Economics of Health Care in India

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Abstract

A person's entire development cycle is dependent on his intellectual abilities, curiosity, and constructive thinking, yet all of these attributes are contingent on his physical well-being. Health is a function of society's total integrated development, and health status is one of the quality of life indices. Health is a positive term that emphasises social and personal resources as well as physical capabilities. It is a resource for everyday life, not the goal of living. Human health is inextricably linked to the health of the life-sustaining ecosystems with which we interact and are connected. Furthermore, the health of future generations is contingent on the ecosystems' integrity and sustainability, regardless of how healthy the current generation is. Because health is such an important aspect of development, everyone is concerned about it. The health, ability, and well-being of the people are the most valuable human resources required for every country's development and economic growth.

Keywords: Health Care, Health Economics, Health Expenditure, Health Insurance, CSR

Introduction

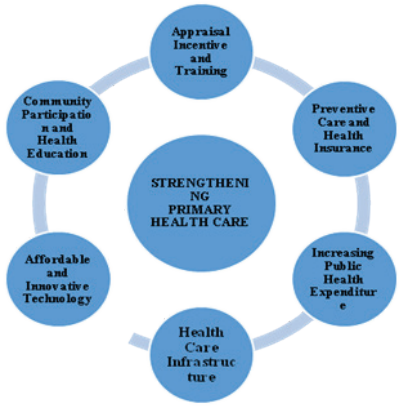
A) Primary Health Care

Individuals, families, and communities' first point of contact with the health system, putting health care as close as feasible to where people work and live. Primary health care should include preventive, curative, and rehabilitative treatments, as well as population education about major health problems and their prevention and control, depending on the country's socioeconomic and political features. Such care could be delivered by a group of health workers working in collaboration with the local community. This is the first level of contract between the individual and the health system, in which basic health care is delivered. The majority of common health complaints and issues can be satisfactorily addressed at this level of treatment, which is closest to the people. This care is delivered by primary health centres and their sub-centries in India, with community engagement.

B) Secondary Health Care

Secondary healthcare is a stage of the health-care system in which patients from primary care are referred to specialists in higher-level facilities for treatment. District hospitals and Community Health Centres at the block level are secondary health care centres in India. At this level, more complicated problems are addressed; care is mostly curative in nature and is delivered by district hospitals and community health centres. This is the initial level of referral in the health system. Medical specialists provide health care services at such centres. They might not meet patients for the first time. Patients may obtain these services through physician recommendation or self-referral, depending on the National Health System's policies. Cardiologists, urologists, dermatologists, and other specialists are examples of secondary health care professionals. Acute care is provided, as well as a brief stay in a hospital emergency department for a dangerous but brief illness.

Psychiatrists, physiotherapists, respiratory therapists, speech therapists, and other secondary care providers may not work in hospitals. In India, Secondary Health Centers include District Hospitals and Community Health Centers at the block level.



C) Tertiary Health Care

Tertiary health care is a third level of medical treatment that provides specialist consultation care to patients who have been referred by primary and secondary medical care. The major components of tertiary health care are specialised intensive care units, enhanced diagnostic support services, and skilled medical professionals. Medical colleges and advanced medical research institutes in India provide tertiary care as part of the public health system. Medical facilities and large hospitals provide extremely technical and advanced services. These are the national specialised hospitals. Clients with diseases that pose a major threat to their health and that require highly technical and specialised knowledge, facilities, and personnel to treat properly are served at this level. This level provides extremely specialised care. The regional central level institutions provide this care. These facilities not only provide highly specialised care, but also planning and managerial skills and training for specialised staff. Furthermore, the efforts taken at the primary level are supported and supplemented by the tertiary level.

Health Economics

Health Economics is the study of how individuals, health care professionals, and governments make decisions about health and health care using economic theory, models, and empirical methodologies. It's a subfield of economics, but it's more than just applying ordinary economic theory to health and health care. Health Economics is strongly rooted in economic theory, but it also includes a corpus of theory built expressly to understand the behaviour of patients, doctors, and hospitals, as well as analytical approaches to aid resource allocation decisions in health care.

