CHAPTER – VI

MAJOR FINDINGS AND POLICY SUGGESTIONS

The present study made an attempt to analyse health expenditure in India using budget documents for public expenditure analysis and NSSO data sets for household expenditure analysis. Key findings and suggestions are summarized below.

6.1 Findings from Public Health Expenditure Analysis:

1. Governments are Constitutionally mandated to provide health care to all the citizens of the country in an equitable and accessible manner. Towards this mandate, a vast network of infrastructure as well as health personnel has been created across the length and breadth of the country since Independence. These efforts have been systematically guided by a number of advisory bodies beginning with Bhore Committee in 1946. This was followed by Mudaliar Committee in the year 1959. Recommendations of these two committees continue to remain the foundations of Indian health care system.

2. Provision of free primary care, particularly in the rural areas is the core recommendation of these committees. Though the health system of the country has made substantial progress towards establishing a strong network of health facilities with substantial public investment, accessible
and affordable free primary care services still remains a distant dream, even after seventy years of Independence.

3. However, achievements such as reduction in the infant mortality rate and improvements in life expectancy are commendable. Life expectancy at birth in British India estimated for the period 1921-30 was 26.91 years for men and 26.56 years for women. This was way below as compared Australia where the life expectancy at birth for men was 63.48 years and 67.14 for women. Though India achieved a commendable progress from about 26 years of life expectancy in the 1920s to 66 years in 2013, we still lag behind many other countries such as Sri Lanka, Thailand, Indonesia and China.

4. Similarly, the infant mortality rate which is another indicator of the status of health system of a country has been reduced from 88.4 per thousand live births in 1990 to 41.4 in 2013. But this is much higher compared, for example Thailand (11.3), Sri Lanka (8.2) and China (10.9) in the year 2013.

5. India has made considerable epidemiological shift by reducing the incidence of malaria, leprosy, cholera and other diseases. Small pox has been eradicated. But the life style diseases such as diabetics and chronic diseases have emerged as new challenges.

6. Compared to countries such as China and Thailand, the share of public expenditure to very low in India at around 30 percent of total health expenditure. Whereas, the share of public expenditure in health in
Thailand is around 80 per cent and that of China is 56 per cent. This suggests that the governments in India are unable to fulfill the Constitutional mandate that health is a subject. This also suggests the government’s inability to accord higher priority to health sector even after seventy years of independence.

7. Independent India adopted Five Year Plan process to accelerate the growth process of the country. Health was one of the important components among social sectors in the planning process. In spite of systematic developmental planning process, recommendations of 1950s by the key committees could not be realized. National Health Policy was first introduced only in 1983 and the second policy in 2002. The recent National Health Policy was just announced in April 2017. All these are clear evidence to lack of commitment of the government towards health sector.

8. Of late, the health sector received substantial technical support and financial support to some extent for selected health programmes. While these supports contributed to the advancement of health status of the country, health administration became fragmented complying to requirements and procedures of the funding/technical agencies.

9. Health expenditure in India in terms of percentage of GDP devoted to health is nearly equal or higher than other similarly placed countries. India spent 3.8 percent of its GDP on health in 2012 (refer Table-1.2). Whereas Sri Lanka spent 3.1 per cent of its GDP and Indonesia spent 3.0
per cent. In spite of spending larger share of its GDP on health, India’s health status indicators are poorer than these countries. This reveals the inefficiency of health investment and misallocation of resources in health sector in the country.

10. Of the total health expenditure, the share of public expenditure remains around 30 per cent. The remaining 70 per cent of health expenditure is accounted large by households as out-of-pocket expenditure. Insurance and other financing sources are negligible in the Indian context. This imposes heavy burden on households and leads to impoverishment.

11. Public expenditure on health was estimated to be around 0.9 per cent of GDP at the time of National Health Policy. Based on the recommendations of the Commission on Macroeconomics and Health and other advisory committees, the health policy 2002 advocated to raise the public expenditure to a tune of 2.5 to 3 per cent of GDP, an ambitious target. This was to be achieved by a corresponding increase in health budget by the state governments along with Central government. Unfortunately, the share of health budgets of states diminished in the subsequent years.

12. National Rural Health Mission (NRHM) was initiated in 2005 to provide a concerted effort to push health sector with substantial financial allocations. NRHM essentially combined existing national health programmes which were functioning in a disintegrated manner. Also, the funds allocated under the Mission were non-lapsing in nature. Though
this provided an opportunity to raise the level of public financing of health, lack of absorptive capacities of states resulted into slow progress.

6.2 Household Expenditure on Health

13. Household expenditure on health was grey area with lack of representative and reliable estimates. The data being collected by the National Sample Survey Organisation since recently provide an opportunity to understand the extent of household expenditures and their implications. Based on a large sample survey, the data on utilisation of health services and corresponding expenditures are collected in a systematic manner. These available for the specific survey reference years. The recent such data available is for the year 2014.

