Health Care Governance: The Missing Links in India[1]

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Abstract

Health policy literature has belatedly begun to recognize the importance of governance in shaping the performance of a country's health sector. There is less recognition, much less agreement, on what specific aspects of governance affect performance and how. The paper starts with the proposition that it is the system of controls and incentives vis a vis providers, insurers and users that have a critical impact on the sector's performance. Without the necessary controls and incentives, the key stakeholders take advantage of the market and government failures to their advantage which subverts the goals they are meant to collectively pursue. The proposition will be explored with reference to the case of India.

Introduction

India has had a dismal health care system almost every respect from a policy perspective: total expenditures are high, out-of-pocket expenditures exceptionally high, and two-fifths of all households encounter hardships due to health care costs. A recent ranking of 166 health systems on outcomes and spending (disability adjusted life years, health adjusted life expectancy, average life expectancy, and adult mortality rates; as well as total spending as share of GDP) placed India in the bottom quintile, far behind economies with similar levels of income per capita and economic development (The Economist Intelligence Unit 2014). These unfortunate indicators have persisted despite endless platitudes of successive governments and 5-year plans over six decades proclaiming commitment to social development and affordable health care. To the extent the government did try to improve health care delivery, it concentrated on relatively privileged groups employed in the

[1] For a fuller version of the paper, see Azad S Bali and M Ramesh, "Healthcare Reforms in India: Getting it Wrong" Public Policy and Administration, forthcoming.

public sector or in large private firms.

India's health policy failures have been well catalogued in the literature and are largely attributed to the lack of resources, urban-rural disparities, poor infrastructure, inadequate workforce, and stemming from other challenges associated with poor social infrastructure: poor education and literacy levels, lack of sanitation and hygiene, poor access to drinking water, etc. (Dreze and Sen, 2011; Rao et al 2011; Radwan, 2005; Rao and Choudhury, 2012; Forgia and Nagpal 2012; Rao 2015; Das Gupta 2005). In this paper we highlight that the problems are to a large extent a result of misguided or neglectful policies rooted in lack of understanding of the dynamics of health care.

This paper asks and addresses a straightforward question: what is wrong with healthcare system in India? To answer the question, it offers a simplified framework of healthcare governance focusing on the role of incentives and controls. This is followed by a review of healthcare reforms in India vis-à-vis the framework developed in this paper. The papers finds the source of the problems in the unregulated private sector and rigid public sector that together combine to produce the worst of both the public and private worlds in health care.

Effective Healthcare Governance: A System of Incentives and Controls

The market's potential to allocate resources efficiently holds great appeal to policymakers seeking optimal use of spending and forms the cornerstone of many contemporary reforms across most domains of public service delivery (Ramesh and Araral, 2010). The standard assumption is that competition among producers lowers prices, improves quality of services and ultimately societal welfare for both consumers and producers. However, the market's ability to allocate resources efficiently, and improve outcomes in the healthcare sector is compromised as most healthcare services despite being private goods have features of public goods (Blomqvist, 2011; Harding and Preker, 2003; Weimer and Vining, 2011). This implies that the market left to its own devices would produce less than optimal amount of healthcare services that are needed in a society.

The systemic governance failures that afflict the healthcare sector across modes of governance largely stem from the uncertainty associated with individual health outcomes, and the stochasticity in the onset of illness. To overcome the welfare loss associated with this uncertainty, and to smoothen consumption during periods of illness and periods of good health, there is a strong economic case for pooling of risks in a given population through any feasible mechanism (e.g. insurance, tax-financed plans, etc.). However the gains from risk pooling, in reality, have to be traded-off with the welfare losses caused by asymmetries in information and conflicting incentive structures between consumers (patients), providers (physicians), and the third-party (insurer) that underwrites the contract. This trade-off is well documented in the health economics literature. However, theoretically simulated solutions to deal with the malfeasance to engage in moral hazard, cream-skimming, and adverse selection have failed to yield effective results when translated to policy or practice.

