



Enabling access to long-term finance for healthcare in India



October 2013



India is currently engaged in battling the dual burden of communicable and non-communicable diseases, which developed countries have had to deal with only sequentially.

Enabling access to healthcare in India

India has achieved considerable progress in the provision of healthcare since independence. Recent reforms and innovations under the National Rural Health Mission (NRHM) have resulted in many states reporting significant improvements in key health indicators such as institutional deliveries, out-patient cases, complete immunisation, availability of diagnostic and family welfare services and disease control programmes.

However, the country's health system continues to face many challenges.

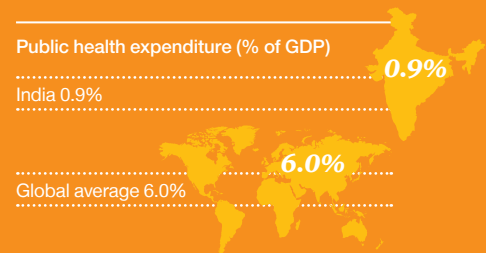
Simultaneously battling communicable and non-communicable diseases

While India is witnessing an increase in chronic disease related morbidity and mortality, it still hasn't overcome health challenges posed by infectious diseases and under-nutrition. The country is currently engaged in battling this dual burden simultaneously, which developed countries have had to deal with only sequentially. Rural India accounts for not only 70% of communicable disease cases, but also over half of non-communicable disease.

Unmet health goals

Several planned health goals have failed to keep pace with the rapid economic growth. The Millennium Development Goals of reducing IMR to 28(per 1000 live births) and MMR to 109(per 1000,000 live births) is unlikely to be achieved by 2015. While the maternal mortality rate has declined over the past 30 years from 460 to 212 per 1,00,000 live births, it still remains high relative to the targets set by the policy. Based on the current trajectory of the 11th Plan India is likely to fall short of the 12th Plan goals for IMR and MMR. Despite a considerable decline in child malnutrition rates over the past few decades, India continues to have the highest number of malnourished children in the world.

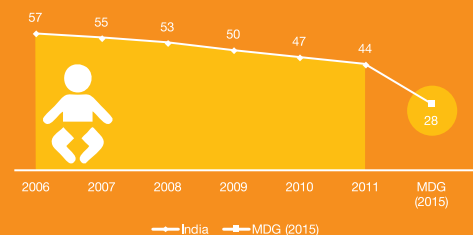
Health expenditure by the government remains at around 0.9% of GDP versus the target of 2.0% of GDP (2010) set by the National Health Policy in 2002.



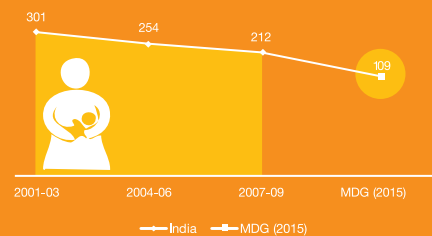
Source: WHO Statistics 2013

India is likely to miss the Millennium Development Goals by 2015.

Infant Mortality Rate (per 1000 live births)

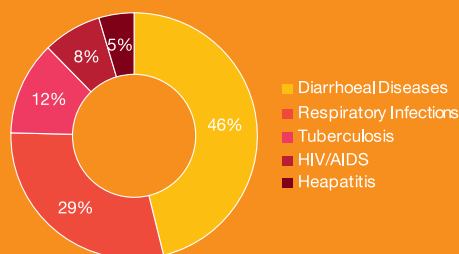


Maternal Mortality Ratio (per 100,000 live births)

