Sheffield
Hallam
University

Who benefits from public health spending: the case of India

GUMBER, Anil <http://orcid.org/0000-0002-8621-6966>

Available from Sheffield Hallam University Research Archive (SHURA) at:

https://shura.shu.ac.uk/30348/

This document is the Presentation

Citation:

GUMBER, Anil (2002). Who benefits from public health spending: the case of India. In: 2nd International Conference on Equity in Health, Toronto. (Unpublished) [Conference or Workshop Item]

Copyright and re-use policy

See http://shura.shu.ac.uk/information.html

Sheffield Hallam University Research Archive
http://shura.shu.ac.uk

Who Benefits from Public Health Spending

The Case of India

Dr. Anil Gumber

Centre for Health Services Studies,

Warwick Business School, Coventry, UK

Issues in Health Care System

- High Health Expenditure (5.5% of GDP), Government's share is just 21%
- Government's share remained constant during 1990s (1.1% of GDP)
- Health provision & financing is State subject
- Central Govt. spends on FW, MCH, Medical education & Vertical Prog.
- State funds Curative Care (Hospitals), Social insurance, Vertical Prog.
- Public spending on preventive & promotive care is just 1/3rd
- Poor states are spending far less on health sector
- New and Continuing Threats-Injury, HIV/AIDS, TB and Ageing population with lifestyle diseases, Unfinished agenda of Childhood and other communicable diseases.
- Large inter-state variations in health outcomes

Morbidity and Mortality Burden

Mortality Burden	Morbidity Burden		
	Low	Medium	High
Low	Maharashtra, Tamil Nadu		Kerala, Punjab
Medium	Gujarat, Haryana, Bihar	AP, Rajasthan, W. Bengal	Karnataka
High	UP	Assam, MP, Orissa	

Objectives

- To examine the extent of utilisation of Public Health Services (inpatient, outpatient, MCH) by Socio-economic Status of Population
- To estimate the distribution of Public Subsidies across Socio-economic Groups

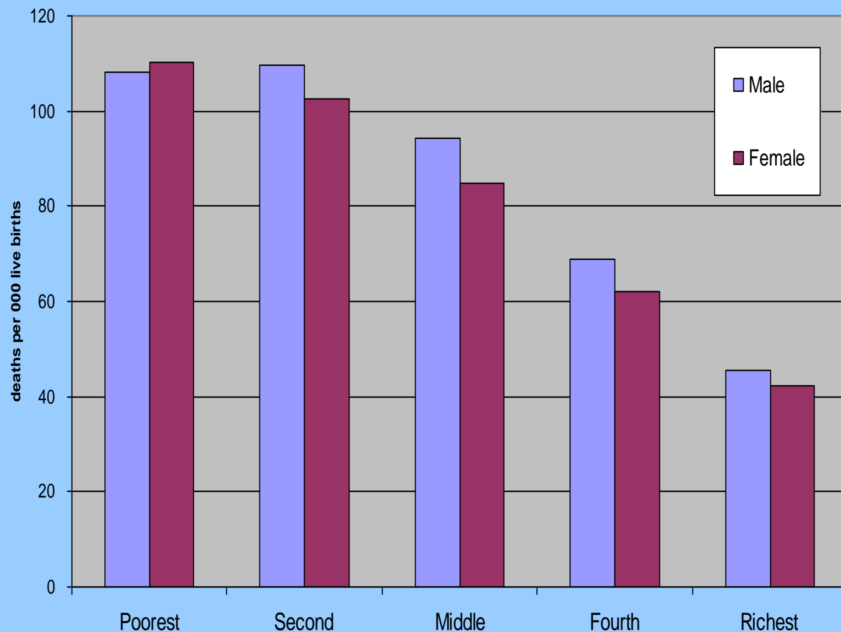
Methods & Materials

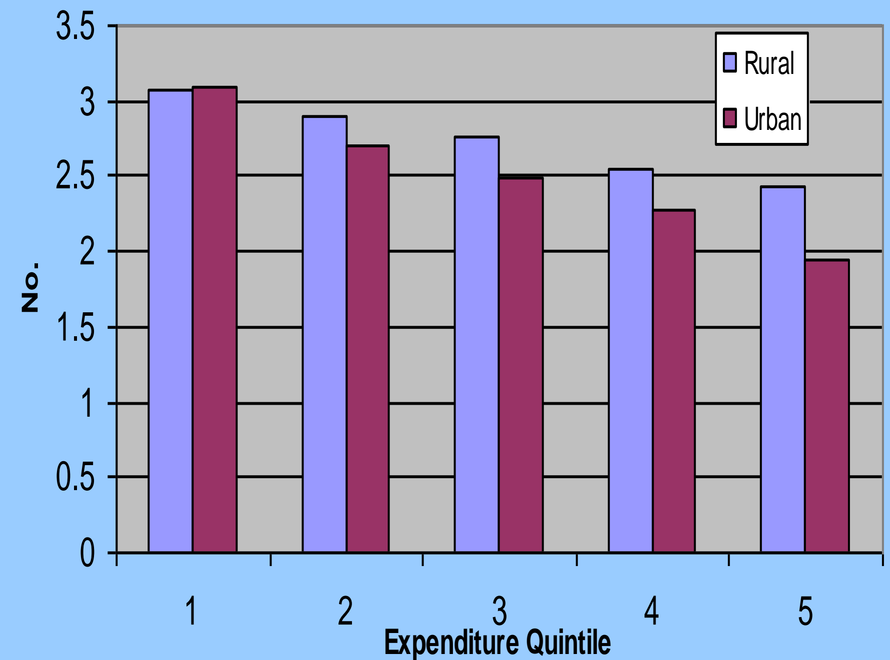
- **Benefit Incidence Analysis**
  - Ranking all individuals from poorest to richest by income or expenditure level
  - Identifying individuals using various publicly provided services
  - Calculating the average unit cost of providing each type of publicly provided service (net of cost recovery fees)
  - Multiplying the utilisation figures by the government's unit (net) cost of provision.
- **Population Groups**
  - Expenditure Quintiles
  - Below vs. Above Pverty Line
  - Scheduled Castes and Tribes vs. Others
- **Disaggregation**
  - Gender, Rural & Urban, Major States (16)

