User Charges Onslaught on Public Health Services

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Healthcare as a public good should be available free of charge at the point of service delivery. This was the case across India until a flurry of reforms from the early 1990s onwards notified user charges for various health services in public health facilities. Since then, public expenditure on healthcare has seen a decline from a high of 1.5% of gross domestic product in the mid-1980s to a low of 0.7% of GDP in the mid-1990s, recovering to 1.2% of GDP presently. However, out-of-pocket healthcare expenditure has risen dramatically with increased user charges in public health facilities, which leads to further inequities.

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At the end of 2017, the Maharashtra government issued a government resolution that from January 2018, user charges in public hospitals for various services will increase substantially, in order to cover the increased costs to hospitals due to goods and services tax (GST) and to finance better quality services and improved maintenance (Jadhav 2017). The government is misleading people. Yes, there is GST now, but it has only replaced excise and custom duties and sales taxes/VAT (value added tax), and service tax. Further, the Fourteenth Finance Commission substantially increased the share of states in national taxes in 2014. Considering this increased revenue inflow, is this recent hike in user charges by the government citing increased costs and deficits in resources justified? Also, patients seeking treatment in public hospitals primarily come from the bottom two quintiles, and hikes in user charges only increase the out-of-pocket (OOP) healthcare expenditure for the poor.

The government resolution issued on 20 November 2017 and the press note that followed a month later (Vernekar 2017) listed the increases proposed in medical college hospitals: registration fees is to double from ₹10 to ₹20; the cost of blood tests for dengue and malaria is to increase from ₹30 to ₹250; eye surgeries from ₹1,200 to ₹3,500; ECGs (electrocardiograms) from ₹30 to ₹70; sonography from ₹100 to ₹120–₹600; MRI (magnetic resonance imaging) from ₹1,600 to ₹2,000–₹3,000; and an overall hike in various types of diagnostic tests and surgeries, with prices ranging from ₹1,000 to ₹11,000, is expected.

In December 2015, the government hiked user charges in general government hospitals by a factor of two to three for various services, citing quality of care and provision of better services (Bhatia 2015). However, studies argue that services in public health facilities have deteriorated, and the government is decreasing its healthcare expenditure following irregularities in the flow of funds from the national level to the state level, and eventually to health facilities (Shukla et al 2017).

Healthcare Budget Insufficient

For the last three years, Jagnyacha Haqacha Aandolan (JHA), a platform for social sector movements, people's movements, and trade unions, has been tracking the budgets and expenditures of the Maharashtra government and has brought these issues to the notice of line departments as well as legislators. For instance, at the end of the 2017 fiscal year, the public health department of Maharashtra had spent only 71% of its allocated budget (*DNA* 2017), thus starving public health facilities of resources. Now, another hike in user charges in tertiary care institutions will further cripple the public health system.

User charges are the wrong medicine to revive a collapsing public health system. Instead, a substantial increase in budgetary allocations for healthcare is needed. In 2017–18, Maharashtra allocated a budget of ₹12,176 crore for healthcare, which was lower than the 2016–17 revised estimate of ₹12,726 crore. Maharashtra is one of the lowest spenders on public

healthcare in the country, committing only 0.46% of its state domestic product (SDP) (national average is 1.2% of gross domestic product [GDP]) or a mere ₹996 per capita to healthcare, in contrast to the average ₹1,538 per capita healthcare spending across the country (Duggal 2017). The National Health Policy 2017 aims to allocate 2.5% of the GDP to healthcare, which translates into ₹2,600 per capita (2015–16 prices). So, the resource gap in achieving this goal, which would help make universal healthcare a reality, is huge.

History of User Charges

User charges as a component of public health policy were introduced in World Bank–promoted healthcare reforms in the 1990s. Many states that received World Bank and other multilateral assistance for health sector reforms were forced to introduce user charges in public health facilities. During this period, the healthcare budgets of governments also declined, from 1.5% of GDP in the mid-1980s to 0.7% of GDP in the mid-1990s. Maharashtra first introduced minimal user charges in 1999 and later increased it in 2001. Utilisation data from the performance budgets (GoM 2003) of public hospitals for that period (1999–2003) shows that this hike in user charges precipitated a decline in footfall in public health facilities for both outpatient and inpatient care. There is clear evidence (Lagarde and Palmer 2008), not only in India, but across the world, that user fees, especially in developing countries, are a regressive measure that reduce the poor's access to healthcare. In fact, the World Bank's own assessments in Africa and Latin America indicate this.

Mizoram, Meghalaya, and Kerala

In India, each state reports a different scenario for user charges as well as OOP expenditure for availing health services. For example, Mizoram has not undertaken any externally funded reforms and, yet, the public health system in Mizoram is robust, well supplied, and well utilised, and it has no user charges. This is despite the fact that there is no competition from the private sector in the healthcare industry in Mizoram, perhaps an indication that in the health domain, state monopolies have an advantage. Mizoram in 2017–18 will spend a whopping ₹4,280 per capita on healthcare (Duggal 2017), and already has reasonably good universal access to at least primary healthcare.

On the other hand, in neighbouring Meghalaya, in addition to user fees, a donation box is kept in each public health facility, and the money so collected is used by the Rogi Kalyan Samiti (Patient's Welfare Committee) for purchasing equipment and maintaining the facility. Meghalaya, for the same year, allocated ₹2,506 per capita towards healthcare (Duggal 2017), but health outcomes and access to healthcare is limited.