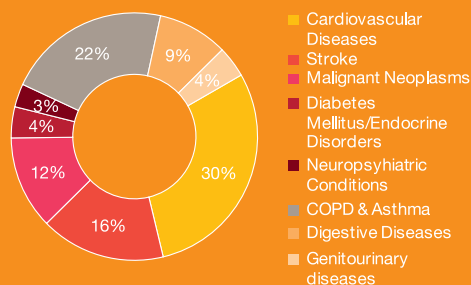


Source: National Health Profile 2011

Leading causes of deaths: Communicable



Leading causes of deaths: Non-communicable



Source: WHO Global Burden of Disease 2010

High out-of-pocket spend financing health expenditure

Most of the country's health expenditure is supported by private spending, primarily out-of-pocket (OOP), with public funds constituting an insufficient amount. Despite several government initiatives relating to social protection, such as the Employees' State Insurance Scheme and the Central Government Health Scheme, only about one-fourth of the population is covered by some form of health insurance. Though several efforts, such as the NRHM, the Janani Suraksha Yojana and the Rashtriya Swasthya Bima Yojana, have been made in the past few years to provide equitable healthcare to Indians, these programmes by themselves cannot accomplish Universal Health Coverage (UHC).

The urban-rural divide

There are considerable gaps between rural and urban areas with respect to disease morbidity and mortality. While the combined problems of under-nutrition and inappropriate nutrition account for almost equal population proportions in the rural (48%) as well as urban areas (49%), under-nutrition is a dominant problem in the former while obesity accounts for half the burden of malnutrition in the latter. Urban areas have about four times more health workers per 10,000 population than rural areas. About 42% of health workers identifying themselves as allopathic doctors in rural areas have no medical training as against 15% in urban areas. Compounding these disparities is an urban bias in health financing. For example, almost 30% of the public health expenditure from the centre and states, is allocated to urban allopathic services while rural centres receive less than 12%.

Variations at the state level

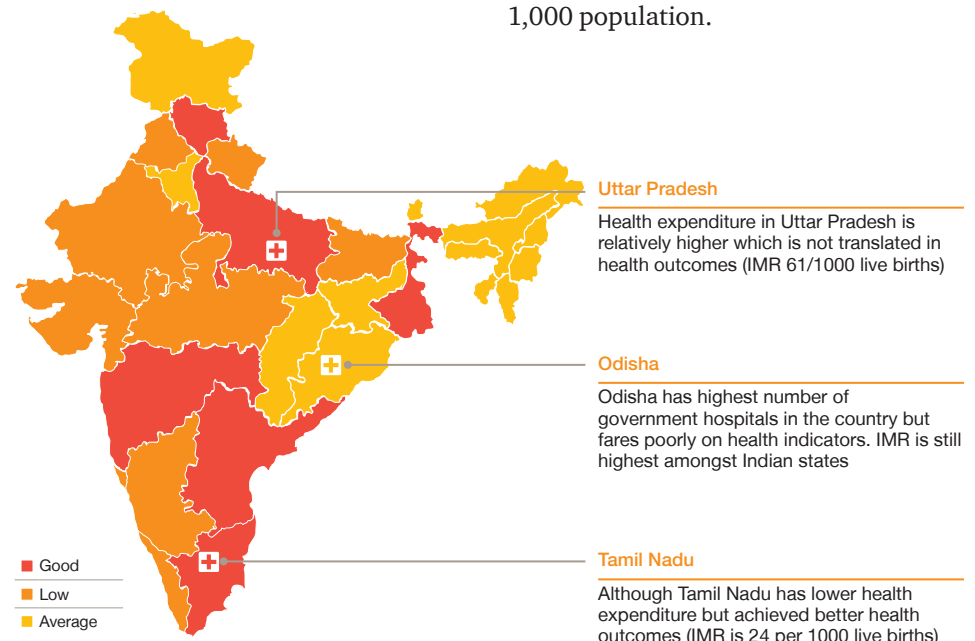
Some states such as Tamil Nadu and Kerala, have model health systems, while others, in particular the states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand and Uttar Pradesh, have a long way to go in terms of sound health infrastructure. The differences are stark. For instance, for a girl born in rural Madhya Pradesh, the risk of dying before she is one is approximately six times higher than that for a girl born in rural Tamil Nadu. There exists an 18-year difference in the life expectancy noted between Madhya Pradesh (56 years) and Kerala (74 years). These disparities suggest that active steps towards addressing the social determinants of health can begin to reverse the chronic underdevelopment that characterises poor health performance of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand and Uttar Pradesh.