Methods & Materials

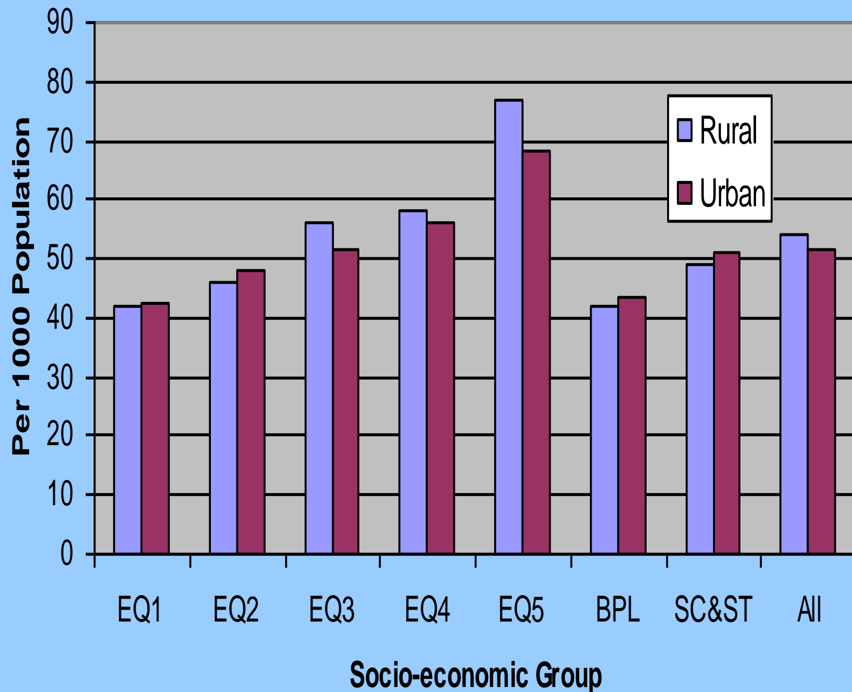
- **Government health expenditure data**
  - **Demand for Grants**
- **Cost analyses of health facilities**
  - **WB, NIPFP and other Studies**
- **Household Health Care Utilization (National Sample Survey Org.)**
  - **All-India survey of 121000 households**
  - **Acute morbidity (last 15 days), Hospitalisation (last 365 days)**
  - **Immunisation, Obstetric Care (ANC, PNC, Maternity)**
  - **Health Behaviour (smoking, alcohol, other intoxicants)**
  - **Perceptions regarding Health Prevention**
  - **Period of enquiry (One year), Information on household characteristics, type and duration of morbidity, source and cost of treatment separately for Ambulatory and Inpatient Care**

