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Healthcare Reform in India – Policy, Governance and Financing

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Abstract

The healthcare industry in India has grown over the years due to increase in latest healthcare facilities, growth in awareness about diseases, rise in per capita income, changing lifestyle etc. However, healthcare demand is driven by families with the ability to spend low and vulnerable parts of society have limited demand for such healthcare services. The industry is considered as the most challenging and highest growing services sector across the world and has direct impact on the country's economy and employment generation. Looking at these issues, there is a need to examine current state of healthcare industry and recommend improvements in Indian context. Thus, the purpose of this paper is to study specific measures adopted as reforms in the healthcare industry in India using the wide range of reform measures in policy, governance and financing.

In this context, the paper will provide a brief background on the current status of the healthcare services market in India. The article assesses the important role of public, state and central government in the reform of health system in India. It argues for a reform of the existing healthcare system by restructuring government legislative reforms and management and institutional transformations. The article also calls for strengthening healthcare services through the development of healthcare policy, governance and financing in India. The article concludes that public investment in the healthcare sector should be increased and suggests possible options for financing healthcare in India.

Key words: India; Healthcare; Healthcare reform; Health Policy; Health Governance; Financing

Jel: I11, I13, I15, I18

Introduction

Good health is one of the basic necessities of human being and a socio-economic development goal recognized throughout the world. Health is an important facet of human life, and it is now also an important aspect of the public services and planning of any country. Each country has its own policy or public healthcare delivery system, whether developed nation or a developing country. Health is determined not only by medical care, but also by non-medical determinants. The answer to public health is to tackle all these determinants of health since the 1950s, with India experiencing a demographic and environmental change that adds to the burden of diseases. Only through an active public health system can this heavy burden of diseases along with disability and death be tackled.

Public health development in India, however, is very slow due to low health financing. Health care out-of-pocket spending controls healthcare costs, and the results are expected to be deteriorating. The growth in economic since 1990 and expected growth of healthcare market to US $280 billion by 2022 has created additional healthcare issues including chronic diseases such diabetes and cardiovascular diseases[1].

[1] Indian Healthcare: The Growth Story, available online at:
http://www.indianhealthcare.in/index.php?option=com_contentandview=articleandcatid= 131

Indian government has initiated multiple health policies for health sector growth, but the country continues to face various health and health issues. Since independence, major public health issues such as malaria, tuberculosis, leprosy, high maternal and child mortality, and in recent years, human immunodeficiency virus (HIV) has been addressed through government concerted actions and various healthcare policies.

This paper reviews the reforms in the healthcare industry in India using the comprehensive measures in policy, governance and financing. The first section of the paper assesses the reforms needed in the Indian healthcare industry and argues that the policies used at each juncture were incompatible with the objectives it aimed to achieve. The paper uses a framework to assess healthcare reforms in India to find that further action is required in the healthcare sector than provided by central and state governments. The insufficient budget allocated for public health programs and the reluctance and incapacity of government to bear primary and secondary care obligations culminated out of pocket funding and service fee charges to healthcare providers. This section of the article also discusses recent reforms in addressing the lacunae but are limited by the pervasive dominance of the private sector limiting the choice of policy tools available to the government.

The second section of the paper describes the development of healthcare policy and governance. It provides an introduction of National Health Policy (NHP) 2017 and explains the goals, objectives and how it differs from earlier health schemes. This section of the article also explains the feasibility of NHP policy and a need of reforms in the healthcare services funding. The concluding section of the paper discusses the financing of the healthcare and analyzes the mechanism of the healthcare financing used among the Indian population.

The need to reform the healthcare system in India

For several centuries, health policy has been at the center of the worldwide policy reform agenda, which is unsurprising considering the huge financial and political cost. Yet governments around the globe are continuing to embark on reform routes that are known to aggravate the cost and access issues that they designed to tackle[2]. India's first policy document on healthcare released in 1946, The Bhore Committee Report, envisaged an ambitious healthcare system that would include central government delivery of public health programs and state main and secondary care[3]. While India has made important progress in enhancing public health results, it fails to cover nearly all indicators of public health compared to other countries with comparable incomes and growth and its instant neighbors. The government has not only failed to attain its ambitious objectives set out in the Bhore Committee Report, but through a series of mistakes it has developed a health system that significantly restricts access and encourages inequity[4].

