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Sub-Optimal Investments in Public Health: A Case for Persisting Poverty

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Abstract - **Investment in Human capital is one of the most important variables that determine long run economic growth of an economy, even more so for low income, capital deficient, labour abundant economies. In the context of additions to value added, endowments of education and health of workers take prominence. This paper theoretically and empirically shows that suboptimal investments in health care lead to slowing down of economic growth in the long run and causes poverty and inequality to persist. This persistence of poverty can be despite rapid rates of economic growth in the short run. The paper uses endogenous growth models to argue that investments in health are necessary for long run, sustainable economic growth. It also uses secondary data to draw an overview of the public health scenario in India, bringing to fore the inadequacies of the structure and the need for a greater and more dedicated intervention by the state.**

Keywords: **Sub-Optimal Investments, Public Health, Persisting Poverty**

I. INTRODUCTION

The achievements that India has made in the field of health care cannot be overlooked. Life expectancy has increased since independence and infant mortality ratio (IMR) has gone down; the former having increased from 41.42 years in 1954-55 to 69.66 years in 2019-20 and the latter having decreased from 29.2 in 1950 to 28.77 in 2020 (Sen and Dreze, 2013). Diseases like polio, smallpox, yaws, tetanus have been eradicated but the threat of spread of communicable diseases remains a major problem. Besides this, endemic diseases such as HIV/AIDS, TB, malaria continue to challenge the public health care system. COVID-19 added to the havoc. Non communicable diseases like cancer, diabetes, pulmonary diseases, and heart diseases are also seen to be spreading widely (Dev and Sengupta, 2020).

Among the more successful public health policies that led to a turnaround in health outcomes, one can count the National Rural health mission, 2005, National Population Policy, 2000, Ladli Scheme, 2008, National AIDS control program, 19992 and the Janani Suraksha Yojana, 2005. This is of course, besides a number of women and children's health initiatives being run by the government in collaboration with international agencies such as UNICEF and the World Bank (Gill, 2012). However, looking at different parameters of health we find improvements but also huge differences amongst states in India (Dreze and Sen, 2013) The authors assert that while positive advancements have been made in almost all public health indicators in India over the decades, inequalities within the urban economy, as between the rural and urban segments of the economy, have only risen. Inter-state and inter-group inequalities have also been found to have increased in other related studies such as Gill, 2012, Kabeer, 2000, Todaro and Smith, 2011 and Bloom *et al*, 2018. While average life expectancy increased from 49.7 years in 1970-75 to 61.6 in 2006-07, the state of Kerala reported the highest life expectancy at 74.2 years and Assam the lowest at 61.9 years. The biggest leap in life expectancy is recorded by the state of Uttar Pradesh with life expectancy rising from 43 in 1970 to 62.7 in 2007, followed closely by Tamil Nadu (49.6 to 67.2 in the same period); Rajasthan and Gujarat also witnessed a considerable rise of more than 18 years in life expectancy, while in Haryana life expectancy rose only slightly from 57 years in 1970 to 67 years in 2007. On the whole, states with low initial values recorded larger gains. Also, to be noted is the fact that female life expectancy has increased in all the states, and is higher than male life expectancy, though with a huge variation (by 1% in Bihar to 8% in Kerala) (Dreze and Sen, 2014) (Baru *et al,* 2010).

Looking at IMR values one finds that while the top 3 and bottom 4 states are consistent with the percentage of gross state domestic product (henceforth GSDP) spent on healthcare facilities, states like Kerala and Gujarat stand out as exceptions to the rule with exceptionally good and poor health outcomes respectively rooted in high investments and inclusive coverage (or a lack thereof). All states show an improvement in the IMR with that for India falling to 129 in 2011 from 44 in 1970. Kerala shows the lowest IMR at 12 in 2011; while Uttar Pradesh records the highest decline from 167 in 1970 to 57 in 2011, closely followed by Gujarat with a decline of 103 points. Female-male gap in IMR has also narrowed uniformly for all India, average it is 46-43, lowest being in Bihar (44-45), followed by Kerala (11-13) and largest gap reported by Madhya Pradesh (57-62) (*ibid*).

