National Health System in India
Access to Medicines and Health Care

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Health Sector in India – Towards Privatisation

Prominent features of Health Sector

- Growth of the for profit sector and its relation to the decline of the public sector
- Introduction of market principles in the public sector viz. user fees, contracting out and insurance schemes with private sector participation

Development of Health Care Services

Phase I

- Post-Independence period -- growth in the public sector up to the seventies
- Investments sub-optimal but effort to build network of services
- Vision of self-reliance informed decisions
- Also informed by Bhore Committee Report (1946) that emphasised need for strong PHC services supported by secondary and tertiary levels of care and estimated that 12 % of GNP need to be invested in health sector

Development of Health Care Services..contd..

Phase II

- Late 1970s to the late 1980s -- cutbacks on public spending and concessions to the private sector
- Several state governments received loans for reforming the publicly provided health services
- Low levels of investment stunted growth of the public sector, thus providing space for growth and expansion of private sector
- Emergence of upper-middle class - initially in urban India and in rural areas since green revolution
- Upwardly mobile elites found the public system inadequate and moved to private sector
- Leading to further weakening of the state's commitment towards public provisioning

Development of Health Care Services..contd..

Phase III

- Since early 1990s in consonance with neoliberal economic policies "withdrawal of the state" from the social sector became part of public policy
- Huge cuts in health budgets in 1993 & 1994, followed by some restoration
- Expenditure as percent of GDP fell from 1.4% to 0.9%
- Led to a virtual dismantling of public services
- Public outcry led to the Govt. promising remedial measures in 2004 and in setting in motion the National Rural Health Mission in 2005.
- The NRHM has strengthened public services in some areas, but intervention and resourcing still extremely inadequate

State of Public Health Systems

- Growth of infrastructure has lagged behind demand.
- Creation of new infrastructure has lagged well behind targets set in the Tenth Plan period.
- Achievement of targets is 76% in the case of sub-centres but just 13% and 37% in the case of PHCs and CHCs.
- Even where sub-centres, PHCs and CHCs exist, their conditions are often abysmally poor -- 50% of sub-centres, 24% of PHCs and 16% of CHCs function in rented or temporary premises

Source of Health Care

Source	Location (percent)		Income Quintile (percent)					Total
	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	
Public sector	29.6	36.8	39.4	37.1	39.0	33.9	22.6	34.4
NGO or trust hospital	0.5	0.3	0.3	0.3	0.3	0.5	0.5	0.4
Private sector	69.5	62.5	59.9	62.2	60.4	65.3	76.4	64.8
Other source	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2

State of Public Sector encourages Growth of Private Sector

- State of the public health system forces people to access the unregulated private sector
- As a consequence in excess of 80% of medical care costs are borne by people through "out of pocket" expenses
- Survey shows that, in the case of ailments considered serious by respondents, ***40 percent cited financial reasons for not taking recourse to treatment***

Structure of Private Sector in India

- Primary: Individual practitioners -- qualified and unqualified -- provide outpatient care and located in both rural and urban areas.
- Secondary level of care provided by nursing homes with a bed strength ranging from 5 to 50
- Further division between small and large nursing homes -- differ widely in terms of investments, equipment and facilities, range of services offered and quality of care.
- Tertiary level: multi-specialty hospitals -- mostly located in the larger cities with a strong Non Resident Indian (NRI) connection with doctors based in the United States and with corporate entities

Health Care Expenditure

- India spends around 5.2 percent of GDP on health -- higher than countries with comparable per capita income or even better off countries
- At 4.2 percent of GDP, India's private expenditure is among the top twenty countries in the world
- Public expenditure (0.9 percent of GDP) is among the bottom five in the world

Households (out of pocket)	69%
Government (Central, State and local)	26%
International funds	2%
Private-not-for-profit	3%

Health Care Expenditure.. Contd..

- 60% of expenditure goes on primary care services, 85% (almost 50% of total spending) for primary curative care services
- Government expenditures account for 24% of inpatient treatment expenditures.
- Although fees in government hospitals are low, households still report sizable out-of-pocket expenditures on drugs and supplies for hospitalized patients
- Estimated that private health expenditure has grown at 12.5% per annum, since 1960-61
- The income elasticity is 1.47, which means that for each 1% increase in per capita income, the private expenditure on health increased by 1.47%

Regulation of Private Health Sector

Necessity:

- Scale economies at which private health care services are produced, since affect cost and quality

- Lack of standardisation of practices, fees and facilities leads to possibilities of profiteering and unethical practices

But Also!

- The organised private sector (often corporate controlled) is also a driver of regulatory norms that favour a greater consolidation of the private sector

Existing Regulations

- Regulations in the field of manufacturing, sale, quality and prescription of drugs and pharmaceuticals (the Pharmacy Act, the Drugs and Cosmetics Act and Dangerous Drugs Act);
- Medical and clinical practice related (Consumer Protection Act, the Indian Medical Council Act, and the Human Organ Transplant Act);
- Registration and inspection of facilities—Nursing Homes Act, and the Nurses, Midwives and Health Visitors Act).

Consumer Protection Act

- Promulgated in 1986 to protect the interests of consumers through the establishment of consumer councils
- Provides resolution of complaints to aggrieved consumers that are quicker and less costly than the time-consuming and expensive process of civil litigation

Nursing Home Act

- Private facilities (Nursing homes) not regulated uniformly, some regulated -- like in Maharashtra and Delhi
- But broad provisions of the NHA not implemented – they have been ineffective in regulating the growth and development of nursing homes
- Only 130 of approximately 1200 nursing homes in Delhi are registered with any local supervising authority, situation similar in Maharashtra
- Many states in the process of formulating Acts, but opposed by powerful (and politically connected!) interests representing commercial medical sector

Public Private Partnerships

- Endorsement by multilateral agencies of PPPs has influenced policy
- At the secondary level, PPPs are involved in contracting out of non-clinical services like laundry, diet, drug stores, diagnostics, ambulance
- Selective contracting out of services to the private sector is often a component of reform packages promoted by bilateral and multilateral agencies for low- and middle-income countries
- PPPs now also extend to contracting out clinical services

Privatisation: Panacea or Problem?

- Common argument promoting increased private provision of health services is that it can bring in desperately needed additional capital and capacity in low-income countries.
- But Private sector provisioning of health care require huge public subsidies to thrive -- cash subsidies, subsidized medical education, subsidized or free infrastructure (land, etc.) and tax breaks
- Private sector also competes to provide care in urban centres, and not in underserved areas – i.e. it does not complement public services but competes
- Competes also by drawing away human and technical resources away from public sector

Health Insurance

- Penetration of health insurance is low: estimated 3-5% covered under any form of health insurance.
- Commercial insurance is <1% of total expenditure
- Existing schemes can be categorised as:
  - Voluntary health insurance schemes or private-for-profit schemes;
  - Employer-based schemes;
  - Insurance offered by NGOs / community based health insurance,
  - Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)

Central Government Health Services (CGHS)

- Since 1954, all employees of the Central Government (present and retired); are covered under the Central Government Health Scheme (CGHS).
- Beneficiaries number 4,32,000, spread across 22 cities
- Criticised for high out-of-pocket expenses due to slow reimbursement and incomplete coverage for private health care -- 80% of cost is reimbursed if referral is made to private facility when such facilities are not available with the CGHS.
- CGHS thus provides an indirect subsidy to the private sector

Employees State Insurance Scheme (ESIS)

- ESIS provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury.
- Beneficiaries: over 33 million
- 125 hospitals, 42 annexes and 1,450 dispensaries with over 23,000 beds
- However performance is unsatisfactory -- over half of those covered do not seek care from ESIS
- Unsatisfactory nature of ESIS services-- low quality of care, long waiting periods, behaviour of personnel, lack of interest or low interest on part of employees and low awareness of ESI procedures

Rashtriya Swasthya Bima Yojana

- Rashtriya Swasthya Bima Yojana (RSBY), launched in 2007-08, aims to transform the way public provision of health services have been designed - moving away from the model of direct provision of health services Govt.
- Every BPL household will be covered against hospitalization cost of Rs.30,000 per annum
- The Union Government is committed to pay a premium of up to Rs.750 per family (the Central govt would bear 75 percent of the total premium); households need to pay Rs.30 annually to register.

Rashtriya Swasthya Bima Yojana … contd…

- 6.5 million Below Poverty Line (BPL) families in India -- to enroll all need to spend around Rs. 4,875 crore annually while current allocation is only Rs.308 crore in 2009-10 – enough to cover just 0.46 million
- Scheme does not cover outpatient treatment, thus living a major source of expenditure (more than 2/3rd of total health costs) out of its ambit
- Involves harnessing of Pvt. sector -- health insurance schemes based on private provision leads to huge cost escalation due to over consumption esp. in the context of weak regulation of private health sector
- According to a Govt. Committee around half of the population in India is BPL

Access to Medicines

- Estimated by different sources -- 50% to 80% not able to access all the medicines they need
- The World Medicine Report (2004) of WHO - India has largest number of people (649 million) without access to essential medicines
- Given India is the 4th largest producer of drugs in the world and exports medicines to over 200 countries, local production/availability not major constraints.
- Studies indicate that poorer populations spend a larger proportion of health care expenditure on medicines.
- World Bank Study: out-of-pocket medical costs alone may push 2.2% of the population below the poverty line in one year

Pattern of Out of Pocket Expenses on Medicine and Health Care

	Health Exp. (Rs.)		Exp. on Medicine (Rs.)		Medicine % Health	
Quintiles	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**
First (Lowest)	7.72	11.71	6.68	9.91	86.47	84.60
Second	13.79	21.66	11.71	17.49	84.89	80.71
Third	19.61	29.73	16.46	22.72	83.94	76.44
Fourth	29.98	47.00	24.44	34.34	81.53	73.05
Fifth	77.47	105.67	55.46	65.90	71.59	62.36
Total	29.58	43.27	22.85	30.14	77.24	69.66

Access to Medicines .. Contd..

- Estimated that total expenditure on medicines in India is in excess of Rs.300 billion per annum -- Rs.1,500 for every family in the country

- Factors that determine access to medicines include:
  - rational selection and use
  - affordable prices
  - sustainable financing
  - responsive health system
  - reliable supply system

- While affordability is only one dimension of access, it continues to be a critical factor in India's Health system

Special Features of Indian Pharmaceutical Market

- Most prominent: very large proportion of drugs consumed in India are through retail sales (85%)

  Retail sales : US$ 6.2 billion
  Institutional sales: US$ 1.1 billion

- Institutional sales include public sector and private hospitals and other institutions.

- Pattern different from most markets, where a bulk of drug consumption is through supplies from large institutional mechanisms (hospitals, health insurance, etc., both in public and private sector).