India's health policy failures have been well cataloged in literature[5] and policy discussions and are mainly attributable to lack of funds, poor governance, urban-rural disparities, weak infrastructure, low qualified workers and other difficulties connected with poor social infrastructure: weak education and literacy, absence of health and hygiene, and poor access to drinking water. Its increasing healthcare expenses, mostly funded by household expenditure out of pocket (OOP), and consequent access and equity problems have gained restricted attention only to be accepted as the result of a poorly functioning public health scheme.

The deterioration of the health of the population in India is also affecting the country's pension system. Health status is a factor that "carries risks for retirement companies that offer lifelong pensions in the insurance market.

[2] Bali, A.S. and Ramesh, M. (2015) Health care reforms in India: Getting it wrong. Public Policy and Administration, 30 (3-4), pp. 300-319.

[3] Bhore J (1946) Report of the Health Surevy and Development Committee. Report, Government of India.

[4] Dreze J and Sen A (2011) Putting Growth In Its Place. Outlook, November 14, 2011.

[5] Rao G and Singh N (2005) Political Economy of Federalism in India. New Delhi: Oxford University Press; Rao G, and Choudhury M (2012) .Health Care Financing Reforms in India. Report, National Institute of Public Finance, New Delhi, India, March; Rao M, Rao KD and Shiva Kumar AK et al. (2011) Human Resources for Health in India, Lancet, 377:587-98.; Rao S (2015) Inter-State Comparisons on Health Outcomes in Major States and A Framework for Resource Devolution for Health. Report, Background Study for the 14th Finance Comission, Government of India, New Delhi, India; Forgia GL and Nagpal S (2012) Government-Sponsored Health Insurance In India!: Are You Covered? Washington DC: The World Bank.

The consideration of this factor is widely debated in the public space. If some restrictions on the purchase of health insurance policies may be imposed in health insurance, it is more of an exception to the pension market than a rule."[6]

In recent times, different specialist groups and literatures have been examining problems of evaluating the quality and accessibility of healthcare in India[7]. Such reviews identified significant legislative gaps and the fragmented and uncontrolled nature of healthcare distribution systems in the private sector[8]. Ineffective implementation, lack of laws, absence of standardized norms and the absence of laboratory or diagnostic center coverage are some of the problems that need to be addressed. There is also insufficient data on the amount, role, nature, structure, functioning and quality of care in private hospitals. Without domestic laws on supplier norms and protocols for healthcare treatment, over-diagnosis, over-treatment and abuse are prevalent[9].

In this regard, the need for reform of the healthcare system in India can be addressed in the following basic directions:

First, Government legislative reforms. Through legislation such as the Clinical Establishment Act, the National Accreditation Board for Hospitals and Healthcare Providers (NABH) and Indian Public Health Standards (IPHS), the government has tried to identify norms for healthcare services. Despite these attempts, there is no single authority and unified system in place to guarantee adequate and cost-effective care is available to individuals. As health is a responsibility of the state, they are left to handle these problems.

Second, Need for broader healthcare approach. The central government had described seven measurable goals to be accomplished in its 11th Five Year Plan. The objectives focused on infant mortality rates (IMR), maternal mortality ratio (MMR), total fertility rates (TFR), under-nutrition among kids, anemia among females and girls, provision of clean drinking water for all, and improvement of child gender ratio for age group 0–6 years. While many of these fields have been improved, much more needs to be achieved. An analysis of the example health indicator IMR demonstrates that Uttar Pradesh, Madhya Pradesh and Odisha (Orissa) are still understated[10].

Experts pointed out that the government needs to embrace a wider strategy to health care in the 12th Plan, while at the same moment taking steps to accomplish further advancement in the seven target fields listed above. On this basis, under the auspices of the National Rural Health Mission, one of the objectives of the 12th Five Year Plan will be to concentrate all current domestic health programs[11].

