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STATUS OF PUBLIC HEALTH AND IT'S FINANCING IN INDIA

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Abstract
The overall survivality of the people as measured by expectations of life at birth shows an impressive improvement during the last sixty years, but the current status of health, as reflected in the demographic and health indicators, shows that India still lags for behind her rivals like China, Brazil, Argentina, South-East Asian nations etc., besides the developed countries. It has been observed that although the government has made much effort in providing health to the people since independence, still a lot needs to be done. The government should not only increase expenditure on health and family welfare but also improve the quality of services provided, only than can we imagine an efficient, disease free and healthy population in India.

Introduction

India is a welfare state, as pronounced by her constitution and other policy documents, took work every step for the well being of the people through a well defined health care system right from the 1st Five Year Plan up to the Xth Five Year Plan. India has succeeded in the complete abolition of mass killing disease like plague, smallpox and a substantial control over diseases such as malaria, tuberculosis etc. The overall survivality of the people as measured by expectations of life at birth shows an impressive improvement during the last sixty years, but the current status of health, as reflected in the demographic and health indicators, shows that India still lags far behind her rivals like China, Brazil, Argentina, South-East Asian nations etc., besides the developed countries.

The government may boast of a heavy increase in expenditure on medical health and family welfare but the real picture tells a different story. The mushrooming growth of private sector nursing-homes and clinics in urban areas and a very large number of quacks in rural areas shows that public health care system has somewhat failed to fulfill its obligations towards the general public especially the poor.

The present paper deals with the current status of health services in India and the public sector achievements in health sector. The paper also analyses the impact of privatization of health care system. We have also discussed the public spending on medical health and family welfare. The paper is divided in four sections namely, introduction, the current status of health in India, public health spending and lastly the conclusion.

Health is fundamental to national progress in any sphere. In terms of resources for economic development nothing can be considered of higher importance than the health of the people. It is measure of their energy and capacity as well as of the potential of man-hours for productive work in relation to the total number of persons maintained by the nation. For the efficiency of industry and agriculture, the health of the worker is an essential consideration (Government of India, 1st Plan, 1951). "Health is a state of complete physical, mental and social well being and not merely an absence of disease and infirmity" (Park, J.E., 1986, p.12).

The WHO definition of health, projects three different dimensions of health- physical, mental and social, they are closely related. Spiritual health a fourth dimension has been added to the concept of health. Organizations like UNDP and social activists highlight a broader concept of health, that is, the improvement of the overall quality of life. The term quality of life has been defined as "the condition of life resulting from the combinations of the effects of the complete range of factors such as those determining health, happiness(including comfort in the physical environment and a satisfying occupation), education, social and intellectual attachment, freedom of action, justice and freedom from oppression" (WHO, 1977).

Thus, health is a positive state of well being in which harmonious development of physical and mental capacities of the individual lead to the enjoyment of a rich and full life. It is not a negative state of mere absence of disease or infirmity. Health involves primarily the application of medical science for the benefit of the individual and of society. Simultaneously, many other factors such as social, economic and education have an intimate bearing on the health of the community. Health is thus a vital part of the concurrent and integrated programme of development of all aspects of community life.

In India, in the pre-independence era health services had two distinct components. Firstly, public health services manned mostly by non-health professionals implementing interventions aimed at preventing health hazards, improving environmental sanitation, monitoring water quality and prevention of adulteration in food and drugs: and secondly medical care services manned by health professionals and para professional providing promotive, preventive, curative and rehabilitative care to individuals. In the post independence period medical care underwent many changes. Specialists in community medicine and

public health focused on providing promotive and preventive care for major public health problems through outreach services. The clinicians provided institution based prevention, promotive, curative and rehabilitative health care to individuals who came to the health care institution (Government of India, Xth Plan, p. 132).