- Given this, major issues related to drug prices are related to those that impact on retail prices

Dilution of Price Controls in Successive Policies

DPCO Year	Drugs under Price Control	% of Market in Price Controlled Category	Mark-up (profitability) allowed
1979	347	80-90%	40%, 50% and 100% in three categories termed “life saving”, “essential” and “non essential”
1987	142	60-70%	75% and 100% in two categories, subsequently one category with 100% mark up
1995	74	25-30%	100%
2002*	20-25**	10-20%	100% or more

Variation in Drug Prices: Generics, Brands, Top Selling

Drug	Generic Price	Top Selling Retail Brand	Company	Price	Under Price Control
Albendazole 400 mg Chew Tab	0.81	Zentel	GSK	14.15	N
Alprazolam 0.5 mg Tab	0.12	Alprax	Torrent	1.70	N
Amlodipine 5mg Tab	0.19	Amlodac	Zydus	1.40	N
Amoxicillin 250 mg Cap	0.89	Mox	Ranbaxy	3.96	N
Atenolol 50 mg Tab	0.20	Aten	Cadila	1.84	N
Betamethasone 0.5 mg Tab	0.18	Betnesol	GSK	0.41	Y
Carbamazepine 200 mg Tab	0.76	Tegritol	Novartis	1.71	Y
Cephalexin 500 mg Cap	3.09	Sporidex	Ranbaxy	12.05	N
Cetirizine 10 mg Tab	0.12	Cetrizet	Sun Pharma	3.00	N
Chloroquine phosphate [150 mg base] Tab	0.32	Lariago	Ipca	0.58	Y
Ciprofloxacin 500 mg Tab	1.03	Cifran	Ranbaxy	8.96	Y
Co-trimoxazole 480 mg Tab	0.38	Septran	GSK	0.60	Y
Diazepam 5 mg Tab	0.09	Calmpose	Ranbaxy	1.55	N
Diclofenac sodium 50 mg EC Tab	0.11	Voveran	Novartis	1.61	N
Domperidone 10 mg Tab	0.20	Domstal	Torrent	2.50	N
Enalapril maleate 5 mg Tab	0.33	Envas	Cadila	2.33	N
Erthromycin Sterate 500 mg Tab	3.72	Althrocin	Alembic	7.07	Y
Ethambutol 800 mg Tab	1.37	Combutol	Lupin	3.96	N
Fluconazole 150 mg Tab	4.71	Forcan	Cipla	32.00	N
Gentamicin sulfate 40 mg / mL Inj (2 ml)	2.60	Genticyn	Nicolas.P	6.72	Y
Glibenclamide 5 mg Tab	0.14	Daonil	Aventis	0.66	N
Ibuprofen 400 mg Tab	0.29	Brufen	Knoll	0.51	Y
Isoniazid 300 mg + Rifampicin 450mg Cap	3.16	R-Cinex	Lupin	5.70	Y
Isosorbide-5-mononitrate 20 mg Tab	0.19	Monotrate	Sun Pharma	2.85	N
Metformin 500 mg Tab	0.24	Glyciphage	Franco Indian	0.80	N
Nifedipine 10 mg Cap	0.10	Depin	Cadila	2.97	N
Nimesulide 100 mg Tab	0.13	Nimulid	Panacea	2.90	N
Norfloxacin 400 mg Tab	0.76	Norflox	Cipla	4.70	Y
Omeprazole 20 mg Cap	0.53	Ocid	Cadila	4.33	N
Paracetamol 500 mg Tab	0.12	Calpol	GSK	0.88	N
Prednisolone 10 mg Tab	0.85	Wysolone	Wyeth	1.35	N
Ranitidine 150 mg Tab	0.30	Zinetac	GSK	0.52	Y
Roxithromycin 150 mg Tab	1.25	Roxid	Alembic	6.50	N
Salbutamol 4 mg Tab	0.08	Asthalin	Cipla	0.52	Y
Tetracycline hydrochloride 250 mg Cap	0.46	Hostacycline	Aventis	0.67	Y
Tinidazole 500 mg Tab	0.50	Tiniba	Zydus	3.61	N

Ensuring Access to Medicines

- Present situation, where in excess of 80% of drugs consumed are paid for through out of pocket contribution by the consumer, is unacceptable
- No regulations on medicines can address this and only long term viable instrument that can ensure access to essential medicines is availability of a majority of drugs through the Public Sector
- There are no alternatives to instituting price controls in the industry
- Market mechanisms do not help to stabilise drug prices
- While instituting price controls, health concerns need to be at the centre of decision making

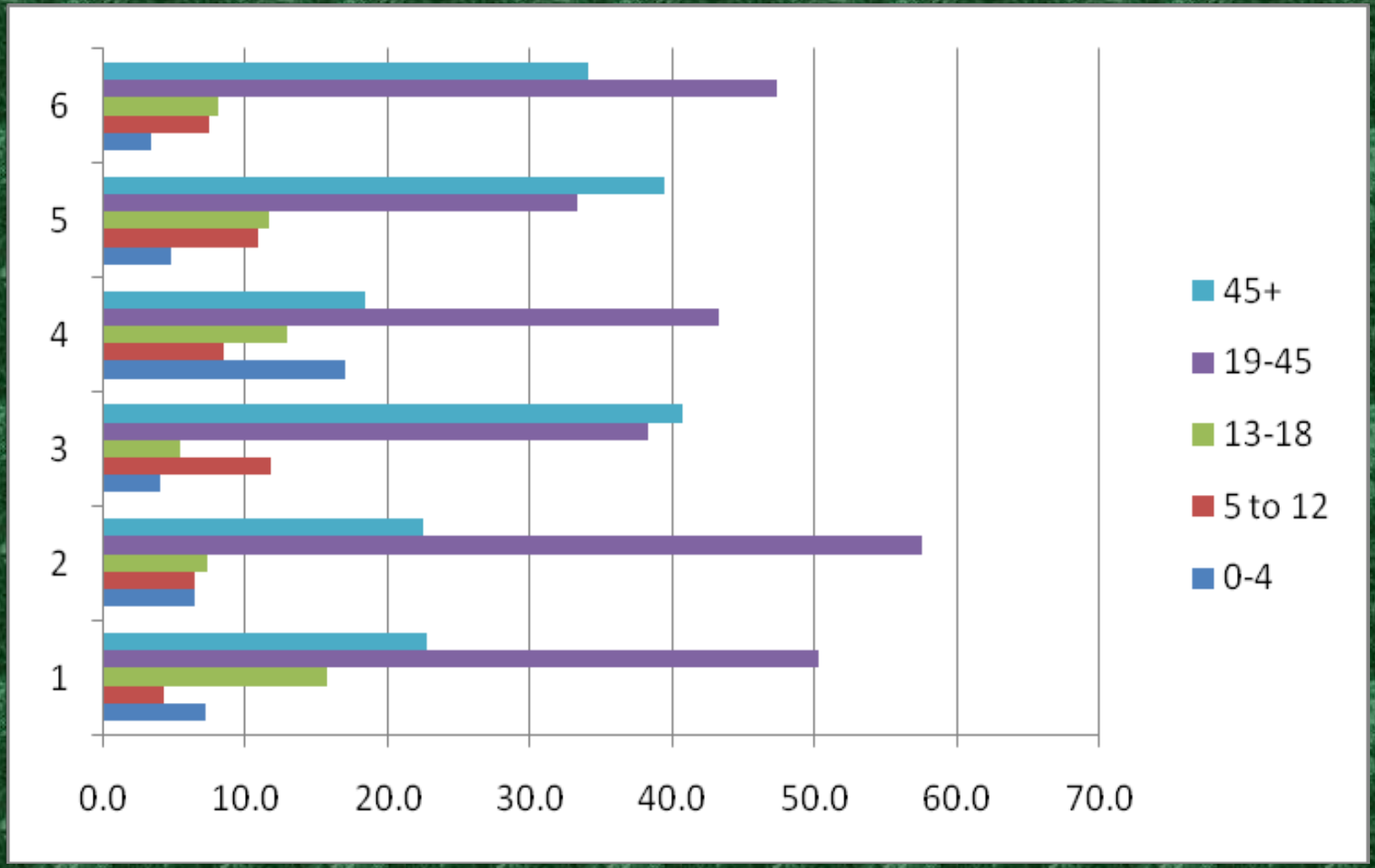
Primary Survey

- To Validate analysis of secondary literature and data
- To gain new insights

Sample Size:

Primary	Secondary	Tertiary
Public (211)	Public (204)	Public (147)
Private (205)	Private (201)	Private (150)

Age Distribution: All categories



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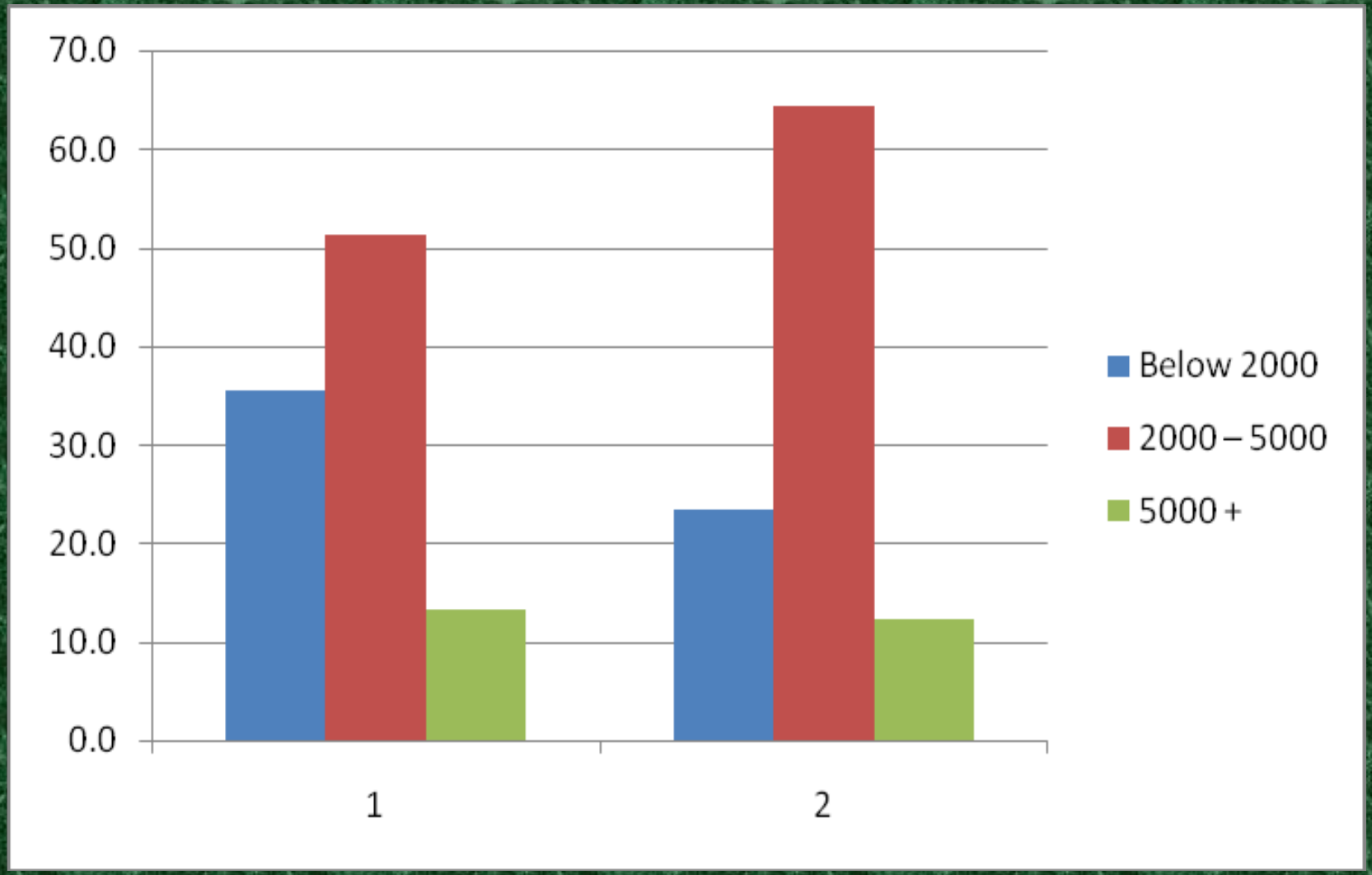
6. Tertiary Pvt.

