record keeping of such providers, they would be difficult to incorporate into mainstream maternal and child health, immunization, and disease surveillance programs. However, several programs have successfully incorporated informal providers into selling family planning products.

The NGO and NFP sector is largely self-regulating and able to offer a high-quality product at low cost to its users. The sector also targets the poor, often playing a complementary role to public facilities by filling the gaps in services provided by the public and for-profit private sector. However, most NGO activities are not centrally directed, and their interventions remain ad hoc; they are often at the mercy of donors, who might lose interest or commitment. In the long term, such models are not sustainable and cannot be scaled up. In the short term, given the small size of the NGO sector, it does not play a significant delivery role. However, given their objectives, NGOs could play a useful supervisory role in a system that involved more for-profit private sector delivery.

The formal for-profit sector encompasses the most diverse group of practitioners and facilities. At the top end of services are hospitals offering international-level quality. Such facilities are

focused almost entirely on tertiary care, however, and are far too expensive to be relevant to the health care needs of the poor. Small private clinics and nursing homes are within the reach of some poor households, but even their moderate costs can plunge such families into poverty. Several studies indicate that parts of the for-profit private sector are involved in unnecessary procedures, such as high rates of caesarian sections and other unwarranted surgeries and tests. Much of the private for-profit sector is also heavily underused, suffering low occupancy rates in all but the most successful hospitals. Because the private for-profit sector forms the largest part of the health sector, any future strategy to improve public health should take that sector into account.

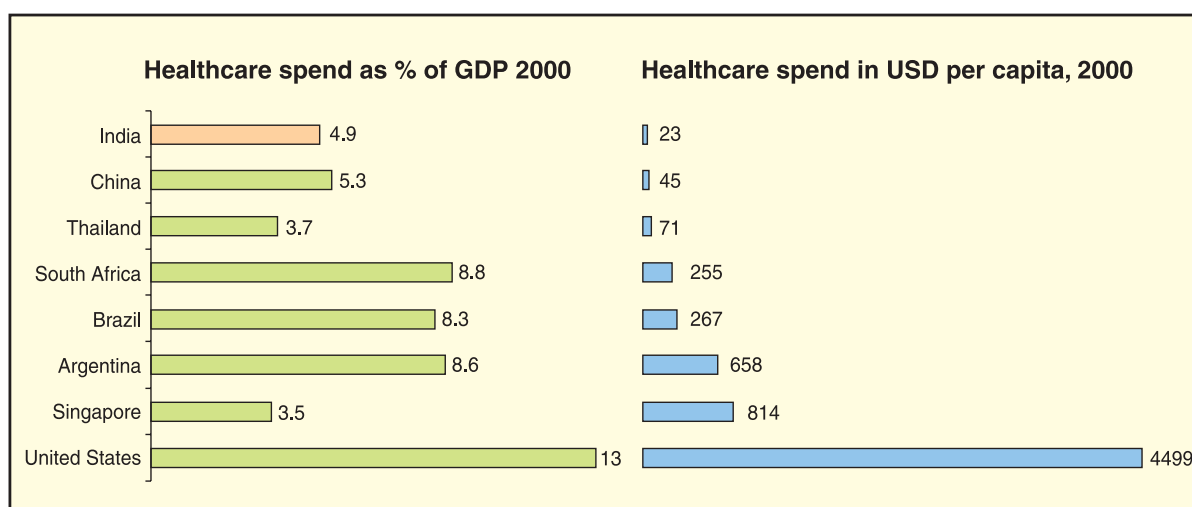
Overall, the private sector's biggest problem is that it has grown without any oversight or regulation from the public sector. This unregulated growth has resulted in duplication of facilities in urban centers, variable quality services in the absence of licensing or accreditation, corrupt practices, variable charges, and lack of integration with public health issues such as disease surveillance. Those areas should form the focus of a future strategy to improve the private sector's performance.

4 FINANCING OPTIONS FOR THE POOR

Total Health Care Spending

India's total health care spending as a percentage of gross domestic product (GDP) averaged 4.9 percent in 1997–2000 (figure 4.1), which was slightly higher than the low-income average, in the same period, of 4.3 percent. However, much more important than the total level of spending are the quality of that spending, its source, and its destination.

Figure 4.1 : Health Care Spending



Source: ICRA Indian Healthcare Industry (2003) and KPMG (2003).

Public Spending

Public sector health spending in India accounts for only a small portion of total spending. India still lags behind other developing countries in public spending on health care, with only 0.6 percent of the country's GDP devoted to health care spending (and only 3 percent of total spending devoted to health care). This figure is just over half the average spent by other low-income countries and less than one-tenth that spent by industrial countries (table 4.1). As indicated previously, because much of this money disappears in corrupt practices such as absenteeism, simply increasing public expenditure without reforming the system is likely to be counterproductive.

It is important also to remember that public spending is heavily skewed (as are other health indicators) by state. Therefore, health care spending in many of the richest states will be several times the average. Bihar, a poor state, allocated just US\$2 per capita for health in its 2003/04 budget.

Table 4.1. National Health Statistics of India Compared to Those of Low- and High-Income Countries

| <i>Economy</i> | <i>Public expenditure on health (percent of GDP)</i> | <i>Access to improved water source (percent of population)</i> | <i>Access to sanitation (percent of population)</i> | <i>Infant mortality rate (per 1,000 live births)</i> | <i>Contraceptive prevalence rate (percent of women)</i> | <i>Total fertility rate (births per woman)</i> | <i>Maternal mortality rate (per 100,000 live births)</i> |
|-----------------------|--|--|---|--|---|--|--|
| India | 0.9 | 81 | 16 | 70 | 41 | 3.2 | 410 |
| Low-income countries | 1.2 | — | 24 | 68 | 24 | 3.1 | — |
| High-income countries | 10.2 | — | — | 6 | 75 | 1.7 | — |

— = not available.

Source: World Bank (2003).

An analysis of state spending patterns also illustrates that far too much public money is devoted to tertiary and secondary care and too little is devoted to primary care. Treatment provided for chronic illness in a tertiary care facility has all the characteristics of a private good. Whether the government should provide any public money to tertiary hospitals and medical colleges is questionable. Providing the poor with viable insurance options to cover catastrophic illness may be a more sensible solution.

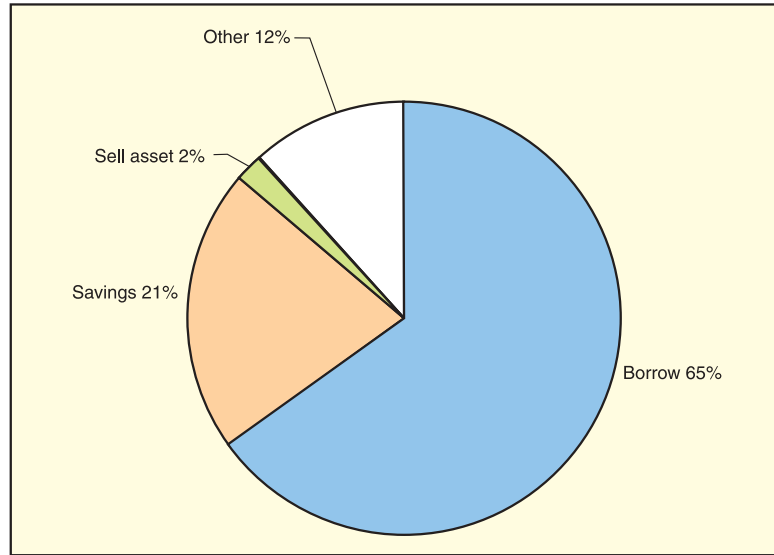
Public spending is also heavily skewed toward spending on salaries, leaving an inadequate budget for drugs and an often nonexistent budget for maintenance. Punjab's state budget is symptomatic of this problem, with 94 percent of the state budget devoted to salaries (see table 4.2).

Table 4.2. Punjab State Health Expenditure by Inputs

| <i>Inputs</i> | <i>2001/02 actual (Rs)</i> | <i>Percentage of total</i> | <i>Percentage excluding grants in aid</i> |
|-------------------------------|----------------------------|----------------------------|---|
| Salary and wages | 4,839,737 | 79.09 | 93.8 |
| Medical reimbursement | 8,796 | 0.14 | 0.2 |
| Supplies, material, and drugs | 91,631 | 1.50 | 1.8 |
| Machinery and equipment | 17,497 | 0.28 | 0.3 |
| Minor works | 0 | 0.00 | 0.0 |
| Grants in aid | 1,021,221 | 16.69 | |
| Other | 202,838 | 2.30 | 3.9 |
| Total | 6,181,720 | 100.00 | 100.00 |

Source: Author's estimates on the basis of Punjab budget documents for various years.

Figure 4.2 : Economic Burden of Hospitalization for Poorset Quintile

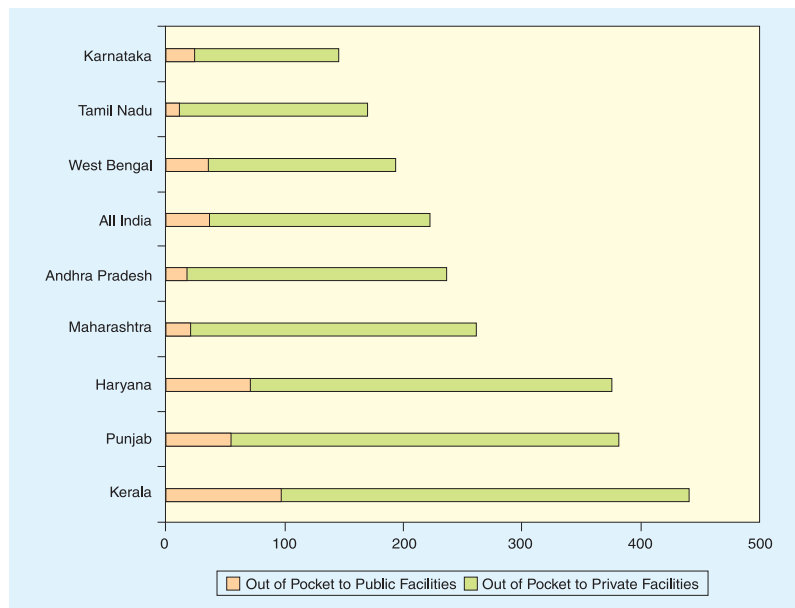


Source: Gumber and Berman (1994) using National Sample Survey 1995/96.

Private Spending

The other main source of financing is a household’s out-of-pocket expenditure. The nascent health insurance sector in India accounts for a trivial portion of the overall market. Only the very rich, government employees, and some formal sector workers enjoy health insurance. According to the 1995/96 National Sample Survey estimates, household total health spending was Rs 223 per capita, and the vast majority of that amount was spent in private facilities. Given the statistics on health-seeking behavior presented previously, much of this out-of-pocket expenditure was likely wasted on unnecessary drips and injections prescribed and administered by informal rural providers (see figure 4.3).

Figure 4.3 : Total Out-of-Pocket Expenditure in Public and Private Facilities, 1995/96



Source: IHSG (2003), based on National Sample Survey 1995/96.

Given that hospitalized Indians spend 60 percent of their total annual expenditure on medical care (a large share from borrowed funds), a clear need exists for health care financing mechanisms that would pool the risk and alleviate some of the financial burden that is associated with hospitalization.

Health Insurance

An effective health insurance scheme in India would provide the poor with coverage for day-to-day care and catastrophic coverage. The current market for private health insurance in India is not well developed. As a result, large numbers of the poor fall below the poverty line when they are hit by illness. An effective insurance scheme with broad coverage and affordable premiums would go a long way toward reducing out-of-pocket expenditures for the poor. To be sustainable, such a scheme would have to be financially viable and run efficiently.

In recent years, growth of the health insurance market has been constrained by several unviable government schemes launched in quick succession largely for political purposes, only to be wound up following elections. Poorly designed government schemes such as the Universal Health Insurance Scheme (UHS) cast the wider health insurance market in a poor light. Poorly implemented schemes, such as the Employees State Insurance Scheme (ESIS), discourage more-affluent workers from purchasing health insurance. Although insurance schemes run by NGOs and community-based organizations generally perform better, they are small, have limited coverage, and depend on heavy donor subsidies that perpetuate the same problems. In some situations, however, they have met with success. (See appendix D for a successful example from Rwanda.)

Government schemes have suffered from a low participation level, primarily because of the low quality of services that are provided as well the cumbersome claims settlement process. Many of these schemes do not cover minor ailments such as flu and malaria, which further reduces their benefit and appeal to policyholders. With so many poor examples of health insurance operating in India, it is not surprising that there is little understanding of health insurance as a concept—especially among poor rural women, the most important target group for any scheme that aims at improving primary health outcomes.

Nonetheless, untapped potential demand exists for a well-structured health insurance product. Out-of-pocket payments, even among the poorest groups, are high. Taken together, such payments exceed US\$10 billion annually, a huge untapped market by any standards. The private sector has begun to make inroads into this market, but because most corporate entities are tackling the high end of the market, their customers are already well covered by medical care, and such corporate efforts are unlikely to affect health outcomes.

To affect health outcomes, insurance schemes must be targeted at vulnerable groups. For long-term sustainability, however, such schemes must be financially viable. What is needed is a hybrid between community-funded insurance schemes and private sector professional schemes. This section presents an overview of a prominent private health insurance scheme, an overview of various public health insurance schemes, and initial observations on development of the insurance market.

Box 4.1. Medical Savings Accounts, an Alternative to Traditional Health Insurance?

Medical savings accounts (MSAs) are health plans that combine a high-deductible health insurance policy with a savings account. The savings account is controlled by the insured and is intended to pay routine health care expenses. MSAs have been tried in many countries (for example, China, South Africa, and the United States) since their introduction in Singapore. Initial indications are that MSAs work best when introduced in the absence of an established universal health insurance system and when supplemented by supply controls.