Third, the need to improve the corporate risk management of the economic entity. The implementation of measures related to the prevention of industrial accidents and the protection of the environment and the health of the population should be a compulsory element in the concept of industrial enterprise safety. In this regard, corporate risk management needs to be oriented towards improving the social policy of the employer in order to ensure an appropriate standard, motivation and quality of life for employees, as well as to ensure healthy and safe working conditions.

The implementation of **changes in management approaches** to solving environmental problems is associated with the expansion of initiatives of enterprises regarding environmental activity, namely:[12]

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[6] Димитров, Ст. Осигурителен пазар и осигурителни продукти. София, Издателство на ВУЗФ, 2010, с. 98-99.

[7] High Level Expert Group Report on Universal Health Coverage for India, 2011, available online at: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf

[8] Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure for the 11th Five-Year Plan, Planning Commission, 2006, p. 4, available online at: http://planningcommission.nic.in/aboutus/committee/wrkgrp11/wg11_hclinic.pdf

[9] Kumar et al (2011), Financing Healthcare for All: Challenges and Opportunities, the Lancet; 377: 668–679.

[10] High Level Expert Group Report on Universal Health Coverage for India, 2011, Quoted work, p. 183.

[11] Faster, Sustainable and more Inclusive Growth: an Approach to the Twelfth Five Year Plan, Planning Commission, October 2011, p. 87-88, available online at: http://planningcommission.nic.in/plans/planrel/12appdrft/appraoch_12plan.pdf

[12] Misheva, Ir. Functional model of environmental insurance in the context of risk manage-ment of enterprises with hazardous production. – International Journal of Humanities and Social Science Review, Vol. 2, No. 7, September

- Increasing corporate social responsibility of enterprises;
- Increase the environmental responsibility of the business unit;
- Extending prevention activities in the context of environmental business security;
- Active cooperation with investors, consumers and all stakeholders on environmental issues in order to protect people's life, health and working ability;
- exploiting the benefits of environmental insurance and environmental auditing in the context of the environmental security of an industrial enterprise.

In recent years, it has been noted that the most significant successes in solving environmental problems are due to the implementation of the systematic approach in the environmental management of a number of European countries, respectively. the implementation of the international standard ISO 14 001, the British standard BS 7750 and the EMAS (European Environmental Management and Audit System) standard. For example, in the United States today, companies performing environmental audits reach 95%.[13]

Fourth, Management and Institutional reforms. The Indian healthcare system suffers from serious manpower shortages and this issue needs to be resolved to accomplish the stated goals. There have been suggestions for management and institutional reforms in relation to enhancing the training of health employees and extending their numbers. It was suggested that, with a view to strengthening the public sector and enabling it to operate as a promoter, supplier, contractor, regulator and health care administrator, and facilitating quality assessment and quality assurance, a Public Health Service Framework should be established at the center and at the state level to include multidisciplinary education experts in public health. This new group of professionals would be responsible for all functions of public health, with the aim of improving the functioning of the health system by improving the effectiveness, efficiency and effectiveness of delivery of health care.

A specialized state-level framework for the management of health systems has also been suggested. Professionals in this group should be responsible for handling the provision of service in the public sector as well as the private sector contract. These health system executives should assume many of the administrative duties presently undertaken by medical staff in fields such as IT, finance, human resources, planning and communication[14]. It was also recommended that the government set up a National Health Regulatory and Development Authority (NHRDA) to regulate and monitor government and private health care providers. The agency would also be accountable for creating ethical norms for providing healthcare and accrediting healthcare providers and linking them to comparable organizations at the state level.

The healthcare segment requires more intervention by the state and central government. Continued advancement in the access, affordability, and quality of healthcare and a major role for the public in the reform of health systems are essential.

