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Provision of health care by the government

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The experiences of countries across the world have demonstrated the need for government involvement in health care (1). Due to the poor quality of India's government health care system, diseases that have declined in many developing countries continue to be common here. Studies indicate that government spending on health care has decreased from 25% to 17% of the country's total health expenditure (both public and private) between 1991 and 2001 (2–6). The annual per capita government spending in India is far below the minimum needed for essential health care in a developing country (7, 8).

Inefficiency of government services

The low level of public spending is compounded by inefficient use of the available resources and inequalities in access to health care based on region, class, caste and gender (1, 2). A recent study of public hospitals in Kerala—one of the better performing states in the country—found that 60% of land, 50% of building space and 25% of the beds remained unutilised (9). Twenty eight per cent of the hospitals reported less than 25% utilisation of their facilities. Most people are dissatisfied with the staff in public services (10). Further, absenteeism among doctors and other public health staff is as high as 67% in some states (11). In some states, the poor are more likely to borrow money when hospitalised in the public sector than in the private sector (7).

People express their dissatisfaction by not using government facilities. The government sector meets the demands of only 18% of outpatient and 40% of inpatient care (2). Even for those living below the poverty line, the private sector accounts for 10% of children immunised, 25% of antenatal care visits, 30% of institutional deliveries and 40% of hospital days.

Today, the very existence of the government health sector is questioned. Increasing input costs, poor absorption of technology by the government sector and the mushrooming of private health care institutions do not help.

Government's failure is private sector's success

The shrinking government sector is accompanied by the growth and expansion of the for-profit, non-governmental sector, encouraged by tax concessions, duty exemptions, and allocation of government land (4, 12).

At the time of Independence, the for-profit sector had a 5%–10% share of the total patient care. Today, it accounts for 82% of outpatient visits, 58% of hospitalisation days, 40% of institutional deliveries, 35% of antenatal care visits, and 15% of children immunised (2). The private sector's success is attributable less to its own efficiency and more to the government's failure (13,14).

At the same time, the growing for-profit private sector, technological innovations and higher awareness levels are some factors responsible for health care costs increasing many times more than general inflation.

Economics and ethics

Economics is 'the study of how societies use scarce resources to produce valuable commodities and distribute them among different people' (15). This means that if society has to optimally allocate 'finite resources' to satisfy 'infinite wants', it must make efficient use of its limited resources.

For the government health care system, efficiency could mean the ideal hospital which is solvent and promotes public health. Alternatively, it could refer to a 'social optimum'— maximising the welfare of the 'whole patient', and not just providing medical care.

Ethics is concerned with the intrinsic importance of many considerations. Of the principles of ethical reasoning, distributive justice is perhaps the most applicable in a discussion of ethics and economics. The ethical view of economic achievement would be to attain wealth not just for one person but for the entire community.

Is it ethical to apply economic principles to assess the performance of government health care provision? One instinctive response is that doing so might deny medical attention to a section of the population. Running a health care system on the basis of efficiency alone may not necessarily meet the needs of the population it is meant to serve. It may, therefore, be seen as unethical to talk of 'efficiency' in government health care provision. On the

other hand, it can be argued that the poor are the most affected when the government health care system ignores economic principles.

On analysing the performance of the government sector *per se* in India, one finds that those sub-sectors serving the advantaged get sufficient resources. Sectors such as health exclude advantaged populations because of their inefficient functioning and, therefore, do not form a part of any policy debate. Health is given low priority during the resource allocation process.

Efficient functioning of government health care institutions should make this sector more competitive and thereby reduce the cost of care in the private sector. At present, the poor are often forced to use the private sector, where health care costs are high. Many go into debt or are denied care because they cannot pay (14). The poor spend 40% of their income on health care while the rich spend just 2.4%. Surely this is an injustice.

In the long run, if government health care institutions do not improve, they may be termed 'sick' and will have to close down. Those most affected will be the poor and disadvantaged who use government facilities the most (2–3).

Thus, it may be ethical to apply efficiency principles to the government health care system. This will also require increasing resources in this sector. Unfortunately, even the latest Union health budget failed to considerably enhance resources in health (16). The overall budgetary allocation to health is 2.1% or about 0.3% of the GDP, which is less than that required (about 0.5% of GDP) to meet the goals of the National Health Policy (6).

Efforts to increase the efficiency of the government health sector

Since the mid-1990s, international agencies have funded health sector reforms in many states of India. A National Commission on Macroeconomics and Health was formed recently. States have implemented various measures including mapping health care provision and utilisation, public–private partnerships, user fees, insurance, community financing, voluntary retirement of government staff, preparation of citizen charters for government facilities, creation of autonomous corporations to improve efficiency of services, and local self-government control of government health care institutions. These are efforts to improve efficiency in the health care system. Their effectiveness is yet to be judged, and there may be further questions on whether some changes pose ethical problems in themselves.

Conclusion

The government's failure to get 'value for money' affects, albeit unequally, both users and non-users of government health care facilities. Users are affected because they get poor care or none at all; non-users are affected because inefficient government facilities increase the costs of private care. Corrective measures would promote distributive justice. The poor and disadvantaged, who bear a higher share of the disease burden and receive a smaller share of public money because of inefficiency, would be the ultimate beneficiaries.

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