HEALTH CARE IN INDIA DURING THE POST-REFORM PERIOD : AN ANALYSIS

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Abstract

Achieving universal access to healthcare is increasingly being recognised as a basic human right and an essential input to growth and development. However, inadequate access to physical and financial healthcare resources, particularly in the low-income countries such as India, limits the scope for narrowing the 'Know-do' gap. Inadequate opportunities for healthcare transform in to slow economic progress, which, in turn, limits the scope for healthcare oppurtunities.Sub-optimal provision of healthcare has been identified as a factor in the slow progress of the Indian economy in the past.

A higher national income enhances the chance of higher resource availability for healthcare. A higher share of resources for health, in turn, translates in to better health status. The health status is also improved as a result of the likely enlargement of healthcare choices and access by way of newer opportunities, technologies and products brought with it by the growth in the GDP.

The optimism apart, the link between the GDP and health is neither exclusive nor uniform, as growth is not automatically translated in to good health and longetivity.Some countries with a high percapita GNI achieved poor health outcome. Hence an improvement in income is an option for, not the sum total of, health development. Economic growth, while creating greater opportunities for healthcare, may also open the door for hitherto unknown diseases through unhealthy lifestyles and environmental damage. Moreover, a higher economic growth may trigger higher private spending on healthcare even while it boosts public expenditure. The increased private spending need not necessarily be met entirely from an increased private disposable income. And may require considerable debt to fill the gap. Especially if healthcare costs grow faster than private disposable income. Hence, economic reform can be both a panacea and an ill for the health sector, depending on how it is shaped vis-à-vis the health sector.

HEALTH CARE CONTEXT

The Indian health care system was established in 279-236 B.C.The Indian Ayurvedic system is one of the earliest attempts to conceptualise the science of health and to utilise rational methods of diagnosing illness. Western medicine was introduced during the 18th century, essentially to treat British soldiers. But, despite its long history, organised healthcare was confined to the cities during the pre-independence period.

Independent India had a different vision and a different blueprint for the establishment of a post-Independent healthcare system, which was rural-centric, population-based and government-dominant. The establishment of Primary Healthcare Centres sub Centres and Community Health Centres continued till the 1980's, when the first National Health Policy was pronounced. As a result of continuous efforts, the Crude Death Rate declined from 44.4per 1000 people in 1901, to 7.6 in 2005.Infant Mortality Rate(IMR) came down from 140 per 1000

live births in 1975, to 58 in 2005.Consequently life expectancy at birth increased from 23.8 years in 1901,to 67 years in 2005.

Despite its phenomenal success, especially during the post-Independence period, India still lags behind many comparable nations. India also does not get sufficient returns from health investment, though it spends a relatively large share (five per cent) of the GDP on health. Even those countries spending less have a higher life expectancy than India does. The poor rate of return could be attributed to the inefficiency of the system in controlling and managing resources.

Basic Health Indicators-Comparison with the Best (2005)

Health Indicator	India	Global best	Scope for Improvement(%)
Life expectancy at birth(years)	67	82.5	23.1
Under-five mortality(per '000 live births)	74	3.0	95.8
IMR(per '000 live births)	56	2.0	96.4
MMR(per '00,000 live births, year 2000)	540	0.0	100.0
Mortality due to injuries(per 100,000, year 2002)	13	2.0	84.6

India has a considerable distance to travel to catch up. As shown in the table, there exists a huge scope for improvement in the reduction of IMR, the under-five mortality. The Maternal Mortality Rate and Mortality due to injuries. By preventing such deaths, India can hope to enhance its life expectancy by 23.1 percent. However, it is easier said than done, especially when India has some distance to travel even to catch up with other developing nations.

ISSUES OF HEALTH FINANCING

In many low-income countries such as India, healthcare resources are simply insufficient to allow the population to have access to even a basic set of key healthcare interventions. Low-income countries face 56 per cent of the global disease burden, but, they only account for two per cent of global health spending. Annual expenditure in these countries averaged 5.2 per cent of the GDP in 2004, compared to the global average of 6.4 per cent. The per capita health expenditure from all sources, including external assistance, averaged $20.33, falling well short of the bare minimum quantum of resources ($34-$50) required to finance even a minimum set of essential health interventions. Interestingly, the low-spending, low-income countries also received proportionately lower contributions (14.8 per cent of their total health spending) from external resources, compared to other low-income countries (26.7 per cent)

HEALTH SYSTEM STATUS

Health System Indicator	India	Global best	Scope for Improvement
Total health expenditure(%GDP)	5.0	15.4	67.5
Government share in health expenditure (%)	17.3	98.8	82.4
Share of health in total govt. expenditure (%)	2.9	33.4	91.3
Share of external resources in health spending (%)	0.5	59.6	-
Share of out-of –pocket spending in private health expenditure (%)	93.8	16.5	82.4
Births attended by skilled health personnel(%,year 2005-06)	48.0	100.0	52.0

India desires to catch up with the best, it needs to address health system issues. First India's health expenditure is well below the best and even below the global average per cent of the GDP(Table 2).Second, the share of the government in total expenditure, lags behind many countries, India ranks among the bottom five nations. Third, in private health care spending is almost entirely unorganised. Fourth, the proportion of births attended by skilled personnel is low; this calls for greater investment in pregnancy, delivery, maternal and neonatal care.

