

Financing of Health in India

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INANCING IS THE MOST CRITICAL OF ALL DETERMINANTS OF A HEALTH SYSTEM. The nature of financing defines the structure, the behaviour of different stakeholders and quality of outcomes. It is closely and indivisibly linked to the provisioning of services and helps define the outer boundaries of the system's capability to achieve its stated goals.

Health financing is by a number of sources: (i) the tax-based public sector that comprises local, State and Central Governments, in addition to numerous autonomous public sector bodies; (ii) the private sector including the not-for-profit sector, organizing and financing, directly or through insurance, the health care of their employees and target populations; (iii) households through out-of-pocket expenditures, including user fees paid in public facilities; (iv) other insurance-social and community-based; and (v) external financing (through grants and loans).

While taxation is considered the most equitable system of financing, as tax is a means of mobilizing resources from the richer sections to finance the health needs of the poor, out-of-pocket expenditures by households is considered the most inequitable. Under a system dominated by out-of-pocket expenditures, the poor, who have the greater probability of falling ill due to poor nutrition, unhealthy living conditions, etc. pay disproportionately more on health than the rich and access to health care is dependent on ability to pay.

Assessing how pro-poor a system of financing is again depends on how the different types of financing interact with each other. For example, a country may have a social health insurance policy but may not cover public hospitals as they are in theory expected to provide free care. In such a situation there may be greater incentives for patients to go to private hospitals as expenses are covered by insurance resulting in no incentives for the public hospitals to function well. In that case, the poor who have no immediate access to insurance or private hospitals may stand to lose with poor quality public care.

In India, as in most countries, there is a clear urban-rural, rich-poor divide. Affluent sections, urban populations and those working in the organized sector covered under some form of social security such as the ESIS or CGHS, have unlimited access to medical services. The rural population and those working in the unorganized sector have only the tax-based public facilities to depend on for free or subsidized care, and private facilities depending on their ability to pay. The impact on equity then gets determined on whether the tax-based public facilities are able to provide a similar quality of care as provided under the Social Health Insurance Scheme. Because, if funding is low and the quality of care falls below expectation, is inaccessible, entails informal payments, etc. then the benefit of free care at the public facility gets neutralized with the second option of paying out-of-pocket to a relatively hassle-free private provider available close by, making the system of financing inequitable as well as inefficient. How and why this is so will be discussed in this section, as an understanding of the current structure of financing is important to identify future options for a better system.

Health Spending in India

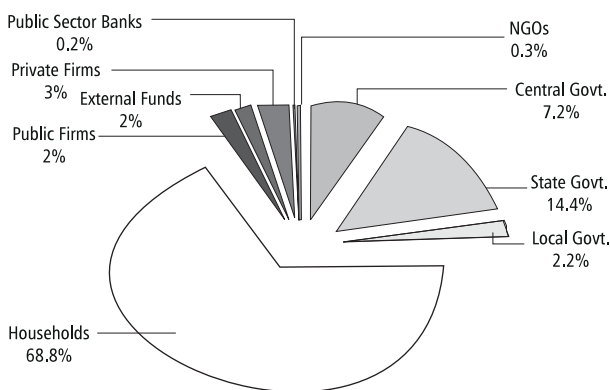
Health spending in India is estimated to be in the range of 4.5%-6%. These estimates are based on a weak methodological background. Therefore, an exercise was undertaken to construct estimates of health spending based on a National Health

Account (NHA) framework. Such an approach enables a better and more reliable understanding of the size and structure of health financing in India.

Results from the NHA show that the estimated health expenditure in India for the year 2001-02 was approximately Rs 108,732 crore, accounting for 4.8% of the GDP at current market price (Fig. 1), while health expenditure as a percentage of the GDP measured at factor cost works out to 5.2%. Out of this, Central, State and local Governments together spend one-fourth of the total health expenditure. The share of other central ministries, which include railways, defence, posts and telegraphs, other civil ministries, etc. is estimated to be about 2.42% of total health spending in the country. The estimate is based on direct spending by the ministries as well as reimbursements provided to its employees. Local governments' resources for health are through transfers from State Governments and their own resources. An estimated 2.2% of total health spending comes from the local government. The estimate involves only spending by municipalities and not Panchayati Raj institutions. It is to be noted that municipalities (in metros and particularly Mumbai Municipal Corporation) are major contributors among local governments while the share of Panchayati Raj institutions are a minuscule part of the health budget, since a substantial part of the panchayat's are mostly composed of either Central or State transfers.

Fig 1

Sources of finance in the health sector in India during 2001-02



Regarding private spending on health, the NHA matrix reveals that 71% of the health budget is contributed by private sector, of which households alone spend 69%. As a percentage of the GDP at current market prices, households spend an estimated 3.3%. Spending by private firms is in various ways: either through their own health facilities, or by providing a lumpsum amount to the employee for health, or reimbursing a part of the health expenditure incurred or by contributions to insurance schemes such as ESIS or voluntary private insurance schemes.

External aid to the health sector, either to the Government or NGOs, taken together forms 2% of the total health budget.

Although the emergence and growth of NGOs have received much attention in India in recent years, their contribution to the health sector is a negligible 0.3% of the total health expenditure.

As financial intermediaries, social insurance accounts for around 2.36% of the entire health budget in the country, with a significant contribution by the ESIS. While community insurance is a non-starter in the country, the share of private voluntary insurance schemes has a share of less than 1% of the total health budget.

Household Out-of-Pocket Expenditure on Health

The dominant role of the private sector in Indian health care system is well known, both in health provision and financing. India is one among the developing countries where households spend a disproportionate share of their consumption expenditure on health care, with the Government's contribution being minimal. Household consumer expenditure data of various rounds of the National Sample Survey Organization (NSSO) suggest that households spend about 5%-6% of their total consumption expenditure on health and nearly 11% of all non-food consumption expenditure.

The analysis here shows the estimate of household expenditure on health for the year 2001-02, using the NHA framework. The estimate is based on the utilization pattern of health facilities and the expenditure involved by different sources of care and services provided.

However, the mean expenditure and utilization pattern of morbidity for the year 1995-96 has been extrapolated (assuming a similar pattern of expenditure by different providers) and anchored to the 2001 Population Census and applying current growth rates worked out from the 50th and 55th rounds of Consumer Expenditure Surveys (CES) by both rural-urban and inpatient-outpatient populations. This growth rate takes into account both the price factor and growth of services during the period under consideration.

Results from the survey suggests that for the year 2001-02, households' out-of-pocket health expenditure is estimated to be Rs 72,759 crore which accounts for 3.2% of the GDP at current market price.

Since 1995-96, household expenditure on health has been growing at the current rate of approximately 14% overall. In 1995-96, households in India spent an estimated Rs 33,253 crore at nominal prices which is then estimated to have increased to Rs 72,759 crore in 2001-02. With an overall growth rate of 14%, household spending is likely to be close to Rs 100,000 crore in nominal terms during 2003-04. Except the category of childbirth/delivery, all other categories registered a current growth rate in double digits. The growth in inpatient expenditure has been highest, in the range of 16%-18% during 1995-96 to 2003-04. (Table 1)

In per capita terms, household expenditure measured in nominal prices has almost tripled from Rs 364 in 1995-96 to Rs 905 in 2003-04, while real per capita household expenditure is expected to only marginally increase from Rs 265 to

Table 1
Household health expenditure by different source of care in India, 1995-96 to 2003-04

Type of service	1995-96	2001-02	2003-04	Growth rate
Outpatient-rural	16,692.96	34,290.99	43,590.87	12.75
Outpatient-urban	7251.45	16,904.82	22,415.01	15.15
Inpatient-rural	3030.04	8536.86	12,057.25	18.84
Inpatient-urban	2092.90	5150.72	6954.10	16.19
Childbirth	1654.22	2258.14	2504.97	5.32
Antenatal care (ANC)	1053.90	2383.27	3128.22	14.57
Postnatal care (PNC)	390.85	1028.10	1419.21	17.49
Immunization	241.02	535.61	698.95	14.23
Contraceptives	207.14	422.74	536.22	12.62
Self-care	638.83	1247.47	1559.23	11.80
Total	33,253.31	72,758.71	94,457.19	13.94

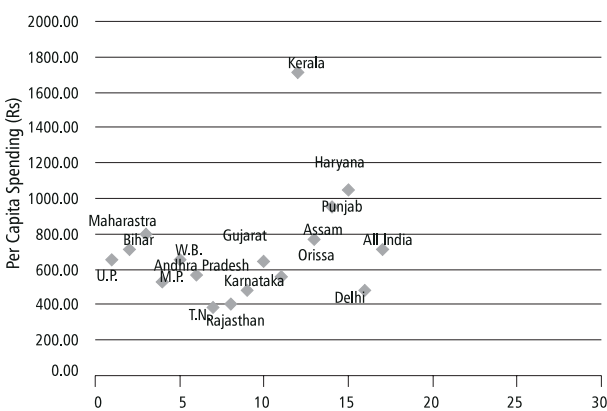
(Rs in crore)

Source: Estimated from the 52nd Round of the NSS, using 2001 Population Census and applying growth rates worked out from the 50th and 55th rounds of the NSS

Rs 347, respectively.