Singapore. Singapore's innovative approach in health financing system has been lauded for its low cost, excellent health outcomes, and consumer choice of providers and quality of care. The program is compulsory, requiring employees to contribute 6 to 8 percent of their pretax wages. It combines universal medical savings accounts (Medisave) with supplementary programs (Medishield, for catastrophic illness; Medifund, for the poor) to protect the poor and address potential market failures. The presence of a financially strong formal sector and the compulsory nature of the scheme have contributed to its apparent success (although there has been a resultant increase in inequity).^a

China. China introduced MSAs initially in two big cities (5 million population) and is currently expanding the reach of the scheme to include 42 other cities, covering about 70 percent of China's urban population. MSA members may pay out-of-pocket health care expenses and the premium for catastrophic insurance from the account. According to one estimate, the introduction of MSAs has lowered the cost of health care by about 25 percent in the original pilot area (Gratzer 2002).

United States. In the United States, an MSA is a special tax-sheltered savings account for medical bills (known as an Archer MSA) and works in conjunction with a special low-cost, high-deductible health insurance policy to provide comprehensive health coverage at the lowest possible net cost. The scheme is currently restricted to the self-employed and employees of small businesses. There are some indications that MSAs have helped reduce the cost of health care.

South Africa. Following the deregulation of the insurance sector in 1994, virtually every type of health insurance plan (health management organizations, preferred provider organizations, and MSAs) entered the South African market. Since their debut a decade ago, MSAs have become the most popular type of private health insurance, constituting about 50 percent of market share for private health insurance in South Africa and covering 4.6 million people. A comparison between conventional insurance plans and MSAs indicates that, on average, South African families' discretionary spending was 47 percent lower under MSAs (Matisonn 2002). The report concluded that patients who opted for MSAs managed to control costs, including those of prescribed medication, thereby avoiding the cost associated with managed care. South Africa's scheme is more flexible, allowing varying deductibles, compared to the across-the-board deductibles covering all medical services in the United States.

Source: A conversation with Rodney Lester, Washington DC 2003.

^a For more on the Singapore model see Taylor and Blair (2003).

Overview of a Prominent Private Health Insurance Scheme: ICICI-Lombard

ICICI-Lombard is a prominent joint venture primarily engaged in banking and insurance that currently offers two health products: a critical illness plan and a newly launched hospitalization product. Like other private sector insurance schemes, it is marketed primarily to the upper- and middle-income groups. From 1999 to 2004, the company has seen a 20–22 percent increase in the sale of health insurance policies and a 45 percent increase in premiums. Management attributes this success to its rapid response to the market's demand for cashless medical transactions.

The critical insurance plan provides coverage for 18 critical illnesses, such as cancer, bypass surgery, heart attack, and kidney failure. The insured person is compensated to the extent of the sum insured if, during the policy period, he or she is diagnosed as having contracted any one or more critical illnesses and if he or she survives for at least 30 days from the date of diagnosis. The premium depends on the person's age, health status, and sum insured and includes significant exclusions.

Launched in November 2003, the hospitalization insurance plan requires a continuous hospital stay of 24 hours for an insured to become eligible for hospitalization benefits. The premium is based on age band, sum insured, and a review of a detailed application form focusing on health history. For a 40-year-old person insured for a sum of Rs 100,000, the premium is Rs 2,000 per year. For an individual age 55 or above, a physical checkup is required. After 4 years of continuous insurance, ICICI-Lombard will cover all preexisting diseases. The product is sold to individuals, families, and corporations, with a policy discount for families.

ICICI-Lombard entered into an agreement with MEDSAFE and Paramount, two leading third-party administrators (TPAs). Between them, they were able to develop a network of 1,600 hospitals nationwide that accept the TPA-ICICI-Lombard health cards issued to members. By showing the card, a member need not make a deposit when he or she is admitted to the hospital, nor is a payment required upon discharge. Those members who access care outside the network are reimbursed 100 percent.

ICICI-Lombard has no sales force; instead it is marketing the product through SPICE telecommunications company. The objective of the alliance was to increase the product's reach at lower costs. SPICE has been in the telecommunications market for 8 years and has 800,000 subscribers. Its customers are primarily middle class. ICICI-Lombard gave SPICE a special premium rate for its customers and also pays a 15 percent commission for every policy sold. After 3 months, the SPICE network generated Rs 400,000 in premiums. This initial success has spawned the development of other alliances.

At present, ICICI-Lombard reports a claim ratio of 140 percent, which ICICI is currently able to bear as a loss-leader. The company is using the opportunity to cross-sell more-lucrative property and marine insurance. To offset the high claim ratio, the company is planning to increase the number of policyholders and the premiums.

Overview of Public Health Insurance Schemes

It is estimated that less than 9 percent of the Indian work force is covered by health insurance through the Central Government Health Scheme, ESIS, and Mediclaim. The proportion that is covered belongs mostly to the organized urban sector. For instance, Mediclaim largely covers formal sector workers (95 percent), including government officials with a high level of service. The vast majority of its members (75 percent) live in urban areas, and outreach to the rural areas and informal sectors is insignificant. Thus, there is great scope for pooling of risks and resources through a well-managed and well-targeted insurance scheme. A number of government and NGO-led initiatives are experimenting with alternative methods of addressing this issue. They include the (a) United Nations Development Programme (UNDP)–Karuna Trust, (b) Farmers cooperative scheme, and (c) Jan Arogya (government of India) scheme. Each of these schemes, plus the Mediclaim scheme, is discussed in more detail below.

(i) UNDP–Karuna Trust Pilot Scheme

The National Insurance Corporation (NIC) has teamed up with UNDP and the Karuna Trust to pilot a community-based insurance scheme in B.R. Hills, Karnataka. The scheme is aimed at encouraging vulnerable groups (members of SC/ST in the community) to take advantage of public health care facilities. By reducing the costs of health care at public hospitals, the scheme is hoped to encourage the increased use of such services. The pilot scheme was also intended to introduce members of the community to the idea of health insurance.

A baseline survey conducted during the design phase of the scheme gathered information on the demographic and health characteristics of the population. It revealed that individuals pay about Rs 150 per day in direct and indirect costs in the public hospital during periods of illness (see table 4.3). The survey also showed that the costs of treatment for patients 5 years of age and under was about half that amount, largely because children so young had no lost earnings or travel costs. Interestingly, the daily costs of treatment at a private hospital were only a little higher at Rs 163, whereas treatment costs at a quack or chemist shop were significantly higher, at Rs 295 per day. The higher costs at both private facilities and quack shops were almost all caused by the increased costs of consultations and drugs. The largest part of the costs was made up of lost wages and the cost of drugs. Those findings informed the design of the scheme.

Table 4.3. Costs of Treatment at a Government Hospital in Rural Karnataka

| <i>Items</i> | <i>Rupees</i> | <i>Percent</i> |
|--------------------------|---------------|----------------|
| Consultation | 193 | 12 |
| Drugs | 180 | 11 |
| Diagnostics | 153 | 9 |
| Patient travel | 132 | 8 |
| Escort travel | 143 | 9 |
| Additional prescriptions | 130 | 8 |
| Wage loss of escorts | 290 | 8 |
| Wage loss of patient | 182 | 11 |
| Speed money | 114 | 7 |
| Other | 118 | 7 |
| Total cost | 1,635 | 100 |
| Average cost per day | 147 | |

Note: The hospital is in T. Narsipura Taluk.

Source: Center for Population Dynamics (2002).

Coverage under the scheme costs Rs 30 (US\$0.70) per person per year and entitles beneficiaries to receive payments for inpatient treatment at selected public hospitals. Those members requiring inpatient treatment are paid Rs 50 per day to cover transportation costs to the hospital as well as lost wages. The scheme pays the hospital an additional Rs 50 per day to cover the costs of scarce medicines. At each participating hospital, a member of the Karuna Trust verifies the member's eligibility and makes the cash payments. The maximum payment per year is fixed at

Rs 2,500 (US\$55) for a 25-day stay in hospital. The scheme is administered by the National Insurance Corporation, a large public insurance company.

The scheme is subsidized by the UNDP. The subsidies go toward the premiums to be paid by the poor. SC/ST members pay nothing. BPL members pay Rs 10 to Rs 15. Above-poverty-line members pay the full Rs 30.

The scheme has the following interesting features:

- *Covers use of public facilities.* It recognizes the reality that public facilities are not free and makes payments to the hospital on behalf of the patient. Some of the Rs 50 per day payment to the hospital will be used to cover formal payments, but most will cover speed money (money traditionally paid informally to health care providers to facilitate access to timely care) and money to purchase drugs that should be provided free of charge. Moreover, the insurance can be used only if the patient receives treatment at certain designated public hospitals in the nearby area and, therefore, does not encourage competition between the private and public sectors. Evidence suggests that some insured patients are still using private health care because of the superior service they receive.
- *Compensates the sick for indirect costs of illness.* Most of the poor cannot afford to take a single day away from their work. Even relatively small payments for transportation to and from the health care facility (often Rs 20 to Rs 50) can deter the poor from inpatient treatment.
- *Covers individuals and not families.* The scheme is based on individual coverage rather than coverage of the whole family. Allowing individuals to join was intended to encourage participation; however, users of the scheme may decide to enroll only wage-earning individuals or may decide to discriminate against female members of the household.
- *Covers only inpatient treatment.* On the one hand, by covering only inpatient treatment and fixing the maximum and daily benefits receivable, the scheme effectively reduces the possibility of corruption. On the other hand, it does not encourage the poor to use primary health care outpatient services. Minor ailments that could be treated effectively with early detection could, therefore, go undetected. This feature of the plan may even be an incentive for those with minor ailments to wait for treatment until their illness becomes serious enough to warrant inpatient care.
- *Involves community.* The scheme empowers the local community and reduces administrative costs through the creation of village health committees at both the district and *taluk* levels. Both committees meet once every 2 weeks to review the number of beneficiaries registered, insurance policies issued, and claims settled; to account for payments to hospitals; and to oversee the hospital revolving funds.

To date, the scheme has had mixed results. All of the SC/ST members of the community were enrolled quickly in the scheme, taking advantage of the subsidized, premium-free membership. A similar number of BPL individuals also decided to pay the subsidized premium and join the scheme. However, only 2 percent of the total group is from the

nonpoor—those above the poverty line who were required to pay the full Rs 30 premium. In total, the scheme has covered about 25 percent of the population in its first year of operation. Bed occupancy under the scheme has gradually increased to approximately eight patients per day.

In its first 4 months of operation, the scheme took in Rs 2.5 million in premiums but paid out only Rs 250,000. This surplus is unsurprising given the relatively high premiums at Rs 30 and the ceiling on the maximum annual payout, which is Rs 2,500. The managers of the scheme believe that all of the community can be covered on a sustainable basis for just Rs 10 per year (US \$0.25), an amount that even the poorest members of the community consider affordable. Alternatively, the premium could remain at the current level and the benefits could be expanded to cover outpatient care. The managers of the scheme are experimenting with a range of possible options for the future.

(ii) Farmers' Cooperative Insurance Scheme: Yashaswini

The government is piloting a number of similar schemes. In Karnataka, the government launched a scheme in November 2002 called Yashaswini, under which it is aiming to cover 2.5 million farmers, who form 90 percent of the cooperative movement. Members of farming cooperatives are offered Rs 100,000 coverage for catastrophic illness. The premium payable is Rs 75 per year, of which the farmer pays Rs 60 per year (in monthly installments of Rs 5), and the government pays the remaining Rs 15 per year.

The design of the scheme is informed by a survey that showed that farmers suffered from heart diseases, bleeding stomach ulcers, burst appendixes, gallstones, enlarged prostates, cataracts, and fractures. Therefore, coverage under the scheme includes treatment for all such diseases. Members can seek treatment at any one of 67 private and public hospitals participating in the scheme.

The scheme's success relies on the hospitals' offering to set low rates for certain major operations in exchange for increased volumes. Many hospitals are running at very low occupancy rates (10 percent or lower) because of the high costs of care at their facilities. The scheme also relies on the fact that it covers only surgeries and only a small fraction of farmers go in for operations.

(iii) Universal Health Insurance Scheme

The government of India is piloting a nationwide insurance scheme, known as *Jan Arogya*, or Universal Health Insurance Scheme. For a premium of Rs 365 (or Rs 1 per day), the scheme covers wage-earning members of the family. There is also an option to cover a family of up to seven members for Rs 1.50 per day and a family of more than seven for Rs 2 per day. The UHIS covers medical expenses up to Rs 30,000 toward hospitalization; death from an accident for Rs 25,000; and compensation for the loss of earnings at the rate of Rs 50 per day, up to a maximum of 15 days (see table 4.4). To make the scheme affordable to BPL families, the government has decided to contribute Rs 100 per year toward their annual premium. The UHIS is effectively targeted to cover care at small, low-cost private nursing homes and government facilities and is marketed by the four state-owned insurance companies.

Table 4.4. Benefit Schedule of the Universal Health Insurance Scheme

| <i>Benefit</i> | <i>Benefit description</i> | <i>Benefit amount</i> | <i>Conditions</i> |
|---------------------------------------|--|--|---|
| Hospitalization | Room, board, doctors' fees, diagnostics, chemotherapy, radiotherapy, dialysis, pacemaker, artificial limbs, others | Rs 15,000 per illness or up to Rs 30,000 per year per policy ^a | Benefits subject to benefit limits. Hospitalization ^b should be for a period of at least 24 hours. |
| Accidental death | Wage-earning head of the family | Rs. 25,000 | Benefit applies to the person named in the policy. |
| Disability because of hospitalization | Wage-earning head of the family | Rs 50 per day of hospitalization caused by accident or illness, up to maximum of 15 days | Waiting period is 3 days. |

^a For a family policy, the total benefit can be incurred by one or more members of the family.

^b The plan recognizes that in certain treatments this time limit may not apply because of technological advancements. In those cases, a 24-hour stay may not be required.

Source: Government of India (2004).

In the absence of accreditation of hospitals, the plan defined a hospital as any government or private facility with at least 10 or 15 beds, depending on location. The hospital should have a minimum of 15 beds for class A and B cities, and 10 beds for class C cities with a population of less than 500,000, with a fully equipped operating theater and a 24-hour complement of fully qualified nurses under the supervision and management of a fully qualified doctor. The definition was premised on the belief that facilities with the specified minimum number of beds would have better facilities and staff. The definition allows users to seek care at any hospital or nursing home registered with the local authorities and under the supervision of a registered and qualified medical practitioner, hospitals owned and/or managed by an NGO or a trust, or private hospitals with a fixed schedule of charges.

