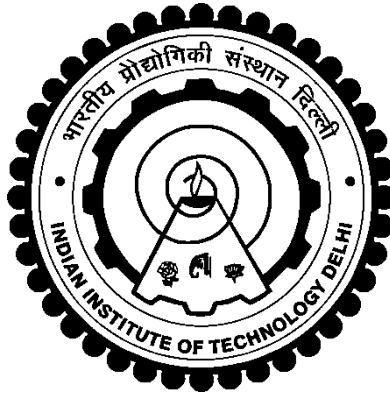


**POLITICAL ECONOMICS: EXPLAINING THE
HEALTHCARE ISSUES IN INDIA**

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**DEPARTMENT OF HUMANITIES AND SOCIAL SCIENCES
INDIAN INSTITUTE OF TECHNOLOGY DELHI
OCTOBER 2018**

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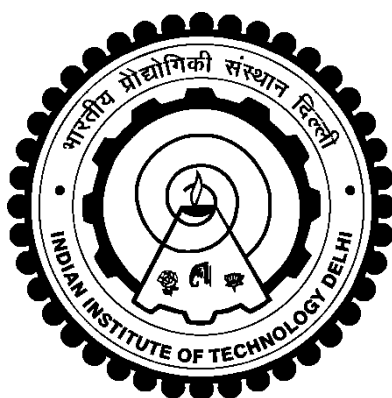
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Submitted

in fulfilment of the requirements of the degree of Doctor of Philosophy

to the



INDIAN INSTITUTE OF TECHNOLOGY DELHI

OCTOBER 2018

Dedicated to my Parents

Certificate

It is to certify that the thesis entitled “**Political Competition: Explaining the Healthcare Issues in India**” being submitted by **Mr. Sandip Datta** to the Indian Institute of Technology Delhi for the award of **Doctor of Philosophy** in Department of Humanities and Social Sciences is a record of the bonafide research work carried out by him under my supervision and guidance. He has fulfilled the requirements for the submission of this thesis, which to the best of my knowledge has reached the requisite standard.

The material contained in the thesis has not been submitted in part or full to other University or Institute for the award of any other degree or diploma.

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Abstract

Indian healthcare sector can be characterized by low level public healthcare spending across states (around 1% of GDP), high out of pocket healthcare expenditure (around 75% to 80% of total healthcare expenditure) and consequently poor health outcomes. Despite the rapid economic growth, India's ranking in health according to Sustainable Development Goals (SDG) index is 143 out of 188 countries, just below Comoros and Ghana. Recent literature suggests that public financing is the key to achieve Universal Health Coverage and better health outcomes are associated with public health financing. On the contrary, private voluntary insurance do not have any impact on health indicators and greater share of "out of pocket expenditure" is associated with higher mortality rate.

Average private healthcare cost was around 4.5% of monthly consumption expenditure in 1993 but it has increased to 7% of monthly consumption expenditure in 2011. During this period (from 1993 to 2011) government healthcare expenditure was hovering around 1% of net state domestic product across all Indian states. To reduce private healthcare expenditure to 2% of monthly consumption expenditure and keep the total healthcare expenditure (public plus private healthcare expenditure) at the current level government must increase its healthcare expenditure from 1% to 3%.

The appalling situation of low level public spending on healthcare is not likely to change, unless public healthcare becomes political demand and electoral issue. In earlier days, public healthcare was not an agenda of political leaders to win election. The situation took a turn for the better post 2000 as several political parties have started giving healthcare spending its due importance. Although increase in healthcare spending in most countries is driven by economic growth and technological progress but political pressure and competition shifts the composition from voluntary private spending to compulsory public spending. Continuous changes in the economy, technological change and political dynamics challenge equitable access to healthcare even in countries with universal health coverage (UHC). So, the debate on how much political engagement is necessary for healthcare is never-ending. Therefore, in a country like India with poor healthcare condition where universal health coverage (UHC) in reality is a dream, political engagement and debate over healthcare is quite inevitable.

Are there any hints of political will to change this situation? Yes, there are few state government initiatives to reduce the out of pocket payment and also there are some schemes and policies to improve the healthcare outcomes in Indian states. The impact of such schemes and policies are limited given the 1.3 billion of population of India. Is there any

political instrument which can stimulate a government to implement such policies which can increase public healthcare expenditure, reduce out of pocket expenditure and improve health outcomes? It is understood that a democratically elected government is accountable to deliver the basic public good like health, education, etc. to benefit its common people. Does political competition ensure this accountability as proxied by delivery of public goods e.g. healthcare, education or by regulating the unregulated private player in these areas. It has been argued in literature that intense political competition makes the democratically elected government more accountable for their actions and regulate the unregulated private companies in these areas. Intense political competition induces a government to work towards the majority rather than serving interest group (organized lobby). Therefore, according to the literature, political competitiveness among the political parties in electoral battle can be such instrument which can induce a government to implement such policies.

