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# AN OVERVIEW OF HEALTH ECONOMICS AND HEALTH POLICIES IN INDIA

***Shailesh Kansal****
***Raj Singh*****

**ABSTRACT**

*Health is an essential part of human development. Health is a state of happiness of an individual as well as community. It encompasses a state of complete mental, physical and social well being. Healthy society is critical for raising productivity and economic growth rate in developing countries like India. India is on the path of achieving the goal of "Health for All" as proposed by the World Health Organization. HFA implies the removal of obstacles to health, interalia, elimination of malnutrition, disease, provision of protected drinking water and hygienic housing. It depends on constant development in medicine and public health. Health economics and health care are important in determining how to improve health outcomes and lifestyle outlines through interfaces between individuals, healthcare benefactors and clinical settings. In broad terms, health economists study the functioning of healthcare schemes and health-affecting behaviors such as Epidemic, Usage of pharmaceutical equipments on economic cost, pandemic, smoking, diabetes, and obesity etc. This paper provides an overview of health economics and health policies in India.*

**Keywords:** Health economics, National Health Policy, Pandemic.

## INTRODUCTION

Health is one of the prime concerns of any nation. Health is an important entitlement that enhances capabilities of the masses. Healthy people refer to those who are physically, mentally and intellectually healthy. A healthy mind and proper intellectual development help develop proper manpower that is suitable for economic development. On the other hand, with greater economic development better health facilities are needed. The need is further accentuated because of the environmental implications of development as well as the opportunities created for attaining health through better facilities. Health determines and is determined by the socio-economic factors like education, nutrition, population growth, income and environment.

***Shailesh Kansal** is Assistant Professor at the Department of Management, Mewar University Gangrar, Chittorgarh, Rajasthan. Email: shelesh@mewaruniversity.co.in

****Raj Singh** is Assistant Professor at the Department of Management, Mewar University. Email: raj@mewaruniversity.co.in

In recent years, the meaning of development has shifted from economic improvement to improvement in human resources. Health should be considered as a fundamental human right and therefore the attainment of the highest level of health should be the most important goal. The Directive Principles of the State policy of the Indian Constitution mentions that it is the duty of the State to raise the level of nutrition and the standard of living of people and improvement of community health (Article 47 of the Indian Constitution). The Constitution of the WHO says, "Enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social condition."

Welfare economics has branched off into many applied discipline and important among them with significant social relevance is "*Economics of Health*". Awareness of the economic manifestation of health and diseases and the limited resources allocated to health care services has brought to the focus, a new discipline of health economics. The ultimate aim of all human activity is social well–being. Maximization of welfare is the keynote of modern planning. In the human resources development process, health occupies major position. Health care is an important aim of normative economics. Improvement in the health status of the population is a priority and suitable political, economic and social action is called for, apart from the growth of the science of health care as such. Man is the primary factor of production. Basic standards of health and improvements thereof provide an entry point to change agents.

"*Health Economics*" is becoming an emerging branch of Economics. Health Economics includes the medical industry as an entire field and spread to such issues as the economic analysis of the cost of diseases, benefits of health programmes, revenues from investment in medical education training and research. Health Economics is the discipline that controls the price and the quantity of limited financial and non-financial resources dedicated to the care of the sick and elevation of health.

Health Economics is difficult to define in a few words because it encompasses such a broad range of concepts, theories, and topics. The Mosby Medical Encyclopedia (1992, p. 361) defines Health Economics as follows:

*Health economics studies the supply and demand of health care resources and the impact of health care resources on a population.*

**Concept of Health Care**

Health is influenced by a number of influences such as adequate food, housing, sanitation, healthy lifestyles, protection against environmental hazardous and communicable diseases. Thus "health care" is not synonymous with "medical care". 'Health Care' covers a broader spectrum of personal health services ranging from health education and information through prevention of disease, early diagnosis and treatment and rehabilitation. The term, 'health services', implies organization, delivery, staffing, regulation and quality control. The term, medical care, refers to the personal services that are provided directly by physicians.`

**Modern Methods of Health Care Analysis**

Models are used in economics to simplify a very complex world and it can be stated in descriptive, graphical or mathematic form.