Table 4.5. Details of the UHIS Hospital Benefits

| <i>Benefit</i> | <i>Limit</i> |
|--|---------------------------------------|
| Room and board | Up to Rs 150 per day |
| Intensive care unit | Up to Rs 300 per day |
| Surgeon, anesthetist, consultant, and specialist fees, plus nursing expenses | Up to Rs 4,500 per illness or injury |
| Cost of anesthesia, blood, oxygen, operating theater, medicines, diagnostic materials, X-rays, dialysis, radiotherapy, chemotherapy, pacemaker, and artificial limbs | Up to Rs 4,500 per illness or injury |
| Total reimbursable expenses for any one illness | Up to Rs 15,000 per illness or injury |

Source: Government of India (2004).

Upon launch, the plan was made available for sale through regular insurance agents and brokers. However, the number of policies sold was extremely low because of the low commission and inaccessibility of potential clients, as well as the inability of clients to pay the premium in full. Although the plan's creators agreed that poor individuals could afford Rs 1 per day, such individuals could not necessarily afford Rs 365 in one installment. The poor response indicated that a mismatch existed between the distribution strategy and the product. In fact, the original plan called for treating the product as a group plan, selling only to groups of 100,⁹ which was intended to prevent adverse selection; however, this restriction was lifted recently because of the difficulty of gathering 100 individuals and families who could all buy at the same time and be able to pay the premium in full.

The public insurance companies decided to market the group policies through NGOs that could act as agents to reach the target market. The insurance companies have developed relationships with a number of NGOs working in poor urban and in rural communities. These NGOs were trained on the features and benefits of the product. They were expected to offer the UHIS to the people they work with. Oriental Insurance has linked the NGOs to a third-party administrator, TTK, which was selected by the central government to solely administer the UHIS.

Penetration in the rural areas allegedly remains weak. Some of the reasons cited include the poor and rural residents' very limited understanding of the benefits and mechanics of health insurance and the still very few NGOs participating in the scheme because of their lack of familiarity with health insurance. Those individuals who have participated have needed continuing orientation to fully understand the mechanics, benefits, and features of the UHIS. NGOs' market coverage in terms of numbers of potential policyholders was also limited. Moreover, the scheme itself does not appear financially viable, and given the meager incentives for the public insurance companies to market the scheme, it is not surprising that the scheme's enrollment remains limited.

TTK, the third-party administrator for the UHIS, has negotiated with a number of hospitals to accept cashless transactions for policyholders upon presentation of the TTK photo-ID health card. At the same time, TTK required all approved application forms to include photos of the policyholder and dependents. The main drawback to this rule was the inability of the poor to pay for getting their photos taken. Thus, even when poor individuals have purchased the policy, they may not be able to access the benefits for lack of the photo-ID card.

The insurance companies have made this problem known to the government. According to Oriental Insurance, in the very near future, the government might ask TTK to allow policyholders to use their BPL or voting photo-ID cards in lieu of a dedicated health card when accessing services and benefits.

A number of concerns with the scheme in its current form are highlighted below:

- *Accessing care.* In many rural areas of Andhra Pradesh, few hospitals fulfill the requirements set forth in the UHIS guidelines. In many instances, the nearest facilities with beds are five- or six-bed PHCs, but they provide very limited inpatient care. According to some experts, many of the privately owned hospitals, whether allopathic or nonallopathic, have fewer than 10 beds. In the tribal areas, only RMPs and other

⁹ According to the central government's actuarial computation, a health insurance policy becomes viable when it covers 100 people.

quacks are present. In this scenario, many policyholders find it hard to get the hospitalization they require, rendering their policies practically useless.¹⁰

- *Obtaining the government subsidy.* Those individuals who belong to the BPL group may not necessarily be able to enjoy the benefit of the subsidy because the prerequisite is difficult to fulfill—getting a certificate from the local tax collector attesting that their income meets the BPL requirement. In Andhra Pradesh, less than 2 percent of policies have been sold to BPL families. Other options, such as using the BPL card, should be considered.
- *Marketing reach and premium payment.* Using NGOs as the major agents of the UHIS makes sense, but their numbers are low and their reach is limited. Even when the NGOs are able to convince an individual or a family to purchase the product, more often than not the target clients do not have the money to pay the premium in full. Many of the NGOs cannot afford to advance the premium payment, and even if they can, they do not have the means to make the daily collection of Rs 1 or Rs 1.50 or Rs 2 a day from policyholders. Paying the premium seems to be one of the main barriers to coverage.
- *Covering outpatient care, including immunization.* Although the premium is considered by many to be reasonable and affordable even for poor families, who actually spend more as a group per year for private health care than individuals of greater means, a substantial percentage of their total expenditure represents outpatient care (Rao, Ramana, and Murthy 1997). The decision not to cover outpatient care seems to have been predicated on a vibrant primary health care system—from the subcenters to the PHCs that efficiently provide preventive and curative outpatient services and primary health care for free.
- *Determining preexisting diseases.* The issue of preexisting diseases hinges on who makes the final determination of a policyholder's preexisting diseases. Given the inability of the poor to access qualified providers most of the time and the low level of literacy among the targeted individuals, who will certify the preexisting diseases? Who will have the onus of proving preexisting conditions? They could be a major reason for rejecting claims. How will the UHIS offer relief to the poor suffering from preexisting conditions and chronic illnesses?
- *Covering maternity delivery.* The exclusion of maternity services, not considered an illness, works against the attainment of a priority objective of the central and state governments—that of decreasing the maternal mortality rate and successfully implementing its strategy of increasing facility-based childbirth. With most rural hospitals, public and private, charging from Rs 600 to Rs 2,000, depending on area and facility, the inclusion of maternity services in the UHIS would greatly contribute to attaining the MMR-related goals of the government.
- *Continuing financial sustainability of the UHIS.* Based on information from Oriental Insurance, table 4.6 shows the breakdown of expenses for an individual policy. Clearly, the government subsidizes all policyholders, with the biggest subsidy going to the poor. The issue of sustainability is further aggravated by the very small numbers of policyholders, forestalling the advantages of risk pooling, and was eroded further by adverse selection when the product classification was revised from group to individual.

¹⁰ Personal communication with Dr. Shyam Ashtekar, Primary Health Care Group, Bharat Vaidyaka Sanstha, 2003.

Table 4.6. Breakdown of UHIS Expenses

| <i>Category of expense</i> | <i>Percentage of premium</i> |
|---------------------------------|------------------------------|
| Allocation for claims | 80 |
| Commissions | 15 |
| Third-party administration fees | 20 |
| Total | 115 |

Note: Premium = Rs 365.

Source: Information provided by Oriental Insurance.

(iv) *Mediclaim*

Mediclaim is reputedly the best-selling health insurance product of the government. Marketed through the government insurance companies, it covers about 2.5 million people, or about 0.5 percent of the population. This product provides institutional hospitalization benefits or domiciliary hospitalization benefits. It is available to individuals, families, and groups.

Group Mediclaim is available to a group with a minimum of 100 members. It pays for medical expenses incurred by a policyholder while in the hospital, either in an institution or at home, under the following conditions: (a) in case of a sudden illness, (b) in case of an accident, or (c) in case of surgery indicated as part of the treatment of a disease that arises during the policy period. Except in cases of domiciliary hospitalization, pre- and posthospitalization are covered up to 30 days and 60 days, respectively. There are *no* annual limits or sublimits set within an illness episode. The natural limit is the amount of sum insured plus a limit for domiciliary hospitalization.

Coverage is for *all* employees of a company. All premiums are paid in full prior to coverage. Groups get the additional benefit of a group discount. Major exclusions include the following:

- Any preexisting disease
- Any expense incurred during the first 30 days of coverage, except injury from an accident
- Any expenses related to family planning
- Treatment for cataracts, benign prostatic hypertrophy, hysterectomy, menorrhagia or fibromyoma, hernia, fistula of anus, piles, sinusitis, asthma, or bronchitis
- All psychiatric or psychosomatic disorders

Individual and Family Mediclaim is a replica of the group policy except that premiums are based on the policyholder's age up to 90 years old (see table 4.7) and, to a certain extent, health, determined through review of a detailed application form. Family policies receive a family discount. Major exclusions include any expenses relating to pregnancy and childbirth.

Table 4.7. Mediciam key parameters, 2003 (Rs)

| Sum insured | Limits for domiciliary hospitalization | Policyholder age | | | | | | |
|----------------------|--|------------------|-------|-------|-------|-------|-------|-------|
| | | < 35 | 36–45 | 46–55 | 56–65 | 66–70 | 71–75 | 76–90 |
| 15,000 ^a | 3,000 | 213 | 232 | 331 | 379 | 427 | 455 | 551 |
| 30,000 | 6,000 | 366 | 398 | 572 | 648 | 723 | 779 | 971 |
| 90,000 | 18,000 | 1,182 | 1,285 | 1,840 | 2,088 | 2,336 | 2,508 | 3,114 |
| 500,000 ^b | 50,000 | — | — | — | — | — | — | — |

— = not available.

^a Minimum.

^b Maximum.

Source: Author's discussions with Mediciam management, Hyderabad 2003.

The Mediciam scheme offers a cumulative bonus of a 5 percent increase in the sum insured for every claim-free year insured, up to a maximum of 10 years. Because health insurance is a new product in India, there is little awareness or understanding among the population of the concept of paying for the possibility of something happening. To overcome this barrier to coverage, Mediciam offers a further benefit: for every 4 years of claim-free and continuous coverage, the policyholder is entitled to reimbursement for the cost of a medical checkup, up to the equivalent of 1 percent of the average sum insured for during the 4-year period.

Remaining concerns about the coverage include the following:

- Spurious claims are reportedly very high for both individuals and groups because of collusion between the policyholder and the provider.
- Adverse selection is a major issue because a majority of individual policyholders are age 45 and above, but they are not subjected to any precoverage medical checkup. Many also conceal their preexisting illnesses.
- Family planning is excluded from the benefits for group policies. Including family benefits could lower the number of claims of maternity benefits.
- The policy does not include any preventive care or disease-prevention programs, yet these programs could avert many instances of hospitalization.
- An annual physical checkup could also detect—and therefore avert—potential major illnesses that would require hospitalization.
- Outpatient care could help detect early onset of illnesses.
- With the increasing incidence of “lifestyle” diseases, a more proactive preventive health program can reduce the potential number and cost of hospitalizations.
- Agents are less discerning than the administrators of the scheme in identifying and going after business. Thus, more time is spent by the insurance company verifying and rechecking the potential policyholders.

(v) Employee State Insurance Scheme

The Employee State Insurance Scheme¹¹ is a social security system that provides medical care and cash benefits for sickness, pregnancy, disablement, and death caused by employment-related injuries to workers and employees of private companies, institutions, and other private business entities. It was aimed at factories employing 10 or more workers but also covers shops and establishments employing 20 or more workers. The scheme has grown rapidly since its inception and now covers 230,000 factories and establishments throughout the country, benefiting 8.6 million families, or about 34 million individuals. ESIS is compulsory; it is the private sector equivalent of the Central Government Health Scheme for central government employees. Together, the two schemes reportedly cover about 3 percent of the population.

Coverage is available to the following:

- Employees earning Rs 7,500,¹² excluding overtime, who work in
 - Nonseasonal factories using power and employing 10 or more employees
 - Nonseasonal factories not using power and employing 20 or more employees
 - Establishments, such as shops, hotels, and restaurants, employing 20 or more employees
- Up to four dependents of employees, including children up to 21 years of age and dependent parents (medical benefit only)
- Retired insured persons and spouses (medical benefit only)
- Insured persons who ceased to be insurable because of permanent disablement from a work-related injury, as well as spouses, upon payment of a contribution of Rs 120 per year (medical benefit only)

The scheme provides a number of in- and outpatient medical benefits, including hospitalization, specialist services, drugs, and diagnostics. It also provides for immunization and maternity benefits, as well as family planning and cash incentives to those undergoing sterilization. Cash benefits include a sickness benefit of 50 percent of wages for up to 91 days, with extended sickness-benefit provisions for long-term illnesses such as tuberculosis, leprosy, mental illness, and malignant diseases. An accident benefit provides a daily wage plus 20 percent. A death benefit pension is also paid to dependents of those insured.

Outpatient consultation and drugs are provided through ESIS-owned dispensaries or through a panel of private medical practitioners, who are paid Rs 120 per year per insured person. Each private practitioner is allowed to register up to 1,000 insured persons. Special drugs are dispensed through a list of accredited private pharmacies. If the drugs are not available at those vendors and are purchased by the insured elsewhere, ESIS will reimburse the cost.

Inpatient hospitalization is provided in ESIS-owned hospitals. For tertiary care, a referral from an ESIS secondary facility is needed to go to an ESIS, government, or networked private tertiary hospital. There are presently no caps on hospitalization.

¹¹ See “Andhra Pradesh: Rapid Private Sector Assessment” for more details on the ESIS.

¹² Those individuals earning less than Rs 40 a day are exempted from the employee portion of the contributions.

Patients diagnosed with occupational diseases are referred to ESIS Occupational Diseases Centers or to ESIS hospitals with bed allocation for occupational diseases.

ESIS is financed primarily through employee and employer contributions.¹³ Employees contribute 1.75 percent of their monthly salary and employers contribute 4.75 percent of employees' monthly salaries to finance the scheme. The government also has a mandated ceiling on payouts from the scheme. The scheme has a number of interesting features that allow it to be self-financing:

- *Mandatory.* The scheme is compulsory and, therefore, avoids some of the problems associated with adverse selection that have plagued other schemes.
- *Fraud.* Combining health care insurance with service provision removes the potential for collusion between the patient and the hospital to create fraudulent bills.
- *Contributions.* The rate of contribution is determined by the threshold for those eligible for the scheme. Raising the threshold automatically increases the amount of money coming into the scheme. Effectively, the level is set at the rate at which the scheme is financially viable.
- *Rationing.* Anecdotal evidence indicates that the facilities are widely underused and that they are of very poor quality, which discourages many members from availing themselves of their services. According to a World Health Organization report, "Poor quality and delivery of services; delay in enrolment and disbursement of cash benefits; non-coverage of temporary workers and their families" characterized the ESIS (WHO/SEARO 2000).