Talent and skill gap

Clinical talent shortage looms large as the single biggest bottleneck affecting the growth of the sector and creation of healthcare access in the country. The last decade saw an increase in physicians from 0.55 per 1,000 population to a mere 0.65 per 1,000, which substantially lags as compared with China at 1.3 physicians per 1,000. It is also substantially lower against the WHO benchmark of 2.5 per 1,000 population. Despite the scarcity of medical personnel, the problem of under-utilisation exists. Ironically, about 50% of the existing medical workforce does not practise in the formal health system.

The healthcare access gap

The biggest challenge of all remains the substantial gap in accessing healthcare. Healthcare infrastructure gaps remain substantial, with only 1.3 beds per 1,000 population, significantly lower than the other BRIC economies and the WHO guideline of 3.5 beds per 1,000 population.



Source: National Health Profile, 2011

70% of India's healthcare infrastructure is concentrated in the top 20 cities.

The gap in healthcare access is not limited to the number of beds indicator. Cardiac disease and cancer have emerged as the top two causes of mortality in India. The state of healthcare facilities for these two diseases has not kept pace either in diagnostics or therapy. India has a mere 1050 cardiac centres, adequate to perform about two million angiography procedures; woefully inadequate to cover the more than 50 million patients afflicted with coronary heart disease. Access to cancer care is a bigger challenge with only around 325 comprehensive cancer centres, despite about 1.2 million newly diagnosed cancer patients every year. India has a mere 90 PET and CT scanners, 1,300 MRI scanners and around 1,400 CT scanners (above six-slice). The existing shortage of diagnostic infrastructure across the country severely limits early detection of diseases and access to care. This lack of healthcare access has resulted in the country facing one of the highest mortality rates in the world.

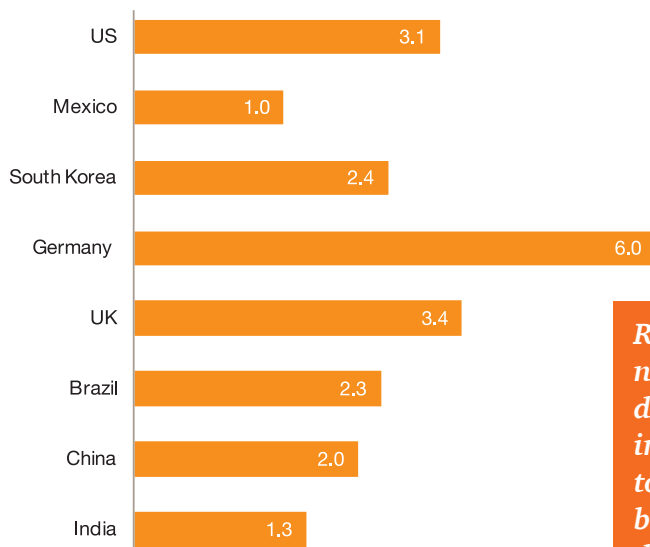
The related challenge of healthcare access is the quality component. The 1.6 million beds in the country are spread over an estimated 55,000 hospitals which translates to an average of 30 beds (approximately) per hospital. About 42,000 of the hospitals in India are nursing homes with an average bed capacity of 20 to 25 beds. The resultant challenge for India is the need for investment to improve access to both primary and tertiary care.

Nearly 50 countries worldwide have attained universal access to healthcare, according to the International Labour Organisation (ILO). Conspicuous gaps still exist, however, in Asia, Africa and the Middle East, and in particular, in India. Globally, there is a greater recognition of the need for health systems to adopt sustainable financing mechanisms that permit population-wide coverage and the efficient delivery of a wide range of health services. The 2005 World Health Assembly (WHA) urged

member states to pursue universal health coverage, ensuring equitable distribution of quality healthcare infrastructure and human resources, to protect individuals seeking care against catastrophic healthcare expenditure and possible impoverishment. It also highlighted the importance of optimising the opportunities that exist for collaboration between public and private providers and health-financing organisations, under strong overall government stewardship. The 2010 World Health Report builds upon the 2005 WHA recommendations and aims at assisting countries to quickly attain universal health coverage. The report highlights three basic requirements for reaching UHC:

