Health Care Services in India:

Problems and Prospects

B. S. Ghuman*

Akshat Mehta**

International Conference

On

The Asian Social Protection in Comparative Perspective

At

National University of Singapore, Singapore, 7-9 January, 2009

* Dean, Faculty of Arts & Professor, Department of Public Administration, Panjab University, Chandigarh – 160 014, India. E-mail: ghumanbs@pu.ac.in

** Lecturer, Police Administration, Centre for Emerging Areas in Social Sciences, Aruna Ranjit Chandra Hall, Room No. 201, First Floor, Panjab University, Chandigarh – 160 014, India. E-mail: akshat_humane@yahoo.co.in

Abstract

This paper examines the problems and prospects of health care services in India. India as a nation has been growing economically at a rapid pace particularly after the advent of New Economic Policy of 1991. However, this rapid economic development has not been accompanied by social development particularly health sector development. Health sector has been accorded very low priority in terms of allocation of resources. Public expenditure on health is less than 1 per cent of GDP in India. It has further witnessed decline during the post economic liberalization period. The meagre resource allocation to health sector has adversely affected both access and quality of health services. The unequal access to health services is reported across strata, gender and location (i.e. urban and rural areas). With a view to improve access and quality of health services, government should enhance public spending on health sector in the vicinity of 3 per cent of GDP.

Key Words:

1. Health Care Services;
2. Public Expenditure on Health;
3. Rural-Urban Divide.

Health Care Services in India: Problems and Prospects

Economic and social development are complimentary to each other. Empirical evidence suggests that mere emphasis on economic development and neglect of social development results in lopsided development and ultimately slowing down the tempo of economic development. The top priority accorded to economic sector and marginal policy attention to social sectors like education and health results in economic prosperity accompanied by social poverty. Social poverty particularly in the fields like education and health finally eclipses economic development and ultimately quality of life. A balanced strategy of allocating resources between economic and social sectors, thus, is very essential policy decision for a developing country like India. Assigning adequate priority to social sectors has also become non-negotiable in the light of knowledge emerging as a new found source of economic growth and also reaping the benefits of 'demographic dividends' which India has in form of a largest number of population in the working age group (15 to 64 years). It is in this backdrop of growing importance of health service that the present paper has been initiated.

The paper has been divided into three parts. Part I of the paper mentions the objectives, hypotheses and research methodology. Major findings of the study have been described in Part II. In the last, Part III of the study puts forth policy recommendations.

I

Objectives, Hypotheses and Research Methodology

Objectives:

The present paper aims to examine the problems and prospects of health services in India. The specific objectives of the study are as under:

(i) to examine the status and problems of health services in India;

(ii) to study the access of health services across economic strata, gender and space;

(iii) to examine the quality of health services in India; and

(iv) to suggest appropriate recommendations to revamp health policy and institutional mechanisms to improve access and quality of health services particularly for the excluded segments of society.

Hypotheses:

The hypotheses of the study are as under:

(i) Health services in India have not been accorded adequate priority in allocation of public funds.

(ii) Health services are unevenly distributed across economic strata, location, (urban-rural), gender and regions in India.

(iii) Commercialization and privatization of health services particularly after the post-Liberalization, Privatization and Globalization era has resulted in excluding a sizeable number of population particularly, socially disadvantaged groups like SCs, STs, Women and Poor from the coverage of health services provided by the organized sector.

(iv) Inadequate infrastructure, manpower and medicines adversely affect the provision and quality of health services of public organizations.

Research Methodology:

The paper largely depends upon secondary sources of data. The various sources of data include reports of the Union Ministry of Health and Family Welfare, the National Planning Commission, National Rural Health Mission, National Health Policies (1983 and 2002), Reports of the Nine Expert Committees constituted by the Government of India, etc. Primary data from an ongoing Project undertaken by the authors has also been used to supplement the findings arrived at from the secondary data. The research project relates to Muktsar District of Punjab State in India. Data about health services has been collected from 352 households comprising 300 from the rural areas and 52 from the urban areas. For data analysis the suitable statistical techniques have been used.