Table 4.8. Summary of Selected Insurance Schemes

| <i>Scheme</i> | <i>Premium</i> | <i>Benefit</i> | <i>Maximum</i> | <i>Coverage</i> |
|---------------|--|--|---|--|
| Mediclaim | Depends on | Rs 15,000–500,000 characteristics | Rs 500,000 | Formal sector |
| UNDP-Karuna | Rs 30 | Rs 100 per day (inpatient) | Rs 2,500 | All (poor subsidized) |
| Yashaswini | Rs 75 | Only inpatient | Up to Rs100,000 | Farmers (subsidy of Rs 15) |
| Jan Arogya | Rs 365 (individual) Rs 547 (family < 7) Rs 730 (family ≥ 7) | Inpatient Accident Lost wages | Rs 30,000 Rs 25,000 Rs 50 per day | All (poor subsidized Rs 100) |
| ESIS | Employee contribution 1.75 percent Employer contribution 4.75 percent | Lost wages Maternity Accident Hospitalization | Rs 600 per year | Formal sector workers earning Rs 6,500 per month or less |

¹³ The information for this section is from the Standard Note on Employees' State Insurance Scheme of India as of January 1, 2003.

Initial Observations on Insurance Market Development

A comparison of the various insurance schemes being piloted (see table 4.8) raises the following issues:

- *Covering of outpatient care.* Most schemes do not address many of the issues raised by the review of the burden of disease because they do not cover outpatient care or basic dental and eye care. Most of the schemes implicitly or explicitly hold that outpatient care is much more affordable than inpatient care and is much harder to verify.
- *Targeting maternal health.* Targeting individuals or wage earners, as many insurance schemes do, is likely to discriminate against women who spend a lot of their time in nonwage labor or child care functions. The maternal mortality rate at 408 per 100,000 births is very high. Normal delivery accounts for 23 percent of hospitalizations in India, and obstetric care is the fifth-leading reason for outpatient visits. Given this situation, future insurance plans should consider special schemes targeted at vulnerable women.
- *Targeting subsidies.* Many of the schemes include a subsidy element. However, the subsidies are all designed with reference to the individual as the unit of analysis. They are based on the idea that government should be helping the poor. An alternative method of targeting subsidies would be to design subsidized schemes that covered only health care services with a public-good element, such as immunizations, communicable diseases, and health education.
- *Limiting catastrophic coverage.* To some extent, all the schemes are aimed at providing catastrophic coverage to the individual. Although it is true that many vulnerable individuals and their families fall into poverty as a result of serious illness, it does not follow that public health care resources should be allocated to cover the costs of secondary or tertiary treatment of such illnesses. Such schemes should be designed within the framework of a comprehensive health care expenditure review and health care financing plan.
- *Involving the private sector.* In theory, the most-efficient health care delivery and health insurance systems would allow private sector health care providers to compete with the public sector on an equal footing. Such a design would entail deriving accurate public sector unit costs for all major types of illness covered by the insurance scheme. If this information was available, it could be used to cap payouts under the scheme, thereby reducing costs. It would also allow the private sector to bid effectively for patients. However, government officials currently have little idea of the unit costs of even the most basic treatments in the public sector. This area would clearly benefit from increased government attention.
- *Using gatekeepers.* Gatekeepers are primary health care providers that ensure that appropriate care is provided. They prevent individuals from obtaining expensive specialty care that is neither necessary nor appropriate.
- *Unifying insurance and health care provision.* One of the major strengths of ESIS is that it combines health care provision with mandatory insurance. Because the hospital and the insurer are effectively one entity, the patient has no incentive to collude with the hospital to submit fraudulent bills to the insurer.

- *Controlling provider quality.* The managed-care model has shown how a selection of providers receiving prenegotiated rates can bring down total cost and improve quality. This outcome could be achieved through a voluntary accreditation system or more formal means. It could also be augmented with patient-satisfaction surveys.
- *Improving financial viability.* Many of the government schemes are not financially viable; in fact, they have rarely aimed at financial viability. Moreover, most private schemes currently being developed have yet to break even. Part of the issue is that the chronic lack of data hampers a more reliable actuarial approach to measuring risk. Improving data gathering would resolve this issue.
- *Reviewing insurance legislation.* Current insurance legislation prohibits small insurers from entering the market. Although the minimum capital requirements were originally established to protect consumers from smaller companies that might easily collapse, such requirements are no substitute for improved insurance regulation. The capital requirements should be reviewed within the broader context of strengthening insurance regulation in India.

Box 4.2. Building a Savings Fund for Self-Help Groups

The Kurji Holy Family Hospital is a missionary-run facility that has operated in Patna since 1939. This 300-bed secondary general hospital provides general and specialty services. As part of its mission to help provide equal access to quality health care for all, it established two community health centers (CHCs). One is located within the hospital compound to give care to poor residents living in the surrounding slum communities within 10 kilometers from Kurji; the other is located in Maner Block, a rural district. Immunization, antenatal care, baby weighing, family planning counseling and commodities distribution, and health education classes are provided for an initial registration fee of Rs 10. Consultations for minor illnesses are also available for Rs 10 for initial registration and Rs 5 for subsequent visits. Vaccines and commodities are supplied by the government.

To complement its health services, each CHC organizes women-only self-help groups (SHGs). In the CHC in Patna, eight SHGs have been organized in a slum area where about 150,000 people reside. Each SHG created an all-purpose savings fund from fixed contributions of its members. Loans can be made from the fund for various purposes, such as microcredit for small businesses and for health expenses.

The SHG in Batta B is called Bajrang. It has 10 members, which is typical for an SHG. The membership agreed to contribute Rs 50 per month per member. From these contributions, it has loaned out a total of Rs 10,500 to its members. It generates additional income from interest on loans, bank interest, and fines imposed on members for infractions. As of January 16, 2004, it has a total bank deposit of Rs 9,835. The fund has been able to cover medical costs for various treatments, thus preventing the members of the group from falling into debt.

5 ENGAGING THE PRIVATE SECTOR TO CARE FOR THE POOR

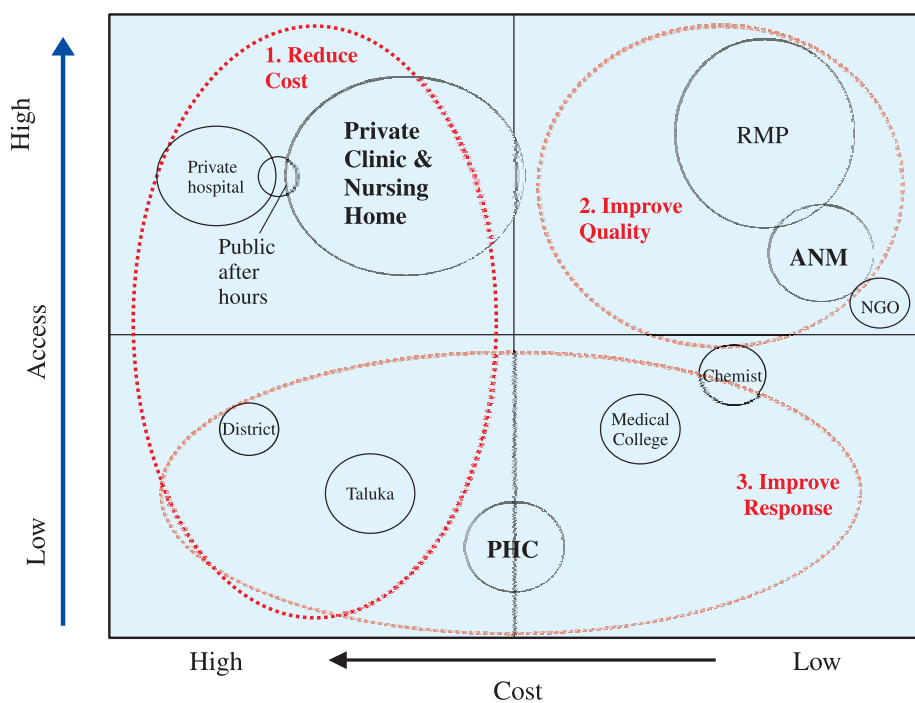
Summary of the Challenge

A huge unmet demand exists for interventions to improve primary health care. Central and state governments are focused on reducing the IMR (69 per 1,000 births) and MMR (440 per 100,000 population) as well as reducing communicable diseases by increasing the percentage of children immunized from the current 53 percent to 90 percent by 2020. In addition to those health challenges, almost half the children in India suffer from some form of malnutrition, and half the women suffer from anemia. Improving primary health care services as well as nutritional practices and emergency obstetric care are the keys to improving those health indicators.

Improving health outcomes will depend on improving the quality, outreach, and responsiveness of primary health care providers. In the past, the government's response has been to attempt to deliver those goods and services through public channels. Since the beginning of the 1990s, this effort has failed in all but a few states, as earlier chapters have shown. This chapter considers alternative responses and ways of improving primary health care for the poor by involving the private sector.

Figure 5.1 illustrates how the various health care facilities and providers compare in terms of access and cost. It is a stylized framework for thinking about health care service provision for the poor. The size of the bubbles in the diagram is roughly indicative of the market share of each provider. (In practice, the market shares would vary with the type of treatment and type of morbidity experienced.)

Figure 5.1 : Cost and Access in Rural Health Service Provision



Source : Author's illustration.

The diagram summarizes the current status of health care options available to the poor in India. Ideally the poor should have easily accessible and low-cost health care (that is, the upper right-hand quadrant) that is also of high quality. This analysis suggests three possible areas of intervention to improve the current situation, represented by the dashed ovals:

1. *Reduce cost.* Options on the left-hand side of the diagram involve high costs. First are the high direct costs of private medical care, and second are the high costs associated with the time and transportation to public facilities, especially those at the higher levels of the health care system. Given the high degree of out-of-pocket expenses, possible responses to this situation will involve implementing innovative health insurance schemes, increasing government funding to the sector (see the previous section), or both.
2. *Improve quality.* Facilities that are available locally and cheaply to the poor, especially the services offered by informal rural providers, fill a need for low-cost, easily accessible services. However, because many RMPs lack even the most basic medical training, the quality of their care is extremely poor. In many cases, the cure may be far worse than the disease.
3. *Improve responsiveness.* Public facilities are unresponsive to the poor for a number of reasons. The reasons behind the failure of the PHC system have been discussed in detail in previous chapters. At the *taluka* and district level the picture is almost entirely different. Public doctors at those facilities have a much higher status and sometimes a higher salary than those working in the rural areas. Those doctors are more willing to locate to such hospitals in urban centers because such locations have the amenities that they are looking for, such as good schools for their children; therefore absenteeism is less of a problem than in rural areas. Urban hospitals are also better stocked with drugs. Finally, owing to the collapse of the PHC system, they are inundated with high numbers of patients who should have been seen at the primary level.

Suggested policy recommendations in each of these areas are highlighted in the following section, using some case studies that describe successful Indian experiences in (a) contracting out, (b) social franchising, and (c) improving public sector performance. International case studies are presented in a background paper to this study.

Successful Case Studies

Contracting Out

In July 2000, Andhra Pradesh established 192 urban health centers (UHCs), each covering a population of 15,000 to 20,000.¹⁴ NGOs were contracted to run the centers on the basis of a model that included (a) delivering services to the residents, (b) mobilizing the community, and (c) engaging in behavior-change communication to encourage greater use of services.

The UHC Advisory Committee and the district health officer set the outputs expected from the UHC and conducted quarterly reviews of progress against established benchmarks. The UHC was allowed to charge Rs 2 per visit, and the UHC managers were provided with less than a quarter of the PHC budget despite covering half the population as a government-run PHC. Free

¹⁴ See “Andhra Pradesh: Rapid Private Sector Health Assessment” for more details on this case study and see “Contracting for Primary Health Care” for more information on contracting models in general.

from government norms and standards, the UHC management was able to recruit staff members such as ANMs on contract at half the government rate.

In their first few years of operation, the contracted UHCs have performed impressively. Most notably, they have increased the proportion of pregnant women visited by a health worker from 10 percent to 95 percent and the number of children fully immunized from 31 percent to 85 percent (see table 5.1)

Table 5.1. Performance of Contracted Urban Health Centers (percent)

| <i>Indicator</i> | <i>2000</i> | <i>2002</i> |
|---|-------------|-------------|
| Pregnant women visited by health worker | 10 | 95 |
| Antenatal care clients registered before 16 weeks | 46 | 65 |
| Institutional deliveries | 66 | 74 |
| Postnatal women who received advice on breast-feeding | 26 | 80 |
| Newborn babies weighed immediately after birth | 42 | 75 |
| Low-birth-weight babies | 8 | 7 |
| Children fully immunized | 31 | 85 |

Sources: 2000: baseline survey conducted by Administrative Staff College of India in January 2000; 2002: evaluation conducted by TNS Mode in June 2003.

Measuring performance clearly provided the NGOs running the UHCs with a powerful incentive to focus on results and outputs rather than on inputs. Involving the community and engaging in behavior-change communication also allowed the NGOs to respond effectively to local demand. The ability to sanction poor performers was also crucial to the success of the program. After the first 3 years of operation, four NGOs that did not manage to meet expected minimum standards did not have their contracts renewed. This action also sent a powerful signal to those that continued with the program.

The program illustrated that even NGOs with no previous experience in health could easily and successfully take on the management and delivery of health care services through a UHC.

Social Franchising

Social franchising programs posit the idea that it should be possible to provide social goods and sources such as pro-poor health care using the same franchising tools developed to deliver consumer goods such as Coca-Cola to every poor village in the world: by standardizing the product and the way it is delivered under a strong brand name. The program is based on the premise that, despite significant demand for health care services from the poor and vulnerable groups that use private health care facilities and RMPs, formal private providers offer little response and informal providers offer only poor-quality care.

Janani has been operating a franchising model in Bihar since 1996.¹⁵ It aims at providing family planning products to vulnerable communities. Janani sells pills, condoms, and other family planning products, such as rapid-test services for pregnancy, blood pressure, and diabetes, in

¹⁵ For more on the franchising model and the Janani case study, see background paper “Franchising for Primary Health Care.”

urban areas through shops and pharmacies and in rural areas through a network of RMPs. The centers are branded with the Titli butterfly logo and ensure the end users of the quality and service that they can expect at a transparent and predictable price. The franchiser provides the retail owners (always at least one female RMP) with training and products that are purchased in bulk and, therefore, provided at less than the market price. The Titli centers are supported by a network of clinics to which patients are referred. Each clinic has a qualified doctor, an ANM, an administrator, a counselor and a lab technician. They operate under the Surya (sun) brand name.

