

# MAJOR DIMENSIONS OF INEQUALITIES IN INDIA: HEALTHCARE

Dimensions of health inequalities operating in the global South are mostly identified by the inequalities associated with access barriers to healthcare facilities. Health inequalities emerge for a number of reasons - one of the major ones being due to inadequate public health financing and public provisioning of healthcare. The need for public funding in health cannot be overemphasised given that there are large positive externalities<sup>1</sup> associated with such spending. The presence of such positive externalities means that if left to the market, there is a strong likelihood that the wider positive external effects would be ignored<sup>2</sup>. Therefore lack of adequate public provision of healthcare is likely to result in healthcare being socially underprovided as well as the poor being denied access to adequate health care. In other words, public health provisioning is necessary both from efficiency as well as equity point of view. The inequities arising from inadequate provisioning of healthcare facilities in turn are aggravated by the existing disparities based on place of residence (rural - urban), caste, occupation, gender, religion, education entitlements and socioeconomic status.

## **STATUS OF PUBLIC HEALTH IN INDIA AND OTHER BRICSAM COUNTRIES (INCLUDING INDONESIA)**

In general, the status of public health in India is much worse compared to other BRICSAM countries (including Indonesia) (Table 1). What is particularly striking is that despite India having comparable level of income and having registered more or less similar pace of economic growth, the health indicators in India are far inferior compared to those in other BRICSAM countries. India accounts for 21 percent of the global burden of disease (WHS, 2013). It is also home to the greatest burden of maternal, newborn and child deaths in the world. No doubt, over the years, there has been significant reduction in Infant Mortality Rate (IMR) from 83 per 1000 live births in 1990 to 42 per 1000 live births in 2011. Maternal Mortality Ratio (MMR) too has reduced from 570 per 100,000 live births in 1990 to 178 in 2010–2012 (RHS, 2012). However, what needs to be noted is that despite the reductions in these two indicators, in every other indicator, India fares worse in comparison to other BRICSAM countries, except for South Africa<sup>3</sup> in some cases.

<sup>1</sup> If a good or service not only benefits those who purchase these or invest in these but others as well, then there is said to be a positive externality in its consumption. The presence of such external effects means that the social return on investment is higher than the rate of return on private investment.

<sup>2</sup> This is because private investors would not take those social benefits into account when deciding on their investment plans.

<sup>3</sup> It is only in the case of MMR that Indonesia and South Africa fare worse than India.

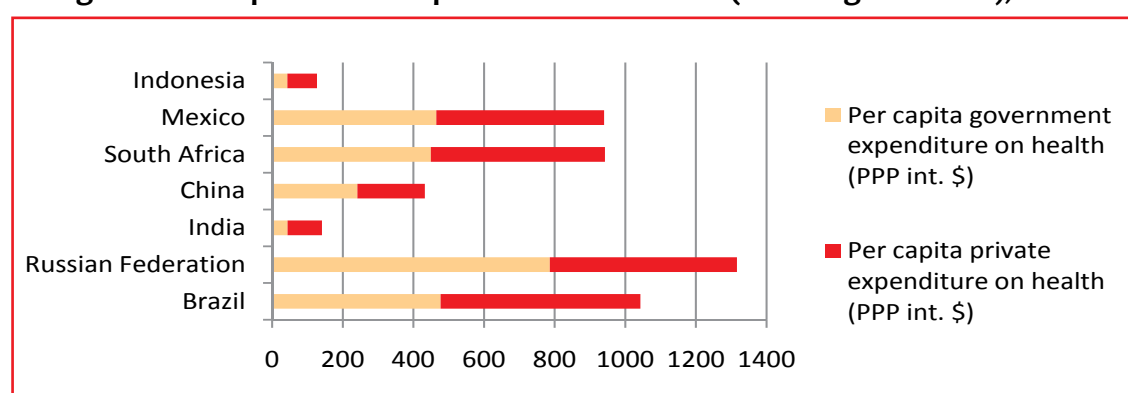
**Table 1: Major Health Indicators across BRICSAM Countries and Indonesia, 2010-12**

