Public Investment on Health Services in India: A Critique

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Abstract. The paper in its limited way provides a critique of the prevailing Health System in India which emphasises increasing private investment in this sector. Although the policy makers are committed to 'Universal Health', it has to be seen whether the private investment helps the government in achieving this ambitious goal. The policy makers should strengthen the Public Health Services vis-à-vis the primacy given to the Medical Health Services and the Single Issue Programmes so as to ensure a long term benefit in improving the overall health outcomes of the people which will in turn result in enhanced working capacity and productivity of the people.

1 Introduction

Health is a valuable economic asset for any country and more so for India given its demographic profile. Yet, Government expenditure on Health in India is one of the lowest in the world (a meagre 1.2% of the GDP[1]) Most of the expenditure on Health is met by the public by means of "out-of-pocket" expenditure. Moreover, the allocations made by the Government are spent primarily on Medical Health Services[2] and Single-issue programmes[3] instead of strengthening of Public Health Services[4] which have long term benefits in improving overall health and productivity of the people.

The National Health Policy 2015 (Draft) has been placed in Public Domain by the Ministry of Health and Family Welfare, Government of India (December 2014). According to it, India is set to reach the Millennium Development Goals (MDG) with respect to material and child survival. The MDG target for Maternal Mortality Ratio (MMR) is 140 per 100,000 live births. From a baseline of 560 in 1990, the nation had achieved 178 by 2010-12, and at this rate of decline is estimated to reach an MMR of 141 by 2015. In the case of under-5 mortality rate (U5MR), the MDG target is 42. From a baseline of 126 in 1990, in 2012 the nation has an U5MR of 52 and an extrapolation of this rate would bring it to 42 by 2015. This

[1] As per Economic Survey 2014-15, para 9.47, page 145
[2] Which treat individuals to disease and injuries
[3] Such as Malaria Eradication Programs, Pulse Polio Programmes etc
[4] Which include population wide preventive health services called environmental health services (which aim at reducing exposure to disease through measures such as mplementing and monitoring health and sanitary regulations) and clinical preventive health services like vaccination etc.

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is particularly creditable on a global scale where in 1990 India's MMR and U5MR were 47% and 40% above the international average respectively. While the narrowing of these gaps and closure, demonstrate a significant effort we could have done better. Notably, the rate of decline of still births and neonatal mortalilty has been lower than the child mortality on the whole. In some states there is stagnation on these two indicators.

2. Inequities in Health Outcomes

We need to be mindful and confront the high degree of health inequity in health outcomes and access to health care services as evidenced by indicators disaggregated for vulnerable groups. There are urban-rural inequities and there are inequities across states.

Table : Disparities in Health Outcomes:

Indicator	India			
	Total	Rural	Urban	% differential
TFR (2012)	2.4	2.6	1.8	44% difference
IMR (2012)	40	44	27	63% difference
Indicator	**States with Good Performance**			**States with greater challenges**
TFR (2012)	HP (1.7), Punjab (1.7), Tamil Nadu, (1.7) and West Bengal (1.7)			Bihar (3.5), UP (3.3), Rajasthan (2.9), MP (2.9)
IMR (2010)	Kerala (12), Tamil Nadu (21), Delhi (24), Maharashtra (24)			Madhya Pradesh (54), Assam (54), Orissa (51), Rajasthan (47)
MMR (2010-12)	Kerala (66), Maharashtra (87), Tamil Nadu (90), Andhra Pradesh (110)			Assam (328), UP/ Uttarakhand (292), Rajasthan (255), Orissa (235)

3. Concerns on Quality of Care:

The situation in quality of care is also a matter of serious concern and this seriously compromises the effectiveness of care. For example though over 90% of pregnant women receive one antenatal check up and 87% received full TT immunization, only about 68.7% of women have received the mandatory three antenatal check-ups. Again whereas most women had received iron and folic acids tablets, only 31% of pregnant women had consumed more than 100 IFA tablets. For institutional delivery standard protocols are often not followed during labour and the postpartum period. Sterilization related deaths a preventable tragedy, are often a direct consequence of poor quality of care. Only 61% of children (12-23 months) have been fully immunized. There are gaps in access to safe abortion services too, and in care for the sick neonate.

