

# The State of India's Health-Care System in 10 Charts..

Mar 24,2020



Source: Credit

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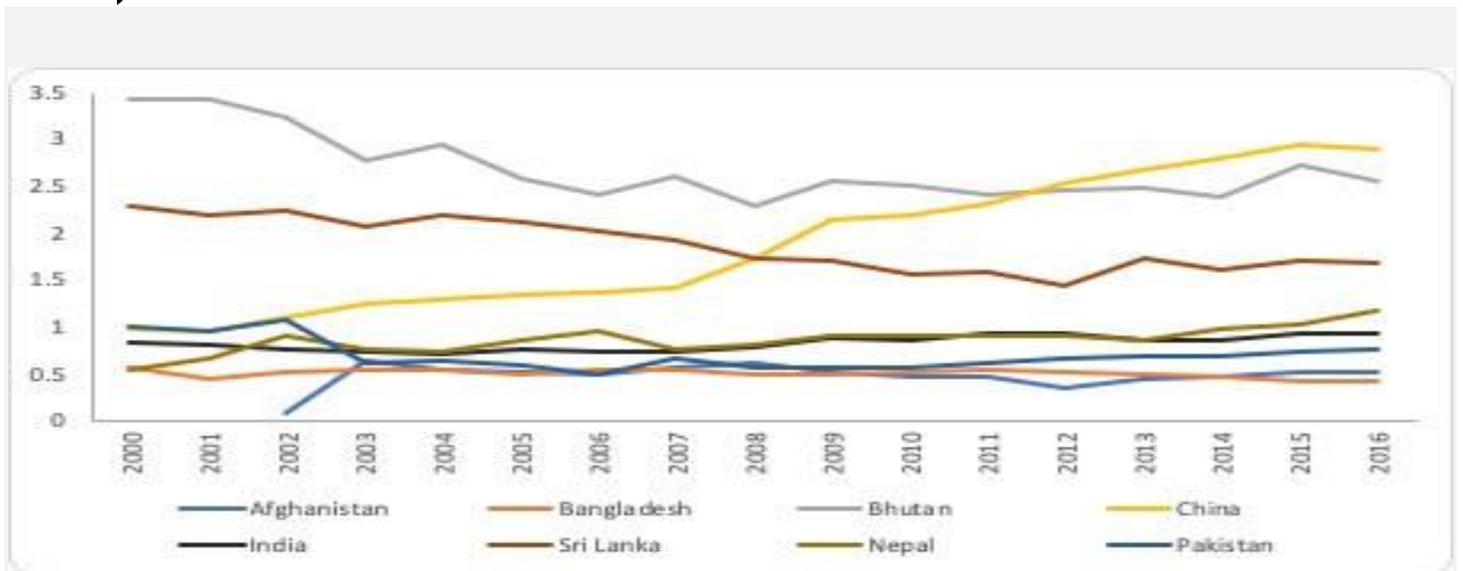
*\*This article has been written more exclusively for South Asian Voices (Stimson Centre) to provide access to additional data-points and explanation, if required...Access to the original article is accessible from [here](#).*

The Number of those testing positive from the novel coronavirus in India rose to 450 today after more than 30 fresh cases were reported, according to Health Ministry data. The figure now includes 41 foreign nationals and the seven deaths reported so far. The 450 figure also includes 24 people who have been cured, discharged or migrated, it said. The Indian Council of Medical Research (ICMR) said 18,383 samples have been tested till 10 am on Monday.

One key question emerges at this stage (and one many have been asking of late): **Is India's healthcare system capable of responding to the surge seen in COVID19 positive cases or worse, an epidemic outbreak?** Here, we bring forward 10 key data-points to help one understand the state of India's current healthcare system.

If one looks at each nation's domestic government spending on health-care (% of GDP), compared to most other SAARC nations, India reports much low public healthcare spending (see Figure 1). Out of pocket health expenditure, as a key component of private health spending (from the citizenry), has remained almost thrice that of public health expenditure during 2000–2016 in India. This is in sharp contrast to the out of pocket reported in either the middle income (39% of current health expenditure in 2016) or low income (40.1% of current health expenditure in 2016) or high-income countries (13.7% of current health expenditure in 2016).[2]