II

Major Findings

Major Findings:

India has entered a high growth rate trajectory of 9 per cent. This high rate of growth, however, is not accompanied by a high level of social development. The social sectors particularly health and education have been accorded a very low priority in terms of the allocation of resources. For example, public expenditure on health services as a percentage of Gross Domestic Product (GDP) in India is less than 1 per cent (See Table 1) likely to be one of the lowest across the globe.

Table 1
Trends in Health Expenditure in India
(GDP is at Market Price, with Base Year 1993-94)

Year	Health Expenditure as % of the GDP		
	Revenue	Capital	Total
1950-51	0.22	NA	0.22
1955-56	0.49	NA	0.49
1960-61	0.63	NA	0.63
1965-66	0.61	NA	0.61
1970-71	0.74	NA	0.74
1975-76	0.73	0.08	0.81
1980-81	0.83	0.09	0.91
1985-86	0.96	0.09	1.05
1990-91	0.89	0.06	0.96
1995-96	0.82	0.06	0.88
2000-01	0.86	0.04	0.90
2001-02	0.79	0.04	0.83
2002-03	0.82	0.04	0.86
2003-04	0.86	0.06	0.91

Sources: Estimated from the 52nd Round of the NSS, using 2001 Population Census and applying growth rates worked out from the 50th and 55th rounds of the NSS: Rao, et al., 2005.

Health sector suffered more during post-liberalization period. Economic Liberalization policy was introduced in India during the middle of 1991. The major thrust of economic liberalization is to give more leverage to market forces so far allocation of resources among various sectors of the economy is concerned. In the pre-liberalization period of independent India, the health expenditure as percentage of

the GDP increased as a whole from 0.22% in 1950-51 to 0.96% in 1990-91. However, it has seen a steady decline ever since in the Post-Liberalization period from 0.96 % in 1990-91 to 0.91% in 2003-2004.

It is not only that India spends very low proportion of its GDP on public health services, another problem is the wide ranging regional variations in expenditure on public health services is also reported.

A comparison of inter-state variations in expenditure on health suggests that Rajasthan spent 5.75 % of its budget on health, whereas it was only 3.63% in case of Gujarat in 2003-2004 (See Table 2). The State wise expenditure on health also reveals that the share of health sector in the overall budget has been declining over time. For example all the States spent 7.02% of their budget on health in 1985-86, which declined to 5.72% in 1991-92 and further to 4.97% in 2003-04.

Table 2
Share of Health in Revenue Budget of Major States (in %)

S. No.	States	Years				
		1985-86	1991-92	1995-96	1999-2000	2003-04 (B.E.)
1.	**Andhra Pradesh**	6.41	5.77	5.70	6.09	5.21
2.	**Assam**	6.75	6.61	6.08	5.25	4.39
3.	**Bihar**	5.68	5.65	7.80	6.30	4.84
4.	**Gujarat**	7.45	5.42	5.34	5.21	3.68
5.	**Haryana**	6.24	4.19	2.99	4.08	3.63
6.	**Karnataka**	6.55	5.94	5.85	5.70	4.85
7.	**Kerala**	7.69	6.92	6.81	5.95	5.42
8.	**Maharashtra**	6.05	5.25	5.18	4.59	4.39
9.	**Madhya Pradesh**	6.63	5.66	5.07	5.18	4.89
10.	**Orissa**	7.38	5.94	5.42	5.03	4.47
11.	**Punjab**	7.19	4.32	4.56	5.34	4.27
12.	**Rajasthan**	8.10	6.85	6.18	6.39	5.75
13.	**Tamil Nadu**	7.47	4.82	6.40	5.51	5.26
14.	**Uttar Pradesh**	7.67	6.00	5.73	4.42	5.13
15.	**West Bengal**	8.90	7.31	7.16	6.30	5.23
16.	**All States**	7.02	5.72	5.70	5.48	4.97