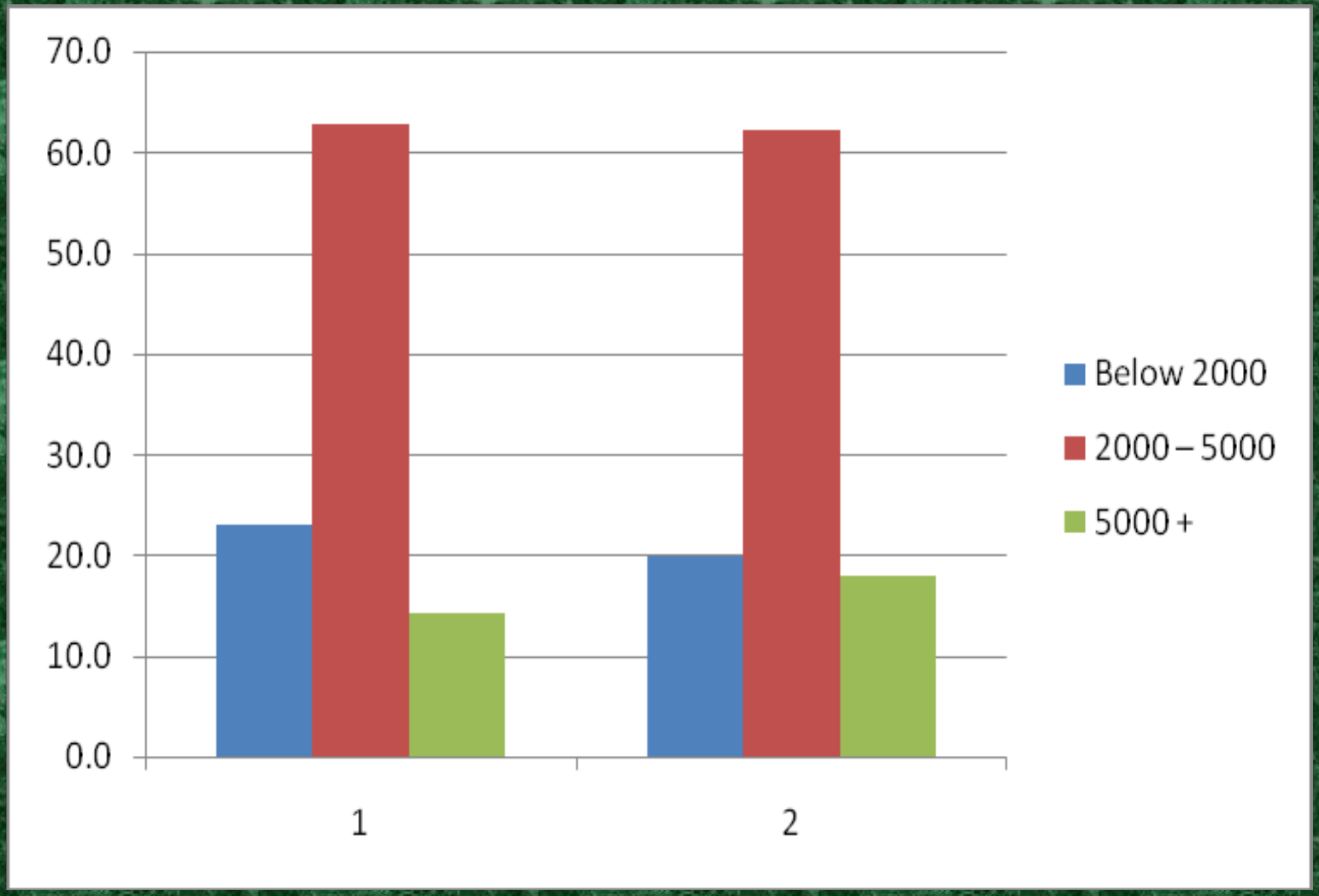
Income Distribution: Primary Level



Public

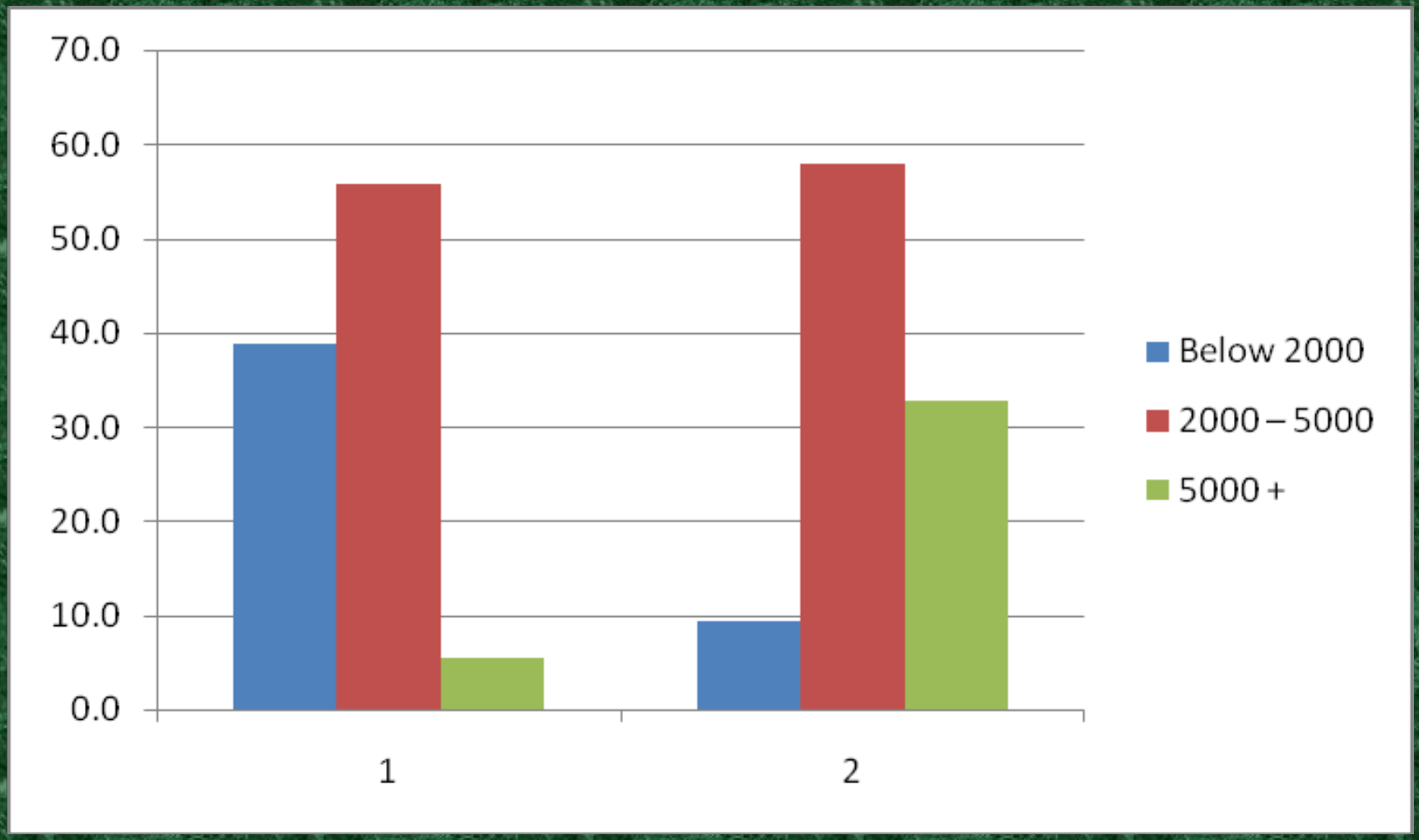
Private

Income Distribution: Secondary



Public Private

Income Distribution: Tertiary



Public

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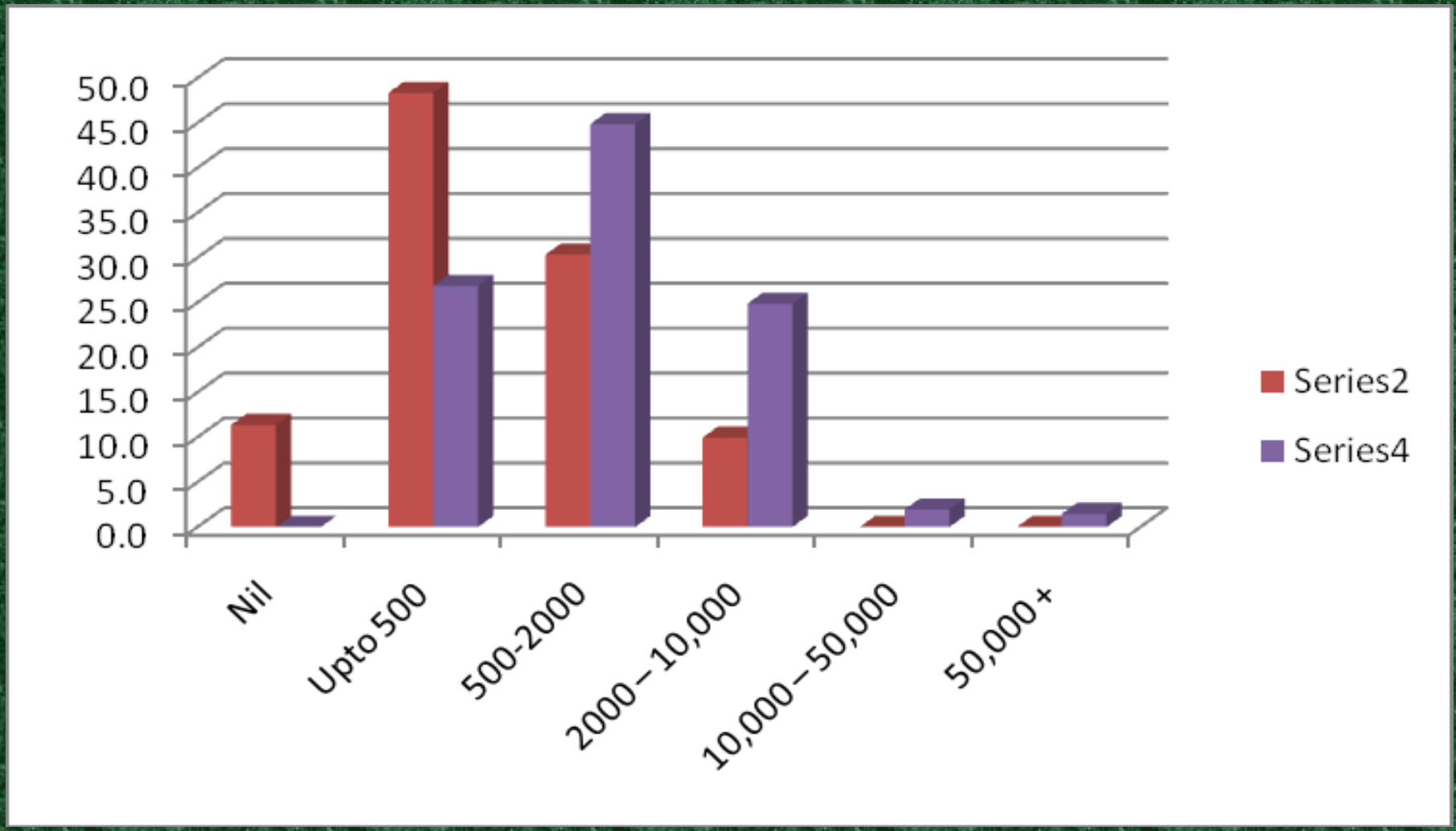