14. During the year 1986-87, public sector hospitals provided nearly 60 per cent of in-patient care services. The remaining 40 per cent of patients were treated by private hospitals. But by the year 2014, the trends reversed. Private sector hospitals emerged as leading providers of in-patient care services and dominated the sector both in rural and urban areas.

15. It is also important to note that the growth of private health sector was prominent in the urban areas than rural areas. Between 1986-87 and 1995-96, the size of private hospitals in in-patient care grew from 40 percent to 60 percent of total in-patients in rural areas. There after, it remained around the same size.
16. But in the case of urban India, the size of private health sector in terms of their share in total in-patients grew consistently year after year from 39.7 per cent in 1986-87 to 56.9 per cent 1995-96 and further to 61 per cent in 2004 and finally to 68 per cent in 2014. This trend indicates that private health sector in growing rapidly in India and particularly in urban India. The mobility of people and lack of faith in the smaller rural health facilities, the patients flock to urban areas thereby providing impetus to further growth of private health sector.

17. The lopsided growth of private health sector and the lackluster growth of public sector hospitals is a serious concern. This trend negates the Constitutional mandate as well as recommendations of a number of commissions and committees that intended the public sector to play a dominant role in Indian health sector.

18. State-wise results from NSSO household data provide more insights into the public and private sector roles in health. In a number of major states of India, including Maharashtra, Gujarat, Karnataka, Punjab and Haryana, public sector health continue to remain less preferred service provider where private sector lead in service provision for in-patient care services.

19. But among backward states such as Orissa, Rajasthan and thinly populated north-eastern states, private health sector has not percolated sufficiently. Public health sector continue to be a major service provider in these states.
20. All the above results indicate that private health sector target the areas and population where there are avenues for higher profits. This results into lopsided growth and unbalanced development of the sector.

21. On the whole, the analysis reveal that the public sector plays a major role in states which are relatively less developed in health status indicators such as Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and other such states.

22. An attempt was made to compare the cost of treatment over two time points for which such data are available from NSSO. While comparing the cost of treatment over ten years, one should be cautious of inflation and other factors that might alter the actual cost.

23. In this study, to compare the hospitalisation cost between 2004 and 2014, GDP/ GSDP deflators were used to arrive at hospitalisation cost at constant prices.

24. It is interesting to note that the cost per hospitalisation treatment in fact has declined in states such as Arunachal Pradesh, Tripura, Jammu and Kashmir, Bihar, Rajasthan and Uttarakhand between 2004 and 2014.

25. It should be noted that these are also states where the size of private health sector is minimal.

26. In all other major states, the cost of treatment for in-patient care increased during 2004 to 2014. These are the states where the private health sector holds a larger market share in the delivery of in-patient care services.
27. The above findings tend to suggest that the cost of in-patient care will be higher where the private sector provides larger share of health care.

28. The major concern is, whether private sector drives the service delivery cost upwards?

29. Chhattisgarh and Jharkhand states have been taken as case studies to understand where smaller and new states do well in health service delivery. These two states exhibit a near similar socio-economic and demographic characteristics.

30. However, on health indicators such as infant mortality rate, Jharkhand enjoys a lower rate at 32 which is lower than all India average of 37. While Chhattisgarh experiences an IMR of 41 that is higher than Jharkhand and all-India average.

31. In terms of GSDP, both Chhattisgarh and Jharkhand grew nearly at the same rate during the last decade.

32. The hunger index of states for India suggests that both Chhattisgarh and Jharkhand are placed at 26 and 28 while the score for India is 23. These two states are somewhat closer to all India average in terms of hunger index.

33. But when we look at ISHI rank on malnutrition, these two states rank on top of the malnutrition. This implies that even though these states perform better in hunger index, they do perform so in malnutrition. This is because poverty and cultural habits of the people in these states.
34. Jharkhand reports the highest level of multi-dimensional poverty in terms of all the three indicators, viz., Multidimensional Poverty Index, Multidimensional Poverty Headcount and the number of Multidimensional Poor.

35. The inequality is higher in urban than in rural areas in both the states. Between the two states, the level of inequality is higher in Chhattisgarh than in Jharkhand. But this is contrary to the one observed in head count ratios that rural poverty more than urban poverty ratios.

36. The human development index (HDI) is relatively easy to measure and easy to comprehend and can be computed from available data. HDI is a weighted average of income, education and health. HDI in Chhattisgarh was lower than the HDI in Jharkhand in all the three years, namely 2004-05, 2009-10 and 2011-12. Both the states marginally improved their HDI levels marginally in 2011-12.