Source: Rao, et al., 2005

Low public sector spending on health services results in over-dependence on private sector for getting health services. In India the share of private sector on health care expenditure constitutes around 72 % and household sector being the major constituent of the private sector claims 68.8% of expenditure on health care (Table 3). In other words out-of-pocket expenditure comprises major share of expenditure on health care. All the three layers of governments (federal, state and local) spend only 23.8 per cent of the total expenditure on health services. NGO sector is almost non-existent in terms of spending on health services. Its share is only 0.3 per cent.

Table 3
Sources of Finance in the Health Sector in India during 2001-2002

	Private		Government			Public		NGOs	External Funds
	Households	Private Firms	Central	State	Local	Firms	Sector Banks		
Health Spending	68.8 %	3%	7.2%	14.4%	2.2%	3%	0.2%	0.3%	2%
Total	**71.8%**		**23.8%**			**3.2%**		**0.3%**	**2%**

Source: Rao, et al., 2005

The results of a recently concluded study in Muktsar District of Punjab State in Indian corroborate over dependence on private health service providers. Both in the rural and urban areas of Muktsar District majority of the people depend upon private health service providers. For example out of 352 respondents, 276 respondents constituting 78.41 per cent of the total use health services of the private sectors (See Table 4). In rural areas 75.7 per cent of the respondents and in urban areas 95.5 per cent respondents prefer to visit private health agency for treatment (Panjab University, 2008).

Table 4
Choice of Health Agency by Ownership

Respondents	Private	Public	Total
Rural	227 (75.66)	73 (24.33)	**300**
Urban	49(94.23)	03 (5.77)	**52**
Total	276 (78.41)	76 (21.59)	**352**

Source: Field Survey, Panjab University, 2008
Figures in Parentheses are Percentages

Over dependence on private sector has resulted in glaring disparities in the distribution of health services between rich and poor. According to Rao, “while

taxation is considered the most equitable system of financing, as tax is a means of mobilizing resources from the richer sections to finance the health needs of the poor, out-of-pocket expenditures, the poor, who have the greater probability of falling ill due to poor nutrition, unhealthy living conditions, etc. pay proportionately more on health than the rich and access to health care is dependent on ability to pay" (Rao, et al., 2005).

It is not only that distribution of health services are skewed across strata, skewness in their distribution is also found while studying Rural-urban access to health services in India. For example, in rural India there are 0.2 hospital beds per thousand population as against 3.0 in urban areas (See Table 5).

Table 5
Rural-Urban Divide in Health Services in India

S. No.	Characteristics	Rural (per 1000 population)	Urban (per 1000 population)
1.	Hospital Beds	0.2	3.0
2.	Doctors	0.6	3.4
3.	Public Expenditures	Rs. 80, 000	Rs. 5, 60, 000
4.	Out of Pocket	Rs. 7, 50, 000	Rs. 1, 150, 000
5.	Infant Mortality Rate (IMR)	74/1000 Live Births	44/1000 Live Births
6.	Under Five Mortality Rate (U5MR)	133/1000 Live Births	87/1000 Live Births
7.	Births Attended	33.5%	73.3%
8.	Full Immunization	37%	61%

Source: Jhilam Rudra De (2008)

Similarly in rural areas there are only 0.6 doctors per 1000 population, which is as high as 3.4 in urban areas. Rural-urban disparities are equally pronounced on account of outcome of health services. For instance Infant Mortality Rate (IMR) in rural areas in 74 per one thousand live births which is about 44 per thousand live births in urban areas. Similarly Under-Five Mortality Rate (U5MR) is 137 per thousand live births in rural areas and 87 per thousand live births in urban areas (De, 2008).