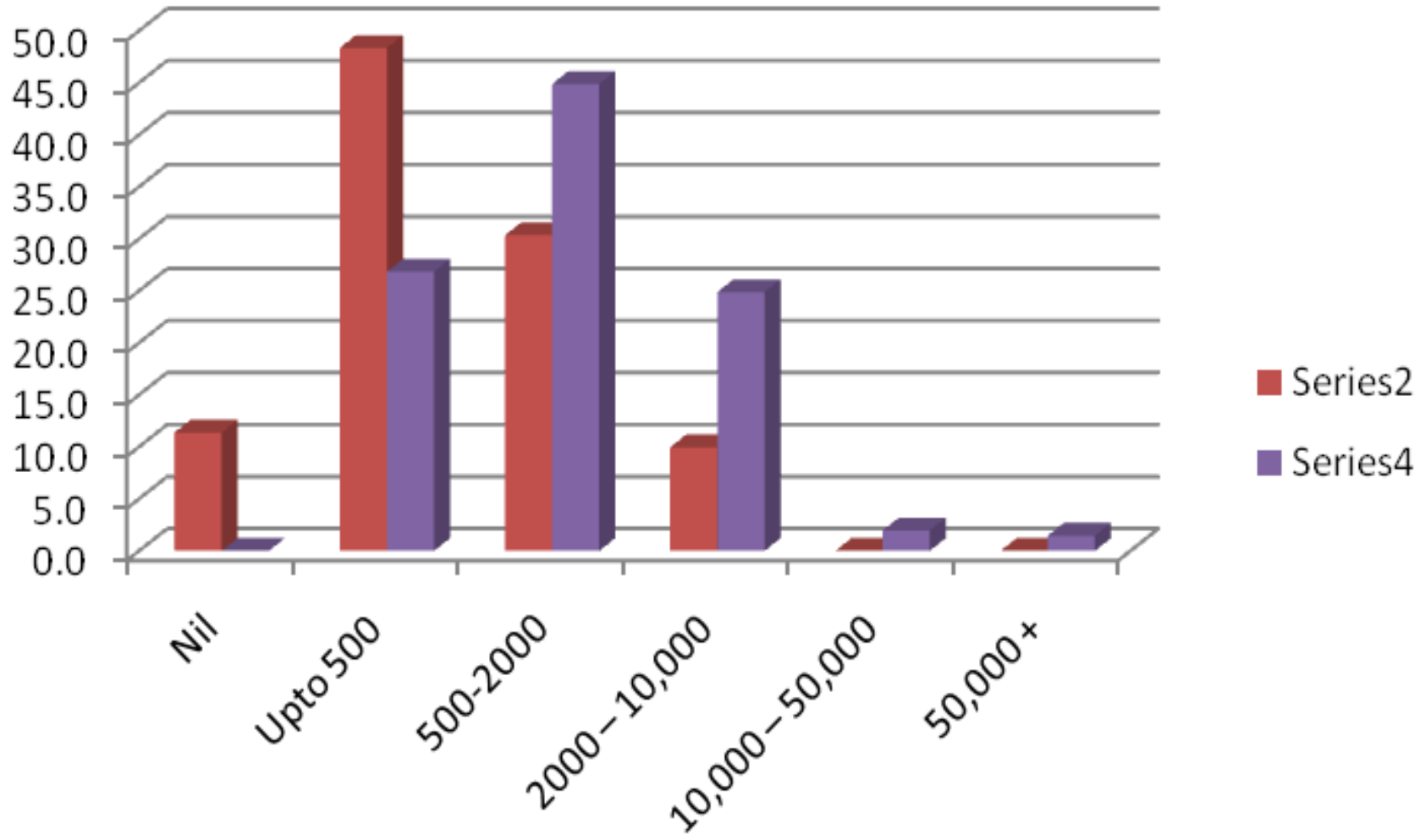
Expenditure: Primary



Series 2: Public

Series 4: Private

Expenditure: Secondary



Series 2. Public

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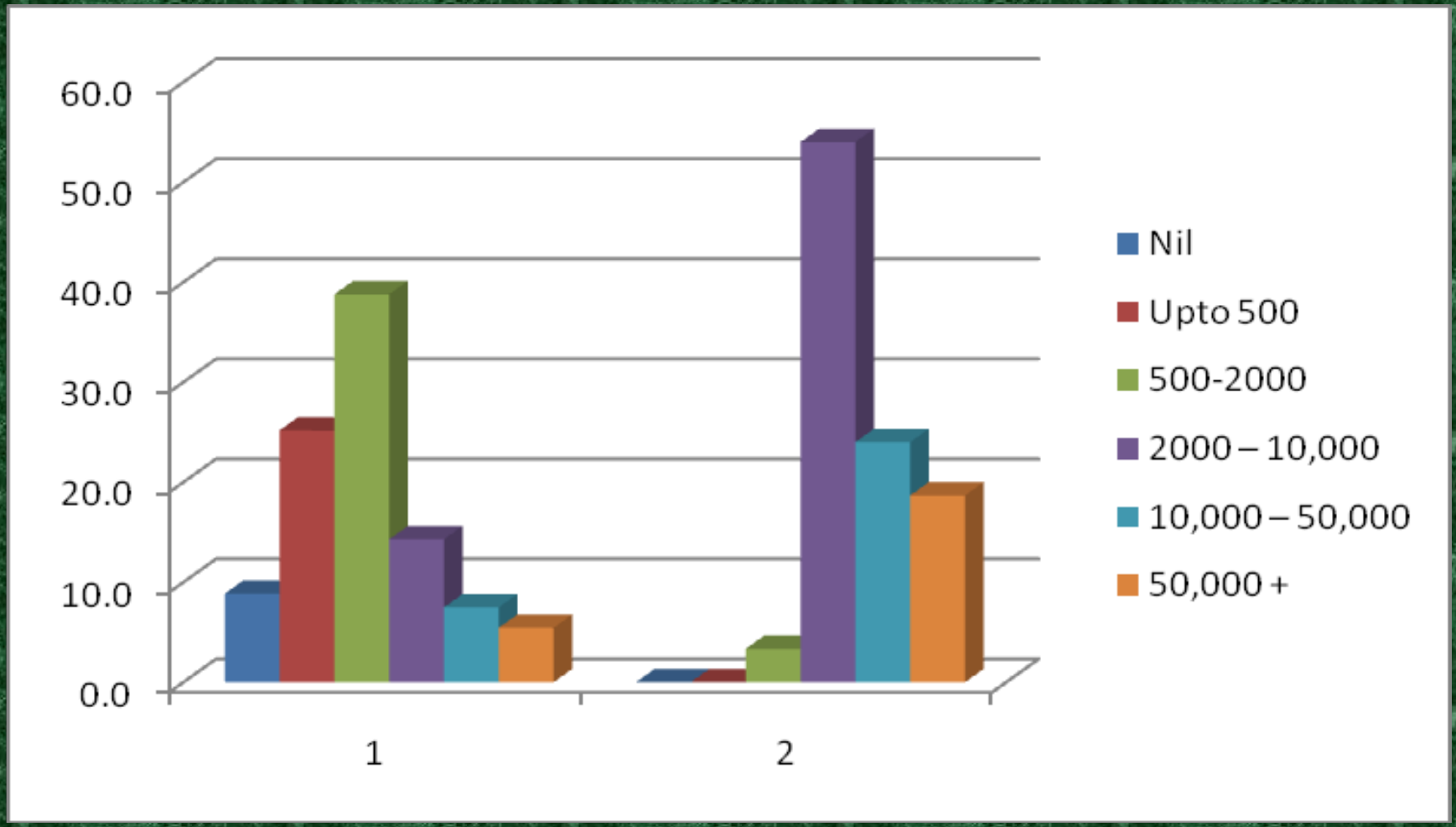
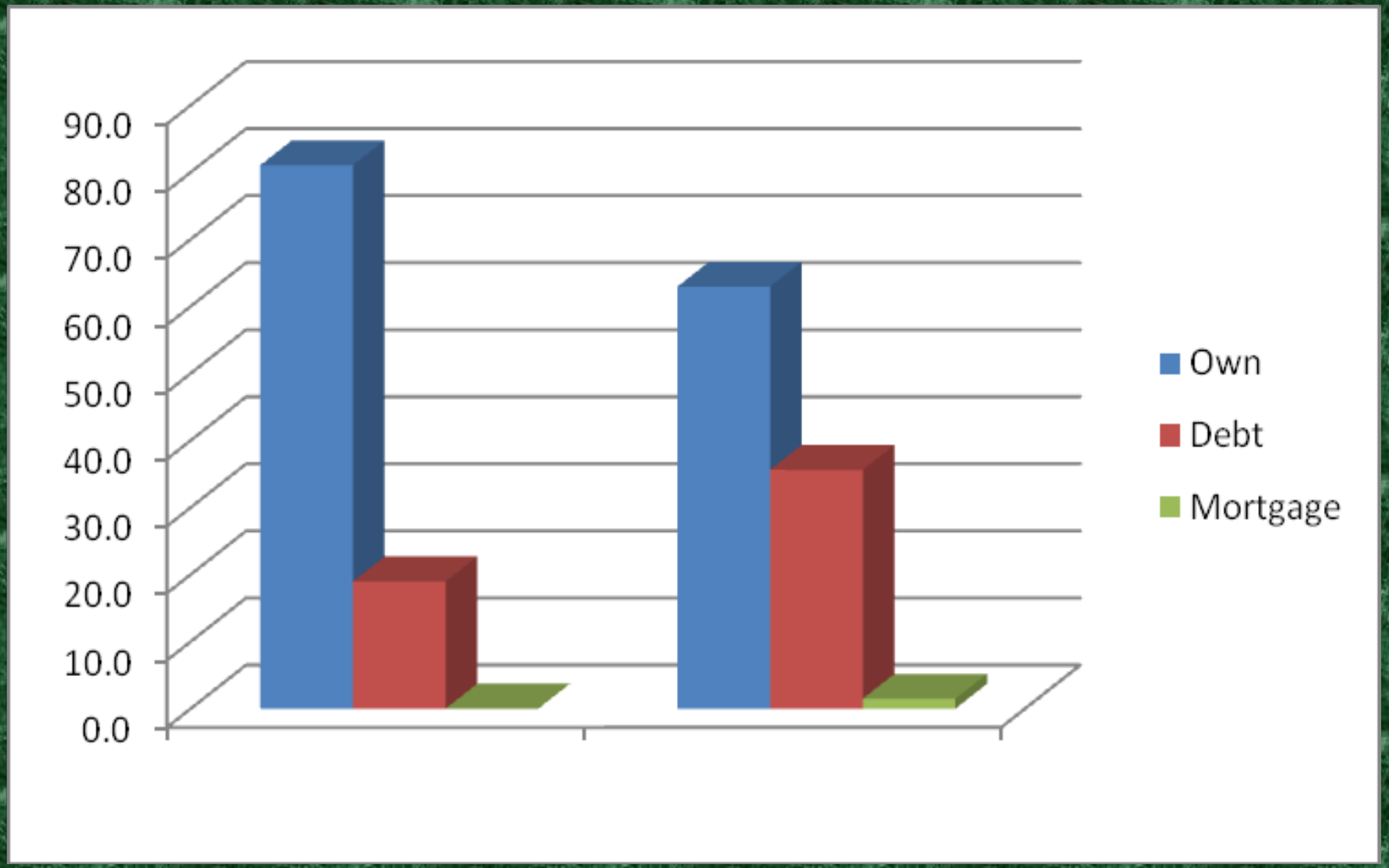
Expenditure: Tertiary