The concept of the public health was initially developed and implemented in maternal and child health but soon all other disciplines including clinical specialities dealing with non-communicable diseases such as cardiology adopted this. As a result, public health is today defined as a discipline aimed at developing a health system to deliver equitable, appropriate and holistic care to improve the health status of the individual and health indices of the country at an affordable cost.

Taken in this broader perspective public health deals with the formulation, implementations and monitoring of evidence based health policies, strategies and programmes. It also attempts to create a supportive environment for the effective implementation of such programmes by addressing critical issues that affect health care including quality, equality, ethics, environment and globalization. Every effort has to be made to ensure policy makers, environment and globalization. Every effort has to be made to ensure that policy makers, programme managers, healthcare providers and people themselves internalize and support this broad concept of public health and contribute towards attaining the public health goals.

As healthy man power is a basic per-requisite for development of the nation, the responsibility of maintaining public health rests with the government of the country. In India, the government has been providing health facilities at various levels, improvement in the health and nutritional status of the population has been one of the major thrust areas for the social development programmes of the country. This has been achieved through improving the access to and utilization of health, family welfare and nutrition services with special focus on underserved and under privileged segments of the population. Over the last five decades, India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care in government, voluntary and primary sectors. The population has become aware of the benefits of health technologies for prevention, early diagnosis and effective treatment for a wide variety of illnesses and accessed available services. Technological advances and improvement in access to health care technologies, which are relatively inexpensive and easy to implement has resulted in substantial improvement in health indices of the population and a steep decline in mortality.

The success and expansion of the public health sector is important also because India is a signatory to the Alma Ata declaration of 1978 which stated “Health for all” by 2000 A.D. (WHO, 1978). The Alma- Ata Declaration was adopted at the International Conference on Primary Health Care. Alma-Ata, presently in Kazakhistan, 6-12 September 1978. It was the first international declaration underlining the importance of Primary health care.Several efforts have been made by the government through policy initiatives to achieve this goal. Again, India is committed to achieve the Millennium. Development Goals as declared by U.N.O. in 2000 (UNO,2000,Washington D.C.).

Table 1, Selected Health Indicators

Indicators	**1951**	**1981**	**1991**	**NHPGoals for 2000**	**Xlii Plan Goals**	**Current Status**
CBR	40.8	33.9	*29.5 r*	21	20	24.8
(per 1000 population)						
CDR	25.1	12.5	9.8	9	6	8.0
(per 1000 population)						
TFR	6.0	4.5	3.6	2.3	2.1	3.0
(per woman)						
IMR	146	110	80	60	45	60
(per 1000 live birth)	(1951-61)					(2003)
MMR	NA	NA	4.37	Below 2	2	4.07
(per 100,000 live birth)				(1992-93)		
Child Mortality Rate	57.3	41.2	26.5	15	20.2	17.8
(0-4 yrs)					(2002)	
Couple Protection Rate (%)	10.4	22.8	44.1	60	66	48.2
Life Expectancy at Birth:						
Male	37.2 .	54.1	59.7	64	65	63.9
(2001-06)						
Female 36.2	54.7	60.9	64.	68	66.9	
(2001-06)						

Source : Ministry of Health & Family Welfare and Office of the Registrar General, India, 2006

The main goals are

- Eradicate universal primary education
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development.

Current Status of Health in India

Despite the best efforts by the government to improve health status of the Indian population, health care services are far from satisfactory in our country. If we compare the major health indicators from the time of independence to the present day there has been a definite positive change however, when we compare the present health indicators with other countries, we find India very far behind.

An analysis of the health indicators (Table-1) shows that the crude birth rate which was 40.8 in 1951 has been reduced to 24.8 currently. The National Health Policy 2000 aimed at reducing it to 21 per 1000 population. The crude death rate has shown a remarkable decline and it has come down from 25.1 per 1000 population to 8 per 1000 population. The X^{th} plan goal has been set to bring this further down to 6 per 1000 population. The MMR rate which was 4.37 per 100,000 live births in 1991 has been planned to 2 per 100,000 in the X^{th} plan. Also the life expectancy at birth of both male and female population has increased from 37.2 and 36.2 respectively to 63.9 and 66.9 respectively in 2006.