In its methodology, health economics has evolved into a highly specialised topic that incorporates epidemiology, statistics, psychology, operations research, and mathematics. Alternatively, it could be considered an important component of a collection of health-related analytical approaches known as health services research.

Scope of Health Economics

In both positive and normative ways, health economics addresses difficulties in the healthcare system. The normative concerns concern what should be the acceptable budget allocation for HIV/AIDS control, for example. In health care/medical care, the positive field of health economics applies all modern microeconomic ideas. Positive health economics deals with the demand for health care and the factors that influence it, such as individual income, tastes and preferences, elasticity of demand for health problems, urgency of treating a disease, preference for public and private healthcare, supply of healthcare, and so on.

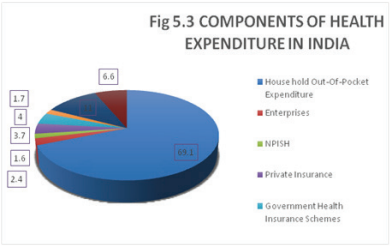
Health Expenditure in India

In India, private spending dominates health spending, a clear result of insufficient public spending. In terms of commitment to improving health services, India's performance is not particularly spectacular. The fact that public health spending in India is so tiny in comparison to GDP is one sign of its insufficiency. Health spending is a crucial indicator of both stronger economic growth and improved health status, making it a useful tool for policymakers. In terms of health, the combined spending on health by both the federal and state governments in India (as a percentage of GDP) have remained stable at roughly 1% for the past half-century. The federal government assists states in covering recurrent and non-recurring programme

costs through direct and indirect (matching funds) assistance. States account for 51% of overall government spending and have wide disparities in health-care spending per capita. Throughout the 1990s, the proportion of public spending on health to overall spending remained constant (Bhat and Jain, 2006).

Out of Pocket Health Expenditure

Out of Pocket Health Expenditure refers to when a person pays for medical care with his or her own money. In other words, charges borne directly by a patient who does not have insurance; also known as direct costs. They include patient payments under cost-sharing clauses unless they are reimbursed by insurance. Spending on general practitioner (GP) and other professional fees (e.g., dentists, opticians, etc.), net outlays on medicines, other medical equipment and services, and net hospital charges are all examples of out-of-pocket health spending. Although statistics on private health expenditure is imperfect and should be treated with caution, the share of out of pocket expenses in overall health care resources has remained consistent over time.



Source: National Health Accounts 2013-14

Table 1: Out-of-Pocket Expenditures on Health (in Rs)

Types of Care (Percent)	Source of Health Care	2004	2014	Compound Annual Growth Rate
Outpatient Care	Public	220	554	9.5
	Private	319	788	9.5
Inpatient Care	Public	3473	6120	5.8
	Private	8804	25850	11.4

Source: Lancet Calculations based on analysis of unit data on NSS 71st round on Health & NSS 61st rounds.

Health Service Costs

The cost of treatment of disease refers to the amount paid by an individual to treat a sickness or disease. Any illness treatment has a cost, and the advantage of avoiding the condition is the cost saved. There are direct and indirect costs. Staff time, medical supplies (including pharmaceuticals), inpatient bed and meal services, capital equipment use, and overheads such as water, heating, and lighting will all be considered. Variable costs, which change depending on the amount of activity (for example, staff time), and fixed costs, which are incurred regardless of the degree of activity, can be separated (for example, heating and lighting). In the long run, almost all costs become variable because those that are fixed in the short run can be changed—for example, by opening and closing wards and establishing new hospitals. All such fixed and variable health service costs are referred to as direct costs in economic evaluation.

Health and Economic Development

Health has a direct and indirect impact on economic development. The results reveal that the indirect influence of health is positive and significant when critical variables such as growth, education, and fertility are all determined simultaneously. The economic benefits of health improvements are underestimated if the indirect function of health is not recognised. In historical terms, health-care measures are likely to have played a minimal part in enhancing humanity's health. Effective medicine was a relatively recent development that occurred late in the twentieth century.

As a result of the current remarkable drop in mortality, the world population has been growing at an unusually fast rate since the mid-1750s. The dissemination of information about the causes of diseases, the improvement in living conditions, and the considerably expanded supply of foodstuffs and hygienic water that became available as a result of the agricultural and industrial revolutions are all factors in the lower mortality rate.