Birth rates have decreased uniformly both in rural and urban areas, but in case of poor and populous states are found to be high and hardly declining. Rajasthan, Madhya Pradesh, Bihar and Uttar Pradesh together add up to about 450 million people indicating that population will keep rising for some years to come. In context, Panagariya (2014) suggests inter-state migration. Following system statistical report 2010; Female to male birth rate is reversing; it has increased from 892 in 2006 to 905 in 2010. At the bottom of the growth is Uttar Pradesh where the ratio has increased only slightly from

870 to 874, Bihar has seen a leap from 881 to 912 in the female to male birth ratio between 2006 and 2010; while Tamil Nadu has seen a worsening of trend from 955 to 927 (*ibid*).

Further, on examination of data we see that all the major health indicators are closely associated with per capita GSDP. Expenditure on health care being positively related with superior state performance. In India, poor states receive less government expenditure on healthcare. Karela is the only state in India that manages to secure roughly even distribution of health subsidies across income groups. Understandably, any inequalities of healthcare are always to the disadvantage of the poor, for instance it is the poor who tend to die early and who tend to suffer from higher levels of morbidity, it is always the poor and the marginalised sectors that are not only more vulnerable but are also most affected by these diseases. Considering the endogenous growth models, human capital and advances therein, is one of the most important determinants of high rates of economic growth (Todaro and Smith, 2011). Human capital refers to workers well-endowed with income generating characteristics. Income generating characteristics refer to all those characteristics in a worker that determine the income earning capability of the individual. These characteristics range from endowments in education, health, leisure, entertainment, freedom, voice to anything that induces a worker to work in a more efficient manner (Atkinson and Bourguignon, 1982). For a more detailed discussion on the subject outside India's specific context, one can refer to the works of Joseph Stiglitz, Jean Dreze and Barbara-Hariss-White, cited in-text. Any study on interpersonal inequalities should delve into assignment of human capital endowments. We believe that investments in health are central to creating human capital.

We argue that suboptimal investments in public health will lead to slower economic growth in the long run. The assertion here routes through endogeneity of health as a determinant of economic growth. Health being a component of human capital has direct effects on productivity of workers and therefore on the income generating ability. A not less significant but indirect impact of health will be seen where a worker less endowed with health will generate lower returns to education, which is the other significant component of human capital. Lower returns to investments in education will hamper not only immediate returns from work to the worker but also lower the future returns to the economy by way of lowering rates of technical progress and skill formation in the economy. Health inequalities arise from failure of health services to reach the poor especially in poor regions and despite their higher disease burden. This ultimately slows down the process of economic growth. To ensure long run, sustainable growth these inequalities need to be corrected. Since, these inequalities arise out of unequal access to income, wealth, subsidies, insurance cover etc. these need to be cured by an efficient public distribution system for health care based on principles of equity and funded by the exchequer (Chakrabarty, 1987).

We begin with a brief algebraic description of how low levels of public health lead to a slowdown in economic growth, thereby, putting forth a case for public investments in health care. Study also discusses why public health cannot be treated like any other commodity tradeable in the market, reasserting the need for intervention of the state in ensuring optimal health care provisions. Secondary data from various sources is analysed to show the state of public health care in India. In context, this paper looks at the differences in access to health care facilities by different income groups. Data shows that access to these facilities is differentially granted and that there is a severe lack of coverage, especially for the lower rungs of the income ladder. These differences and lack of coverage underline the fact that sudden and heavy out of pocket expenditures on health care leads to people getting stuck in poverty traps. It goes without saying that this is a dangerous phenomenon, as the name suggests the trap, traps people, one generation after the other into poverty (Atkinson, 2015). It impacts not only the individual who is sucked into poverty but also the entire economy.

II. ENDOGENEITY OF HEALTH AS A DETERMINANT OF GROWTH

This subsection was an exercise in showing that investments in human capital are important for growth of an economy. Any carelessness on this front can push the economy towards lower rates of growth in the long run and increase poverty and inequalities in the country. The human capital investment that this paper takes into consideration is the investment in health.

Consider the production function, $Y = (l, k)$, where Y is the output and l and k are used for labour and capital respectively. Output thus produced is either consumed (C) or saved (S), $Y = C + S$; part of output that is saved is invested in capital augmentation. If we assume that a fraction s of total output is saved ($S = sY$), and that capital in the base period t is $k(t)$ then, capital in next period $k(t+1)$ would be,

$$k(t+1) = k(t) + sY - \theta k$$

Where, θ is the rate of depreciation of capital. Since labour grows as a result of growth in population, we do not deliberately add to it. Growth of the economy thus becomes contingent on levels of capital accumulation which in turn depend on saving in the economy.