Development of Health Care Policy, Governance and Strategy in India

On the eve of Independence in 1946, the most extensive health policy and plan paper was prepared in India[15]. This was popularly referred to as the Bhore Committee's Health Survey and Development Committee Report. This Committee prepared a detailed country-specific National Health Service plan that would provide the entire population with universal coverage free of charge through an extensive state-run wage health service. The proposals of the Bhore Committee required structural changes to be implemented in the healthcare system at the time, and had they been implemented, they would have radically altered the access to healthcare and health status of the Indian masses, especially the 80 percent rural population.

2016, ISSN 2415-1157 (Online), ISSN 2415-1335 (Print), published by Research Institute for Progression of Knowledge, http://www.ijhssrnet.com/vol-2-no-7-september-2016/, p. 14.

[13] Misheva, Ir. Insurance audit as a factor for the effective environmental pollution liability insurance of enterprises with hazardous production. Second International Conference on Advances in Management, Economics and Social Science – MES'15, 18-19 April 2015, Rome, Italy, organized by Institute of Research Engineers and Doctors – IRED, USA, published by SEEK Digital Library**,** ISBN: 978-1-63248-046-0, p. 159-163.

[14] High Level Expert Group Report on Universal Health Coverage for India, 2011, Quoted work, p. 31.

[15] Gangolli LV, Duggal R, Shukla A. (2005). *Review of healthcare in India*. Mumbai Centre for Enquiry into Health and Allied Themes; Historical Review of Health Policy Making; pp. 21-40

In 1983, India has adopted a formal or official National Health Policy[16]. Before that, the state's health operations were developed through the multiple committees ' Five Year Plans and suggestions. There were a number of schemes in each plan era and each subsequent plan added a few more and dropped a few.

The government of India has rolled out numerous healthcare policies involving both rural and urban population health. The National Health Policy (NHP) proposes ' universal, extensive primary health care facilities that are applicable to the real requirements and priorities of the society at a price that individuals can afford in light of the Directive Principles of the Indian Constitution[17]. Providing universal health care as an objective is a welcome move because the government is speaking about universal extensive health care for the first time after the Bhore Committee. The main characteristics of the National Health Policy of 1983 were:

- It was critical of the curative-oriented western model of health care,
- It highlighted a preventive, encouraging and rehabilitative strategy to primary health care
- It suggested a decentralized health care system, the main characteristics of which were low cost, de-professionalization (use of volunteers and paramedics), and community involvement.
- It called for an expansion of the private curative industry to assist decrease the strain on the government
- It suggested that a nationwide network of epidemiological stations be established to promote the integration of different health interventions and
- It set goals that were mainly demographic in nature for accomplishment.

Nation Health Policy 2017 - Following the National Health Policy 1983 and the National Health Policy 2002, the Union Government endorsed the National Health Policy in March 2017 to guide the strategy for the health industry in the Five-Year Plans. The strategy for NHP 2017 seeks to project an incremental assurance-based strategy that highlights the need for a new health policy to address changing priorities in India's abysmal healthcare delivery system. This includes building a more 'robust healthcare industry' reducing 'disastrous spending' in the form of out-of-pocket healthcare expenses and improving 'fiscal ability' to satisfy an increasing deficit in healthcare funding[18]. Some of the specific goals and objectives as laid out by the policy are:

- Increase Life Expectancy at birth from 67.5 to 70 by 2025
- Reduce infant mortality rate to 28 by 2019
- Increase utilization of public health facilities by 50% from current levels by 2025
- Meet need of family planning above 90% at national and sub national level by 2025
- Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission)
- Increase health expenditure by Government as a percentage of GDP from the existing 1.15 percent to 2.5 percent by 2025
- Increase State sector health spending to > 8% of their budget by 2020
- Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025
- Ensure district-level electronic database of information on health system components by 2020.
- Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.
- Establish federated integrated health information architecture, Health Information Exchanges and National Health Information Network by 2025.

[16] Banerji D., 1985. Health & Family Planning Services in India: an Epidemiological, Socio-cultural and Political Analysis and a Perspective. Lok Paksh, New Delhi.
[17] MoHFW, 1983 : National Health Policy, Govt. of India, Ministry of Health & Family Welfare, New Delhi
[18] Mohan, D., 2017. New National Health Policy Paves Way For More Hype and Less Action. *The Wire*, March.

