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Commentary

Financing Common Goods for Health: A Public Administration Perspective from India

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CONTENTS

The Measurement Agenda
A Fragmented Government Landscape
Implementation Pathways
Monitoring and Accountability
References

On average, higher per capita GDP is correlated with improved health outcomes. In parallel, improved population health also seems to foster higher GDP. Yet health and growth need not increase proportionately with one another, nor is this relationship universal. Patnaik highlights potential externalities resulting from growth that could negate efforts to improve population health: development itself can both increase and decrease certain health risks depending on how the process is planned, implemented and regulated.

Over the last 35 years, India’s GDP grew annually at 6.3% (doubling every 11 years or so) but population-based health indicators did not improve proportionally. Instead, new health risks emerged while old ones remained unresolved. Decades of rapid urbanization led to unsafe buildings, unplanned cities, bad drainage and sewage, dysfunctional garbage disposal systems, polluted air and water, among other issues. For example, with the construction of roads catering to high-speed traffic, accompanied by inadequate design of road safety systems, road accident fatalities have surged since 1999.

Today, India’s disease burden is evolving into two streams. The first is the persistent poverty-related health agenda (e.g., malnutrition or high infant and maternal mortality). The second relates to growth that does not consider new health risks emerging from it (e.g., air pollution resulting from rapid urbanization or infrastructure built on areas prone to natural disasters). In both areas, the key policy response involves population-based government financed interventions that generate large societal health benefits, i.e., Common Goods for Health (CGH). Moving forward, CGH is therefore at the center of Indian health policy. In this commentary, we draw on India’s experience to decompose the overall CGH agenda and identify common obstacles that countries may face in financing such goods.

THE MEASUREMENT AGENDA

A government cannot finance and provide CGH unless it is continuously informed on the nature and extent of evolving...
health risks (i.e., the inputs affecting population health such as purity of air and water, prevalence of sub-standard drugs, food safety, reliable measures of the knowledge of health care workers). This requires periodic monitoring to allow for comparison over time. While the sustained measurement of traditional population health outcome indicators (such as birth rates or measures of mortality) has been critical in improving global health policy, a comparable effort in measuring basic health functions that influence these indicators, like CGH, are weak, especially in developing countries.

Only upon continuous measurement can the actors that are responsible for financing and delivering CGH (countries, local governments, regulators, etc.) be held accountable. A systematic effort is now required to standardize the fine-grained description of the CGH landscape and develop a global statistical system for all its components.

For example, India is home to seven of the ten most polluted cities worldwide. It witnessed a 41.5% rise in ischemic heart disease from 2005–2016, which is now the leading cause of premature and total deaths. Yet India’s National Air Quality Monitoring Programme (NAMP) consists of 731 operating stations covering only 312 towns. The latest census data, for 2011, shows there are 8000 towns. Even if we assume that no new urban areas emerged since 2011, a mere 3.9% of towns in India can monitor air quality in some capacity.

A FRAGMENTED GOVERNMENT LANDSCAPE

Traditional thinking on health policy perceives the entire health sector agenda under a Ministry of Health (MoH), with health policy experts trying to improve a country’s health policy by engaging with the MoH. In contrast, the CGH agenda involves engaging with a sprawling organizational diagram spread across an array of government agencies involved in setting up laws, regulations, standards and norms, implementation, monitoring compliance, among other roles. This fragmentation across various sector agencies (i.e., horizontal fragmentation) is further complicated in India by a complex decentralized setting, where fragmentation also occurs across different levels of government (i.e., vertical fragmentation).

Horizontal Fragmentation

Under conditions of low state capacity, some CGH functions are often implemented through an excessively fragmented organization diagram. Table 1 shows how the components of CGH can be placed in the organizational structure of the Indian government, highlighting the complexity of the governmental landscape in India.

Vertical Fragmentation

Fragmentation at the national level can be further exacerbated by poor coordination and overlapping organizational mandates at the local level. This problem of agency proliferation is demonstrated by the case of infrastructure development in one Indian city (Jaipur, Rajasthan).

The Jaipur Municipal Corporation (established under the Rajasthan Municipality Act 1959) is responsible “for maintaining the city’s civic infrastructure as well as carrying out associated administrative duties.” The Rajasthan Housing Board (established through the Rajasthan Housing Board Act 1970) is responsible for providing “measures to be taken to deal with … housing accommodation in State of Rajasthan.” This includes developing “townships … which include modern amenities, community services, hospitals, educational institutes, neighborhood parks and playgrounds.”