Endogenous growth models differ from the traditional models in saying that labour needs to be replaced by 'human capital'. Human capital refers to labour that has been invested in, these investments can be in anything that leads to strengthening the income earning capacity of the individual. With the introduction of human capital, the role of savings changed from merely adding to physical capital to that of making additions in productivity of labour too. The household or the state can now use the savings to invest in its workforce by adding to expenditures made on education and health. Taking a simple endogenous production function, $y = k^{\alpha} h^{1-\alpha}$, where k is physical capital and h is human capital;

savings get bifurcated into savings in physical capital (sy) and savings in human capital (qy), where, s is the ratio of savings that go into physical capital and q is the ratio of savings going into human capital.

Rate of growth of physical capital is given by,

$$\frac{k(t+1)-k(t)}{k(t)} = sr^{1-\propto}$$

Where, r is the ratio of human capital to physical capital.

Rate of growth of human capital is similarly given by,

$$\frac{h(t+1)-h(t)}{h(t)} = qr^{-\propto}$$

In the long run, both these growth rates need to be equal to ensure that the ratio of physical capital to human capital stays constant.

$$sr^{1-\propto} = qr^{-\propto}$$

Implying that,

$$r = \frac{q}{s}$$

Replacing the value of r in equations for rate of growth of physical and human capital gives,

$$k = s^{\alpha}q^{1-\alpha}$$
$$h = s^{\alpha}q^{1-\alpha}$$

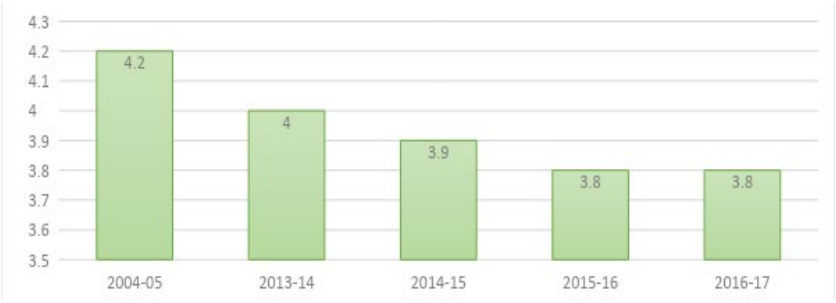
The rate of growth of all variables is given by, $s^{\alpha}q^{1-\alpha}$. Introduction of human capital shows that two countries, despite similar levels of savings and technology can be earning different income levels and these income levels will be linked to differences in investments in human capital. That is, a country with a higher $\frac{q}{s}$ ratio will show a faster rate of growth. The endogenous growth model also explains why rates of return to physical activity may remain higher for richer countries if they keep investing in human capital and technological advances. Interestingly, richer countries can always keep growing at a faster pace as compared to poorer countries simply because they have higher investments in human capital. Conditioning on the per capita incomes, countries with more human capital grow faster.

Investments in healthcare are therefore important for a multitude of reasons; one, health directly impacts the income earning capability of an individual. Secondly, poor health reduces the outcomes of other investments like education for the individual. Thirdly, by virtue of its impact on economic growth health becomes a policy matter and cannot be left to be sold in markets. If health is sold in the markets, it becomes a very expensive commodity (I say this with ample proof in the markets) and the masses are left with low or limited access to it, which is detrimental to the people and the economy. Next section is an overview of the public healthcare system in India.

III. PUBLIC HEALTH CARE SYSTEM IN INDIA

The public health care system in India is marred not only with insufficient provisions but also with an unequal distribution of whatever little there is (Baru *et al.*, 2010). Association between poverty and health is well known and the health indicators strongly correlate with per capita income, these also show a strong correlation with expenditure on health care. An analysis of trends of government expenditure on social sector and rates of growth of various states of India show that states with better social and physical infrastructure, market friendly governance and better state institutions were able to reap higher benefits from the growth of the economy as compared with states having poor quality institutions and a less developed infrastructure (Ray, 1998). Similar results also follow from the celebrated models of endogenous growth. The endogenous growth models show that long-run economic growth is determined by forces that are internal to the economic system, particularly the forces governing the opportunities and incentives to create technological knowledge. In the long run the rate of economic growth, as measured by the growth rate of output per person, depends on the growth rate of total factor productivity (TFP), which is determined in turn by the rate of technological progress.

