Chronic Disease in India

An Impending Economic Crisis and Evolving Resolve

Ali Mehdi

New Delhi, India

Sixteen million people died prematurely (under 70 years) due to noncommunicable diseases (NCD) in 2012—3.4 million in India alone, the highest in the world. Although total NCD mortality was much higher in China—8.6 vis-à-vis 5.9 million in India—only 36% of it was premature compared to 58% in India [1]. Within a decade, chronic diseases will overwhelm health systems in India—89% of total mortality would be concentrated in the 30+ year age group (author's calculation from the World Population Prospects: The 2015 Revision for 2025 to 2030 using medium fertility variant) [2]. Even at its current level of development, 72% of deaths at this level are due to NCD [3]—as the country grows, the proportion of NCD-related deaths will only increase. What India does to tackle chronic diseases will be critical for global efforts to achieve the third Sustainable Development Goal target 3.4 calls for one-third reduction of premature mortality (30 to 70 years of age) due to NCD between 2016 and 2030, hence the focus of this paper on the Indian situation.

India has assumed a leadership role on this issue and is the first country to develop specific national targets and indicators to reduce premature NCD mortality [4]. In 2010, the Government of India launched the National Program for prevention and control of Cancers, Diabetes, Cardiovascular diseases and Stroke (NPCDCS), with a package of services to be offered at various levels of public health facilities. NPCDCS aims at integration of NCD interventions within the framework of the National Health Mission (NHM)—India's flagship health initiative—for the optimization of scarce resources, provision of seamless services to patients and ensuring the sustainability of interventions. However, the share of NCD expenditure in NHM was only 2.6% last year, while approved outlay for the financial year 2015-16 increased slightly to 3%. Even within this 3%, only 42% was earmarked for NPCDCS—the rest went into national programs for blindness, deafness, burns, and mental and oral health. Further, as Table 1 illustrates, NPCDCS budget keeps shrinking in phases—from proposal to approval to actual expenditures.

Obviously, as in several other spheres, there has been a severe mismatch between political and financial/systemic commitments. Despite a quarter century of economic reforms and high growth rates, the health sector in general continues to be ignored, let alone chronic diseases—India is the only country among top 10 economies (by gross domestic product [GDP] constant [U.S. Dollars (USD) 2005] for the year 2013) that spends more on military than health (public component): its military expenditure was third highest (2.4% of GDP), more than China's (2.1%), whereas its total government health expenditure was the lowest (1.3%) [5]. The Indian federal government, on its part, spends 8 times more on military than health. From a fiscal perspective, chronic diseases currently only get a thin slice from a tiny pie. Several policymakers and health sector analysts in India argue that public allocations to the health sector are low because public's demand and expectations for government-financed or government-provisioned health care are low, so there is no pressure on the government to increase allocations. I had conducted 40 expert interviews in Delhi and Mumbai in 2008 and this view was upheld by almost all respondents. In sync with international focus, the government has found it convenient to stress primary prevention and shift responsibility on to individuals for behavioral change, with yoga coming in handy for this purpose. (In this paper, we have tried to put forth an economic explanation for the neglect of chronic diseases. There are obviously other reasons as well. For instance, the course and impact of NCD are insidious, their surveillance and public awareness weak, and together with the tag of "lifestyle" diseases [holding individuals responsible], as well as low public expectations and accountability, it becomes easy for governments in developing countrieswhere premature deaths due to NCDs are concentrated - to ignore them. Even arguments regarding the economic impact of NCDs seem far-fetched given more immediate challenges to economic growth and productivity. On the other hand, infectious diseases spread and seem like wildfire, and with a firefighting style of policymaking, as we have in India, they tend to get more public attention (from the media, the general public and eventually the government). Further, health systems in developing countries like India seem to adopt a sequential approach to health challenges - with the unfinished agenda of reproductive and child health (RCH) and periodic outbreaks of infectious / vector-borne diseases, the need to go beyond and address chronic diseases is not felt strongly. Then, there are challenges of governance and human resources which have been discussed in detail in one of my co-authored papers [6].)

According to India's Economic Survey 2015-16, "controlling for democracy, India taxes less and spends less (especially on human capital)" [7]. In 2010-11, India's tax-to-GDP ratio was 16.6%, lower than each of its BRICS (Brazil, Russia, India, China, and South Africa) counterparts and nearly half of the OECD (Organization for Economic Cooperation and Development) average. Several

The author reports no relationships that could be construed as a conflict of interest.