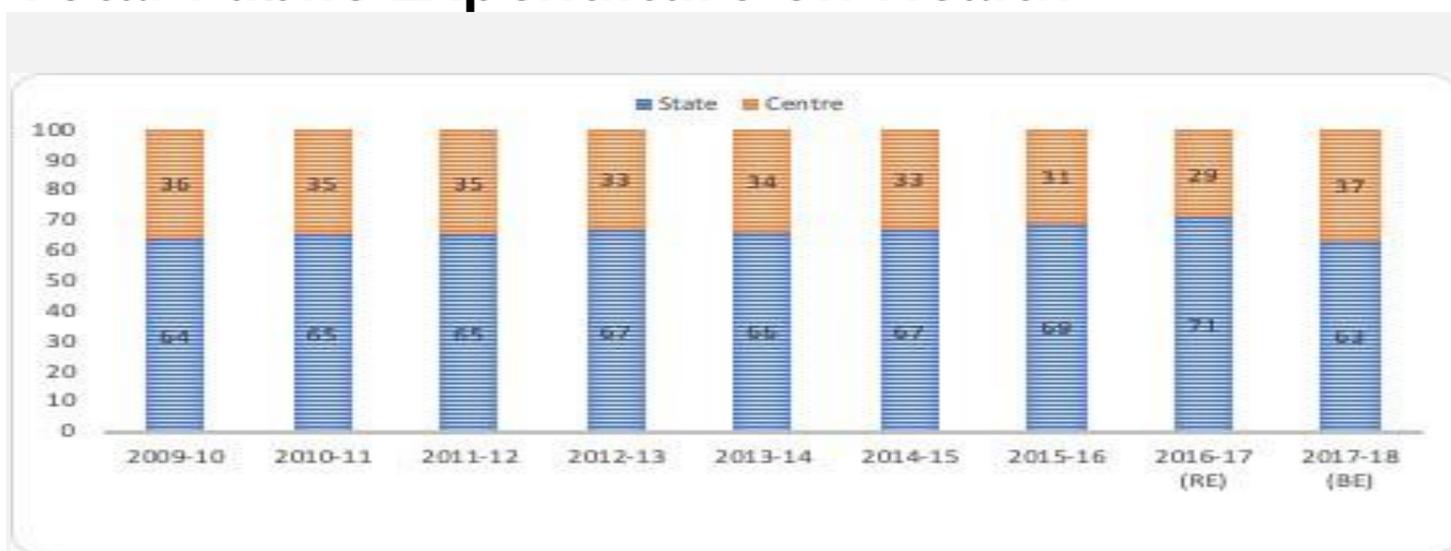
**Figure 1: Domestic Government Health Expenditure (% of GDP) in India–China & select–SAARC nations**



Source: <https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?view=chart>, accessed on 20th March 2020

Even though Article 47 of the Indian Constitution directs the states to raise levels of population nutrition and to improve public health, overall public healthcare spending in India comprises of different allocative expenditures by the central, state government and local bodies. Figure 2 below shows the trends in centre-state share in health spending in India, with only a recent increase in the centre's share.

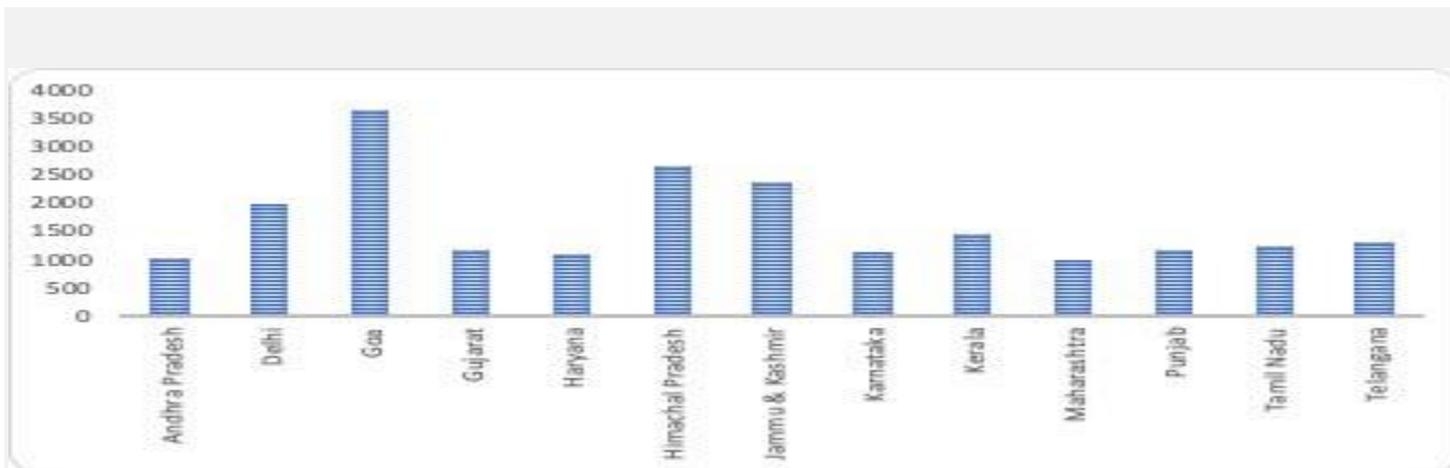
## Figure 2: Trends in Centre–State share (%) in Total Public Expenditure on Health



Source: <http://www.cbhidghs.nic.in/showfile.php?lid=1147>, (page 197), accessed on 20th March 2020

While state governments constitute the major share of health spending, there exists variations across the states, as reflected by variations in per capita health expenditure (see Figure 3). It is needless to say that there are larger variations within states, across rural and urban areas.