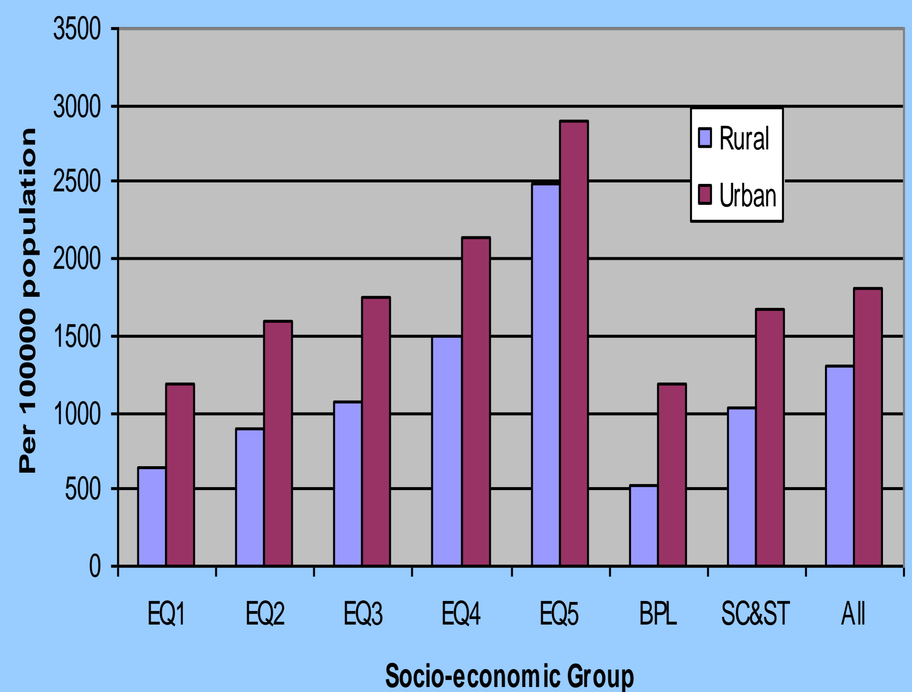
Poor are Less Healthy…



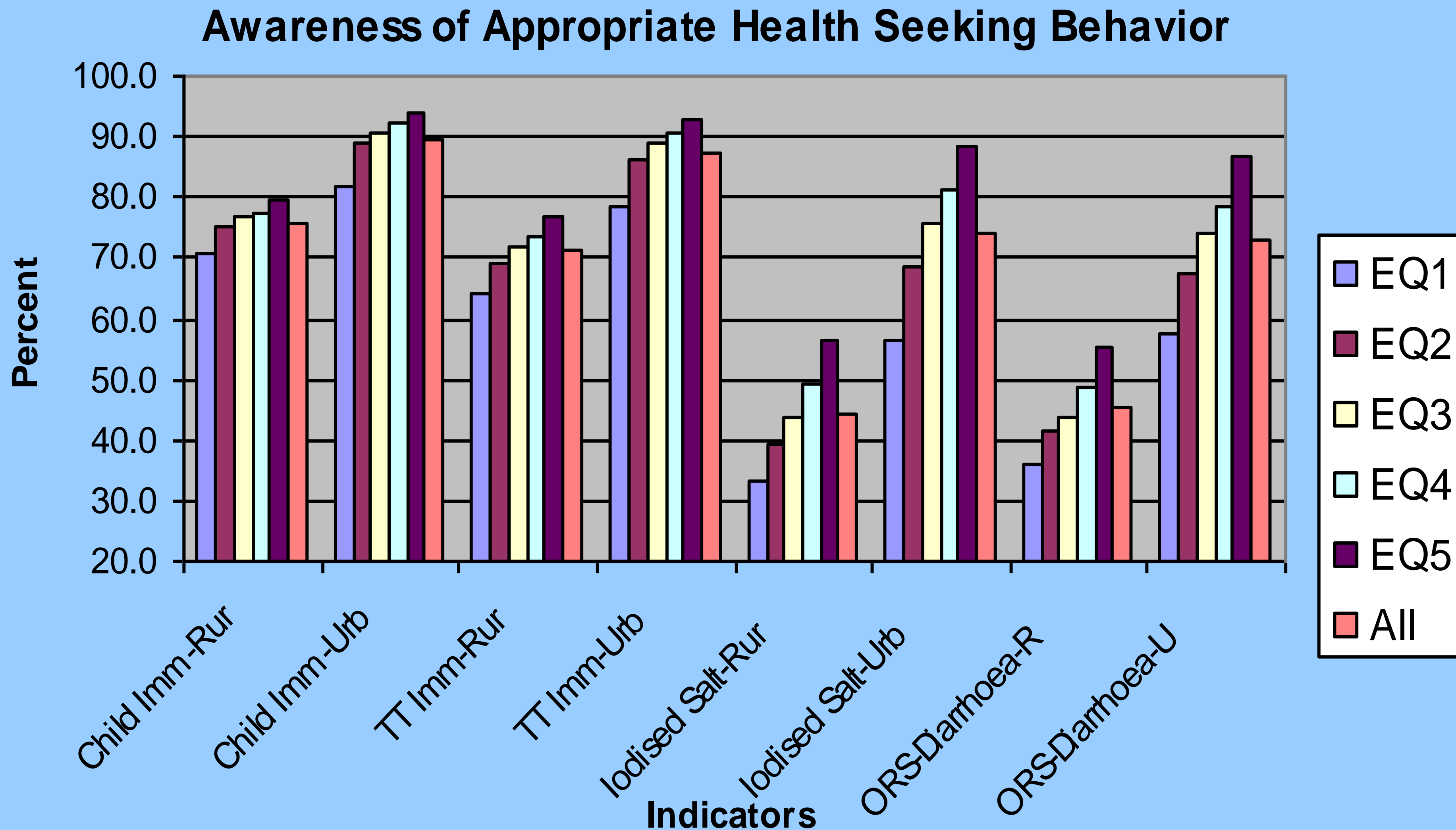


Poor are Less Healthy…

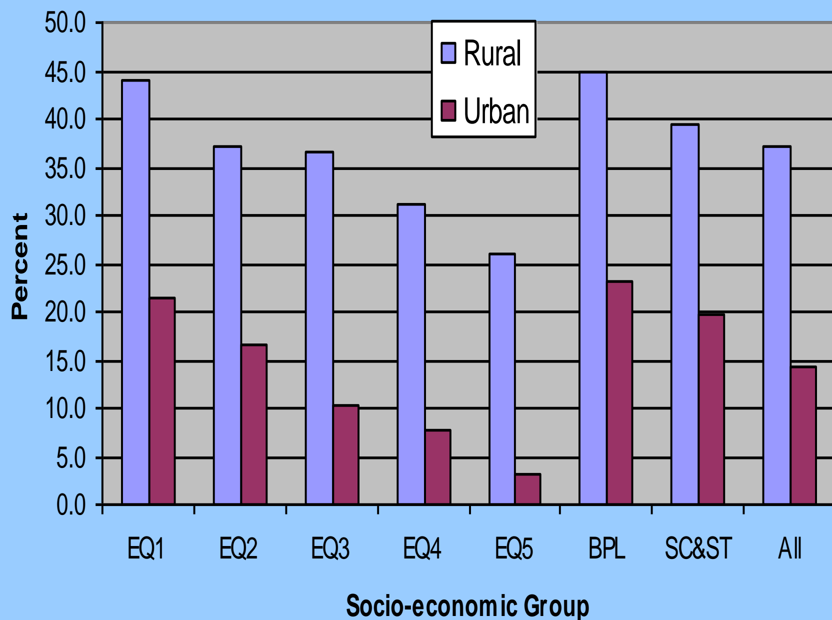


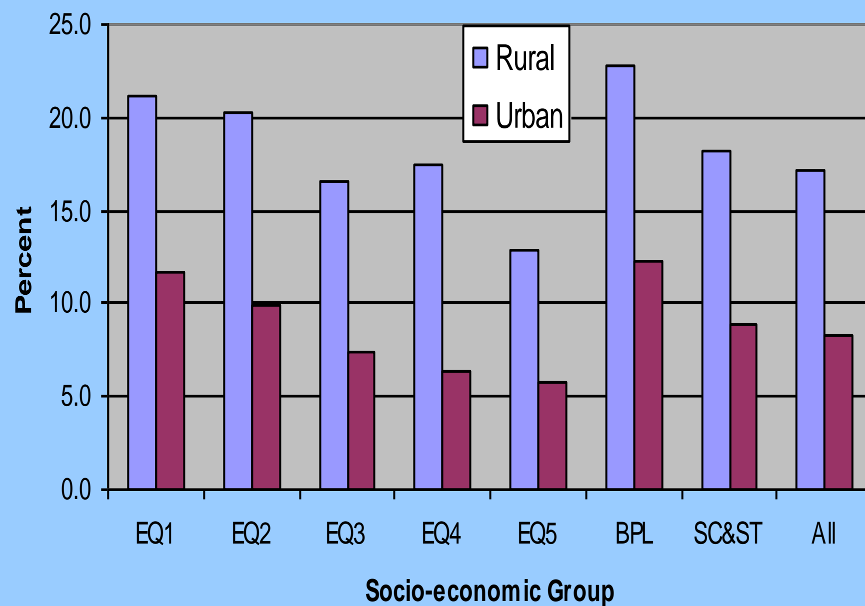


Poor are Less Aware….Accessibility

