The seminar, the twenty-second sponsored by the World Bank’s hnp/poverty thematic group, was attended by approximately forty people. Dave Gwatkin moderated.

The session was in two parts. The first featured a presentation by Ajay Mahal, an economist with the National Council of Applied Economic Research in New Delhi, India. He reported on a benefit-incidence study of government health services that he and his colleagues had undertaken with support from the Bank’s New Delhi field office. The second part was a floor discussion of Ajay’s presentation initiated by commentator Adam Wagstaff.

Ajay opened by describing how the study fits in with current thinking about the contribution of health to economic growth and poverty alleviation, and by introducing benefit-incidence analysis, the technique used in the study. He noted that such analysis starts by estimating the use of different types of health service by members of each socio-economic class, on the basis of household survey information. The next step is to estimate the net cost to government of providing each type of service – that is, the total cost of the service less the amount of user charges paid. The net unit cost for each type of service can be multiplied by the number of people in each socio-economic group who use that service, and the results for the different types of service can then be aggregated to produce an estimate of the magnitude of the benefits accruing to the different classes.

After explaining some of the limitations inherent in the benefit-incidence approach, Ajay described the data sources that he and his colleagues had used. The principal source on health care use and socio-economic status was the 1995/96 round of the National Sample Survey, which covered some 120,000 households. The sample was large enough to permit separate studies for the sixteen most populous states of India, containing 97% of the country’s population. The total cost data came from governmental expenditure reports in each of the states covered. Data on the volume of user fees came from the NSS, and were compared with governmental reports on revenue.

The principal findings were that:

• In India as a whole, Government health service expenditures benefit the rich considerably more than the poor. About 31-33% of the financial benefit from those services goes to the richest population quintile, compared with around 10% of the benefit that reaches the poorest quintile.
• The poor-rich inequalities are considerably larger in rural than in urban areas. In the former, the richest quintile receives 38-39% of the financial benefit; the poorest quintile 9-10%. The comparable figures for urban areas are 16-20% for the richest and 14-16% for the poorest quintiles.

• There are also large inter-state variations, with inequalities tending to be larger in the poorer states. The least unequal states are Kerala, Gujarat, Maharashtra, and Tamil Nadu. The most unequal are Orissa and the collection of Northern poor states known as the “BIMARU” group: Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh.

• The financial benefits from outpatient and primary health care are generally less unequally distributed than the benefits from hospital services; but the majority of government health service expenditures goes to hospitals.

• The immunizations provided by government institutions appear to be fairly evenly distributed across socio-economic groups.

Commentator Adam Wagstaff opened the ensuring floor discussion by noting that many of the Indian findings reported by Ajay were similar to those found in benefit-incidence studies in other countries. For example, the poor almost inevitably receive fewer financial beneficial benefits from government health services than the rich; poor-rich inequalities are typically worse in hospitals than in lower-level services; and they are also worse in urban than in rural areas. But findings from the India study are distinctive. Many such findings arise out of the fact that the study design permits inter-state comparisons. Examples include:

• The wide range of inter-state differences in inequality patterns. This is considerably larger than the comparable range of differences among European countries. Adam wondered what could explain these large differences, other than the income factors to which Ajay had referred. For example, to what extent do they result from differences in the health service delivery systems relative to differing social conditions in the states covered?

• Large inter-state differences in the pattern of gender inequality in health service use. These, too, deserve further examination.

Several additional points emerged during the subsequent floor discussion. Among them were:

• Possible causes of inter-state differences. In response to Adam’s query, a participant pointed to two features of high- and low-inequality states that might help explain the variations. One concerns the availability of Central government funds: the high-inequality states tend to receive smaller transfer payments than the low-inequality ones. A second is the existence of different types of land tenure.

• The policy implications of the findings. In response to a question from the floor, Ajay acknowledged that the diagnosis provided by his and his colleagues’ findings does not in itself lead directly to a set of policy recommendations for the problems the diagnosis revealed. However, the diagnosis points to problems that have been largely unrecognized, and it can thus serve to start the public debate that is a necessary and important first step toward producing acceptable recommendations. Other participants
pointed to specific problem areas identified in the study, on which policy makers might profitably focus. An example concerned hospitals, which, as noted above, are at present used primarily by the better-off. One might think of increasing the user fees charged to the better-off patrons of hospital services, although the fact that the user fee structure is already rather progressive might limit the further amount that can be accomplished in this way. A second possibility is to look for ways of reducing long hospital stays – four months or over – which are responsible for a large percentage of total hospital costs and occur principally among the rich.

- Inequalities in the health service sector relative to other inequalities. A participant noted that in many countries the inequalities in the health service sector, while favoring the rich, are notably less inegalitarian than the inequalities found in other areas like overall consumption or taxation. If the inequalities in health service use are less than those in taxation, the health services might be considered progressive, in that the rich get fewer services than they paid for, while the poor receive more. Ajay responded by comparing inequalities in health service use and in income. The picture is mixed, he said: in some states, poor-rich inequalities in health service use are smaller than income inequalities; in others, they are larger.