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HEALTH AND HEALTH EXPENDITURE IN INDIA: A PROGNOSIS

Dr. Alka Mishra* Vivek Kumar Mishra**
**Guest Faculty, Department of Economics, Jagat Taran Girls Degree College, University of Allahabad, Allahabad.*
***Junior Research Fellow, Department of Economics, University of Allahabad, Allahabad, India.*

Abstract
People are subject to various types of illness, which require medical manpower and infrastructure, and which go untreated or are expensive, in their inadequate presence. Since healthcare services are an important component of health, this paper tries to assess the level of health and healthcare services in India.

The paper is based on secondary data, collected from various sources. The paper concludes with the remarks that the high proportion of out-of-pocket health expenditure, in the paucity of public healthcare services, reflects the poverty of healthcare. This is a cause of concern in a country with more than one-thirds of the people below the poverty line, leading one to believe that only the rich can afford ill-health. One way to improve the quality of public as well as private healthcare services is to have them obtain Accreditation with Standards for hospitals developed by NABH. The Standard for Hospitals has been accreditation by the International Society for Quality and Healthcare (ISQua), which sets global benchmarks in quality healthcare. The highly developed IT industry in the country can be harnessed to monitor the various schemes.

Introduction

Health is man's natural condition, his birth right. Health is multidimensional like socio-economic, environmental, educational, nutritional, curative and preventive. **W.H.O.'s Constitution (1992)** defines health as, "A state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Health is important in every individual's life and so we say "Health is Wealth".

Good health is a vital part of human's standard of life. The **World Development Report (1993)** asserted that with improved health a society could contribute to economic growth in a better manner. Besides, enhancing the productivity of labour, it would increase educational attainment of children and their learning ability.

This, however, is debatable because many believe that poverty is the basic cause of ill-health. This leads one to wonder whether public spending on poverty alleviation programmes can be an alternate to public spending on health. However, the various poverty alleviation programmes in the past have not led to any significant change in the poverty status of the people in India, which has been seen at around 37% as per the Tendulkar Committee report.

Following the natural laws, the flora and fauna on this earth, not unlike humans, also need a healthy life to survive, because ill-health certainly leads to their death. They either wither away or are killed by higher species. There may some in-built preventive properties for their health, like the leaves of a plant contract to reduce vapour outflow. Animals have curative properties in the form of their tongue to heal injuries. Mankind is no different, except for his reasoning power which puts him at the top of the living ladder. Good health enables a person to pursue his normal economy activity, so that he can earn and look after himself and his family, which indirectly contributes of society and economy. However, if a person is not well or has ill-health, his capacity to work decreases, leading to reduction in his income which, in turn, leads to reduced consumption and aggravates his ill-health, resulting in the person being caught in the **"Vicious circle of ill-health"**.

Myrdal (1969/1974) told us, in no uncertain terms, that a people are poor because they are sick, they are sick because they are poor, poor because sick and the vicious cycle continue. On the same lines, the World Bank, almost two decades ago, acknowledged the reciprocal dependency between progress in health and economic development. This acknowledgement was not an earthshaking revolution, particularly to those who worked in the field of health and development in Asia and Africa, where the bubonic plague of HIV had already started taking a heavy toll. Yet, this revelation brought a turning point in the emerging global movement towards poverty alleviation. It was not until 2001 that the international community, through the World Health Organization Commission on Macroeconomics and Health, documented that not only poverty leads to ill-health, but also that ill-health leads to poverty **(WHO & World Bank, 2002)**. This is no secret now, that ill-health is one of the prime culprits of underdevelopment, both at individual and collective levels.

Studies **(Upadhaya S, 2007),** show that people are hardly aware of the benefits of good health and, even if they were aware, it does not translate into actual effort. Consequently, they are subject to various types of illness, which require the services of trained medical manpower. This manpower however, may not be available or easily accessed, especially in the rural areas.

Assuming that these are present, it is not necessary that they may be affordable. Consequently, healthcare services are an important component of health. This paper tries t compare the level of health and health expenditure in India.