Under the organization of delivery of public health care, the policy focuses on extensive care, the system of referrals to regulate patient flows, the output-based purchase of private services to fill gaps, the provision of free medicines, diagnostics and emergency services in all government centers, the strengthening of urban health, infrastructure and resources in underserved areas and the integration of all domestic health programs and the provision of Ayush services[19]. What this policy seems to lack is a cohesive, concrete action plan to tackle the issues of any of the As (accessibility, affordability and responsibility) – particularly in view of the difficulties experienced by the current government health equipment due to bad governance and bad financing.

While more public healthcare expenditure remains a central focus of NHP 2017, it is crucial to realize that one of Indian healthcare system's main issues is its bad management, administration, and whole governance structure. The significance of management and governance framework can be noted by the differences in health indicators seen across India's different states. It is seen that states with better ability and stronger governance have more efficiently used the National Rural Health Mission resources than countries with bad initial conditions. Years of misgovernance and negligence have given perverse incentives to our public management structures. Our schemes have become very essential to chronic absenteeism, corruption and personal exercise[20].

The new system of governance requires to balance responsibilities, accountability and flexibility. At best, our systems now assign responsibility, but executives lack the flexibility and accountability to construct an efficient system. One of the models that can be implemented in the nation is the one developed by Tamil Nadu Medical Services Corporation. It was established by the Tamil Nadu Government to supply the public health system with drugs. At the top of the corporation is an autonomous board of directors, including the health secretary. Its managing director is an Indian Administrative Services officer and experts and scholars are hired as needed. The model has been highly effective in enhancing Tamil Nadu's drug supply[21]. A latest study by Niti Ayayog ranks Tamil Nadu in Health Index number three. Other states can adopt a comparable model to fit their own governance framework to promote government and preventive healthcare development in India. Present public staff (health workers and physicians) can be taken on deputation while the corporation builds fresh ability and hires. Such a scheme will guarantee that workers are not limited due to public regulations and the adverse picture of short-term agreements does not influence program execution.

United Kingdom's National Health Service (NHS) is a much wider-scale effective application of such a model. Most of the corporation operates as an autonomous entity although the state sets its mandate and goals. Local health authorities are liable for their finances. They buy or contract NHS main care providers and hospitals on a service-based basis, ensuring local and high-level accountability[22].

The feasibility of National Health Policy in India is in questionable state due to limitations of the funds allocated to various healthcare schemes. The policy requires significant reforms in the funding of services for public health care. There is also a lack of clarity about how these funding reforms will be implemented and who will handle them, or how the need for a medical insurance plan per capita will interact with this.

Health financing in India

Funding for healthcare is defined by some authors as "a set of ways to raise funds, allocate and spend the money needed to replicate activities related to promoting, protecting and improving health".[23]

[19] Vikaspedia, 2017. National Health Policy 2017.
[20] Shamika Ravi, R. A., 2015. Priorities for India’s National Health Policy, s.l.: Brookings India.
[21] Shamika Ravi, R. A., 2015, quoted work.
[22] Guardian, T., 2016. 10 truths about Britain's health service. The Guardian, January.
[23] Гладилов, Ст. и Делчева, Е. Икономика на здравеопазването. София, Primceps, 2000, с. 170. (Gladilov, St. i Delcheva, E. Ikonomika na zdraveopazvaneto. Sofiya, Primceps, 2000, s. 170).