Indicator	Brazil	Russian Federation	India*	China	South Africa	Mexico	Indonesia
Births attended by skilled health personnel (%)	98.9	99.6	57.7	96.3	-	95.3	79.8
IMR (per 1000 live births)	21	7	42	13	47	16	21
MMR (per 100,000 live births)	56	34	178	37	300	50	220
TFR (per woman)	1.8	1.5	2.5	1.7	2.4	2.2	2.4
CBR (per 1000 population)	15.1	11.8	21.0	13.4	21.1	18.8	19.6
CDR (per 1000 population)	6.2	14.6	8.0	6.5	11.6	5.4	6.9

Source: Global Health Repository Data, WHO, \*updated India figures are from RHS, 2012 and SRS Bulletin, Census of India

### HEALTH EXPENDITURE ACROSS BRICSAM INCLUDING INDONESIA

The poor health indicators in India reflect the paucities of public health financing and provisioning in the country. India ranks at the bottom among the BRICSAM (including Indonesia) countries in terms of the level of per capita public health spending. Despite some increase in per capita health spending in the 2000s, the country's per capita health spending was only about Int. \$ 123 in 2010-11, of which government expenditure was Int. \$ 36. Even in the case of Indonesia, which fares equally poorly in terms of per capita spending on health, per capita public expenditure of around Int. \$ 44 in 2010-11 was higher than that of India (Figure 1)<sup>4</sup>.

**Figure 1: Per Capita Health Expenditure in BRICSAM (including Indonesia), 2010-11**

Source: World Health Statistics, 2013, WHO

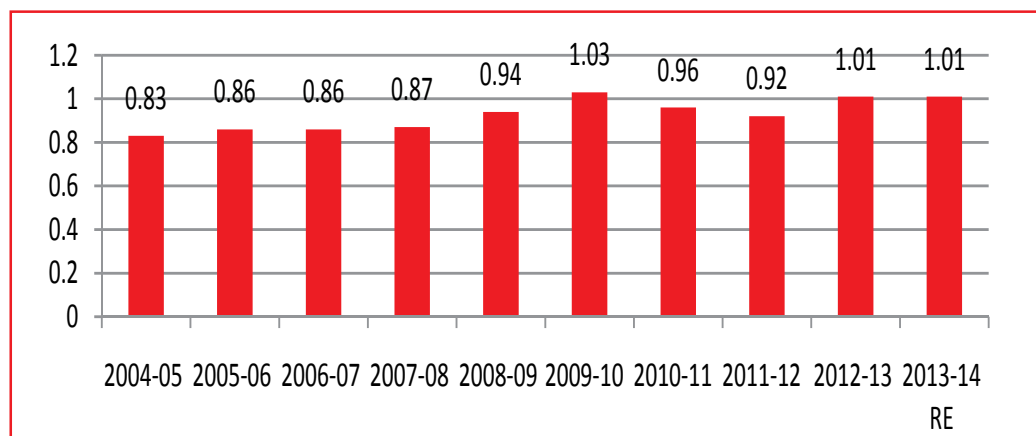
Government spending on healthcare in India has been below the required levels for a long time. As a proportion of GDP, India's public spending on health, after increasing in the period up to the mid-1980s, stagnated thereafter (in the period 1995–2005), and stood at a mere 0.86 percent of GDP in 2005-06. This is considered to be among the lowest in the world.

Post 2005, with the implementation of the National Rural Health Mission (NRHM) in India (which envisages provisioning universal healthcare facilities), the level of public

<sup>4</sup> AK Shiva Kumar, Lincoln C Chen, Mita Choudhury, Shibam Ganju, Vijay Mahajan, Amarjeet Sinha, Abhijit Sen, (2011) Financing health care for all: challenges and opportunities, Lancet, Volume 377, No. 9766, p668–679, 19 February

spending on health has gone up marginally but it still falls far short of 3 percent of GDP, as demanded by the People’s Health Movement (Figure 2)<sup>5</sup>.