State-wise analysis (of only major 15 States in India) reveals that Kerala, which is a leading State in terms of health indicators, also accounts for the highest household spending in India, with a little over Rs 1700 per annum (Fig. 2). This is followed by Haryana and Punjab whose households spend an estimated Rs 1000 annually. It is interesting to note that these States comparatively have higher levels of public spending on health. Although Tamil Nadu's public expenditure on health is high, household spending is among the lowest. In States such as UP, MP and Orissa, both public expenditure

Fig 2
Household spending in Indian States



and household expenditures are relatively low.

It is disquieting to note that nearly 70% of the total health expenditure in India comes from households, while around 25% is financed by the Central, State and local Governments. If we consider only out-of-pocket and State and Central Government spending, then households in Bihar and

UP met almost 90% of their health care needs by out of pocket means. In other States, which have strong public health systems such as Tamil Nadu, Delhi and Karnataka, households' spending is relatively lower than the public expenditure, accounting for about two-thirds of the total health expenditure in these States. (Table 2)

Public Financing of Health

Even though public sector spending accounts for less than a quarter of the total health spending in India, it has a major role in terms of planning, regulating and shaping the delivery of health services. Such public provisioning is considered essential to achieve equity and to address the large positive externalities associated with health. As a result, a vast and widespread public health system grew over time across the country; there were 137,311 subcentres, 22,842 PHCs, 3043 CHCs, 4048 hospitals and a workforce of 345,514 in 2001-02. The way in which the sector is financed determines the effectiveness of service delivery and requires an understanding of the financing mechanisms in this sector.

Health being a State subject, the sector is financed primarily by the State Governments. The per capita total health spending was estimated to be around US\$23 during 1997-2000 (World Bank 2003). As compared to the levels of spending by countries such as Sri Lanka (US\$31) and Thailand (US\$71), the spending in India is substantially low. A breakdown of health expenditure reveals that expenditure by the public sector in these countries is twice that of India. Substantially higher levels of health outcomes in these countries as compared to India clearly indicate that there is a strong case to markedly increase public sector spending on health, as stated in the National Health Policy 2002 and the National Common Minimum Programme (CMP) 2004.

The primary source of public financing is the general tax and non-tax revenues. These include grants and loans received from both internal and external agencies, which face competing demands from various ministries and departments. This pool of resources is used to finance the Centre's and States' own programmes. The Central Government plays a catalytic role in aligning the States' health programmes to meet certain national health goals through various policy guidelines as well as financing certain critical components of centrally sponsored programmes implemented by the State Governments. In addition to tax revenues, a meagre amount is also raised through user charges, fees and fines from the sector, and further supplemented through grants and loans received from external sources. In the case of local governments, the respective State Governments largely finance their health programmes. Local governments do raise resources through user charges and certain fees though the quantum varies widely from States to States. Overall, the sector is underfunded, not without consequences.

An issue that is often raised in the context of inadequacy of resources to the sector is the efficiency of the resources allocated. The current level of funding to the sector is grossly inadequate as brought out by various studies over the past

Table 2

Household, public and total health expenditure in India (2004–05)

States	Household Exp. (Rs. Crores)	Govt. Exp. (Rs. Crores)	Other Exp. (Rs. Crores)	Aggregate Exp. (Rs. Crores)	PC HH Exp. (Rs.)	PC G. Exp. (Rs.)	PC Other Exp. (Rs.)	PC Exp. (Rs.)	HH as % of THE (%)	PE as % of THE (%)	OE as % of THE (%)
Central Govt.	0	14819	730	15549	0	137	7	144	0	95.3	4.7
A. P.	6441	1696	640	8777	820	216	82	1118	73.38	19.39	7.29
Arun. Pradesh	430	67	0	497	3776	589	0	4365	86.51	13.49	0
Assam	3054	672	52	3778	1089	239	19	1347	80.84	17.78	1.38
Bihar	11854	1091	202	13147	1021	124	23	1497	90.17	8.3	1.53
Delhi	1004	721	55	1780	664	476	37	1177	56.41	40.48	3.11
Goa	524	116	22	662	3613	798	153	4564	79.17	17.48	3.35
Gujarat	4893	996	424	6313	920	187	80	1187	77.51	15.78	6.71
Haryana	3385	421	175	3981	1518	189	79	1786	85.03	10.56	4.4
H.P.	2126	306	40	2472	3377	486	64	3927	85.99	12.38	1.63
J & K	1759	471	47	2277	1609	431	43	2082	77.26	20.69	2.05
Karnataka	3847	1267	353	5467	702	231	64	997	70.36	23.18	6.46
Kerala	8373	1048	281	9702	2548	319	86	2952	86.3	10.8	2.9
M.P.	6432	1051	228	7711	746	164	35	1200	83.41	13.63	2.96
Maharashtra	11703	3527	726	15957	1156	348	72	1576	73.34	22.1	4.55
Manipur	420	89	8	517	1680	356	32	2068	81.24	17.2	1.56
Meghalaya	58	94	8	160	242	388	34	664	36.45	58.37	5.18
Mizoram	38	58	0	96	405	623	0	1027	39.39	60.61	0
Nagaland	1024	84	7	1116	4897	404	37	5338	91.74	7.57	0.7
Orissa	2999	684	111	3795	786	179	29	995	79.04	18.02	2.93
Punjab	3493	827	273	4593	1379	326	108	1813	76.05	18	5.95
Rajasthan	3399	1190	267	4855	565	198	44	808	70	24.5	5.5
Sikkim	72	55	0	127	1274	965	0	2240	56.89	43.11	0
T.N.	3624	1590	760	5974	566	248	119	933	60.67	26.61	12.72
Tripura	253	100	13	366	760	301	40	1101	68.99	27.35	3.66
U.P.	17158	2650	550	20359	924	150	31	1152	84.28	13.02	2.7
W.B.	7782	1715	433	9929	931	205	52	1188	78.38	17.27	4.36
U.Ts.	3160	325	227	3712	11168	52	37	598	85.13	8.74	6.12
State Totals	109308	17965	5906	133178	1012	167	54	1233			
GT [GOI+State]	109308	32784	6636	148727	1012	304	61	1377	73.5	22	4.46

Source : Based on National Health Accounts (NHA), 2001-02

Notes : i) Household Expenditure Based on NHA for the year 2001-02 and extrapolated for 2004-05

ii) Central Govt. expenditure includes transfer to states, other central ministries and central PSUs; and data obtained from Demand for Grants (Provisional), Govt. of India.

iii) Govt. Expenditure includes Central, States, Local Govt., and PSUs; data obtained from States Finances (Provisional), RBI, Various issues

iv) Others include foreign agencies, private firms and NGOs; data relates to 2001-02, which is subsequently extrapolated for 04-05.

v) PC HH Exp. – Per Capita Household Expenditure; PC G Exp. – Per Capita Govt. Expenditure; PC Other Exp. – Per Capita Other Expenditure; HH as % of THE – Household as % of Total Health Expenditure; PE as % THE – Public Expenditure as % of Total Health Expenditure; OE as % of THE – Other Expenditure as % of Total Health Expenditure; C. Govt. – Central Govt.; U.Ts – Union Territories.

decade or so. A concern that is equally voiced is how judiciously the funds allocated currently are utilized. Countries such as Bangladesh and Indonesia spend about US\$14 and US\$19, respectively, per capita on health; relatively less than the per capita spending by India (US\$23). But the health outcomes in terms of child mortality are considerably better in these countries—74 for Bangladesh and 45 for Indonesia compared to 93 for India (World Bank 2003). This clearly reveals that the current level of spending has the potential to improve the outcomes if properly allocated. In the following sections an attempt is made to understand the present trends and structure of public spending on health to critically evaluate the above issues in detail.