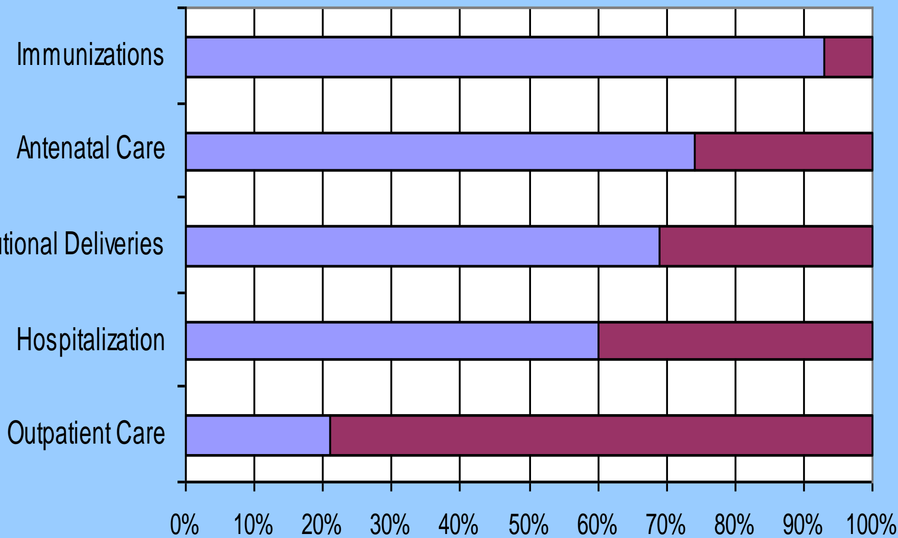


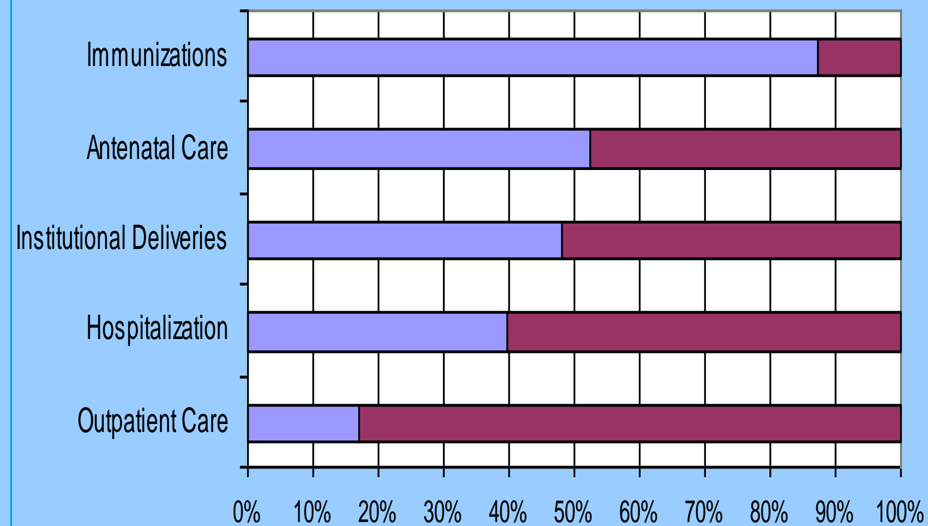
Poor are Less Aware….Accessibility





Poor Rely More on Public Facilities….Cost

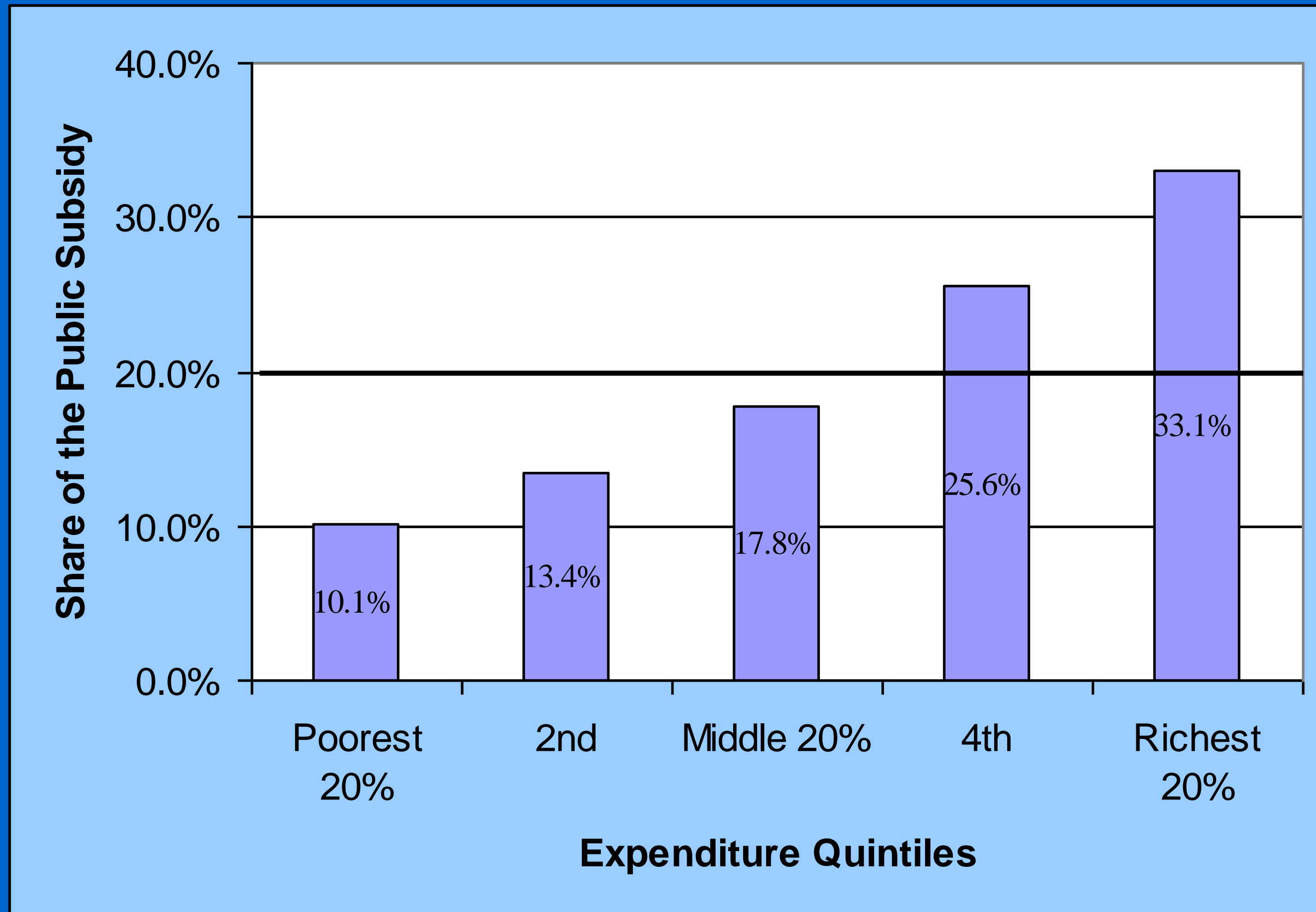