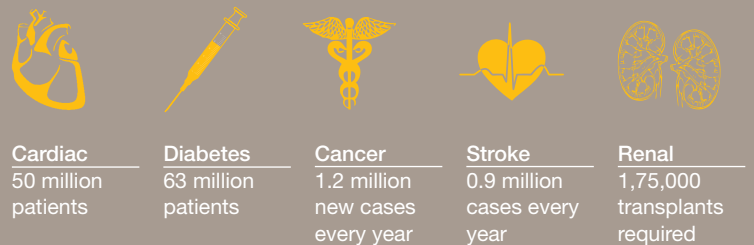
- Raising sufficient resources for health
- Reducing financial risks and barriers to care
- Increasing efficient use of resources

Beds per 1000 population



Source: WHO Statistics 2013

The non-communicable disease burden in India



Rising incidence of non-communicable disease will adversely impact the economy to the extent of 230 billion INR in a decade.

About 70% of patients diagnosed with cancer die within the first year.

45% of the population travel more than 100 kms to access a higher level of care.

Despite healthcare being accorded infrastructure status, the benefits of this are yet to accrue to the healthcare providers.

The healthcare infrastructure imperative

The Planning Commission has laid out a vision to establish a system of UHC in the 12th Five Year Plan draft (2012-17). This was based on the recommendations of the High Level Expert Group constituted by the Planning Commission in October 2010, with a mandate to develop a framework to provide easily accessible and affordable healthcare to all Indians.

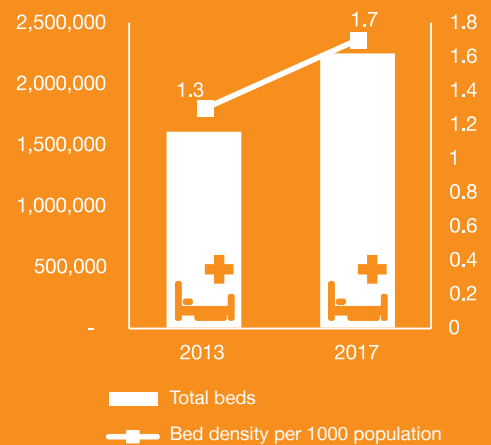
Setting realistic goals for healthcare access

To avoid unmet goals at the end of the 12th Plan period, India will conservatively need to aim to add at least 650,000 beds by 2017. This will help improve access to healthcare infrastructure from the current 1.3 beds per 1,000 population in 2011 (approximately 1.6 million beds on a population of 1.21 billion) to 1.7 beds per 1,000 population (2.25 million beds on an estimated population of 1.33 billion) by the end of the 12th Plan period in 2017. While this will still be

less than half the WHO recommended guideline of 3.5 beds per 1,000, it will be the minimum required to build India's healthcare access towards the Vision 2020 goal of 2.0 beds per 1,000. Achieving Vision 2020 will require not just the availability of healthcare infrastructure, but also parallel progress in universal healthcare coverage, a skilled health workforce and affordable care in order to ensure the quality of care given to every citizen.



Projected bed requirement by 2017



Source. WHO health statistics and PwC analysis

The addition of 650,000 beds in India by 2017 will require a capital investment of 162,500 crore INR (approximately 26.2 billion USD at the current exchange rates). This translates to more than 50% of India's annual healthcare expenditure.

In India, this scale of creation in healthcare access will require a strong partnership between the public and the private stakeholders. In the last 10 years (2002-12), private healthcare providers have created 80% of the new bed capacity. Venture capital and private equity, external commercial borrowings and rupee debt were used as primary mechanisms by the private healthcare providers to finance this expansion.

Based on the publicly announced government plans (center and state), we estimate that approximately 130,000 beds (20%) will be put up in the government or the public sector. This will necessitate the addition of approximately 520,000 beds by the private healthcare providers which implies a capital investment of approximately 130,000 crore INR over the next four years.

The Rangarajan Committee and the Cabinet Committee on infrastructure have identified hospitals as a separate 'infrastructure sector'.