Trends in public spending on health in India

Public spending on health in India gradually accelerated from 0.22% in 1950-51 to 1.05% during the mid-1980s, and stagnated at around 0.9% of the GDP during the later years (ie. spending by only Central and State health departments) (Table 3). Of this, recurring expenditures such as salaries and wages, drugs, consumables, etc. account for more than 90% and is on the rise in recent years. In terms of per capita expenditure, it increased significantly from less than Re 1 in 1950-51 to about Rs 215 in 2003-04. However, in real terms, for 2003-2004 this is around Rs 120. Estimates, irrespective of the definition, reveal that the per capita spending by the

Table 3

Trends in health expenditure in India (GDP is at market price, with base year 1993-94)

Year	Health expenditure as % of the GDP			Per capita public expenditure on health (Rs)
	Revenue	Capital	Total	
1950-51	0.22	NA	0.22	0.61
1955-56	0.49	NA	0.49	1.36
1960-61	0.63	NA	0.63	2.48
1965-66	0.61	NA	0.61	3.47
1970-71	0.74	NA	0.74	6.22
1975-76	0.73	0.08	0.81	11.15
1980-81	0.83	0.09	0.91	19.37
1985-86	0.96	0.09	1.05	38.63
1990-91	0.89	0.06	0.96	64.83
1995-96	0.82	0.06	0.88	112.21
2000-01	0.86	0.04	0.90	184.56
2001-02	0.79	0.04	0.83	183.56
2002-03	0.82	0.04	0.86	202.22
2003-04	0.86	0.06	0.91	214.62

Sources: Report on Currency and Finance, RBI, various issues; Statistical Abstract of India, Government of India, various issues; Handbook of Statistics of India, RBI, various issues

Government is far below the international aspiration of US\$12 recommended for an essential health package by the World Development Report 1993 (World Bank) and, again by the Commission on Macroeconomics and Health (World Health Organisation 2002) CMH (WHO) for low-income countries.

As a result of stagnant budgetary allocations, the quality of care suffered substantially and adversely impacted on the utilization of government services by households. Besides, health services that were earlier being provided free were in some cases charged, forcing patients to seek private health care.

Impact on equity due to low public spending

The results of the NSS of 1986-87 and 1995-96 showed a considerable decline in the utilization of public health services by the poor, especially the rural poor (Table 4). Besides, the study also showed that the rich consumed public services three times more often than the poor. The ratio of access to admission between the lowest 10% quintile and the richest 10% was reported to be 6.1 and 2.2 between the below poverty line (BPL) and the above poverty line (APL) populations.

The 52nd Round of the NSS provided insights into the quintile-wise health-seeking behaviour. As per this data, of the poor who availed of services, 61% used public facilities compared to 33% among the rich. The poorest, however, benefit relatively more from spending on primary care only (Mahal 2001). This is primarily on account of the poor quality and irregular supply of these services which dissuade the rich from accessing them. Further, many of the services that benefit

Table 4

Utilization of government hospital services for in-patient treatment

Fractile groups	1986-87 (42nd Round)		1995-96 (52nd Round)	
	Rural	Urban	Rural	Urban
0-10	12.94	11.59	3.13	12.87
10-20	10.59	11.42	6.30	7.40
20-40	22.94	25.66	16.70	20.90
40-60	18.69	23.91	17.20	18.17
60-80	19.73	17.28	24.30	19.77
80-90	8.82	3.63	14.07	10.23
90-100	6.30	6.52	18.30	10.67
All groups	100.00	100.00	100.00	100.00

All values are in percentages
 Note: Government hospitals refer to public hospitals, PHCs and public dispensaries.
 Sources: 1. NSSO. Morbidity and Utilisation of Medical Services. Report No.364, Department of Statistics, CSO, Government of India, September 1989, pp. A-8-13.
 2. NSSO. Morbidity and treatment of ailments. Report No.441, Department of Statistics, CSO, Government of India, November 1998, p. A-65 and p. A-170.

the poor are, to some extent centrally funded vertical programmes such as immunization, ANC, TB, Malaria, Leprosy, etc. The inequity in the access to and distribution of public health services has been a concern because of the extent of impoverishment households face on account of ill health, and catastrophic illnesses in particular.

Health Expenditure by the Central Government

Major policy initiatives and reforms relating to health emanate from the Ministry of Health and Family Welfare (MOHFW), which plays a crucial role in financing this sector.

The Union Ministry of Health and Family Welfare consists of three departments. The department-wise break-up of the Health Ministry's budget suggests that over one-third of the budget is spent by the Department of Health, while roughly two-thirds goes to the Department of Family Welfare. The Indian Systems of Medicine and Homeopathy (ISM&H) (AYUSH) Department receives a paltry 2%-3% of the total budget of the Ministry. There are 5 important aspects to the nature of central spending in recent years:

1. The gradual reduction in the proportion of funds released to States at a time when the States were themselves under fiscal stress;
2. The sharp reduction in capital investment in public hospitals at a time of technological innovation, shifts in the epidemiology and health needs and expectations of the people, besides the sheer increase in disease burden in absolute terms;
3. Increased subsidy for own employees;
4. Low priority to preventive and promotive health; and
5. Allocative inefficiencies under the National Health Programmes

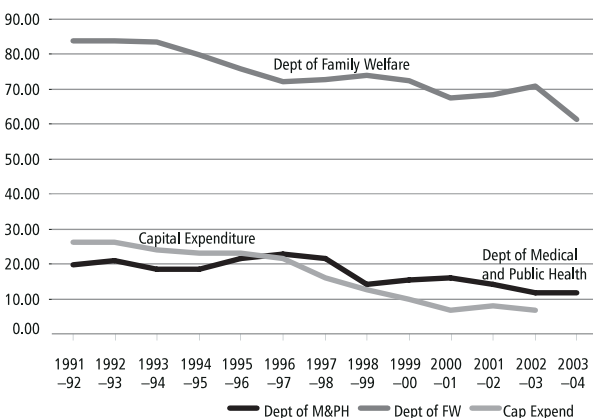
Centralization of funds and inadequate capital expenditures

The Ministry implements certain schemes such as the Central Government Health Scheme (CGHS), national disease control programmes, etc. by itself, and other schemes through the State Governments. A large part of the Ministry's budget is passed on as grants-in-aid to States for implementing various national health programmes. Such transfers accounted for about 43% of the total budget of the Ministry in 2003-04. Even though the size of the Central health budget has grown considerably from Rs 1670 crore in 1991-92 to Rs 7851 crore in 2003-04, transfers to States as a proportion of the total budget of the Ministry declined sharply from nearly 57% to 44%. This in effect reveals the increasing role that the Central Government has been assuming in health service delivery. As a result, roles such as stewardship and governance that the Central Government is expected to play are undermined.

The share of the Central Government expenditure on health, including grant-in-aid to States, constitutes over a third of the combined expenditure by the States' and Centre. Figure 3 shows that during the period 1991-2003, the overall increase in central allocations was 4%-6% annually. Despite this, there was a sharp decline in capital expenditure, which fell from about one-fourth of the Ministry's expenditure to less than 6.7% of the net MoHFW expenditure (excluding grant-in-aid to States and UTs but including capital expenditure incurred by the Ministry of Urban Development on hospitals such as RML and LHMC). During the same time, allo-

Fig 3

Trends in grant-in-aid allocations by MoHFW to States and declining capital expenditures



Note: 1. Figures in parentheses denote percentage share of central spending and grants-in-aid to states as a percentage of total MoHFW (GOI) expenditure.

2. Grants-in-aid has been calculated as the sum of expenditure under major heads 3601, 3602 and 3606.

Source: Demand for Grants, Ministry of Health and Family Welfare, respective years

cations for materials and supplies for central sector public hospitals also fell from 22% to 15% to accommodate the increase in salaries from 56% to 63% on account of the Fifth Pay Commission. This has had an adverse impact on the declining level of quality in these once premier hospitals which are expected to act as a benchmark in the quality of care.

CGHS—a mandatory social health insurance scheme for the Central Government Employees

Six per cent of the combined budget of the department or 18% of the budget of the Department of Health was spent on 44 lakh beneficiaries or 0.5% of the country's population under the Central Government Health Scheme (CGHS). Since the introduction of contracting of private hospitals for providing health services and permitting beneficiary members to purchase drugs at pharmacy shops in 2000, there has been an escalation in expenditure under this programme. Over and above the Rs 503 crore incurred on the CGHS by the Department of Health, an additional Rs 200 crore was spent by the various administrative departments on medical reimbursements of their serving employees during 2001-02. All taken together, the outpatient expense under the CGHS per card is estimated to be about Rs 3478 per year and the inpatient expense per card issued to retired civil servants and dependents is Rs 6692 per year.