The access to healthcare with equity and accessible to everyone is closely linked to financing of healthcare services. In expert opinion, the health care and the activities linked with it (as the health insurance) exert influence on the labor market – for example the mandatory health insurances of the employees increase the production cost and reduce the competitiveness of the companies; the stable health insurance is a factor for competition between the companies for attracting qualified workers, as well as factor for mobility of the labor resources in the frames of a global market. Particularly strong is the link between health expenditures and the common public expenditures (usually positive). For example, for each unit of expenditures made in public health programs for the restriction of tobacco smoking are saved 2 units of prevented future expenses of the state, which could be invested in more productive way. In many developed countries the deficits in the healthcare worsen the macroeconomic stability. The healthcare exercises substantial influence on the investments in high technologies and health related construction.[24]

The countries which provide accessible health and equity in accessing the healthcare have developed the healthcare system with public finance funding two-thirds of healthcare spending. In developed countries, these public financing are through state revenue or social insurance. All OECD countries excluding the USA, have health-financing mechanism to finance healthcare[25]. In these countries, 85 per cent of financing is contributed from public resources like taxes, social insurance or national insurance that ensures over 90 percent population has access to healthcare. The developing countries like India still reliant on out-of-pocket payments.

In India, the missing link is the gap between rural and urban hierarchy and budget allocation based on regions. Moreover, the high cost treatment due to high technology innovation, changing profile diseases etc. is beyond the reach of majority and will have great impact on the economy and health profile of society.[26] Out of 6% GDP spends on healthcare sector, 15 per cent is publicly financed, 4 per cent is from social insurance, 1 per cent private insurance and the remaining 80 per cent being out of pocket expenditure.[27] Latest estimates based on national accounts statistics indicate that private expenditure on healthcare in India are about Rs. 1,552 billion[28]. Public expenditure on healthcare are about Rs 250 billion on top of this (Table 4). Together this sums up to 6.5 per cent of GDP, with out-of-pocket expenses resulting for 83 percent of the share in the total health expenditure. It was also noted that even these minor public expenditure are skewed towards the wealthier communities, especially those residing in urban regions[29]. The 90% of the users paying from the out of pocket belong to the poorest section of the society. The National data also discloses that 50 per cent of the bottom of the pyramid (BOP) patients sold assets or took loans to access the healthcare. Therefore, debt and assets sale are estimated to contribute significantly to financing healthcare.

[24]Delcheva, E. Study on the Health Systems' Efficiency in Five South-East European Countries. Economic Alternatives, issue 1, 2008, p. 37.

[25] OECD (2003), OECD Health data. Available online at http://www.oecd.org/document/39/0,234,en_2649_201185_2789735_I_I_I_,00.html

[26] Chandra, C., Kumar, S., and Ghildayal, N.S., (2009) 'Hospital cost structure in the USA: what's behind the costs? A business case'. International Journal of Health Care Quality Assurance Vol. 24 (4), pp. 314 328

[27] Gangolli LV, Duggal R, Shukla A. (2005). *Review of healthcare in India*. Mumbai Centre for Enquiry into Health and Allied Themes;

[28] Central Statistical Organisation (2004), *National Accounts Statistics*, Central Statistical Organisation, New Delhi: Government of India

[29] NCAER (2002), *Who Benefits from Public Health Spending in India*. New Delhi: NCAER

Table 1. Financing Healthcare in India

	Estimated users in millions	**Expenditure (Rs. Billion)**
Public Sector	250	252
Social Insurance	55	3
Private Sector	780	1250
Social Insurance	30	24
Private Insurance	11	11.5
Out of Pocket	739	1214
Total	**1030**	**1552**

(*Source: National Sample Survey 52nd*)

Public healthcare financing comes mainly from public budgets of state government, about 80%, and the Union government contributes 12% and local government balance of 8%.Of the total public health budget, approximately 10% is externally funded as opposed to approximately 1% prior to the World Bank's Structural Adjustment loan and other agency loans. Private financing is mostly out of pocket expense mainly for hospitalization coming from savings, loans and sale of assets. The health insurance contributes in small proportion whether social insurance or private insurance premiums.

The following literature is presented in the specialist literature according to sources of funding in healthcare, namely:[30]

- Government financing - state budget; local budgets; funds from government, state and municipal organizations.
- Private financing:

● directly - by consumers, who pay all or part of the cost of health services and products;
● indirectly - by employers and companies that fund and sponsor health care organizations and pay for the value of health services and products / e.g. medicines, rehabilitation facilities / for their staff; another form of private indirect funding is the payment of health services and products to risky and needy contingents by non-governmental private charities and social organizations such as foundations, societies, etc.