MINISTRY OF FINANCE (Department of Economic Affairs) (Infrastructure Section) NOTIFICATION New Delhi, the 6th May, 2013		
F. No. 13/6/2009-INF.—In partial modification of this Department's Notification published in Part I, Section 1 of Gazette of India (Extraordinary) (No. 59) on 5th April, 2013, the following may be substituted against Sl. No. 5 of the Updated Harmonised Master List of Infrastructure Sub-Sectors in Annexure-I of the Notification :		
S.No.	Category	Infrastructure Sub-sectors
5.	Social and Commercial	<ul style="list-style-type: none"> • Education Institutions (capital stock)
	Infrastructure	<ul style="list-style-type: none"> • Hospitals (capital stock)⁶ • Three-star or higher category classified hotels located outside cities with population of more than 1 million • Common infrastructure for industrial parks, SEZ, tourism facilities and agriculture markets • Fertilizer (Capital Investment) • Post-harvest storage infrastructure for agriculture and horticultural produce including cold storage • Terminal markets • Soil-testing laboratories • Cold chain⁷

Source: Gazette Notification, Ministry of Finance, May 2013

Despite this, long term and concessional lending that has been available to the Indian infrastructure sector has not been made available to healthcare providers in India. Bank lending has been largely restricted to seven year loans at commercial rates of interest, which has constrained the ability of private healthcare providers to scale and create healthcare access. Tertiary care hospitals have longer gestation periods (similar to the core infrastructure) and typically require at least three years to break even.



The addition of 650,000 beds will require a capital investment of 162,500 crore INR by 2017. This will require enabling access to long term and concessional funding similar to core infrastructure.

Funding access to healthcare

Raising the needed 130,000 crore INR will require an equity infusion of 39,000 crore INR (30%) by the private healthcare providers and a long term debt funding of 91,000 crore INR (70%).

This scale of equity infusion to build healthcare infrastructure will require the government and the private healthcare industry together to put in place six key enablers:

#01: Creation of a government corpus for a healthcare infrastructure fund

The government can lead to the creation of healthcare infrastructure through the establishment of a healthcare infrastructure fund (HIF) with an initial corpus of 15,000 crore INR similar to the establishment of the IIFCL for core infrastructure. The initial corpus can be raised through bilateral investment treaties and long term pension funds. The management body for the HIF will be appointed by the government to handle investment allocation, portfolio, and fund management. The core mission of the HIF will be to spur investment in healthcare through lead investment (equity and long term debt) in the creation of healthcare infrastructure and providing viability gap funding for healthcare projects that are aligned with the Vision 2020 goals and the recommendations of the High Level Expert Group (HLEG) by achieving UHC.

#02: Allowing business trusts and real estate investment trusts (REITS) in healthcare

REITS is defined as, any corporation, trust or association that acts as an investment agent specialising in real estate and real estate mortgages” (as per US federal Laws). Thus it operates and owns income generating real estate ranging from residential, retail, hospitals, hotels, etc. It offers the advantage of offsetting the instability of the stock or bond markets as their long-term real estate investments are mostly dependent on debt ratings and interest rates.

Key advantages of REITS

Transformation of business from asset heavy to asset light model

Monetisation of assets: Realisation of market value

Perpetual growth capital raised: Not a debt but ownership by investors for perpetuity

Business continues to control assets

Promoters fund raising at low cost

Business can focus on core-expertise: Segregation of operations and Infrastructure

International fund raising vehicle for future funding



#03: Establish a nodal agency for healthcare

The industry and government stakeholders need to work together to establish a nodal facilitation agency to spur the growth of the sector and creation of healthcare infrastructure. The mission of this nodal agency will be to facilitate and expedite investment approvals in healthcare infrastructure, coordinate inter-ministerial deliberations and be a single window for public private partnerships, as identified by the Planning Commission, as essential to the creation of healthcare access and achievement of UHC. The establishment of this agency will help overcome the current bureaucratic delays and multiple hurdles that any green field healthcare project faces.