The conventional approach of dealing with market or government-centric failures is to rely on an alternate mode of governance in the provision and financing of the good or service (Weimer and Vining, 2008). This however has limited utility in the healthcare sector, as the governance

challenges are deeply entrenched in both government as well as market and hybrid modes of governance. For instance, the challenges associated with *information asymmetry* which places providers in the dominant position due to users' inability to assess the cost or quality of service or indeed even the need for it (Dranove and Satterthwaite, 2000; McGuire 2000), are prevalent in both state-financed as well as privately insured plans. Malfeasance of m*oral hazard* wherein both users and providers have the incentive to over-utilize health services if they know that the costs will be borne by a third-party, insurer or the government (Zweifel and Manning, 2000), which results in over-consumption of services and eventually over-spending are equally pervasive in publicly-financed plans. *Adverse selection* wherein high-risk users seek generous insurance coverage, insurers look for low-risk users, and providers look for sicker patients who are fully insured ("cream skimming") (Rothschild and Stiglitz, 1976) is one of the few failures that are not dominant across government modes of governance. Without government regulation, adverse selection and cream skimming can lead to a 'death spiral' of the insurance plan (Cutler and Zeckhauser, 2000; Pauly et al., 2007).

While the market failures associated with asymmetrical information and moral hazard are equally pervasive in government-financed healthcare programs, governments can potentially address some of these shortcomings in healthcare markets. Thus, for instance, it can directly provide those services with public goods features or pay private providers to produce them. Similarly, use its position of authority and regulate providers to disclose information on quality, price, and outcome information to empower users vis-à-vis providers. It can also reduce the scope for adverse selection by banning risk selection by insurers and providers and mandating compulsory insurance for the population segment. There are also tools available to governments for containing moral hazard by altering payments and financing mechanisms in ways that reduce the incentive for over-servicing or over-charging (Preker and Harding, 2003).

In reality, these are extraordinarily difficult tasks that require a level of information and political and administrative capabilities that most governments lack (Wu, Ramesh, Howlett 2015). The incomplete information on consumer and producer behaviour and the cost and benefits of different medical options make it difficult for the government to make informed choices. Even when they are able to make a good choice, governments may lack the capacity necessary to implement the choice in the face of opposition from vital stakeholders.

Public Choice and New Public Management theories that emerged in the 1980s buttressed by neo-classical economic scepticism towards the effectiveness of governments' ability to provide services recommended that governments purchase the service from private producers on a competitive basis. However, these theoretical propositions failed to recognize policy domain-specific nuances and size of governance failures that the unfettered pursuit of efficiency can result in. Indeed, an uncompromising pursuit of improving efficiency through the market mechanism is an unworthy goal to pursue due to the severe impediments it encounters in the health care sector.

A more worthwhile goal would be effectiveness, defined as the extent to which goals are achieved, which in the case of health care is providing basic access to all those who need it, regardless of the technical efficiency of the mechanism. It does not mean that effective mechanisms are necessarily inefficient: it rather implies that technical efficiency is not their primary concern. To achieve effectiveness in health care, it may be necessary for the government to intervene

comprehensively by establishing an overarching policy framework that incentivises desired behaviour while constraining the undesired behaviour of key stakeholders: *providers, users, and the third-party.* The innate incentive of the three key stakeholders are not compatible with the goals of effectiveness, nor are they aligned with the goals of each other, which lead to sub-optimal outcomes even when they are technically efficient.

Table 1. Simplified Framework of Incentives and Controls in an Effective Health System

	INCENTIVES	**CONTROLS**
Providers	• Containing costs and improving quality, while ensuring access to users	• Limiting providers' ability to exploit information advantage • Monitoring costs, utilization, and quality • Containing over-servicing through gate-keeping and triaging
Users	• Adopting cost-effective treatment of illnesses (conversely, avoiding access to unnecessary advanced and acute care)	• Moderating demand for healthcare through cost-sharing, while ensuring access
Third-Party Payers	• Risk-pooling for managing uncertainties • Negotiating and bargaining with providers for a better deal • Fostering competition among providers	• Restricting opportunities for cream-skimming or dumping. • Restricting ability to pass on higher costs, through higher premium

