MAJOR DIMENSIONS OF INEQUALITIES IN INDIA: HEALTHCARE

Dimensions of health inequalities operating in Global South are mostly identified by the inequalities associated with access barriers to health care facilities. Health inequalities in most cases emerge due to inadequate provisioning of healthcare facilities which in turn is aggravated by the existing disparities based on place of residence (rural - urban), caste, occupation, gender, religion, education entitlements, **s**ocioeconomic status and social capital or resources.

STATUS OF PUBLIC HEALTH IN INDIA

The paucities of public health provisioning are reflected in the poor health indicators of the country when compared to other BRICSAM countries (table 1). The health indicators seem starker due to the sheer fact that the corresponding income level and the pace of growth of GDP in India has been almost similar when compared to these countries whose health indicators fare better than India. India accounts for 21 percent of the global burden of disease (WHS, 2013). India is home to the greatest burden of maternal, newborn and child deaths in the world. Infant mortality rate (IMR) declined from 83 per 1000 live births in 1990 to 42 per 1000 live births in 2011 and maternal mortality ratio (MMR) reduced from 570 per 100,000 live births in 1990 to 178 in 2010–2012 (RHS, 2012). However, both remain high in comparison to other BRICS countries, except for South Africa in some cases.

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

INDICATOR	BRAZIL	RUSSIAN FEDERATION	INDIA*	CHINA	SOUTH AFRICA	MEXICO	INDONESIA
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

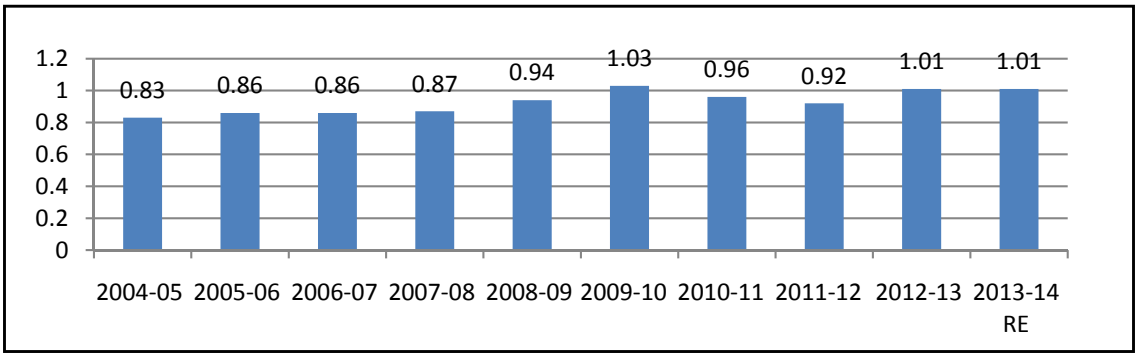
*Source: Global Health Repository Data, WHO, *updated India figures are from RHS, 2012 and SRS Bulletin, Census of India*

HEALTH EXPENDITURE ACROSS BRICSAM+INDONESIA

Government spending on healthcare in India for a long time has been below the required levels. As a proportion of the GDP, India's public spending on health, after increasing between 1950–51 and 1985–86, stagnated during 1995–2005, was 0·95 percent of the GDP in 2005. This is considered among the lowest in the world, compared with 1·82 percent in China and 1·89 percent in Sri Lanka.

Post 2005, with the implementation of the National Rural Health Mission (NRHM) in India, which envisages provisioning universal healthcare facilities, the level of public spending on health has gone up marginally but falls far behind the much required 3 percent of GDP (Figure 1).

Figure 1: Public Health Expenditure as Percentage of GDP, India

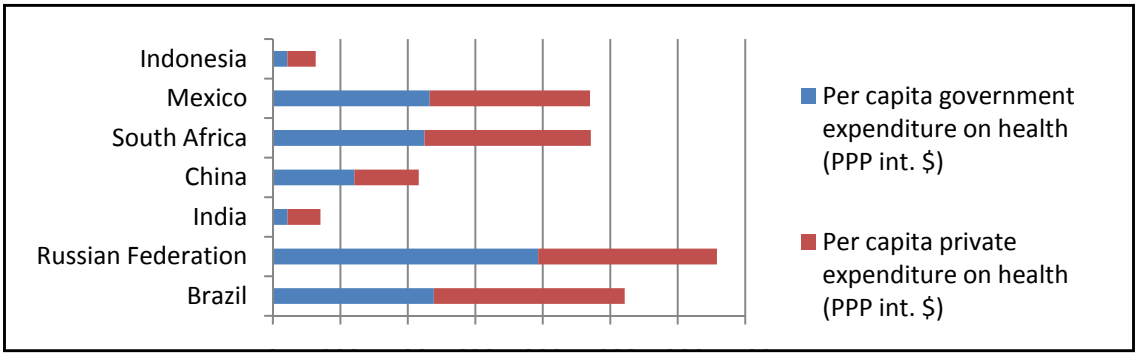


Source: Union budget documents, RBI State Finance, various years

The total expenditure on health is 4.2 percent of GDP. Of this, current public expenditure is only 1.01 percent of GDP. Nearly 70 percent of the expenditure is out of pocket. The country's per capita health spending has risen from Int. $ 63 in 2000