37. Status of a state is reflection of variations among regions/ districts of the state. These variations hide a number of realities. The trends in the HDI of districts suggest that three districts have improved their relative ranks in 2011-12 compared to 2001-02. But, five districts’ ranks have declined during the same period, indicating an overall decline of the HDI in the state.

38. In the absence of measures like HDI for Jharkhand, economic measures such as wages and consumption have been used to assess inter-district variations. The estimates reveal a high degree of variation in wage levels.
across districts between Rs.70.60 in Dumka to Rs. 0.3 in Dhanbad. But in terms of monthly per capita consumption expenditure (MPCE), the maximum expenditure is reported in Ramgarh district and the minimum in Ranchi.

39. In terms of health infrastructure such as beds, labour room, transport, etc., Jharkhand seems to be the lacking as compared to Chhattisgarh. Chhattisgarh however fares better when compared to the all India average figures. These only indicate that these states have not invested and built up the health care infrastructure required for level of population in those states.

40. Availability of health personnel have been major issue in many states. Chhattisgarh and Jharkhand are no exception to this. In fact these much more vulnerable because of lack of facilities such as residence, schools for their wards, roads and other facilities, trained medical professional would not prefer to be in these locations.

41. Average population served per government hospital is about 39,611 patients and for the same each bed serves about 2,101 patients in Chhattisgarh. And in Jharkhand the same is 59,682 and 6,052 respectively. The ratio is very much high for Jharkhand compared to the other state.

42. Availability of Ayurvedic, Unani and Siddah health services are better than the allopathic services in these states. More patients depend on these services as they are accessible relatively easier as well as cheaper. Also
the cultural settings deter the people in accessing allopathic health services.

43. Data available for about 14 years reveals that the infant mortality rate is declining from the rate of 70 per thousand live births in 2003 to 41 by 2015 in Chhattisgarh.

44. Fertility rate among women in Chhattisgarh is declining from 3.0 in 2003 to 2.3 in 2014. Declining fertility is an indication of better child survival and family welfare practices in the state. The same in Jharkhand has declined from 3.3. to 2.6 during the same period. The initiatives and programmes of the national rural health mission are likely to contributing to these improvements. Under NRHM, these states are treated under high focus states and would be receiving substantial inputs and finances.

45. Since public expenditures play a major role in these states as observed earlier, its growth over time was assessed to understand if the introduction of NRHM made any improvements in these states.

46. The estimated growth rates reveal that public expenditure on medical care services which are basically curative care including primary care showed a sign of faster growth during the post-NRHM period than the pre-NRHM period in Chhattisgarh.

47. Similarly, expenditures by government of Chhattisgarh on family welfare programmes attained higher growth during the post-NRHM than the pre-NRHM period.
48. On the contrary, expenditure on public health programmes which includes largely the disease control programmes witnessed a setback in the growth during the post-NRHM period in Chhattisgarh.

49. However, the overall public expenditure on health in Chhattisgarh witnessed an accelerated growth during the post NRHM period.

50. In Jharkhand, the estimated growth parameters for period-1 and period-2 suggest that the possibility of diversion of state health budget from medical component to public health component.

51. Growth of medical expenditure during the pre-NRHM period is higher than the post NRHM period in Jharkhand. While the expenditure for public health grew faster during post-NRHM as compared to pre-NRHM period.

52. The requirement of matching contributions from the states to NRHM as well as the compulsions to implement NRHM schemes would have forced the state to reallocate the funds away from medical component in Jharkhand.

53. Estimated growth rates tend to suggest that the efforts of NRHM and policy changes have not resulted into an enhanced budget allocations to health sector in Jharkhand. It rather led to reallocation of available resources to health sector rather than injecting additional funds from the state.

54. Results from the National Health Accounts reveal that per-capita expenditure on health in Chhattisgarh at Rs.770 is higher than that of
Jharkhand with Rs.500. But more than two thirds of this amount comes from households as out-of-pocket expenditures.

6.3 Policy Implications

1. There have been suggestions from 1950s through Bhore Committee and Mudaliar Committee to strengthen the primary and community based health services. Even though the successive governments made attempts to augment the capacities of primary care services, they are far from satisfactory. Therefore, the governments should undertake these specific tasks to ensure a modest level of facilities are setup urgently.

2. On the information such as budget data to analyse government spending on health is highly complicated at present. The way in which the data are presented are mere accounting rather than information for public. These do not support either the government or the public to assess their effectiveness.

3. Similarly, household expenditures are collected by the NSSO on a random basis over a gap of 8 to 10 years. While these are highly useful, they lack consistency from one survey to another. As a result, strict comparisons are technically not accepted. Government may step-in to make necessary corrections in the data collection process as well as their methodology to ensure uniformity over time.