

## Composition of the sub-commission

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## Dissent note

Received from Dr. Bharat Jhunjhunwala and commented upon by Dr. V.R. Panchamukhi, Dr. Abhay Bang, Dr. Ranjit Roy Chaudhury, Shri Alok Mukhopadhyay - all members of the NCMH.

The Commission's Report seeks to enhance government expenditures on health from present 0.9% to 3.0% of GDP. There is no evidence that present government health expenditures are having a positive impact on the health status of the people. An increase was, therefore, acceptable only if the direction and quality of government health expenditures had been re-prioritized keeping in view the experience till now.

Data from the National Human Development Report 2001 are given in the table below. It is seen that low IMR states had lower public spending on health and vice-versa. This shows that higher public expenditures on health are not having a positive impact on health indicators.

The same result was confirmed in a study undertaken for 49 large countries. It was found that the impact of government social sector expenditures on economic growth was neg-

State	Public Spending on Health as Percentage Of Gross State Domestic Product, 1998-99 (Table 7.8)	Infant Mortality Rate 1991 (Table 5.9)
<b>Averages</b>		
Low IMR States	1.49	56.9
High IMR States	1.63	93.1
<b>Low IMR States</b>		
Manipur	1.95	28
Kerala	0.95	42
Goa	1.48	51
Haryana	0.71	52
Tamil Nadu	1.35	54
Andhra	1.61	55
Sikkim	4.92	60
West Bengal	0.94	62
Karnataka	1.01	74
Maharashtra	0.61	74
Punjab	0.86	74
<b>High IMR States</b>		
Bihar	0.75	75
Gujarat	0.94	78
Meghalaya	2.32	80
Himachal	2.63	82
Tripura	2.14	82
Rajasthan	1.35	87
Arunachal	3.65	91
Assam	1.05	92
Uttar Pradesh	0.91	99
Orissa	1.25	125
Madhya Pradesh	0.94	133

ative - a one percent increase in social sector expenditures as a share of GNP was observed to lead to a negative impact of (-) 0.14% on the growth rate (Bharat Junjunwala, Welfare State and Globalization, Rawat Publications, 2000, page 372).

The Commission's Report fails to recognize this fact and seeks higher allocation of public revenues on health. It was necessary to explain the ineffectiveness of present public expenditures upfront and to seek higher expenditures after removing the bottlenecks.

## Comments

The above said tables and statistics do not necessarily prove the points which Dr. Jhunjhunwala is making. The reasons are the following:

- Effectiveness of public spending on health sector cannot be and should not be gauged in terms of only Infant Mortality Rates.
- The direction of the flow of causality is not clear when only two variables are considered. One could also argue that the states that had had relatively lower IMR's were the ones, which received lower public spending on health- indeed a rational situation. Obviously, the states that had already realized lower IMR's, did not require higher public spending.
- The IMR's refer to the period 1991 and the public spending on health pertain to the year 1998-99. (We presume the years given in the tables are correct.) If that is so, then, how can Dr. Jhunjhunwala draw inferences about the impact of public spending on IMR's? Some logical flaw seems to be there.
- All the averages seem to be simple averages. They should be weighted averages with suitable weights. Analysis based on simple averages for such diverse states is methodologically not correct.
- Rearrangement of the states with a different cut off rate for IMR's, as Low IMR and High IMR would give different results. Take, for example, 70 as the cut off rate for High IMR states. Then, Karnataka, Maharashtra and Punjab also get included in the High IMR category. Then, the table of the averages (again simple averages) reads as follows:

Low IMR States	1.73	50.5
High IMR States	1.45	89.0

The inference in this case is quite contrary to what Dr. Jhunjhunwala puts forward. The states with lower IMR rates had had higher public spending rates!?! (Of course, we use the flow of causality in the same direction as used by Dr. Jhunjhunwala). This should mean that higher public spending on health has been effective in reducing the average IMR rates. This inference is as spurious as the earlier one drawn out by Dr. Jhunjhunwala.

In regard to the inference drawn in the study entitled Welfare State and Globalization, it is not clear as to what kind of regression equation has been used. If it is based on a two variable equation, then the direction of causality is debatable. Direction of causality is a debatable issue even in a multiple regression model. Further, there are questions about the good-

ness of fit, statistical significance of the estimate, tests for multicollinearity in the context of a multiple regression model, etc. It is a well known fact that results based on cross section data are of doubtful utility, unless the diversity of the country level characteristics, such as, initial conditions, institutional framework, educational status, stage of development etc. etc. is properly accounted for.