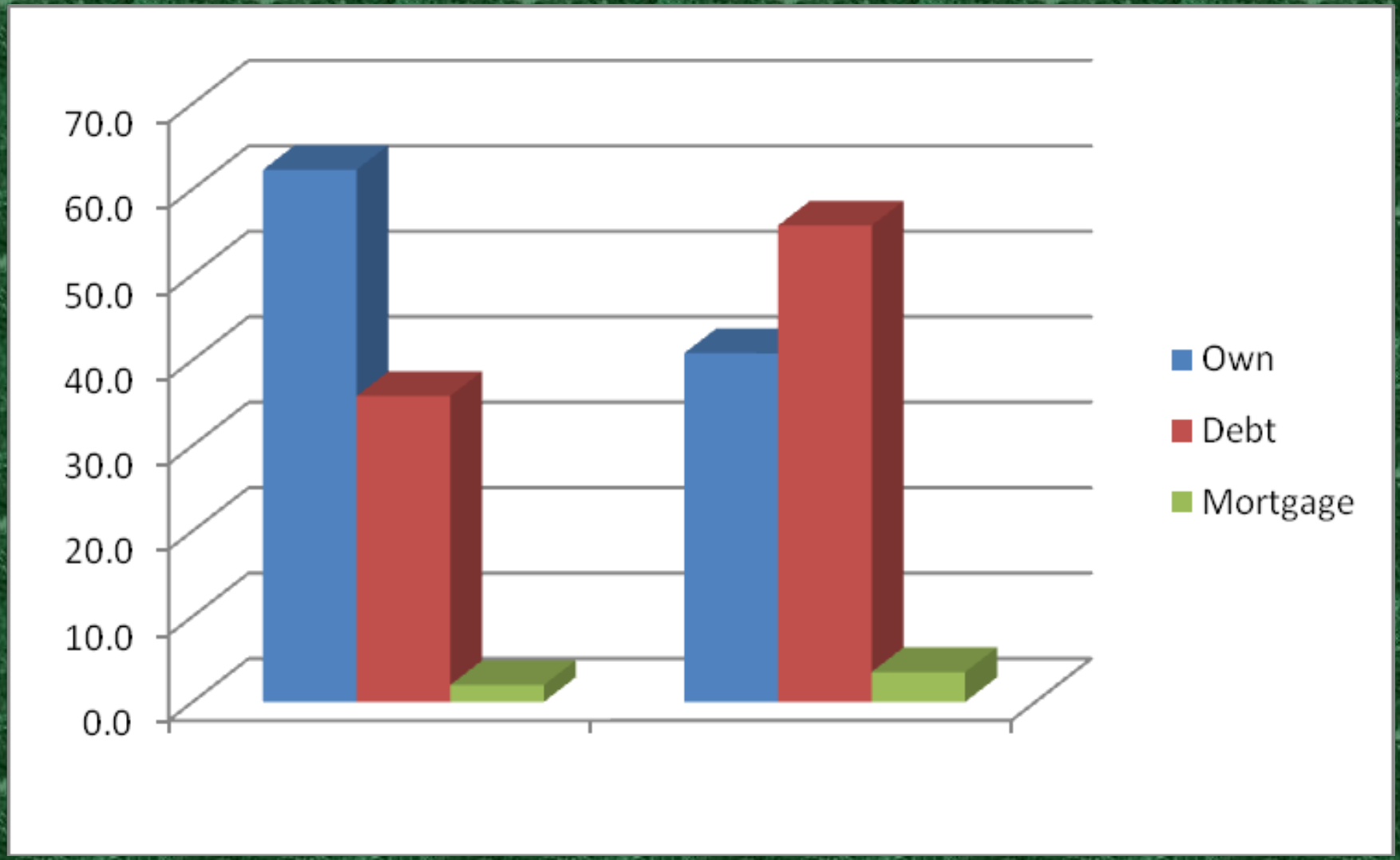
Series 2: Public

Series 4: Private

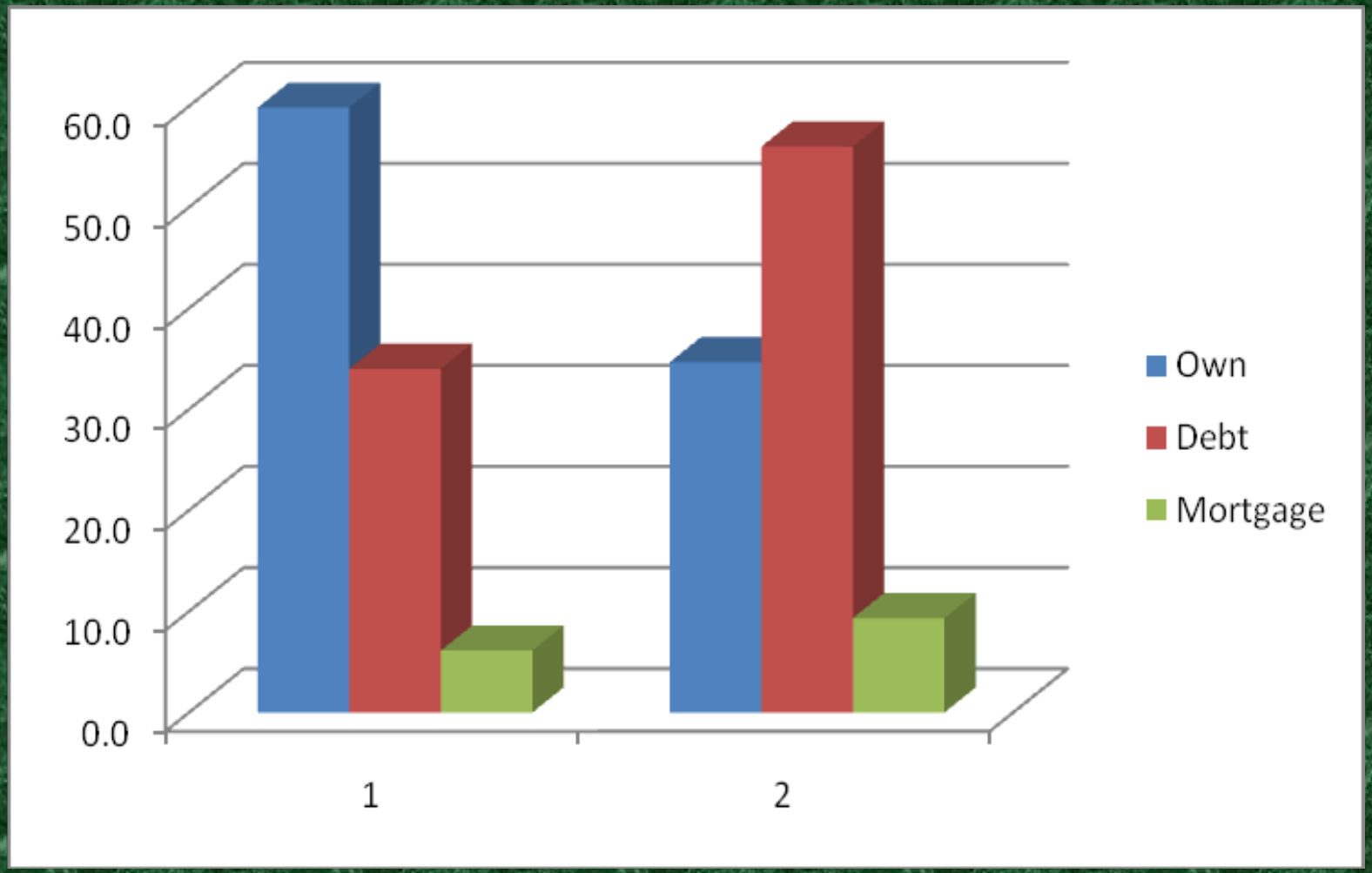
Source of Funds: Primary



Source of funds: Secondary



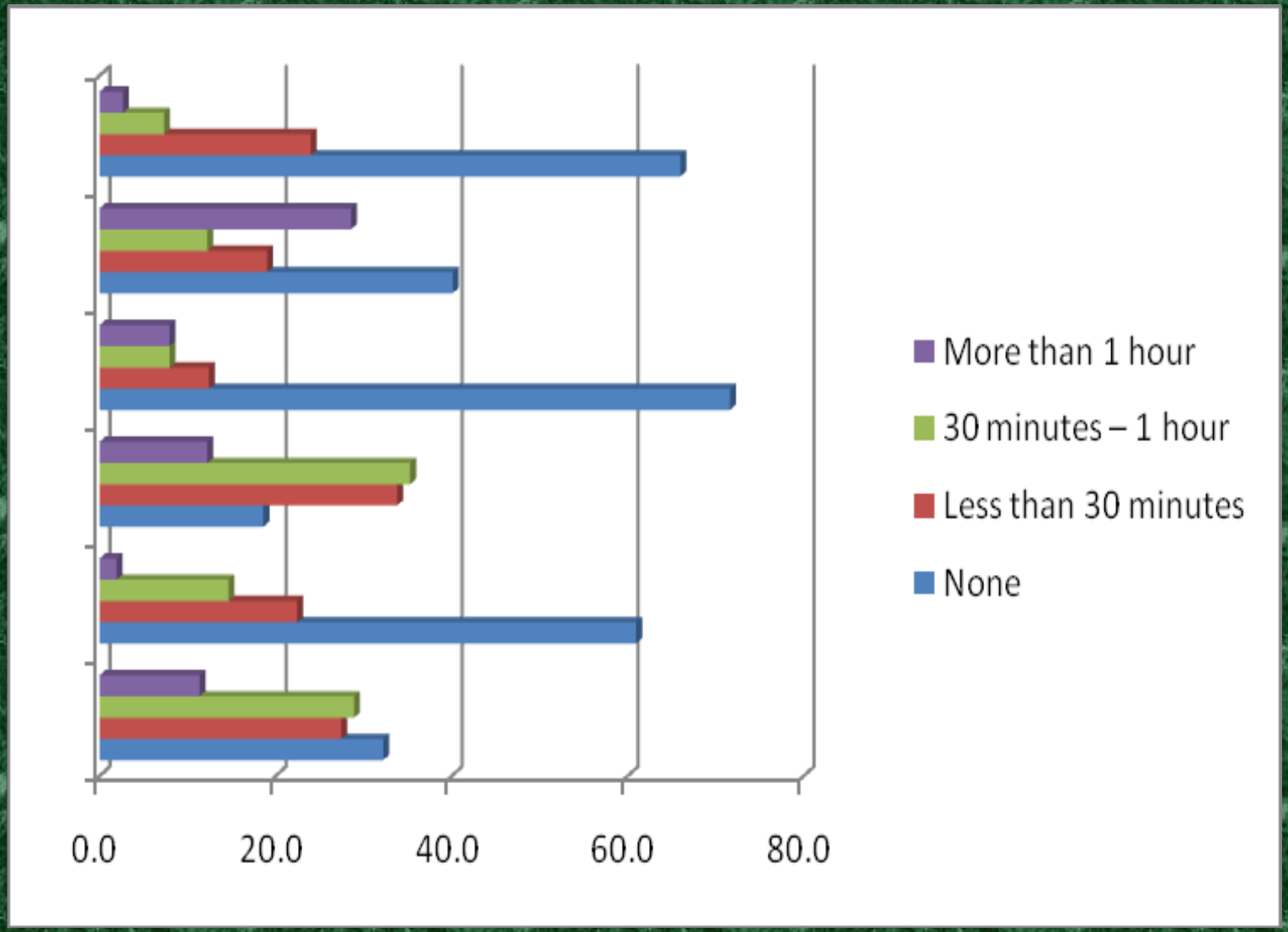
Source of Funds: Tertiary



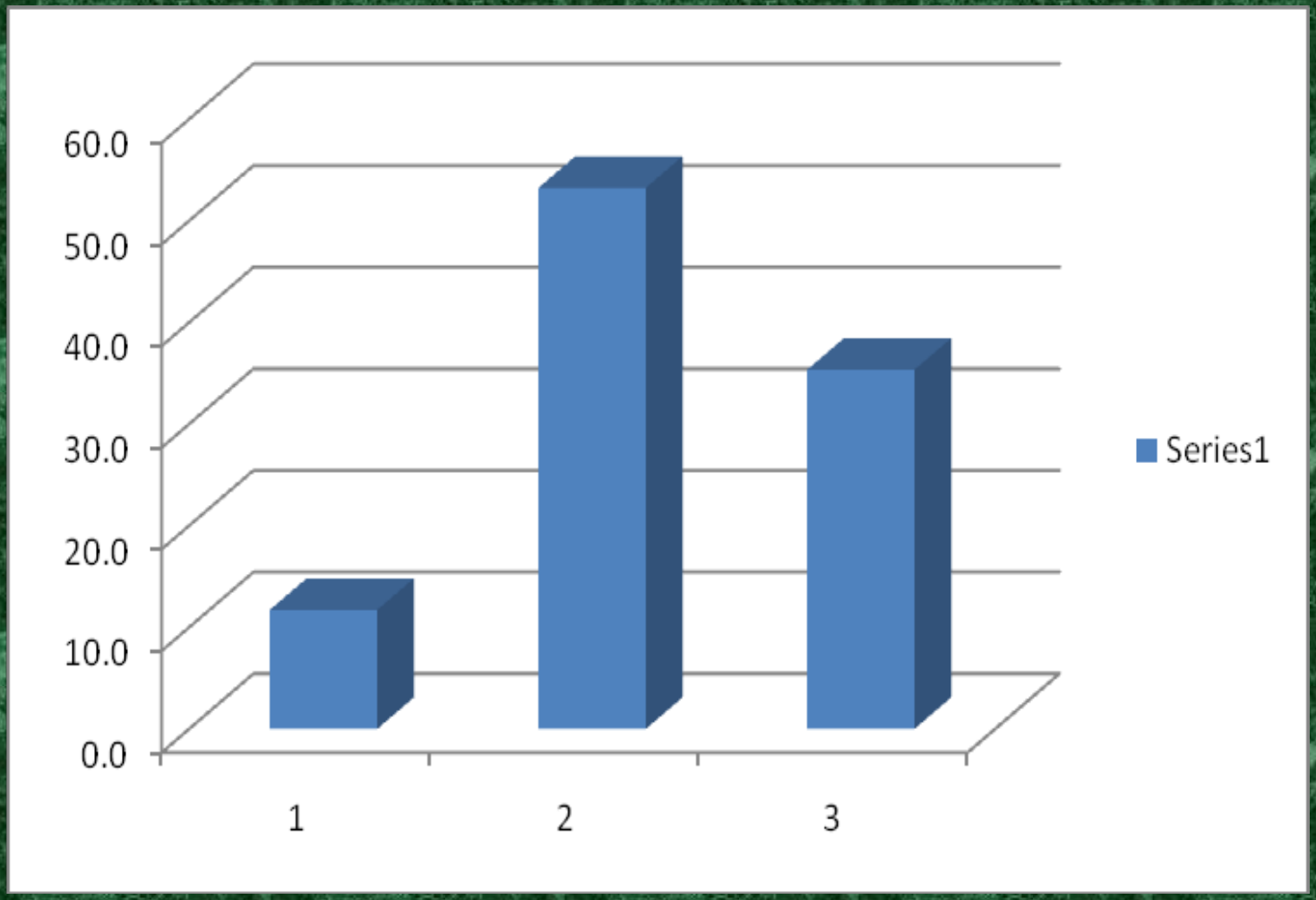
Public

Private