There are two type indicators of healthcare, one is preventive and other is curative. In preventive healthcare, precautions are taken like immunization against various diseases, personal care, develop good habits, drink clean water and take hygienic food etc. In curative healthcare if we fall sick we take symptomatic care by ourselves, doctor, chemist family members and from others. In healthcare, awareness is necessary but awareness is not sufficient. There are two themes which have emerged in the delivery of healthcare services first, the health services should be organized to meet the needs of entire population. Health services cover the full range of preventive, curative and rehabilitation services. Effective primary healthcare services, is needed to provide healthcare to the vast majority of underserved rural people and urban poor and it must have a referral system to keep watch on the progress. It is generally perceived that health services given by the private health sector are better than public health sector. However, these facilities and services are very exclusive in the private sector, but people want better health facilities, so they incur out-of-pocket (OOP) expenditure in availing private healthcare services, instead of the government facilities, even though they are poor and cannot afford the cost of private facilities. At the same time, however, it is debatable whether government health services are really cheaper than the private health services. This is because the public healthcare system involves a period of waiting and the associated wage costs. At the same time, the user fee and the cost of pleasing and greasing the health staff, along with the treatment cost, may add up, more or less, to almost the same expenditure that would be incurred if private health services were available. Thus, people generally tend to prefer private healthcare services over the public services.

Review of Literature

Pramod, M. *et al* (2003) emphasized the state of poor living conditions, health awareness, medical manpower and infrastructure, etc. The paper is descriptive in its nature. The study observed that the private healthcare services providers insist on unnecessary diagnostic tests and medicines (for a commission) which maybe expensive, thereby unnecessarily increasing the OOP expenses of the people. In some cases, it has been observed that the private hospitals refer their cases to the public hospitals/institutions, as they fear to treat the patients for repercussions from patient's family or attendants.

Filmer, *et al* (1999) attempted to explore the relationship between national income and the level of health care. Filmer used a demand function approach and found a positive relationship between national income and health care. **Baru Rama (1999)** looked at the structure and utilization of health services in the Indian states. The paper observed that although Private health care services in the country have grown and diversified, the private sector provision and spread however, has been uneven and guided by professionalism.

Wide variations in per capita health spending across states has been observed by the **National Health Accounts (2001-02)** and elaborated that the Private health expenditure dominated the same in nearly every state. **Objectives of the Study &**

Methodology of the Research

1. To explore the current status of health expenditure in India.
2. To identify the determinants of health expenditure in India.

The paper utilizes the secondary sources of information to achieve the objectives of the study. Data have been collected from Census of India and WHO reports. The study is descriptive in its nature.

Analysis

The health sector in India has emerged as an industry, promoting medical tourism, mushrooming five star hospitals in and around the mega cities. The consumer led economic environment of post liberalization era has created a magic lamp of medical tourism, which attracts the people from abroad to the countries like India to have cost efficient medical treatment accompanied with other attractions in the form of healing environment.

Experiences tell us that India has revealed comparative advantage in terms of some medical treatments over the USA, Thailand and Singapore. It is generally recognised fact also that India offers the lowest cost of medical treatment. The heart bypass procedure cost ($ 210,842) and single heart valve replacement ($ 274,395) in United States is much higher than the cost ($ 10,000 and $ 9,500 respectively) in India. These cost differentials offer people in other countries the opportunity of availing highly specialized health treatment in super speciality hospitals in India at only around 10% of the cost in the USA. This appears to be approximately the same in the developed countries, as compared to the parity level found in South-East Asia, especially in Thailand and Singapore. Thus, this brings in the attraction for people in the developed economies for undergoing medical treatment in India, even after including airfare, boarding and lodging.

However, there is another side to the same coin, which is in stark contrast to the Ricardian theory of international trade, whereby a country gains by specializing and exporting that commodity which has comparative lower cost of production. In the case of medical tourism, India 'exports' low cost health care which benefits the other countries at the cost of the Indian population, the majority of which cannot even think of it, leave alone availing it. Thus, a moot question comes up whether it is advisable in the context of social welfare, and, which prompt us rethink whether it should be made available to foreigners and earn valuable foreign exchange or try and provide it to the indigenous population at a still lower cost through government subsidy.

A paradoxical side of health tourism is that, while, many foreigners come to India for the supposedly best treatment at lowest cost, our bureaucrats and rich persons who can afford expensive healthcare go for treatment out of country, especially to the developed countries. And their behaviour shows they do not believe in our so called advanced healthcare system. A case in point is the recent sending of a Delhi girl to Singapore for treatment and where she subsequently died.

Table-1 shows improvement in infant mortality ratio (IMR), maternal mortality ratio (MMR) and child sex ratio (CSR) in 2011. Only the sex ratio has increased, and this may be due to the decline in CSR. However, we believe that this sex ratio of 940 would decline in the years to come. This is because of the increase in sex determination of the foetus and, consequently female foeticide, which has spread at an alarming rate, even in the rural areas. The decline in the IMR and MMR which, no doubt is welcome, leaves much to be desired. However, the improvement in quality and accessibility of public healthcare services in India would go a long way in determining the future significant reduction in these rates. These reductions are necessarily liked to the achieving of a stable population by 2045, as envisaged.

