Universal Access to Healthcare: Urgent but Sidelined Component in India’s Inclusive Growth Strategy

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Abstract
Over the last two decades, India’s economy has grown at an impressive pace as result of wide ranging structural reforms to open up the economy and make it more competitive. These reforms have resulted in unprecedented economic changes in the domestic and external sectors of the economy (agriculture, trade, foreign Investment, technology, Public sector and so on). These reforms marked a steady break from the previous policy regime. Due to these reforms, GDP and investment growth have recorded the historical increase and India has raced to the top of the world chart in terms of the GDP growth. But has the growth of Indian economy been really inclusive during the reform period? Has the higher growth provided secure and better employment to its citizen? Has the growth made health and education facilities more accessible to the common people? Has it resulted in reduction in the reduction of real poverty? Policy makers have to pay serious attention towards these issues to make the Indian economy move towards Inclusive growth. Here, in the present paper, an attempt is being made to explain the priority and urgent issues of social sector in India’s Inclusive growth strategy, with special reference to healthcare. Achieving universal access to healthcare is increasingly being recognised as a basic human right and essential input to growth and development. But in India health sector has grown in terms of commercial importance. The government is adopting such a planned disinvestment policy that it is facilitating the corporate/commercial bodies to invest in health services and earn enormous profits by exploiting the sickness of people.

I. Full Paper
India implemented structural Adjustment reforms in the context of an unprecedented economic crisis arising due to acute Balance of Payment problems. This led to mounting external and internal debt, galloping inflation and severe infrastructural constraints. The economic reforms implemented in this context since 1991 have resulted in unprecedented economic changes in the domestic and external sectors of the economy (agriculture, Industry, trade, foreign Investment, Technology, Public sector and so on). The main objective of these reforms was to put the Indian economy out of the low level equilibrium trap. These reforms have marked a steady break from the previous policy regime. Due to these policies, India has raced to the top of the world chart in terms of the GDP growth. Since the last two decades or so, GDP and Investment growth have recorded the historical increase and India has raced to the top of the world chart in terms of the GDP growth. But has the growth of Indian economy been really inclusive since the last two decades. Who is actually benefiting from this higher growth trajectory is the other question. Has the higher growth provided secure and better employment to Indian people? Has the growth made health and education facilities more accessible to the common people? Has it resulted in reduction of incidence of real poverty? All these issues need serious attention of the policy makers. Normally, the policy makers believe in the theory of “Trickle Down Effect” that with the passage of time the fruits of higher growth will trickle down to the lower levels also. But in India, this trickle down has not worked yet. Here, in the present paper, an attempt has been made to explain the neglected aspects in India’s economic growth, with special reference to healthcare.

II. Defining Inclusive Growth
The concept of Inclusive Growth has dominated discussion across India. Its popularity has sparked intense discussion among politicians, policy-makers and general public. In addition to this, Inclusive Growth has also been the focus of study in many bilateral and multi-lateral aid agencies like World Bank, The United Nations Asian Development Bank and also various NGOs. Despite of too much attention towards this concept, there is no precise and universally agreed upon definition of the term Inclusive Growth. The entire discussion and literature on Inclusive Growth is mainly focused on two concepts of the term- i) whether the benefits of growth reach the poor? ii) Whether the benefits reach poor proportionately more than it reaches the non-poor? As far as the first concept is concerned, India has made remarkable progress. But if the second definition of Inclusive Growth is considered then the position of India seems to be lacklustre (Abhishekh Pandey).

In the 12th five year plan, Inclusive growth has been projected as the strategic pillar. The policy designers are of the opinion that Inclusive growth strategy for the 12th five year plan should be based on the experience of inclusive outcomes of the 11th plan. The approach to 12th plan titled “Faster, Sustainable and more Inclusive growth” defines Inclusive Growth as “ Inclusive Growth should result in lower incidence of poverty, universal access to school education including skill and education, better opportunities for wage employment and livelihood, improvement in health outcomes, improvement in provision of basic amenities like water, electricity, roads, sanitation and housing, special attention to women and children and also special programmes for physically challenged/minorities and other excluded groups to bring them into the mainstream”.

III. Health as A Basic Input to Development
The ultimate goal of development is to reduce poverty and improve standard of living. For this, inclusive growth is required, which allows people to contribute to and benefit from economic growth. Unquestionably, rapid pace of growth is necessary for sustained and rapid poverty reduction, but for this growth to be sustainable in long run, it should be broad-based across sectors, and inclusive of the large part of the country’s labour force. This also requires investment in people, which primarily involves quality healthcare, good nutrition, better education and a hygienic environment etc. (Kulwant Singh Phull 2009)
In a simple and important sense, health is wealth. If one measures welfare more broadly than income or consumption, poor health is, itself a deprivation that is part of poverty. The HDI introduced in 1990 by Mahbub Haq & colleagues, reflects achievements in “the most basic human capabilities- leading a long life, being knowledgeable, & enjoying a decent standard of living (UNDP, 1990) that can be represented as health, education, & income, Which are indeed the three pillars of human development.