Low priority for preventive health care

An important public health function that governments are expected to perform is expanding access to public goods by focusing on preventive and promotive education. Preventive and promotive education does not mean only disseminating disease-specific messages to raise awareness among people for behaviour change but also includes a range of other aspects such as laws for the use of helmets for preventing road accidents, or providing nutritional information to consumers regarding food products, on risky behaviours and exhorting people to adopt healthy lifestyles such as non-consumption of addictive substances such as tobacco, daily exercise, healthy diets, etc. In India, such an interventionist role of the State is negligible with some information, education and communication (IEC) activities undertaken under the National Health Programmes. This is a serious omission, given the huge treatment costs that will be required to cope with the emerging epidemic of non-communicable diseases.

Under the NHP, the amount spent on preventive care aimed at prevention and behaviour change during the financial year is an estimated 21% as given in the Table 5; of this a large amount was for vaccines under the universal immunization programme (UIP). In terms of use of mass media and interpersonal communication, the expenditure under this head in the National Programmes is a mere 2% of the overall budget. For TB, the amount spent during 2001-2002 on preventive care is very low, as most of the expenditure was on drugs, equipment and staff. As people are unaware of the free services under the National Health Programmes, a large number

Table 5

Expenditure on preventive and promotive activities under NHPs during 2001-02 (Rs in Lakhs)

Activity	Name of the programme						Total	% TE†
	Malaria	Leprosy	TB	FW*	HIV/AIDS	Blindness		
Distribution of IEC materials	846.09	1089.92	205.35	8542	15000	958.26	26,641.62	6.0
Immunization	0	0	0	54,722		0	54,722.00	12.4
Supply of condoms	0	0	0	11,821		0	11,821.00	2.7
Supply of bednets	239.05	0	0	0		0	239.05	0.1
Supply of insecticides	4301.36	0	0	0		0	4301.36	1.0
Total	5386.5	1089.92	205.35	75,085	15,000	958.26	97,725.03	21.1
TE	21978	6105.07	10,058.06	391,663	22,500	11,802.23	464,106.36	
% TE	24.5	17.9	2.0	19.2	66.7	8.1	21.1	

* 2002-03; † Total expenditure
IEC: information, education and communication; TE: total expenditure; TB: tuberculosis; FW: Family Welfare;
Source: Ministry of Health and Family Welfare, GOI

of them continue to go to the private sector for treatment..

Expenditures under the Reproductive and Child Health (RCH) Programme pertain to the immunization programme which helps avoid vaccine-preventable diseases but is of limited value in achieving the goal of bringing down IMR and under-5 child mortality rate for which commensurate investments have to be made on propagating a range of behavioural practices. These include breastfeeding, use of oral rehydration solution (ORS), healthy practices such as consumption of boiled water or washing the hands with soap, prevention of acute respiratory infections (ARI), etc. These interventions are as important for child health as the use of vaccines for vaccine-preventable diseases. Since preventive and promotive expenditures are an investment on the demand side, it is necessary to not only increase the level of expenditure under this component but also implement these activities more rigorously to reduce the disease load and public expenditures on curative care.

Centrally sponsored schemes–National Health Programmes (1991–2003)

Of the total combined central budget 70% is spent on National Health Programmes related to the disease control programmes and family welfare. The allocation of funds for the 5 National Communicable disease control programmes (Leprosy, Malaria, TB, Blindness and HIV/AIDS) went up from 18.6% of the budget during 1991-92 to 26.8% of the budget in 2002-03, accounting for Rs 704.3 crore. Due to limited expansion of the budget, malaria got gradually crowded out giving way to HIV/AIDS. In 1991-92, malaria accounted for over 66% of the total outlay under disease control programmes of the Department of Health, shrinking to just 29.3% in 2002-03. During this period there was a corresponding increase in the HIV/AIDS programme: from 5% to 34.3%. In gross terms, the disease control programmes got a higher allocation as they were all funded under World Bank projects. The quantum of external funding received by the Department of Health on the communicable disease control programmes went up from a negligible amount

in 1990-91 to Rs 513.26 crore in 2002-03, constituting almost 20% of the Department's expenditure during the year, as shown in Table 6.

Table 6

External funding of National Health Programmes (2002-03) (Rs in crore)

NHPs	Total allocation	Share of external funding	Share of external funding (%)
Malaria	206.6 (29.3)	97.96	47.4
TB	96.8 (13.7)	95.10	98.2
Leprosy	75.0 (10.6)	67.99	90.7
AIDS	241.4 (34.3)	239.96	99.4
Blindness	84.6 (12)	12.25	14.5
Total	704.3 (100)	513.26	72.9

Figures in parentheses are the proportion of the total allocated for these 5 programmes
Source: Demand for Grants, Ministry of Health and Family Welfare, respective years

Another major national programme that is centrally funded in substantial measure is the Family Welfare Programme. Under this programme, recurring expenditures of subcentres, the RCH Programme and free supply and social marketing of contraceptives are the main activities receiving 40%, 20% and 12%, respectively, of the budget allocations.

Health expenditure by State Governments

At the State level, public health is also financed through general tax and non-tax revenue resources as the cost recovery from the services delivered has been negligible, at less than 2% (Selvaraju 2001). As a result, resource allocation to this sector is influenced by the general fiscal situation of the respective State Governments. For instance, the implementation of the recommendations of the Fifth Pay Commission during the late 1990s resulted in an increase in the fiscal deficit and a general resource crunch. Evidence

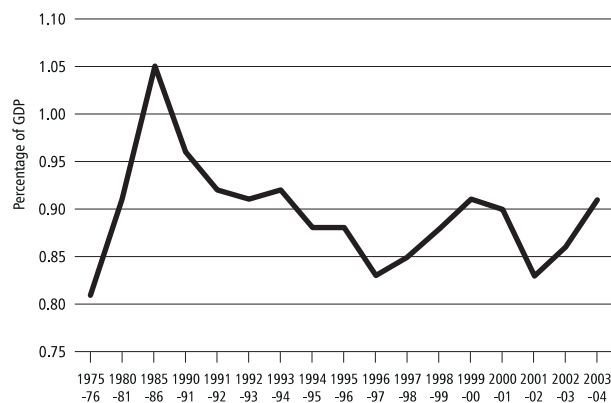
from other countries also suggests that whenever there is a fiscal consolidation and stress, social sectors like health and education are targeted for pruning expenditures and reducing budget allocations (Tanzi and Schuknecht 2000). The figures presented in Table 7 confirm the above findings. The budgetary allocations to the health sector during the year 1999-2000 declined to the extent of about 2 percentage points as compared to 1985-96. Despite reduction in the health budget from 7.02% in 1985-86 to 4.97% in 2003-04 the fiscal deficit as a percentage of the GSDP recorded an increase, implying that allocation to health does not necessarily accentuate fiscal deficits.

Public spending on the health sector in the States increased to about 0.9% of the GDP as per the estimates for 2003-04, from 0.8% in 1975-76 as seen in Fig 4. During the decade 1975-85, it registered a substantial increase and reached a high of 1.05%. Thereafter, it deteriorated steadily due to the general fiscal stress during the late 1980s followed by the reform measures initiated in the 1990s. The severity of the fiscal strain during the late 1980s forced the State Governments to introduce austerity measures and the 'soft' sectors such as health were targeted for expenditure compressions. Similarly, when reform measures were initiated at the Centre during the early 1990s, fiscal transfers to States were compressed leading to reductions in health sector allocation at the State level. The recommendations of the Fifth Pay Commission in 1997 forced the governments to increase the budget to meet the increased salary cost of public sector personnel. However, these improved allocations could not be sustained beyond 1999-2000 when deceleration set in again. By the year 2001-02, the relative allocation to the sector reached levels closer to those prevailing in 1975-76. (Figure 4)

Fig 4

Trends in public health spending

Sources: State demand for grants for various years



Budgeting allocation and outcomes

The manner of resource allocation to and planning for the health sector shows a wide disparity in spending and outcomes across States, indicating the absence of appropriate norms for allocation and monitoring of health programmes. Table 8 gives the budget allocation function-wise (See Appendix 1). Although the table does not attempt to establish any correlations between such functional spending and key outcomes such as IMR or safe deliveries, it may be a proxy for assessing the functioning of the health system. Yet, the data are juxtaposed only to highlight the point that it is the low-performing (high IMR and low safe delivery) States which spend relatively higher amounts on pri-

Table 7

Share of health in revenue budget of major States (in %)

States	1985-86	1991-92	1995-96	1999-2000	2003-04 (B.E.)
Andhra Pradesh	6.41	5.77	5.70	6.09	5.21
Assam	6.75	6.61	6.08	5.25	4.39
Bihar	5.68	5.65	7.80	6.30	4.84
Gujarat	7.45	5.42	5.34	5.21	3.68
Haryana	6.24	4.19	2.99	4.08	3.63
Karnataka	6.55	5.94	5.85	5.70	4.85
Kerala	7.69	6.92	6.81	5.95	5.42
Maharashtra	6.05	5.25	5.18	4.59	4.39
Madhya Pradesh	6.63	5.66	5.07	5.18	4.89
Orissa	7.38	5.94	5.42	5.03	4.47
Punjab	7.19	4.32	4.56	5.34	4.27
Rajasthan	8.10	6.85	6.18	6.39	5.75
Tamil Nadu	7.47	4.82	6.40	5.51	5.26
Uttar Pradesh	7.67	6.00	5.73	4.42	5.13
West Bengal	8.90	7.31	7.16	6.30	5.23
All States	7.02	5.72	5.70	5.48	4.97