**Figure 2: Public Health Expenditure as Percentage of GDP, India**

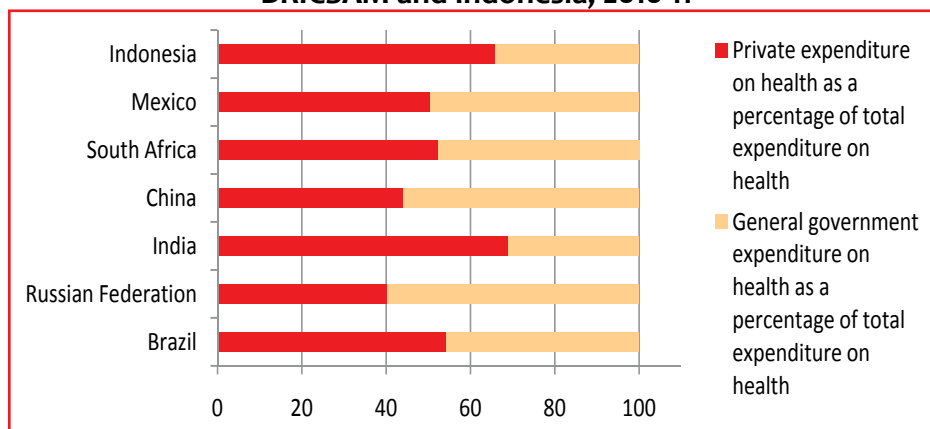


Source: Union Budget Documents, RBI State Finances, various years

Such low level of public expenditure means that health expenditure in India is dominated by private spending. For instance, in 2011-12, while the total expenditure on health was 4.2 percent of GDP, of that, public expenditure was only 1.01 percent of GDP. In other words, nearly 70 percent of the expenditure was out-of-pocket. This is inherently regressive and puts a disproportionate burden of healthcare on the poorer sections<sup>6</sup>.

The abysmally low share of public expenditure on health and the resultant high share of private expenditure on health (and the high incidence of out-of-pocket expenditure) in India have been captured in Figure 3. Clearly, among the BRICSAM countries (including Indonesia), India has one of the lowest ratios of public to private health expenditure, followed by Indonesia and Brazil.

**Figure 3: Share of Public and Private Spending in Health in BRICSAM and Indonesia, 2010-11**



Source: WHO, World Health Statistics, 2013

<sup>5</sup> GOI, 2005, “National Rural Health Mission, Mission Document (2005-12)”, Ministry of Health and Family Welfare, Government of India, New Delhi, see NRHM web site: <http://mohfw.nic.in/NRHM.htm>.

<sup>6</sup> This is discussed briefly in the subsequent section on ‘rising costs of healthcare’.

While healthcare spending for the US and the UK are 15 per cent and 8.5 per cent of their overall expenditure respectively, the corresponding values for BRICSAM hover around only 5 per cent. It is evident that BRICSAM including Indonesia as a whole spend much less on healthcare than the developed nations and within that India fares much worse.

