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A Study on Public Expenditure on Health Sector in India

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ABSTRACT :- In India, the health sector is accounted through various sources of funding. They include Central Government, State Government, Local Government, Households, External Funding, Firms and other sources including NGOs. The funding by Central, State and Local Governments constitute the public expenditure. Under the budget, the public expenditure is classified into two main accounts. One is Revenue Expenditure Account, wherein the consumption expenditure incurred in the country is recorded and on the other hand is the Capital Expenditure Account, wherein the capital expenditure incurred in the country is recorded. With regard to health sector in India, transactions are recorded by two major heads under both the accounts i.e., Medical & Public Health and Family Welfare.

The objective of this paper is to examine the trends, composition and rate of growth with regard to Government Expenditure on Health in India during the period of 2001 to 2015. The paper focuses on expenditure incurred by the Central Government on health sector in India. It covers the period of 2001 to 2015. Further the study peruses the "Annual Financial Statements" of Union Budget of various years available at the website of Ministry of Finance, Bank of India, Government of India as the chief source for analyzing the expenditure incurred by the Government on health sector in India.

Key words: *Public expenditure, Health and Family welfare.*

I. INTRODUCTION

Health is an important asset of a community. The standard of health of the people depends on level of living, literacy and provision of health care services which in turn depends on money, materials, men and institutions. It is a logical prerequisite or socio-economic development. It is an important input for development human resources, and in turn the social and economic development of the country. Health care is fundamental to the quality of life. Good health is prerequisite to human productivity and the development process. Health is considered as the most important thing for a human being.

Health status of people determines the average expectations of life, productive age and production, productivity, erring capacity, employment and well-being of the people. On the other hand, several economic variables like employment, income, purchasing power and poverty determine the health status of the people.

In a dynamic economy, social services which give much more productive capacity which gives since the expenditure on social services is of prime importance among the government activity. Among the various health services is prime importance among the government activity. Among the various health services medical and public health, family welfare and other social services are very important one. Therefore, this study concentrates on the growth and trend of the government expenditure in the above mentioned activities.

A comprehensive document of detailed estimates of health expenditure in India has been the National Health Accounts (NHA) published by the Ministry of Health and Family Welfare. The latest estimates provided by this document however, are not very recent and pertain to the year 2004-05. The estimates of the NHA are also affected by methodological issues. It overstates the States' contribution and understates the Centre's contribution (discussed later). While the aggregate estimates are unaffected by the methodology used in the NHA, the estimates of the relative contribution of the Centre and States in NHA are biased. The Indian Public Finance Statistics (IPFS) provides more recent information on the contribution of the Centre and the States, but the definition of health expenditure includes water supply and sanitation. These features have made it difficult to examine the relative contribution of the Centre and States in total public spending on health in the country. With the National Rural Health Mission (NRHM) aiming to change the Centre-State sharing of health spending from 20:80 to 40:60 in the long run, deriving recent estimates of the relative contribution of Centre and States assume importance.

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The level of public spending on health has been a widely discussed issue in India in recent times. Various research studies as well as policy documents have repeatedly highlighted the low level of public spending on health in India. In particular, public spending on health as a per cent of GDP has been the focus of discussions, as it is an indicator of the priority accorded to health in the planning process of the country. Policy documents like the Approach Paper to the Twelfth Five Year Plan (2012 to 2017), the High Level Expert Group for Universal Health Coverage (HLEG), the Programme Implementation Framework of the National Rural Health Mission (NRHM) and the Report of the National Commission on Macroeconomics and Health (NCMH) have all endorsed the need to raise the level of public spending on health in India from around one per cent to 2 to 3 per cent of GDP.

The analysis of health care expenditures in general has been a topic of research and discussion in recent times globally. In particular, the relationship between the income and health care expenditure (HCE) has been focus of Research for the reason that it helps us to understand the key determinants of healthcare expenditures and also provides insights into linkages between income variable on the one hand, and demand and supply side of health on the other. Since in India we are talking about increasing the public expenditures on health to 3 per cent of GDP, this analysis would provide some insights into our proposed goal.

II. DEFINITIONS OF HEALTH

Health is common theme in most cultures. In fact, all communities have a concept of health as part of their culture. The word health first appeared in the English language in 1000AD and comes from the root word "heal" or "Whole".