**Positive and Normative Analysis**

Positive analysis uses economic theory and empirical analysis to make statements or predictions concerning economic behavior. Positive economics deals with objective explanations and the testing and rejection of theories. For example; a fall in incomes will lead to a rise in demand for own-label supermarket foods. And, if the government raises the tax on beer, this will lead to a fall in profits of the brewers.

Normative analysis deals with the desirability of an economic outcome or policy. It seeks to answer the question, '*What ought to be'* or *'which is better*?' Normative statements are subjective statements – i.e. they carry value judgments. For example; 'Pollution is the most serious economic problem'; Unemployment is more harmful than inflation'; 'the government is right to introduce a ban on smoking in public places.'

**Cost-Benefit Analysis**

Economists treat people as rational decision makers. Rationality means people know how to rank their preferences from high to low or best to worst, people will make choices based on their own self-interests and choose those activities, they expect, will provide them with the best net satisfaction.

**Utility Analysis**

Why an individual desires health?

The stock of health generates a flow of services as other durable goods do. The services yield satisfaction or what economists call 'utility'. As a good, health is desired for consumption and investment purposes. From a consumption perspective, an individual desires to remain healthy because he or she receives utility from an overall improvement in the quality of life. The investment component worries the relation between health and time these models would help to resolve several health care problems faced by the individuals, organizations and society at large.

**Health for All**

In 1997 AD, it was decided, in the Health Assembly of the World Health Organization, to launch the movement known as "Health for all" by the year 2000 AD. In 1978 AD, the Alma Ata Conference reaffirmed 'Health for All" as the major social goal of Governments. In 1981 AD, the global strategy for 'Health for All' was adopted by the World Health Organization, which was later endorsed by the United Nations General Assembly.

'Health for All' has been defined as attainment of:

"A level of health that will enable every individual to lead a socially and economically productive life".

The Declaration of Alma Ata stated that the best way to achieve the goal of 'Health for All' is by providing primary health care, especially to the vast majority of under-served rural people and urban poor. But it is left to each Government to decide how it should be made available in a manner appropriate to the people's need.

To achieve the goal of health for all, a number of intermediate goals have been planned in between as below.

1. Providing adequate basic sanitation for all.
2. Providing adequate supply of drinking water for all.
3. Immunization of children against five common diseases viz., Measles, Whooping Cough, Tetanus, Polio and Tuberculosis.

**National Strategy for Health in India**

In the context of achieving the goal of 'Health for All', the Ministry of Health and Family Welfare, Government of India, had convened a National Conference in February 1980 to discuss about national strategies and action plans. In July 1980, the Planning Commission, appointed a Working Group on `Health for All' to evolve national strategies for implementation of health care programmes, to move towards the goal of 'Health for All' and to suggest suitable indicators to monitor the progress achieved from time to time.

The concept of 'Health for All' implies a substantial change in basic health policies and its approaches to health care. The changes may entail a complete restructuring and revamping the health and social security systems. The Working Group, appointed by the Planning Commission, felt that the existing health care system in the country should be restructured to provide universal primary health care to all sections of the society with special attention to the needs of those living in tribal, hilly and remote rural areas.

**National Health Policy**

Health has been a major problem in India during the British regime. The colonial administration did not pay serious attention to improve the health standards of the people. Realizing the gravity of the situation, the Constitution Framers have made a specific mention that the 'State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public as among its primary duties. But unfortunately, till 1983, National Health Policy was not formulated. It was carried on as merely a part of the National Five Year Plan Programme.

In successive Five Year Plans (FYP), several measures have been taken to provide health facilities to all people. In the first two Five Year Plans, it was aimed at putting the foundation of basic health services including creation of primary health Centers and district/block level hospitals. Significantly, the Third Plan gave birth to the Countrywide Extension Approach to Family Planning (FP). The next two Plans contemplated on integration of health and family planning services with focus on communicable diseases. India, being signatory to the Alma Ata Declaration, 1978, a landmark declaration towards health care, was committed for achieving the goal of 'Health For All' by 2000 A.D. through Primary Health Care Approach. This had led to the formulation of comprehensive National Health Policy (NHP), in 1983. It was adopted in the Sixth Plan and implemented during the Sixth and Seventh Five Year Plans.