For instance, healthcare providers have an inherent incentive to exploit their monopoly power and information advantage over patients and the third-party. Users have an inherent incentive to continue to seek medical treatment and not be cost-conscious consumers when they know that the costs are borne by a third-party. Similarly, the third-party has inherent incentives only to insure healthy patients, or pass on costs across the risk pool it insures through higher premiums. Therefore, the government has to intervene to shape economic behaviour of these agents through a series of incentives that encourage desired outcomes, while penalising any form of economic malfeasance. The overarching framework of incentives and controls will need to be accomplished through offsetting hybrid tools (rather than state- or market-centred tools) to achieve the balance between incentives and controls (Ramesh, Wu, and Howlett, 2014). Without such a governance framework, and the will and capacity to apply it, the goal of achieving effectiveness will remain elusive.

An orchestrated use of policy tools will enable governments to achieve the goal of providing universal health at costs affordable to society more effectively than either through market mechanisms or government regulations. The incentives for malfeasance under any form of conventional insurance or state-sponsored health plan by all stakeholders are large and cannot be controlled through either the market or regulation (Preker et al., 2007).

The proliferation of studies on health systems (Hafner and Shiffman, 2014; Mills 2014; WHO 2009), healthcare governance (Brinkerhoff and Bossert 2008; Balabanova et al. 2009; Savedoff 2011); design aspects of financing arrangements (Liu, 2003; Paolucci, 2011; Langenbrunner et al. 2009; Preker and Langenbrunner; 2005); and case studies on recent healthcare reforms in middle-income economies (Bonilla-Chacin and Aquilera, 2013; Hanvoravongchai, 2013; Somanathan, Dao and Tien, 2013; Savedoff et al 2012) underscore the need for orchestrated efforts across multiple dimensions of health systems to achieve universal coverage.

The current reform orthodoxy in the international health policy community advocates a complex schema that developing economies with impoverished capacities must accomplish to achieving universal coverage. While this is a useful endeavour in the march to achieving universal healthcare coverage, in many developing economies including India, the challenges that afflict the sector are more fundamental: governments are unable to steer the sector and shape health outcomes.

The framework developed in this paper therefore takes a much narrower perspective and focuses only on the extent to which health policy reforms have been able to overcome key governance failures that afflict the healthcare sector. The framework therefore eschews many of the complexities and nuances of the type of policy tools required, its settings, its institutional prerequisites for them to be used effectively; similarly the nature of regulations, and the sequence of these regulatory controls in shaping behaviour. In doing so, for the purposes of this paper, it usefully side steps the controversies in the health policy literature on specific choices on policy tools and instruments and their efficacy in organizing the healthcare system (e.g. for example should tax financed or contributory plans be used to expand government programs – Mills 2014).

The essential proposition that this framework tests is the extent to which these incentives and controls, i.e. the 'building blocks' of an effective health system, were incorporated into health system reforms, India would be able to intervene in its health sector and shape outcomes. Without the ability to steer the healthcare sector and shape outcomes, implementing checklists on achieving universal healthcare coverage is a wasted endeavour.

Healthcare Reforms in India: An Overview

After more than five decades of neglect, the government of India began to pay attention to health care, following the 2004 parliamentary elections in which the Congress Party won against odds on "common man" platform. The new government introduced two national health financing schemes. the National Rural Health Mission (NRHM) in 2005 and Rashtriya Swasthya Bima Yojana (RSBY) in 2007.