The major difference between other Asian countries and India lies in the composition of healthcare resources-private resources dominate Indian healthcare scene, whereas the government accounts for the maximum in other countries. The share of the government in health expenditure in India is one of the poorest in the world. The poor government spending is reflected in the poor health outcome.

THE LINK BETWEEN REFORM AND HEALTHCARE

Economic reform is expected to have close linkages with health outcomes through its impact on health risks, the health system, the level and distribution of household income and other sectors closely related to the health sector.

Trade in health services is likely to grow with the rapid increase in trade liberalisation and the increasing use of technological advances. This could facilitate access to a higher level of health care services by the better off. But could also cause neglect of the poor. For instance, access to innovations such as telemedicine is restricted to the educated and rich sections of the population.Similarly,R&D efforts may be directed towards solving the problems of the rich, but with the comparative neglect of the poor. Reform also offers insurers and providers with the means to engineer favourable risk pools to maximize their profits. Thus, reform conflicts with the principles of universal

coverage of health care and shared risk, upheld by the tax-funded health system. The result is a medical poverty trap with more and more people likely to remain untreated.

At the same time, reform also brings unprecedented opportunities to achieve better health, through the development of the health system by enhancing availability, access, utilization, quality of care and affordability. It can happen through various routes such as the budget, trade, privatisation, decentralisation, health knowledge, health promotion, prevention, case management, health system performance and international mobility of health services.

IMPLICATIONS FOR HEALTH

Except during some specific years, when there have been big pushes in favour of health, the Indian approach towards health has been a mere absorber of the reform process initiated elsewhere, rather than effecting its own. Economic reform was no exception and the reform was thrust on the health sector. The Indian health sector accepted the reform without resistance, basically due to the impatient middle class and the private sector.Nevetheless, the real impact of the reform on health care per se is not clearly known. However, indirect signals are now emerging to suggest that human health will get affected in the years to come. For instance, the resource flow to health steadily declined during the 1990s, from 6.1percent of the GDP in 1991 to five per cent in 2004.Though the decline has been steady since 1970, it was more pronounced during the 1990s. The share of the government in health expenditure in the country has come down, about 25 per cent in the early 1990s to 17.3percent in 2004.As a percentage of the government expenditure, the allocation to health declined from 3.1 per cent in 1992-93 to three per cent in 2003-04.The share of health in central government expenditure remained at 1.7 per cent, while the share of the states in health expenditure has come down from five per cent in 1992-93 to 4 per cent in 2003-04.The trend in plan allocation to health indicates that the rate of increase has not matched with even the rate of population growth.

At the state level, the share of health in government expenditure declined during the 1990s,except in Andrapradesh,Karnataka and Tamilnadu. The expenditure of states on health did not show a significant increase because of compelling demands of the non-social sector and the relatively slow- growing fiscal capacity. It is also noticed that the government's allocation to education is larger than the private sectors allocation. In the case of health, it is just the opposite. As a result of declining resources, the programmes designed to improve health conditions of the poor have encountered constraints of funding,resolting in shortages in infrastructure and trained staff, and quantitative and qualitative deficiencies in services.

Private health care expenditure too has been coming down after the reforms. The per capita private expenditure on health and medical care in India, at the 1980-81 constant prices, come down fromRs.44.34 in 1991-92, to Rs.43.7 in 1998-99.The share of health in private disposable income has declined from 2.4 per cent in 1985-86, to 1.5 per cent in 1996-97.While the growth rate of per capita disposable income from 1971 to 1996 was 0.12 per cent, the growth rate of private expenditure on health was mere 0.01 per cent during the same period. The elasticity of private expenditure on health, with respect to private disposable income, was estimated as 0.11 from 1971-1996.

COMMERCIALIZATION OF HEALTHCARE

The Indian health sector has grown in terms of commercial importance since 1991.The background behind the commercialization seems to be the failure of the traditional commercial sectors to yield the requisite profit. Since the profitability in other commercial sectors has come down over a period of time, the developed nations started focusing on service sectors such as healthcare, which is being seen as a sector with great potential for profit. The expansion of non-government sector depends on the opening of markets in the traditional areas of public provision, and the public sector is left to bear the risk for more vulnerable populations, but with the diminished risk-pooling, to finance healthcare.