The Government of India has taken a new massive policy initiative known as National Rural Health Mission (NRHM) to reduce the divide between urban and rural areas in the field of health. The major objectives of NRHM are to improve the availability of and access to quality health care by people, especially for those residing in rural areas,

the poor, women and children (NRHM, 2005). The pace of implementation of the Mission is very slow. Garg and Nath have opined that the progress of the Mission in Uttar Pradesh, one of the most populous states is very dismal. In NRHM, Accredited Social Health Activist (ASHA) is the key player, whose role is to work as an interface between the community and the public health system. In case of Uttar Pradesh, the performance on account of ASHAs is very discouraging. The State has selected only 9,548 ASHAs against the target of 65, 000. Unfortunately, the State has not made any arrangement for their training. In most of the other States also the progress of NRHM is very tardy. In India as a whole out of the total 228,327 ASHAs proposed to be selected; only 145,546 ASHAs were selected (Garg and Nath, 2007).

A government-funded review of NRHM also revealed its slow progress. The major problems in the implementation of the NRHM are: administrative constraints, governance issues, inadequacies in human resources as well as the poor investment in public health services in the recent past (Shrivastava, 2008).

Commercialization and privatization of health services and introduction of users' charges in pubic health institutions during post-globalization phase have excluded a sizeable number of population particularly belonging to socially disadvantaged groups and poor from the coverage of health services provided by organised sector.

An earlier study by the authors has found that since the start of economic liberalization, privatization, and globalization in the 1990s, the Punjab government had introduced two drastic reforms in health policy. First policy decision was the significant opening of health-care services to the private corporate sector. Private sector hospitals were given land and facilities at concessional rates and were expected in return to provide free treatment to yellow card holders (people below the poverty line) – up to 10 per cent of outpatients and 5 per cent of inpatients. The second policy decision was that the Punjab Government set up the Punjab Health Systems Corporation (PHSC) in October 1995, under the World Bank-sponsored State Health Systems Development Project II, and transferred more than 150 health-care institutions run by the government to PHSC. To mobilize more resources, the hospitals no longer provided free services and instead charged all patients a user fee, barring few categories of patients including people below the poverty line. It was

revealed in the study that only a negligible proportion of people below poverty line availed themselves of exemptions from user charges at government hospitals. According to field survey ignorance among the poor about free treatment and the complex and cumbersome procedure were constraining the access of the poor to the health care services (Ghuman and Mehta, 2006).

The unequal access to health services has succinctly been stated by the 11th Five Year Plan of India (2007-2012), "… there is also a divide between those who have access to essential services such as health, education, drinking water, sanitation, etc, and those who do not. Groups which have hitherto been excluded from our society such as Scheduled Castes (SCs), Scheduled Tribes (STs) and some minorities and Other Backward Classes (OBCs), continue to lag behind the rest" (Planning Commission, 2006).

Gender disparities in health services are also very acute and deserve special attention of the policy makers. Gender disparities are found on account of utilisation of health services both for in-patient and out-patient care. National Sample Survey Organization (NSSO) data reveal that in the rural areas the money spent per illness episode for outpatient care was Rs. 151 and Rs. 137 respectively for male and female. The respective amounts for urban areas were Rs. 187 and Rs. 164. Gender variation is expenditure spent for in-patient care is also reported (Saha and Ravindran, 2002). Glaring spatial disparities in health services and their outcomes are also found particularly in rural India (Kathuria and Sankar, 2005).

In addition to inequity in health services, the quality of health services and governance of public health organizations are also matter of concern. First the infrastructural facilities are inadequate followed by their poor maintenance. Secondly most of public health institutions are understaffed accompanied by a high absence rate among the personnel. Thirdly, medicines are normally not available in the health institutions (Dreze, 2004).