Strategic importance of social sector's development and social sector expenditure in the context of overall development of a nation and not just growth is well recognized in the literature. The World Bank study on Indonesian crisis of the late nineties has clearly brought out that one of the factors responsible for the adverse effects of the crisis situation is the inadequacy of social sector expenditure, even during the high growth period. The Social Summit, held in the early nineties, has clearly brought out the compulsions of recognizing the importance of the social aspects of development and the government's role in this regard. It is common experience that the countries that have not cared for social sector development, have landed themselves into a realm of instabilities and even poor pace of overall development.

Overall, the relationships between variables are spurious and not systematic. The specification of the econometric model is not based on any theory or on past evidence and is adhoc. Nor is a appropriate estimation method identified or used. Besides, simple regression method is inappropriate and the problem of simultaneity and specification tests have to be taken into account. Finally, definition and measurement of variables are also not given.

### Dissent note

The issues of poor management of public health facilities presently have been recognized in the Commission's Report. But the issue of inter-se prioritisation between different types of health expenditures has been ignored. The focus of present public health expenditures is on medical relief or cura-

tive services (including primary, secondary and tertiary health-care). Less attention has been given to public health education, regulation, research, etc.

In a study undertaken by the National Institute of Public Finance and Policy, K N Reddy had ranked the impact of various components of public health expenditures by their impact on IMR (Health Expenditures in India, Working paper No 14, National Institute of Public Finance and Policy, New Delhi, 1992):

It will be seen that medical relief which accounted for the largest share of the public expenditures had a low rank of 5; while mass education, laboratories, research and prevention of disease were all ranked higher yet accounted for only 13.5% of the public health expenditures.

### Comments

- (i) Again, one should recognize that IMR is not a comprehensive index of the Health Status of a nation. (ii) The above study is a highly dated one. (iii) Mere ranking of the different variables is not a good basis for prioritisation. One should study, in quantitative terms, (say, through analysis of variance), the relative contributions of the different variables to the explanation of the behaviour of the dependent variable in a regression equation. (iv) While one may not deny the importance of prevention and medical education and research, one should recognize that medical relief and related medical services deserve priority attention in a highly disease ridden society. (v) Comparison with many other countries clearly brings out that in India, expenditure on medical relief has been highly inadequate, in relation to the needs of the society. (vi) The absorption capacities of the different segments of the society in the different regions of the country would be quite diverse in quantity and quality. Prioritisation of the different types of services should be based on micro level studies.

### Influence of Health Expenditures on IMR

Description	Rank	%share
Mass Education Training, Research & Evaluation	1	1.41
Public Health Laboratories	2	0.39
Health Education, Training & Research	3	0.68
Prevention & Control of Diseases	4	11.03
Maternal & Child Health	5	1.52
Rural Family Planning Services	5	6.18
Medical Relief	5	39.47
Urban Family Planning Services	6	1.12
Medical Education, Training and Research	7	10.74
Other Systems of Medicine	8	3.99
Others (including administration, etc)		32.47
Total		100.00

### Dissent note

The Commission's Report has failed to face this issue upfront. As a result it has again asked for Rs.40,600 crores or 58% of the proposed allocation for Delivery of Services; and the total outlay proposed on Health Promotion, Regulatory Systems, and R&D is Rs.8,906 crore or 12.7% (Table 32). This will lead for the vast amount of money being spent on activities which are not effective.

### Comments

Unfortunately it is true that the public health care is insensitive and inefficient, and hence, may appear not

cost effective. However, this feature is not unalterable, and should not be used to conclude that the socially supported primary health care is redundant. It only underscores the important need to make the public health care sensitive and efficient. We do not agree that the Report does not recognize these shortcomings in the public health delivery systems. Infact it quite explicitly points to the urgency of improving the efficiency of the delivery system and streamlining of its Organizational framework. The Report does provide lot of material for self-appraisal by the Government system and also for a critical assessment of the role of the Private sector, as of today. In our view, The health system, characterized by the blend of the private and public sectors, needs to be revamped and the public sector has to provide the lead for the same. This step needs to be taken up in addition to the task of expanding the Medical Relief activities in the different parts of the country.