4. Cost of Care and Efforts at Financial Protection:

The failure of public investment in health to cover the entire spectrum of health care needs is reflected best in the worsening situation in terms of costs of care and

impoverishment due to health care costs. All services available under national programmes are free to all and universally accessed with fairly good rates of coverage. Thus India has one of the largest programmes of publicly financed ART drugs for HIV anywhere in the world. All drugs and diagnostics in all vector borne disease programmes, tuberculosis, leprosy, including rapid diagnostic kits and third generation anti-microbicidals are free and so are insecticide treated bed nets that cover the population of whole geographies. This is also true for all of immunization and much of the pregnancy related care. Private markets have little contribution to make in most of these areas. Yet if health care costs are more impoverishing than ever before, almost all hospitalization even in public hospitals leads to catastrophic health expenditures, and over 63 million persons are faced with poverty every year due to health care costs alone, it is because there is no financial protection for the vast majority of health care needs. In 2011-12, the share of out of pocket expenditure on health care as a proportion of total household monthly per capita expenditure was 6.9% in rural areas and 5.5% in urban areas. This led to an increasing number of households facing catastrophic expenditures due to health costs (18% of all households in 2011-12 as compared to 15% in 2004-05).

5. Investment in Health Care

Despite years of strong economic growth and increased Government health spending in the 11th Five Year Plan period, the total spending on healthcare in 2011 in the country is about 4.1% of GDP. Global evidence on health spending shows that unless a country spends at least 5-6% of its GDP on health and the major part of it is from Government expenditure, basic health care needs are seldom met. The Government spending on healthcare in India is only 1.04% of GDP which is about 4% of total Government expenditure, less than 30% of health spending. This translates in absolute terms to Rs.957 per capita at current market prices.

The Central Government share of this is Rs.325 (0.34% GDP) while State Government share translates to about Rs.632 on per capita basis at base line scenario. Perhaps the single most important policy pronouncement of the National Health Policy 2002 articulated in the 10th, 11th and 12th Five Year Plans, and the NRHM framework was the decision to increase public health expenditure to 2 – 3 % of the GDP. Public health expenditure rose briskly in the first years of the NRHM, but at the peak of its performance it started stagnating at about 1.04% of the GDP.

Country	Total Health Exp per capita (USD) - 2011	Total Health Exp as % of GDP - 2011	Govt. Health Exp as % of Total Health Exp - 2011	Life Expectancy at birth (years) 2012
India	$62	3.9%	30.5%	66
Thailand	$214	4.1%	77.7%	75
Sri Lanka	$ 93	3.3%	42.1%	75
BRIC Countries				
Brazil	$ 1119	8.9%	45.7%	74
China	$ 274	5.1%	55.9%	75
Russia	$803	6.1%	59.8%	69
South Africa	$670	8.7%	47.7%	59
OECD Countries				
USA	$ 8,467	17.7%	47.8%	79
United Kingdom	$ 3,659	9.4%	82.8%	81
Germany	$ 4,996	11.3%	76.5%	81
France	$ 4,968	11.6%	76.8%	82
Norway	$ 9,908	9.9%	85.1%	82
Sweden	$ 5,419	9.5%	81.6%	82
Denmark	$ 6,521	10.9%	85.3%	80
Japan	$ 4,656	10%	82.1%	84

6. Financing of Health Care & Engaging the Private Sector:

To reduce out of pocket expenditures, catastrophic expenditures and eliminate impoverishment, tax based financing would remain the predominant source of financing for at least 70% of the population who are poor and vulnerable (whose per capita monthly consumption expenditure is less than Rs.1640 in rural and Rs.2500 in urban areas at current prices). Free primary care provision by the public sector supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and private sector would be the main financing strategy of assuring health care services.