Among definitions still used probably the oldest is that health is the "absence of disease". Health is one of those terms which most of the people find it difficult to define its meaning. Therefore, many definitions of health have been offered from time to time including the following:

- The condition of being sound in body mind or spiritspecially freedom from physical disease or pain (Webster)
- Soundness of body or mind that the condition in which its functions are duly and efficiently discharged (Oxford English Dictionary)
- A condition or quality of the human organism expressing the adequate functioning of the organism in give conditions genetic and environmental.
- Health is a state characterized by anatomic integrity; ability to perform personally valued family, work and community roles; ability to deal with physical, biologic and social stress a feeling of well-being; and freedom from the risk of disease and untimely death. (Stokes, 1996)

III. OBJECTIVES

On the basis of relevant literature, specific objectives are formulated for the present study.

1. To study the Composition, growth and trends of public expenditure on health sector in India over the study period.
2. To analyse the public health expenditure in India by its broad heads
3. To examine the provision of health infrastructure India.

IV. DETERMINANTS OF HEALTH

There is a wide recognition in many setting that health is a dynamic state that embraces wellbeing as well as the absence of illness. Health is defined as state of wellbeing and the capability to function in the face of changing circumstances. Health is, therefore, a positive concept emphasizing social and personal resources as well as capabilities. This definition also underscores the important contributes to health that are made outside the formal medical care and public health system. For the individuals and populations health depends not only on medical care bur also on many other factors. Health has physical, mental social and spiritual dimensions. Health is more than not being sick and is a resource for everyday living. It's the ability to realize hopes, satisfy needs, change or cope with life experience, and participate fully in society.

V. SIGNIFICANCE OF HEALTH EXPENDITURE

"Health and Development have a two-way relationship. While in the process of economic development health forms an important variable and that the development spread its effects upon the health of the people".

A recent review of various country papers prepared for the tenth meeting of the health ministries of the common wealth countries confirms that the most basic needs for quality and quantity of water, sanitation and waste management safe food and dealing with pollution are commonly shared. After considered the experience of various counties and the need in this area, the conference recommended that the health sector had a central role to play in pursuit of environmentally sustainable development. It has redefined its role in order to face the challenge posed by a period of rapid change in the field of health, development and environment.

These challenges include the environmental health consequences of global changes such as global warning and

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sea level use, ozone depletion, loss of biological diversity and increasing migration of population. It was recognized that "Health" encompassed much more than disease management and reactive, like in the past. This proactive role requires that the health sector co-ordinates with other sector and provides inputs at an early stage of policy formulation to prevent such problems from occurring.

Health also may be defined in terms of life expectancy at birth or in terms of infant mortality rate, crude death rate, mortality and in terms of morbidity. Improvement in the health of masses increases their productive capacity and leads to qualitative improvements in human capital. Therefore, expenditure on health are important in building and maintaining a productive Labour force as well as well as improving the lives of the people and the quality of society. Basically, expenditure on health takes the form of investment in medical knowledge, disease prevention and treatment and rehabilitation.

VI. NEEDS FOR STATE INTERVENTION IN HEALTH

Health is a state subject in India which means that the primary responsibility of financing and providing health care rests with the state governments. Indian constitution chares the states with "the raising of the level of nutrition, the standard of living of its people and the improvement of public system". Public health therefore is one of the important responsibility of the state. The central government's role has been to fund centrally sponsored schemes, to develop policies and guidelines and to provide statutory grants or general transfers to the states.

However, the quality and quality of health care provision varies widely across states reflecting their widely varying of economic development, their health sector priorities and their current and past investments in health. Similarly, there are wide variations in health outcomes across states, across socio-economic groups and across rural and urban areas.

The National Health Policy 1983 (NHP 1983) had proposed a "Health for all by the Year (2000)" program through the provision of comprehensive primary health care services. It is essential to have linkages with all departments concerned with Human Resource Development, such as medicine and pharmaceuticals, agriculture and production of food, rural development, education and social welfare, housing, water supply and sanitation, avoiding adulteration, maintaining standard in drug industry and sale of drugs and conservations of environment.

VII. STATEMENT OF THE PROBLEM AND NEED FOR THE STUDY

Historically, the right to health is one of the last to be proclaimed in the constitution of most countries of the world. But scenario has changed now. In the increasing number of societies health is no longer accepted as a charity for all. However, when resources are limited the government cannot provide all the needed health services. Under these circumstances the aspirations of the people should be satisfied by giving those equal rights to available health care.

Health care is not only medical care but also pro preventive care too. The term health care covers a wide spectrum of a personal and community services for treatment of disease, prevention of illness and promotion of health etc. It includes factors from availability of basic health care infrastructure to services rendered by super specialty hospitals. In fact, performance of health care system is to make health care equitable and sustainable with the efficient use of resources. Increasing use of health services is the main goal for many developing countries including India. Increasing access to health care according to need can promote equity and also efficient through a reduction in per capita health care costs.