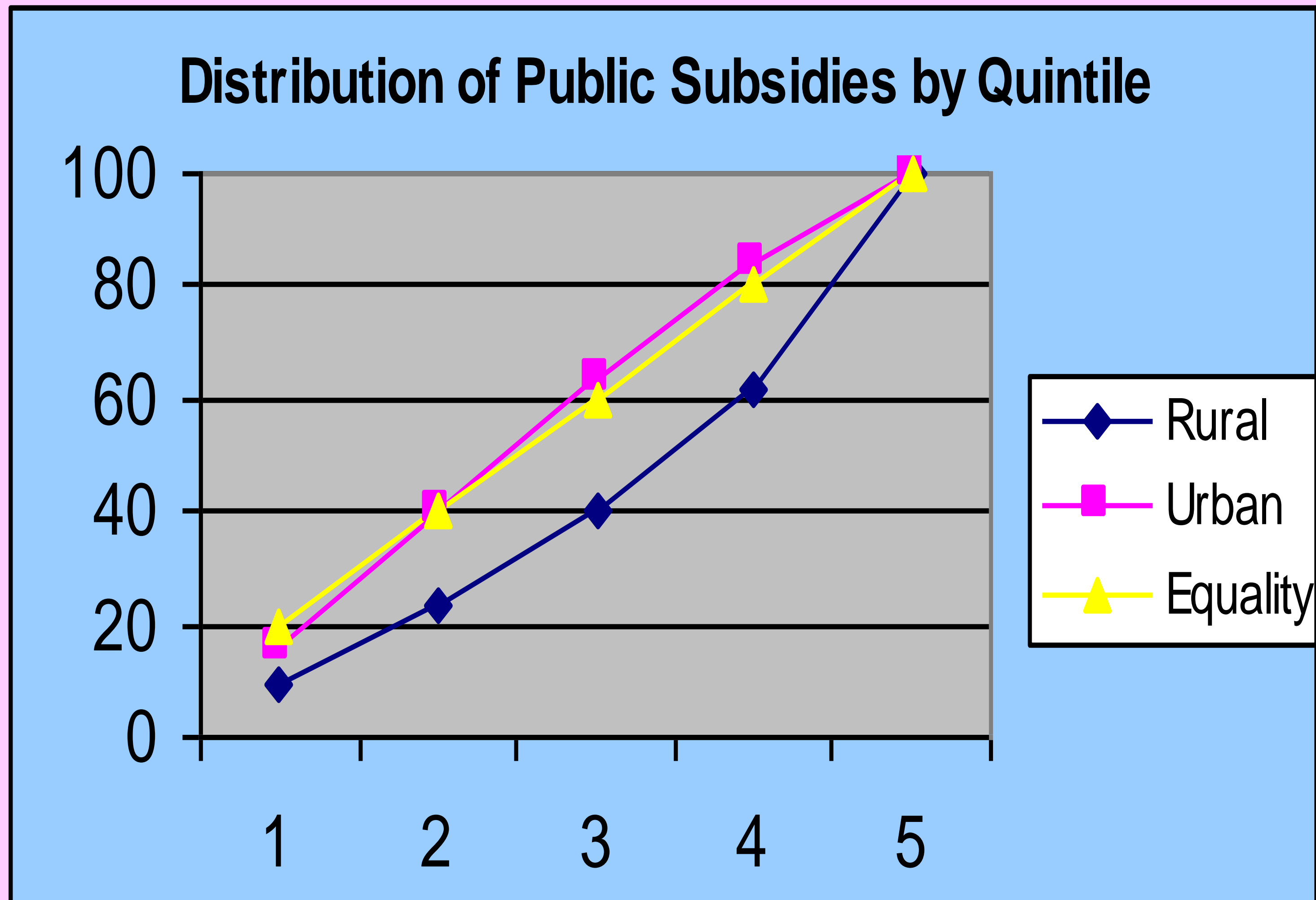
Poor Receive Less Share in Public Service Use

Use of Services Amongst Poor and Affluent			
	Bottom 20%	Top 20%	Ratio
Hospitalisation Rate per 1000 Population	5.6	34.5	6.16
Inpatient days	6.6	38.5	5.83