Table-1: Health Indicators in India

Indicators	2001	2011
IMR/1,000 live birth	68	50 (2009)
MMR/10,000 live birth	301	212 (2010)
Sex ratio	933	940
Child sex ratio (0-6 years)	927	914

Source: Census of India 2001 and 2011, State of World Population 2010, UNFPA.

The various National Family Health Surveys data regarding anaemic women and children, child immunization and under-weight women and children, are still relevant in portraying the utter neglecting health and healthcare services. Given the past trend at which healthcare services move, it can be said that not much improvement in these health indicators should be expected in the near future. The two reasons for this pessimism evolve from the slow change in the mind-set of the people with regard to traditions and superstitions one hand, while on the other, the slow pace of increase in quality medical infrastructure and manpower, due to the inadequate resources and various irregularities witnessed in the recent past. Hence, there is no denying the fact that these indicators are far from being comfortable for a country and reflect ***the health poverty in India***.

Table-2 shows the inter-country differentials regarding number of physicians, their density per lakh population, the number of nursing and midwives personnel and their density per lakh population during 2005 to 2010. When we consider number of physicians, China has the highest, followed by India and Indonesia.

Country	Physicians (2005-10)		Nursing and midwifery personnel (2005-10)	
	Number	Density (per lakh population)	Number	Density(per lakh population)
Australia	62,800	299	2,01,300	959
Canada	65,440	198	3,48,499	1,043
China	19,05,436	142	18,54,818	138
Germany	2,97,835	360	9,18,000	1,110
France	2,12,132	345	18,835	31
India	**7,57,377**	**65**	**11,46,915**	**100**
Indonesia	65,722	29	4,65,662	240

Japan	2,74,992	214	5,31,210	414
Pakistan	1,39,555	81	95,538	56
USA	7,49,566	242	2,92,700	982

Table-2: Inter-Country Health Manpower and Infrastructure Differentials

Country	Physicians (2005-10)		Nursing and midwifery personnel (2005-10)	
	Number	Density (per lakh population)	Number	Density(per lakh population)
Australia	62,800	299	2,01,300	959
Canada	65,440	198	3,48,499	1,043
China	19,05,436	142	18,54,818	138
Germany	2,97,835	360	9,18,000	1,110
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Indonesia	65,722	29	4,65,662	240
Japan	2,74,992	214	5,31,210	414
Pakistan	1,39,555	81	95,538	56
USA	7,49,566	242	2,92,700	982

Source: WHO Report, 2012.

In the context of density, Germany, France and USA are in the best positions, while India, Indonesia and Pakistan are in worst positions. In the context of nursing and midwifery personnel, China attained highest position in the selected countries, followed by India and Japan but, in the context of density of nursing and midwifery personnel, Germany is in best position followed by Canada and USA, France, Pakistan and India are in worst position in the world.

China has obtained the highest position in both the fields, due to its being the fastest growing economy in the world and its concern and emphasis on a healthy population. The same can now be said for India, even though it started focusing on the health sector rather late, as its primary concern was education. The developed countries, on the other hand, had a much higher density of physicians, possibly because of the small population. The same can be applied in the case of nursing and midwifery personnel and hence, needs no further discussion.

The per capita public health spending is low in India, being among the five lowest in the world. The public health expenditure in the country over the years has been comparatively low and, as a percentage of GDP, it has declined from 1.3% in 1990 to 0.9 per cent in 1999, increased marginally to 1.1% by 2009. The Central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3%, but has almost doubled to 2% by 2008-09. The Eleventh Five-Year Plan (2007-12) document suggested the necessity of building a responsive public health system, with the need for increasing the public spending on health from 0.9 per cent of GDP to 2-3% of GDP and stepping up investment on primary care, communicable diseases and HIV/AIDS prevention (Godfrey Daniel).

It has been observed by W.H.O. (2012) where India and Pakistan show a diminishing trend in total health expenditure, as percentage of GDP, between 2000 and 2009. Even the government health expenditure, as percentage of total health expenditure, stood as low as 30.3% in India and 34.8% in Pakistan in 2009, the difference being that it has stagnated in India, but declined in Pakistan. The exceptional case is of Indonesia, which has managed an increase under both expenditure heads.

Mostly, those who access 'free' government health services are expected to purchase medicines from private pharmacies, pay user fees for laboratory tests and, of course, the ubiquitous informal fees. Also those who use the private services have to pay considerable amounts. Significantly, those who are insured also do not get full financial protection, as they still have to pay for ambulatory care and excluded conditions. It is clear that Indians (especially the vulnerable sections) do not have any form of financial protection and are, thus, forced to make OOP payments when they fall sick. This is regressive and has both, economic, as well as social consequences.