Medical care in India was handed over to the private sector without mechanism to ensure the quality and standards of treatment, as well as access to services. Not only were the secondary and the tertiary health care sectors deprived of resources, but inevitably the primary healthcare sector also suffered. At the same time, the private investment in public sector and user fee failed to make an impact, either on the efficiency or on the range of services offered to the poor. By increasing the costs of medical care, they made it more difficult to access public sector for those who need help the most.

With the increased emphasis on market processes and competition, the sluggish performance of public healthcare provision has now come under scrutiny. There appears to be a disguised unemployment of health care resources. The inefficiency of the public health care sector affects the rural population and the poor, who utilize the public sector health care more. The justification exists for the location of public facilities in rural areas. But, hospitals, dispensaries and health centres are actually located in urban areas, where only 27.8 per cent of India's population lives. Kerala is the only state where about 60 per cent of the hospital beds are located in rural areas.Inter-state variation in availability of doctors and beds is respectively six and 100 times. State with a higher of medical institutions is found to have an urban bias and a larger proportion of hospitals. As a result of the urban-rural differences in the availability of health care services, the rural population ends up spending a far larger proportion of their income on health than their urban counterparts.

NATIONAL RURAL HEALTH MISSION-A WAY FORWARD

This seven-year (2005-12) mission is a new vehicle of the national government to rebuild the rural health care infrastructure where it is weak. It is a massive nationwide mission targeting 18 states where the rural health care infrastructure is identified as a weak and health status indicators are poor. The mission also serves tribal and under-served areas of other states. One of its major goals is to raise public spending from 0.9 per cent of the GDP to 2-3 per cent of the GDP.It also aims to undertake 'architectural correction' to allow the health systems to absorb the increased allocation to health from the government. Flexible and decentralised planning, community ownership of health care facilities, and provision and maintenance of adequate health care infrastructure are its major tasks in attempts to revamp the rural health care provision.

The National Rural Health Mission is one of the good things to have happened to the health sector since Independence. It is reform=driven from inside with appropriate allocation of resources; the annual budget allocation

to health has increased by 20 per cent since 2005-06.Although it is too early to assess its impact, progress has been patchy with some areas doing really well in enhancing the health care access of the rural population. At present, its functioning appears to be in the hands of whoever is handling it and so, the outcome is as good as the person in-charge at the local level. No scheme can survive if its progress depends solely on officials.Alsom the amount of resources allocated and predicted is too huge, and experts have already questioned its sustainability. Moreover, the mission, like many of the national-level initiatives in this past, seems to be developing a parallel system instead of strengthening the existing one. This approach is expensive and ineffective.However,the drive is there for everyone to see and one can only hope that the spirit, efforts and resources survive longer so that the rural community benefits.

The Indian economic reform has opened up many possibilities in health. It aimed at an improved health status through an increased resource base, made possible by a higher GDP growth and efficient government spending. With increased economic growth taxation and other revenue-raising measures, it was hoped that sectors like health and education would receive a higher share of government resources. The panchayath was to be a prominent vehicle for the government to expand its developmental interventions, including the health system development. With the reforms openly supporting the active growth of the private sector, even in areas such as health, public-private partnerships were to optimally mix the positive potential of the government and the private sectors to benefit the disadvantaged populations.

While the GDP grew at a higher rate, there was no clear evidence of 'saved' resources through higher efficiency. The increased GDP, as in the case of some other countries as well, failed to raise additional government resources for health. On the contrary, government allocation to health declined in relative terms. The private sector increasingly commanded more resources with its dominance extended up to the provision of primary health care. Hence, instead of moving more government resources in to health, the reforms succeeded in moving more government resources in to health, the reforms succeeded in moving the health sector towards the market.

The National Rural Health Mission seems to be a counter attack on the market or on 'commercialization'. Countries like Srilanka and Malaysia. And Indian states like Kerala and Tamilnadu have demonstrated that effective and efficient government provision of health care enhances the physical access to health care, besides eliminating the reliance on out-of-pocket resources and providing a barometer to measure the performance of the private sector. Whether the mission would replace, strengthen, repair or patch-up the damaged rural health care infrastructure, would make an impact on the rural health care scenario and on the government resource availability for health. The panchayaths have provided another dimension to the management of the health system after the mid-1990s.But their role or effectiveness in countering the ill effects of reforms is yet to be ascertained. Even in states like Kerala, where the in government of the panchayaths vis-à-vis the private sector. The role of the private sector in health remains a 'conjecture'.

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