## Figure 3: Per Capita Health Expenditure (Rs), as of 2015–16

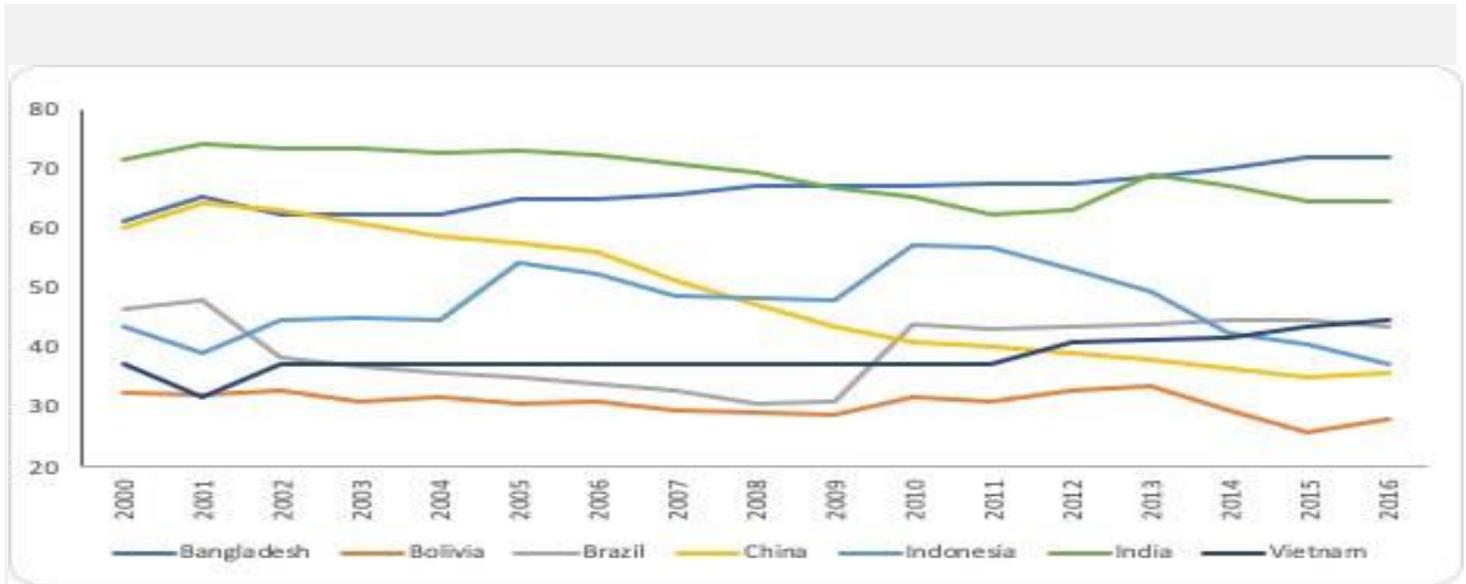


Source: <http://www.cbhidghs.nic.in/showfile.php?lid=1147>. (pg 177), accessed on 20th March 2020

Not only is private healthcare spending much higher than government spending in India, but within the private health spending component, the share of out of pocket spending is higher than most the other developing countries.

As more and more private labs are asked to increase testing, the affordability of tests (inclusive of COVID19 cases) will be a major decision-making barrier for those at the bottom scale of the socio-economic pyramid. Figure 4 shows that the level of such expenditure has remained high in India over time, compared to some other developing countries.