The Titli center owners pay an annual membership fee equivalent to US\$12 for those services. Membership fees cover the cost of advertising and marketing campaigns as well as franchise maintenance. The marketing campaigns are based on empowering the poor through education—not just providing information about the franchise products, but also providing more general information about family planning issues.

The focus on quality of care is reinforced through a network of franchise supervisors who ensure transparent pricing, infection control, waste disposal, and diagnostic facilities are implemented correctly at the Titli centers and the clinics. In general, the franchising model works because it is self-regulating. Membership in the franchise has the potential to improve outcomes for both the provider and the client. For the providers, there is the potential for increased revenue through increased volume and lower input costs as well as through an expanded range of services and access to training and advertising services. Meanwhile, the client is assured of high-quality care, a consistent stock of important products, clean facilities, and courteous service. Although the current pilots in Indian states center around family planning services, the model could in theory be used to deliver other health services; however, it is more difficult to provide services than products.

Although the model has been very successful in expanding outreach of family planning services to rural areas, it has not stopped the RMPs from continuing to practice quackery with all its concomitant dangers. Other challenges faced by the model include the financial sustainability of the franchisers and, to a lesser extent, the franchisees. Those franchises that include a public health component often require ongoing subsidies to remain viable. However, given the positive externalities associated with such primary health care interventions as family planning and immunizations, it might be sensible for government to partially subsidize the costs of the public-good components of those services.

Improving Public Sector Performance

In 1996, Punjab embarked on an ambitious program to improve the state's public secondary health system.¹⁶ The initiative began with the introduction of the Punjab Health Systems Corporation (PHSC), which was established to run the secondary health facilities outside the authority of the stifling government bureaucracy.

User charges were introduced at all the facilities, and the revenue generated was retained at the facility level to provide drugs, patient facilities, equipment, and building maintenance. Although

¹⁶ For a more detailed explanation of this pros and cons of this case study, see the background paper "Punjab: Health Sector Assessment."

user charges account for only 7 percent of spending, they have made a great difference not only in providing for items that were not previously budgeted for (such as maintenance) but also in providing hospital management with greater autonomy in using the budget. The chief medical officer in each facility has the ability to waive user charges for the poor, and all BPL yellow cardholders are provided with free treatment.

A health management information system was established to provide the timely and accurate information required to improve facility management. The computerization of hospital records and their publication on the Internet (see <http://www.punjabhealth.org>) also established a transparent performance culture in which each facility is graded on key indicators. PHSC also introduced nonmonetary incentives, such as letters of appreciation to outstanding health workers, that have far surpassed targets.

PHSC outsourced several nonclinical services, such as ambulances and sanitation. Charging for ambulance use at Rs 3.50 per kilometer provided the operators with a regular revenue from which to ensure that the fleet was always operational. Outsourcing sanitation resulted in very clean hospitals, as confirmed by a recent patient-satisfaction survey that indicated 71 percent of PHSC patients were satisfied with the cleanliness of the toilets compared with 42 percent in non-PHSC facilities.

The results of the reform program have been impressive, with tremendous increases in key performance indicators. In the past 2 years alone, surgeries have increased by 58 percent, the number of deliveries by 36 percent, and the number of laboratory tests by 82 percent.

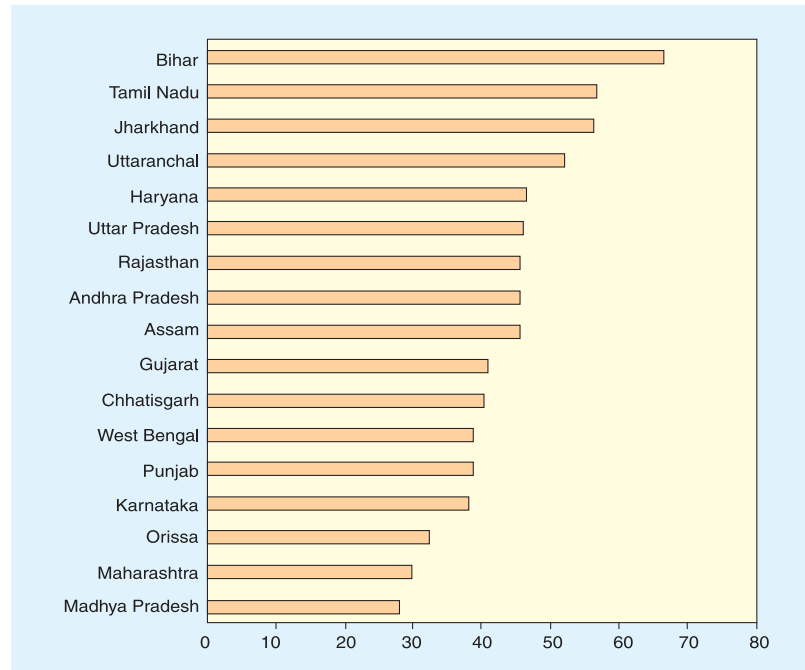
Political Economy of Change

Whatever suggestions are adopted, reform of the health system will have to overcome powerful vested interests. The current system has evolved largely in response to the incentives embedded within the system. Changing the incentives will create winners and losers, and therefore reformers can expect that reforms will be strongly opposed by certain stakeholders and that reforms will only be adopted if reformers consider the political economy of change before designing the reform program. Some suggestions, largely based on our discussions with key stakeholders, are offered here.¹⁷

Who Gains from the Current Situation?

At the moment, both the public and private sectors are failing to improve health outcomes in India. The public sector is characterized by low levels of funding, poor incentives to perform, and little or no effective oversight. Inadequate budgets result in unfilled posts and constant shortages of essential drugs. Because the public sector has no institutionalized incentives to perform, it is entirely up to individual health care workers (especially the medical officers in charge of PHCs) whether they will offer decent health care services to the community and, in fact, whether they will turn up for work. Figure 5.2 indicates that between one- and two-thirds of doctors are absent at PHCs throughout India. The corresponding numbers for other health workers are just as high (see table 5.2).

¹⁷ A full list of stakeholders consulted in each state is found in the state-level documents that accompany this main report.

Figure 5.2 : PHC Doctor Absentee Rates by State

Note : The absentee rate is the percentage of providers who are supposed to be present but who are not on the day of an unannounced visit.

Source: Chaudhury and others (2004)

Too often, doctors posted to rural areas are not resident locally. Some visit intermittently, while others never visit their official postings at all. Such doctors are reported to collect their government salaries while engaging in full-time private practice in nearby urban centers. By the time that complaints are lodged and investigated, the doctors will have been rotated to another district. This year, for the first time, the government of Karnataka dismissed two doctors from the service. Their offense was not reporting for work during the past 10 years. It is claimed that such doctors often escape censure by bribing their superiors and that corruption within the system is endemic.

Public doctors who do turn up for work often charge patients for basic medical care that should be offered free of charge. Many also operate private practices after hours. Both practices blur the distinction between public and private practice (see Heywood 2003). Stakeholders consulted in the course of this study report that, in such cases, doctors' superior officers will receive a portion of the profits in exchange for turning a blind eye to these practices. It is also reported that the position of district health officer is one that carries a lot of prestige and status within the Department of Health, in part because such officers can extract payments from absentee doctors and others infringing the regulations.

Any reform of the system that attempts to make doctors turn up for work in return for receiving their salaries is likely to encounter tremendous opposition from the doctors' associations. Early discussions with doctors and their associations undertaken during the course of this study indicate that they are unwilling to consider alternative methods of oversight. For instance, one simple method of ensuring that doctors turn up is to allow the Panchayati Raj institutions to play a more prominent and official role in the oversight of the doctors. Doctors have stated that they would not be willing to consider being sanctioned by the heads of local Panchayati Raj institutions, who are likely to have little knowledge of health care issues and to be much less educated than the medical officers.

Other winners in the current situation are the quacks and informal providers. More than 15 years have passed since the first Supreme Court edicts banned the practice of quackery, yet it continues to flourish all over the country. Governments are unwilling to implement the Supreme Court's decision for the simple reason that RMPs constitute an important constituency and are often closely connected to the Panchayati Raj in many villages. RMPs outnumber qualified doctors by at least 10 to 1 and, therefore, wield considerable political clout by virtue of their numbers and their standing as opinion leaders in rural settings. Qualified doctors complain that villagers often have more faith in the healing capabilities of such quacks than they do in medical doctors.

In some areas, quacks are so powerful and well entrenched in the local community that they are able to drive out qualified public sector doctors who threaten them. In other communities, RMPs build lucrative symbiotic referral relationships with unscrupulous private sector doctors. RMPs are often careful to share a percentage of their profits with the local police and elected officials to ensure that those groups offer them protection when needed.

In many ways, reforming the informal providers will prove much more difficult than dealing with the formal sector because government has little leverage other than the court rulings. Informal providers receive no funding from government, and it is almost impossible—and perhaps counterproductive—to attempt to harass them out of business. Interestingly, government officials are often the most keen to drive informal providers out of business, pointing to the illegality of their current practices and their potential role as competitors to the public sector. Doctors we consulted have a more ambivalent attitude. They are aware that quacks can sometimes represent stiff competition for them in rural settings and that allowing others to practice medicine without a degree cheapens their profession. However, they are also aware that quacks can represent a lucrative source of income and referrals, which led to the Indian Medical Association's suggestion that quacks be registered and brought under the authority of PHCs and qualified doctors operating in the rural areas.

Who Are the Losers in the Current System?

Several forms of fraud (such as absenteeism and drug procurement) within the public sector clearly have a tremendously detrimental effect on health outcomes for the poor. Salaries quite often form 90 percent or more of the budget of Indian health facilities. If 30 to 65 percent of such salaries are going to absent health workers, up to half the public health budget is being wasted. Moreover, the recent experience in contracting out the UHCs in Andhra Pradesh has shown that some government health workers are paid up to 4 times what they could earn outside the government. This evidence clearly establishes lucrative government jobs as a source of patronage to be handed out by politicians to their supporters, usually just before elections. The losers in such a system are the end users, especially those in rural areas.

Parts of the private sector are losing opportunities under the current situation. As long as the government maintains a monopoly on the management and delivery of public health, the private sector will be missing an opportunity to get involved. Medical colleges are especially interested in running PHCs to allow their trainee doctors to get firsthand exposure to a variety of patients. The government clearly has an opportunity to capitalize on potential synergies in this area. There is also a strong tradition of charitable work by both for-profit and nonprofit organizations that can be tapped successfully to augment limited public budgets devoted to health care.

In all these cases, ordinary people are the ultimate losers.

Who Are the Champions of Reform?

Key reformers within the state include senior government health officials who see the need for reform and who are willing to experiment with pilot projects that can be replicated. However, they often come up against a bureaucracy that feels threatened by private sector participation. In many cases, the public sector does not have a clear understanding of what the term *private sector* means, and perhaps a better term to use might be *nongovernmental sector*. On the one hand, many government officials believe that the private sector comprises corrupt rent-seekers and that it is involved only in high-cost, tertiary care in urban centers. On the other hand, the private sector is wary of getting involved with government, especially in any ventures that might involve getting paid by government. The private sector sees government officials as self-centered individuals seeking opportunities for illicit payments and favors. Any successful reform program would have to start with a process of dialogue that would overcome such misunderstandings and mutual suspicions.

Other key stakeholders that have an incentive to implement reforms include motivated doctors and the general public, especially the end users of rural PHCs. Independent NGOs and their leaders have also proved strong proponents of reforms, able to hold the government accountable and to raise the alarm about the most egregious examples of corruption and public sector failure.

The private sector is also a strong lobby group for increased private sector participation. However, most public sector health officials in India view the private sector with suspicion. Many are reluctant to encourage partnerships with the private sector, which they see as potential competitors. For instance, in Andhra Pradesh a successful experiment with NGO contracting out of UHCs has not been augmented to cover PHCs, and government officials remain reluctant even to continue the current model.

The poor have the greatest interest in improved health care provision. Unfortunately, they also have the least voice in the process. Improved health care outcomes will require increased community mobilization, education, and awareness. Government must also consider methods of empowering the people by adopting nontraditional techniques and community-based approaches usually piloted by NGOs. For that reason, a flexible contracting model that allows NGOs and for-profit private providers to run PHCs is potentially powerful. It will introduce a results orientation and innovative methods of structuring and managing health care provision that a public sector monopoly will never be able to achieve.

What Institutions Are Required for Change?

As the previous section indicates, powerful vested interests militate against private sector participation in health. Moreover, additional constraining factors are the lack of capacity (managerial and technical), the technical complexities and the fiscal risks, and the space required to pilot such initiatives. Experience in other countries, most notably Chile and Colombia, has shown that governments need to build institutional capacity to deal with the transition from managing and financing public providers to maximizing the effect on the populace.

At the core of this transition, two changes need to occur. First, government needs to create a separate financing and purchasing function, either internal or external to the Ministry of Health, to counterbalance the traditional provider role. Second, the newly created unit needs to shift financing from historical budgets to performance- and results-based financing. This groundwork is essential to successfully undertaking contracting, demand-based financing, or insurance, and it forms the heart of the first policy recommendation presented in chapter 6.

6 POLICY RECOMMENDATIONS

Different Solutions for Each State

This analysis illustrates that within India huge disparities exist between the states. A single policy prescription, or “one-size-fits-all” recommendation, does not make sense in such a context. The background papers for each state highlight the most important health challenges and most promising policy options on a state-by-state basis. This chapter offers a range of policy suggestions that each state could consider, depending on the particular health challenges, fiscal space, and implementation capacity within each state. Building on the analysis in chapter 5, the suggestions are grouped into the following areas:

- Improving stewardship and oversight
- Improving responsiveness
- Improving quality
- Reducing cost

Improving Stewardship and Oversight

This study has illustrated that delivery of health care by the private sector has grown without any guidance or oversight from the public sector. In turn, this unregulated growth has led to duplication of facilities in urban centers, variable quality of services, corrupt practices, and lack of integration with respect to public health issues such as public health surveillance. It is vital that the government improve its stewardship capacity and augment its authority to cover the private sector.