It is realized that population policies including family planning can only be successful if promoted together with improved plans for social services. So there is a need to study on the major determinants of public expenditure on medical and public health, family planning and other social services.

VIII. HEALTH EXPENDITURE IN INDIA

The Indian constitution charges the states with "the raising of the level of nutrition and the standard of living of its people and the improvement of public health". Central government efforts at influencing public health have focused on the five year plans, on coordinated planning with the states, and on sponsoring major national health programs. For most national health programmer's government expenditures are jointly shared by the central and state governments. Healthcare expenditure is a very necessary social expenditure for any country. Like any other social expenditure health expenditure also requires a significant contribution from the Government. Whether it is a developed country or a developing one state's role in developing a good health infrastructure and assuring good health to everybody becomes very critical and important. The spending on health has major contributions coming from private households (75 per cent). State governments contribute 15.2 percent, the central government 5.2 percent, third-party insurance and employers 3.3 percent, and municipal government and foreign donors about 1.3 (World bank 1995). Of these proportions, 58.7 percent goes toward primary health care (curative, Preventive, and Promotive) and 38.8 percent is spent on secondary and tertiary inpatient care. The rest goes for non-service costs.

Net domestic product of India measured at constant prices is steadily growing over the years. Any rise in the NDP should also lead to rise in the health expenditure. India's

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public health expenditure as a percentage of GDP is just above 1per cent of the GDP for public health care while the allocation to this sector stands at 2 per cent for the least developed countries (UN classification). Most of the economies such as Australia, United States, and United Kingdom and
so on, contribute above 6 per cent, while India being a mixed economy and having the aid of public intervention policies contributes 1.08 per cent, five times lesser allocation than the world average and far from the allocation of the lower middle income economies we belong in. Given the imperatives of spending, the low level of public expenditure has warranted private expenditure of 4.8per cent of GDP. Thus, the poor state of public health infrastructure has forced the less privileged to seek unregulated private healthcare with significant adverse impact. Low level of public spending has particularly resulted in poor infrastructure for preventive healthcare. Percentage of public health expenditure out of total health expenditure incurred is 26.18. Most of the developed economies are spending more than 60 per cent on health out of the total public expenditure.

Globally, investment in health is regarded as an integral component of human development. Evidence establishing the interrelationship between good health and the creation of wealth, between the environment and population health and the growing interdependence among countries, has contributed to attributing peoples' health status to good governance. (CMH, 2000) Further, the wide externalities and spillover effects of health and correlations between public health spending, poverty and social wellbeing at the aggregate level, has gradually transformed health care from an individual to a social responsibility and a political imperative.

India is among the handful of 15 countries1 that stubbornly continues to accord a low priority to the health and wellbeing of its citizens. Even as it has transited from being a low income country to a lower middle income country, whether at times of low growth or high growth, for over six decades, public spending on health has stagnated within the narrow band of 0.8 to 1.2 % of GDP.

With the available resources, meager as they may be, the government at the central and state levels managed to establish a wide network of health facilities, provide free care to the poor under the reproductive and child health and infectious disease control programmes, run medical colleges and specialty hospitals etc. But outcomes have been disappointing. India contributes to 17.6% of the global disease burden and is responsible for a third of all deaths on account of common infectious diseases like TB or leprosy that are curable and inexpensive to treat (WHO Statistics, 2012). India accounts for a quarter of global maternal mortality and infant mortality. It has the second highest number of persons living with HIV AIDS. Compare to China: it too had a debilitating colonial past and has a large population base, yet life expectancy – a measure of development along with average height - is 10 years ahead of India. Even the neighboring countries like Thailand, Bangladesh (except for MMR) and Sri Lanka have a better record of health indicators than India.

Table 1 provides the breakup of public health expenditure with regard to these broad heads from the year 2000 to 2012. Under Medical and Public Health, the expenditure has seen an increase from Rs. 1811.31 crore in 2000-01 to that of Rs. 9781.92 crore in the year 2010-11. The revised estimates of budget reveals that an amount of Rs. 10366.89 crore is expected to be incurred in the year 2011-12. For the year 2012-13, the budget estimate for medical and public health is earmarked at Rs. 13360.47 crore, with an increase of 12.78 per cent over the previous year 2011-12. Likewise, under Family welfare, the expenditure has increased from Rs.661.02 crore in 2000-01 to that of Rs. 8859.55 crore in the year 2010-11. Further in the year 2010-11, an amount of Rs. 9080.78 crore is expected to be incurred as revealed from the revised estimates of the Budget. For the year 2012-13, a budget estimate of Rs. 10900.59 crore is earmarked with an increase of 11.36 per cent over the previous year 2011-12.