Achieving universal access to healthcare (adequacy of care and extent of population coverage) is increasingly being recognized as a basic human right and an essential input to growth and development. However inadequate access to physical and financial healthcare resources, particularly in low income countries such as in India, limits the scope for narrowing the ‘know-do-gap’. Inadequate opportunities for healthcare transform into slow economic progress, which in turn, limits the scope for healthcare opportunities. Sub-optimal provision of healthcare has been identified as a factor in the slow progress of the Indian economy in the past. On the other hand, economic reforms aiming at higher growth can be a platform for health development.

There is now a large body of theoretical and empirical research on the determinants of economic growth. Much of the early work highlighted growth in labour and the stock of physical capital as the key determinant of economic growth. However, early empirical work was unable to explain a significant portion of economic growth in GDP & per capita income, by the growth in labour force and capital alone, & so attention turned to other factors- most notably technological change embodied in capital goods, and on the quality & quantity of labour, referred to as human capital, in promoting economic growth. Two key elements of human capital are the extent to which labour is educated & the level of its health. Recent empirical work has sought to assess the association between human capital and aggregate economic performance and found that, given labour and capital, improvement in health status and education of the population lead to a higher output. (Barro and Sala-i-Martin 2004).

The role of health in influencing economic outcomes has been well understood at the micro level. Healthier workers are likely to be able to work longer, be generally more productive than their relatively less healthy counterparts, and consequently able to secure higher earnings than the latter. All else being the same; illness and disease shorten the working lives of people, thereby reducing their lifetime earnings. Better health also has a positive effect on the learning abilities of children, and leads to better educational outcomes (school completion rates, higher mean years of schooling, achievements) and increases the efficiency of human capital formation by individuals and households (Strauss and Thomas 1998; Schultz 1999).

However, more recent research has also established a strong causal association running from health to aggregate economic performance. Thus Bloom, Canning and Sevilla (2004) report evidence from more than a dozen cross-country studies and all these studies, with a single exception, show that health has a positive and statistically significant effect on the rate of growth of GDP per capita. The causal relationship does not run in only one direction-from health to aggregate economic performance- and there is strong case for considering a reverse link, running from ‘wealth to health’. Higher incomes potentially permit individuals (and societies) to afford better nutrition, better health care and, presumably, achieve better health. There is some cross-country evidence that such a relationship holds at the national level (Pritchett and Summers 1996; Bhargava et al. 2001). Several experts believe, however, that the causal direction from health to economic performance is stronger.

IV. Performance of Social Indicators in India

Spending on social sector is very important. But in India it has recorded a secular decline after the introduction of neo-liberal policies. During 2011-12, wide range of social sector activities accounted for only 18% of the total budgetary expenditure. Among the social indicators, health and education are the two important components. As Dreze and Sen (2011) argued, in the light of high GDP growth, India’s common man surely deserves the educational and health facilities comparable not to those of USA, European Union, Socialist Cuba, and China but at least to its neighbouring countries which have the same kind of political and social setup. According to Human Development Index of 2012, India ranks 136 out of 187 countries, In terms of human development, India’s public expenditure on health ranks among the lowest in the world. In India, public expenditure on health as percentage of total public expenditure is 4.1%. The draft of the 12th plan projected merely 1.95% of GDP as public health expenditure by the end of the 12th plan, which is less than the overall norms of 5% suggested by World Health Organisation.

No doubt in India, healthcare industry is one of the fastest growing sectors and it is expected to reach $280 billion by the year 2020. Unquestionably, the country has made remarkable progress in having world-class hospitals, highly qualified medical personnel. India is also emerging as the preferred destination for medical tourism even among the people of developed nations. But for a large part of the local population, the delivery of the healthcare services is not adequate. If we compare India with other developing countries, then its performance on various parameters such as hospitals bed density, physical density and public expenditure on healthcare is very poor. In India, health insurance penetration is also low (only 15% of the population has any form of health insurance). Healthcare in India is not easily available to all sections of the society. A rural person seeking healthcare has to travel approximately 10 kms, due to poor physical connectivity. The lack of infrastructure, poor monetary compensation and social prejudices resulted in doctors being reluctant to practice in rural areas.

