The staggering statistics in health conditions of India demand quick actions, and thus it is advised to come up with a solution which takes less time as compared to a complete design of a new system. This paper starts with background study of UK, Netherlands and Indian health care financing models, followed by an analysis of feasibility of transplantation of financing policies from the UK to India. It is proved from literature survey that UK and Netherlands has one of the best financing models. Though Netherlands' model is also considered; but due to economic incompatibility of model in India, and UK's similar legislation background with India, UK's health care system is chosen to be analyzed further as a donor country in this case. A thorough study through Hofstede's cultural dimensions (Hofstede, Hofstede, and Minkov, 2010), family of nations, and actors pulling-in and goodness of fit perspectives study end with strategies of implementation to provide some recommendations for successful transplantation. The results of transplantation can be interpreted as "great example" (Rose, 1993) if the strategies of implementation are clearly kept in mind.

Keywords: Healthcare Financing, Hofstede’s Cultural Dimensions, Family of Nations, Perspectives of Policy Transplantations, UK, India

JEL classification: I18

1. Introduction

India is developing at the fastest growth rate possible of 5% annually (Taborda, 2015), overtaking even the most developed countries like the USA. India like every developing country struggles with two major challenges; providing sufficient resources for the citizens and maintaining a globalised economy. India with its growing economy has proved the latter, but it is still falling short of the former in terms of basic conditions of health care delivery for all citizens. Despite economic development, there are some critical issues like high infant mortality rate due to diseases in India. More than 2,000,000 children die every year from preventable infections. Thus, there is urgent need of an innovation in the existing system. As for pooling best practices, policy transplantation is seen as a good strategy to lower the cost of innovation and to speed up its diffusion (Lalenis, de Jong, and Mamadouh, An Introduction to Institutional Transplantation, 2002). Another supporting argument in the Indian context is the ability of India to adapt policies from developed countries as can be seen from India’s previous experience. Mentioned as one of the best world’s metro line infrastructure, Delhi metro has proved how a successful transplantation is possible from a highly developed system (London Metro) to India (PTI, 2014).

The major reason of mentioned health conditions is a lack of accessibility and quality of health care delivery in India. High-quality medical care is limited or completely unavailable in most rural areas (WHO, 2012). Moreover, rural areas in India face a shortage of more than 12,300 specialist doctors. There are vacancies for 3,880 doctors in the rural health care system along with the need for an astounding 9,814 health centres (Dasgupta, 2013). This not just demands a better health care delivery and accessibility, but also a bigger amount of money to be spent on health care sector. Effective and efficient use of money for healthcare is also a prerequisite to achieve the goal of a good healthcare system.
2. Research Objective and Research Methodology

Based on the complex problem mentioned above, this paper tries to answer on how to transplant health financing policy from top-tier quality in health care delivery country to India successfully. Quantitatively speaking, the study aims to design the health care financing policy in India so that better health care delivery and quality can be achieved. In turn, it can lead to a better life expectancy, lower mortality, lower morbidity, lower disability-adjusted life years and lower costs as mentioned on measures to calculate public health (Services, 2010).

The next stage of this research is to choose the right donor country serving as the best top tier healthcare system in the world. Thus, a comparison is carried out to check the best country among the leading countries in healthcare i.e. UK and Netherlands. After choosing the right country, as shown in Figure 1, this research is split into three main stages. Firstly, a comparative study is done between the host country and the donor country of the policy implementation. Hofstede’s six cultural dimensions and the notion of family of nations are used for this purpose. Based on the comparative study, the expected arising issues when transplanting the health financing policies are analyzed from actors pulling-in and goodness of fit perspectives. Finally, strategies and methods of implementation are described upon the analyzed perspectives from the previous stage.

![Figure 1: Research Methodology](image)

3. Literature Review on Healthcare Financing Models

Health care financing model mainly consists of two parts: how the government collect the money and how they spend the money for enhancing health quality of the nation (Pointer and Stillman, 2004). In this section, existing health care financing model in India and proposed donor countries health care financing model are presented.

3.1 Existing Health Care Financing Model in India

Indian health care system is extensive but suffers from substantial inequalities in the quality of service between rural and urban areas, as well as between public and private health care providers.