The basic objective of National Health Policy was promotion of health as integral part of the human resource development. The Eighth Five Year Plan emphasized upon the

improvement in the efficiency and effectiveness of both the programmes and services. Besides, special programmes for mothers, children and the disabled were launched along with hospital-based interventions and referral care at all levels. A rapid expansion of health care services, infrastructure and strengthening of personnel has been visible during the nineties. The Ninth Five Year Plan Perspective on Health is not much different from earlier goals. It provides a gloomy picture of the existing health care services and reveals that health care system is functioning sub- optically.

**Health Related Issues in India**

The health problems of India could be conveniently grouped under the following heads:

**Communicable Disease Problems**

Communicable diseases continue to be a major problem in India. Diseases considered to be of great importance today are Malaria, Tuberculosis, Leprosy and Venereal diseases, Diarrhea, Dysentery, Skin Diseases, Fever and Viral Hepatitis.

**Nutritional Problems**

Surveys indicate that the major bottleneck in Indian diet is shortage of calories. Against the recommended allowance of 2,400 calories for an average male adult engaged in secondary occupation in rural areas, the typical Indian diet hardly supplies 2,000 calories. The specific nutrition problems in the country are: (I) Protein malnutrition, (2) Anemia and (3) Vitamin deficiencies.

**Environmental Sanitation**

The twin problems of environmental sanitation are: (a) lack of safe drinking water in many areas of the country, and (b) embryonic methods of excreta disposal especially in the rural areas where 70 per cent of the population live. The causes for the leading diseases in India are deep rooted in the environment. A major reduction in these diseases cannot be expected to occur without a basic change in the environment especially with regard to water supply, sewerage and waste disposal.

**Pandemic Situation:**

A pandemic is defined as the "worldwide spread of a new disease." When a new disease first emerges, most of us lack the natural immunity to fight it off. This can cause a sudden, sometimes rapid, spread of the disease between people, across communities, and around the world. Without a natural immunity to fight off an illness, many people can become sick as it spreads.

How the spread of the disease fits into the following phase:

- **Phase 1**. At the point when another ailment initially rises, the majority of us come up short on the characteristic in susceptibility to fend it off. This can cause an abrupt, once in a while quick, spread of the illness between individuals, across networks, and around the globe. Without a characteristic resistance to fend off a sickness, numerous individuals can get wiped out as it spreads.

- **Phase 2.** Virus infection flowing among the animal populaces appears to transmit to individuals. This new infection is viewed as a danger and sign of the potential danger of a pandemic.
- **Phase 3.** This type of animal virus cause disease in a small cluster of human beings through animals to human transmission. However, human to human transmission is too low to cause community outbreaks. This means that the virus places humans at risk but is unlikely to cause a pandemic.
- **Phase 4.** There has been man-to-man transmission of the new virus in considerable enough numbers to lead to community outbreaks. This kind of transmission among humans signals a high risk of a pandemic developing.
- **Phase 5**. There is transmission of the new virus in at least one additional country within the WHO region. This is known as the pandemic phase and signals that a global pandemic is currently occurring.

Nowadays the whole world is facing a big pandemic situation i.e. COVID 19.The COVID-19 pandemic has led to lockdowns and many of us are staying at home and there is reduced social interactions and exercise. This can have a negative effect on one's physical and mental health.

**Medical Care Problems**

Medical care in India is mostly based on western medicine. With the advancement of technology, medical care has become complex and costly. Increased public awareness about the potentialities of medical care has increased its demand.

**Problems of Rural Health**

In low income countries, Government hospitals and clinics, which account for the major part of the modern medical care, are often insufficient, suffering from highly centralized decision making, wide fluctuations in budgetary allocations and poor motivation of managers and health care workers.

People, in general, in rural areas, are not knowledgeable about health matters, such as, the prevailing health problems in the community, methods to prevent and control them, the needs for the maintenance and promotion of health, the resources available and to utilize them etc. Socio-economic backwardness, ignorance, traditions and superstitions have been acting as blocks to progressive thinking including development of positive health.

**Health Attainment**

The National Human Development Report, 2001, has brought out the indicators on health attainment for the country and states for different periods. It is found to be relevant to analyze that health attainment made by the country and states, which will facilitate better understanding of the problem of health of the country, states and regions.

**Death Rate**

The death rates for three years viz., 2000, 2001 to 2020, combined for rural and urban

areas for the nation and the states, are presented in this diagram. As shown in the table, the death rate has declined from 8.304to 7.309 between 2020 to 2000 for the country.