A comparison of the health indicators of India with other developing countries of Asia reveals the real position and condition of the health of the Indian population. The countries of the region like China, Sri Lanka, South Asia even Bangladesh have better health indices than India.

The ailing public health services in the country are manifested in the poor health infrastructure besides the health indicators. The health infrastructure in India has a long way to go towards achieving 100 percent quality, technology and superior health-care delivery systems (Table 2). Looking at the available public health care infrastructure, the private sector provides 80 percent of the health care services and only 20 percent are provided by the government (www.buyusa.gov/india).

Structure of the government health service

- Primary Care (in rural areas) : 22,271 primary healthcare centres and 137,271 sub-centres.
- Secondary Care (healthcare centres in smaller towns and cities) : 1,200 PSU (public sector unit) hospitals, 4,000 district hospitals and 2,935 community healthcare centres.
- Tertiary Care (hospitals): 117 medical colleges and hospitals.

Table 2
Healthcare Infrastructure

Hospital (numbers)	15,393
Public	4,049
Private	11.344
Hospital beds (numbers)	875,000
Doctors	592,215
Nurses	737,000
Dentists	80,000
Medical Colleges	170
New Doctors every year	18,000
Retail Chemist (Pharmacy) outlets	350,000

Source : Ministry of Health, Medistat Outlook Espicon report January, 2005, ICRA Report Indian Health care Sector, February 2005, Confederation of Indian Industry.

The private healthcare providers consist of private practitioners' hospitals and nursing homes and charitable hospitals. They are numerous and fragmented. In the absence of a national regulatory body, some private providers practice without minimum standards and the quality of treatment varies from one provider to another. The average size of private hospitals/ nursing homes is 22 beds, which is low compared to other countries (Table 3).

Table 3,Size of Hospitals

84 per cent of private hospitals	< 30 beds
10 per cent	30 - 100 beds
5 per cent	100 - 200 beds
1 per cent	>200 beds

Source: Ministry of Health, ICRA Report, Indian Health Care Sector, 2005.

The government share was even less for the number of facilities to the poor, since the public sector was more prominent in expensive hospital care, than it was in primary care. There is also a strong tendency in the public sector to believe that its clientele is predominantly poor. In fact, the use of public sector was much greater for those better off. Most public in-patient services (more than 65%) are used by the richest 40 per cent of the population, compared with 19 per cent of the poorest 40 per cent, as were most out-patient services (48 for the richest 40%) and 31 % for the poorest 40 per cent (Mahal and Others, 2001).

International comparison supports the above observation that the private sector dominates India's health system (Table-4). India's public expenditure on health reflects its low income. The X'" Plan document substantiates the World Bank observation, it says that there has been a substantial increase in the number of hospitals under the private sector during the 1990's as compared to public sector. A majority of government and private sector hospitals are located in urban areas. Qualified and registered private sector doctors or private sector institutions are not readily available in remote rural and tribal areas because people do not have ability to pay (Government of India, X^{th} Plan, 2001, p.94). **It** is a bare fact that even after sixty years of

Table 4,Health Spending and Comparator Countries

Country	***GDP/per capita***	***Total Health Spending (% of GDP)***	***Public Health Spending - (%of GDP)***	***Pvt. Health Spending (% (of GDP)***
Pakistan	420	4.1	0.9	0.2
India	460	4.9	0.9	4.0
Indonesia	690	2.7	0.6	2.1
China	890	5.3	1.9	3.4
Russia	1750	5.3	3.8	1.5
Thialand	1940	3.7	2.1	1.6
South	2820	8.8	3.7	5.1
Brazil	3070	8.3	3.4	4.9
Malaysia	3330	2.5	1.5	1.0
Mexico	5530	5.4	2.5	2.9

independence unqualified persons still provide health care especially to the poorer segments of the population living in urban slums, remote rural and tribal areas. It is a common phenomenon in India that wherever and whenever public authorities remain unsuccessful to provide basic services such as primary health care and education, private sector has entered not for social cause but for profit making.