India spends 4% of its national GDP on medical services, which is not enough to provide good quality of public health care (World Bank, 2014). As a consequence, the private sector takes the responsibility for the majority of health services. The share of funding of the medical service from private sources is estimated around 68% for the whole health care spending. The public funding comes from income tax, accounting only around 32% of all health expenses and is distributed mostly by central and state governments (World Bank, 2014). The Indian government is still unable to cover all the needs with money from taxation, mostly due to low tax-to-GDP ratio estimate of 15%.
The main reasons for relying on private health care providers pointed by the Indian citizens are low quality of public health care facilities and lack of accessibility to public health care (Wikipedia, Health in India, 2015). Relatively high costs of private health care make it generally inaccessible to the poor. According to the Government of India, only around 17% of India's population has any kind of health insurance. Because of that, a great number of people have to incur large out-of-pocket expenditure to cover needed medical service.

3.2 Choice of Right Transplantation Donor Model

Comparative analysis between healthcare systems in Netherlands and the UK is done to chose the donor country. These two countries were announced as the countries with the best healthcare system in the world (Bjornberg, 2014) (Campbell and Watt, 2014).

(a) UK

The United Kingdom is an example of a country having a tax financed health system, which is currently unique in the world (Adam Smith Institute, 2007). Almost 99% of the funding of National Health Service (NHS) comes from general taxation and National Insurance. The remaining 1% comes from charges for services like optical care, prescriptions and dental care (Hawe and Cockcroft, 2013). The budget is set each year centrally by the Ministry of Finance and then distributed by the Ministry of Health to NHS, which is under the authority of the government. NHS distributes the funds further to Primary Care Trusts (PCTs), which are responsible for proper funding health services at the lowest level to meet local needs. The UK spends approximately 9% of its GDP on health care (World Bank, 2014). Generally, health services are free for the patients at the point of use. One of the advantages of this system is its equity, which means that the rich subsidize the poor, and the sick don’t pay more than the healthy (Adam Smith Institute, 2007).

(b) The Netherlands

The health care funding system in the Netherlands is an example of the social insurance-based health system. All primary and curative care is financed from private compulsory insurance (ZVW), while long term care of the elderly, the dying, or long-term mentally ill is covered by social insurance funded from taxation (AWBZ). While Dutch citizens are automatically covered with AWBZ, still every person living or working in the Netherlands is obliged to obtain the standard private health insurance. In addition to that it is possible to obtain a non-obligatory, additional health insurance covering services not provided in the standard insurance, i.e. physiotherapy or dental care. Besides the nominal premium, every employee must also pay an additional income-related contribution, which is fixed as a percentage of income (ZVW contribution) (Government of the Netherlands, 2015) (Wikipedia, Healthcare in the Netherlands, 2015).

(c) Comparison and conclusion

The systems of UK and Netherlands are fundamentally different when it comes to the financial system: In UK it’s the government that decides the amount of money from taxation which is going to be spent for health care, which can differ depending on the income from taxes. While in the Netherlands the insurance premiums are previously fixed, explicitly earmarked for health and go straight to insurance funds (Adam Smith Institute, 2007). It is true that an institutional transplantation cannot change the way people have been attached to their core values of societies (Hofstede, Hofstede, and Minkov, 2010). But still this transplantation method is preferred as the modern Indian legislation has proved to be fairly adaptive of new changes due to the extensive high paced development (Legal India, 2011), towards a fairly modern legal framework. In such a scenario, the best fitting model for this case can be the UK. This is due to similar legal and administrative conditions caused by colonial past of India. Furthermore, poverty struck population (BPL) leads to
reluctance of buying insurance. However, the problem that has to be tackled while implementing this policy is a high level of corruption and low tax-to-GDP ratio. Therefore strict control of taxation process is required. Below (Table 1) can be seen a comparison between the countries showing key elements of analyzed systems.