The study of Muktsar District (Panjab University, 2008) has revealed that inadequate infrastructure, manpower and medicines adversely affect the provision and quality of health services of public organizations. The field survey reveals that there is a huge

shortage of manpower in the district with only 633 medical staff at present against around 3100 required. The high degree of absenteeism of doctors and paramedical staff particularly in rural areas further aggravates the situation from bad to worse. The performance of health institutions on account of infrastructure including condition of buildings, water supply, toilets, 24x7 safe delivery, labour room, staff quarters at Sub Centre and Primary Health Centre level was far from satisfactory (See Table 6).

Table 6
Status of Infrastructural Facilities at Health Institutions in Muktsar District

Health Institutions	Condition of the Building	Availability of Labour Room	24x7 Safe Delivery	Availability of Water Supply	Availability of Toilets	Availability of Staff Quarters
Sub Centres	96.2%	1.96%	None	96.2%	21.6%	21%
Primary Health Centres	36.8%	10.5%	None	26.3%	42.1%	Nil
Community Health Centres	100%	100%	-	100%	100%	100%
Rural Hospital	100%	100%	-	100%	100%	70 Quarters
Sub Divisional Hospital	100%	100%	-	100%	100%	100%
District Hospital	100%	100%	-	100%	100%	100%

Source: Government of Punjab (2007), *State Health Facility Survey Report*, December, EPOS Health India, Pvt. Ltd., Gurgaon.

The emergency room/casualty room, separate wards for males and females, availability of x-ray facilities, ultrasound, cardiac monitor for Operation Theatre, ECG, number of beds available, operation theatre, telephone, computer, generator/inverter, lift and vertical transport facility, staff quarters, and vehicle, facilities were also inadequate in some of the institutions. Absence of testing facilities undermine the utility of rural hospitals and compel the patients to travel long distance for getting the treatment from hospitals well equipped with these facilities. It is lamented that availability of equipment is very poor in public health institutions in

Muktsar district. The ill-equipped equipments have failed in delivering good quality health services to the people (See Table 7).

Table 7
Average Availability of Equipments at Health Institutions in Muktsar District as per IPHS Norms

Health Institutions	IPHS Norms For Equipments	Average Availability of Equipments	Gap with IPHS Norms
Sub Centres	55	23	**32**
Primary Health Centres	99	7.9	**91.1**
Community Health Centres	236	67.3	**168.7**
Rural Hospitals	236	40	**196**

Source: Government of Punjab (2007), *State Health Facility Survey Report*, December, EPOS Health India, Pvt. Ltd., Gurgaon.

The empirical evidence suggests that availability of drugs in practice is far less than the drugs prescribed by the IPHS norms (See Table 8).

Table 8
Availability of Drugs at Primary Health Centres, Community Health Centres and Rural Hospitals in Muktsar

Health Institutions	IPHS Norms for Drug Availability	Average Availability of Drugs in Muktsar District	Gap with IPHS Norms
Primary Health Centres	236	23.1	**212.9**
Community Health Centres	70	20	**50**
Rural Hospitals	70	14	**56**

Source: Government of Punjab (2007), *State Health Facility Survey Report*, December, EPOS Health India, Pvt. Ltd., Gurgaon.

III

Policy Recommendations

With a view to take optimal advantage of demographic dividends and knowledge as a source of growth, it is essential to improve quality of human resources. For enhancing quality of human resources through health sector the following policy recommendations have been made:

First very meagre funds are allocated to health sector in India. It is recommended that level of public expenditure on health in India should be enhanced considerably. Most of the policy documents including National Health Policy, 2002; and the National Rural Health Mission (205-2012) have recommended to increase health expenditure to around 3 per cent of GDP (Choudhury, 2006). This recommendation should be adopted with immediate effect.

Secondly, it is recommended to reduce regional disparities in the provision of health services. With a view to ensure minimum health services across states a study undertaken by the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Government of India (Rao, et al., 2005) has recommended expenditure on basic health services State wise. Poor and backward states lagging behind need quantum jump in the level of funding of health services. The study has recommended that expenditure on health services should be stepped up to the level of 5 per cent of State Domestic Product in most backward states like Bihar and Jharkhand, 3.65 per cent in case of Orissa and finally 1.1 per cent in case of an industrially advanced state like Gujarat.