### Dissent note

In particular, there was a need to enhance public expenditure on research to say, Rs.20,000 crores from the Rs.4,000 crores provided. The country will have to invest heavily in this area to bring down the price of new drugs and technologies and to give a healthy and fitting contest to the high-cost technologies being provided by the Multinational Corporations. This money can be used to give research contracts to government institutions, universities as well as private drug companies.

### Comments

In our view the expenditure on research should be increased in a phased manner keeping in mind the absorption capacity of the society. Further, the state expenditure on research should only act as a catalyst and as an engine for provoking more expenditure by the private sector on R&D activities. Further, the government should design policies in such a way as to attract more and more of multinational expenditure for setting up research laboratories within the country, so that the research talent of the country is retained within the country and the value addition benefits accrue to the nation. Government should streamline the institutional facilities for registration of patenting and for improvement of the regulatory system. In other words, it is the composition of expenditure on research support and not the size of spending alone, which matters more.

### Dissent note

The difficulty ..... is that of implementation. Rajiv Gandhi had once said that only 15 paise of the money reached the intended beneficiaries. An increase of this massive proportion will have a negative impact on economic growth, employment and welfare of the people due to heavier tax-

tion; but the benefits will be uncertain given the problems of government delivery systems that we are presently straddled with.

### Comments

No one denies the need for improving the delivery system in the country. Can the Government wait until the delivery system is overhauled in such a way that full one rupee reaches the final beneficiary? Has the government stopped its spending ever since Rajiv Gandhi made those celebrated observations? The purpose of those observations was to provoke some sort of streamlining of the delivery system and to improve the status of public accountability of the governmental machinery.

### Dissent note

A further difficulty is that the government has to decide between various expenditure options. The Commission has rightly established that economic growth will be positively impacted by an increase in government health expenditures along with quality improvements. But similar results may be obtained by investment in highways, irrigation, forests, power, etc. The case for higher investment in health has to be made not merely by showing a Benefit-Cost Ratio of greater than one; but by showing that the Benefit-Cost ratio in health is higher than in other investments. This has not been done. The result is likely to be that increase in public investment in health will not take place in view of the competing claims from other sectors also showing a positive impact of investment on economic growth and this report will become a non-starter.

### Comments

- (i) The above paragraph recognizes with appreciation the point made in the Report that economic growth will be positively impacted by an increase in government health expenditures along with quality improvements. This recognition seems to be in contrast with the observations made at the beginning of the Dissent Note, to the effect that social expenditure has negative effect on growth.
- (ii) We should remember that this Commission was not set up to prepare a comprehensive development plan for the nation. While the benefits of investments in infrastructure etc. are well recognized in the academic and policy circles, the important fact that health expenditure should not be ignored, has not received the same attention. There is no harm in the initiative of the Commission in acting as a spokesperson for the health sector and for making a case for more resources for the health system in the country. We do not agree with the view that in view of the resource constraint, the report would be a non-starter.

We feel that the Ministry of Health should use all its clout to get the main recommendations of the Report implemented.

In one of the meetings we have found that the Honourable Minister of Health has been quite supportive of the main thrust of the Report. Missing the present opportunity once again would be, in our view, quite detrimental to the long-term interests of the people of the country.

### Dissent note

The Commission has duly recognized that labour-intensive sectors need to be protected and employment and incomes generated for the poor. While this is in the right direction, a mere recommendation is inadequate in the absence of strong supporting data. The need was to place this in a comparative policy framework.

The objective is to provide the people, especially the poor, with health care services. An alternative method of attaining this would be to incur the additional 2.1% of GDP as a cost for the promotion of labour-intensive production. A heavy taxation of, for example, machine woven cloth will immediately generate crores of jobs for the poor in weaving of handloom cloth while the nation will have to buy high-priced cloth leading to lower growth rate. This will be a type of indirect taxation by forcing people to buy high-priced goods produced by labour-intensive methods. A comparative analysis of these two approaches was required. The increased incomes would enable the people to increase their household expenditures on health services and procure them from the market. This approach for reaching health care services to the people will empower the people instead of making them dependent on government provision. The cost to the economy may also be less than the 2.1% of the GDP - though this has to be studied in detail.