Table 1: Comparison Between India, UK And Netherlands Health Care Financing System

<table>
<thead>
<tr>
<th></th>
<th>India</th>
<th>UK</th>
<th>Netherlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP spent on health care [%]</td>
<td>4.0</td>
<td>9.1</td>
<td>12.9</td>
</tr>
<tr>
<td>Out-of-pocket spending (related to total healthcare expenditure) [%]</td>
<td>85.9</td>
<td>56.4</td>
<td>41.7</td>
</tr>
<tr>
<td>Public health expenditure (related to total health expenditure) [%]</td>
<td>32.2</td>
<td>83.5</td>
<td>79.8</td>
</tr>
</tbody>
</table>

4. Analysis of Background of Cultures

Before starting analysis of the transplantation of health financing policy from the United Kingdom to India, it is best to first consider the similarities and differences of both countries. In this study, two approaches of countries comparison are presented: the Hofstede’s Six Cultural Dimensions and the Families of Nations. A deeper knowledge of the legal, political-administrative and cultural traditions of both the donor country and the host country, as well as a specific analysis of the congruence between the transplant at hand and its future institutional environment, are presented.

4.1 Hofstede’s Cultural Dimensions

There are six dimensions which can be used to compare the cultures between nations (Hofstede, Hofstede and Minkov, 2010). The summary of United Kingdoms and India’s score on the six dimensions are presented in Figure 2 (Itim International, 2015).
4.1.1 Power Distance Index

Power Distance Index (PDI) scores the distribution of power (gap) of authorities and subordinates. With a higher PDI score, hierarchical structure in Indian organizations is quite rigid. In daily life, for example in consulting with a doctor, Indian people often take the doctor’s prescription for granted. They seldom ask the doctor for a thorough explanation of their illness.

In UK, patients treat doctors equally as them. The doctors have to vigorously give a description of the patient’s illness and justification of the prescriptions given.

4.1.2 Individualism vs Collectivism

Individualism (IDV) dimension captures the level of interdependencies between a person and their social relations. Low IDV in India implies that in social life, there is a more frequent conversation in public space as people exchange information through their social network and thus believe in norms related to health as followed by communities.

In UK, people tend to stand only for themselves and their immediate family. The individualistic culture also makes the media as the main source of information instead of the social network.

4.1.3 Masculinity vs Feminism

Masculinity (MAS) measures the extent of aggressiveness in the people. MAS of India and United Kingdom don’t differ much with a tendency to be more. In both countries, displaying wealth, earnings and achievement is a sign of success in life. Although British has high ambition in their life, they also value work-life balance and peacefulness of life. Most Indians have strong religious influence in their life, making them value the essence of life more than only work-related achievement. Thus, both countries in their own way chose to value their health and personal time.

4.1.4 Uncertainty Avoidance

Both India and the United Kingdom score low on Uncertainty Avoidance (UAI) dimension, which means that both are contented in facing uncertain situations. On health perspective, people are not afraid of their health because they are more prepared to face undesirable conditions in their life.
4.1.5 Long Term Orientation vs Short Term Orientation

The United Kingdom and India have the same exact score for Long Term Orientation (LTO). LTO nations tend to believe that actions taken today should benefit the future condition. In terms of health, they believe that preserving good health condition since young adult as an important decision.

4.1.6 Indulgence vs Restraint

Indulgence dimension (IVR) measures the degree to which a person can freely satisfy their needs and happiness. In India, gratification is controlled by the society. The actions in such societies are much likely governed and controlled by the social value. Conversely, UK doesn’t perceive basic needs and happiness as regulated by society. This means in India any decision regarding personal healthcare investments are usually collective decisions of family.

4.2 Families of Nation

Besides seeing a country from a cultural perspective, countries comparison can also be done by understanding the notion of Family of Nation (Lalenis, de Jong, and Mamadouh, Families of Nations and Institutional Transplantation, 2002).

4.2.1 Legal families

Legal experts distinguish nations into four categories: western legal styles, (ex)soviet or communist, religious or theoretical, and the far-east or Confucian (Zweigert and Kotzh, 1998). As a country dominated by Hindu and Islam, India belongs to the religious or theoretical legal system family. Religion extremist sometimes pushes their way for changing the regulation so it complies with their belief. The United Kingdom belongs to the Anglo Saxon common law group which is part of the western legal systems. Arguments and analogous reasoning play a bigger role in determining the law to be executed in public.