Table 8

Sectoral allocation of health expenditure by States: 2001-02 (Rs in lakhs)

	Primary	Secondary	Tertiary	Social health insurance	Administrative	Research and training	IMR/1000* live-births 2002	Safe delivery 2002** (% Rounded off)
Well-performing States								
Andhra Pradesh	63,241 (47.53)	22,844 (17.17)	27,625 (20.76)	5419 (4.07)	11,592 (8.71)	2326 (1.75)	62	68
Karnataka	51,334 (47.28)	23,883 (22.00)	23,626 (21.76)	4719 (4.35)	4164 (3.83)	844 (0.78)	55	62
Kerala	19,389 (25.88)	26,460 (35.32)	21,198 (28.30)	3502 (4.67)	1979 (2.64)	2385 (3.18)	10	97
Tamil Nadu	52,700 (43.92)	18,120 (15.10)	34,114 (28.43)	8011 (6.68)	5266 (4.39)	1772 (1.48)	44	80
Medium performing States								
Punjab	26,078 (42.17)	10,078 (16.30)	9419 (15.23)	3131 (5.06)	12140 (19.63)	995 (1.61)	51	61
Gujarat	30,336 (41.61)	4986 (6.84)	20,430 (28.02)	6623 (9.09)	8968 (12.30)	1558 (2.14)	60	59
Haryana	16,217 (50.38)	5060 (15.72)	5507 (17.11)	2436 (7.57)	2518 (7.82)	412 (1.28)	62	44
West Bengal	46,184 (34.79)	35376 (26.65)	30,153 (22.71)	6737 (5.07)	12457 (9.38)	1839 (1.39)	49	43
Maharashtra	102,106 (55.70)	27722 (15.12)	36,292 (19.80)	11120 (6.07)	4645 (2.53)	1380 (0.75)	45	61
Poor Performing States								
Assam	21,002 (58.98)	6003 (16.86)	6109 (17.16)	0 (0.00)	2182 (6.13)	314 (0.88)	70	20
Bihar	46,349 (64.96)	6047 (8.48)	11,728 (16.44)	768 (1.08)	4765 (6.68)	1692 (2.37)	61	18
Chhattisgarh	17,166 (74.02)	2348 (10.12)	1541 (6.64)	328 (1.41)	1157 (4.99)	394 (1.70)		
Madhya Pradesh	41,650 (54.14)	10,791 (14.03)	14,420 (18.74)	2049 (2.66)	4915 (6.39)	1771 (2.30)	85	32
Orissa	20,370 (45.33)	11,837 (26.34)	6590 (14.66)	1054 (2.34)	4407 (9.81)	645 (1.43)	87	37
Rajasthan	57,831 (58.50)	7556 (7.64)	24,598 (24.88)	2275 (2.30)	5159 (5.22)	1419 (1.44)	78	38
Uttar Pradesh	142,193 (61.18)	50,257 (21.62)	18,138 (7.80)	6680 (2.87)	12034 (5.18)	621 (0.27)	80	26
Total	754,143 (50.18)	269,369 (17.92)	291,486 (19.40)	64,850 (4.32)	98,346 (6.54)	20,366 (1.36)		

Figures in Paranthesis are percentages to total spendings by states
RE figures for 2001-02 have been used for Bihar, all others are actuals
Source: Demand for grants for respective States, 2003-04 (2002-03 for Bihar)
* SRS, 2004 ** Source: MICS 2000

mary care as compared to other States and yet continue to have such poor outcomes, raising the question as to whether there is any correlation of public spending to programme outcomes. However for such analysis longitudinal data are needed.

Table 8, however, seems to suggest that an equitable spread of resources among all the three sectors—primary, secondary and tertiary—may be necessary. As can be seen in the case of UP—the skewed spending on primary and negligible amount on tertiary, which deals with medical colleges and training—

can have long-term effects in two ways: on the quality of people trained or in creating a shortage of skilled personnel. Whether poorly trained or low in numbers, the impact on access to primary care services will be adversely affected as the care provided will depend, in the ultimate analysis, on the availability of human resources.

Structure of health sector spending

Analyses of the structure of spending on health by State

Governments shows that spending on salaries and wages account for more than 70% of health budgets. The huge network of services developed over time covering the length and breadth of the country is manned by doctors, nurses and paramedical staff and no doubt needs a large budgetary allocation. Of the remaining budget, nearly 12% is allocated for drugs, medicines, supplies and consumables; purchase of machinery and equipment account for 8%, and nearly 5% is allocated for maintenance of equipment, buildings, electricity, rent, taxes, etc. The remaining 5% is spent on other routine expenditures.

The large proportion of the budget allocation for salaries is often criticized as unproductive. It is true that the rising share of salaries has squeezed out other components causing severe imbalances. With the less-than-proportionate increase in the total budget to the sector and political compulsions to not cut the salary head, the non-salary component used for fuel, drugs and medicines, maintenance and repair of equipment and buildings, etc. declined sharply.

Does fiscal deficit impact on per capita public health spending?

To analyse the spending behaviour of States and its connection if any with fiscal deficits, an analysis of five States was taken up—two well-performing and three poor-performing States. The analysis shows that the burden of fiscal deficit is much higher in Orissa, Rajasthan and Uttar Pradesh compared to Tamil Nadu during the past decade as seen in Fig 5 below. This might have seriously hampered resource allocations to the health sector in these States affecting their ability to perform. As can be seen, with the increase in the overall fiscal deficit as a percentage of the GDP, there is a decline in per capita public health spending. The fall has been sharpest in UP.

Public spending on health plays an important role in the imperfect health market. It ensures minimum service delivery under the difficult circumstances that prevail in backward States such as Orissa, UP, Bihar and, at the same time, acts as a corrective force for market failures where a number of players deliver services. Studies on health financing emphasize that even though the aggregate spending level in India is comparable to a few developing countries, the levels of per capita public spending on health needs to be stepped up (Prabhu 1993). This gains further importance as a large share of out-of-pocket expenditure by users of public hospitals goes to pay for drugs and diagnostic tests from private providers. This expenditure actually substitutes the government's expenditure. As seen in Table 8, States that allocate larger resources per capita are also the States with better health outcomes as also seen in Fig. 5. Therefore, in States such as Orissa and Uttar Pradesh, per capita public health spending needs to be increased more than proportionately because of low levels of out-of-pocket spending due to low incomes and poor purchasing power. In fact, out-of-pocket spending as a share of the household expenditure is among the highest in UP—the State where per capita public expenditure is also low, calling

Fig 5

Fig. 5. Burden of fiscal deficit

Source: RBI, prices are in real terms

Per Capita Real Spending on Health (Rs.)

■ 1991-92 ■ 1995-96 ■ 1999-2000

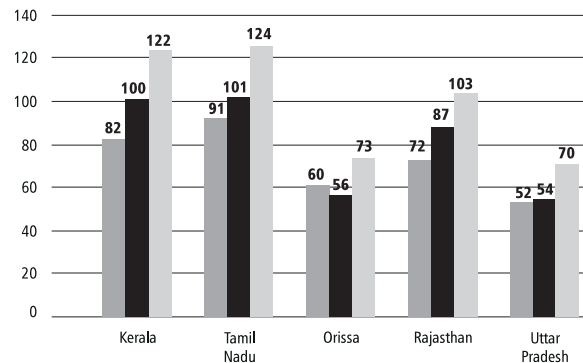
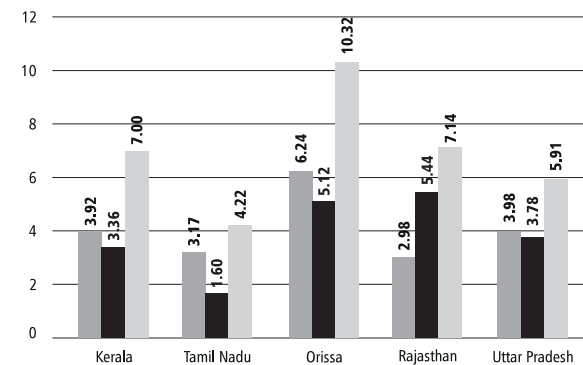


Fig 5A

Fiscal Deficit as % of GSDP

■ 1991-92 ■ 1995-96 ■ 1999-00



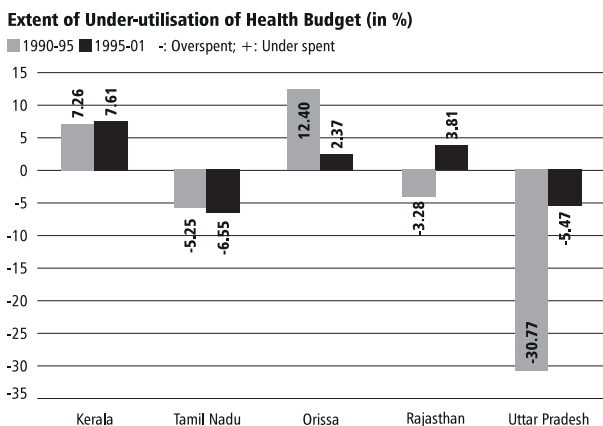
for an increase in public spending. It is, however, true that no correlation can be established between per capita public spending and household expenditure as the actual access to services depends on other factors such as the efficiency with which the system is functioning. In other words, if the health system is inefficient or poorly managed, mere increase of financial resources may have little impact.