## Figure 4: Out-of-pocket expenditure (% of current health expenditure) for select few lower-middle income economies

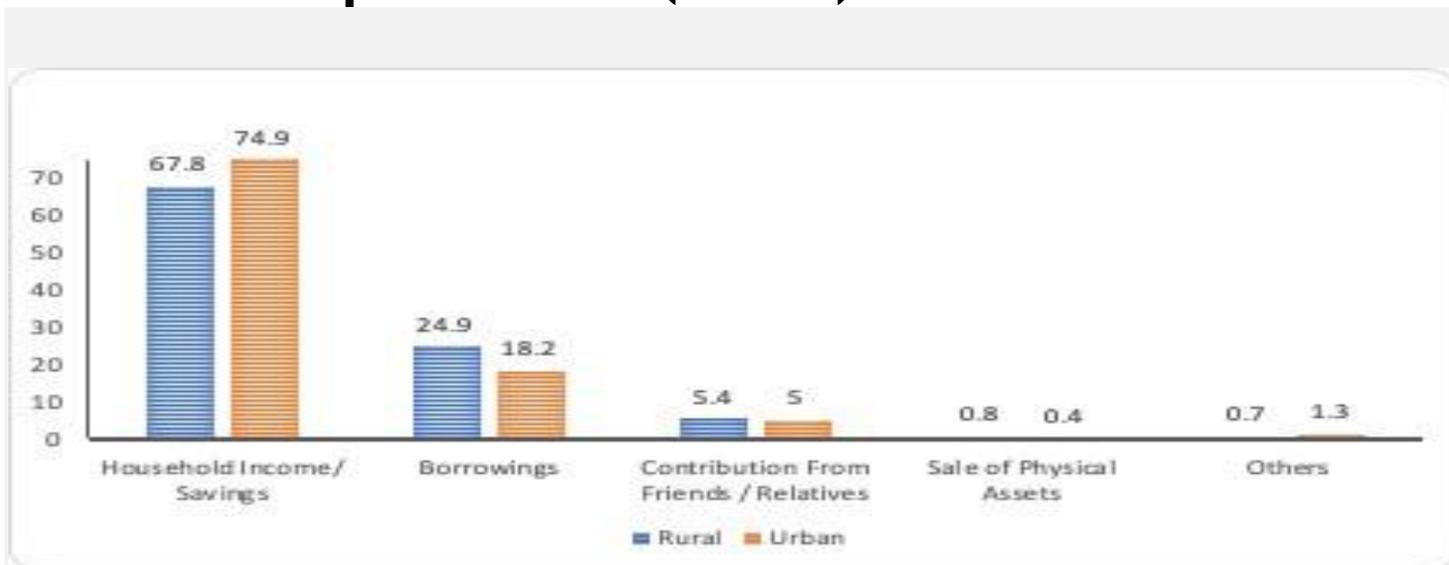


Source: <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?view=chart>, accessed on 20th March 2020

Incidence of personal medical expenditure is unpredictable and unavoidable for many citizens unlike any other expenditure. In absence of financial protection, as in most developing countries, households adjust their health expenditure either by divesting savings, borrowing, selling assets or by forgoing treatment.

Figure 5 below shows how, for most Indians, household income or savings is the key source of health expenditure in both rural and urban areas. This presents a strong case for more direct transfers to people -at the earliest possible time-period, in enabling them to afford costs of treatment-testing along with other basic essential utilities (this includes many of those who are vulnerable and work in the unorganized, informal sectors).

## Figure 5: Percent of households reporting different sources of finance for meeting their medical expenditure (2014)



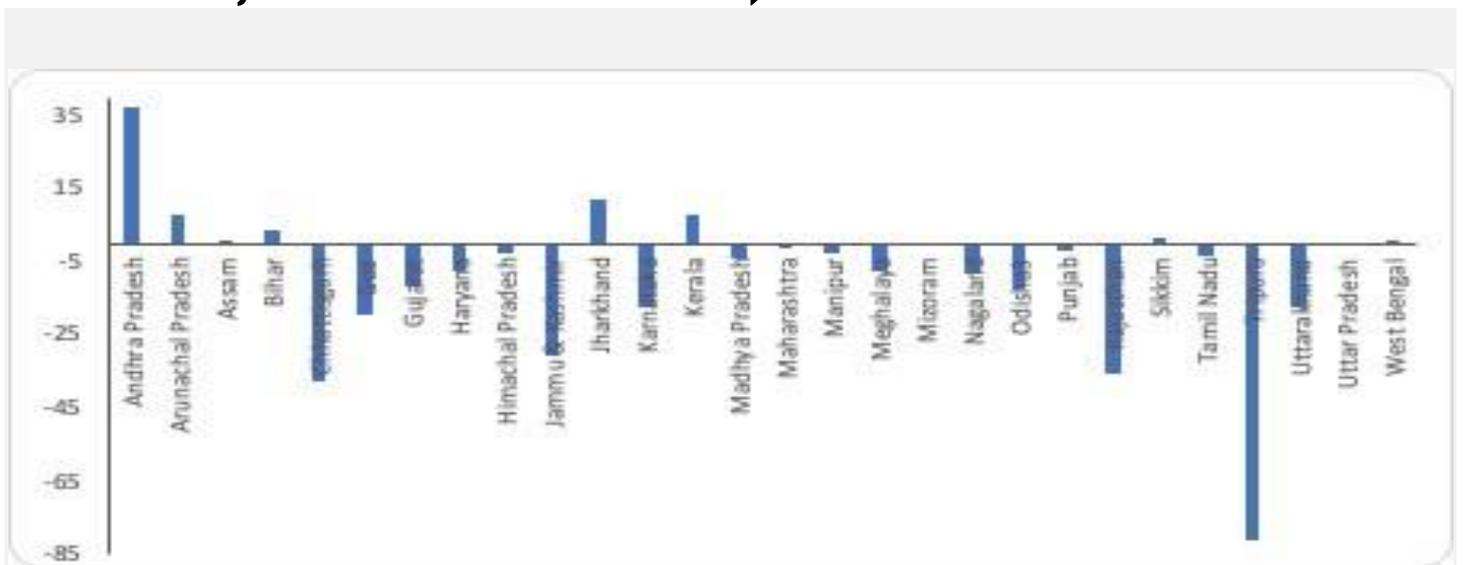
Source: <http://www.cbhidghs.nic.in/showfile.php?lid=1147>, (page 182), accessed on 20th March 2020