From the Indian Council for Research on International Economic Relations (ICRIER), Core 6A, 4th Floor, India Habitat Centre, Lodhi Road, New Delhi 110003, India. Correspondence: A. Mehdi. (amehdi@icrier.res.in).

GLOBAL HEART

VOL. 11, NO. 4, 2016
ISSN 2211-8160/$36.00.
http://dx.doi.org/10.1016/j.gheart.2016.10.006

TABLE 1. Proposed, approved, and spent amounts under NPCDCS in selected Indian states, financial year 2014-15

State*	Proposed (INR millions)	Approved (INR millions)	Percent approved	Approved as percent of NHM budget†	Spent (INR millions)‡	Percent spent
Uttar Pradesh	1543.9	309.8	20.1	0.8	245.3	79.2
Rajasthan	896.0	211.6	23.6	1.1	9.2	4.3
Tamil Nadu	611.1	42.3	6.9	0.3	0.0	0.0
Kerala	318.0	111.6	35.1	2.0	63.9	57.3

1 U.S. dollar = 67.3 Indian rupees (INR) (Bloomberg Markets, as of 7:29 AM EDT May 25, 2016).
NPCDCS, National Program for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke.
*Two of these states are health advanced (Tamil Nadu, Kerala), the other 2 being health backward (Uttar Pradesh, Rajasthan).
†Total National Health Mission (NHM) state Program Implementation Plans (PIPs) budget approved (in INR billions) for 2014-15 was 38.3 for Uttar Pradesh, 19.3 for Rajasthan, 12.4 for Tamil Nadu, and 5.7 for Kerala.
‡Up to February 2015 for Uttar Pradesh and December 2014 in the cases of Rajasthan, Tamil Nadu, and Kerala.
Reproduced with permission from Main and Supplementary state PIPs, NHM, Ministry of Health and Family Welfare, Government of India. 2014-15 and 2015-16. Available at: http://nrhm.gov.in/nrhm-instate/state-program-implementation-plans-pips.html. Accessed October 21, 2016.

influential economists in the country argue that the bigger pie of tax revenue has to increase before the public health pie could be sustainably increased. To bolster revenues for health, the government is going to launch a sin tax on tobacco, alcohol and aerated drinks, which is expected to not only reduce access to these chronic disease risk factors, but also generate revenue to fund the health sector. Recently, a group of health economists argued in a paper, that "increasing cigarette taxes to Rs. (Indian rupees) 3,691 per 1,000 sticks would further add Rs. 146.3 billion to tax revenues and prevent 3.4 million premature deaths" in India [8].

There are several concerns with this approach. First, on a principled basis, it is debatable whether imposing a sin tax is a justifiable measure as health is a core function of the State and should be paid from general taxes; this has also been recommended in India's draft National Health Policy 2015. Second, until taxes related to chronic diseases are earmarked for their prevention and treatment, they would neither help their cause nor carry legitimacy among the taxpayers. One of the main reasons for low tax revenue

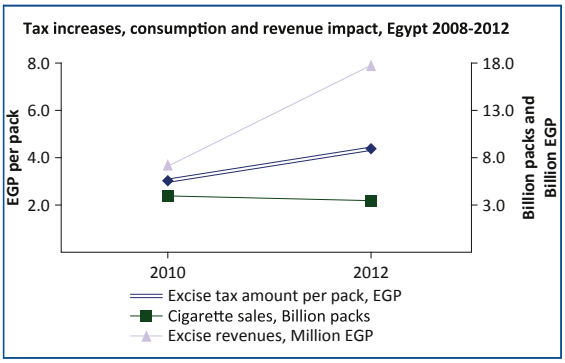

FIGURE 1. Tax increases, consumption, and revenue impact, Egypt 2008 to 2012. EGP, Egyptian Pounds. Reproduced with permission from WHO Report on the Global Tobacco Epidemic, 2013.

is low legitimacy of the State, which is not just due to corruption, but also due to budgetary inefficiencies and skewed priorities. Third, as Figure 1 shows, although the revenue impact of tax increase on cigarettes was dramatic, consumption impact was negligible in the case of Egypt. Based on available data, tobacco consumption among men (15 to 54 years of age) increased substantially among all socioeconomic groups in India between 1998 and 2005, particularly among the most vulnerable [8]. State revenue from tobacco and alcohol is massive—annual revenue from alcohol excise tax in India was third highest in the world (USD 6.4 billion), after the United Kingdom and United States, in 2006, the latest year for which data is available for India [9].