Although life expectancy has a major beneficial impact on economic growth, it raises the age-old argument that it is a proxy for worker experience, and that the extension of a life time signifies more workforce engagement rather than health benefits. To separate the influence of health from that of

experience, control for worker experience, and show that life expectancy as a proxy for health has a large beneficial impact on economic growth. Health has a meaningful productivity impact on economic growth. Education investment will increase as life expectancy rises. Education is thought to be the driver of economic growth, and an increase in life expectancy will lengthen the time horizon over which educational returns can be obtained, encouraging investment as the present value of lifetime wages rises.

Per Capita Expenditure on Health Care Services

From 2008 to 2015, per capita healthcare spending is expected to increase by 5%, reaching US$ 68.6 by 2015. This is attributable to rising affluence, easier access to high-quality healthcare, and more personal health and hygiene awareness. Health insurance penetration has assisted the rise in healthcare spending, which is expected to continue in the future decade. The market for generic pharmaceuticals has become more affordable as the economy has improved. Given the breadth of India and the fact that health is a state topic, examining interstate variances in spending patterns is critical. While the federal government gives funding to states through nationally sponsored schemes based on universal guidelines, state per capita expenditure differs depending on the frequency of diseases and how the funds are used. When these factors are included, there is little variance in central government spending between states.

States spend very different amounts per capita on health. States like Bihar, Madhya Pradesh, Uttar Pradesh, and Orissa, on the other hand, have low per capita expenditures, limited access to health care, and poor health indices. Despite their larger expenditures, Rajasthan and Assam continue to have dismal health indices. (2002, Planning Commission) The private and public sectors' high and low spending do not necessarily go hand in hand. Because the state has been levying user fees and giving pharmaceuticals at cost price to people admitted to government hospitals, out-of-pocket spending in private and government hospitals is nearly identical. In other states, public health spending is woefully inadequate. The public must pay for their own health care, which puts impoverished people in a vulnerable position and is the leading cause of poor health, particularly in poorer states.

Table 2 Per capita Expenditure on Health, As Share of Total Expenditure, for Selected States and Union Territories (Selected), 2014-2015

State / UT	Total State Expenditure on Health (Rs. in Crore)	Total State Expenditure (Rs. in Crore)	Health Expenditure as a Percentage of Total State Expenditure	Per Capita Health Expenditure (Rs)	Health Expenditure as a percentage
Andhra Pradesh	-	106308	-		
Delhi	4256	33113	12.85	GSDP (Gross State domestic Product)	0.86
Goa	566	9761	5.8	2927	1.39
Gujarat	7131	120002	5.94	1156	0.80
Haryana	2835	61450	4.61	1055	0.64
Himachal Pradesh	1562	23417	6.67	2228	1.50
Jammu & Kashmir	2344	41175	5.69	1918	2.33
Karnataka	6416	128078	5.01	1043	0.70
Kerala	5082	79780	6.37	1437	0.97
Maharastra	10973	219075	5.01	931	0.61
Punjab	2873	53258	5.39	1001	0.78
Tamilnadu	8001	160873	4.97	1162	0.73

West Bengal	6140	120727	5.09	665	-
Assam	3626	63609	5.70	1137	1.83
Bihar	5411	128581	4.21	530	1.45
Odisha	3832	73026	5.25	913	1.19
Rajasthan	9311	120861	7.70	1303	1.52
Uttar Pradesh	14159	252919	5.60	665	1.36
Arunachal Pradesh	671	10899	6.16	5196	4.00
Mizoram	536	7359	7.29	5130	4.64
Sikkim	361	6627	5.44	5667	2.37
Chandigarh	307	n.a	-	1823	1.10
Puducherry	444	5703	7.79	2778	1.85

Source: 'Health Sector Financing by Centre and States/UTs in India', National Health Accounts Cell, Ministry of Health & Family Welfare

Trends in Public Expenditure on Health in India

With the advancement of modern health care technology, the cost of health care services has risen as a result of increased use of technology in detection and treatment of diseases, among other things. As health-care costs have risen, access to health-care services has become more inequitable. In India, public expenditure on health accounts for 1.12% of GDP. In nominal terms, health expenditure per capita increased from Rs 621 in 2009-10 to Rs 973 in 2014-15. In 2014-15, the state's share of overall public health spending was 33:67. The Center's percentage of total public health spending has been continuously decreasing over time.