The organizational structure of the government—at both the central and the state levels—currently lacks a strong unit that can analyze health system performance and key health system strategies. An organizational locus for monitoring and evaluation of health system development and consequent use of that information in policy design are also lacking. Along with this lack of organizational structure as a base for the government’s stewardship role, limited training and technical capacity exist among senior and mid-level officers to design, plan, implement, and evaluate major health system innovations such as health financing reform or engagement of private providers in the provision of essential services. Strategic planning and stewardship over the whole sector are nonexistent.

Policy Recommendation 1: The Government Should Strengthen Its Public-Private Partnership Capacity

The government should review its structure and consider what organizational and capacity-building strategies could be proposed to address the deficiency described. Possible actions to be considered include developing a public-private partnership unit at the state and national levels, establishing a health policy institute outside of the government organizations, and contracting out specific work in the private sector to existing institutes.

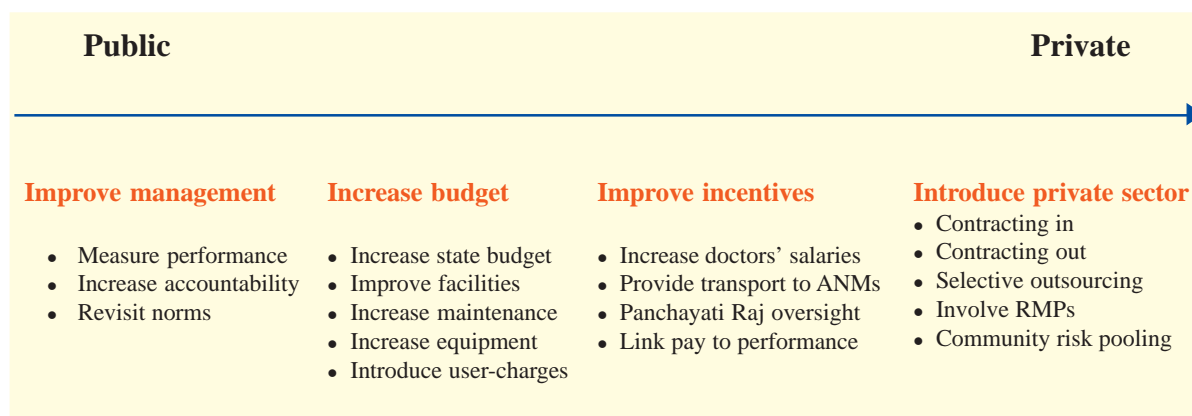
These units should develop a long-term policy for national- and state-level private sector participation in health. In particular they should

- *Draft a vision statement or policy paper for the whole health sector.* Central and state departments of health need to draft a policy paper for the whole sector—both public and private—focusing on the primary level. The resulting paper would need to be the subject of wide-scale stakeholder consultation and debate before being adopted and approved by the respective governments.
- *Consider partnerships with the private sector.* Because the private sector is the entry point to health care for most illnesses, an effective public health system must incorporate the private sector. At the very least, the government should consider methods for exchanging records on the most important communicable diseases. The government should consider bringing in private sector representatives to take part in the design and implementation of national health programs and priorities. The government can also build capacity to purchase primary health care from the private sector where appropriate, as discussed previously.
- *Review pertinent legislation.* In some cases, the current legal framework is not conducive to private sector participation in health. For instance, high minimum-capital requirements for private insurance companies effectively protect the sector from competition. In some states, outdated regulations constrict the ability of the formal private sector or drive it into informality. Any attempt to partner with the private sector should be based on a sound and up-to-date legal framework.
- *Increase capacity for strategic planning.* Government must augment its planning and reform capacity. This process should start with a realization that good doctors do not necessarily make good managers. The skills required to be an eye surgeon are entirely different from those required to manage public health care or contract with the private sector. Top-level positions in the department need to be filled with excellent managers, private sector representatives, public health specialists, and health economists in addition to doctors.

Improving Responsiveness

The previous chapters have shown that the current health system is not meeting the needs of the poor, especially for low-cost, high-impact primary health care. The private sector is either focused on providing expensive tertiary care for the rich or providing poor-quality informal services for the poor. Meanwhile, the public sector has failed to deliver even basic primary health care, such as immunization, antenatal care, and improved nutrition. Confronted with such a situation, government can either improve the performance of the public sector or contract with the private sector to provide primary health care. A range of options for reform lies between these two poles. These options are presented in figure 6.1 and are not intended to be mutually exclusive.

Figure 6.1 Method of Improving the PHCs



Source: Author's illustration.

It is important to realize that inviting the private sector to deliver primary health care services does not mean that the public sector is withdrawing from this area. Rather it is changing its role from one of providing health care to one of financing, monitoring, and making policies regarding health care.

Policy Recommendation 2: States Should Contract Out the PHCs

Introducing private sector participation is perhaps the most promising and challenging reform option. States like Karnataka and Andhra Pradesh have shown that contracting out PHCs to NGOs can result in improved outcomes and reduced expenditure. States that already have a track record in contracting out to NGOs should consider building on this experience and scaling up their efforts to include the for-profit sector. Other options available are contracting in and outsourcing selective functions to the private sector—for instance, immunizations or antenatal care.¹⁸

States that are new to private sector partnerships can start by piloting initiatives in limited geographical areas. Contracting the private sector to run a certain number of PHCs in a contiguous area has the advantage of offering economies of scale and reducing the private sector costs of bidding. Focusing on a particular location also allows government to select a poorly performing area and reduces the spillover effects of patients and diseases from other jurisdictions. The steps required to contract out PHCs to the private sector are spelled out in detail in the background paper to this study “Contracting for Primary Health Care.”

Another way to improve the responsiveness of the system is through demand-led financing that uses vouchers or health cards. Voucher programs are a potential way of increasing access for vulnerable groups. They have not been tried yet in India but have been successful in other countries, most notably in Nicaragua to provide reproductive health services to vulnerable groups and in the Philippines. Voucher programs work best for discrete services, where there is little or no opportunity for patients or doctors to generate excess demand. The best demand-side mechanisms would allow BPL households access to either public or private facilities. More detailed information on voucher schemes is included in the background paper on international case studies.

¹⁸ These options are discussed in detail in the background papers to this study.

In theory, the public sector could manage PHCs as well as the private sector. In practice, that does not happen because the incentive framework within the public sector is not conducive to the efficient delivery of goods and services. Improving the incentive framework could involve introducing some of the management techniques used in the private sector, such as measuring performance (and linking it to pay), holding absentee doctors and other health workers accountable, and reducing the number of transfers. Considerable scope for improvement exists within the current system. However, such improvements are likely to be marginal at best. An approach that relies on inflexible norms and standards, that is focused on inputs, that is operated almost without management oversight, and that is grossly underfunded will never be able to rise to the current health care challenges. Reform within the system would more beneficially start with a complete overhaul of the PHC structure and reconsideration of the existing PHC norms. Some suggestions along these lines are included in appendix E, which also highlights the tremendous improvements that Punjab has seen through a corporatization of its secondary health facilities.

Improving Quality

Informal providers dominate the private sector. They provide the majority of outpatient care and account for a large amount of out-of-pocket health care expenses, especially for the poor. In the medium term, informal providers will gradually disappear as the health system improves and rural villagers have access to better care and become better informed. In the short term, informal providers are a reality of India's health system. Ignoring the informal providers will not make the problem disappear. Experience in Bihar illustrates that informal providers can play a role both through social franchising of family planning products and improved care of sick children (Chakraborty and others 2000).

Policy Recommendation 3: Devise a Strategy for Improving the Performance of Informal Providers

Some suggestions for improving the performance of informal providers that will not preempt government's strategy follow:

- *Mainstream some RMPs.* Some stakeholders have suggested that some informal providers could be mainstreamed and trained as general health workers. The average PHC covers about 30 to 35 villages and would, therefore be likely to include an area in which up to 80 informal providers are operating. These RMPs could be brought under the control and supervision of a qualified doctor at the PHC. Although this idea seems appealing at first, it might prove unworkable in practice. First, qualified doctors at the PHC are not effectively supervising the PHC staff, much less a large number of unqualified practitioners in remote rural areas. An improvement in PHC operations would have to take place before this option could become a reality. Second, because many RMPs are well paid, making between Rs 5,000 and Rs 10,000 per month in consultations and reportedly several times that amount in referral commissions, they would be unwilling to be mainstreamed if it resulted in a reduction in their incomes.
- *Provide training and accreditation.* A brief review of the operations of the RMPs illustrates that the vast majority are unqualified to practice allopathy. In giving injections or prescribing medicines to almost all their patients, they are potentially exposing

themselves and their patients to HIV/AIDS and other diseases. Research has shown that those RMPs who are provided with an intensive package of support, including INFECTION (a training methodology based on observation and trial) and observed case studies, dramatically improve the quality of the care they provide to sick children (Chakraborty and others 2000). The government could consider offering advice, information, and possibly accreditation to the RMPs. This education will ensure that they have the required information to offer safe injections and may move some way toward replacing irrational treatments with evidence-based medicine. Some RMPs currently pay for and attend training. If trained RMPs could charge higher prices or attract more clients, they would have a greater incentive to attend training. However, this scheme would require training to be accompanied with some recognized form of certification or accreditation, which would help users to selected better quality care; government oversight of the training course material and provision; and public demand for accredited providers, which could be stimulated through education and awareness campaigns (see below).

- *Conduct public education campaigns.* This review points out a huge need for the government to invest in better knowledge for patients and their health care providers. In addition to training RMPs, a public education campaign would play a useful role in health care delivery. A health awareness campaign could cover the potential hazards of visiting RMPs as well as general information on illnesses that the rural poor are likely to experience and their appropriate treatment. Such a program, if successful, could create a demand for improved needle protocols and reduced use of drips, steroids, and antibiotics. Community mobilization and public education components could easily be built into PHC contracting-out arrangements and indeed have been an integral part of the successful pilots in Andhra Pradesh (see chapter 5).
- *Use social franchising.* Franchising is traditionally used in the private sector to expand outreach of a certain product and to capture economies of scale while ensuring a high product quality. Those characteristics make it particularly suitable for improving access to health care, especially health care that can be packaged as a product. Involving RMPs in a franchise scheme has a number of advantages. It can train the RMPs to provide useful services such as family planning products and advice. It can build on an existing grassroots network that is already well established and respected in rural areas. The Janani experience in India illustrates that outreach through an RMP franchise scheme can be rapid and effective. However, the current model also illustrates that such a program faces greater difficulties in trying to reduce the inappropriate responses of RMPs. The government's role in such a scheme could be to support the public-good elements, such as through an awareness campaign or a subsidy to the franchisers. A separate background paper to this study provides more detail on the social-franchising model and the Janani experience.

Reducing Costs

In India, out-of-pocket expenditures are estimated to finance approximately 70 percent of an individual's health expenditures. As shown previously, paying for health care in such a manner often pushes families into poverty. Reducing costs for the poor could simply involve increasing

government spending allocations to the sector. Plenty of evidence shows that public health care budgets in India are extremely low, woefully inadequate to address current challenges, and completely incongruent with the current national strategy and coverage targets. In the past, however, increased allocations to health have simply gone for new hiring and increased salaries to health workers, who are often absent from their posts. Increasing spending in the absence of reform is, therefore, unlikely to have a significant effect on health outcomes.

Policy Recommendation 4: Promote Sustainable and Affordable Health Insurance

An alternative method to reduce out-of-pocket expenditures is to establish affordable health care insurance for the poor or medical savings accounts (see chapter 4). Expanded coverage of successful insurance scheme pilots might go a long way to pool the risks and overcome the reluctance of the poor to seek inpatient treatment. However, such an initiative is fraught with difficulty. The government has made several vain attempts to establish such schemes in the past, as chapter 4 illustrates. Unfortunately, government schemes are prone to political interference and mismanagement. It is suggested that the delivery of health insurance should be left to the private sector and that the government should focus its efforts on improving the regulatory and enabling framework.

The government should analyze existing risk pooling and health insurance schemes. Such an analysis should form the basis for a new strategy aimed at mobilizing more resources for health on a prepaid basis, pooling them, allocating them effectively, and using payment and purchasing methods to achieve priority health goals. A start has been made in this regard, and the initial findings and key challenges are presented in chapter 4. More details are found in the background papers, especially the state-level reviews of Andhra Pradesh and Karnataka. Further work in this area has been undertaken by a World Bank team, and the results of this research are shortly to be published separately.

Strengthening health care financing includes developing the health insurance market and risk-protection schemes. The agreed emphasis on strengthening health insurance must be based in a larger health system financing strategy that addresses the government's overall goals of improving health outcomes, is logically consistent, and is fiscally and administratively sustainable. The development of a health financing strategy requires sound information and evidence that includes the following:

- A health public expenditure review will improve the evidence basis on the flow of funds with the public system. It should include a public expenditure management review to understand at which levels and according to which criteria decisions concerning allocation of public resources for health are made.
- National health accounts are needed to better understand the flow of funds within the health sector, including private sources of financing and private providers. The beginning of a system of health accounts has been completed in some states, including Karnataka (Annigeri 2003).
- Development of a medium-term fiscal plan for health is needed as a means of strategic financial planning. Such a plan will encourage the use of health financing tools in a well-planned and focused way to improve the priority outcomes set for the health sector.

Areas for Further Research

This study has provided an overall assessment of the current and potential role of the private sector in health care delivery for the poor. It points to the potential benefits that will come as a result of improved government stewardship over the whole sector, followed by contracting for primary health care and facilitating the introduction of financially sound insurance and social franchising schemes.