The policy should aim to bring about complimentarity in the role played by private and public institutions, and not encourage competition between them. This recognizes that there are certain public health functions, even in curative care for which a robust public health system must remain. Private sector has grown passively and continues to evolve with very little, if any, policy guidance and regulatory mechanism. As a result, they are not oriented to public health goals and are not available for many public health interventions. The aim is to enhance investment in the sector – not merely substitute public by private services. The following table summarizes the findings of the Human Development Report (2014, pp. 188):

Table: Adult Health and Health Expenditures (2011)

Country	HDI Rank	Health Expenditure (% of GDP)	Out of Pocket Expenditure
Sri Lanka	73	3.4	45.9
Brazil	79	8.9	31.3
South Africa	118	8.5	7.2
India	135	3.9	59.4
Bhutan	136	4.1	15.3

The figures above show that India has one of the lowest State spending and one of the highest out of pocket expenditures on Health when compared with other similarly placed countries. The Economic Survey (2013-14) notes that India has the lowest spending on Health in the BRICS group.

Fernandez (2015) notes that India's spending on Health began to decline from 2006 while Brazil's spending on the same began increasing steadily from 2007 till 2010 (around the time of the recession) Its spending as a proportion of GDP has reached levels comparable to developed countries such as Australia, Norway and UK.

The Economic Survey of India (2014-15) notes that a direct relationship exists between water, sanitation, nutrition and health and human well being. Given the multiple determinants of health, it is clear that a preventive agenda that addresses the social and economic environment requires a cross-sectoral, multilevel intervention that involves sectors such as food & nutrition, education, drinking water and sanitation, housing, flood control and water management etc.

According to Das Gupta (2005) Public Health Services which reduce a population's exposure to disease through measures such as sanitation and vector control are an essential part of a country's development infrastructure. In India, policies have focused largely on Medical Services. Public health services have been neglected. Conclusions have been drawn by comparing India with developed countries like the U.S.A. The findings however, have dwelt more on the administrative set up rather than the economic and financial implications of skewed focus on Medical Services and "Single-issue" programmes.

Rao et al (2015) critique the National Health Policy 2015 and opine that the policy seems to suggest that strategic purchasing of curative health services from both the public and private sector can enable India to achieve the goal of "Universal Healthcare" It is argued that the key recommendations are flawed by highlighting the various contradictions inherent in them. However, the focus of the work has been more on the dangers of allowing the private sector to be used for achieving public health goals. Suggestions regarding measures for improving Public Health Services in the National Health Policy 2015 have not been made.

Berman (1998) has pointed out that most developing countries have pursued healthcare strategies that accord primacy to the Government in financing and delivery of health services. However, the solution offered is flawed in the sense that it lays emphasis on

nongovernment (including private) provision of services. In developing countries where equitable access is of major concern, relying extensively on non-state agents is fraught with risks. Goel and Khera (2015) have compared the public health facilities in the four States of Rajasthan, Himachal Pradesh, Bihar and Jharkhand and have found that in the case of public health services, there are notable differences among the Northern States. Higher spending in Rajasthan through NRHM has translated into a marked improvement in the availability of services and infrastructure at public health facilities. However, the utilization rate of public health facilities was found to be abysmal. In Jharkhand and Bihar, the most basic infrastructure was missing and utilization was even lower. Himachal Pradesh was the only exception with a well equipped and well utilized system at Sub Centers (SCs) and Primary Health Centers (PHCs). The study needs to be extended to the other States of India as well, such as Tamil Nadu which has one of the best health parameters since it continues to give due importance to Public Health Services.

Das Gupta et al (2009) have rightly concluded that the central government policies, through well intentioned, have inadvertently de-emphasized Environmental Health Services and other preventive Public Health Services in India in favour of politically motivated “Single-issue” programmes which offer only short-term often reversible and have easily measurable “visible” outcomes. These decisions have introduced policies and fiscal incentives that have inadvertently enabled states to prioritize Medical Services and “Single-issue” programmes over broader Public Health Services and as a result, disease from poor environmental health conditions continue to impose high costs even among the more affluent and hinder development. However, the study could be further developed by supporting it with empirical data.

7. Concluding comments:

Scholars and policy makers have realized that one of the most important constraint in attaining the desired goal of universal and inclusive health coverage has been the failure to allocate the minimum level of public health expenditure. International experience has shown that health outcomes and financial protection are closely related to absolute and relative levels of Public Health Expenditure. It has also shown that and integrated approach to Healthcare with equal emphasis on the three categories[5][5] of the Public Health System is the key to achieving success.

[5] Environmental, Clinical and Medical Health Services

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