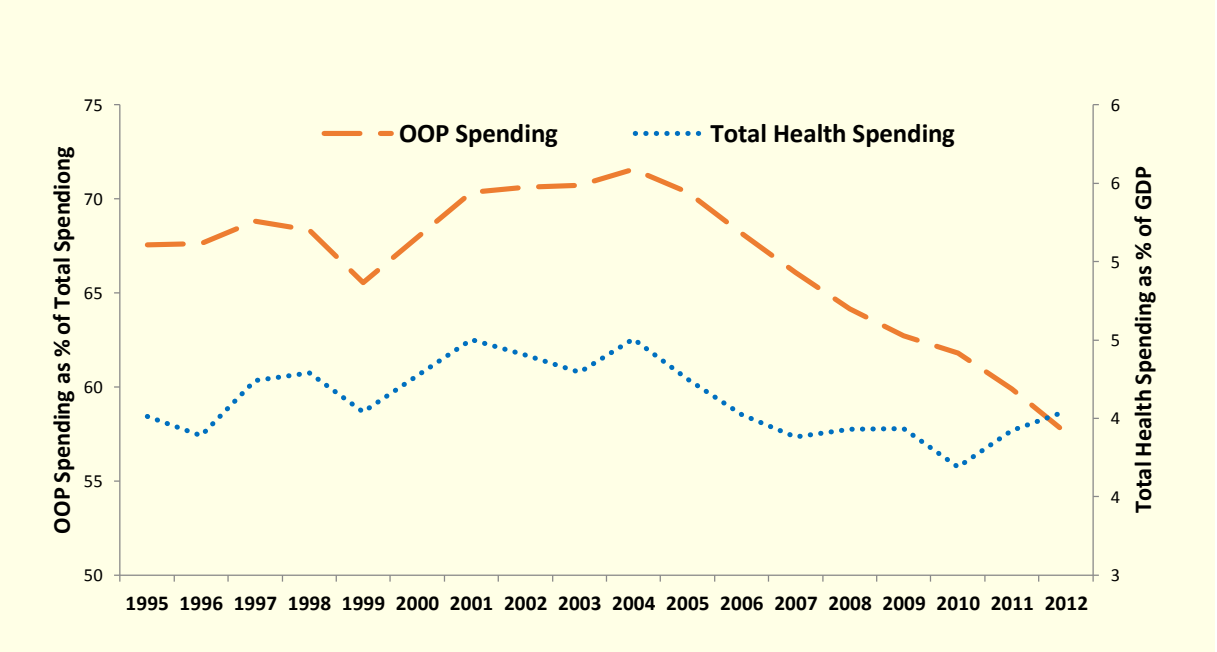
NRHM focused on improving maternal and child health, and providing primary care to rural population in the 18 least developed states (out of 28). The central government provides funding to state governments on a matching basis for delivering NHRM programs. Since many states lack both administrative and fiscal capacity to implement the program, less than half the funds allocated by the national government was actually spent (Rao and Choudhury, 2012). Further, the increased central funding through NRHM did not necessarily result in increased spending on the sector due to cut-back in expenditure by state governments (Duggal, 2009; Rao and Choudhury, 2012). A

nationally representative sample studied in 2006 found that 40 percent of those hospitalised had to borrow money or sell assets to pay for their healthcare expenses; and 35 percent of those hospitalised fell below the poverty line after paying for hospital related expenses (Ministry of Statistics and Programme Implementation, 2006)

RSBY provides free inpatient and outpatient in designated private and public facilities to recognized poor households to a maximum of INR 30,000 (USD 500) per annum. State governments identify eligible families but the scheme is implemented through private insurance companies. The premium for the scheme is shared 75: 25 between central and state governments. Many states have introduced more generous versions of the scheme. RSBY and related programs expanded rapidly and by 2010 they covered over 300 million people, or more than a quarter of the population, up from 55 million in 2003-04. More than 180 million of the newly covered were people were living below the poverty line.

The growth of OOP expenditure slowed down after the launch of NRHM and RSBY, from 71 percent in 2005 to 58 percent in 2012 (Figure 1). Remarkably, and contrary to popular perceptions and theoretical expectations, healthcare spending as share of national income also declined from 5 percent to about 4 percent of GDP during the period (Figure 1).

Figure 1: Healthcare Expenditure in India 1995-2012



Source: World Health Organisation (WHO)

However, the overall health care conditions remain dire. Despite substantial improvements over the decades, its average lifespan of 66 years, infant mortality rate of 43 per 1,000 live births, and maternal mortality rate (MMR) of 190 in recent years is one of the lowest among emerging economies (Joumard & Kumar 2015). These average indicators mask the vastly inferior performance in many states given the considerable inequalities across states discussed in the subsequent section.