The background papers provide more detailed information that would be required by government officials interested in piloting such schemes. However, several issues are beyond the scope of this study that deserve to be studied in further depth, including the following:

- *Surveying the private sector survey.* This study has drawn on existing surveys of the formal and informal private sector in selected states. A more-extensive effort is required to assess the size, scope, charges, services delivered, quality-control mechanisms, and so on of the private sector.
- *Understanding success.* Although the public sector in most Indian states has failed to deliver quality health care to the poor, it has succeeded in certain states, such as Kerala and Tamil Nadu. Health care stakeholders are undecided on the reasons behind this success. A study examining the reasons behind these successes could point the way toward improving public sector health interventions in other states.
- *Piloting insurance schemes.* As described in this study, although several pilot insurance schemes have been attempted by both the public and private sectors, none has successfully addressed the needs of the poor in an equitable and sustainable manner. Further action-oriented analysis, such as the formulation of a successful pilot scheme, would represent a major breakthrough in this important area.
- *Analyzing social franchising.* Although social franchising schemes have been shown to be tremendously successful in extending outreach of basic family planning products and services, to date there is no robust cost-benefit analysis that would determine whether such schemes represent the best use of public resources.

APPENDIX A: POVERTY IN INDIA

Approximately 29 percent of the Indian population is estimated to live below the poverty line (World Bank 2003). However, using the internationally comparable standard of the proportion of people living on less than US\$1 a day, the poverty rate for India was 39 percent in 1999/2000. Although India has made significant progress in reducing poverty (down from an estimated 36 percent in 1993/94), a considerable challenge remains. To meet the Millennium Development Goals, India will need to reduce the number of people in poverty by an additional 123 million people by 2015.^a

To set the context for the study and focus it exclusively on the poor, a brief review of some of the social and demographic characteristics of the poor is useful. This section reviews the following factors that affect health outcomes of the poor: geographic location, economic characteristics, gender inequalities, educational attainment, health status, ethnicity, and access to clean water and improved sanitation. Readers who are familiar with the Indian context may skip this section.

Geographic Location

The poor are concentrated in the northern region of the country, primarily in the states of Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh (BIMARU); the total population of those states is approximately 366 million. More than 80 percent of this population lives in rural areas, where there is a high dependency on the land and agriculture as a source of income. Wealth varies widely between these poorer states and the richest states in India; Bihar has a gross domestic product (GDP) per capita of approximately US\$85, whereas Delhi, the country's richest state, has a GDP per capita of approximately US\$600. This difference illustrates the wide variation between the states in terms of income levels and standards of living.

Economic Characteristics

The poor live overwhelmingly in rural areas, where they are engaged in agriculture, either working as laborers or working their own land. Many of them lack any type of material assets to use in case of emergency and tend to have very limited access to institutional sources of credit. All these factors, combined with limited public spending on health care, put the poor at a high risk of not receiving adequate health care for their ailments. Statistics show that more than 40 percent of hospitalized Indians are forced to borrow money or sell assets to cover their expenses, and of those who are above the poverty line, 25 percent fall into poverty as a result of their hospitalization (Peters and others 2002, p. 5).

Gender Inequalities

Women are typically more disadvantaged than men in terms of economic status because of their lack of education and the “triple burden” of child care, housework, and labor. Women are often considered to be part of the household's dependency burden because many of them earn less for their unskilled labor than men. Women are also disproportionately affected by the poor state of the health care system; the maternal mortality rate is approximately 410 per 100,000 live births, which puts India in the highest category of maternal mortality rates in the world.

^a Population in poverty in 1990 was estimated at 347 million.

Illiteracy

Illiteracy rates in the poorest regions of the country are above 60 percent, much higher than the national average of 43.5 percent. Illiteracy hinders the ability of the poor to become socially and economically mobile. Illiteracy among women is higher than it is for the men in every area. “Spending” (forgone wages) on education for women is not seen as beneficial because many of them are married young and the education would benefit only their husband’s family, not their own. On average, illiterate women have more children, do not immunize them, and have a higher rate of disease prevalence (see table A1). Improving female education will improve health outcomes.

Table A.1. Selected Statistics Pertaining to Child Health Care among the BIMARU States (percentage of children)

| <i>State</i> | <i>Infant mortality rate</i> | <i>Under-5 mortality rate</i> | <i>Age 12–23 months who have received all vaccinations^a</i> | <i>Under 3 years under weight</i> | <i>Under 3 years stunted</i> | <i>Under 3 years wasted</i> |
|----------------|------------------------------|-------------------------------|--|-----------------------------------|------------------------------|-----------------------------|
| Bihar | 72.9 | 105.1 | 11.0 | 54.4 | 53.7 | 21.0 |
| Madhya Pradesh | 86.1 | 137.6 | 22.4 | 55.1 | 51.0 | 19.8 |
| Rajasthan | 80.4 | 114.9 | 17.3 | 50.6 | 52.0 | 11.7 |
| Uttar Pradesh | 86.7 | 122.5 | 21.2 | 51.7 | 55.5 | 11.1 |
| All India | 67.6 | 94.9 | 42.0 | 47.0 | 45.5 | 15.5 |

^a BCG, measles, and three doses each of diphtheria, pertussis, and tetanus and polio vaccines

Source: National Family Health Survey, India 2002.

Scheduled Castes/Scheduled Tribes

Studies on scheduled castes and scheduled tribes (SC/STs) indicate that they are more prone to fall below the poverty line than other segments of Indian society. Of SC/ST households, 65 percent are below the poverty line. SC/STs also have higher rates of infant and child mortality, malnutrition, and morbidity. In addition, SC/STs have the highest fertility rates in Indian society, which only increases the financial burden on this group.

In Uttar Pradesh, SC/STs constitute less than one-quarter of the population yet continue to account for one-third of the poor in that state, which furthers the assumption that social identity is a strong predictor of who is and is not poor. “Lower castes often live on the fringes of rural villages, often distant from public services such as schools, health centers, public hand pumps, and shops that distribute subsidized grains, in principle all services meant to assist poor families” (World Bank 2002). Reports show that even if SC/ST members have access to public facilities, they are often discriminated against by upper-caste members who control these facilities.

Access to Water and Sanitation

Access to clean drinking water is a critical element in reducing the spread of diseases such as cholera and diarrhea. According to statistics of the United Nations Children’s Fund, only 84

percent of the Indian population has access to safe water, which leaves approximately 164 million people vulnerable to waterborne diseases. It would be safe to assume that a large portion of this population falls below the poverty line and is located in rural areas, where basic utilities have yet to reach many communities.

Only 2 percent of the Indian population has access to adequate sanitation. Recent studies in the country also show that there is a large variance between rural and urban communities in access to adequate sanitation. According to a 1998 World Bank study, of the poorest quintile in the rural areas, only 9 percent of the households had a latrine in the dwelling compared with 31 percent for the wealthiest quintile. This finding contrasts sharply with that for the similar group in urban areas, where 71 percent of households in the poorest quintile had a latrine in the dwelling and 94 percent in the wealthiest quintile (World Bank 1998, p. 54).

Alcoholism and Tobacco Use

Alcohol and tobacco use are high-risk factors for cardiovascular disease. National Sample Survey data show that, throughout India, alcohol and tobacco use is higher among the poor than the nonpoor, which puts the poor at a higher level of risk for cardiovascular disease than the nonpoor. These habits also make the poor more susceptible to other related diseases, such as cancer and liver disease (Peters and others 2002, p. 208). This trend is on the increase in many rural areas.

Box A.1. Effective Technologies to Combat Communicable Diseases

The following drugs and technologies are highly effective when used correctly:

- Antibiotics for treating pneumonia are 90 percent effective. Cost: Rs 15 per course.
- Oral rehydration for treating dehydration caused by diarrhea is highly effective. Cost: Rs 20 per dose.
- Measles vaccine is 85 percent effective in preventing measles. Cost: Rs 12 per vaccination.
- Tuberculosis medicines are 95 percent effective in curing TB. Cost: Less than Rs 500 for a six-month course.
- Antimalarials are 95 percent effective. Cost: Rs 6 per course.
- Bednets, by reducing mosquito-borne malaria, can reduce child deaths by 25 percent. Cost: Rs 200 each.
- Latex condoms are highly effective at preventing HIV. Cost: Rs 650 for year's supply.

Source: WHO also quoted in World Bank 2001.

APPENDIX B: THE PUBLIC PRIMARY HEALTH CARE SYSTEM

Public primary health care in rural Karnataka is centered around the primary health center (PHC). Karnataka currently has 1,685 PHCs and 583 primary health units (PHUs). The PHC is intended to serve an average population of 30,000, covering smaller populations in the more remote rural or hilly areas and larger populations in urban areas. However, political interference in the site selection of PHCs has caused their distribution to be uneven. PCH distribution needs to be rationalized to more closely reflect actual needs. Occasionally, PHCs are accompanied by smaller PHUs, called “additional PHCs” in some states; however, PHUs have been gradually phased out or upgraded.

PHCs are hubs for five or six subcenters that each cover three villages and are operated by an auxiliary nurse midwife (ANM). In addition to the subcenters, which are often no more than the ANM’s quarters, village-level primary health care is supported through a network of *anganwadi* (nursing) centers that offer free nutrition and child care to children between the ages of 3 and 6 years.

At the higher levels, Karnataka is aiming for a community health center (CHC)—a 30-bed hospital—for every four or five PHCs. Each of these CHCs is expected to include at least one physician, one general surgeon, and one gynecologist and should cover a population of at least 100,000. At the moment there are 249 CHCs in the state (1 per 220,000 persons).

A comparison with other states in India illustrates that Karnataka matches or does slightly better than all-India averages in terms of population covered by public primary health facilities (see table B.1). However, several states, such as Kerala and Tamil Nadu, have a higher number of facilities at the lowest levels of the health care system.

Health facilities in Karnataka are clearly more concentrated at the higher levels of the health care system, with fewer subcenters to each PHC and more CHCs per PHC. However, it should be noted that the number of subcenters under each PHC is determined by population norms and that simply increasing the number of facilities alone is unlikely to contribute to improved health outcomes.

Table B.1. Rural Health Infrastructure, Selected Indian States

| <i>Health indicator</i> | <i>Karnataka</i> | <i>Andhra Pradesh</i> | <i>Kerala</i> | <i>Tamil Nadu</i> | <i>India</i> |
|--|------------------|-----------------------|---------------|-------------------|--------------|
| Average area covered (square kilometers): | | | | | |
| Subcenter | 23.03 | 25.54 | 6.97 | 14.27 | 22.89 |
| PHC | 117.13 | 202.18 | 36.98 | 86.27 | 136.22 |
| CHC | 774.88 | 1,303.93 | 443.76 | 1,720.58 | 1,154.82 |
| Area radial distance (kilometers): | | | | | |
| Subcenter | 2.71 | 2.85 | 1.49 | 2.13 | 2.70 |
| PHC | 6.10 | 8.02 | 3.43 | 5.24 | 6.58 |
| CHC | 15.70 | 20.37 | 11.88 | 23.40 | 19.17 |
| Area number of villages covered: | | | | | |
| Subcenter | 3.32 | 2.52 | 0.27 | 1.82 | 4.29 |
| PHC | 16.91 | 19.91 | 1.44 | 11.02 | 25.54 |
| CHC | 11.84 | 128.43 | 17.30 | 219.75 | 216.53 |
| Number of subcenters per PHC | 5.09 | 7.92 | 5.31 | 6.05 | 5.95 |
| Number of PHCs per CHC | 6.62 | 6.45 | 12.00 | 19.94 | 8.48 |
| Ratio of female to male MPW | 1.62 | 1.32 | 1.36 | 4.62 | 2.09 |
| Average population covered by ANM/female MPW | 3,837 | 4,466 | 4,748 | 4,305 | 4,707 |

PHC = Primary Health Center; CHC = Community Health Center; ANM = auxiliary nurse midwife; MPW = multipurpose workers.

Source: Government of India, Central Bureau of Health Intelligence, Annual Report 1998.

Table B.2. PHC Absentee Rates per State (percent)

| State | Doctors | Nondoctors |
|----------------|----------------|-------------------|
| Andhra Pradesh | 45.8 | 32.3 |
| Assam | 45.7 | 60 |
| Bihar | 66.7 | 49.7 |
| Chhatisgarh | 40.3 | 18 |
| Gujarat | 41 | 52.9 |
| Haryana | 46.7 | 39.8 |
| Jharkhand | 56.5 | 41.3 |
| Karnataka | 38.2 | 41.6 |
| Madhya Pradesh | 28.2 | 27.5 |
| Maharashtra | 29.9 | 30.3 |
| Orissa | 32.5 | 29.4 |
| Punjab | 38.8 | 43.8 |
| Rajasthan | 45.8 | 36.7 |
| Tamil Nadu | 57 | 33.5 |
| Uttar Pradesh | 46.2 | 41.8 |
| Uttaranchal | 52.1 | 39.6 |
| West Bengal | 38.8 | 34.6 |

Note: The absentee rate is the percentage of providers who are supposed to be present but who are not on the day of an unannounced visit.

Source: Chaudhury and others (2004).

APPENDIX C: RURAL MEDICAL PROVIDERS

Every village has at least one rural medical provider (RMP). Some states make a distinction between those who are registered and those who are not. The latter are often pejoratively termed “quacks.” Because none are qualified to practice medicine and little difference exists between those who are registered and those who are not, this book makes no distinction between them. These individuals are either doctors who are qualified and registered in traditional Indian medicine such as ayurvedic medicine or practitioners who have no formal medical training at all. In rare cases, a group of RMPs is subsidized by donors, NGOs, or wealthy philanthropists, but the vast majority survive by charging for their services. The profile of the typical RMP described here is derived from visits to more than a dozen RMPs in Karnataka, Bihar, Punjab, and Andhra Pradesh.

Equipment

In general, RMPs operate from a single, rented room, often living in a room above or adjacent to the clinic. The only equipment that is commonly found is a patient’s chair or bench, a stethoscope, a blood pressure gauge, and syringes. Closer to urban areas, RMPs will sometimes have an additional room where intravenous drips are administered, while some have the ability to carry out urine or blood tests. All RMPs visited had a telephone and connection to the electric grid (although power supply was extremely erratic, no more than a few hours per day, in most areas), but none had a refrigerator.

Qualifications

About half the RMPs that we visited were registered and qualified in ayurvedic medicine. One was a qualified doctor, and the remainder had no formal qualifications or training. The ayurvedic doctors are able to provide ayurvedic services, but they report that little demand exists in the village for such treatments. One RMP in Hubli District attends an annual refresher course in ayurvedic medicine for which he pays Rs 500. The course is provided by a union of 400 or 500 ayurvedic practitioners operating in the area. Despite their lack of qualifications in allopathic medicine, all RMPs practiced allopathic medicine, largely in response to popular demand. Among those with no formal qualifications, some had inherited the practice from their fathers and others had learned the trade working in primary health centers (PHCs) or private nursing homes. The Supreme Court has ruled that any person practicing in a medical system in which he or she is not qualified is a quack. The vast majority of RMPs fall into this category.