The Planning Commission's mid-term appraisal of the Tenth Plan observes "when people first seek treatment, an estimated 70-85%visit a private sector provider for their health care needs". However, as the appraisal says, "the poor avail of the costlier services provided by the private practitioner even when they have access to subsidized .or free public health care, due to reasons of distance but more importantly. on account of the unpredictable availability and very low quality of health care services provided by the rural primary health sector" (Government of India, 2005, p.l05).

Data from 52nd round of NSSO (1995-96), National Family Health Survey-II and National Council for Applied Economic Research shows that for in-patient care for all ailments, 60 per cent of the population below poverty line families tend to use government hospitals and equal proportion of above poverty line families prefer private hospitals (NSSO-5 and NFHS-II).

Public Health Spending

The condition of expenditure on health services in India is no less dismal. As a ratio of GDP, public expenditure on health is among the lowest in the world, about 1.17 per cent in 2002-2003. In fact, the health system is almost totally privatized. By contrast, the ratio of public expenditure to total health expenditure is 40 per cent in East-Asia, 50 per cent in Latin America, 75 per cent in Europe and as high as 85 per cent in Britain. In large parts of India, there are no

Table 5,Combined Revenue and Capital Expenditure of Centre. States and Union Territories

Year.	*Medical & Public Health*			*Amount (Rs crore)*	*Family Welfare % of total expenditure*	*% of GDP*
	Amount (Rs crore)	*% of total expenditure*	*% ()f GDP*			
1986-87	4068	4.41	1.57	570	0.61	0.22
1987-68	4744	4.62	1.61	642	0.62	0.21
1988-89	5274	4.50	1.49	713	6.60	0.20
1989-90	5772	4.15	1.41	820	0.58	0.20
1990-91	6564	4.20	1.28	932	0.59	0.18
1991-92	7336	4.11	1.24	066	0.59	0.18
1992-93	8265	4.12	1.31	1055	0.52	0:16
1993-94	9536	4.19	1.30	1342	0.59	0.18
1994-95	11091	4.25	1.29	1489	0.57	0.17
1995-96	12453	4:24	1.16	1827	0.62	*0:17*
1996-97	4287	4.35	1.15	1834	0.55	0.14
1997-98	16865	4.48	1.21	2134	0.56	–
1998-99	20584	4.57	1.28	2222	0.49	0.13
1999-00	22698	4.36	1.28	2667	0.51	0.15
2000-01	24360	4.37	1.28	2826	0.50	0.14
2001-02	25255	4.07	1.21	3185	0.51	0.15
2002-03	2649$	3.96	1.17	2924	0.43	0.12

Source: GOI, Public Finance Statistics, 1999-2000, 2004-05, Ministry of Finance, New Delhi.

Pattern of Investment of Health, Family Welfare (Plan Outlays) during Different Plan periods in Public Sector - Centre, States and UTs

Table 6
Pattern of Investment of Health, Family Welfare (Plan Outlays) during Different Plan periods in Public Sector - Centre, States and UTs

Total Plan Investment (All Dev. Heads)	*Outlays/ Exp.*	*Health. (Centre & States) % of total Plan Investment*	*Family We(fare Outlays/ Exp. Plan Investment*	*% of total*
1960.00	65.20	3.33	0.10	0.01
4672.00	140.80	3.01	5.00	0.11
8576.50	225.90	2.63	24.90	0.29
6625.40	140.20	2.12	70.40	1.06
15778.80	335.50	2.13	278.00	1.76
39426.20	760.80	1.93	491.80	1.25
12176.50	223.10	1.83	118.50	0.97