In addition, Jaipur’s Development Authority (established under the Jaipur Development Authority Act 1982) is responsible for the “urban development of Jaipur … [and] … to create basic infrastructure to meet the needs of the ever-increasing population and also for the required expansion of the city.” These three overlapping statutory bodies performing the same function create an inefficient system that allows for riskier urban planning, decreased ability to hold professionals (planners, architects, engineers) accountable, and infrastructure developed according to inconsistent or even inadequate safety standards.
| Ministry                                      | Department/Regulator/Agency                                                                 | Functions                                                                 |
|----------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1 Ministry of Agriculture and Farmers welfare | Department of dairy, fisheries and animal husbandry                                        | Food safety                                                              |
| 2 Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) | Department of AYUSH                                                                      | Optimal development of AYUSH systems of health care                       |
| 3 Ministry of Chemical and Fertilizers       | Department of Pharmaceuticals and National Pharmaceutical Pricing Authority (NPPA)        | Regulation of quality, quantity and price of pharmaceutical products     |
| 4 Ministry of Consumer Affairs, Food and Public Distribution | Department of Consumer Affairs, Consumer Courts and Department of Food and Public Distribution | Consumer/Patient protection and Food security                            |
| 5 Ministry of Drinking Water and Sanitation  | Department of Drinking Water and Sanitation                                               | Policy, planning, funding and coordination of the National Rural Drinking Water Program (NRDWP) and the Swachh Bharat Mission (Gramin) |
| 6 Ministry of Environment, Forests and Climate Change | Central Pollution Control Board (CPCB), Genetic Engineering Appraisal Committee | Maintaining biodiversity, clean environment                              |
| 7 Ministry of Human Resource Development     | Department of Higher Education and National Board of Examination                           | Education standards                                                      |
| 8 Ministry of Road Transport and Highways    | National Highway Authority of India, Road Safety Engineering Cell and Indian Roads Construction Corporation | Safe roads regulation                                                   |
| 9 Ministry of Science and Technology         | Departments of Science and Technology, Department of Biotechnology and Scientific and Industrial Research | Research and policy planning based on scientific evidence                |
| 10 Ministry of Health and Family Welfare     | Medical, Dental and Nursing Councils, National Health System Resources Centre, Department of Health Research, Food Safety and Standards Authority of India (FSSAI), Central Drugs Standard Control Organization (CDSCO), National Technical Advisory Group on Immunization, National Health Agency | Managing human resources for health, health care, public health issues |
| 11 Ministry of Skill Development and Entrepreneurship | Directorate General of Training, National Skill Development Agency, National Skill Development Corporation India and Sector Skill Councils | Skill based programs for human resources for health                     |
| 12 Ministry of Statistics and Programm Implementation | National Statistical Office, Program Implementation Wing and National Statistical Commission | Standardize, measure, consolidate and report health statistics           |
| 13 Ministry of Tourism                       | Department of Tourism                                                                      | Maintaining database regarding medical tourism                           |
| 14 Ministry of Women and Child Development   | Department of Women and Child Development                                                | Implementing women and child safety, nutrition programs and reporting on related statistics |
| 15 Ministry of Home Affairs                  | National Disaster Management Authority (NDMA)                                              | Disaster risk resilience                                                 |

**TABLE 1.** CGH Regulatory Map for India
India’s current urbanization context, where many areas meet the minimum criteria for a municipality with the exception that they are not legally notified as such. These areas made up 3892 of 7933 urban towns in the 2011 census but did not have powers or responsibilities to undertake urban or town planning, as they were never notified as municipalities.

Indian municipalities similarly suffer from financing constraints. Under the present constitutional arrangement, municipalities do not have the authority to levy taxes without approval from their parent state. In addition, municipalities rarely have the requisite executive authority to collect taxes. This leaves municipalities dependent on transfers from the state government. With no linkage between taxation and expenditure, municipal governance lacks the transparency needed for tax-payers to hold municipalities accountable in providing public services commensurate to tax revenue.

These areas are also responsible for providing drinking water, minor irrigation, water management, and watershed development but are not empowered to ensure water supply. There is therefore a risk that the pipes and drainage systems they develop will not meet minimum standards for as long as the areas are not legally notified as municipalities. This example suggests two things that are applicable across countries. First, the CGH agenda will need to intricately examine the nature of decentralization, including responsibilities for financing. Second, that solving problems of CGH will require solving the barriers to sound decentralization.

IMPLEMENTATION PATHWAYS

To realistically address issues of fragmentation coordinated mainstreaming of various CGH elements across the multitude of agencies involved in their provision and financing is essential to avoid direct conflicts. The health policy community will need to look beyond the MoH to ensure broader state capacity reforms that improve foundational processes (such as human resources, procurement, finance, and budgeting).