As notified by the Union health ministry, those allowed to test for COVID19 symptoms in private labs will charge a (maximum) fee of Rs. 4500/ for screening and confirmatory tests. Many of those-at the bottom of the socio-economic pyramid would find it extremely difficult to afford any of these expenses (without any form of direct income support or unless all testing is made free).

For worse, what could happen is many low-income groups might refrain from pursuing tests or getting treatment -even with COVID symptoms- due to (high) cost concerns. Immediate Direct cash transfers are essential in allowing most within the vulnerable working group population to meet high estimated medical expenses.

From the perspective of state-wise per capita medical resources available (i.e. hospitals, hospital beds, no. of doctors etc.), Figure 6, 7 and 8 below show the state wise distribution of these with data points on: Total number of sub-centres Primary health clinics (PHCs), Community level centres (CHCs), Public hospitals and Hospital beds.

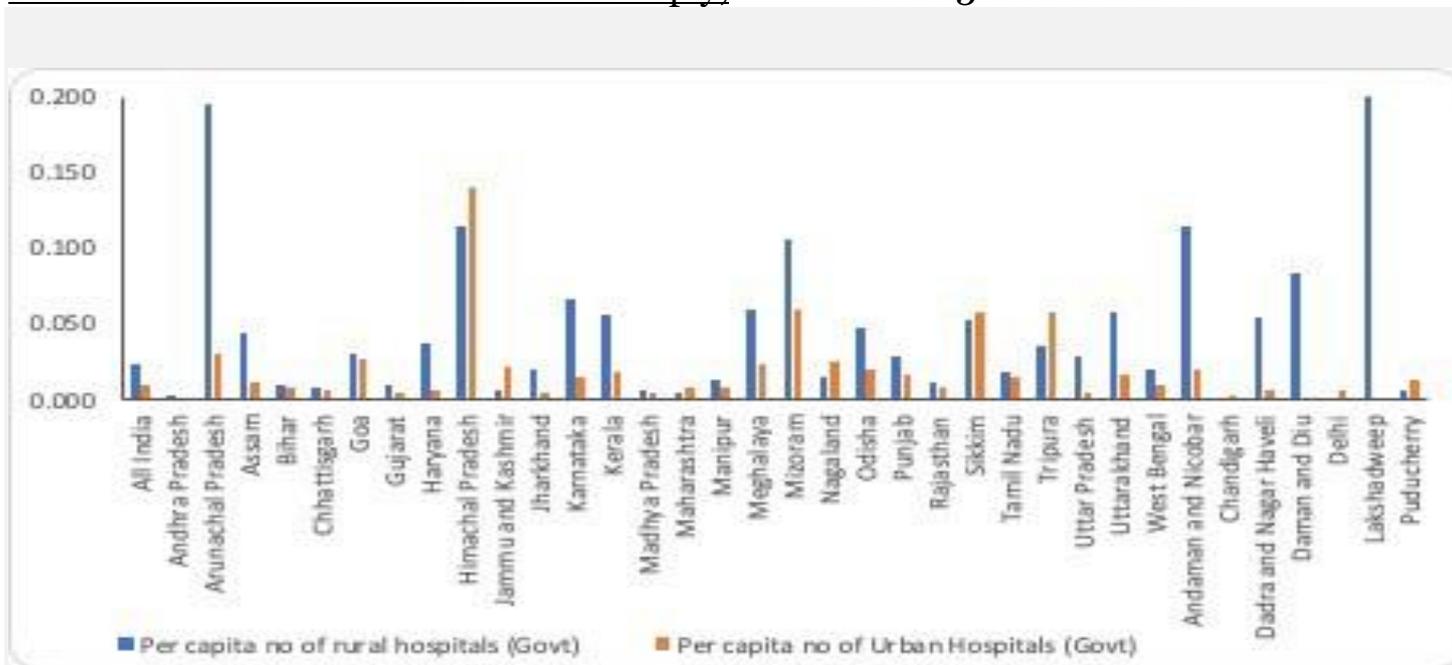
## Figure 6: Percent change in number of public health facilities between 2005 to 2015 (Sub-centres, PHCs and CHCs)