4.2.2 Demographic Family Structures

The family of nations can be determined by the dominance of family structure type in the countries. Most Indian family still adopt the communitarian family. People also have faith in equality among children. This is not the case of the United Kingdom where absolute nuclear family type dominates the country. Children which have grown into adults are given liberty to make their own life and live elsewhere with their partner. (Duranton and Rodriguez-Pose, 2008).

4.3 From Countries Comparison to Policy Transplantation

The above information can be used in further analysis to determine the threats and benefits of implementing health financing policy. For example, from PDI index it is known that Indians and British behave differently when coming to the doctor for medication. This might have some degree of influence to the effectiveness of the proposed healthcare financing system. The transplantation can also consider the difference between both nations law family group where Indian laws are more influenced by religion and belief.

5. Analysis of Policy Transplantation

Below considered are two perspectives of how the transplantation process occurs and what makes it successful. They provide some checklists to ensure that the policy transplantation doesn’t
turn up as a boomerang (Lalenis, de Jong, and Mamadouh, Drawing Lessons about Lesson Drawing, 2002).

5.1 Actors Pulling-in Perspective

Actors pulling-in perspective argues that a successful institutional transplantation comes from the strength of the practical and administrative matters of the host institution. As a rule of thumb, three propositions are considered from this perspective.

5.1.1 Imposition vs Adoption

While intuitively a policy will work better if it is voluntarily adopted, research shows that external force from other organizations makes the policy transplantation process easier. Since in this case the health care funding policy from the UK is voluntarily adopted by India, two issues might arise from the adoption.

The first issue is about the political conflict at the central level. There are three political alliances in India: the National Democratic Alliance, the United Progressive Alliance, and the Third Front alliance, all emerging from different ideological belief. Therefore, if there is any alliance who is against the proposed health care funding policy, the transplantation process may be menaced.

Additionally, the tension between central government and local governments often occurs. People believe in their local government more than the central. Regulation developed at central level might not be accepted by the local governments. If the policy is going to be adopted, alignment with all governmental levels is needed in the first place.

5.1.2 Xeroxing vs Adaptation

Xeroxing the health care funding policy from the UK is almost impossible since the formal health care institution structure of India differs a lot from the UK. UK compromise two levels of institutions: the central level (Directorate for Health and Social Care) and the local level (National Health System (NHS) Boards). Local municipalities work together with the NHS Boards by assigning their representatives in the Boards. Other NHS Boards members are also chosen by the central level, which makes it easier to align the health care delivery from cradle to grave (Steel and Cylus, 2012).

India has three levels of health care institutions: the central level, state level, and local/peripheral level. Unlike the UK, the state level of the health care institutions is not chosen by the central level. The central level is only responsible for planning, guiding, assisting and evaluating the lower levels which make each state level institution can freely determine the delivery of health care (Ma and Sood, 2008). This is different from the UK where all the institutions members and policies are aligned. Thus, it is easier to adapt the policy here than Xerox, considering the changes required as per the structure of Indian institutions.

5.2 Goodness of Fit Perspective

The second perspective takes political, legal and cultural affinities and similarities between the donor and host nations into account. This type of approach consists of three different aspects.

5.2.1 Endogamy vs Exogamy

Endogamy refers to transplanting from a country belonging to the same family of nations or having very similar legal and cultural background. Exogamy means drawing solutions from a country with very different characteristics.
As it has been shown before in the comparison of both countries, according to Hofstede’s cultural dimensions India and UK have three very similar indicators (MAS, UAI, LTO), but the other three differ substantially. Therefore, the major conclusions in this perspective is unclear. But it may be necessary to, for instance, impose more strict control of the quality of doctors performance in India.

5.2.2 Concrete procedures vs Guiding Principles

This aspect addresses the extent of similarities in legal frameworks existing in both the donor country and the country adapting the policy. If both systems are congruent it is more likely that transplantation will proceed using concrete procedures by using existing legal solutions. If not, it is more likely that it will occur using guiding principles and abstract policy ideas.