Consider Figure 1, it shows total health expenditure as a percentage of GDP. We see that the expenditure on health as a percentage of GDP has been rapidly declining over years.



Source: NHA 2016-17

Fig. 1 Total health expenditure as percentage of GDP

According to the World Bank, the given level of expenditure on health in India is lower than the international standard. The spending is also found lower than the level required for providing the basic health facilities. Even though this low expenditure on public health is unevenly distributed, the access to health care facilities are not uniformly distributed. The following section shows different income groups have differential access to health care facilities.

IV. INEQUALITIES IN ACCESS TO HEALTH CARE FACILITIES

Figure 2 below shows a break-up of current health care expenditures by different health care financing schemes. State government and central government expenditure on non-employee finances is respectively 10% and 7% of the total health expenditure and the category others that includes employer-based insurance, other primary coverage schemes, community-based insurance, non-profit households serving households, resident foreign agencies schemes enterprises finance another 10% of the expenditure. The Union government finances 3% of expenditure on health by way of paying for its employees and the Social insurance sector adds another 3% to financing schemes. Every other body listed, contributes just 1% more. The pie chart clearly shows that 63% of all expenditure is met by individuals' own resources, termed as 'out of pocket expenditure', this is as reported by health and family welfare statistics of India (2019-20).

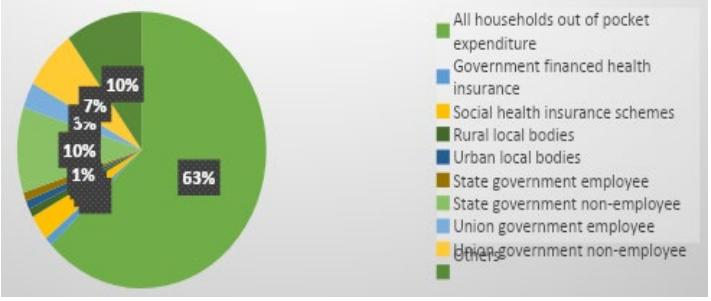


Fig. 2 Current health care expenditure (2016-17) by health care financing schemes

These figures show a grim picture of public health scenario in India, we see that 63% of health care expenditure is met by people from their own pockets, further by its nature health expenditure is contingent in nature, it arises suddenly, without any warning at times and financing it becomes burdensome, especially to people who are not covered under any health care financing scheme. Table I shows percentage breakup of people by health expenditure coverage. Percentage of people not covered under any type of insurance is 86% in rural areas, closely followed by urban areas at 81%. Government sponsored insurance is the largest cover which is followed by self-insurance in urban areas. Further, there is a sea gap between self-insurance in rural and urban areas. Though medical and health insurance has been increasing rapidly in the past quarter century, it still has a long way to go. The inadequacy of insurance becomes all the more prominent when we realize that there is no insurance cover for those who need it the most.

TABLE I PERCENTAGE BREAKUP OF PERSONS BY HEALTH EXPENDITURE COVERAGE

Sector	Not covered	Govt sponsored insurance	Govt/PSU as employer	Employer supported	Arranged by household insurance cos	Others
Rural	85.9	12.9	0.6	0.3	0.2	0.1
Urban	80.9	8.9	3.3	2.9	3.8	0.2

Source: Health and Family Welfare Statistics in India 2019-20

V. HEALTH CARE EXPENDITURE AND POVERTY TRAPS

Poverty traps are said to exist when people get stuck in vicious cycles of poverty and are unable to come out of it. In such a situation one of the most important effects of poverty is to perpetuate itself, that is a poor person caught in the poverty trap will not be able to break free of the trap because the trap reinforces different types of deprivation on the individual (Ray, 1998). For instance, a current generation poor family will not be able to invest in building up human capital for their children and thus the next generation remains poor too. Due to its direct and indirect impacts on income earning capabilities, health is one of the most important determinants of poverty. Poor health leads to lower income generation by a worker, it also ensures lower returns to education, and a failure to invest in health care by an individual or by a society is a sure way of reducing income levels (Bloom *et al,* 2018).

Table II shows average medical expenditure incurred in different income groups. The income groups are divided into quintiles, moving from lowest income earners to the highest income earners. The data here presents some interesting stories, males in the highest quintile of urban income groups report highest expenditure on health care, followed by females in the same group. This is followed by the females and males respectively in the third income quintile of urban households.