97500.00	1821.00	1.87	1010.00	1.04
109291.70	2025.20	1.85	1387.00	1.27
180000.00	3392.90	1.88	3256.30	1.81
218729.60	3788.60	1.69	3120.80	1.43
61518.10	960.90	1.56	784.90	1.28
65855.80	1042.20	1.58	856.60	1.30
434100.00	7582.20	1.75	6500.00	1.50
547557.00	5314.00	0.97	15088.00	2.75
893183.00	9253.00	1.03	27125.00	3.04

Public health facilities worth the name except for female sterilization and polio immunization (Dreze Jean, 2004 The pattern of revenue and capital expenditure of centre, states and the union territories shows that spending on medical and public health increased almost four fold from 1986-87 to 2002-03, but as percent of total expenditure and as percent of GDP. It is decline (Table-5). During 1986-87, the combined revenue and capital expenditure on medical and public health was Rs. 4086 crore and it was 4.41 percent of total expenditure and 1.5 percent of GDP. The total expenditure on medical and public health was Rs.26495 crore during 2002-03 and it was 3.96 percent of the total expenditure and only 1.17 percent of the GDP during the same year. The story is the same for public expenditure on family welfare. The total expenditure on family welfare increased from Rs 570 crore during 1986-87 to Rs 2924 crore during 2002-03, but its share in total expenditure decreased from 0.61 to 0.43 percent and a percentage of GDP it decreased from 0.22 percent to 0.12 percent for the same period.

Smo. Period.	
1	FirstPlan (Actuals) (1951-56)
2.	Second Plan (Actuals) (1956-61)
3.	Third Plan (Actuals) (1961-66)
4.	Annual Plans. (Actuals) (1966-69)
5:	Fourth Plan (Actuals)(1969-74)
6.	Fifth Plan (Actuals) 1974-79)
7.	(1979-80)(Actuals)
8.	Sixth Plan (Outlay)(1980-85) Sixth Plan (Actuals)
9.	Seventh Plan (Outlay)
10	1990-91 (Actual)
11	1991-92 (Actual)
12	Eighth Plan Outlay(1992-97)
13	Ninth Plan (outlay) (1997-2002)
14	Tenth Plan (outlay) (2002-07)

Source: F.R. Division, Planning Commission, 2004.

So far as the planned efforts are concerned. Table 6 shows the patterns of investment on health and family welfare during different plan periods in public sector, by the centre, state and the union territories. The data shows that investment on health has increased from 65.2 crore during the First plan to Rs 9253 crore during Tenth plan, it shows an increase of nearly 14000%.

However, its ratio to total plan investment is on a declining trend. Investment on health during First Plan was 3.33 percent of total plan investment. It came down to 3.01 percent in Second plan, 2.63 percent in Third Plan and finally to 0.97 percent in Ninth Plan. As per Tenth plan projection the outlays for the health is merely 1.03 percent of total plan investment in public sector. On the contrary to investment on health, the investment on family welfare has increased Tenth plan. The investment on family welfare as percent of total plan investment also increased from 0.01 percent during the First plan to 3.04 percent during Tenth plan.

The pattern of investment either by the central government or by the state governments shows the apathy on the part of the government.

The state of health services whether in urban or rural areas is in poor shape? As per X[th] plan document (Govt. of India, 2001, p.119). India's share in global health problems is still at an alarming stage. India, with 17 percent of the world population, claims 17 percent of the total deaths, 23 percent of child deaths, 26 percent of childhood vaccine preventable deaths, 20 percent of maternal deaths, 68 percent of leprosy cases, 30 percent of TB cases and 10 percent HIV infected persons. Expectancy of life at work is 64 years against 71 years for china and more than 85 years for developed countries: infant mortality rate was 63 per 1000 live births during 2003 as against 30 for china, 13 for Sri Lanka, and only 4 to 6 in developed countries. Maternal mortality rate in India is as high as 540 per 100,000 live births in 2005 as against 36 in China, 92 in Sri Lanka and 10-15 in developed countries.