Waiting time: All facilities

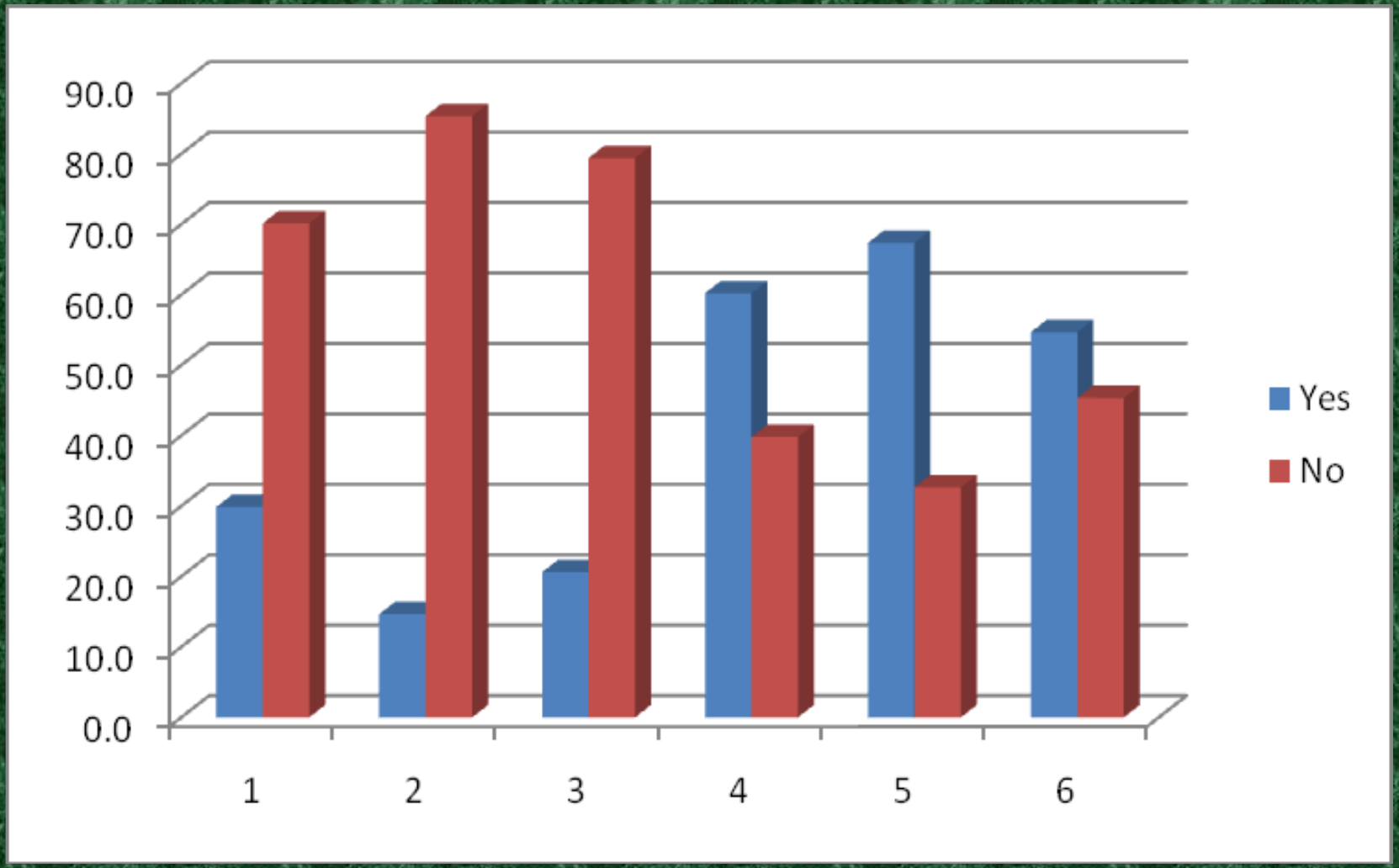


If Told of Costs: Private Sector



Primary Secondary Tertiary

If Explained About Illness: All Groups



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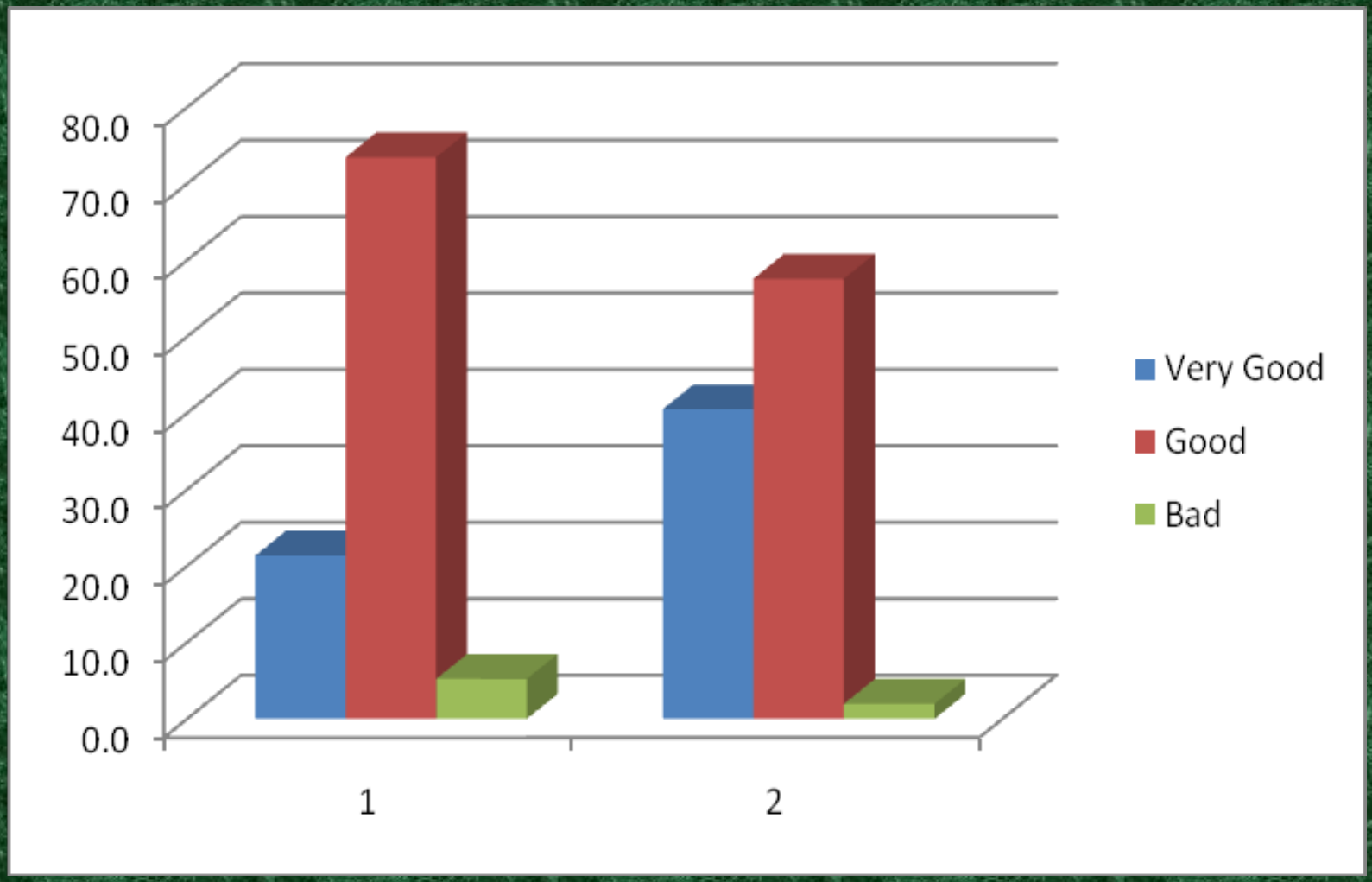
Behaviour of Personnel: Primary