Health Insurance:

● Government and social security - compulsory insurance and, to a lesser extent, voluntary insurance for employees;
● Private provision - voluntarily covers individual population groups;
● Employer insurance - the employer finances the employees employed by him.

External funding - in the form of humanitarian aid and loans from various state, international and non-governmental organizations.

In India, the financing of the health system is realized in three main ways. They are as follows:

First, Social health insurance. Today's total employment in India is estimated at 400 million, of which only 28 million are in the organized industry, covered by social security legislation, including social insurance. The largest of these is the ESIS which covers 8 million employees and including family members provide health insurance to 33 million persons. The ESIS Corporation spends Rs 12 billion annually on healthcare for its members averaging Rs 365 per beneficiary. This effectively covers 3.2 per cent of the population. About half per cent of the population is covered through the CGHS. The annual spend of the CGHS is Rs 2 billion averaging Rs 450 per beneficiary. While these social insurance plans have been around for a long time, their credibility is at stake and large scale out-sourcing to the private sector is taking place.

The government employees of Indian railways, defense services and the postal & telegraph department have significant healthcare services for their employees which amounts to Rs 16 billion per annum and averages to Rs 1,150 per beneficiary.

[30] Мишева, Ир. Здравно застраховане. Quoted work, p. 34-35

The special welfare funds have been setup by the acts of parliament for specific ethnic groups including selected un-organized sector like plantation workers, construction workers, mine workers, load workers etc. that includes benefits of healthcare, education, housing and water supply. This welfare fund is estimated at about Rs 24 billion per year, averaging Rs 3000 per worker per year. About 10 percent of the country's population has some form of social insurance cover for health through their employment.

The Indian government also introduced social security schemes from time to time, including health coverage for various groups of population, especially the poor or below poverty line groups, in the unorganized sector, like the Krishi Shramik Samajik Sanstha Yojana, National Social Assistance Program, National Family benefit scheme, National maternity benefit scheme, handloom workers thrift, health and group insurance, agricultural workers central scheme, janashree bima yojana, state govt welfare funds, national illness assistance fund and state illness funds etc. These schemes are not run on regular basis and not guaranteed for the next year of the scheme.

Second, Private Health Insurance. The recent phenomenon was studied starting in an organized way in the mid-eighties through the public sector insurance companies called as Private Health insurance[31]. Prior to that these private insurance companies provided the group insurance schemes for their selected clients that covered insignificant number of employees and their families. Post mid '80s, the mediclaim scheme which is an individual hospitalization policy and does not cover comprehensive healthcare was started.

The private health insurance picked up momentum gradually and entered the growth phase around 1998 but even today covers just over one percent of the population. The public sector insurance companies gross annual premiums of Rs 10 billion for mediclaim policies from 10 million insured lives. In the last few years, some private insurance companies have also entered the fray but they are as yet very small players having less than 10 per cent of the market share.

Third, Mutual Healthcare Insurance. Mutual healthcare insurance scheme constitutes a fair distribution of the costs of care among different social groups. It includes risk pooling initiatives by sharing costs among the healthy and the sick leading to insurance schemes as a substitute to private health insurance. It also covers risk sharing initiatives across wealth and income involving public policy decisions on progressive taxation, merit subsidy and cross subsidization by dual pricing. Risk pooling within private voluntary insurance schemes has become inevitable in all countries because of the double burden of sickness and to ensure that financial costs of treatment do not become an excessive burden relative to incomes.

The Indian political economy of healthcare in India puts India in the category of the most privatized health sector in the world. The main mechanism of financing healthcare in India is out of pocket expenditure.