A possible explanation for such a trend can be derived from the fact that households in the fourth income quintile have a higher access to income and therefore better facilities and might end up requiring less health care as compared to households in the third income quintile. The curious difference in the health care difference between the first and second quintile can be similarly explained. It is important to note that expenditure in this head is systematically lower in case of rural households.

In fact, the highest expenditure as reported by rural households in the highest income quintile is lower than that reported by lowest income earners in the urban areas. It needs to be mentioned here that expenditure on health care stems from a multitude of factors. In poor economies this expenditure is low because of factors like incomplete information, careless attitudes towards health and also from the general trend of ignoring health care. The fact that high-income earners in rural areas spend less than low-income earners in urban areas highlights that access to or lack of access to income is not the only (neither the most important) parameter in determining expenditure on health care. Awareness (or lack thereof), attitudes towards health and the trends of healthcare also play a role in determining this expenditure. Heavy out of pocket expenditures on medical care often leave families with a huge dent in their finances (Dev and Sengupta, 2020).

The higher income classes do find some solace in insurance or as employee benefits, but the majority of the population remains without any such cover. In case of sudden expense arising out of bad health in the family or from sudden inability of the principal bread earner to continue earning, the households resort to various sources to finance this medical expense (Kundu *et al*, 2007). Table III, that follows enlists various sources of financing medical expenditure by households. We see that household savings are the cushion used by families across income groups in both rural and urban areas. The next biggest head being borrowed funds.

TABLE II AVERAGE QUINTILE CLASS OF HOUSEHOLD HEALTH EXPENDITURE

Quintile Class of Household Health Expenditure	Urban Households			Rural Households		
	Males	Females	All	Males	Females	All
I (lowest 20%)	620	631	627	500	552	528
II	589	612	602	657	589	619
III	734	768	752	631	597	613
IV	688	684	686	619	482	545
V (highest 20%)	834	810	822	645	567	619
All	711	710	710	621	567	592

Source: Health and Family Welfare Statistics in India 2019-20

VI. PROXIMATE DETERMINANTS OF HEALTH INEQUALITY

Household resources: these are the resources that are at disposal of the household. These resources usually form the household savings, more so, when we're looking at the poor and the marginalised sections of the society. It is these resources that come in handy in times of financial trouble. In case of a physical illness or morbidity households use these resources as a cushion. What needs to be noted here is the fact that not all households will have this cushion to fall back upon and even where these savings are available not every member of the household would be allowed to use these savings uniformly (Kabeer, 2000). For instance, womenfolk in the household (or the elderly) might be denied the use of such savings in event of their bad health or in event of the caretaker being rendered unable to take care of such people. Thus, the household sources even were available may not be available for all without discrimination and bias. It is interesting to note that in case of intra household discrimination even the non-poor and the non-marginalised sections of the society may fall prey to below poverty line levels in case of a loss in health of the provider (*ibid*).

Community factors refer to the environmental and the geographical influences on people's health. It is both common knowledge and empirically evident that the weaker sections of the society depend more on environment and environmental attributes. For instance, a water body being polluted will hurt everybody but all those whose livelihoods are dependent on that water body would be hurt the most (Hariss-White, 2005). Similarly, a common property resource being damaged would invariably hurt those who depend on that resource for their living. So far as the geographical influences are concerned, we find them working in a similar manner, that is, it would invariably be the poor who suffer more from Any inconveniences (Ray, 1998). Unavailability of roads for instance will hurt the have-nots more than it would hurt the haves. Lack of or inadequacy of any infrastructure would always cause more loss to the deprived classes.

With regards to community factors, we can also talk about the sanitary practices and people's attitudes towards health. The deprived classes would lack sufficient information about the need for and the advances in sanitary facilities and their impact on health in general (Bloom *et al*, 2018). A community that is unwilling to treat its girls, women, elderly or children to proper health will be affected by poor health, low ability to work and thus lower levels of income.

Public health system determinants such as insurance which for obvious reasons disadvantages the poor. It is the lower income classes that are in higher need of risk cover and sadly, it is these very classes that have no risk cover at all. The existence of private healthcare, existence of more and better information, availability of more money, possibility of better health treatments along with a better risk cover for the privilege classes augments the already existing inequalities. To be noted and underlined is the fact that being poor is a

disadvantage (Todaro and Smith, 2011). One can also find a detailed discussion on this in Ray, 1998. Out of pocket payments from poor health care seekers to the large private players are huge regressive payments. These payments are entirely avoidable if the public health sector is able to cater to the needy. The magnitude of these payments can be reduced if social security is put in place, this is necessary, especially in face of insurance facilities being almost non-existent for the poor. In absence of social security, absence of insurance facilities and a weak public health system, healthcare drives households into or further into poverty (Gill, 2012).