Almost 80 per cent of urban households and 90 per cent of rural households are estimated to find average cost of in-patient treatment to be almost half of their annual household expenditure. It is estimated that 3 per cent of India's population slips below poverty line each year due to health-related expenses. Moreover, nearly 12–15 per cent of reported ailments are estimated to remain untreated due to the cost of treatment being unaffordable. The problem is especially acute in rural areas, which bear three-fourths of the ailment burden but have only one-ninth of the total number of beds and one-fourth of the number of healthcare workers (Ernst and Young and FICCI 2012)

Discussion

The poor outcomes are easy to understand when the Indian health care system is assessed against the criteria for effective health care system proposed in the preceding section.

As summarized in Table 2 below, nearly every condition for effective health care policy was absent from the healthcare system in India. Of the three channels of intervention potentially available to governments in the health care sector - pr*oviders, users, and third party payers* - the government possessed few levers over providers and almost none over users and third party-payers.

Table 2: Incentives & Controls in Health System in India

	INCENTIVES	**CONTROLS**
Providers	Providers faced no incentive to reduce costs because they could pass on the costs to users paying out of pocket.	There was no effective measure to control providers' behaviour or monitor their performance.
Users	Bulk of the population was uninsured and did not use public facilities and, hence, could not be reached through incentives or controls. Those with the means to pay could access any private facility they wished while users of public facilities were limited only by the level of physical access.	
Third-Party payers	Small insurance coverage and low government spending denied the government the opportunity to intervene in the sector through incentives or controls.	

The reliance on OOP has had an incapacitating effect on the government's ability to influence the sector through the users. Since most users could visit any provider they wished and paid directly out of pocket, the government had no direct way to affect their behaviour either through incentive or control. Those able and willing to pay for health care did so, but with the disadvantage of information asymmetry and absence of effective controls on providers' behaviour which increased the financial burden on them and on the society as a whole.

Third party payers have played a similarly insignificant role as a health policy tool in India. Public spending on health care has been so small that the government could not meaningfully use fiscal transfers as a tool for either incentive or control. Similarly, insurance covered less than 5 percent of the population which was not large enough to offer the government a tool for shaping the sector's behaviour and performance. Health insurance for public employees, the largest insurance scheme in India until recently, provided services at its own facilities, which were run

poorly and largely avoided by members, thus reducing the opportunity for government to intervene in the sector.

While providers offer the government a potentially powerful tool for affecting the functioning of the health care sector, in the case of India the potential was severely limited by the financing and payment mechanisms that exist in the country. OOP and FFS require appropriate monitoring to ensure that providers do not engage in moral hazard that undermine population's access to necessary health care. But in India, as mentioned earlier, there was no meaningful control over FFS charged by providers and no substantial help for users with their OOP payments.

Indeed the government had limited incentive to control FFS or OOP, because government officials and elite groups were already covered by comparatively generous programs and so did not face the burden that the rest of the population faced. While healthcare providers are politically and economically powerful in most countries (Duran-Arenas and Kennedy, 1991; Fuchs, 2011; Pauly, 2009), they are especially powerful in India due to their overwhelming size. Their monopoly over prescription of diagnosis, treatment procedures and drugs coupled with information asymmetry allows them to evade accountability to the government as well as users. The inability of the government to shape and influence outcomes in the health sector through users and third party-payers due to weak governance arrangements further emboldens providers to pursue their interests unencumbered.

Providers, insofar as they are driven by profits, compete aggressively to attract patients but, once successful, use their monopoly power and information advantage to maximise their income. This resonates with the healthcare reform experience of China and Vietnam over the past decade. Healthcare providers (public hospitals in this case) were incentivised to generate and retain revenue through user fees from patients. This resulted in rapidly increasing costs mostly financed out of pocket by patients with insignificant improvements in healthcare outcomes (Ramesh and Wu, 2009; Somanathan et al 2013). Strict government monitoring and regulations can constrain such behaviour but require high level of information and administrative capacity on the part of the government (Wu, Ramesh, Howlett, forthcoming). However, material interests of dominant actors are advanced in a reform process the government has limited options for reform. It requires formidable capacity across many dimensions for the government to change status-quo and empower other stakeholders in the health system.