**Table 1**: **India - Historical Death Rate Data**

| Year | Death Rate | Growth Rate |
|---|---|---|
| 2020 | 7.309 | 0.49% |
| 2019 | 7.273 | 0.50% |
| 2018 | 7.237 | -0.07% |
| 2017 | 7.242 | -0.07% |
| 2016 | 7.247 | -0.08% |
| 2015 | 7.253 | -0.07% |
| 2014 | 7.258 | -0.07% |
| 2013 | 7.263 | -1.48% |
| 2012 | 7.372 | -1.44% |
| 2011 | 7.48 | -1.44% |
| 2010 | 7.589 | -1.40% |
| 2009 | 7.697 | -1.40% |
| 2008 | 7.806 | -1.44% |
| 2007 | 7.92 | -1.42% |
| 2006 | 8.034 | -1.39% |
| 2005 | 8.147 | -1.38% |
| 2004 | 8.261 | -1.36% |
| 2003 | 8.375 | -1.68% |
| 2002 | 8.518 | -1.65% |
| 2001 | 8.661 | -1.62% |
| 2000 | 8.804 | -1.60% |

***Source:*** Macrotrends.net

**Health Problems in Urban Areas**

Generally, it is assumed that people in urban areas are well covered by health services saturated with large hospitals, innumerable dispensaries, nursing homes, specialists and general practitioners.

In spite of such concentration of health facilities in the cities compared to rural areas and relative proximity of hospital and other facilities, standards of health care seem to have fallen far below reasonable minimum levels for those who live in slums. There is a phenomenon of an “inverse care law”, whereby, those who are in greatest need of medical care have poorest access to it. While the principles of delivery of primary health care are equally applicable to

urban health system as to the rural health, the slum population remains ignored on this account to this date. There also exists a vast discrepancy between the qualities of health care delivered by the private sector within the different sections of urban population.

The health delivery system of an urban area, particularly that of large cities, consists of hospitals, dispensaries and maternal and child health and urban family welfare centers run by the Government, Municipal Corporation, Central Government Health Scheme and Employees State Insurance Scheme.

The presence of large number of hospitals and out-patient departments certainly cause a depressing effect upon the development of a more coherent health infrastructure in cities. Network of health centers and sub-centers such as those planned in rural areas do not exist in urban situations. In practice, many people in the city go to pharmacists for basic advice and visit hospitals only when there is an emergency. This practice inevitably leads to highly curative and irrational approach to health care. Emphasis on cure has been at the cost of preventive and public health measures. Health professional and workers are not properly motivated to serve the weaker sections of the community.

In order to gain deeper understanding of issues involved in urban health care including needs for family welfare services, various area specific studies were undertaken in the past.

The urban poor live with or die from their burdens of disease and despair. Urban health problems are both easier and more difficult to manage than in the rural settings: easier because of access, greater readiness for change, and more resources; more difficult because of social fragmentation, heavily contaminated environments, and political instability.

**Health Care Programmes**

Since India became free, several measures have been undertaken by the national government to improve the health of the people. Conspicuous among these measures are the National Health Programs, which have been propelled by the focal government for the control/ annihilation of transmittable maladies, improvement of ecological sanitation, increasing the expectation of nourishment, control of populace and improving citizen's wellbeing. Various international agencies like the WHO (World Health Organization), UNICEF (United Nations Child Emergency Fund), World Bank, as also a number of foreign agencies like SIDA (Swedish International Development Agency), DANIDA (Danish International Development Agency), NORAD (Norwegian Agency for Development) and USAID (United States Agency for International Development) have been providing technical and material assistance in the implementation of the health care programmes.

Due to various programmes of eradiation and control of several preventable communicable diseases, tangible progress in reduction of morbidity and mortality has been achieved. The availability of safe drinking water to the rural population considerably reduces the incidence of communicable diseases such as cholera, malaria, filariasis and Japanese Encephalitis.

A government sector that provides publicly financed and achieved healing and preventive health care services from primary to tertiary level, through the country and free of cost in many programmes to the consumer. The provision of health care by the public sector is a

responsibility shared by state, central and local government, although it is effectively a state responsibility in terms of service delivery, state and local governments incur about three-quarters and the center about one-quarter of public spending on health.