Kerala, which has the best health outcomes in the country, undertook health sector reform projects and introduced user charges in the mid-1990s. Money was collected at health facilities for various services, and it was accumulated in local accounts. Hospital development committees were appointed to manage the user fees so collected. The committees were administered by people's representatives (politicians) who fought amongst themselves about how to use the money. The result was that the money was never spent. Each primary health centre (PHC) accumulated ₹60,000 to ₹70,000 per year, and each district hospital collected ₹8 lakh to ₹10 lakh per year; this money, which was collected from the poor, was not used for their benefit. Supplies of medicines continued to be inadequate, and there were no funds for maintenance, etc. Noticing the growing discontent, the Kerala government proactively banished user charges in June 2002 (Duggal 2003), but they have come back under the National Health Mission with an exemption for those below the poverty line.

The Case of Maharashtra

Maharashtra began its World Bank–funded health sector reform project in 1999 and, due to a conditionality, increased user fees substantially in 2001. The condition that fees thus collected would accumulate in local accounts and will not be transferred to the treasury was provided. Here, the civil surgeon or medical officer in charge of the facility was empowered to use the funds as per various government resolutions.

We compiled user fees data from different districts in Maharashtra and found that the government resolutions were very restrictive, and the medical officers in charge were unable to use these local funds, as for each transaction they have to seek the approval of district-level and sometimes state-level authorities. Hence, district hospitals accumulated ₹20–₹30 lakh per year (Duggal 2003). Apart from these, funds are also being accumulated in teaching hospitals and rural and cottage hospitals. Calculations from 2003 show that these unspent funds could cover one-third the total expenditure of these health facilities, if used wisely.

More recently, the registration fees collected at each PHC is being accumulated at the district level. For instance, the Pune Zilla Parishad budget for 2017–18 shows ₹40 lakh was collected across all PHCs from Pune district, but the PHCs had no access or control over these resources (Pune Zilla Paishad 2017). These funds should be returned to the PHC so that these can be utilised for its effective functioning. However, in reality, there is no mechanism to return the funds to the PHC, as all received registration fees go into the kitty of district (ZP) funds.

The medical officer of the concerned PHC cannot ask for the fees collected, as the funds and the power to utilise them are concentrated in the hands of district-level authorities. Here, again, despite paying user charges, patients do not get access to requisite drugs free of charge,

Table 1: Receipts and Expenditure of Ministry of Health and Family Welfare, Maharashtra (₹ crore)

	2013–14	2014–15	2015–16	2016–17 (RE)	2017–18 (BE)
(1) Total receipts of Ministry of Health and Family Welfare	346	321	549	488	512
(2) ESIS contributions# as a part of total receipts	128	134	245	220	231
(3) Net receipts for health services (1–2)	218	187	304	268	281
(4) Total health expenditure	7,369	8,967	10,007	12,726	12,167
(5) Net receipts as a part of total expenditure (3 as a % of 4)	2.96	2.09	3.04	2.11	2.31

RE=Revised estimates; BE=Budget estimates; ESIS= Employees State Insurance Scheme.

ESIS receipts from employees are included under the health ministry and hence these have been subtracted from total receipts to arrive at net receipts.

Source: Calculated from Budget Documents 2015–16 to 2017–18, Departmental Books and Receipts, https://beams.mahakosh.gov.in/Beams5/BudgetMVC/MISRPT/MistBudgetBooks.jsp.

and instead receive prescriptions; equipment does not work properly; diagnostic tests were prescribed to be done privately; and hospital maintenance remains poor. Often, the effort and human resources needed to collect user charges exceed the amounts collected, as various studies have shown (Kurian et al 2011).

Table 1 (p 24) shows the receipts of the health department, which are 2%–3% of the total public health spending in recent years. This amount does not add any significant value to the total health budget, but, on the contrary, fees pose a barrier for the poor seeking healthcare in public health facilities. Data on user charges for the last two years have shown that the money collected from patients has in no way helped improve health infrastructure or quality of healthcare, but has only added to OOP healthcare expenditure, as is revealed by the National Health Accounts. The most recent release, for 2014–15, shows that in Maharashtra, the burden of private health expenditure is one of the highest in the country at ₹3,739 per capita (NHSRC 2017). And, now, a further increase in user charges will only add to this already high OOP expenditure in Maharashtra. So, in the interest of the people, the Maharashtra government should do what Kerala has done and do away completely with user charges and allocate more resources towards healthcare as has been envisaged in the National Health Policy towards healthcare.

World over, wherever universal access to healthcare prevails, the only method of financing healthcare is pooling together resources under a public authority, whether it is through social insurance, tax revenues, payroll deductions, and other such collective mechanisms in some appropriate combination, but never through individual modes of payment like user fees or private insurance. For example, National Health Services in the United Kingdom, National Health Insurance in Canada, Thai Universal Healthcare System, Sri Lanka, all Organisation for Economic Co-operation and Development (OECD) countries with the exception of the United States, and many other middle and lower income countries pool resources to reduce private expenditure burden to less than 25% of total health spending, unlike in India, where it accounts for over 70% of total health expenditure (WHO 2015).

It is time we learnt from these experiences and allow user charges to wither away. Wherever healthcare is a core function of the government, health becomes a public good. People pay taxes to finance public goods like health and education, and thus, any form of fees would be an onslaught on their right to access these services and will only contribute to further increasing inequities.

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