VII. FAILURE OF PRIVATE PROVISIONING OF HEALTH CARE

The flourishing private health sector in India was largely ineffective in dealing with successive waves of the COVID-19 pandemic. Not only it failed the public when it was needed the most, the private sector was seen to be making huge profits at the cost of people. Reports by the United Nations repeatedly assert that privatization has a negative impact on people close to the poverty threshold. Report of the special reporter on Extreme Poverty and Human Rights (2018), United Nations.

Disaster Risk Reduction in India: Status Report, 2020, Asian Disaster Preparedness Center. This report clearly points out that "privatization often involves systematic elimination of human rights and protections and leads to a further marginalization of interest of low income earners and that the existing human rights accountability mechanisms are inadequate for dealing with challenges presented by large scale and why desperate privatization."

Despite the high growth rate, the private sector failed to reach people in rural areas. Private healthcare facilities are also beyond the reach of poor people living in the urban areas (Ray, 1998). If we look at the comparative cost per case in the government and private hospital, we see that cost per hospitalization case in private facilities was nearly six times that of government facilities in the rural areas and increased to 8 times in urban areas.

TABLE III PER CASE AVERAGE MEDICAL EXPENDITURE ON HOSPITALISATION

Type of Hospital	Average Medical Expenditure		
	Rural	Urban	Rural + Urban
Govt/Public	4290	4837	4452
Private	27347	38822	31845
All (including charitable/ NGO/ trust run etc)	16676	26475	20135

Source: Health and Family Welfare Statistics in India 2019-20

It is predominantly these sections of the society that are not able to bear the financial losses arising out of bad health, it is these sections that need to be taken care of by the public health policy and it is these very sections that are neglected by the private sector. Table III, based on data from health and family welfare statistics in India (2019-20) show the vast difference between per case average medical expenditure on hospitalisation in public and private hospitals.

In an economy where almost 30% of the population survives at less than $1.25 a day and 68% make a living at less than $2 a day, it is ridiculous if not inhuman to expect masses to be able to meet the health care expenditure. According to an article published by Down to Earth on 7th April 2021, "the number of poor in India (with income of $2 per day or less in purchasing power parity) has more than doubled to 134 million from 60 million in just a year due to the pandemic-induced recession. This means, India is back in a situation to be called a "country of mass poverty" after 45 years." The article further says that, "though India has not counted its poor after the census of 2011, but the United Nations estimated the number of poor in the country to be 364 million in 2019, or 28 per cent of the population. The estimated incremental numbers of the 'new poor', pushed into poverty due to the pandemic is obviously in addition to this. Also, as estimates point out, millions in urban areas have also slipped below the poverty line. Cutting across population and geographical segments, millions of Indians have either become poorer, or poor, or on the brink of becoming poor."

VIII. CONCLUSION: WAY AHEAD WITH THE PUBLIC POLICIES

For effective policy designing one needs, first and foremost, an acceptance of facts. In India's case, for instance, one can begin by acknowledging the twin problems of infrastructural deficit and inequalities in access to healthcare, as they are on the ground. India, today is not in a position to force her people to rely on private health care, especially not when the policy maker has failed in providing either employable education or substantial income earning opportunities to the masses. Any insurance based policy solutions then stand to have limited relevance, especially for the rural poor where markets for private healthcare provisioning are often summarily missing and public infrastructure poor and inadequate (Gill, 2012). It is only unfortunate then that in the face of COVID-19, NITI ayog advocated a strengthening of private healthcare and insurance-based access to the same, instead of recommending expansion of public healthcare infrastructure and ensuring fair access to it.

