Side-effects of poor public health

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The economic benefits of higher public health outlays have been overlooked. And, growth alone does not improve health outcomes.

India aspires to make full use of its demographic advantage, with 31 per cent of its population under the age of 15. However, a key worry is the poor health status of its population.

This is evident from worrisome health indicators such as an infant mortality rate of 47 per thousand, under-five mortality rate of 59 per thousand and proportion of one-year-old children immunised against measles at just 70 per cent, way below the Millennium Development Goals. Maternal health indicators are more worrisome.

This poor record is a result of woeful inadequacies in government healthcare services, in terms of both physical infrastructure and qualified manpower.

Government neglect

In terms of physical infrastructure, there is a shortage of 19,590 sub-centres, 4,252 primary health centres (PHCs) and 2,115 community health centres (CHCs) in the country, according to Rural Health Statistics (RHS), 2010. On the manpower front, there is a 10 per cent shortage of doctors at PHCs, 62 per cent shortage of specialists at CHCs and 25 per cent shortage of nurses at the PHCs and CHCs. Poor health infrastructure and outcomes are a result of the low priority accorded to public spending on health. Between 1996-97 and 2005-06, government spending as proportion of GDP was stagnant at about 1 per cent. The Union Government introduced the National Rural Health Mission in 2005 to improve health infrastructure in rural areas. Notwithstanding this intervention, public spending on health accounted for a meagre 1.3 per cent of GDP in 2010.

Seen in another way, the share of government expenditure on health as percentage of total government expenditure has been stagnant at 3.6 per cent between 2000 and 2010. The low level of public spending has led to greater dependence on the private sector for healthcare facilities. We find that 80 per cent of doctors, 26 per cent of nurses, 49 per cent of beds and 78 per cent of ambulatory services and 60 per cent of in-patient care are sourced from the private sector.

Further, people bear 70 per cent of the spending on health from their pocket; the government contributes only 30 per cent of the total spending on health.

Poor access

The callous approach of the government towards public health has serious ramifications on the health and wealth of its population.

This can be seen from some startling National Sample Survey statistics. As per NSS figures, 28 per cent of rural
residents and 20 per cent of urban residents have no funds for healthcare. More than 40 per cent of them borrow money or sell assets to pay for their care.

More than 2.2 per cent of the population faces the threat of being pushed into poverty because of hospital expenses.

**Universal coverage**

Rural-urban differences in health resources are also glaring, with 80 per cent of doctors, 75 per cent of dispensaries and 60 per cent of hospitals being situated in urban areas.

Towns and cities have 11.3 qualified physicians per 10,000 population, against 1.9 in rural areas.

It is no surprise that universal health coverage (UHC) eludes India after five and half decades of independence. The Planning Commission constituted a High Level Expert Group (HLEG) in October 2010 to explore the possibility of UHC. The committee under the Chairmanship of Srinath Reddy made a convincing case for UHC in November 2011. Subsequently, the steering committee on health for the 12th Plan endorsed the idea of UHC, and suggested a phased rollout during this period. The committee recommended that cashless and portable UHC be piloted in one district in each State and UT during the first year of the 12th Plan and gradually rolled out thereafter.

To implement UHC, the HLEG had recommended that public spending on health should reach 2.5 per cent by the end of 12th Plan and 3 per cent by 2022 or the end of the 13th Plan.

The draft approach paper to the Twelfth Plan, however, pegs the actual public spending on health at 1.95 per cent of GDP. The projected government spending on health at the end of the 12th Plan is less than the proposed spending of 2 per cent of GDP envisaged in the 11th Plan. The intent to spend on public health is not only lower than previous commitments made by the Government, but much lower than a minimum of 5 per cent of GDP recommended by the World Health Organisation.

**Missed Opportunity**

India missed a good opportunity to create a bias in public spending towards health when the economy was growing at 9 per cent per annum between 2003-04 and 2004-08. Now that growth has significantly decelerated and Central government finances have deteriorated, it is going to be more difficult to earmark a large share of spending on public health.

The macroeconomic benefits of higher public spending on health need to be understood. A study of the empirical relationship between State domestic product, public health expenditure and IMR for 17 major States for the period 2000-2012 suggests that health outcomes are more impacted by public spending on health, than by economic growth rates. Further, the health status of the population significantly affects output. Therefore, higher public spending on health boosts both health and economic outcomes.

The issue of arranging the extra funds for health is considered a constraint. This, however, need not be a problem, when we consider that subsidies account for 3-4 per cent of GDP, whereas public health gets only 1 per cent of GDP.

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