### INEQUALITIES IN HEALTH OUTCOMES AND INFRASTRUCTURE ACROSS STATES

There are sharp inter-state differences in health outputs and outcomes. Several factors, such as the income level of the state, priority accorded to health in the state budget, etc., influence health outcomes and availability of health infrastructures. An overview of the existing health infrastructure and the shortfalls from the requisite norms for both logistical as well as human resource requirements has been provided in the table below. In general, the four southern states have fared better in terms of access to healthcare facilities compared to the rest of the country. Infrastructural gaps are observed to be more in states like Bihar, Madhya Pradesh, Chhattisgarh, Rajasthan and Jharkhand, which have lagged behind others in terms of health outcomes. Similar situation is observed in terms of human resource necessities, especially for specialists at the Community Health Centres (CHCs). Although fresh recruitments of trained health workers, such as Auxiliary Nurse Midwife (ANMs), and specialist doctors have taken place, substantial gaps still remain. In urbanised states like Maharashtra, Karnataka, Haryana, there is also a shortage of doctors at the Primary Health Centre (PHC) level. While the Accredited Social Health Activists (ASHA) have been employed in large numbers and are being trained and female health workers/ANMs are in surplus, it is a problem of skilled healthcare professionals that plague the PHCs and CHCs at the District and Block levels. Table 2 clearly shows that states with poor infrastructure are also the ones which are burdened with low health outcomes.

**Table 2: Health Outcomes, Infrastructure Shortage and Human Resource Shortage: Variation by States, 2012**

States	IMR	MMR	TFR	% of fully immunised children	Shortage of PHCs (%)	Shortage of CHCs (%)	Shortage of doctors at PHCs (%)	Shortage of specialists at CHCs (%)
Andhra Pradesh	41	110	1.8	68.0	19.0	44	-	69
Assam	55	328	2.5	59.1	-	54	-	72
Bihar	43	219	3.7	49.0	40.0	91	-	46
Chhattisgarh	47	230	2.8	57.3	3.0	23	40.1	88
Delhi	25	104	1.9	71.5	62.0	-	-	-
Gujarat	38	122	2.5	56.6	19.0	11	19.4	94
Haryana	42	146	2.3	71.7	32.0	34	47.4	93
Jharkhand	38	219	3	59.7	66.0	22	-	89
Karnataka	32	144	2	78.0	-	50	64.1	31
Kerala	12	66	1.8	81.5	-	-49	-	11

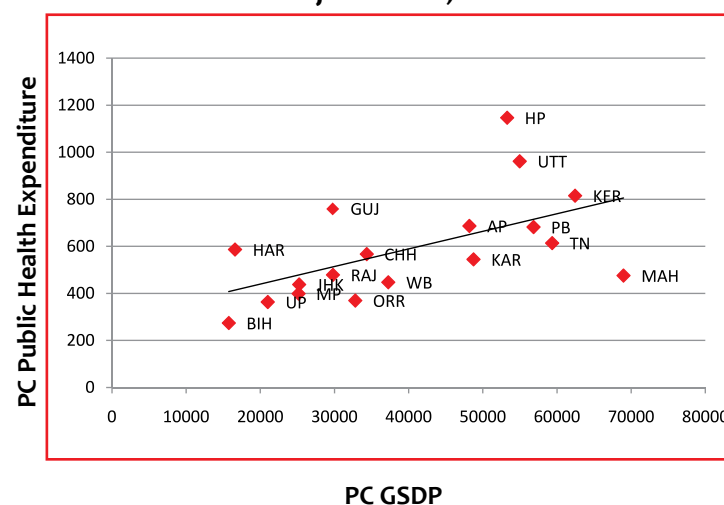
Maharashtra	25	87	3.2	78.6	42.0	34	43.3	65
Madhya Pradesh	56	230	1.9	42.9	17.0	33	-	80
Odisha	53	235	2.3	59.5	6.0	-15	-25.2	79
Punjab	28	155	1.8	83.6	22.0	8	-	47
Rajasthan	49	255	3.1	53.8	34.0	34	-	90
Tamil Nadu	21	90	1.7	77.3	2.0	-23	-	-
Uttar Pradesh	53	292	3.5	40.9	29.0	60	146.7	78
West Bengal	32	117	1.8	64.9	58.0	36	-	87
India	42	178	2.5	61.0	26.0	37	60.7	70