. Most of the countries show adverse changes as a percentage of total health expenditure, between 2000 and 2009. For example in India it declined from 78.2% in 2000 to 69.7% in 2009. The basic reason for this appears to be increasing

importance being attached to various health schemes, especially the National Rural Health Mission. Outstanding case is Indonesia, where the private health expenditure declined from 61.7% in 2000 to 53.9% in 2009 with some fluctuations, because of the various initiatives taken to reduce the financial burden on the people. Pakistan shows decrease to 65.2% in 2009, but it is difficult to visualize the reasons thereof, because of the political uncertainty there. However, it would not be out of place to say that, India and Pakistan stand out as *"shining"* examples of government apathy towards health and healthcare. This is also seen from the fact that out-of-pocket health expenditure accounted for 86.4% in India and 81.9% in Pakistan during 2009.

In terms of inter-country per capita public expenditure on health (PPP USD) for some countries, during 2000 to 2009, one country which stands out is China, with four-fold increase from $42 to $182, followed by Indonesia by more than three times increase and less than three times increase in India.

Again, with the exception of China, almost all countries show a flat increase during the study period, with the exception of India and Indonesia which show a decline, with Pakistan remaining constant. The basic reason for this state of affairs appears to be the global financial crisis, which diverted funds from the health sector towards the fiscal packages offered by the countries, to combat this crisis. It may not be out of place to maintain that China, Indonesia and India started attaching importance the last decade and, which, accounted for this significant increase in per capita public health expenditure.

Conclusions

The "shining" India story gradually developed into a double digit "growing" India but, unfortunately, was truncated due to the global crisis. No doubt, high growth rates are important for a country to present itself as an emerging economic power; however, growth by itself does not translate into real development, unless it is accompanied by all-round increase in all sectors, such as health and education, among others. The benefits of the demographic dividend cannot accrue without significant improvements in labour employability, which depends on these sectors. Even the human development index (HDI) has included a skilled and healthy workforce as one of its parameters. This indicates that mere high growth rates do not necessarily benefit a country, without taking account the health and educational aspects of the people.

The poor health status of India is directly reflected in the relatively high IMR and MMR which, along with the anaemic women and children and the slow progress in universal immunization of children, leads one to ponder on the health situation in India in the future when, they enter the labour force or workforce, irrespective of the formal and informal sector. We, therefore, are very apprehensive of the health poverty in India becoming an obstacle to India becoming a real economic power.

India has fared behind many countries with regard to public expenditure on healthcare. Although there are signs of improvements, since the launch of National Rural Health Mission (NRHM), this is nothing to crow about. More so, because of the high proportion of out-of-pocket (OOP) health expenditure, which places an enormous burden on the majority of the people leave aside the poor. This is all the more a cause for concern, in a country with more than one-third of the people below the poverty line, leading one to believe that only the rich can afford ill-health. We, therefore, conclude that India has "miles to go" before it can become a real power.

Suggestions

According to a **WHO (2006)** study, 25% patients in government hospitals developed infections, other than the ailment for which they were admitted, due to the unhygienic conditions there. 97 hospitals, both public and private from all over India, applied for National Accreditation Board for Hospital and Healthcare Providers (NABH), out of which 34 hospitals received it, including just one government hospital, the rest being private hospitals. So, to improve the quality of public, as well as private, healthcare services, one way is to have them obtain accreditation with the Standards for Hospitals developed by the NABH. The standard for hospitals has been accreditation by International Society for Quality and Healthcare (ISQua), which sets global benchmarks in quality healthcare.

The highly developed IT industry in the country can be harnessed. Tamil Nadu took the lead in providing universal health coverage by setting up an effective drugs procurement and distribution mechanism in 1994. Its IT-enabled supply chain management system ensures delivery to needy patients, transparency to prevent misuse and stringent quality control to eliminate spurious drugs. Kerala and Rajasthan are successfully emulating this model. 86% of India's healthcare expenditure (2009) comes out of the patient's pocket, where drugs account for 72% of this expenditure.

In a financial crisis, government cuts back resources from the social sector, which is important for the economy. This sector provides an educated and healthy manpower to economy; hence the government should not cut resources and invest even more in this sector. Since the gross enrolment ratio (GER) has increased significantly in recent years, through education cess financing, a case could be built to reduce this cess by 1% and keep a health cess of 1% in the union budget for 2014-15. This would not entail any extra tax burden on the people. The alternate can be an additional health cess which would obviously impact the tax payers.

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