In this respect, the potential of voluntary health insurance is to contribute to solving many of the problems related to people's health and working capacity. The aim is to increase the role of health insurance in eliminating the negative changes in the health and demographic situation of the population. This should in practice be done by attracting a constant new influx of insured persons and by including in the liability of the insurance company new risks related to various diseases, as well as covering the medical expenses for the diagnosis and treatment of the insured persons.[32]

In the context of health reform, consumer demands for health insurance are steadily increasing. To this end, insurers should focus on: examining consumer behavior when seeking health insurance; optimizing the quality of health insurance against the individual needs of different categories of clients; meeting the expectations of consumers of health insurance from the quality of the services, etc.[33]

[31] Gangolli LV, Duggal R, Shukla A. (2005). *Review of healthcare in India*. Mumbai Centre for Enquiry into Health and Allied Themes;

[32] Мишева, Ир. Здравно застраховане (теория и практика). Quoted work, p. 31.

[33] Мишева, Ир. Застрахователен маркетинг. Второ преработено и допълнено издание. София, ИК – УНСС, с. 284. Misheva, Ir. Zastrakhovatelen marketing. Vtoro preraboteno i dopŭlneno izdanie. Sofiya, IK – UNSS, s. 284).

The Indian political economy of healthcare in India puts India in the category of the most privatized health sector in the world. The main mechanism of financing healthcare in India is out of pocket expenditure. Thus, increasing the role of government health expenditure will be critical if India is to enhance health results and access equity. In addition, the healthcare system will have to be organized and controlled within a universal access framework. As India has its own distinctiveness, any healthcare system will have to be designed with keeping financing in mind[34]. Table 4 showed a profile of India's present financing system and spending, and presented trends in health expenditure over the past three decades. It is quite clear that public healthcare finances are weakening and that private expenditure is becoming even higher.

India can adopt new health financing strategy using the following mechanism[35];

First, modifications in macro policy in how funds are allocated could bring about a significant enhancement in equity through decreasing the inequalities between rural and urban regions within the current public healthcare financing. This would be a significant help of more than twice as much funds for rural healthcare, which could assist fill the gaps in rural healthcare systems in both human and material terms.

Second, nearly 80 per cent of medical graduates are receiving virtually free education from medical schools, the government should demand compulsory public service for at least three years from graduates as return for the social investment. In addition, a public service spell should also be made compulsory for those who wish to undertake post-graduate studies, which presently attract as many as 55 percentage of graduates of government medical schools.

Third, Government shall raise further resources by imposing health taxes n health-degrading products such as cigarettes, alcohol, and tobacco.

These are just few examples of what can be done in the existing system. The growing out-of-pocket expense financing of the healthcare system shall be replaced with a combination of public finance and collective financing options such as social insurance and other methods of collective fund-raising.

Conclusion

This study found that India's health policy has failed in every key dimension. The paper argued that effective health policy requires systemic regulation and supervision of the medical sector by reforming the government legislation to manage healthcare providers, patients and healthcare financers. The government had few political leverages over the healthcare sector with little government spending or national insurance hence needed to embrace a deeper approach to healthcare in the 12th Plan. Implementing policies relevant to industrial accident prevention and environmental protection and population health should be a mandatory component in the definition of industrial enterprise security and effectively implemented by the government.

The Nation Health Policy attempted to address the above-mentioned issues in one way or another, but has failed to develop a strategy for achieving such an architectural reformation. The scheme only tried to promote smoother flow of resources to the lower levels to create a more 'robust healthcare industry' that reduces 'disaster spending' in the form of out-of-pocket healthcare expenditure to meet the healthcare financing deficit. The government policy would require restructuring to include all capital, financial or human, and must be transferred to governments at the district level, which will have to draw up comprehensive district plans based on local funding needs and expectations.

[34] Duggal, R. (2007). Health Care in India: Changing the Financing Strategy. *Social Policy & Administration*, 41(4), ISSN 0144–5596, pp. 386-394

[35] Duggal, R. (2007), Quoted work.

The healthcare financing is a thrust area in healthcare sector and beyond the reach of common population. The study revealed that most patients spend their medical expenses out of their pocket. The study shows that some patients had familiarity with healthcare financing and thought in the past to save money for future treatment, but not everyone could. To conclude, public finance and collective financing options such as social insurance and other methods of collective fund-raising shall replace the growing out-of-pocket healthcare financing.

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