Mainstreaming Implementation and Building Capacity

Fragmentation is not unique to health but common across many areas of public administration. Some interesting insights come from the developments which have been taking place to address the problem of disaster risk resilience (DRR) in India. As with CGH, the DRR agenda must be owned by numerous government organizations. The disaster resilience community has coined the phrase “mainstreaming” for society-wide improvement of resilience to natural disasters.

The National Disaster Management Authority (NDMA) is the lead organisation in India in the field of natural disasters, and may be thought of as somewhat analogous to the role played by MoH in the field of health. However, the bulk of the implementation work in DRR has to take place across numerous line ministries which must “mainstream” DRR, i.e., integrate DRR where appropriate and needed into their mandate. As an example, the MoH needs to think about mainstreaming disaster response in health care, including contingency plans, preparedness and mitigation, mass casualty plans, among others.

In parallel, the Public Health Engineering Department must provide for drinking water in extreme events and the Revenue and Disaster Management Department is responsible for lifeline infrastructure operations and construction compliance with Indian construction codes, training and capacity building. To achieve DRR, the puzzle is one of implementing a complex multi-sectoral effort, where DRR is mainstreamed as a consideration in the behavior of numerous agencies. The same approach is needed for all CGH.

When highways are built, for example, the planners must bring road safety considerations into the design process, so that the adverse impact upon the health of the people caused by new highways is minimized. A coordinated system to do so, one that ensures accountability, is needed.

MONITORING AND ACCOUNTABILITY

Given the multi-sectoral nature of CGH, the health sector budget cannot be equated to the MoH budget. Effective health policy making requires an outcome-oriented budgeting process that looks across the government to enable cross-cutting investments that all contribute to the provision of CGH.

When performance measurement and budgeting are carried out by independent agencies, the risk is that budgeting reflects previous trends without any optimization or changes due to policy developments. Reddy and Selvaraj show that between the 1960s and 1980s almost all the increase in India’s health budget went to increasing wages in the sector. Investment in equipment and capital goods did not increase at a time when medical science was going through a technological revolution with the advent of new technologies like ultrasound in the 1960s and magnetic resonance imaging in the 1970s and 1980s. Even with today’s emphasis on performance measurement, there is no connection between health budgeting and performance measurement in India. The National Health Mission tracks multiple health output and outcome measures down to the lowest administrative units in India, but this information is not reflected in health budget documents or government priorities.

Similarly, the National Institution for Transforming India (NITI) recently developed a nation wide health index to...
measure health outcomes, governance and information, and key inputs/processes, using weighted and scaled indicators. This index was measured at the baseline year (2014–15) to give an overview of the state of affairs, and then again in the reference year (2015–16) to measure incremental improvement across these indicators. Yet as NITI is only an advisory body with no power to allocate funds to sectors or states, performance measurement and budgeting remains disjoint. To ensure each element of government is held accountable for delivering results, the allocation of funds should be associated with measurement of inputs, outputs, and outcomes. The CGH agenda requires deeper state capacity improvement in the form of public financial management reforms.

A WAY FORWARD: THE ROLE OF REGULATION

How can the state pursue the CGH agenda? In some areas, resourcing a public expenditure program is required. But in many areas, the CGH agenda requires invoking the regulatory power of the state. As an example, reducing air pollution requires various kinds of private persons to behave in different ways. This cannot be achieved through an expenditure program but rather by establishing regulatory capacity. While there is considerable focus on health financing, in the field of health policy, a great deal of the CGH agenda involves using the regulatory power of the state and not the spending capability of the state. The magnitude of resourcing required for regulation is relatively modest when compared with population-scale health care programs.

We take two Indian regulators to demonstrate this and find that the money received from the government by the Food Safety and Standards Authority of India (FSSAI) and Competition Commission of India (CCI) came to an annual average of INR 509.7 Million (USD 7.28 Million) and INR 1306 Million (USD 18.7 Million), respectively. This is a small sum of money considering that total expenditure for 2015–16 under the National Health Mission alone was INR 264 Billion (USD 3.77 Billion), of which the central government releases were INR 173.7 Billion (USD 2.48 Billion). Many elements of the CGH agenda involve developing state capacity, which is an onerous challenge. They do not, however, involve spending large amounts of money.

Moving forward, what we need now is a new body of work that (based on an agreed definition of CGH) tracks expenses and organization diagrams on a cross-country scale. Within a country, CGH provision needs to be informed through proper measurement of population health risks. This needs to be implemented within a well mapped out government landscape to convert fragmentation into mainstreaming, while developing broad state capacity on fundamentals such as human resources or budget processes. Only when this process is linked to performance will true monitoring be feasible, and accountability enforced through regulation.

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