Suggestions to increase budgetary allocations for health are often questioned because of the widely prevalent opinion that the budget allocated is seldom utilized. An analysis of the budget allocated and utilized at the end of the year for five States showed a mixed trend (Fig. 6). For instance, Kerala has been underutilizing about 7% of its budget allocated to the health sector whereas, in Tamil Nadu, expenditure exceeded allocation by about 6%. The evidence does not seem to fit a pattern. At periods of higher fiscal deficit, percentage utilization should be low, but in UP during the four-year period 1990–1994 there was consistently excess spending. While reasons for this will need a closer analysis, intuitively, it could be inferred that at times of fiscal stress, budget allocations are reduced to the bare minimum such as for salaries, which get

Fig 6

Extent of underutilization of the Health budget

Source: Reserve Bank of India



utilized without effort quite automatically. Conversely, the lower utilization of funds at better times could perhaps have more to do with the budgeting process than in the States' ability or capacity to absorb the funds, calling for a restructuring of the way in which health is financed.

Issues of Concern**Financing of National Programmes—not as per need**

Financing of disease control programmes are effected through societies created for the specific programmes at State and district levels. The mechanism for allocating funds directly to district societies was found to be effective as it enabled quicker absorption of funds. However, there has been a measure of scepticism. For instance, it was envisaged that such decentralization of funds to district societies would enable need-based, bottom-up programme planning and budgeting. However, this seldom happened. Most programmes are designed at the Centre and funds are released with strict guidelines and well-defined budget line items, not very different from for regular health programmes except that the unspent budget does not lapse at the end of the fiscal year. In addition, these programmes have little flexibility in issues such as contracting selected services or procurement of critical supplies.

More importantly, analysis showed that in a number of instances budget allocations are not need-based and in consonance with the extent of the disease burden. For example, while the disease burden and caseload under leprosy in Bihar was 21.3% of total cases, the State received only 9.4% of the funds, while West Bengal having a caseload of 7.5% got over 10% of the allocation. Likewise, UP and MP together accounted for 37% of the total caseload under child morbidity but received only 24% of the total budget for RCH.

Figures 7a and b show such mismatch between funds and need explicitly. For instance, out of 20 major States, the extent of funds allocated to States such as AP, Bihar, Madhya Pradesh and Maharashtra for the Malaria Programme was substantially

larger than the caseload in those States, while the position was reversed in Karnataka, Orissa and West Bengal.

Another important case of misplaced emphasis is the Pulse Polio Initiative, introduced in 1996. Implemented as a vertically driven scheme, an estimated total of Rs 3592 crores has been spent so far. This amount does not include the extra-budgetary expenditures incurred by the WHO on the appointment of over 1000 consultants in the country to monitor the programme and the amounts being incurred by the UNICEF on IEC. It is estimated that one drop of polio vaccine is almost 30 times more than the drop given in routine UIP. Moreover, almost 13% of the department's budget during 2003–2004 was spent on this single activity, which has limited impact on reducing the IMR, a principal national and Millennium Development Goal.

Box**Typical case of the National Malaria Programme**

The State Malaria Officer (SMO) plans and places the demand for funds. When the budget is approved, it is about 50% of the demand placed by the SMO.

The SMO still carries on with the 50% budget by rationalizing the funds. The SMO selects areas/blocks that have a high incidence and goes on selecting the second highest, third-highest blocks until the budget is exhausted.

When the next budget allocation is made, the SMO continues the implementation process. By the time the SMO controls the incidence in about 50% of the blocks by the third or fourth year, the blocks where the programme was implemented in the first year again show up on the high incidence list.

This cyclical process continues and eradication of the disease is further complicated. Increase in the drug resistance for every reoccurrence makes eradication a herculean task.

Gross underfunding of National Health Programmes: A mismatch between policy and practice

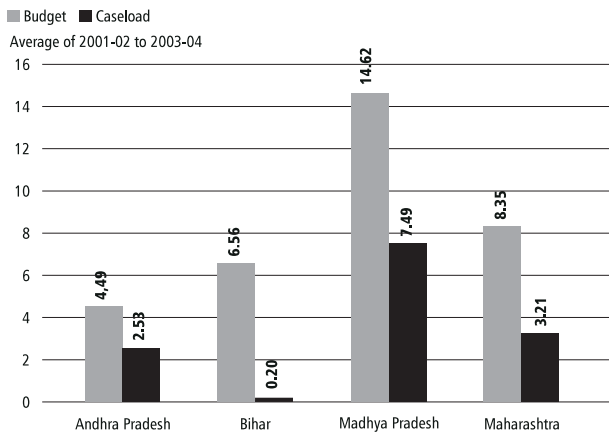
Policy governing the National Health Programmes is that services being provided under them are free for all. Theoretically, therefore, regardless of income class, all citizens of the country are eligible for availing of services free of cost under the NHP that cover vector-borne diseases, TB, leprosy, Family Welfare, cataract blindness and HIV/AIDS. Our calculations show that such a policy would need a minimum of Rs 12,000 crore against which the total amount that is spent by the Centre and States on these programmes is about Rs 5000. The sub-optimal functioning of the delivery system due to gross underfunding explains the huge out-of-pocket expenditures being incurred by individual households in seeking services 'guaranteed' to them under the NHP.

A survey of households conducted by the IIHMR, Jaipur (IIHMR 2000) showed that a married woman in the age group of 15–49 years of age spent an average of Rs 400 for RCH serv-

Fig 7a

National Malaria Programme: A case of mismatch in funds and incidence-I

Source: Government of India



ices, with urban households spending Rs 604 and rural households about Rs 292. Of this, Rs 835 was spent for delivery, Rs 440 for RTI treatment and Rs 160 for child care. Similar studies show that the reluctance of women for institutional deliveries and the persistently high proportion of domiciliary deliveries are driven by cost factors. A delivery in a public hospital is reported to cost an average of Rs 601 while in the private sector it costs about Rs 3593, while at home it costs only Rs 93. The major item of expenditure was also found to be drugs, which constitute 62%. Such findings are not surprising as government spending on RCH is very low. Of the Centre's total FW budget during the period 1997-98 to 2003-04, the amount for activities directly impacting on maternal health was Rs 2531 crores accounting for 9.7% of the total budget and Rs 17 per capita per annum for women in the age group of 15-49 years of age. Thus, it is clear that if we are to achieve the National Goals of IMR and MMR, there is a need to step up public spending and also develop social health insurance schemes to address the financial barriers that hinder women from seeking good quality care.

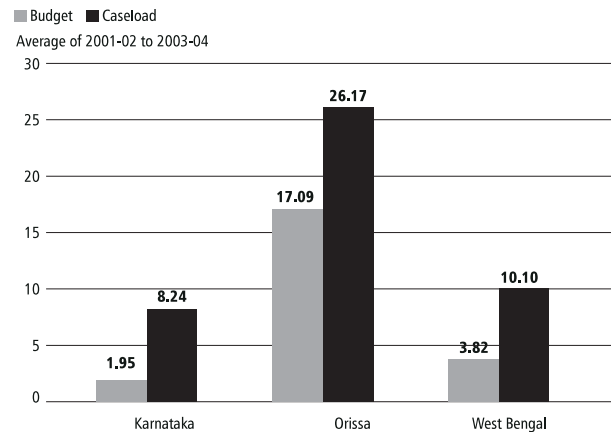
Weak absorption capacity in the Government

Even while there is mounting evidence to justify a quantum jump in public budgets for health, the Central Ministry routinely surrenders budgets allocated to it. Under World Bank projects also, there have been frequent expressions of concern at the slow pace of expenditure and poor draws. What is the reason for this apparent disconnect between a shortage of funds and an inability to spend? Why does money not get translated into an outcome, particularly in the poor-performing States where the people are so desperate for subsidized health care? The reasons for the slow pace of expenditure are both systemic and institutional as well as poor designing and sequencing of expenditure items.

