

Small Increases in Investments in the Public Healthcare Sector Can Translate into Big Gains for Equitable Universal Health Coverage in India

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Introduction

In India, public spending on health is low, at 0.9 per cent of the country's Gross Domestic Product (GDP), and socio-economic disparities shape severe health inequities. Most primary healthcare in rural India is delivered by private providers without formal medical qualifications, raising serious concerns that unregulated, sometimes hazardous providers constitute the most accessible healthcare option for India's rural poor. While there is evidence of the protective effect of public healthcare spending on population health in India, the association between healthcare spending and how people use the health system is unclear.

Our study (Mulcahy et al. 2021) analysed the relationships between State-level public spending on healthcare and the choice of medical provider among patients in India, and whether these relationships varied by socio-economic groups. Across all the models, increased public spending on healthcare was associated with reduced odds of choosing private healthcare providers. This pattern was most prominent among the poorest patients (a 17 per cent reduction) as compared to the most affluent (9 per cent). These results indicate that policies which increase public spending on healthcare are associated with a shift in patients' health-seeking behaviour towards government medical providers in India. This provides empirical evidence of the effectiveness of 'regulation by competition' (poor-quality private healthcare providers are driven out of the market by the greater availability of better-quality public sector services). Our findings have implications for policy efforts to promote greater equity in healthcare access and health outcomes. This research presents a compelling argument for focusing on strengthening public health systems for achieving universal health coverage in India.

Need for better regulation of healthcare to achieve Universal Health Coverage (UHC) and health equity.

Due to insufficient government funding for the public health system, since the 1980s, the proportion of healthcare provided by the private sector has expanded (Mackintosh et al. 2016). Alarming, an analysis of national survey data has shown that most primary healthcare in rural India is delivered by private, informal providers without formal medical qualifications, and private services are preferred over government services. Long waiting times, lack of geographical access, and frequently absent healthcare staff—all factors related to insufficient funding—are key determinants shaping low/non-use of government healthcare services (Morgan et al. 2016). The high proportion of healthcare provided by the private sector is plagued by serious concerns regarding unregulated and sometimes hazardous healthcare providers (Calnan and Kane 2018), and broader issues regarding oversight, quality of care, and health equity for India's poor.

In 2019, India's public spending on healthcare was 0.9 per cent of its GDP (Apeageyi, Dieleman, and O'rourke, 2020) which was notably lower than that of other countries with similar levels of GDP per capita, including Vietnam (2.7 per cent) and the Philippines (1.4 per cent). This suggests that there is fiscal space to make significant investments in public healthcare services. At the same time, public healthcare spending in India varies across States, which offers a unique opportunity to explore how this variation affects people's healthcare seeking behaviour.

Making sense of gains from investments in public health spending.

The protective effect of public healthcare spending on population health is well-documented in India: a 10 per cent increase in public healthcare

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expenditure reduced the all-cause mortality by about 2 per cent (Farahani et al. 2010) and health systems were shown to be more responsive if they spent more on public healthcare (Malhotra and Do 2017). The Indian Government is committed to investing in the healthcare sector, for example, by providing the poorest 100 million households—encompassing a total of 500 million people—access to health insurance coverage worth up to INR 500,000 (≈USD 6500) annually (Nirula et al. 2019). However, there is limited evidence of the association between public spending on healthcare and how people use the health system, and the potential mechanisms linking investments in public healthcare services to health outcomes.

To address this critical evidence gap, our study examined the relationship between State-level public spending on healthcare and the decision on whether to seek healthcare or not; as well as the relationship between State-level public spending on healthcare and the choice of medical provider; and whether these relationships varied by socio-economic groups, among patients in India.

Research Overview

Our study (Mulcahy et al. 2021) drew on data pertaining to 26,142 people, who reported recent ailments in the nationally representative 71st National Sample Survey (NSS) of India in 2014, and State-level information on government healthcare spending per capita (Central Bureau of Health Intelligence 2016). Using two regression-based statistical approaches, we analysed the associations between public spending on healthcare, the odds of seeking treatment, and the patients' choice of medical providers. The healthcare provider choices were classified into nine categories describing private or public provider, outpatient or inpatient healthcare, and the type of healthcare setting (that is, a hospital, clinic, or other facility). We also investigated the differential impacts of public spending on healthcare utilisation by socio-economic groups.

Our analysis found that an overwhelming majority (96.9 per cent) of the patients sought healthcare when they experienced ill-health. In general, patients favoured private healthcare, particularly for outpatient care—33.8 per cent of the people sought outpatient treatment at public

clinics while 51 per cent did so at private clinics, including private hospitals. Private healthcare was also preferred for inpatient care, with 6.3 per cent of the total visits being as inpatients to government facilities and 12 per cent to private facilities; 8.4 per cent sought care from either a “medicine shop” or “other” informal provider.

Key Policy Problems

- In India, socio-economic disparities lead to earlier mortality and barriers to healthcare access among the most marginalised—these unacceptable health inequities stunt India's progress towards UHC.
- Most primary healthcare in rural India is delivered by private providers without formal medical qualifications, suggesting that unregulated, sometimes hazardous, providers constitute the most accessible healthcare option for India's poor.
- Regulating India's heterogenous, pluralistic for-profit part of the health system is very difficult.

Higher investments in public health translate into lower use of private healthcare, particularly by the poor and the socially disadvantaged.