#04: Transparent and viable pricing formula for reimbursement

One of the key factors that contributed to the investment growth in the power sector was the transparent pricing formula for investors. While the need for affordability is well recognised the lack of a transparent and viable CGHS pricing formula has made investors and long term lenders wary of funding projects in this sector. A key to the creation of healthcare access on the scale required to meet the 12th Plan goals will be the establishment of a CGHS pricing formula similar to the one used for the power sector. This will help provide the transparency and certainty sought by equity investors, banks and long term lending institutions to provide long term funding for the growth of this sector and creation of healthcare access.

#05: Standardising collateral and exit clauses for PPP projects

The Planning Commission and the HLEG have identified public private partnerships (PPPs) as an important route for the creation of healthcare infrastructure. While a few PPP projects have been executed in the healthcare sector, especially in greenfield hospitals and radiology, the healthcare sector has significantly lagged core infrastructure sectors like roads and airports in PPPs. The growth of PPPs in the roads sector has benefited from the transparent master guidelines and concession agreements with standard collateral and exit clauses that have enabled long term funding. Scaling up PPPs in the creation of healthcare infrastructure will require a similar effort to standardise concession agreements and collateral and exit clauses. This will substantially help banks, long-term lenders and equity investors to back these projects.

A study carried out by PwC on Queen Elizabeth II hospital in Lesotho revealed a more comprehensive PPP arrangement.

Public private integrated partnerships (PPIPs) are a special form of PPP that comprise long-term, highly structured relationships between the public and private sectors designed to achieve significant and sustainable improvements to healthcare systems at national or sub-national levels.

#06: Enhancing financial access through Universal Health Coverage

Finally, we believe the enhancement of financial access through UHC for every citizen will be the 6th key pillar required to ensure the successful attainment of the Vision 2020 goals. This has already been outlined in detail by the HLEG in their recommendations to the Planning Commission and incorporated in the 12th Plan draft. Strong implementation of this plan will place India on the same path to progress that around fifty countries around the world have achieved in health outcomes.

Key characteristics of public private integrated partnerships (PPIPs)

+ Quality of care

- Improved quality of care, including the poorest and most marginalised
- Better healthcare access

+ Cost neutrality

- Patients utilising the new PPIP healthcare facility experience no change in out-of-pocket payments
- The PPIP may be cost neutral to the government, ensuring its annual expenditure for the new PPIP facilities and services is equal to historical expenditures.

+ Equity of access

- PPIP facilities are open to all, regardless of a patient's income level or social status
- Especially critical for poor or disenfranchised populations which may not have had access to quality healthcare services previously

+ Predictable government health expenditures

- Fixed payments and capped overall project costs promotes predictability in government health expenditures

+ Independent monitoring and evaluation

- An independent private or public agency to collect and validate performance data, ensure all contractual obligations are met and administer and arbitrate rewards and penalties.
- Important role in maintaining public confidence in the new PPIP

+ System-wide efficiency gains

- PPIPs strive to set high and transparent standards for service delivery and outcomes, thus raising the bar for the entire national healthcare system.

Source. PwC health systems innovation in Lesotho report

Summary

The creation of physical and financial access to healthcare for every citizen is core to the development of the economy. This will be essential to build the 'safety net' that every citizen is entitled to. India can draw learnings from several countries (developed and developing) around the world in how they have progressed in building the backbone of infrastructure (physical and social) for the growth of their economies.

Enabling access to long-term funding will be essential to the creation of this infrastructure in India.

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About NatHealth

With a view to safeguard and nurture the gift of good health for all in our country, **NatHealth**, 'Healthcare Federation of India' was formed in May 2012.

A new healthcare paradigm needs a lot more infrastructure, facilities, resources and empowerment. Moreover, a robust healthcare delivery system needs the wholehearted commitment of its fraternity and a foundation of strong legislature and far-reaching policy.

It is therefore important for all stakeholders in the healthcare industry to come together, address the inequalities and challenges that characterise Indian healthcare today, and strive to build a better tomorrow

NatHealth is the endeavour to facilitate just that. It is the voice that will speak for us, that will address the urgent issues and in time redefine our space. **NatHealth** will work for Indian healthcare stakeholders.

Anjan Bose

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