Illness Rate per 1000 population	28	61	2.18
Immunisation Doses	2.9	4.1	1.41
Childbirth (mn of inpatient days)	2.6	11.9	4.58
Ante&Post natal visits (mn)	6.7	13.2	1.97

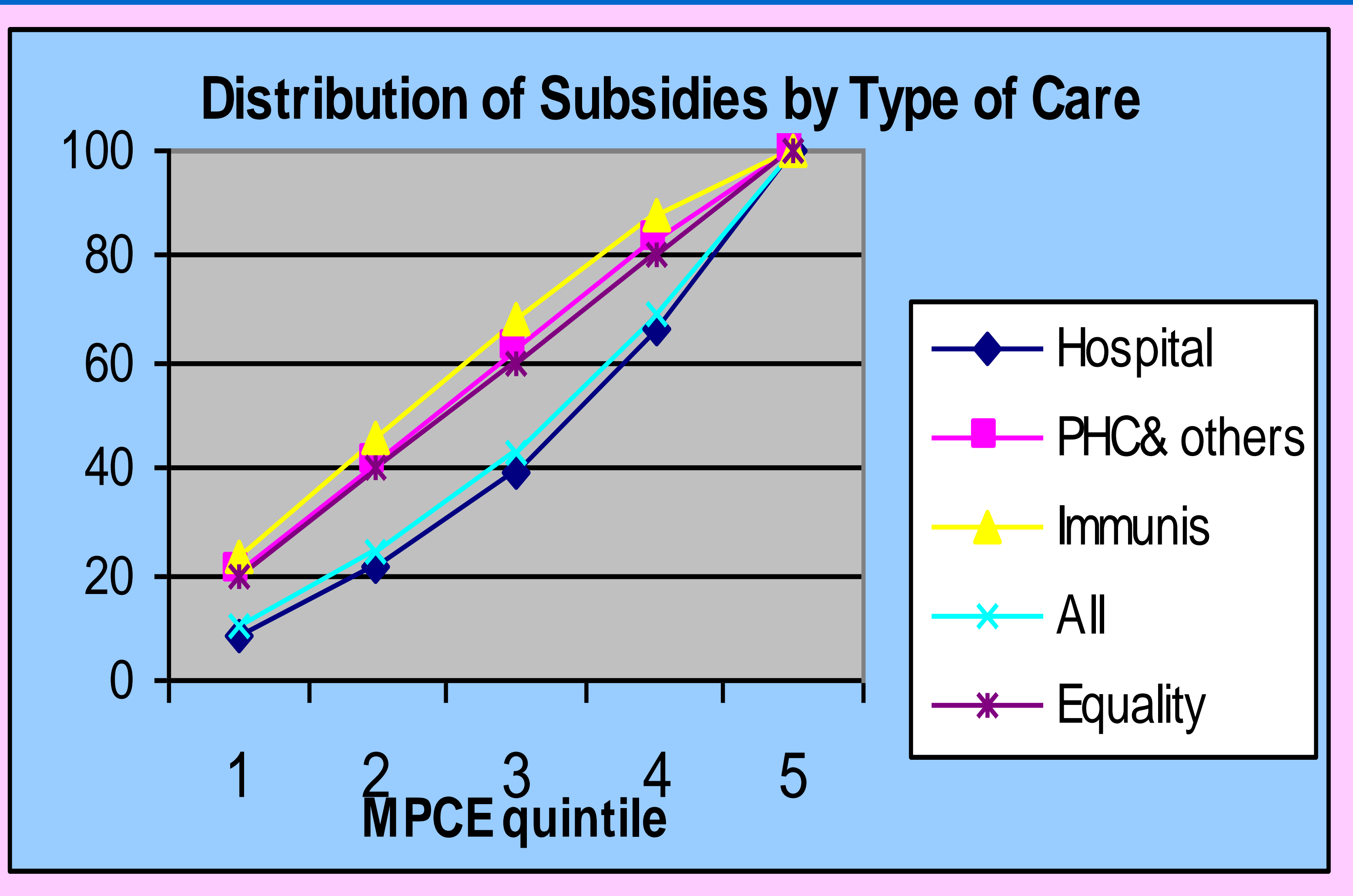
Poor Receive Less Share in Public Subsidy...