This thesis explores the above hypothesis, whether political competition truly affects the public healthcare expenditure, out of pocket healthcare spending and health outcomes. This thesis theoretically and empirically establishes that political competitiveness among political parties in electoral battle helps to increase the public healthcare expenditure and also helps to reduce the out of pocket healthcare expenditure. Consequently, intense political competition improves the health outcome of the Indian states. Simple theoretical models are presented in this thesis in order to show the relationship between political competition and health outcome which was earlier missing from the literature and finally, this theoretical findings are validated by some analysis in Indian context.

सार

इंडियन हेल्थकेयर सेक्टर को राज्यों में कम स्तर के सार्वजनिक स्वास्थ्य देखभाल (सकल घरेलू उत्पाद का लगभग 1%), जब हेल्थकेयर व्यय से अधिक (कुल स्वास्थ्य देखभाल व्यय का लगभग 75% से 80%) और इसके परिणामस्वरूप खराब स्वास्थ्य परिणामों की विशेषता है। तेजी से आर्थिक विकास के बावजूद, सस्टेनेबल डेवलपमेंट लक्ष्यों (एसडीजी) इंडेक्स के अनुसार स्वास्थ्य में भारत की रैंकिंग 188 देशों में से 143 है, जो कि कोमोरोस और घाना के ठीक नीचे है। हाल के साहित्य से पता चलता है कि सार्वजनिक वित्त पोषण सार्वभौमिक स्वास्थ्य कवरेज हासिल करने की कुंजी है और बेहतर स्वास्थ्य परिणाम सार्वजनिक स्वास्थ्य वित्तपोषण से जुड़े हैं। इसके विपरीत, निजी स्वैच्छिक बीमा का स्वास्थ्य संकेतकों पर कोई असर नहीं पड़ता है और "जब व्यय से बाहर" का अधिक हिस्सा उच्च मृत्यु दर से जुड़ा होता है।

औसत निजी स्वास्थ्य लागत 1993 में मासिक खपत व्यय का लगभग 4.5% था, लेकिन 2011 में यह मासिक खपत व्यय का 7% तक बढ़ गया है। इस अवधि के दौरान (1993 से 2011 तक) सरकारी स्वास्थ्य व्यय शुद्ध राज्य घरेलू उत्पाद का लगभग 1% हो रहा था सभी भारतीय राज्यों में। निजी स्वास्थ्य व्यय को मासिक खपत व्यय का 2% तक कम करने और मौजूदा स्तर पर कुल स्वास्थ्य व्यय (सार्वजनिक प्लस निजी स्वास्थ्य देखभाल व्यय) को बनाए रखने के लिए सरकार को अपने स्वास्थ्य देखभाल व्यय को 1% से 3% तक बढ़ा देना चाहिए।

स्वास्थ्य देखभाल पर निम्न स्तर के सार्वजनिक खर्च की भयानक स्थिति में बदलाव होने की संभावना नहीं है, जब तक कि सार्वजनिक स्वास्थ्य देखभाल राजनीतिक मांग और चुनावी मुद्दा न हो। शुरुआती दिनों में, सार्वजनिक स्वास्थ्य सेवा चुनाव जीतने के लिए राजनीतिक नेताओं का एजेंडा नहीं था। हालात ने बेहतर पद 2000 के लिए एक मोड़ लिया क्योंकि कई राजनीतिक दलों ने हेल्थकेयर को अपना उचित महत्व देने शुरू कर दिया है। हालांकि अधिकांश देशों में स्वास्थ्य देखभाल में वृद्धि आर्थिक विकास और तकनीकी प्रगति से प्रेरित है, लेकिन राजनीतिक दबाव और प्रतिस्पर्धा स्वैच्छिक निजी खर्च से अनिवार्य सार्वजनिक खर्च में संरचना को बदल देती है। अर्थव्यवस्था में निरंतर परिवर्तन, तकनीकी परिवर्तन और राजनीतिक गतिशीलता सार्वभौमिक स्वास्थ्य कवरेज (यूएचसी) वाले देशों में भी स्वास्थ्य देखभाल के लिए समान पहुंच प्रदान करती है। इसलिए, स्वास्थ्य देखभाल के लिए कितना राजनीतिक जुड़ाव आवश्यक है इस पर बहस कभी खत्म नहीं होती है। इसलिए, भारत जैसे देश में खराब स्वास्थ्य देखभाल की स्थिति जहां सार्वभौमिक स्वास्थ्य कवरेज (यूएचसी) वास्तविकता में एक सपना है, राजनीतिक जुड़ाव और स्वास्थ्य देखभाल पर बहस काफी अनिवार्य है।

क्या इस स्थिति को बदलने के लिए राजनीतिक इच्छाशक्ति का कोई संकेत है? हां, जब भुगतान से बाहर निकलने के लिए कुछ राज्य सरकार की पहल हैं और भारतीय राज्यों में स्वास्थ्य देखभाल परिणामों में सुधार के लिए कुछ योजनाएं और नीतियां भी हैं। भारत की 1.3 अरब आबादी को देखते हुए ऐसी