Source: RHS, 2012, SRS Bulletin, Census of India

### UNEQUAL EXPENDITURE PATTERNS ACROSS STATES

According to the Constitution of India, health is a state subject and therefore the responsibility of provisioning for healthcare rests mainly upon the states. However, health expenditures are marked with severe inter-state disparities. This is a continuation of the earlier trends whereby some states undertook high expenditure on health, e.g. the four southern states, but most others neglected the sector in order to meet the Fiscal Regulation and Budget Management (FRBM) legislations and other requirements to control the fiscal deficit. Further, barring a few states, most have not prioritised health expenditure. While this was mostly true for the low income states, even certain high income states spent negligible proportion for health provisioning. Figure 4 shows that apart from Himachal Pradesh and Uttarakhand which have high per capita GDP and commensurately high per capita spending on health, states like Maharashtra, Haryana and Karnataka show reverse trends. However states like Kerala, Tamil Nadu and Andhra Pradesh show high per capita health expenditure as against moderate per capita GDP.

**Figure 4: Per Capita Public Health Expenditure and Per Capita GDP in 18 Major States, 2011-12**

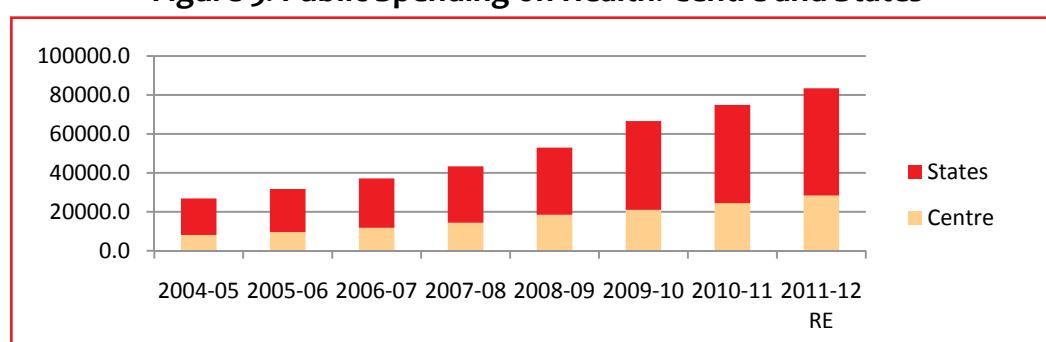


AP - Andhra Pradesh, BIH – Bihar, CHH - Chhattisgarh, GUJ- Gujarat, HAR- Haryana, HP -Himachal Pradesh, JHK - Jharkhand, KAR – Karnataka, KER -Kerala, MAH - Maharashtra, MP - Madhya Pradesh, ODI- Odisha, PB - Punjab, RAJ – Rajasthan, TN - Tamil Nadu, UP - Uttar Pradesh, UTT - Uttarakhand, WB - West Bengal

Source: Union Budget Documents, 2012-13, RBI State Finances, 2012-13, National Account Statistics, 2012-13 and census of India 2011.

However, during the period of the NRHM, there has been a change in this trend. The states, as part of the requirements for implementing NRHM, had to provide a matching grant of 25 percent of the total NRHM allocations. As a consequence, state budgets for health increased (Figure 5).

**Figure 5: Public Spending on Health: Centre and States**



Source: RBI State Finances, Union Budget Documents, Various Years

The overall increase in the share of state spending in total public health expenditure notwithstanding, severe inter-state disparities continue to remain. As Table 3 below reveals, in 2011-12 too (as in 2004-05), the difference between the amounts of per capita public health spending for Kerala on the one hand, and Bihar on the other, continues to remain very high. Clearly, these differences also show in health outcomes and health infrastructure gaps in the two states. In general, states which have prioritised health spending over a relatively longer period of time (reflected in their per capita health spending relative to other states), tend to show better health outcomes. One of the reasons for this is that in the absence of a reasonably well-funded public health system that provides access to preventive and curative services, citizens are forced to depend on private providers. As a result, ability to pay becomes the key determinant of healthcare use. The high out-of-pocket expenditure that this entails, works against the health outcomes of poorer states.