Table 3 Trends in Public Expenditure in India

Year	Public Expenditure on Health (in Rs. Cr)	GDP	Per Capita Public Expenditure on Health (in Rs.)	Public Expenditure on Health as Percentage of GDP (percent)
2009-10	72536	6477827	621	1.12
2010-11	83101	7784115	701	1.07
2011-12	96221	8736039	802	1.10
2012-13	108236	9951344	890	1.09
2013-14	112270	11272764	913	1.00
2014-15	121600.23	12433749	973	0.98
2015-16 (RE)	157743.37	13675331	1252	1.15
2016-17 (BE)	180656.77	15251028	1411	1.18

Source: Compiled from National Health Profile, Central Bureau of Health Intelligence (CBHI) 2017, Govt. of India, (Note: BE-Budget Estimate, RE- Revised Estimate)

The graph shows the trend of Indian government spending. In 2009-10, India spent Rs. 72536 crore on health, accounting for around 1.12 percent of GDP (GDP). There were no extraordinary changes. In 2014-15, public health spending as a percentage of GDP was around 0.98 percent (less than one per cent). The budget forecast for 2016-17 was 1.18 percent of GDP. This demonstrates that, in comparison to other industrialised countries, India's government is unconcerned about health-care financing and spending. The public expenditure on health data per capita increased from Rs. 621 in 2009-10 to Rs. 1411 in 2010-11. (2016-17). The per capita public health expenditure was increased to boost money income rather than to raise people's real income.

Corporate Social Responsibility (CSR)

Section 135 of the revised Companies Act of 2013 includes a provision on corporate social responsibility (CSR). It states that any company with a net worth of $80 million (Rs 5,000 million or more), a turnover of $159 million (Rs 10,000 million or more), or a net profit of $0.80 million (Rs 50 million or more) during any financial year must spend at least 2% of its average net profits over the previous three financial years in accordance with its CSR Policy (GOI 2013). Schedule VII of the 2013 Act, which broadly specifies the areas of CSR spending, will guide the spectrum of CSR operations.

The likelihood of a large sum of money flowing into the social sector has reignited interest in Indian company financial profiles. Although figures ranging from $1.59 billion to $2.39 billion (Rs 100 billion to Rs 150 billion) have been reported, it is difficult to accept them because they are not backed by background study citations (Shrivastava 2014). We calculate the projected CSR pool using Prowess (The Centre for Monitoring Indian Economy generates Prowess, a database of the financial performance of listed and unlisted Indian enterprises, primarily from annual reports of these companies) and the Act's terms.

For the year 2013, 13,951 businesses met CSR requirements. Their average net profit (profit after taxes) for previous three years was $60.73 billion (Rs 3812.28 billion). At a minimum of 2%, CSR liability amounts to $1.21 billion (Rs 76.25 billion), or around 1% of India's current social sector spending.

Importance of Health Insurance

Health insurance is a risk hedge against the possibility that if and when someone falls ill, requires expensive treatments, or is afflicted with a chronic ailment that necessitates long-term care, they will not face financial ruin. Health and wellness are influenced by high-quality health care. A health insurance policy is a contract between an insurance company and a policyholder that protects them from expensive and unexpected medical expenses. Although policyholders pay a monthly premium, co-payments, co-insurance, and deductibles, the total cost is predicted to be far lower than if paid entirely out of pocket.

A government agency, a private enterprise, or a non-profit organisation may give health insurance as a reward. A provider analyses a population's collective medical bills and spreads that risk among policy subscribers to determine pricing. In theory, insurers understand that one person may face significant unexpected costs while another may not. The cost is then shared among a group of people in order to make health care more affordable for everyone. Coverage through a health insurance policy or a government-sponsored health-care programme can help to alleviate the financial burden of health-care costs associated with Cerebral Palsy. Uninsured or underinsured individuals may face financial hardship and seek assistance from other financing sources such as neighbourhood groups, charitable organisations, or local businesses. Providers frequently require payment in advance of services or a payment plan arrangement when there is no health insurance. Long-term protection is provided by health insurance, which helps a family's physical, emotional, and financial well-being.