In the Eight Five Year Plan (1992-97), Indian Council of Medical Research (ICMR) attempted to consolidate significant leads in "priority" or "thrust" areas that were identified by various scientific expert groups. These areas included emerging health problems like HIV/AIDS, other important communicable diseases like tuberculosis, leprosy, diarrhea diseases, malaria, filariasis, Japanese encephalitis etc., non-communicable disease like cancer, cardiovascular diseases, metabolic disorders, etc., contraception, Maternal and Child Health (MCH) and nutrition.

Health education and promotion has been an integral component of all national health care programmes and family welfare programmes. The Information Education and Communication (IEC) approach uses a community based strategy. National health programmes are supported with health education and promotion strategies and activities specifically designed to suit programme needs. Such national programmes include leprosy eradication, tuberculosis control, malaria eradication, and HIV/AIDS control, as well as the national iodine deficiency disorder programme and the environmental health and sanitation programmes.

The availability of health and family welfare facilities to the people is directly or indirectly linked with the prevailing mortality and morbidity conditions. It is not surprising that the half of the world's tuberculosis patients and one-third of the world's leprosy patients are in India. Also water-borne diseases such as malaria, cholera, typhoid and gastroenteritis kill a sizeable number of our people every year. The need for health facilities for the growing population has been recognized and there has also been a significant infrastructural development in the health sector. However the high population growth rate has led to constraints and even contributed to the deterioration of the quality of health.

The Government of India takes concerted measures to combat communicable, non-communicable and other major diseases. For this purpose several national health programmes are launched and run by the Union Ministry of Health and Family Welfare which can have a bearing in the reduction of mortality and morbidity and also have a salutary effect on efforts to improve the quality of life of the common man. These programmes also reinforce the delivery of primary, secondary and tertiary health care throughout the country.

Some of these are as follow:

1. National Leprosy Eradication Programme(1955)

   (The word 'control' was modified as 'Eradication'. The new policy named as National Leprosy Eradication programme was introduced in 1983).

2. National Tuberculosis Control Programme(1962)

   (Revised National Tuberculosis Control Programme (DOTS strategy) was implemented in 1997).

3. National Cancer Control Programme(1975)

4. National Programme for Control of Blindness(1976)
5. National Mental Health Programme(1982)
6. National Guinea-Worm Eradication Programme(1984).
7. National AIDS Control Programme(1987)

   (It has been renamed as National AIDS prevention and control Policy and introduced in 2002).
8. National Diabetes Control Programme(1987).
9. National Iodine Deficiency Disorder Control Programme(1992)
10. Yaws Eradication Programme(1996-97).
11. Reproductive and Child Health Programme(1997)
12. National Nutritional Programme(1997)

    (This programme includes Integrated Children Development Scheme (ICDS) (1975), The Balwadi Nutrition Programme (1990-91) and the National Nutritional Anemia Prophylaxis Programme (1990).
13. National Surveillance Programme for Communicable Diseases(1997-98)
14. National Programme for Control and Treatment of Occupational Diseases (1998-99).
15. Vector Borne Diseases Control Programme(2004)
16. The Global Fund supported Intensified Malaria Control Project (2010)
17. SBI COVID-19 Funding Scheme (2020)

The central Government plays a very important part in planning, guiding and co-coordinating all the national health programmes in the country. The programmes are implemented at the state level. These national programmes are not static. New programmes can be added and old programmes can be deleted from the list.

These National Health Programmes are administered and monitored by THE Union Ministry of Health and Family Welfare.

The benefits of the health care programmes are realized by the rural people through primary health care delivery centers as well as the hospitals situated at the district level. With the efforts of the government the morbidity and mortality due to various diseases have been reduced. But it is not sufficient. In many parts of rural areas, due to the lack of treatment and non-availability of medicines from government health centers and impoverishment of patients to meet costly private treatment and medicine expenses, various diseases have caused mortality and morbidity in India.

Care Programmes are not implemented in all the states of India. Selected programmes are implemented in the states of India on the basis of requirement of people and the burden of disease. Malaria fever, tuberculosis, leprosy, women and children mortality and morbidity, Iodine deficiency and blindness are the major diseases prevailing in India. The country has travelled a long distance in health care. But immense challenges still remain to be surmounted.

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