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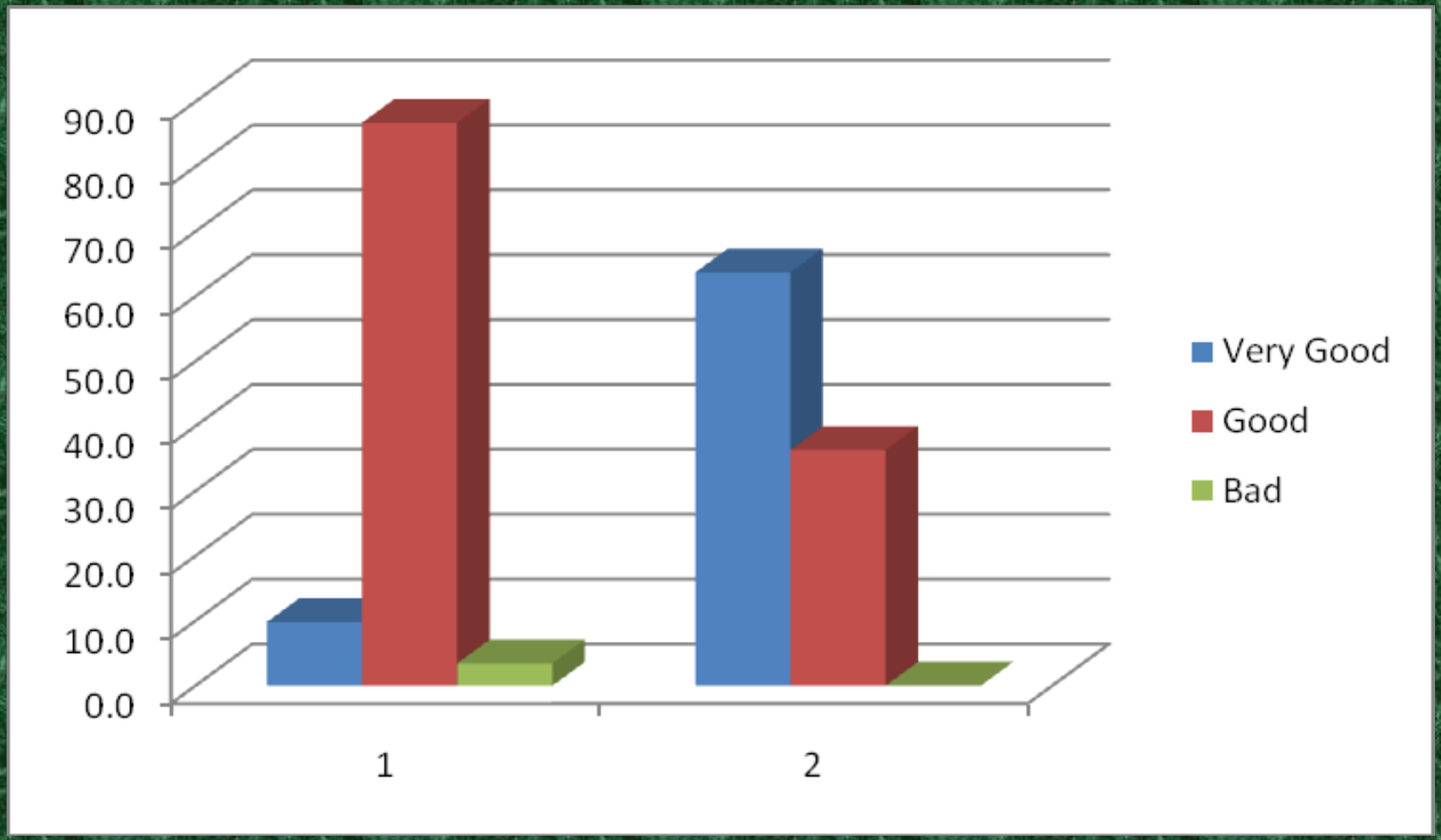
Behaviour of Personnel: Secondary



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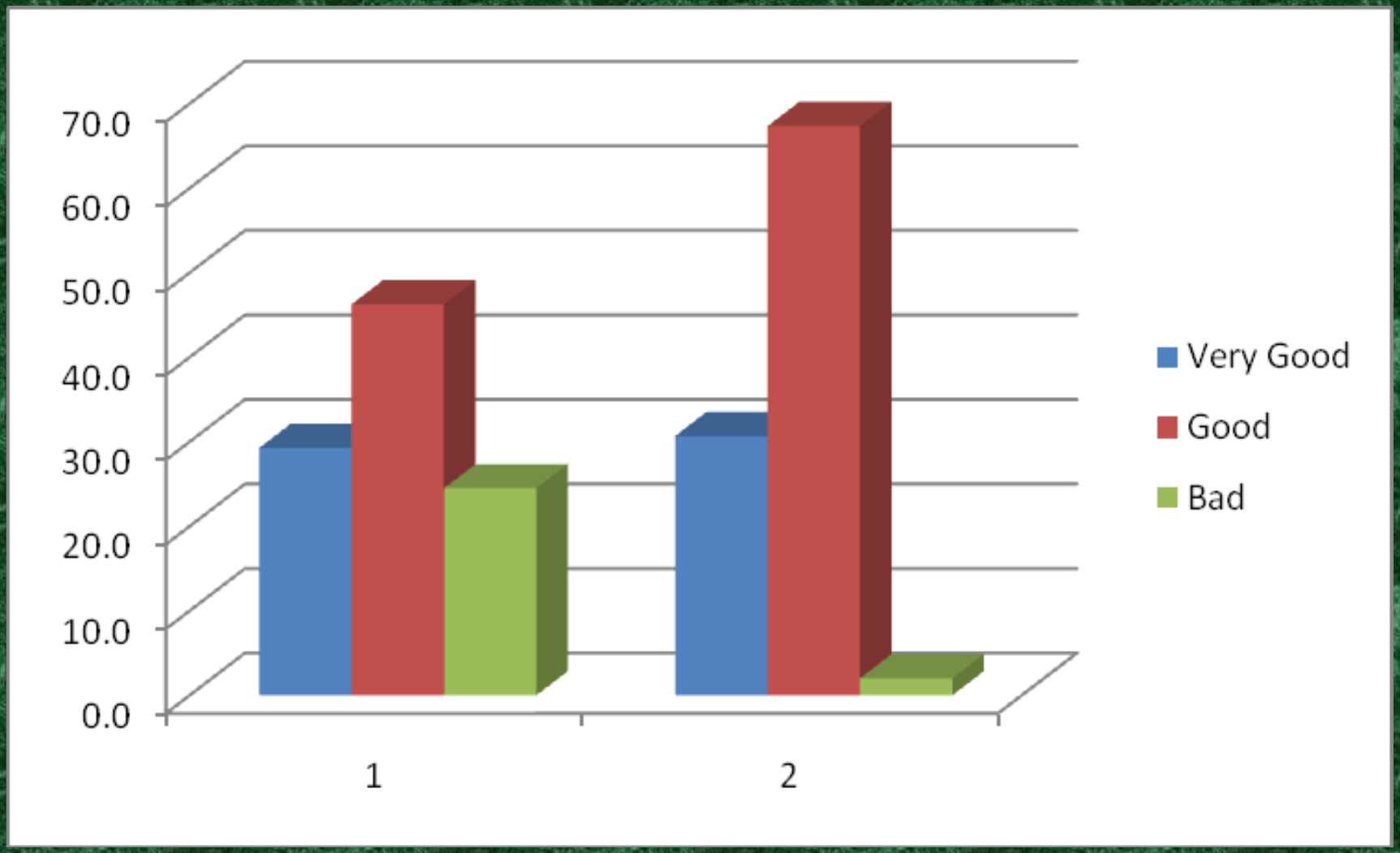
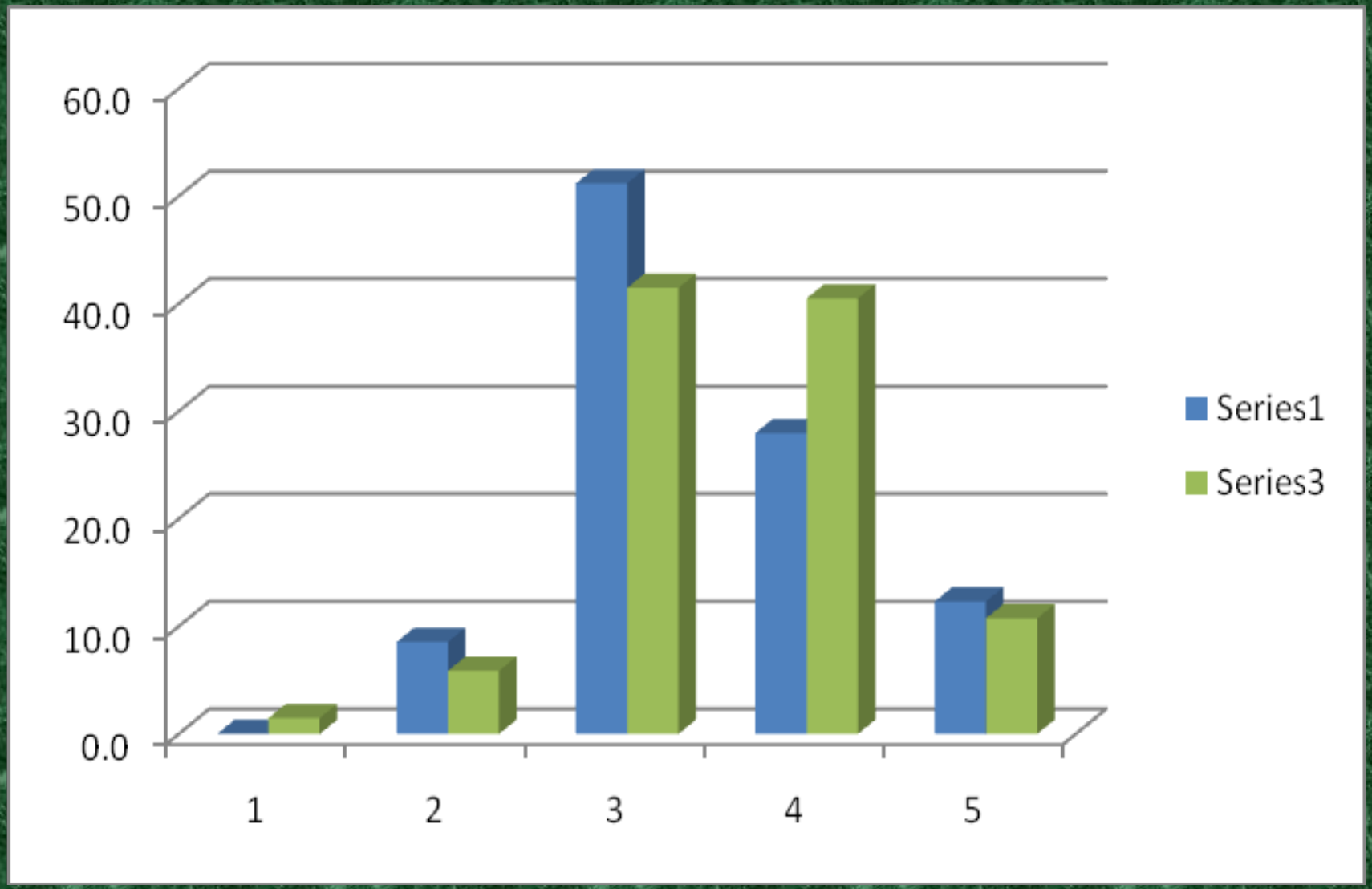
Behaviour of Personnel: Tertiary