Fig 7b

National Malaria Programme: A case of mismatch in funds and incidence-II

Source: Government of India

**Lack of stability in budgetary processes**

State Governments normally pass the budget between April and June every year. Once the budget is passed, treasuries located at various districts are intimated of the budgets allocated to various sectors, followed by a budget authorization. The amounts authorized vary widely depending on the financial situation of the State, and the current priorities and reasons could range from political compulsions to debt repayment. Several times during such a bad fiscal situation, budget authorizations are released but instructions are issued informally to treasury officers not to release money, disrupting ongoing activities and processes, such as finalizing a contract for procurement of drugs or equipment. The department does not only lose the 'unutilized' funds at the end of the fiscal year but these are also shown as 'surrender of funds' and the next year's allocations accordingly pegged onto the funds 'actually spent'. Secondly, expenditure items are also fixed and no discretion is given at any level to reallocate available funds for meeting a need or an emergency. For any such 'deviation' the approval of the State Finance Department (and if a centrally sponsored scheme then the Central Government) is required which normally takes a few months at the minimum. Thirdly, utilization of funds also does not take place as the first instalment could be inadequate for any meaningful activity necessitating the release of subsequent instalments. Finally, in the month of December, the expenditure levels are reviewed and revised estimates for the department fixed. At times of acute fiscal stress, budget cuts are arbitrarily imposed across the department.

All these factors are mainly responsible for the lumping of releases, non-timeliness of the availability of drugs or other inputs for any meaningful utilization, the lack of synchronization of the mix of inputs, etc. There are another two worrying aspects. One, at times, to not let funds 'lapse' the amounts are spent on inessential items; and two, across the board budget

cuts could often also mean interruptions in the supply of essential drugs carrying unintended consequences of drug resistance or burdening the patient to buy drugs.

Analysis of annual accounts of district societies for 2002-03

As has been argued earlier, various societies have been created at the district level for the implementation of the National Health Programmes, including the District RCH Society, District Blindness Control Society, District Tuberculosis Control Society, District AIDS Control Society, District Leprosy Control Society, etc. These societies are registered under the Societies Act, and the governing body of these societies usually include representatives of District administration, District Health officer (or his equivalent), and the respective programme Officers, often along with elected representatives from the district and some representation from civil society.

The purpose of creating these societies is to provide autonomy for programme implementation, decentralize the planning, implementation and monitoring of the programme, and also as a funding mechanism wherein funds do not lapse at the end of the financial year and can be carried over to the next year. Funds are provided by the Central, and/or the State Government in the form of grant-in-aid to society, which is to be spent for the purpose of programme implementation.

However, funds often reach the societies late, and sometimes the last instalment for the year is not even received at the end of the financial year (and is accounted for as 'Funds in Transit'). The first instalment for a financial year can take

anywhere between 1 and 4 months or more to be released, and even more time to finally reach the District Society.

At the society level, often this fund is not adequately utilized during the financial year, resulting in a high closing balance with the society at the end of the financial year. To some extent, this closing balance is also necessary, as it allows for a buffer to meet the expenditure for the new financial year before a new instalment of funds is received. However, in some cases, huge balances lie unutilized with the district societies. In a study of 17 such societies from five districts, for which the annual accounts and balances were available at NCMH, one society had a reserve balance at the end of 2002-03 which was adequate for 5 years of its current annual expenditure, while 5 other societies had reserve balances at the end of 2002-03 which were adequate for more than 1 year's requirement. Table 9 Notably, 4 societies (out of 17) had negative balances, i.e. they had spent more than what had been released from the Centre/State, and this exemplifies delayed releases where funds did not reach even by the end of the financial year.

A break-up of the items of expenditure showed that the predominant item of expenditure for Blindness societies was grant-in-aid to NGOs, constituting between 41% and over 80% of the total expenditure incurred by these societies in 2002-03, but was insignificant for other societies. Similarly, barring one district, the remaining 4 Tuberculosis societies had salaries of the contractual staff as the largest component, varying from 55% to 83% of their expenditure during the year. If all the resource is spent on staff, what does the district society do to raise awareness? Further analysis showed no uniformity in focus.

Table 9

Break-up of expenditure of district societies in different States for various programmes in 2002-2003 (Rs in lakhs)

District	Society	Closing balance on 31-3-03	Expenditure during year 2002-03	Funds available at end of year (in months of requirement)
Vaishali	AIDS	150,314	117,686	15.3
Nadia	Leprosy	318,502	1,931,458	2.0
Kozhikode	Leprosy	416,071	185,273	26.9
Vaishali	Leprosy	916,235	1,003,017	11.0
Nadia	Blindness	-683,361	688,734	-11.9
Nadia	Tuberculosis	1,873,881	3,211,496	7.0
Vaishali	Tuberculosis	1,421,618	1,125,594	15.2
Vaishali	Blindness	493,284	84,726	69.9
Kozhikode	Blindness	-660,950	1,019,019	-7.8
Kozhikode	Tuberculosis	2,762,057	851,114	38.9
Jalna	Tuberculosis	1,131,043	1,034,195	13.1
Nadia	RCH	263,555	5,875,035	0.5
Pune	Tuberculosis	0	1,445,881	0.0
Pune	Blindness	-1,298,941	1,814,016	-8.6
Pune	Malaria	872,747	1,127,253	9.3
Pune	Leprosy	-137,903	346,704	-4.8
Pune	AIDS	1,266,104	1,309,104	11.6

Source: Accounts of the various district societies made available to NCMH

Dysfunctional system of financing

Departmental budgets are made in a five-year cycle, categorized into various heads and subheads. The broader divisions are revenue and capital, plan and non-plan. Revenue budgets finance current consumption such as salaries and wages of staff, purchase of drugs and medicines, and repair and maintenance of machinery, equipment and buildings including purchase of minor equipment, machinery, etc. Capital budgets are a one-time investment for purchase of land, building construction, equipment, machinery, etc.

The budget of the health directorate is further categorized into rural, urban, allopathic, other systems of medicine, medical education and public health, and again into activities such as training, urban and rural family welfare services, contractual services, transport, and so on. All these budget heads are further allocated to numerous minute budget heads thereby making the allocations very specific.

The budget process so developed over decades has resulted in fragmentation of the health sector budget into more than 4000 small heads. The funds allocated under those numerous budget heads are non-transferable and are surrendered to the State's general pool of funds if they remain unutilized at the end of the fiscal year. This is strictly followed to ensure that the funds budgeted for specific activities at the beginning of the year should be spent on those activities to fulfil the intended objective.

Such systems of budgeting are extremely useful for audit and accounting purposes as the key objective is expenditure control. Such procedures also help insulate the budgets from arbitrary diversions, misuse of funds and deviation from stated objectives. However, the system, from the perspective of achieving health system goals, is archaic and needs to be changed. Firstly, fixing budgetary allocation on five-year and annual plan cycles is not based on any meaningful programme audit. There are neither baselines, nor endlines, evaluations nor reviews taken into account or made available to serve as the basis for resource allocation. The exercise is routine with incremental shifts and some programmatic targets that move from year to year. In fact, targets have little to do with the professed goals that in turn have little to do with financial allocations. Therefore, since the physical targets have no bearing on the financial allocation, the focus shifts to budget utilization to protect future allocations. And since financial expenditure is the key indicator for achievement, the major proportion of the cumulative energy of the department go towards obtaining 'utilizations certificates' and releasing funds to States and district societies, rather than focusing on the promotional activities that impact on health outcomes. Secondly, health sector needs are different, requiring a measure of flexibility as, barring some broad heads of expenditure where advance planning can be done, under operational costs, the level of unpredictability could be high. The type, nature and intensity of diseases change with seasonal variations, demographic shifts and the macroeconomic environment. Health managers cannot therefore be tied down to a five-year plan of activities nor can they foresee their needs five years in advance, as

Box

In Ontario province of Canada, all hospitals are required to furnish detailed financial returns to the department once a quarter based on which budgets are released. The returns run into over 2000 budget lines provided department-wise and indicating not only utilization of the budget but also utilization of the services. Such concurrent utilization, financial and physical line item-wise, is what gives the hospital manager an understanding of the kind of services for which the demand is growing, where there is an excess of drug budgets or the workload of staff allocated can be calculated. This then helps them to re-deploy staff to needy areas by training, wherever required; reconfigure resources, shutting down departments where there is inadequate demand; bring in control on prescription of drugs or tests wherever they are found to have crossed reasonable limits, etc.

a SARS epidemic can upset the whole budget allocation and priorities. Similarly, at the local level, also, hospital managers have to be taking multiple decisions all the time requiring flexibility and some autonomy in financial decision-making.