योजनाओं और नीतियों का असर सीमित है। क्या कोई राजनीतिक साधन है जो ऐसी नीतियों को लागू करने के लिए सरकार को प्रोत्साहित कर सकता है जो सार्वजनिक स्वास्थ्य व्यय में वृद्धि कर सकता है, जब व्यय से कम हो सकता है और स्वास्थ्य परिणामों में सुधार कर सकता है? यह समझा जाता है कि लोकतांत्रिक ढंग से निर्वाचित सरकार अपने आम लोगों को लाभ पहुंचाने के लिए स्वास्थ्य, शिक्षा इत्यादि जैसे बुनियादी जनता को अच्छी तरह से वितरित करने के लिए उत्तरदायी है।

क्या राजनीतिक प्रतिस्पर्धा इस जवाबदेही को सार्वजनिक सामानों के वितरण के रूप में सुनिश्चित करती है जैसे कि स्वास्थ्य देखभाल, शिक्षा या इन क्षेत्रों में अनियमित निजी खिलाड़ी को विनियमित करके? साहित्य में तर्क दिया गया है कि तीव्र राजनीतिक प्रतिस्पर्धा लोकतांत्रिक ढंग से निर्वाचित सरकार को उनके कार्यों के लिए अधिक जवाबदेह बनाती है और इन क्षेत्रों में अनियमित निजी कंपनियों को नियंत्रित करती है। तीव्र राजनीतिक प्रतिस्पर्धा एक सरकार को ब्याज समूह (संगठित लॉबी) की सेवा के बजाय बहुमत की ओर काम करने के लिए प्रेरित करती है। इसलिए, साहित्य के अनुसार, चुनावी लड़ाई में राजनीतिक दलों के बीच राजनीतिक प्रतिस्पर्धा ऐसे साधन हो सकती है जो ऐसी नीतियों को लागू करने के लिए सरकार को प्रेरित कर सकती है।

यह थीसिस उपर्युक्त परिकल्पना की पड़ताल करता है, भले ही राजनीतिक प्रतिस्पर्धा वास्तव में सार्वजनिक स्वास्थ्य देखभाल व्यय को प्रभावित करे, जब स्वास्थ्य देखभाल खर्च और स्वास्थ्य परिणामों से। यह थीसिस सैद्धांतिक रूप से और अनुभवी रूप से स्थापित करती है कि चुनावी लड़ाई में राजनीतिक दलों के बीच राजनीतिक प्रतिस्पर्धा सार्वजनिक स्वास्थ्य व्यय को बढ़ाने में मदद करती है और जब स्वास्थ्य देखभाल व्यय को कम करने में भी मदद करती है। नतीजतन, तीव्र राजनीतिक प्रतिस्पर्धा भारतीय राज्यों के स्वास्थ्य परिणामों में सुधार करती है। राजनीतिक प्रतिस्पर्धा और स्वास्थ्य परिणामों के बीच संबंध दिखाने के लिए इस सिद्धांत में सरल सैद्धांतिक मॉडल प्रस्तुत किए गए थे, जो साहित्य से पहले गायब थे और आखिरकार, इस सैद्धांतिक निष्कर्ष भारतीय संदर्भ में कुछ विश्लेषण द्वारा मान्य किए गए हैं।

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E.24 Descriptive Statistics of the Infant Mortality Rate 220

Abbreviations

AAP	Aam Admi Party
AIDS	Acquired Immune Deficiency Syndrome
BJP	Bharatiya Janata Party
CBR	Crude Birth Rate
CDR	Crude Death Rate
EAG	Empowered Action Groups
ECI	Election Commission of India
EU	European Union
FGLS	Feasible Generalized Least Square
GDP	Gross Domestic Product
HHI	Hirschman-Herfindahl Index
HIV	Human immunodeficiency virus
IMR	Infant Mortality Rate
INC	Indian National Congress
JSY	Janani Suraksha Yojana
LEB	Life Expectancy at Birth
MCE	Monthly Consumption Expenditure
MDG	Millennium Development Goals
NFHS	National Family and Health Survey
Non-EAG	Non-Empowered Action Groups
NRHM	National Rural Health Mission
NSDP	Net State Domestic Product
NSS	National Sample Survey
OOP	Out of Pocket
PCSE	Panel Correcting Standard Error
PRI	Panchayati Raj Institution
SDG	Sustainable Development Goals
TFR	Total Fertility Rate
UHC	Universal Healthcare
UNICEF	United Nations Children's Fund
WDI	World Development Indicator
WHO	World Health Organization

Symbols

α	Alpha
β	Beta
γ	Gamma
δ	Delta
ϵ	Epsilon
η	Eta
θ	Theta
λ	Labmda
σ	Sigma
τ	Tau
ψ	Psi