India's federal political system and decentralized administrative system further undermine effective governance of the sector. This horizontal and vertical fragmentation over the provision of healthcare services stymies the government's ability to deliver quality health care through the public sector, allowing private providers to dominate the sector to their advantage.

The recent launch of NRHM and RSBY has created new opportunities for the government to establish a system of incentives and controls. Notwithstanding their failure to achieve targets (Ashtekar, 2008; Rao and Choudhury, 2012), evaluations show that the NRHM improved access and utilisation at primary centres (Husain, 2011). For the purposes of effective health care system outlined in this paper, the central government financing for the NRHM gives it the leverage to intervene in the sector, an opportunity it sorely lacked in the past. In exchange for funding, the government can now impose conditions, monitor progress, and hold state governments accountable

on key performance indicators as continued funding is contingent on meeting targets. This in turn pressurizes state governments to improve the performance of their healthcare facilities.

Similarly, the design of the RSBY allows the government to exploit its monopsony power as a large purchaser of healthcare services, a powerful tool to exert market power in the healthcare (Preker and Langenbrunner, 2005). The government has negotiated package rates with hospitals in its network for most illnesses. As of 2012, a total of about 5,000 private hospitals and 3,000 public hospitals across 25 states had joined the RSBY (Forgia and Nagpal, 2012). While the benefit package is relatively small (USD 500) per family per annum, it gives the central government leverage to establish incentives for providers and controls over treatment costs. As a large purchaser of services, it allows the government to also implement controls over the third-party payers (i.e. insurance companies) who until recently were inactive participants in India's health system.

The design of the RSBY has also empowered users, the weakest and most vulnerable stakeholder in the system. Benefits are portable and patients can visit any empanelled provider in India. While competition for patients among providers does not drive down prices in health care due to various market failures (Dranove and Satterthwaite, 2000; McGuire 2000), it does force physicians to compete on quality of services. This not only reduces the power of the physician agency, but also empowers patients who had previously remained vulnerable and at the discretion of the healthcare providers.

Experiences from universal coverage reforms underway across developing economies suggest that the 'near poor' and those employed in the informal sector are the most challenging population segments to cover under contributory programs. China and Thailand have avoided this challenge by abandoning contribution requirement from their health financing schemes. The Popular Health Insurance (PHI) rolled out in Mexico also financed from federal and state governments revenues (Bonilla-Chacin and Aguilera, 2013). The non-contributory design of the RSBY, with portable benefits, makes it an attractive proposition for targeted beneficiaries to enrol. However, its low benefit level and low levels of government spending limits their usefulness as policy tools for promoting policy effectiveness. The HLEG recommends that the government must increase healthcare spending from 1.2 percent of GDP currently to 3.0 percent by 2022 to make a significant improvement (Government of India, 2011). However, the increased government spending on health care unaccompanied by appropriate incentives and controls discussed earlier will only result in ballooning of healthcare costs without ameliorating issues of access and equity in the long run.

Conclusion

This paper has argued that effective health policy requires systemic regulation and oversight of the medical sector through coordinated use of policy tools to manage economic behaviour of providers, users, and insurers. When viewed within the context of effective governance framework proposed in the paper, India's health policy failed along every key dimension. With little government spending or national insurance, the government had few policy leverages over the sector. Regulating the providers, most of whom were private, was its only workable instrument and the government did not deploy it effectively.

This paper's contention is that healthcare reforms in India failed to achieve their professed goals because the government did not exercise the needed stewardship over the health system and indeed weakened it. Not only did the government not intervene to reduce the market power of private providers, it gave them unfettered access to exploit the inelastic demand for healthcare services. The problem of poorly regulated private providers was aggravated by, and entwined with, the FFS-OOP instrument mix which favoured private provision and financing. Overcoming the political and economic leverage of providers that thrived in the absence of government regulation for more than five decades was a daunting challenge and the government failed to meet it.

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