The case is more or less the same in education. In primary education, we are well behind the other nations which have comparable level of economic growth and per capita income. During 2011, the mean year of schooling in India was 4.4 and female literacy rate was lower than the overall average. In 2004, UPA government has announced to raise the public spending on education to 6 per cent of GDP. But the ground reality shows that the public expenditure on education as percentage of GDP has declined from 4.2 per cent in 2000 to 3.1 per cent in 2011-12. After the introduction of neo-liberal policies, the private sector investment in education has increased sharply and it has become one of the major profits earning sectors. In India, the percentage of private schools has increased from 53 per cent to 62.4 per cent in 2006-07. The number of deemed universities has also recorded a sharp increase in the last decade or so. These corporate sector led universities and institutions are more concerned about the quantitative addition in their strength and higher profits rather than quality of education. Since the last decade or so the quality of education in India has greatly deteriorated. Planned reduction in public expenditure on education and health on one hand and...
Incentives provided to the private sector to invest in these two priority fields, which are essential for common people, on the other hand is a cause of serious concern.

Healthcare system in India

The system of healthcare in India was established in 270-236 B.C. The Indian ayurvedic system is one of the earliest attempts to conceptualise the science of health and to utilise rational methods to diagnosing illness. Western medicine was introduced during the 18th century, essentially to treat British soldiers. But despite its long history, organized healthcare was confined to the cities during the pre-independence period.

Independent India had a different vision and a different blueprint for the establishment of post-independent healthcare system, which were rural-centric, population based and government dominant. The establishment of primary health centres, sub-centres and community health centres continued till 1980s, when the first National Health Policy was pronounced. As a result of continuous efforts, the Crude Death Rate declined from 44.4 per 1000 people in 1901 to 7.48 in 2011. IMR came down from 140 per 1000 live births in 1975 to 47.57 in 2011. Consequently Life Expectancy at birth increased from 23.8 years in 1901 to 66.8 years in 2011.

Table 1: Crude Death Rate, IMR, & Life Expectancy in India before & after reforms

<table>
<thead>
<tr>
<th>Year</th>
<th>Crude Death Rate (Per 1000 people)</th>
<th>Infant Mortality Rate (per 1000 live births)</th>
<th>Life Expectancy at birth (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>13</td>
<td>110</td>
<td>56</td>
</tr>
<tr>
<td>1986</td>
<td>11</td>
<td>96</td>
<td>57</td>
</tr>
<tr>
<td>1991</td>
<td>10</td>
<td>80</td>
<td>58</td>
</tr>
<tr>
<td>1996</td>
<td>9</td>
<td>72</td>
<td>60</td>
</tr>
<tr>
<td>2001</td>
<td>8.74</td>
<td>63.19</td>
<td>62.86</td>
</tr>
<tr>
<td>2005</td>
<td>8.18</td>
<td>54.63</td>
<td>64.71</td>
</tr>
<tr>
<td>2011</td>
<td>7.48</td>
<td>47.57</td>
<td>66.81</td>
</tr>
</tbody>
</table>


No doubt phenomenal success has been achieved by India in the post-reform period, it still lags behind many comparable nations. Life Expectancy in India falls short of the average for the developed countries, while IMR is 14 above the average. India also does not get sufficient returns from health investment. Even the countries spending less have a higher Life expectancy than India does. Srilanka, for instance spends 4.0% of its GDP on health but has a Life Expectancy 10 years higher than in India. The poor rate of return could be attributed to the inefficiency of the system in controlling and managing the resources. India has to travel a considerable distance to catch up. As shown in table No.2, there exists a huge scope for improvement in the reduction in the IMR, Under-5 Mortality Rate & Maternal Mortality rate. By preventing such deaths, India can hope to enhance its life expectancy by 29.6%. However it is easier said than done, especially when India has some distance to travel even to catch up with other developing nations.

Table 2: Basic Health Indicators – Comparison with The Best (2011)

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>India</th>
<th>Global best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Expectancy at Birth (years)</td>
<td>66.81</td>
<td>83 (Hong kong, Japan)</td>
</tr>
<tr>
<td>Infant Mortality Rate (Per 1000 live births)</td>
<td>45</td>
<td>2 (Iceland)</td>
</tr>
<tr>
<td>Life Expectancy at Birth (Male)</td>
<td>64</td>
<td>81 (Iceland, Switzerland)</td>
</tr>
<tr>
<td>Life Expectancy at Birth (Female)</td>
<td>68</td>
<td>87 (Hong kong)</td>
</tr>
<tr>
<td>Pregnant women receiving prenatal care (%)</td>
<td>75</td>
<td>2 (San Marino, Iceland)</td>
</tr>
<tr>
<td>Under -5 Mortality (per 1000 live births)</td>
<td>59</td>
<td>3 (Greece, Singapore)</td>
</tr>
<tr>
<td>Maternal Mortality Rate (per one lakh live births)</td>
<td>200 (2010)</td>
<td>100</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (%)2008</td>
<td>53</td>
<td></td>
</tr>
</tbody>
</table>


The above table shows that if we compare performance of India on different health parameters then we find that India lags much behind the global best positions.