Besides, for a policy-maker, the structure of budgeting makes it impossible to identify the cost centres, where expenditure control needs to be exercised, the type of skills mix needed, which departments should be closed down and which expanded in keeping with the changing disease burden, etc. Such lack of flexibility is the reason for the low occupancy of beds in public facilities. Since hospital budgets are not global and are factored based on bed strength, which determines the staff and drug support, etc. there could be situations where one department has funds though few patients, while another may have restricted funding but have two patients on one bed.

Complex design

Funds also do not get spent if the design of the scheme or intervention is very complex and process-oriented. Participatory systems that involve all stakeholders do provide, in the long run, greater sustainability to the programme. However, such approaches are time-intensive as different constituents of stakeholders have different and varied ideas, expectations and needs. Harmonizing them takes time, as community responses are not always uniform. Therefore, when any activity has to be implemented within a strict time-frame, then such processes get short-circuited and data are fudged or money not spent. Second, and more so in donor-funded projects, the emphasis is on spending. The release of funds is in equated instalments spread over all the project components. In such a system, delay in the completion of one activity upsets the implementation of others. For example, training may get held up due to delays in the preparation of training modules or training of trainers or the procurement of equipment may get stalled due to delay in the construction activity.

Inadequate allocation of funds under externally funded projects

A frequently heard issue in relation to externally funded

projects is the slow pace of expenditure. This happens for three reasons: First, while the Government approves several stand-alone projects and agrees to a yearly funding plan, in practice, funds made available under the 'EAP' (Externally Assisted Projects) component are normally short of the amounts agreed to. This is because of the system of capping the proportion of the EAP for each ministry based on the total resource position of the country calculated on the basis of total domestic and external revenues.

Second, the procedures for implementing activities are cumbersome and require multiple clearances at several stages. Construction activities and procurement of equipment take, on an average, eighteen months to two years for starting the activity, or obtaining the equipment. Third, complex procedures are involved in the recruitment of staff, and the process of selection is highly time-consuming, taking over a year. States are also often reluctant to create posts for which they will have to pay after the cessation of the project in five years, adding to their non-plan budget. Besides, due to low salaries, often posts do not even get filled up. To circumvent this problem, increasingly projects are recruiting persons on contract. While this enables quicker placement of people, it affects the human resource issue of the department in the long term, since contractual appointees are neither provided training nor given any financial delegation of powers and responsibilities as they are seen as temporary workhands.

A serious matter related to external funding is that such funding is not provided as an additionality. In such a system, instead of the health system being strengthened by external funding, priorities get skewed and distortions created, as non-funded programmes, which could be equally if not more important, get lower funding priority. Besides, since external funding is not an additionality, there is little incentive for the department to mobilize donor aid. At times of acute fiscal stress, again, two things happen: either the externally aided components of the budget are protected to the exclusion of all else as seen in AP during the late 1990s, distorting departmental priorities once again, or the crises may end in curtailing the availability of funds to the externally aided projects also, affecting the spending and credibility of the State for raising future funding.

Budgeting not functional

In other countries, budgets have two heads—capital and operational. A budgeting system based on an artificial classification of plan and non-plan makes it impossible to know what money is going where. Since the annual planning process only considers the plan or 'new' activities, the maintenance of assets never gets the required attention under the non-plan budget. So while under the plan budget, buildings are constructed, the cost of maintenance is not factored in from year to year. Second, the aggregation of budget heads keeps changing making any trend analysis difficult. Third, there is no uniformity in budget lines in the country. For example, in Karnataka and Maharashtra, the Director of Health Services

is aware of and responsible only for budgets released to hospitals having more than 100 beds, whereas budgets related to facilities having less than 100 beds are administered and monitored by the respective Zila Parishads with funds released by the Department of Finance. Moreover, as already observed, the budget lines are useful only for accounting purposes and not for policy planning. We tried, for example, to calculate how much government departments spend on the health care of its serving employees. For the Government of India, this information is spread over 8000 drawing officers, 700 autonomous bodies, 38 departments and 220 PSUs. Each DDO again has to scrutinize the salary bills to disaggregate the amount spent on medical care! In State Governments, obtaining this information was impossible.

Weak financial capability

At almost every level—central, State or district, administrative directorates or hospital units—the staff dedicated for financial oversight functions are few and their capacity weak. In most cases, the staff consists of one or two officers and a few clerks. None is trained on either financial management or on health needs. Several times their knowledge of financial rules is superficial. While the Central Government has an internal audit system, at State and district level, such concurrent audit systems do not exist. Computerization is poor and so is the capacity for planning and budgeting. Weak systems give room for discretion and scope for fraud and, more importantly, for delays due largely to raising meaningless and frivolous queries. This therefore calls for greater professionalism of the finance set-up and sharing of responsibility, making them equally responsible for poor expenditure. Changing their mindset from account-keeping to being facilitators for achieving certain goals should be the key for the future.

Conclusion

Health sector in India suffers from gross inadequacy of public finance and therefore an immediate and significant scaling-up of resources is an imperative. The undue burden on households for spending on health cannot be wished away. Further, it is also clear that there is an urgent need to restructure the budgeting system to make it more functional, amenable to review of resource use to take corrective measures in time and be flexible enough to have the capacity to respond to an emergency or local need. Rules and procedures for actual release of funds, appointment of persons, labour laws, procurement systems all need a thorough review. Greater decentralization of funds, aligned with functional needs and responsibilities, is necessary. However, any decentralization and financial delegation needs to be carefully calibrated and sequenced. In other words, decentralization can only be done after developing the requisite financial capability and laying down rules and procedures for accounting systems. Unless such restructuring takes place, greater absorption of funds will continue to be difficult.

Appendix 1

Primary care: For the purpose of this paper, primary care has been taken to include all facilities which provide outpatient care, which may be preventive, promotive or curative, and also those facilities which provide outpatient as well as limited inpatient care, wherein the admissions are primarily for stabilization or observation, etc. Thus, in this paper, primary care includes subcentres, PHCs and CHCs, as also ISM dispensaries.

Secondary care: This category includes institutions with inpatient facilities, above the level of CHCs, but not providing superspecialty care. Therefore, this category includes taluk and district hospitals. While these institutions also provide primary care, and for some of these, this could be a major activity, the entire expenditure of such institutions is classified as secondary.

Tertiary care: Teaching hospitals and medical colleges have been included in this category, which includes allopathic as well as Indian systems of medicine. While these institutions also provide primary and secondary care, and for some, these could be major components of their activities, the entire expenditure of such institutions is classified as tertiary.

Research and training: Expenditure incurred on institutions mainly engaged in health-related research or health-related training activities have been classified in this category. Teaching hospitals and medical colleges have not been included here, for example, as patient care is the major activity undertaken by them.

Social health insurance: Expenditure incurred on subsidizing the running of schemes such as CGHS, ESIS and other such funding mechanisms for the health care of specific groups of people, have been included in this category.

International cooperation: This includes expenditure incurred on contributions to UN agencies and other international agen-

cies such as Red Cross.

Administrative: Although each of the above categories will have administrative components therein, this category only lists those expenditures that are exclusively administrative, for example, the secretariat of the ministry, or a regulatory agency.

As will appear later in this chapter, a similar methodology for these categories has also been followed in the case of State budgets, except that small amounts of other expenditure that could not be allocated in the above categories are also grouped under the category of Other Expenditure. Since there was no expenditure by the status on International Cooperation, the category does not figure in the table on expenditures of the State governments.

The budgetary data were categorized according to sub-heads and detailed heads in rows, and object heads in columns, and were entered into spreadsheets. Each of these detailed row items was then categorized as belonging to one of the above categories, and then the sum totals of expenditure under each category were obtained and tabulated. For the Central Government, actual expenditures for 5 different financial years, from 1991-92 till 2002-03, were similarly categorized and analysed. As the heads of accounts used in the 1991-92 budget were different from the ones in use now, these have been adapted to the ones in use at present.

For States, this analysis was similarly done for 16 major States, for the year 2001-02, based on the actual figures published in the Detailed Demand for Grants of the respective health ministries. The only exception here was Bihar, where the 2003-04 demand did not contain all the actual expenditures, and the 2001-02 Revised Estimates (RE) figures for Bihar have been used throughout this study.

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