In case of both considered countries it has to be pointed out, that existing legislation procedures in India are mostly based on British system, which was implemented by the British during the colonial period at the turn of 20th century, and after regaining independence by India only small changes were made in this area, in laws regarding issues not relevant to this case. Therefore, the process of transplantation is more likely to be carried out using concrete procedures rather than guiding principles.

5.2.3 System Upheaval and/or Performance versus Protracted Sense of Policy Dis-satisfaction

It is argued, that transplantation process is more likely to run smoothly if it happens in more dramatic periods, like a national emergency or urgency, system upheaval, economic or political crisis.

Due to the increase in working population significantly and exponential increase in need of major amenities, it can be assumed that considered policy transplantation is going to be carried out during the period of System Upheaval.

6. Policy Implementations

After a thorough analysis of the feasibility of the policy transplantation, the sections discuss the methods to make the implementation successful.

6.1 Strategies for Transplantation

Based on the above analysis of perspectives, it has to be looked upon that how this transplantation will be practically implemented. Below is a study to make the transplantation successful (Lalenis, de Jong, and Mamadouh, Drawing Lessons about Lesson Drawing, 2002).

6.1.1 Methods to Make Transplantation Successful

(a) Locally induced transplantation:

The sense of acquiring progress is even stronger if the borrowing is locally induced. Thus, the best practice would be to implement this policy not only at central or state but also involving local government. Local government in India at the rural level called panchayat plays a big role in spreading awareness among people. Bringing them onboard on the operational level can help the transplantation process to be occurring at a better pace. Before implementation, local government can help conducting community meets making people understand the need of more facilities and benefits.
Implementing in stages:

A sudden shock to a culture is not accepted, but if it is done in stages the acceptance rate might be much better. The steps can be:

1. Make people aware about importance of health-care facilities
2. Charge less money as taxation which includes basic vaccination
3. Full provision of facilities by the government by involving an organisation like IMF, World Bank.

Organised society and flexible state strategy:

It is always easy to do transplantation in a system which have its legislation in order and when the hierarchy structure of administration is organised very well. This facilitates an easier transfer of policies from one stage of the administrative system to another. The administration of India (as local government plays a big role and it lacks structure) is not organised to the extent of organisation of UK. Thus, special care will be needed to be taken for transplant in such a background.

Similarly, the government and people need to be flexible for a change. India due to its higher acceptance of diverse culture without any instability proves that it is easier for the people and government to adopt a new system as compared to many countries which just have one majority.

Presence of an outside force:

In 2012, India was able to completely eliminate polio with the help of WHO, which proves example of benefits of outside force. Similarly, financing just based on taxation and exports is difficult in a growing economy. Thus, organisations like World Bank and IMF can help here as was done in the case of Indonesia (IMF, 2014). This will also help in imposing (there will be some conditions to be achieved on the basis of which Indian government will be given the loan) the healthcare facilities rather than just adoption and it is a better way to make transplantation easier.

Historical or macro-social perspective:

India is a country which respects its ethnic history and values tremendously. Thus, more stress on domestic changes will lead to acceptance of policies overall. They will adopt a partial approach in which one or two changes will be proposed and substantiated statements can be made as to their effects.

Critical Scenarios to be Considered

(a) Tension between formal and informal institution:

Something implemented at central government level with an intention for the development of the country cannot be accepted easily by the local government as the local government perceive the change or transplant as a threat to the culture and preserved history. This needs to be looked upon very critically in case of India as the policies in the UK are not at all or very rarely based on values (considering the vast difference in their cultural values)

(b) Failure to include support structures:

Uninformed transfer, incomplete transfer or inappropriate transfer of information or knowledge may lead to failure of policy transfer. This might not be a big issue in this case as the
medium of transfer is based on common official language at central level: English.

(c) Failure to include the economic and industrial differences

India belongs to one of the developing countries and UK is one of the most developed countries in the world, thus it makes their economic scenarios completely different. Consequently, there is need to reconsider the feasible amount that can be allocated for every stratum of the economy for their health-care facilities. The graph below in Figure 3 explains the difference between the economic conditions of UK and India.