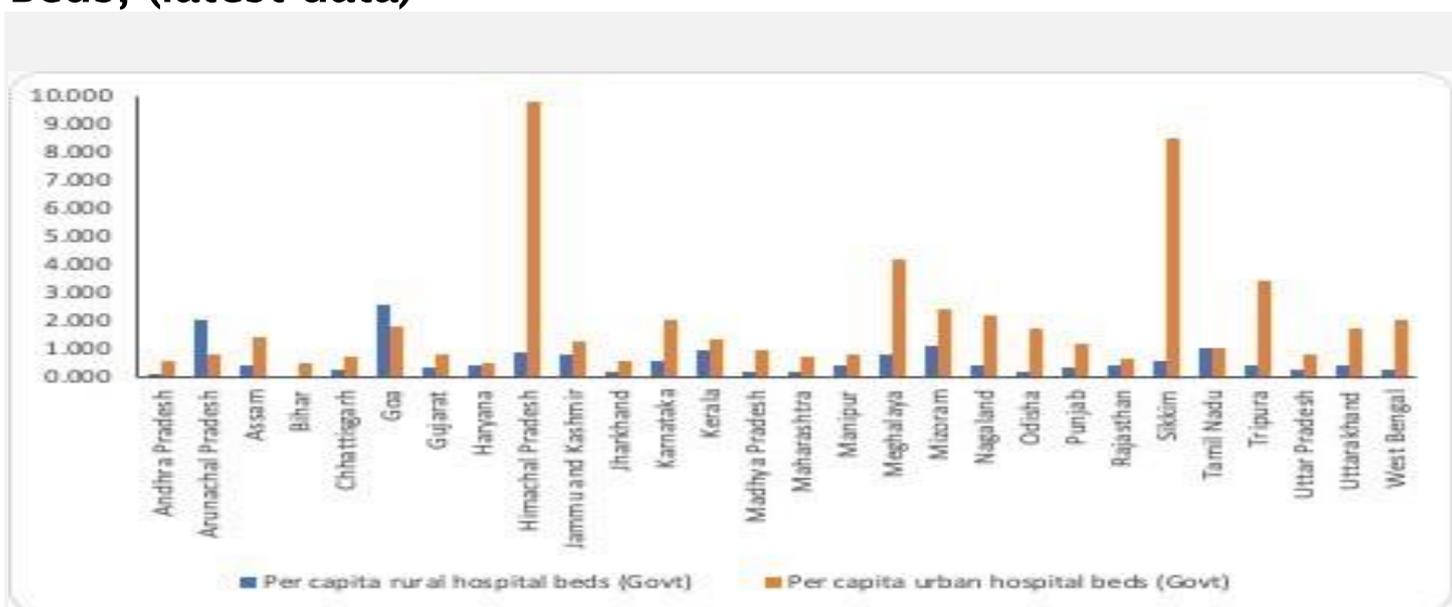
Source: <https://niti.gov.in/content/health-infrastructure>, accessed on 20th March 2020

**Figure 7: Per capita State–Wise Availability of Public Hospitals, (latest data)**

Source: <https://data.gov.in/resources/stateut-wise-number-government-hospital-beds-facilities-rural-and-urban-areas-reply>, accessed on 13th March 2020