For persons in poor socioeconomic situations, India's public health care system is the major face of health care. Despite recent efforts to expand and modernise public health facilities, the public health care system continues to be plagued by inadequate management, low service quality, and a lack of funding. Private health care facilities, on the other hand, are more expensive since they offer a mix of high and low-quality treatments. As a result, in the absence of other health-financial options, families are forced to borrow, sell assets, or deplete significant resources to cover hospitalisation bills.

Health Insurance in India

Inequalities in access to health care persist in Indian communities even after more than 70 years of independence. These disparities in health-care access are linked to socioeconomic position, geography, and gender, and are exacerbated by high out-of-pocket costs, with households bearing more than 3/4 of the rising health-care costs. The rise in health-care demand has driven up the cost of care to the point where specialist care is out of reach for the average person. Only 14% of Indians have health insurance, most of which is inadequate.

Only 5% of households are covered by any health system or insurance, according to the National Family Health Survey-3. Because to their distinct social and economic situations, such as the inability to bear hospital expenses at an uncertain time, rural inhabitants are more vulnerable to hazards such as illness, injury, accident, and death. For the same reason, financial assistance to poor families is required. Health insurance may be a tool to overcome financial obstacles and provide access to high-quality medical treatment. Health insurance is a financial instrument that allows "an individual or group" to pay a premium in advance for health care coverage.

In India, health insurance is becoming a more important part of the economy. The health sector accounted for 3.9 percent of India's gross domestic output in 2011. This is one of the lowest among the BRICS (Brazil, Russia, India, China, and South Africa) economies, according to the World Health Organization (WHO). There are policies available that protect both individuals and families. Health insurance accounts for 5-10% of this 3.9 percent, employers for about 9%, and consumer spending accounts for an incredible 82 percent. The health insurance premium for the financial year 2014-15 was Rs.20,440 crores.

Primary health care services, whether provided by a skilled doctor working privately or in a public clinic, should ideally be covered by health insurance plans because they provide the greatest health benefits. It has been suggested that the current emphasis on hospital treatment may fuel greater hospital salaries and make it more difficult to recruit doctors to community health institutions (HLEG, 2011). The government's current five-year plan (Planning Commission, 2012) forecasted the expansion of health insurance to cover primary health care services, which might assist allocate monies to primary care. One possibility is to use insurance contributions to boost the operational budgets of community primary health care centres. Funding based on the quantity of services provided would encourage clinic availability and sustain many under-funded clinics. Priority should be given to areas of highest need when gradually implementing such a strategy (rural communities and urban slums).

Conclusion

Health economics has become a critical tool for those who plan, deliver, receive, or pay for health care. It is critical that everyone involved in this process understands and is aware of the ideas of health economic evaluation. Economic evaluations examine the costs and advantages of using health programmes in comparison to competing options. Various economic assessment strategies exist, which aid decision-makers in obtaining information regarding value for money and, as a result, improving the impact of the resources we spend.

References

Datt, Ruddar; and K.P.M. Sundharam. *Indian Economy*. S. Chand Group, 2009.

Ravindran, T.K. Sundari. "Public-Private Partnerships in Maternal Health Services." *Economic and Political Weekly*, vol. 46, 2011.

Chellaiyan, Vinoth G., et al. "Telemedicine in India: Where do we Stand?." *Journal of Family Medicine and Primary Care*, vol. 8, no. 6, 2019, pp. 1872-76.

Bharadwaj, Krishna "Regional Differentiation in India." *Industry and Agriculture in India Since Independence*, edited by T.V. Sathyamurthy, Oxford University Press, 1995, pp. 189-99.

Economic Survey 2009-10. Ministry of Finance, Government of India.

Zodpey, Sanjay, and Habib Hasan Farooqui. "Universal Health Coverage in India: Progress Achieved & the Way Forward." *Indian Journal of Medical Research*, vol. 147, no. 4, 2018, pp. 327-29.

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