Table 7,Per Capita Expenditure on Medical, Public Health and Family Welfare

Year Population	*Expenditure on Medical & Public Health (Rs. Crore)*	*Per capita Expenditure on Medial and Public Health*	*Expenditure on Family We{fare (Rs. Crore)*	*Per capita Expenditure on Family Welfare*
1986-87	40680	53.07	5700	7.44
1987-88	47440	60.61	6420	8.20
1988-89	52740	65.99	7130	8.92
1989-90	57720	70.75	8200	10.05
1990-91	65640	78.84	9320	11.19
1991-92	73360	86.13	10660	12.52
1992-93	82650	95.24	10550	12.16
1993-94	95360	107.89	13420	15.18
1994-95	110910	123.25	14890	16.55
1995-96	124530	135.07	18270	19.82
1996-97 941.6	142870	151.73	18340	19.48
1997-98 959.8	168650	175.71	21340	22.23
1998-99	205840	210.45	22220	22.72
1999-2000	226980	227.80	26670	26.77
2000-01	243600	240.05	28260	27.85
2001-02 1033.2	252550	244.43	31850	30.83
2002-03	264950	252.19	29240	27.83

Table 7 reveals that total spending on medical and public health, may have increased by 6.51 times between 1986-87 to 2002-03, however, per capita expenditure on medical and health could increase only by 4.75 times during the same period. Also in the course of spending on family welfare, total expenditure grew by 5.12 times and per capita expenditure by 3.74 times. During 2002-03, the per capita expenditure on medical and public health was Rs. 252.19 and on family welfare is adjusted with the price indices the expenditure is much lower than the figure for 1986-87. While India's overall expenditure, as discussed above is low due to its large billion plus population and low per capita income. This scenario is not likely to improve in the near further due to the rising health care costs and India's growing population.

The issue of how much the government sector, private individuals and the country as a whole is spending on health care and which segments of the population are benefiting has been debated widely during the last decade. The WHO has estimated that India, at present, is spending 4.5 percent of Gross Domestic Product (GDP) on health, of which 0.9 percent is public expenditure. India ranks thirteenth from the bottom in terms of public spending on health (World Health Report, 2000).

There is an urgent need to evolve, implement and evaluate an appropriate scheme for health financing for different income groups. Health finance options, may include health insurance for individuals, institutions, industries and social insurance of BPL families.

Conclusion

A healthy workforce is an essential pre-requisite for agricultural and industrial development of a country. In India, at the time of independence the country had a population of 300 million. Famine, starvation and epidemics took a massive toll of human life, infant maternal mortality rates were among the highest in the world and life expectancy was about 33 years. The country

then embarked on a large scale expansion of medical and pre-medical facilities so that the health requirements of the population could be met. Six decades later a vast health care infrastructure in the government, voluntary and private sector has been created and now we have overcome major epidemics, life expectancy has increased and the general health of the people is much better. However, it is matter of great concern that there are huge gaps in critical health manpower in government institutions that provide health care to the poorer segments of population living in urban, rural and tribal areas. The poor health infrastructure of the government has resulted in the mushrooming growth of private nursing homes and clinics throughout the country. There is an urgent need to increase the expenditure on public health services by the government. However, it is also necessary that the spending on health is properly utilized such that it benefits the entire population, especially the under privileged. The government expenditure must be properly managed so that there is an overall improvement in the health indices. It is imperative that a system of National Health Accounting, reflecting total government expenditure on health is established. This will enable periodic review and appropriate policy decisions regarding modalities for ensuring optimal utilization of the current government investment in the health sector and also future investments to meet public health need Thus, in the end we can say that although the government has much effort in providing health to the people since independence, still a lot needs to be done. The government should not only increase expenditure on health and family welfare but also improve the quality of services provided, only than can an efficient, disease free and healthy population in India.

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