The fault line of poor health infrastructure

As and when India emerges on the other side of the pandemic, bolstering public care systems has to be the top priority

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As the second wave of the COVID-19 pandemic ravages India, many bitter home truths and fault lines have been starkly exposed. One of these is the abysmally poor state of the country's health infrastructure. World Bank data (https://bit.ly/3u4cHfg) reveal that India had 85.7 physicians per 1,00,000 people in 2017 (in contrast to 98 in Pakistan, 58 in Bangladesh, 100 in Sri Lanka and 241 in Japan), 53 beds per 1,00,000 people (in contrast to 63 in Pakistan, 79.5 in Bangladesh, 415 in Sri Lanka and 1,298 in Japan), and 172.7 nurses and midwives per 1,00,000 people (in contrast to 220 in Sri Lanka, 40 in Bangladesh, 70 in Pakistan, and 1,220 in Japan).

Stagnant expenditure

This situation is a direct result of the appallingly low public health expenditure. The latest data narrative from the Centre for Economic Data and Analysis (CEDA), Ashoka University, shows that this has been stagnant for years: 1% of GDP 2013-14 and 1.28% in 2017-18 (including expenditure by the Centre, all States and Union Territories) (https://bit.ly/3bw3O7Y).

Health is a State subject in India and State spending constitutes 68.6% of all the government health expenditure. However, the Centre ends up being the key player in public health management because the main bodies with technical expertise are under central control. The States lack corresponding expert bodies such as the National Centre for Disease Control or the Indian Council of Medical Research. States also differ a great deal in terms of the fiscal space to deal with the novel coronavirus pandemic because of the wide variation in per capita health expenditure.

Inter-State variation

CEDA has prepared an interactive graphic that allows users to see the inter-State variation in per capita health-care expenditure in 21 major States and how this has changed from 2010-11 to 2019-20 (https://bit.ly/3bw3O7Y). Kerala and Delhi have been close to the top in all the years.

Bihar, Jharkhand and Uttar Pradesh, States that have been consistently towards the bottom of the ranking in all years, are struggling to cope with the pandemic, as a result of a deadly combination of dismal health infrastructure as well as myopic policy disregarding scientific evidence and expert advice. Odisha is noteworthy as it had the same per capita health expenditure as Uttar Pradesh in 2010, but now has more than double that of Uttar Pradesh. This is reflected in its relatively good COVID-19 management.

Given the dreadfully low levels of public health provision, India has among the highest out-of-pocket (OOP) expenditures of all countries in the world, i.e. money that people spend on their own at the time they receive health care.

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The World Health Organization estimates that 62% of the total health expenditure in India is OOP, among the highest in the world. CEDA's analysis shows that some of the poorest States (Uttar Pradesh, Bihar, Madhya Pradesh, Jharkhand and Odisha) have a high ratio of OOP expenditures in total health expenditure.

This regressive nature of OOP health expenditure has been highlighted in the past (https://bit.ly/33RpyXq). Essentially, this means that the poor in the poorest States, the most vulnerable sections, are the worst victims of a health emergency. The surreal and tragic visuals of bodies floating in the Ganga serve as a grim reminder that the poor have no dignity in life or in death. Families that have been stripped to the bone trying to save the lives of their loved ones cannot even afford a decent final farewell for them.

Government's role critical

The inter-State variation in health expenditure highlights the need for a coordinated national plan at the central level to fight the pandemic. The Centre already tightly controls major decisions, including additional resources raised specifically for pandemic relief, e.g. the Prime Minister's Citizen Assistance and Relief in Emergency Situations (PM CARES) Fund. The early declarations of victory over COVID-19 were very clearly credited to the central government. CEDA has shown that the first round of vaccinations, where the vaccines were procured by the Centre and distributed to the States, was marked by considerable inter-State variation, which was neither explained by the case load nor by the share of eligible (45+) population (https://bit.ly/3bx9Gh5).

Now that the disease is ravaging the country and the need for a coordinated strategy on essential supplies of oxygen and vaccines is acute, the central government has shifted most of the responsibilities on to the States, including that of procuring vaccines from the international market. This is inefficient, as the Centre can bargain for a good price from vaccine manufacturers in its capacity as a single large buyer (like the European Union did for its member states) and benefit from the economies of scale in transportation of vaccines into the country. Once the vaccines arrive in India, these could be distributed across States equitably in a needs-based and transparent manner.

Another benefit of central coordination is that distribution of constrained resources (medical supplies, financial resources) can internalise the existing disparities in health infrastructure across States. A decentralised management, on the other hand, exacerbates the existing inequities, as better-off States can outcompete others in procuring resources. This is evident in the vaccine procurement with various States floating separate global tenders.

A policy brief

In April 2020, CEDA came out with a policy brief, where among other measures, it recommended the creation of a "Pandemic Preparedness Unit" (PPU) by the central government, which would streamline disease surveillance and reporting systems; coordinate public health management and policy responses across all levels of government; formulate policies to mitigate economic and social costs, and communicate effectively about the health crisis (https://bit.ly/2RV4ywh). We had not foreseen the ferocity of the second wave; but knowing how deadly this is, our suggestion acquires even greater urgency.

Indians were already "one illness away" from falling into poverty (https://bit.ly/3oxXvWq). Families devastated by the loss of lives and livelihoods as a result of this pandemic will feel the distress for decades to come. The central government needs to deploy all available resources to support the health and livelihood expenses of COVID-19-ravaged families immediately. As and when we emerge on the other side of the pandemic, bolstering public health-care systems has to be the topmost priority for all governments: the Centre as well as States.

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