Public Private

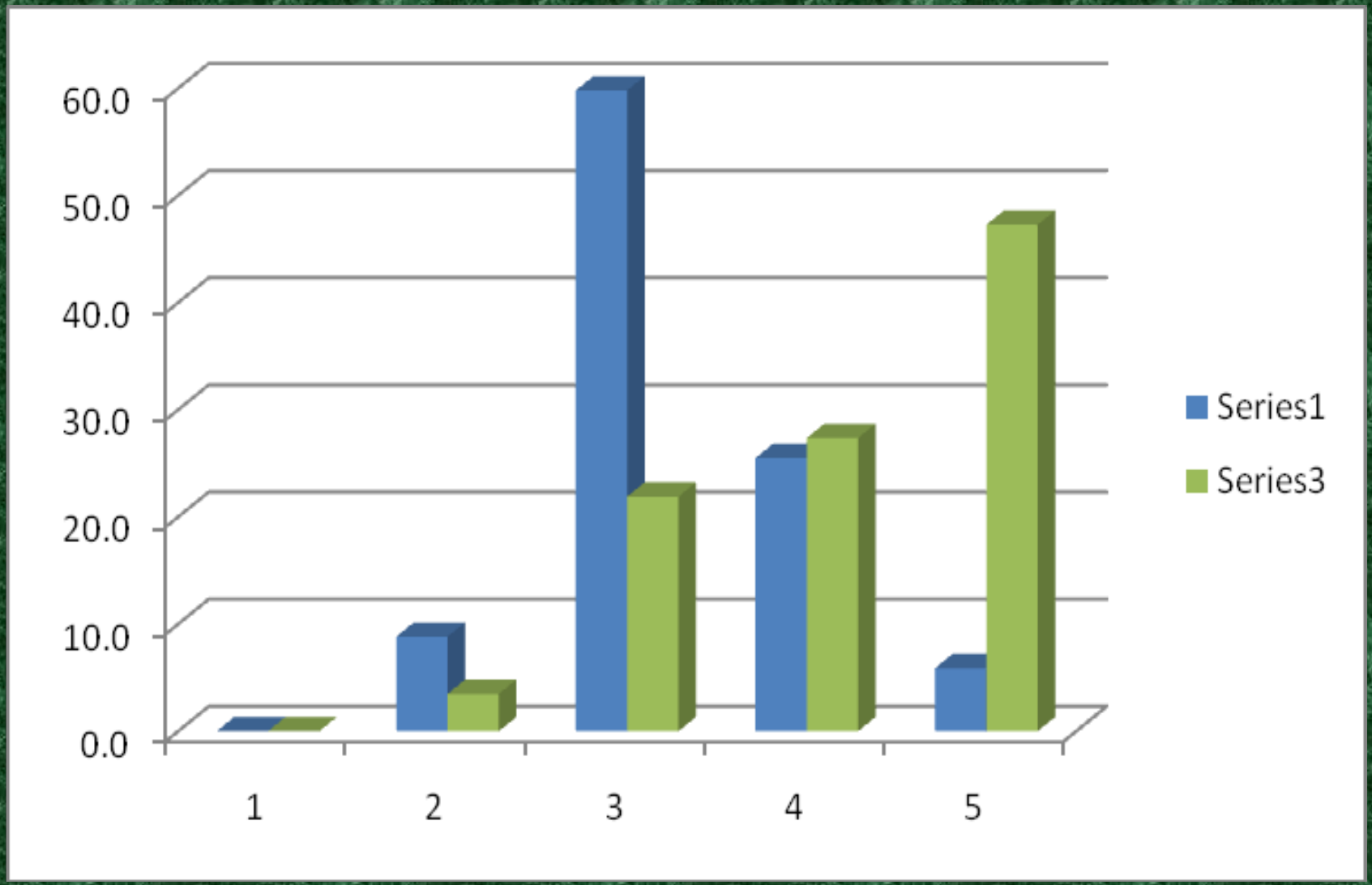
Level of Satisfaction: Primary



Series 1: Public

Series 3: Private

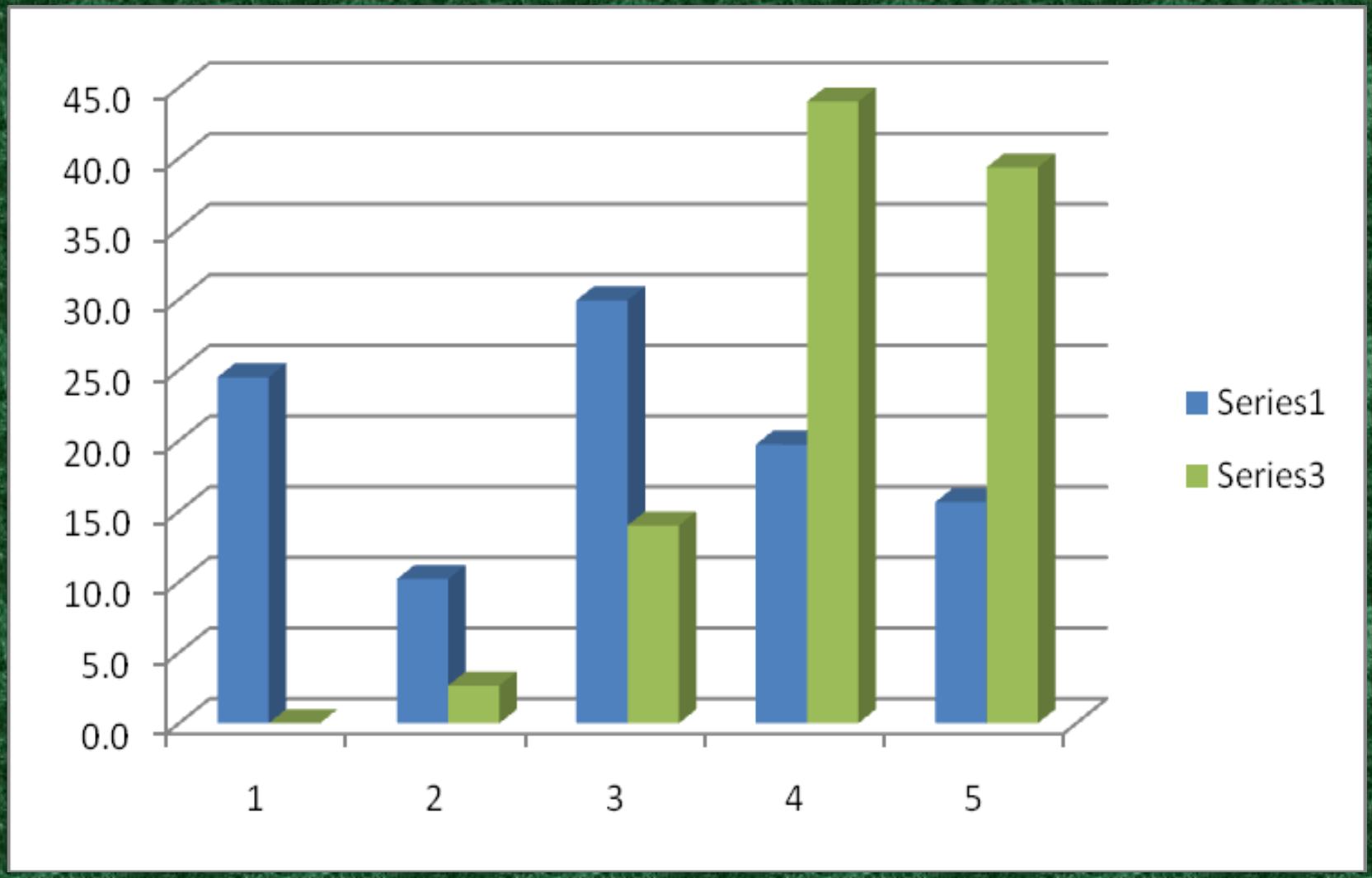
Level of Satisfaction: Secondary



Series 1: Public

Series 3: Private

Level of Satisfaction: Tertiary



Series 1: Public

Series 3: Private