Our study identified a statistically significant association between per capita public spending on healthcare and the choice of medical provider among the people who chose to seek healthcare. Across all the models, the odds of utilising private healthcare services for both outpatient and inpatient care were negatively associated with increases in per capita public healthcare spending. An extra INR 100 in public healthcare spending per capita was associated with a 6-9 per cent reduction in outpatient care at private hospitals, a 9-17 per cent reduction at private clinics, and a 6-11 per cent reduction in inpatient care at private hospitals and 5-14 per cent at private clinics. In a model adjusted for confounding factors, including age, gender, educational attainment, rural versus Urban location, caste, and monthly consumer expenditure, increased public spending on healthcare was significantly associated with reductions in patients choosing private medical providers [AOR = 0.88 (95%CI – 0.85–0.91) for outpatient private clinics] as compared to outpatient government clinics. Our data also suggest that these associations are stronger among more the economically marginalised groups relative to their more affluent counterparts.

In examining the impacts of public spending on the choice of medical provider by socio-economic groups, our study identified significant socio-economic patterning of health-seeking behaviour. The poorest quintile had a higher proportion reporting ‘no treatment’ or use of outpatient government clinics, as well as a lower proportion going as inpatients to private hospitals. In the most advantaged quintile, a higher proportion of the respondents attended private hospitals as outpatients.

Conclusions

Our study is the first to systematically examine the associations between State-level per capita public spending on healthcare and the choice of medical provider in India. Drawing on data from a nationally representative sample, our study found that increased State-level public spending on healthcare was associated with reduced odds of choosing private healthcare providers, with the greatest reduction seen in private outpatient clinics relative to government outpatient clinics. This finding was most pronounced among the most economically marginalised patients (a 17 per cent reduction) as compared to the most affluent (9 per cent). These results indicate that policies which increase public spending on healthcare are associated with a shift in patients’ health-seeking behaviour towards government medical providers in India. Our findings have implications for policy options towards achieving greater health equity, particularly for the most economically marginalised, on the road towards UHC.

Policy Implications and Recommendations

Our study found that increased public spending on healthcare was associated with the decreased use of private healthcare providers, particularly outpatient facilities. These findings demonstrate that higher levels of government investment in healthcare services translate into greater use of public services, particularly by the most vulnerable. This signifies a strong argument for a policy focusing on strengthening public healthcare services, and highlights the possibilities and potential strategies towards achieving UHC through public investment.

A novel approach to regulating what has been very unregulatable thus far.

Currently, most healthcare in India is provided by the for-profit private sector, and monitoring and regulating its quality has remained an intractable challenge (India Health System Review 2022). Calls and proposals to better regulate the vast and heterogenous for-profit private healthcare sector abound. However, there is mixed evidence for such proposals, and they would require significant investment—financial, political, and administrative alike. Meanwhile Indians, the poor and non-poor alike, continue to be at high risk of being misled, exploited, and often harmed by unscrupulous healthcare providers and pay immense out-of-pocket costs for low-quality healthcare (Kane et al. 2022; Mohanty and Srivastava 2013).

Our results provide evidence for the idea of ‘regulation by competition’, suggesting that improving the quality of healthcare in the public sector will lead to improved quality of private sector healthcare by triggering competition for customers between healthcare providers (McPake and Hanson 2016). The notion of regulation by competition offers governments (national, state, and city) across India a potential pathway to regulate a market which has proven notoriously difficult to regulate so far. By ensuring a good quality public healthcare system, governments drive out poor quality private provision. This is achieved by suppressing the demand for the poorest quality healthcare providers and stimulating providers to improve their quality over what is available in the public sector in order to retain customers. This implies that as the quality of the public health system improves, so too does that of the private system. Investing in public healthcare spending instead of in policing private healthcare providers directly will police private providers indirectly through regulation by competition.

Investing in public health services will promote health equity and benefit everybody.

Our finding of a substantial shift in the patients’ use of medical providers from private to public outpatient facilities, with additional public investment of as low as INR 100 per capita,

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provides evidence that some combination of affordability, access, and quality improves as per capita public spending on healthcare increases. Further, as India's rural poor have the fewest options and are thereby often forced to seek healthcare at ostensibly low-quality providers due to cost constraints, the maximum benefits of increased per capita public spending on healthcare would accrue to the poor, thereby promoting greater equity in healthcare access and quality of services for the most economically marginalised patients.

Our findings provide strong empirical evidence that investing in public healthcare will bring a range of benefits. Increasing per capita public healthcare spending will raise the minimum quality of healthcare services by making low-quality private providers uncompetitive, will enhance the quality and accessibility of health services utilised by India's rural poor, and promote health equity by disproportionately benefiting the most economically marginalised. This evidence

Key Policy Implications

'Regulation by Competition', that is, driving poor-quality private healthcare providers out of the market by improving the availability of better-quality public sector services.

- Policies which increase public spending on health are associated with a shift in patients' health-seeking behaviour, with decreased use of private healthcare providers and increased use of government providers, especially among the poor.
- Monitoring private providers is complicated and unreliable, and requires significant investment. Therefore, investing in public healthcare spending instead of on attempting to police healthcare provider behaviour will police low-quality providers naturally through regulation by competition.
- Investment in public healthcare spending will improve the quality of all healthcare services by making low-quality providers uncompetitive, by ensuring that high-quality services are accessible to India's poorest patients, and by promoting greater health access and equity towards achieving UHC.

should be urgently leveraged to inform policy and practice, towards ensuring healthcare access for all and achieving UHC in India.

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