to Int. $ 141 in 2012 (with government expenditure within it increasing from int. $ 14 to int. $ 44) (Figure 2). India ranks at the bottom among the BRICSAM countries in terms of the level of public health spending.

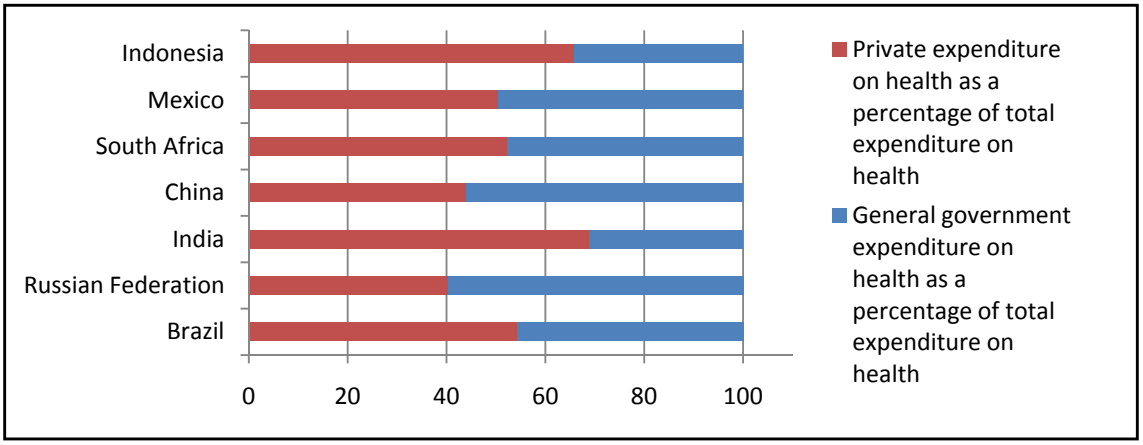
Figure 2: **Health expenditures in BRICSAM and Indonesia, 2011-12**



Source: World Health Statistics, 2013, WHO

The lowest share of public expenditure on health and very high share of private expenditure on health which explains the high incidence of out-of-pocket expenditure in India has been captured in Figure 3. India remains among the countries to have a high share of private spending on healthcare, followed by Indonesia and Brazil.

Figure 3: Share of Public and private spending in health in BRICSAM and Indonesia, 2011-12



Source: WHO, World Health Statistics, 2013

While the healthcare spending for 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+Indonesia as a whole spend much less on healthcare than the developed nations and within that India fares much worse.

INEQUALITIES ACROSS STATES

The differences in health outcomes in India are stark within the states. The four southern states have fared better in terms of access to healthcare facilities compared to the rest of the country. The differences across states are also an impact of provisioning of better health infrastructure across the country. 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. Infrastructural gaps are observed to be more in states like Bihar, MP, Chhattisgarh, Rajasthan, Jharkhand, which lagged behind others in terms of health outcomes. Similar situation is observed in terms of human resource requirements, especially for specialists at the Community health centres (CHCs). Although fresh recruitments of trained health workers, ANMs, and specialist doctors have taken place, substantial gaps still remain. In urbanized states like Maharashtra, Karnataka, Haryana, there is a shortage of doctors as well at the Primary Health Centre (PHC) level. While ASHAs have been employed in large numbers and are being trained and female health workers/ANMs are 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 low health outcomes are those with poor infrastructure.