Thirdly, with a view to reduce rural-urban divide in the provision of health services, the government of India has launched a programme known as National Rural Health Mission (NRHM). The pace of implementation of the Mission is very slow. It is suggested that the implementation of this mission should be speeded up so that the access to health services by the rural people in general and poor in particular gets improved.

For improving the quality of health services the government on priority basis should fill all the vacant posts of medical personnel particularly doctors and nurses, improve the quality of infrastructure and availability of medicines.

Private sector has emerged as the major provider of health services in India. With a view to control private sector on account of price, quality of services, unethical practices, it is recommended to evolve an effective regulatory mechanism.

References

Choudhury, Mita. (2006). Public Spending on Health in Low-Income States and Central Transfers. *Financing Human Development Policy Brief* (No. 1, September, 2006). Retreived December 5, 2008, from National Institute of Public Finance and Policy Web site: http://www.nipfp.org.in/tapasreport/Policy%20Brief-1.pdf.

De, Jhilam Rudra. (2008). Strategies to Cope Up With Disparities in Health Services in India. June 4. Retrieved December 5, 2008, from Indian MBA Web site: http://www.indianmba.com/Faculty_Column?FC834/fc834.html.

Dreze, Jean. (2004). Health Checkup. *The Hindu*. March 12.

Garg S, Nath A. (2007). Current Status of National Rural Health Mission. *Indian Journal of Community Medicine* (Vol. 32, No. 3, pp. 171-172). Retrieved December 5, 2008, from: http://www.ijcm.org.in/text.asp?2007/32/3/171/36818.

Ghuman, B.S. and Mehta, Akshat. (2006). Health Care for the Poor in India with Special Reference to Punjab State. In Raza Ahmad (ed.), *The Role of Public Administration in Building a Harmonious Society*. Network of Asia-Pacific Schools and Institutes of Public Administration and Governance (NAPSIPAG), Asian Development Bank.

Government of Punjab. (2007). *State Health Facility Survey Report*. December. Gurgaon: EPOS Health India, Pvt. Ltd.

Kathuria, Vinish and Sankar, Deepa. (2005). Inter-State Disparities in Health Outcomes in Rural India: An Analysis using a Stochastic Production Frontier Approach. *Development Policy Review* (Vol. 23, No. 2, March, pp. 145-163). U.K.: Blackwell Publishing, Oxford.

National Rural Health Mission. (2005). Ministry of Health and Family Welfare, Government of India, New Delhi. Retrieved December 5, 2008, from NRHM Web site: http://mohfw.nic.in/nrhm.htm.

Panjab University. (2008). *Economic and Social Development of Punjab with Special Reference to Muktsar District*. A Research Project Sponsored by Punjab Government, Chandigarh.

Planning Commission. (2006). Towards Faster and More Inclusive Growth: An Approach to the 11th Five Year Plan (2007-2012). New Delhi: Government of India. December, p.9.

Rao, Sujatha K.; Selvaraju, S.; Nagpal, Somil; and Sakthivel, S. (2005). Financing of Health in India. *Financing and Delivery of Health Care Services in India*. New Delhi: National Commission on Macroeconomics and Health, Ministry of Health & Family Welfare, Government of India. August.

Saha, Shelley and Ravindran, T.K. Sundari. (2002). *Gender Gaps in Research on Health Services in India: A Critical Review of Selected Studies (1990-2000)*. New Delhi: Creating Resources for Empowerment in Action (CREA), p.3.

Shrivastava, Bhuma. (2008). Rural Health Mission: Slow to Take Off, Hit by Manpower Crunch. Thursday, May 15. Retrieved December 5, 2008, from livemint.com Web site: http://www.livemint.com/2008/05/15233313/Rural-health-mission-slow-to.html.