**Figure 8: Per capita State–Wise Availability of Public Hospital Beds, (latest data)**



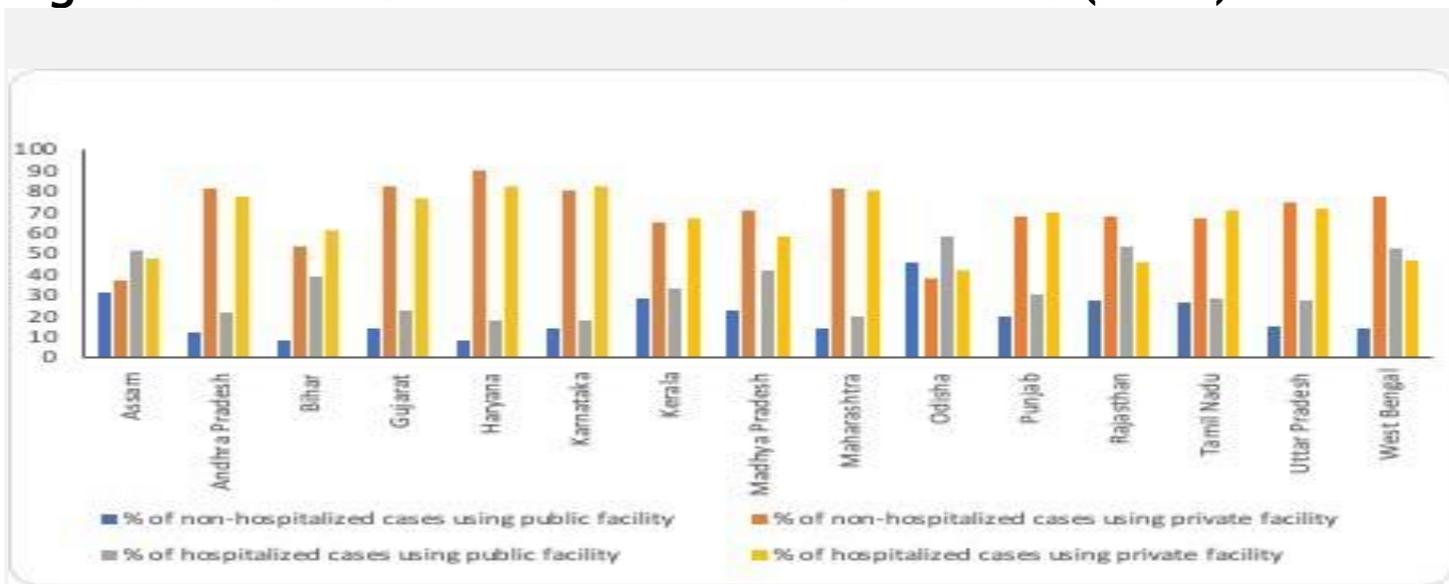
Source: <https://data.gov.in/resources/stateut-wise-number-government-hospital-beds-facilities-rural-and-urban-areas-reply>, accessed on 13th March 2020

Wide variation in the number of public hospital beds per capita in different states is worth noting (see Figure 8). States like Arunachal Pradesh and Tamil Nadu have relatively higher number of per capita public hospital beds.

Also, in a heterogenous, asymmetric distribution of medical facilities and resources in terms of the number of public hospitals, hospital beds poses serious challenges for many states- and require urgent intervention and support from the Union Government.

There are also serious variations in terms of healthcare utilisation -as seen across rural and urban areas within states. Figure 9 below shows how the percent of non-hospitalised cases in urban areas are higher in private facilities across all the reported states, except Odisha. Percent of hospitalised cases in public hospital are reported higher only in Assam, Odisha, Rajasthan and West Bengal. The share is higher in private facilities for all the other states.

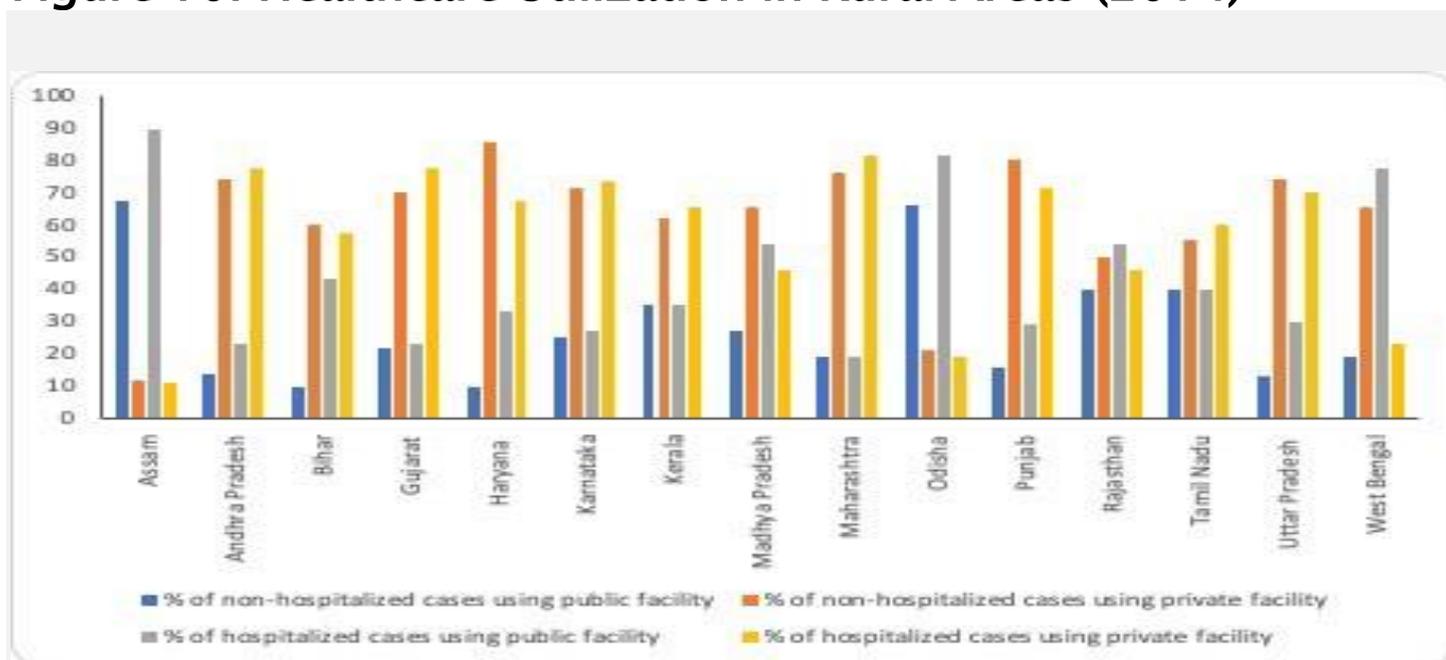
**Figure 9: Healthcare Utilization in Urban Areas (2014)**