According to the World Bank, public health expenditure as a percentage of government expenditure in India was just 1.28% of the country's GDP in 2018 (compared with 17.12% in the USA, 6.57% for China and 2.51% for Bangladesh in the same period). The IMF says high levels of inequality hurt growth and "it is imperative to address inequality of opportunities, in particular to broaden access to education, health, and financial services, as well as to tackle labour market duality and informality. The International Monetary Fund's April 2016 report on the Asia-Pacific region shows that India has not only one of the highest levels of inequality

in the region but has also been experiencing a very large increase in inequality since 1990. The capture of subsidies by the rich, the rural-urban income gap and the heavily skewed distribution of wealth can be cited as reasons for high and rising inequality in the whole of the rural economy, healthcare included (Dreze and Sen, 2013). Public financing is critical to good access to healthcare for the poor and its adequacy is closely related to poverty levels in the country. Any economy that is concerned with reductions in the level of poverty and inequality should pay due importance to public healthcare as health care facilities are central to faster growth of an economy. The private sector cannot be expected to become a provider for an economy's growth and developmental needs, especially in low income, primarily agrarian economies like our's, where market failure and missing markets for social and merit goods is a common phenomenon (Ray, 1998) (Bloom *et al,* 2018).

Moreover, it is unreasonable to expect the low and lower middle classes, exhibiting pathetically low savings and asset formation rates, to be able to pay the expensive unexpected treatment costs from their own pockets, even if they liquidate any assets held. Goes without saying, it is important, even inevitable, to keep the lower rungs of the society centre-stage while making development strategies for a low income economy like India, where 88% of the population survives on less than 5 dollars a day, of which 33% earn less than a dollar a day. In conclusion it is once again asserted that it is unreasonable, unfair and impudent of the policy maker to leave such a large number of people to the mercy of market forces, especially in the face of hardships such as the recent pandemic that not only cost people their lives but also imposed upon them costs as huge as displacement, reverse migration, loss of access to educational opportunities and more than everything else, loss of livelihoods in proportions unknown in recent history.

REFERENCES

[1] Acemoglu, D., & Robinson, J. (2010). The Role of Institutions in Growth and Development. *Review of Economics and Institutions, 1*(2), Article 1. DOI:10.5202/rei.v1i2.1.

[2] Ahmad Ahsan & Ashish Narain. (2008). Towards Understanding Development in Lagging Regions of India. paper presented at the Conference on Growth and Development in the Lagging Regions of India, Administrative Staff College of India; Hyderabad 2008.

[3] Atkinson, A. & Bourguignon, F. (1982). The Comparison of Multi-Dimensioned Distributions of Economic Status. *Review of Economic Studies, 49*, 183-201.

[4] Alkire S and James Foster (2009). Counting and multidimensional poverty measures. OPHI, Working Paper No. 7.5.

[5] Atkinson, A. B. (2015). Inequality: What can be done? Harvard University Press, New York.

[6] Bloom, D. E., Kuhn, M. & Prettner, K. (2018). IZA DP No. 11939, Health and Economic Growth, November 2018.

[7] Bourguignon, F. & Chakravarty, S. R. (2003). The measurement of multidimensional poverty. *Journal Of Economic Inequality, 1*(1).

[8] Chakarbarty, S. (1987). *Development Planning: The Indian Experience*. Oxford: Clarendon Press.

[9] Chintan R. Covid-19 Pandemic Woes: An Opportunity for the Private Sector and Niti Ayog?, 9 August 2021, News click.

[10] Daron Acemoglu, Simon Johnson & James A. Robinson. (2005). Institutions as a Fundamental Cause of Long-Run Growth. *Handbook of Economic Growth*, Volume IA edited by Philippe Aghion and Steven N. Durlauf.

[11] Deolalikar, A. B., Brillants *et al.,* (2002). Poverty and Role of Institutions in Developing Asia. ERD Working paper No.10, ADB.

[12] Dev, Mahendera, S. & Sengupta, R. (2020). Covid-19: Impact on the Indian Economy. IGIDR Working paper series, WP-2020-013.

[13] Dreze, J. and Sen, A. (1996). Economic development and social opportunities. OUP

[14] Duggal R. Poverty & health: Criticality of public financing, (November, 2007). *The Indian Journal of Medical Research, 126*(4), 309-17.

[15] Economic survey (various). New Delhi, Ministry of Finance, Government of India.

[16] Ehsan, S. M. (2001). Institutional framework and poverty: A Transition Economy Perspective. CESifo Working paper No. 593.

[17] Gill, Kaveri (2012). Promoting Inclusiveness: A framework for assessing India's flagship social-welfare programmes. UNICEF Social policy Working paper series 2.

[18] Gordon, D. (2005). Indicators of Poverty & Hunger. Expert Group Meeting on Youth Development Indicators United Nations Headquarters, New York 12th-14th December 2005.

[19] Gordon, Jim & Poonam, Gupta. (2004). Understanding India's Services Revolution. IMF Working paper WP/ 04/171.