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

STATES	IMR	MMR	TFR	% OF FULLY IMMUNISED CHILDREN	SHORTAGE OF PHCS (%)	SHORTAGE OF CHCS (%)	SHORTAGE OF DOCTORS AT PHCS (%)	SHORTAGE OF SPECIALISTS AT CHCS (%)
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

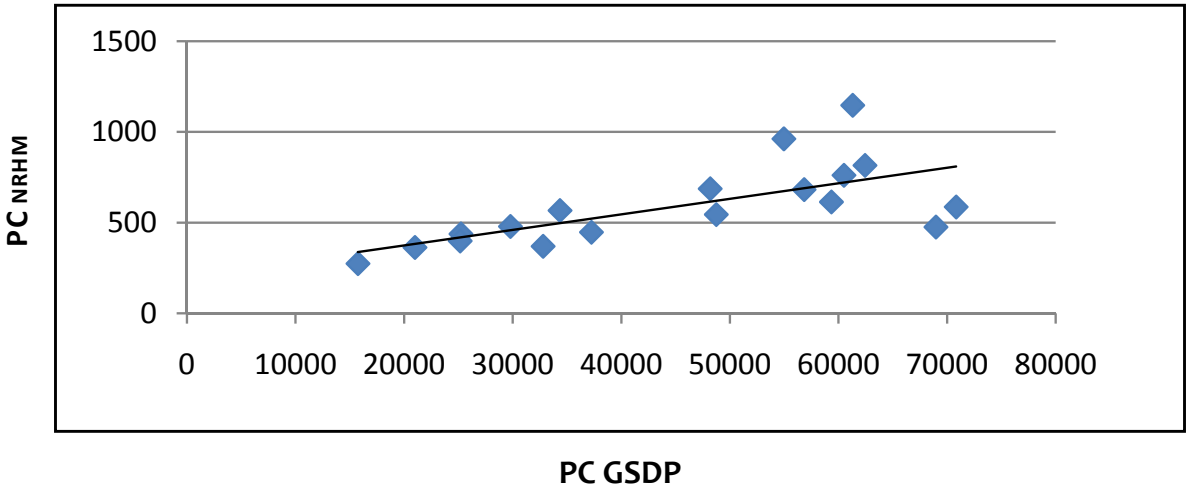
Source: RHS, 2012, SRS Bulletin, Census of India

UNEQUAL EXPENDITURE PATTERNS ACROSS STATES

According the Constitution of India, health has been a state subject and therefore responsibility of provisioning for healthcare rested mainly upon the states. However, health expenditures are marked with interstate variations. This is a continuation of the earlier trends where some states had high expenditure on health but most others neglected the sector in order to meet the Fiscal Regulation and Budget Management (FRBM) legislations as well as other requirements to control fiscal deficit. This was mostly true for the low income states, although certain high income states also had negligible percentage spent towards health provisioning. Figure 4 shows that apart from HP and Uttarakhand which has a high per capita GSDP and a commensurately high per capita spending on health, states like Maharashtra, Haryana and Karnataka show reverse trends. However

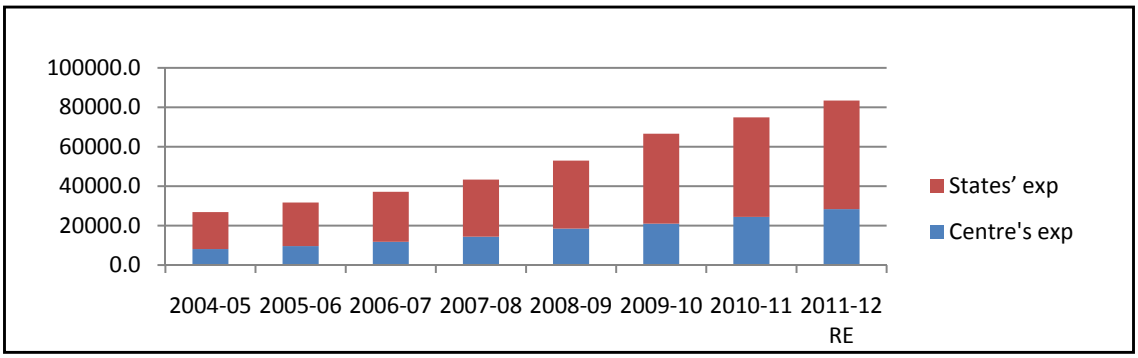
states like Kerala, TN and AP show high per capita health expenditure as against moderate per capita GSDP. Such trends are also reflected in better health indicators in those states specifically HP, TN and Kerala.

Fig. 4: Per capita public health expenditure against per capita GSDP in 18 major states, 2011-12



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). But it has also been observed in recent past that due to the additional central spending on health, many states diverted their health spending to other sectors and therefore the central funds for health, instead of being *in addition to* existing state budget, ended up *replacing* parts of state spending.

Figure 5: Public spending on health: centre and states



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

Variations in expenditure on health across states would continue to persist unless provisioning of healthcare facilities meet the required levels and the health outcomes for the states meet their targets. 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 facilities, water and sanitation facilities, improved communication infrastructure and adequate employment and livelihood opportunities.

[*For comments and queries, please write to sona@cbgaindia.org*]

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