Such approaches find resonance with governments trying to bolster revenue. If tobacco is not good for public health, why just raise taxes and not ban its manufacturing altogether? The state of Bihar in India recently imposed a total ban on sale and consumption of liquor, even as its Chief Minister proposed that companies "can use digital lock system and GPS monitoring equipment in vehicles transporting the liquor manufactured in Bihar to places outside the State for sale" [10]. People in Bihar are buying monthly train passes to travel to the neighboring state of Uttar Pradesh for a 40-min happy hour [11]. In neighboring Bangladesh, tobacco is the biggest contributor to the national exchequer. The economic impact of NCD seems distant; the economic benefits from NCD risk factors instant.

Pathways do not always work as expected. In the name of health, governments have been and will continue to raise taxes and expand the revenue base. Whether this approach would inhibit access to health/chronic disease risk factors is debatable. Whether sin tax revenues are earmarked for health is also debatable. Whether additional revenue for health lead to higher allocation for tackling chronic diseases is also debatable. Given India's political economy, governments will continue to use the chronic disease morbidity and mortality arguments to increase tax and revenues, and at the same time, appropriate the

international discourse on primary prevention to shift primary responsibility on to individuals. Chronic disease deaths are concentrated among the most vulnerable—they are barely responsible for their health outcomes and barely have an influence on policymaking, and this is quite marked in a hierarchical society like India's. In their turn, these citizens have also given up on the State and taken recourse to unregulated private health care, whose quality is suspect, but certainly does have an indebting/impoverishing impact on the seekers of chronic care in particular. The federal government has a health insurance scheme for them, the *Rashtriya Swasthya Bima Yojana* (National Health Insurance Scheme), with a coverage of Rs. 30,000 for a family of 5 members. For its own employees, it has a different scheme—the Central Government Health Scheme (CGHS)—with unlimited coverage for them as well as all of their dependents, a level of coverage probably unparalleled in the world. India is, indeed, a land of baffling diversities.

Tackling chronic diseases requires strong financial commitments. Unless governments—national and local—are committed, in word and deed, little progress would be made in tackling their enormous burden. Indian policymakers have to match budgetary allocations with their international commitment and leadership towards chronic diseases. They have already signed the Sustainable Development Goal agenda—now is the time to act upon it.

REFERENCES

1. Global Status Report on Noncommunicable Diseases. Geneva, Switzerland: World Health Organization; 2012.
2. World Population Prospects: The 2015 Revision. New York, NY: United Nations Population Division, Department of Economic and Social Affairs; 2015.
3. Institute of Health Metrics and Evaluation. Global Burden of Disease. University of Washington. Available at: http://vizhub.healthdata.org/gbd-compare/. Accessed May 25, 2016.
4. World Health Organization. India: First to Adapt the Global Monitoring Framework on Noncommunicable Diseases (NCDs). Available at: http://www.who.int/features/2015/ncd-india/en/. Accessed May 25, 2016.
5. The World Bank. World Development Indicators. Available at: http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators. Accessed May 25, 2016.
6. Mehdi A, Chaudhry D, Tomar P, Joshi P. Prevention of chronic diseases: reorienting primary health systems in India, ICRIER working paper 321. New Delhi: Indian Council for Research on International Economic Relations; 2016.
7. Ministry of Finance. Economic Survey 2015-16, Volume 1. New Delhi, India: Government of India; 2016.
8. Rijo J, Rao RK, Rao MG, et al. The Economics of Tobacco and Tobacco Taxation in India. Paris, France: International Union against Tuberculosis and Lung Disease; 2010.
9. Global Health Observatory Data Repository. Annual Revenues From Alcohol Excise Tax, Data by Country. Available at: http://apps.who.int/gho/data/view.main.53920. Accessed May 25, 2016.
10. Tewary A. Nitish imposes total ban on alcohol in Bihar. The Hindu [Patna edition] April 6, 2016.
11. Dikshit R. Bihar's tipplers take train to UP for 40-min happy hour. The Times of India [New Delhi edition] May 4, 2016.