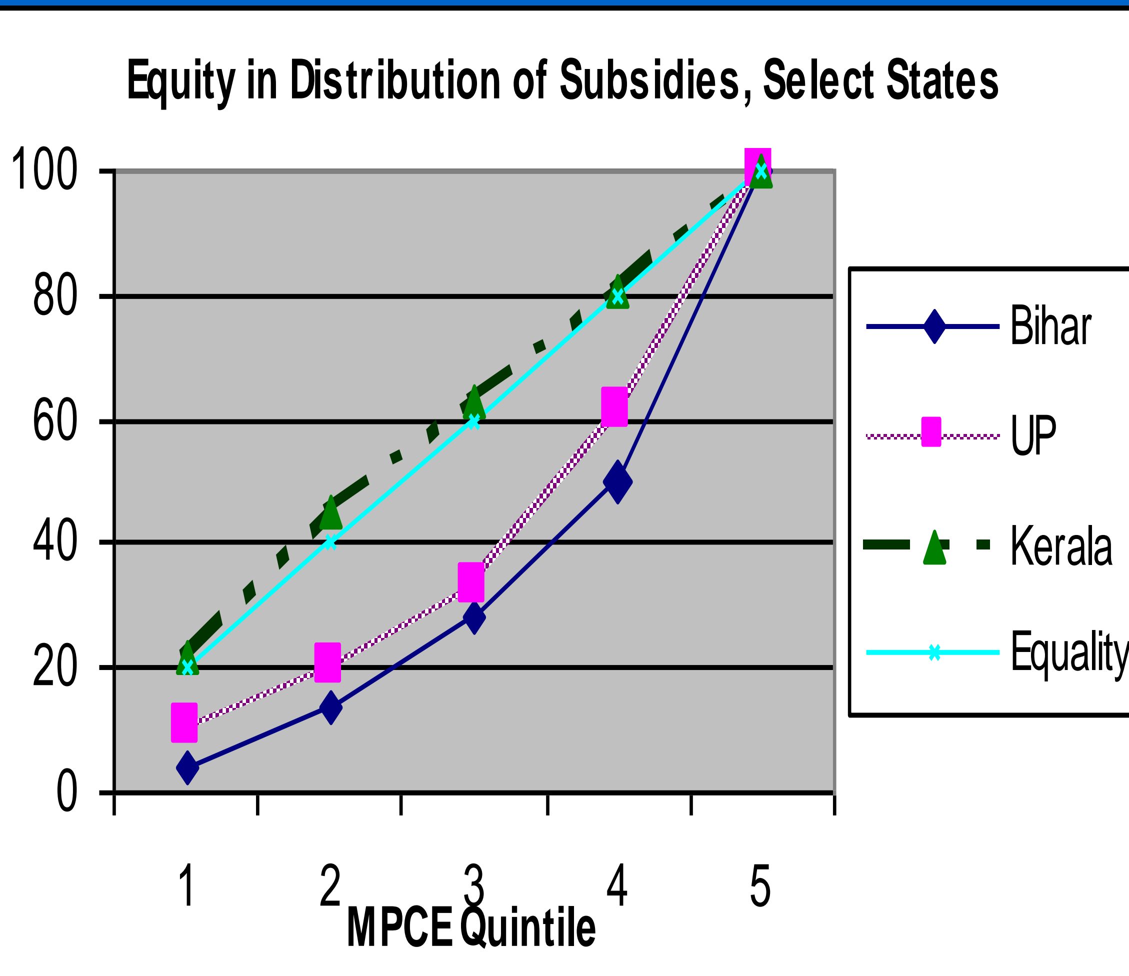
Poor in Rural Areas are Worse off…



Public Hospital Services are Most Inequitable…



Equity in Distribution of Public Subsidies...