Source: [http://nhsrcindia.org/sites/default/files/State%20Fact%20Sheets Health%20care%20Utilization%20and%20Expenditure%20in%20India.pdf](http://nhsrcindia.org/sites/default/files/State%20Fact%20Sheets%20Health%20care%20Utilization%20and%20Expenditure%20in%20India.pdf), accessed on 15th March 2020

When comparing the percent of hospitalised and non-hospitalised cases in public versus private facilities in the rural areas, we observe that the share is higher in the public facilities in Assam and Odisha (see Figure 10). Shares are higher in public facilities for the non-hospitalised cases in Assam, Madhya Pradesh, Odisha, Rajasthan and West Bengal. Overall, Odisha reports higher utilisation of public facilities (for hospitalised and non-hospitalised cases) in both rural and urban areas.

**Figure 10: Healthcare Utilization in Rural Areas (2014)**



Source: [http://nhsrcindia.org/sites/default/files/State%20Fact%20Sheets Health%20care%20Utilization%20and%20Expenditure%20in%20India.pdf](http://nhsrcindia.org/sites/default/files/State%20Fact%20Sheets%20Health%20care%20Utilization%20and%20Expenditure%20in%20India.pdf), accessed on 15th March 2020

All these data-points thus, reflect the asymmetric, fragmented nature of India's underfunded public healthcare system. In the current landscape, it lacks the capacity to deal with any form of calamitic/pandemic/epidemic outbreak (unless radical national level measures are pursued now). From an institutional-agency perspective, as argued before, the Union government through its emergency powers can consider establishing one stop-shop, time-bound special purpose vehicle in the form of a National Health Finance Corporation (NHFC).

The NHFC- earlier proposed by noted American economic historian Barry Eichengreen, can function as a remodelled version of the Reconstruction Finance Corporation — created in response to the Great Depression in the US to support plans under the New Deal (under Roosevelt) and helped stabilise the banking sector under the Hoover Administration (1932).

An NHFC can also help coordinate with various central, state and local government public and private health facilities and help scale up the hospital infrastructure (in cities and rural areas) through a centralized channel. It can help ensure transfer of swift capital and medical resources to states with large affected populations, and provide essential units of ventilators, respirators, masks and other private protective equipment for medical staff and doctors (to limit their own exposure).

With exclusive financial powers granted from the Union government, the institution can also help ensure a swift transfer of capital and medical resources for transport to states with large-infected populations (as of now states like Maharashtra, Kerala could to be prioritized).

On how to finance an institution like this, a government owned special purpose vehicle like NHFC- as proposed here, can be financed through a special contingency fund that can sourced from a set of contingent wealth tax (say, 2–3%) on the top 1% wealth-income group, along with an encouragement for voluntary contributions (exempt from taxes) from the most wealthy to generate enough private-capital in pooling resources for an emergency one is likely to witness in days-and maybe weeks to come.

[1] *Deepanshu Mohan is Associate Professor and Director, Centre for New Economics Studies, O.P. Jindal Global University. Ayona Bhattacharjee is Assistant Professor at International Management Institute in New Delhi.*

[2] Data Source: Data on out of pocket expenditure (% of current health expenditure) from The World Bank database, accessed on 20th March 2020