Medical Practices

Patients visiting an RMP typically come with aches, pains, fevers, diarrhea, or vomiting. RMPs also care for pregnant women and report giving them tetanus immunizations, hematoxic tablets, and calcium. All RMPs report that the public wants to see a doctor and get an injection that will provide an instant cure. Failing that, patients are prepared to take tablets, but few will leave if they have been given only counseling and advice. RMPs agreed that perhaps 90 percent of patients are given an injection following the consultation and that the charging structure is such that patients pay only for the injection and not the consultation. Only one of the RMPs we

visited was actually qualified to give injections. The others were practicing varying degrees of what the Supreme Court has termed quackery, such as injecting through clothing and not using clean needles. The most common injection given was a vitamin B12 complex, little more than a placebo to satisfy the demand for injections. However, all the RMPs also administered a variety of antibiotics and steroids, and one of the unqualified RMPs also offered intravenous saline solutions. RMPs displayed a variety of attitudes to needle protocols, ranging from reportedly using disposable needles to boiling needles in hot water. Some RMPs use the same syringe and change the needle, whereas others do not bother changing either. Even those who did follow sterile procedures were not able to dispose of their needles in an appropriate manner.

Referrals

RMPs refer their patients to the local PHC or *taluka* hospital if the latter is nearby. Sometimes they are paid a finder's fee by private nursing homes. The cost of the bus journey to the local PHC varies between Rs 10 and Rs 20, depending on location. Reportedly, patients would have to make an informal payment of at least Rs 5 per visit at the PHC.

Popularity

In the absence of regulation, such providers have been allowed to prosper. Even small villages of between 6,000 and 10,000 inhabitants often support two or more RMPs. Adapting flexibly to demand, some RMPs visited two or more villages during the week. Villagers stated that the reasons for using RMPs include convenient hours (RMP practices are usually operated from 8:00 a.m. to 1:00 p.m. and then again from 6:00 p.m. to 10:00 p.m. and those in which the RMP lives on the premises are open all the time), willingness of RMPs to make house calls on elderly or incapacitated patients, good standing and reputation of RMPs in the community, and treatment of patients with kindness and respect. Another attractive feature is service provided on credit to those who cannot afford to pay immediately.

Cost Structure

There are little or no capital costs involved in starting up such a practice. The consultation room can be rented for Rs 150 per month and a further Rs 300 per month secures reasonable accommodation. The RMPs obtain their drugs from private pharmaceutical companies. Sometimes they receive a bonus (either cash payment or free samples) based on drugs ordered from the company. The unit cost per injection comes to approximately Rs 1.2, whereas commonly dispensed tablets such as analgesics cost Rs 47 per 1,000. The saline drip, administered approximately once a month, is charged at Rs 50–100 and costs Rs 40.

RMPs in rural areas typically charge Rs 10–20 per visit with the understanding that the consultation is free and the patient pays only for medication. RMPs in semiurban areas tend to charge more. All practitioners report offering free (or reduced-price) services for the very poor and higher charges for those who wish to jump the queue (usually Rs 30 to Rs 50). Demand for RMPs varies a great deal among particular providers. We estimate that each RMP treats between 20 and 50 patients per day, providing a comfortable monthly income of between Rs 8,000–20,000.

In the long term, when every village has access to effective medical care, these RMPs, or quacks, will gradually disappear. In the short term, it is important to differentiate between those who can play a productive and useful role in health care provision and those who should be barred from continuing to practice medicine, or at least ignored by the health system if closing them down proves impossible.

Some Suggestions on RMPs

The following actions could prove beneficial in addressing the situation:

- *Undertake an in-depth survey of RMPs.* Although this brief study has shed some light on the operations of the average RMP, it does not provide enough information from which to draw strong conclusions. A representative facility survey of such private practices would reveal the illnesses treated, medical practices, training levels, tariffs, and reasons for high demand.
- *Consider franchising or accreditation.* RMPs are currently unregulated; therefore, although their operations are illegal, it is impossible to shut them down. An alternative method of improving quality is to accredit those who go through basic training—either publicly or privately provided. Training, at the very least, could cover safe needle protocols. Accreditation could also take the form of social franchising, whereby selected RMPs are reoriented to provide health care products and services that require limited training for effective delivery.
- *Educate the public.* The majority of RMPs are quacks who often offer a cure that may be worse than the illness. The public needs to be informed that injections, saline drips, and tablets offered by nonqualified practitioners are at best useless and at worst may expose the patient to HIV/AIDS, hepatitis, and other diseases. A related public education campaign could increase awareness of the most serious illnesses and provide information on proper treatments.

APPENDIX D: COMMUNITY-BASED HEALTH INSURANCE

As part of the national effort to rebuild the country, the government of Rwanda was interested in promoting innovative strategies to generate additional resources to fund health care services. In Rwanda, public health centers and hospitals earn most of their revenues from user fees, which impose a financial burden on patients at the time of need. As a result, use of formal health services is low, and people delay obtaining care until they are very ill (Schneider and Diop 2001). As a consequence, there are insufficient funds to operate health services, which results in drug stock-outs and unmotivated staff. Community-based health insurance (CBHI) was the strategy tried in Rwanda to address the issues of low use, lack of financial protection, and insufficient resources to fund health services. The Ministry of Health chose to test community-based prepayment schemes in three districts, using an approach that involved community members in design, management, and oversight. This experience has been well documented and evaluated by Schneider and Diop (2001), using study and control districts and before and after comparisons, and it contains valuable lessons for design, implementation, and management of community-based prepayment schemes in resource-poor settings.

In the first year of the pilot study, starting in July 1999, 54 prepayment schemes were initiated that enrolled 88,303 members representing 8 percent of the population of the three districts (Schneider and Diop 2001). In exchange for an annual premium, families could obtain access to all preventive and curative services and drugs offered in their chosen public health center and to a limited package of inpatient services from the district hospital. Hospital services were covered only if the patient had a referral from the health center. By prepaying for services at a time when households had income, families were able, after a 1-month waiting period, to insure themselves against large out-of-pocket payments for services throughout the year. One result was that new case consultations for members were up to five times higher than for nonmembers. Strong improvements in the use of preventive services also resulted. Immunization rates increased by 50 percent, and prenatal care by 25 percent. Also, there were 45 percent more assisted deliveries among the covered population (Schneider and Diop 2001). Rather than being interpreted as a moral-hazard effect of insurance leading to excessive use, these results were interpreted as eliminating the gap between needed and obtained health services that existed before the introduction of community-based health insurance (Schneider and Diop 2001).

With the introduction of CBHI, each of the 54 health centers in the three pilot districts became a partner that offers one prepayment scheme. Families that enroll choose their preferred participating public health center. Each month, scheme managers retain 4 percent of premiums for administration, send 4 percent to the district hospital fund that pools risks for the district and manages funds to cover hospital services for members, send 49 percent to health centers to cover per capita payments, and retain 43 percent in bank assets to cover future payments (Schneider and Diop 2001). Health centers receive a monthly payment for each member who enrolls with them. Hospitals are paid by the district federation per episode for cesarean sections, malaria treatment, and nonsurgical pediatric cases and on a fee-for-services

This appendix is based on Marek and others (forthcoming)

basis for consultations and overnight stays. By the end of a year, 7 percent of premiums were spent on administration, 7 percent on hospital services, and 86 percent on health center–level care (Schneider and Diop 2001).

As part of the evaluation of the effect of the pilots, the Ministry of Health wanted to understand what population groups chose to enroll in the CBHI schemes and whether membership improved financial access without increasing the overall burden of out-of-pocket spending. To answer these questions, Schneider and Diop (2001) estimated three demand models using household data.

Results indicated that the probability of purchasing insurance was determined not by health need or economic factors but by the level of education of the head of the household, family size, district of residence, distance to the health center, and radio ownership. The income quartile of families was not shown to be significant, and cattle ownership—an indication of household wealth—was also insignificant. The second model looked at the determinant of use of services and found that members used up to 5 times the number of curative and preventive services as nonmembers. The probability of a visit decreased with distance to the health center and increased with severity of illness, but those with coverage sought care when less sick. Results from the third model found that annual per capita contributions of members are up to 5 times greater than payments by nonmembers, but payments at the time of service are significantly lower for members. This finding indicates that the presence of insurance changed care-seeking behavior of members, causing them to access care more frequently and sooner.

APPENDIX E: IMPROVING PUBLIC SECTOR MANAGEMENT OF HEALTH FACILITIES

There are many different ways of potentially improving the responsiveness of the public health care system. In general, the most successful methods will involve changing the incentives embedded in the system for providers to offer quality health care to the poor. This appendix introduces a number of suggestions for the primary and secondary sectors.

Improving Primary Health Care

Increasing Budgets

Increasing the budget will only provide more of the same failures unless it is also accompanied by strategic reforms. Paying absentee doctors a higher salary will not improve health outcomes. Although facilities in many states could be improved with additional resources, again, without a rational, demand-led plan for the location of such facilities and without a maintenance budget or performance system, improving facilities alone is unlikely to bring about the targeted improvements in health outcomes. Increasing user charges is likely to be counterproductive at the primary level because it would deter the poorest from approaching primary health centers (PHCs), and exempting the poor can be difficult or costly.

Improving Incentives

A reform of the system could alter the incentives for performance and health outcomes. A comprehensive reform would start with a consideration of the health challenges in each state and work backward toward possible solutions. However, a partial reform to improve PHC functions could be contemplated. It would start with an examination of the current PHC norms and ask the following questions:

- Does it make sense to have a doctor at the PHC?
- Does it make sense to have the same number of auxiliary nurse midwives (ANMs) per population in every state, given that birth rates differ dramatically from state to state?
- Does government have the capacity and funds to adequately maintain and operate the current level of infrastructure?
- How can government attract doctors to the rural areas?
- How can the Panchayati Raj play a bigger role in oversight of PHCs?

Attracting Health Care Workers to Rural Areas

Methods of increasing the incentives for qualified health care workers to locate in rural areas need to be explored. These could include (a) upgrading the role of the ANMs; (b) requiring trainee doctors to spend 1 or 2 years of their training period in rural areas; (c) introducing diploma, or “barefoot,” doctors; (d) altering the selection criteria for medical college to encourage more individuals from rural communities to qualify; (e) introducing a small user charge for the nonpoor; (f) increasing the salaries of doctors working in the rural areas; and (g) simply improving

monitoring and enforcement mechanisms in the public sector.

Measuring Performance

Unless performance is measured, no incentive exists to improve. Although this requirement seems obvious, the performance of PHCs is not measured or benchmarked against statewide norms. Punjab state government has demonstrated that simply by measuring and publishing performance statistics, the government can have a significant effect on improving efficiency and effectiveness within the public health system. (See background paper, “Punjab: A Rapid Private Health Sector Assessment 2005.”)

Alternative Payment Methods

The current system whereby health care workers are paid regardless of work completed does not provide any incentive to deliver quality care. Effective alternative payment methods would include schemes making part or all of the public health care workers’ salaries dependent on care provided and allowing the poor to choose between public and private providers to create competition within the system. (See background paper on international case studies for a good example of using vouchers to strengthen demand for care for sexually transmitted diseases in Nicaragua.)

Improving Secondary Health Care

Recent experience in improving secondary health care in Punjab illustrates that successful reforms within the current system are possible (See background paper, “Punjab: A Rapid Private Health Sector Assessment 2005.”)The government of Punjab recently embarked on a process of corporatizing its secondary health facilities. The policy implications of the Punjab experience are discussed below.

User Charges

Introducing user charges in a transparent and accountable way, while exempting below-poverty-line individuals, can provide an incentive for secondary hospitals to increase the number of patients served, especially if revenues are used at the point of collection. Even a modest charge can significantly expand the maintenance and equipment budget and provide increased flexibility and responsiveness at the facility level.

Health Management Information System

Introducing a health management information system (HMIS) can provide timely and accurate information needed to improve management of public facilities. A good HMIS gives managers the ability to monitor inputs and outputs of the system and helps assess the costs and returns from various procedures. Measuring performance and distributing that information automatically provides an incentive to perform.

Outsourcing Nonclinical Functions

Outsourcing nonclinical functions, especially sanitation, has resulted in much cleaner hospitals

(evidenced by independent patient surveys) at a far lower cost. It has also resulted in reliable ambulance, telephone, and canteen services.

Customer Satisfaction Surveys

Another potential way of addressing this situation is to introduce customer-satisfaction surveys. If doctors' salaries, promotions, or both were linked to the outcome of such surveys among other things, doctors would have a greater incentive to provide care to the poor and treat them courteously. Because a large segment of the rural poor are illiterate, they would not be able to complete written questionnaires. Perhaps the feedback could be collected through periodic random exit interviews by independent assessors of a number of public sector patients. Alternatively, the assessors could visit a representative number of poor individuals in the community to avoid self-selection of those who visit health facilities. Although such surveys can be expensive, preliminary experience in Punjab has shown that they can affect service delivery and quality.

Community Voice

Health outcomes can be improved if local communities have a greater input into the provision of public health care. At the moment, in most states the local Panchayati Raj system of oversight is not working because the health management committees are not functioning or are not representing the poor. Even when the system works, the local health committee has no authority over the medical personnel, whose salaries, transfers, and promotions are controlled at the district and state levels (Dugger 2004). Improving decentralized administration and oversight would improve responsiveness.

Citizens' Charter

An alternative method to stimulate improved services is to educate the public about their rights. Each PHC can post a patients' bill of rights. PHCs could also be asked to post a list of charges for services and a list of drugs that are not currently available, thereby eliminating the practice of extracting additional payments to procure drugs that health workers claim are not available. Government can consider these cost-effective schemes to increase the transparency and responsiveness of the system.

Complaints Line

Another related idea is to institute a complaints bureau or build on the role currently being played by the Lokayukta. This function could improve responsiveness and reduce corruption, provided the political will to support such an effort were forthcoming. Karnataka is a particularly good example of where this idea has worked well (see A. Rao 2003).

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