Fig.1: No. Of Hospital Beds (Per 1000 Persons) in 2011
Source: WHO Health Statistics 2011

As per WHO Report (2011), no. of hospital beds per 1000 persons in India was just 0.9 in 2011. But in Russia this figure is as high as 9.7, in China 4.1 and in Brazil 2.4.

V. Issues in Health Spending

In many low income countries such as India, healthcare resources are simply insufficient to allow the population to have access to even a basic set of key healthcare interventions. Low income countries face 56% of the global disease burden, but, they only account for two percent of global health spending. If India desires to catch up with the best, it has to address health system issues more seriously.
Moreover there is also the difference in the composition of Healthcare resources between India and other Asian countries. In India private resources dominate the healthcare scene, where as in other countries government accounts for the maximum. The share of government in health expenditure in India is one of the poorest in the world (Fig. 2). The poor health spending is reflected in the poor health outcome.

Fig. 2 : Government Share in Health Expenditure (%of total) in Different Countries (2011)
Source: Compiled from http://dataworldbank.org/indicator

At the state level, the share of health in government expenditure declined during the reform period, except in Andhra Pradesh, Tripura and Tamil Nadu (figure 3). The expenditure of states on health did not show a significant increase because of compelling demands of non-social sectors and the relatively slow growing fiscal capacity. It is also noticed that the government allocation to education is larger than the private sector allocation. But in case of health, it is just the opposite. As a result of declining resources, the programmes designed to improve the health conditions of the poor have encountered constraints of funding, resulting in shortage in infrastructure, and trained staff, and quantitative and qualitative deficiency in services.

Fig. 3 : Share of Health (%) in State Government Expenditure: Before and after Reforms

VI. Commercialisation of Health in The Reform Process
Since 1991, the Indian health sector has grown in terms of commercial importance. The basic factor responsible for the commercialization seems to be the failure of the traditional commercial sector to yield the requisite profits. Since the profitability in the other commercial sectors has come down over a period of time, the developed countries started focusing on service sector such as healthcare which is being seen as a sector with great potential for profits.

In India healthcare was handed over to private sector without a mechanism to ensure the quality and standard of treatment, as well as access to services. The list of drugs under price control has been reduced from 378 to 73 in the name of economic reforms (1995), which compounded the problem since the prices of the drugs have rocked. Due to which the monetary value of pharmaceutical production has gone up substantially. But this increase in the value of pharmaceutical production need not indicate increase in the availability of drugs in the country. It could simply be a value transfer from consumers to producers. The patent regime under the neo-liberal agenda it is such planned disinvestment policy of the government that is facilitating the corporate/commercial bodies to invest in health services and earn enormous profits, exploiting the sickness of common people. At present, three quarter of the advanced medical technology and 68 per cent of hospitals are in private sector. The government health services, which were well reputed in the past, have hardly any patients today and if there is any it is because costly private hospitals are inaccessible to the public. There are no or very few medicines in government hospitals. The patients have to often buy the medicines from private stores which are directly linked with the doctors through commissions. This corporate sector led health network is

Table 3: Health Expenditure Status in India (2011)

<table>
<thead>
<tr>
<th>Health system indicators</th>
<th>India</th>
<th>Global Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health expenditure(% of GDP)</td>
<td>3.9</td>
<td>19.5(Liberia)</td>
</tr>
<tr>
<td>Government share in health exp. (%)</td>
<td>31.0</td>
<td>94.7(Cuba)</td>
</tr>
<tr>
<td>Health expenditure per capita (current US $)</td>
<td>59</td>
<td>9721 (Switzerland)</td>
</tr>
</tbody>
</table>

Source: world Bank, http://dataworldbank.org/indicator
exploiting the bottom strata of society and deepening the health inequalities in India. The retreat of the State from health sector and rising corporatisation of these facilities through government incentives have put a serious question mark on the state of our public health facilities and its future. Thus in the urgent and priority spheres of education and health, the ‘Inclusive growth strategy’ of the government has proved to be a failure. Therefore, it is essential for the policy designers to realise the ground realities and act accordingly. There is urgent need to give a second thought to the so called ‘inclusiveness of India’s present economic model. The policy makers must realise that the uncontrolled and unconditional privatisation of education and health facilities is a real threat to inclusive growth. The government should keep at least these two priority sectors in the hands of the state. Policies should be designed in such a way that these facilities become accessible to poor and weaker sections of the society. Government should undertake appropriate investment in these two sectors so that there are sufficient number of quality educational institutions and hospitals with trained and qualified staff. Prof. Sen in this regard has rightly observed that India needs to spend more on basic healthcare and education if economic growth is to benefit all the members of the society. Education and healthcare expansion are the biggest part of inclusive growth because an illiterate labour with very indifferent health is not in position to seize the opportunities that the globalised economic relations provide today. Policy-makers should keep in mind the fact that investing in Education and health is a key to Inclusive Growth in India.

References
