People Power

Public Health Expenditure and Inequity

That economic prosperity and the state of health of a community go together is a self-evident proposition. As global prosperity improved after the Second World War, there has been significant improvement in health indicators. According to the Economist (Dec 20, 2001), between 1960 and 1995, life expectancy in poor countries rose by a remarkable 22 years. Infant mortality, which was around 150 per 1000 live births, fell to 40 on an average.

Just as prosperity improves health, better health promotes economic growth. High incidence of disease forces a society to spend disproportionate sums of money on health care, starving other critical sectors. The plight of many African countries ravaged by AIDS is a testimony to the devastating impact of ill health on a society and economy.

At the level of the individual and family, the impact of poor health on economic wellbeing is even more pronounced. Sickness forces poor families to sell their precious, and often productive, assets to pay for medical care. Poor families in India spend on an average 7 to 8 percent of their annual household income on health care (Charu C Garg: 1998). World Bank studies (Raising the Sights: Better Health System for India's Poor: 2001) show that nearly all private spending for health care is out-of-pocket, and consequently the poor are highly vulnerable to health risks. The poor generally avoid hospitalization because of their inability to pay, and absence of effective risk-pooling (insurance) mechanisms. Not surprisingly, to most of the poor and middle classes hospitalization frequently means financial disaster. As the World Bank documents shows:

- Only ten percent of Indians have some form of insurance, and most of this is inadequate.
- Hospitalized Indians spend more than half (58%) of their total annual expenditure on health care.
- More than 40 percent of those hospitalized borrow money, or sell assets, to cover expenses.
- At least one quarter of hospitalized Indians fall below poverty line because of hospital expenses. This figure is close to 35 percent in UP and Bihar, and below 20 percent in Kerala and Tamil Nadu.

These are horrific statistics in any modern society. Our very claim to being civilized is questionable if we cannot address these problems of inequity in health financing in this day and age.

Evidence from NSS surveys shows that public sector in India accounts for only 19 percent of out-patient care, as opposed to private sector's 81 percent. The only countries with higher proportions of private payments on health than India are countries that have undergone civil conflict and collapse of the public sector, like Georgia, Cambodia, Mynmar and Afghanistan!

From mid 80's to mid 90's, the public sector share of in patient care fell from 60 percent to 45 percent. Yet another well-known inequity in health sector is that rural areas with 73 percent of the population account for only 33 percent of government health resources. Urban population has thus received more than five times what the rural population received in per capita terms! No wonder, the infant mortality rate is 75 per thousand live births, and under-

five mortality 103.7 in villages, whereas the corresponding rates for urban India are 44 and 63 respectively!

Our public health expenditure itself is very low at 0.9 percent of GDP, well below the OECD norm of 5 to 7 percent. More pertinently, the public health expenditure in OECD countries is of the order of 15 to 20 percent of the total government expenditure. In India, the share of public health expenditure is 1.3 percent of the central budget, and 5.5 percent of states' budgets. The weighted average is probably close to 3 percent of the total government expenditure, or less than a fifth of the OECD countries in relative terms. This gives us a measure of the inequity of health services availability in India, and the distance we need to travel if a healthy future is to be ensured to our people.

Privatization and health insurance are not the answers either. In general, insurance coverage is available to only organized sector employees, and a small number of high-income persons. Out of India's 370 million workers, only 8 percent are in the organized sector. The unorganized and poor are unlikely to benefit from centrally organized health insurance services. And yet they are most in need of risk pooling and health coverage. When we realize that even in the US, with the highest per capita health expenditure, about 44 million citizens have no health insurance cover, we can begin to understand the complexity of the problem in India.

Clearly, health sector deserves much higher priority in our budget making and public discourse, even as measures are taken for restoring fiscal health. We need to reinvent the state, reorder priorities, and make public money do much more in critical areas. In mature democracies, not a day passes without public and media attention being focused on health and education policies, or the state of those services. Most elections are fought on education and health care issues. In India, much of our political process and economic debate is divorced from real issues of life and death and empowerment.

The struggle for better health, the fight for accountable democracy, the quest for people's sovereignty, the desire for economic growth, and the urge for best value for public money spent are all inseparable. We are privileged to live in the 21st century, when all these dreams can be realized without great difficulty. But we need to wake up and apply the lessons of past experience to solve our real problems of life and death.

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