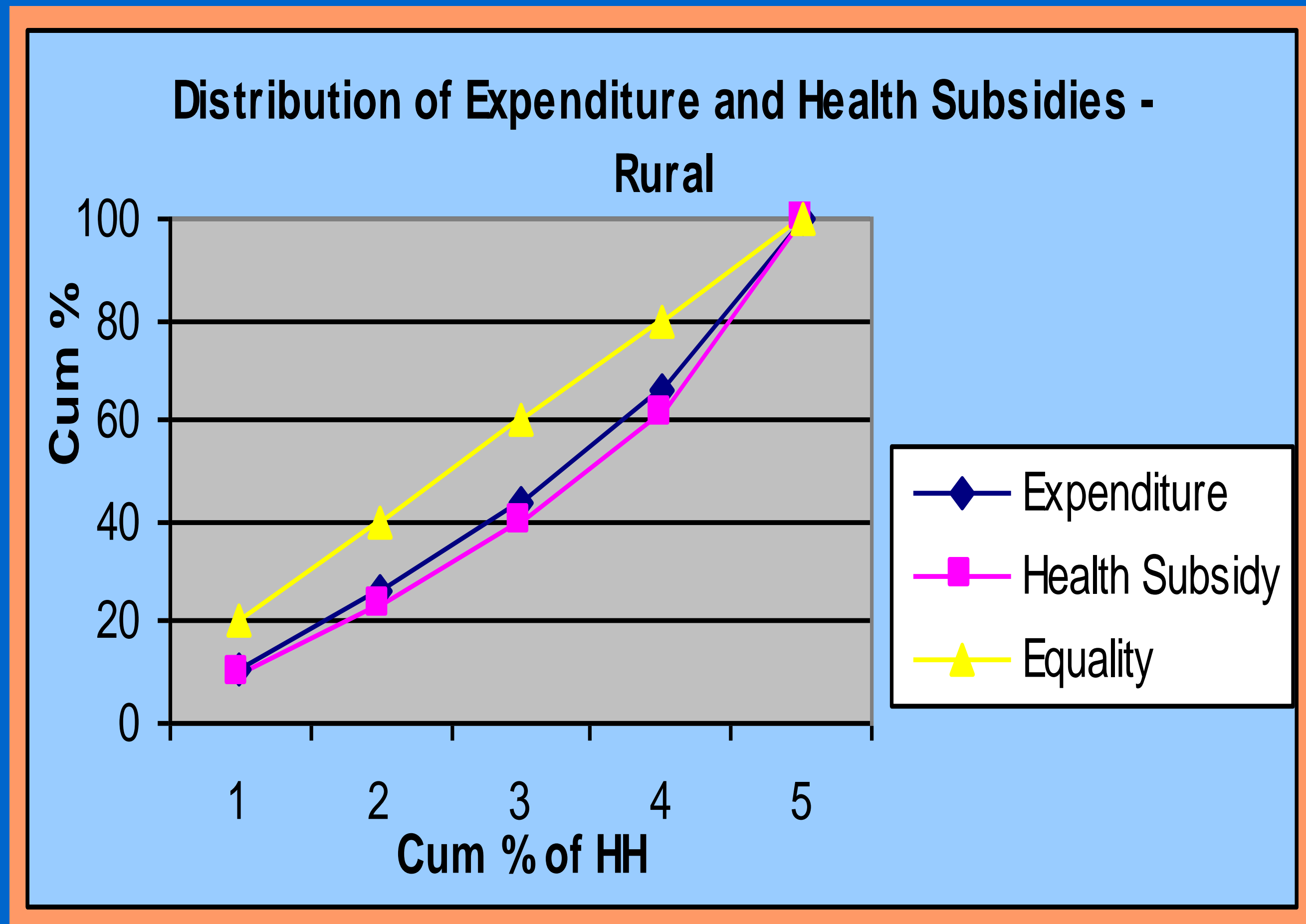


- Females both in rural and urban area receive more subsidies than their male counterparts
- In most states, poor are benefiting more in terms of using PHC & Immunisation services
- But not in hospital care
- Highly egalitarian distribution of subsidies in Guj, TN, Kerala & Punj
- Benefits are highly inequitable in Bihar, Haryana, HP, MP, NE, Orissa, Raj & UP

Equity - State Results….

Rank	State	Concentration Index	T-Statistics
1	KERALA	-0.041	-2.556
2	GUJARAT	0.001	0.012
3	TAMIL NADU	0.059	1.484
4	MAHARASHTRA	0.060	1.205
5	PUNJAB	0.102	3.587
6	ANDHRA PRADESH	0.116	7.574
7	WEST BENGAL	0.157	2.988
8	HARYANA	0.201	9.092
9	KARNATAKA	0.208	3.489
	ALL INDIA	**0.214**	**5.069**
10	NORTH EAST	0.220	4.742
11	ORISSA	0.282	3.033
12	MADHYA PRADESH	0.292	7.244
13	UTTAR PRADESH	0.304	11.097
14	RAJASTHAN	0.334	5.546
15	BIHAR	0.419	5.421

Inequity - Consumption Expenditure & Health...



Major Threats in Achieving Equity in India...

- Private Sector Handles Major Load of Curative care
  - Heterogeneous, Large and Widely Dispersed
  - No regulatory mechanisms
  - Huge Price and Quality differences
- Accessibility problems in hilly, backward and remote areas
- Significant proportion of people do not seek care (Financial reasons)
- Reliance on Government Sector is declining
- Government Subsidies are not Well Directed
  - (Relative shift of resources from hospital to PHC?)
  - (Or Increasing share of hospital subsidies going to the poor)
- Health care prices are rising faster than General Inflation
- Rising income inequalities (intra and inter state) during 1990s

Policy Options to Raise Equity, Efficiency,Sustainability...

- Health reforms per se
- State Initiatives
- Increase resources to PHC
- Better management of existing physical, financial and manpower resources
- Better targeting of services to poor and disadvantaged
- Alternative financing mechanism (User charges, Cost sharing, Health insurance)
- Strengthening partnership with Private & NGO sector
- Decentralisation and Governance