[20] Barbara Harriss-White, (2005). India's market society: three essays in political economy. Three Essays Collective, Gurugram, India.

[21] Holt, S. L. (1990). Role of Institutions in poverty reduction. WDR.

[22] Hulme, D. & Paul Mosley. (1996). Finance Against Poverty. Routledge, London.

[23] Kabeer, Naila. (2000). Social Exclusion, poverty and discrimination: Towards an analytical framework. *IDS bulletin, 31*(4).

[24] Kanbur, R. & Lyn Squire. (1999). The Evolution of Thinking about Poverty: Exploring the Interactions. Meier, Gerald M and Stiglitz, Joseph E. (Ed.), *Frontiers of Development Economics: The Future in Perspective*. World Bank and Oxford.

[25] Kundu A. (2006). Globalization and the Emerging Urban Structure: Regional Inequality and Population Mobility. India: Social Development Report, Oxford, New Delhi.

[26] Kundu, A. & Sarangi, N. (2010). Inclusive Growth and Income Inequality in India under Globalisation: Causes, Consequences and Policy Responses. *Proceedings of the Conference of Regional Disparities in Asia,* UNDP, Colombo.

[27] Kundu, A. Shariff, A. & Ghosh, P. K. (2007). Indexing Human Development in India: Indicators, Scaling and composition, in Abusaleh Shariff and M. Krishnaraj ed. 'State, Markets and Inequalities', Orient Longman, New Delhi.

[28] Musgrave, R. A., *Merit goods, The New Palgrave Dictionary of Economics.* Second Edition. Eds. Steven N. Durlauf and Lawrence E. Blume. Palgrave Macmillan, 2008. http://www.dictionaryofeconomics.com/article?id=pde2008_M000152

[29] Nachane, D. M. (2011). India Development Report, OUP.

[30] Naila, K. (2008). Social exclusion, poverty and discrimination, Critical Quest, New Delhi.

[31] North, D. C. (1990). Institutions, institutional change and economic performance. Cambridge university press.

[32] Panagariya, Arvind, Rao, M. Govinda, Chakraborty, Pinaki (2014). State Level Reforms, Growth, and Development in Indian States. United States: Oxford University Press.

[33] Partha Dasgupta. (1995). An Inquiry into Well-Being and Destitution. Oxford University Press.

[34] Quibria, M. G. (2012). Microcredit and Poverty Alleviation: Can microcredit close the deal?. UNU WIDER, Working Paper No. 2012/78, September.

[35] Rama Baru *et al.,* (2010). Inequities in Access to Health Services in India: Caste, Class and Region. *Economic and Political Weekly, 52*(3).

[36] Ray Debraj. (1998). Economic Development. Oxford University Press.

[37] Sen, A. (1976). Poverty: An Ordinal Approach to Measurement. *Econometrica, 44*(2), (1983). Poor relatively speaking. Oxford economic papers serial no. 35, (1992). Inequality reexamined. Oxford Clarendon press, (1999). Development as Freedom. Oxford OUP, (2004). Social exclusion concept application scrutiny. critical quest, New Delhi.

[38] Sen, A. K. & J. Dreze. (2013). *India and her contradictions: An Uncertain Glory*. Princeton University Press. New York.

[39] Sen Abhijit & Himanshu. (2004, September). Poverty and inequality in India II: Widening disparities during the 1990s. *Economic and Political Weekly, 25*, 4361–4376.

[40] Sen, B. (1997). Health and poverty in the context of country development strategy: a case study on Bangladesh. Geneva: World Health Organization. Macroeconomics and Health Development Series No. 26. Unpublished document WHO/ICO/MESD.26.

[41] Stiglitz, J. E. (May, 1989). Markets, Market Failures and development. *AEA Papers and proceedings, 79*(2).

[42] Srinivasan R., Health care in India - Vision 2020, Issues and prospects, Retrieved from https://niti.gov.in/planningcommission.gov.in/docs/reports/genrep/bkpap2020/26_bg2020.pdf.

[43] Todaro, M. P. & Smith, S. C. (2011). *Development Economics*, Pearson, New York.

[44] Wagstaff. A Poverty and health sector inequalities, based on: Wagstaff A. Poverty and health. (CMH Working Paper Series, Paper No. WG1: 5. Retrieved from www.cmhealth.org/wg1_paper5.pdf.