### Comments

- i) Yes, it is important to argue that job-less growth is not good for the country. (We could also argue that growth that aggravates income disparities is not desirable. Similarly, a strategy that generates growth, which is not environmentally sustainable, should not be pursued.) It is also important to recognize that the country should encourage labour-intensive technologies in the different economic activities. But how do these contentions belittle the strategic importance of allocating more resources for strengthening the health system in the country? In fact, we should recognize that the productivity of labour, for use in labour-intensive activities, would be considerably enhanced if the health status of the human resources were made stronger.
- ii) We do not agree with the contention that by merely creating additional job opportunities and by enhancing the income levels of a few persons, we would be able to improve the health system of the country. In the globalizing world, we are dangerously poised on a situation wherein adoption of labour intensive technologies would not remain a matter of our choice. We

are also observing that as the country is integrating itself more and more with the rest of the world, income disparities are widening, costs of medical services are increasing and unethical practices on drugs supplies and medical services are growing. How can mere reliance on market forces stop all these processes? Moreover, as the State is withdrawing more and more from the production activities, its responsibilities in providing the long-neglected social sector services would increase manifold.

- iii) We fail to understand as to how heavy taxation on machine woven cloth, for generating crores of jobs for the poor, would be a feasible proposition in this fast changing market driven competitive world, particularly when the Multifiber Agreement ceases to be operative shortly. In case, this step is feasible, let it also be adopted for generating more jobs and also more resources, which could be then utilised for implementing the recommendations of this path-breaking Report of the Commission.

### Dissent note

This is important because health is a State subject and the Union Government has little leeway in being able to influence the health delivery systems at the state level; while it has much greater policy freedom in economic policies.

This approach will be in tune with philosophy of lean government and the objective of reduction of fiscal deficit placed by the Fiscal Responsibility and Budget Management Act.

### Comments

It is difficult to accept the contention that the Fiscal Responsibility Act should be enforced by cutting expenditures on the social sectors, in particular health expenditures. There are many other elements of wasteful government expenditures, which need to be cut and streamlined.

### Dissent note

Instead of trying to reduce the household expenditures as a measure of reaching to the poor; it would be better to increase household expenditure-and-income of the poor.

The recommendations of the Commission will come to a naught if the State Governments are not able to increase their share of the tax-and-spend in the health sector. The above mentioned economic policies will not be implemented since they have not been asked for; and the tax-and-spend policies will not be implemented because of competing claims other political factors.

### Comments

We do not see an alternative to an increase in public spending on health. A task force has been recommended to examine these very cases related to resource mobilization.

Some of the above points need to be taken up by the implementing ministry and other agencies, when once an action programme is worked out for implementing the Report.

### Dissent note

#### Role of the Private Sector

The Commission's Report faults the private sector for focusing on profit maximization and being "hardly concerned with public health goals, making state intervention essential" (page 39). Certainly state intervention is necessary. But it need not be through tax-and-spend mechanism. We have successfully privatised airports, telecom, ports, electricity distribution and highways. The private sector in these areas is equally focused on profit maximization and not concerned with public welfare goals. But the regulatory framework ensures that the private sector works in tandem with public welfare goals. The ability lies in creating a regulatory framework that harnesses the energy, zeal, innovativeness and creativity of the private sector for attaining public goals.

The same approach should be adopted in the health sector. State intervention should take the form of regulations that cajole and prod the private health sector in directions determined by state policy.

### Comments

The Report does recognize the imperatives of setting up regulatory mechanisms for motivating the private sectors to fall in line with the noble social obligations and responsibilities, which the public health system is supposed to uphold. The Report has also not taken kindly on the failures of the pub-

lic health system and has recommended some alternative organizational innovations for improving the functioning of the drivers of the health costs.

### Dissent note

This applies to drug market as well. The Commission's Report has suggested price control on essential drugs. It should be examined whether the same price reduction could be achieved by implementing a competition policy. Government regulation should mainly be in the area of quality control rather than price.

This applies also to the area of medical education. The Commission's report says that high cost of medical education leads to high cost of medical services (page 64). The solution proposed is to provide government subsidies in medical education. An alternative would be to implement a competition policy and strengthen regulation in medical education. Competition in the medical education market will bring down the price of medical education and also the cost of services in due time.

The potential in medical tourism and telemedicine is immense and a proactive policy framework is required to fructify this potential. The Commission's report does not deal with the potentials, obstacles and policies required in this direction.

### Comment

The above issues have been discussed and tradeoffs particularly in respect of welfare implications have been spelt out in the Report. As already noted, tertiary care and its attendant medical tourism was not deliberated upon in this Report.