**Table 3: Per Capita Public Health Spending and Selected Indicators of Health Outcomes, Infrastructural Shortage in 14 Most Populous States, 2011–12**

States	Per capita public health spending, 2004-05 (in Rs.)	Per capita public health spending, 2011-12 (in Rs.)	% of fully immunised children	MMR	Shortage of CHCs (%)	Shortage of specialists at CHCs (%)
Kerala	287	815	81.5	66	-49	11
Gujarat	198	761	56.6	122	11	94

Andhra Pradesh	191	687	68	110	44	69
Punjab	247	682	83.6	155	8	47
Tamil Nadu	223	614	77.3	90	-23	-
Haryana	203	586	71.7	146	34	93
Karnataka	233	545	78	144	50	31
Rajasthan	186	479	53.8	255	34	90
Maharashtra	204	476	78.6	87	34	65
West Bengal	173	447	64.9	117	36	87
Madhya Pradesh	145	399	42.9	230	33	80
Odisha	183	369	59.5	235	-15	79
Uttar Pradesh	128	363	40.9	292	60	78
Bihar	93	274	49	219	91	46

Note: States are ranked in descending order of per person public health spending in 2011-12.

Source: RHS, 2012, SRS Bulletin, Census of India, Union Budget Documents, RBI State Finances, various years.

Besides, it has also been observed in the recent past that due to the additional central spending on health, many states have diverted their health spending to other sectors. As a result, the central funds for health, instead of being *in addition* to existing state budgets, have ended up *replacing* parts of state spending.

### RISING COSTS OF HEALTHCARE

Apart from adequacy of public provisioning both at the state and central level, as discussed above, out-of-pocket expenditure on health, as a proportion of household expenditure, has increased over time, in both rural and urban areas. This has direct implications on poverty levels of households, particularly the poorer households. A study by Balarajan, Selvaraj and Subramaniam (2011) had shown that the proportion of expenditure on health has increased more for the poorest households. The financial burden of both inpatient and outpatient care has been consistently rising with rapid increase in inpatient expenditures per admission. Hospitalisation has also become more expensive; hospitalised Indians spend 48 percent of total annual expenditures/savings on healthcare. Expenditures on medicines account for the largest burden of inpatient treatment cost. Drugs, diagnostic tests and medical appliances account for more than half of out-of-pocket expenditures<sup>7</sup>.

Health spending inflation is another major factor constraining access to health services and equity in financing. These financial constraints of healthcare do not include the additional costs associated with seeking care, such as the opportunity costs of forgone wages, transportation, childcare, or the loss of earnings due to ill-health. The implications of these additional costs disproportionately impact poorer households' capacity to seek care.

All the above factors, namely the inadequacies of public provisioning, variations in expenditure on health across states as well as inflation in healthcare spending, would

<sup>7</sup> Yarlini Balarajan, S Selvaraj and S V Subramanian (2011), Health care and equity in India, *Lancet*, 377(9764): 505-515, Feb 5.

continue to aggravate health inequalities unless provisioning of healthcare facilities meet the desired levels. Given the extent of access barriers to health, universalisation of healthcare facilities with an aim to address the persisting inequalities would require substantial public spending on health budgets of both centre and states. However, this is not to argue that healthcare differences are caused solely due to unequal health budgets across the states. The inadequacies in the healthcare outcomes are additionally related to other infrastructural requirements such as access to education, water & sanitation facilities, improved communication, infrastructure and adequate livelihood opportunities. It is also linked to rising inflation.

Further, in order to demand equity in health and better quality healthcare at reasonable costs, it becomes important to highlight that multilaterals, national and local government, NGOs, the private sector, pharmaceutical industry and all research and academic need to engage, empower and build capacity within the larger civil society.

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**THE AUTHOR ACKNOWLEDGES EDITORIAL INPUTS BY MALINI CHAKRAVARTY**

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PUBLISHED BY:



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