Figure 3: Comparison of Economic Conditions of UK versus India (Wikipedia, Angus Maddison, 2015)

6.2 Method of Implementation

Some methods to ensure a smooth transplantation are discussed in this section (Lalenis, de Jong, and Mamadouh, Drawing Lessons about Lesson Drawing, 2002) and they are:

1. copying exact policy programmes,
2. adapting them to the domestic context,
3. making hybrids by merging programmes from different sources into one,
4. making syntheses by combining elements of three or more programmes
5. just being inspired

As discussed above from the strategies, it is highly recommended to follow the second and third method for this case. The local government can help in awareness building and preparing people for a small cultural shock while, central government can ensure a smooth implementation without major complications considering the population of India.

It is recommended that the transplantation occurs at urban area first, where people are well off and can afford a health tax and then it shifts to the lower economic strata and rural areas where accessibility to health facilities is lower.

A better taxation system was proposed for which considers the co-payment to private healthcare sector via the taxation. It also considers provision of insurances to people who chose voluntary insurance through a form of financing from the taxes towards insurance payments. Both of these recommendations from these proposals fit very well with Indian healthcare scenario due to the majority of private healthcare organisations. It would be beneficial to consider a co-payment system for private hospitals and insurance firms (Adam Smith Institute, 2007).
6.3 Results of Policy Transplantation

Whether this was a successful transplantation or not, can be decided on the basis of how the definition of success/goal is framed. The goal here is to make the financing policies better in India such that it establishes a stable, sufficient and affordable financial system for funding healthcare system of India. The indian government will not be able to put this in robust form in just a year or so.

Assessment of a potential transplant is done to check whether this is a great example or fatal attraction as this falls in the highly desirable zone. Table 2 below depicts that due to high desirability and high practicality (Assuming the considerations of the above recommendations in implementations) we can expect this to be a great example and a satisfactory transfer.

Thus, this will be a highly acceptable transfer for the stakeholders in India, if the following conditions are fulfilled:

1. The debt from IMF is paid off on time by an increased healthy working population

2. The taxation is considerate of the incomes of people below poverty line and the system of free health care facilities for them continues.

3. There is no or under-control level of corruption in the proposed system (taking example from Indonesia’s case(Lewis, 2006))

Table 2: Index to Check the Success of Transplantation (Rose, 1993)

<table>
<thead>
<tr>
<th></th>
<th>High Desirability</th>
<th>Low Desirability</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Practicality</td>
<td>Satisfactory transfer “Great Example”</td>
<td>Unwanted Policy Solution</td>
</tr>
<tr>
<td>Low Practicality</td>
<td>Siren call “Fatal Attraction”</td>
<td>Double Rejection</td>
</tr>
</tbody>
</table>

7. Conclusion

This paper has shown difficulties, opportunities, and strategies in making a successful health care financing policy transplantation from United Kingdom to India. Starting by conducting comparative study from each country, it can be seen that both countries have contrasting scores in three out of six cultural dimensions. Indian people make their law based on religious and traditional belief while British people make their law based on logical reasoning. However, colonization and globalisation has made the legislation and governmental structure of India similar to UK, proving this transplantation to be easier.

In policy transplantation analysis, actor pulling-in perspective gives two key points: First, adopting policy can be tricky due to tensions at central level and tension between central and local government. Secondly, India can’t directly copy UK’s financing policy due to different health institutional structure. The insight derived from analysing goodness of fit perspective indicates that due to similar legislation process in UK and India, policy transplantation is going to be carried out using concrete procedures rather than guiding principle. It is necessary to focus on three cultural dimensions, which are considerably different for UK and India, and analyse them in the context of health care, in order to proceed with successful policy transplantation.
Further, this study has developed strategies and methods of successful implementation. Five prerequisites of successful transplantation are discussed: making a locally induced transplantation, implementing the policy in stages, creating organized society and flexible state strategy, requesting help from a third party organization, and adapting the policy to fit macro-social perspective. Three critical scenarios that may lead to a transplantation failure have been addressed: the tension between formal and informal institutions, failure to include support structures, and failure to consider economic differences. A strategic level of transplantation method with the steps of implementation including city level transplantation followed by rural expansion, a co-payment system for including private hospitals and insurance firms, is then discussed after knowing pits and falls. The expected results of transplantation look as “great example” if corruption and population growth issues are combated.

References