The composition of heads of public health expenditure to that of the total public health expenditure in India in terms of percentages is given in Chart 3. It reveals that during the year 2000-01, out of the total public health expenditure of Rs. 2472.33 crore, around 73.26 per cent of the public expenditure was incurred on medical and public health and the remaining 26.74 per cent was on family welfare. In the later years, the percentage of public expenditure incurred on medical and public health out of the total public health expenditure in India got considerably reduced. During the year 2010-11, 52.47 per cent of the public health expenditure was on medical and public health. On the other hand, the picture was totally different with regard to family welfare. The percentage of public health expenditure incurred on family welfare out of the total public health expenditure in India increased considerably over the years. During the year 2000-01, it was 26.74 per cent which got increased to 47.53 per cent in the year 2010-11. If we look at the chart, it reveals that the graph has taken more or less the shape of a scissor. On one hand the percentage of public expenditure incurred on medical and public health has seen a downfall trend and on the other hand the percentage of public expenditure incurred on family welfare has seen a rising trend.

For the year 2012-13, out of the total budget estimate of Rs.21635.36 crores 55.07 per cent is allocated for the medical and public health sector and the remaining 44.93 per cent is earmarked for family welfare. Likewise the percentage of public expenditure incurred on medical and public health has seen a downfall trend and on the other hand the percentage of public expenditure incurred on family welfare has seen a rising trend from the year 2013-2014 to 2014-2015.

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Table:1 :- Public Health Expenditure In India By Its Broad Heads

Years	Total Public Health Expenditure (Rs in crore)			Percent to the Total Public Health Expenditure	
	Medical & Public Health	Family Welfare	Total	Medical & Public Health	Family Welfare
2000-01	1811.31	661.02	2472.33	73.26	26.74
2001-02	2061.93	764.68	2826.61	72.95	27.05
2002-03	2230.62	797.42	3028.04	73.67	26.33
2003-04	2494.86	1266.26	3761.12	66.33	33.67
2004-05	2914.75	1396.62	4311.37	67.61	32.39
2005-06	3469.03	3215.46	6684.49	51.90	48.10
2006-07	4254.94	4070.72	8325.66	51.11	48.89
2007-08	5022.32	5704.46	10726.78	46.82	53.18
2008-09	6924.87	6825.63	13750.50	50.36	49.64
2009-10	8231.87	7656.97	15888.84	51.81	48.19
2010-11	9781.92	8859.55	18641.47	52.47	47.53
2011-12	10366.89	9080.78	19447.67	53.31	46.69
2012-13	13360.47	10900.59	24261.06	55.07	44.93
2013-14 RE	12311.43	26126.00	273116.61	45.08	9.56
2014-15 RE	15005.18	-	15005.18	100.00	-

Source: Annual Financial Statements of various years, Budget Documents, GOI

Note: RE – Revised Estimates; BE – Budget Estimates

The table no:2 provides Public expenditure on Health sector in India. During the year 2000-01, the Public Expenditure on Health stood at Rs.2472.33. It drastically increased to Rs.15949.02 during the year 2014-15. The total population of India was during the year 2014-15. The total population of India was during the remained at 101.90 crores. The revised estimates of the population for year 2014-15 to the around Rs.126.70 crores. The GDP reveals that during the year 2000-01, has increased from Rs 2177413 crores to Rs 12653762 crores in the year 2014-15. The per capita Public Expenditure on health increased gradually from the year 2000-01 to 2014-15. The Public expenditure on Health as percentage to GDP result shows that there is a decreasing trend from 11.35 percent in the year 2000-01 to 1.26 percent in the year 2014-15.

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Table: 2 :- Trends In Public Expenditure On Health In India

Year	Public Expenditure on Health (in Rs.Crore)	Population** (in Crores)	GDP* (in Rs.Crore)	Per Capita Public Expenditure On Health (in Rs.)	Public Expenditure On Health as Percentage Of GDP (%)
2000-01	2472.33	101.90	2177413	24.26	11.35
2001-02	2826.61	104.00	2355845	27.18	11.99
2002-03	3028.04	105.60	2536327	28.67	11.94
2003-04	3761.12	107.20	2841503	35.09	14.82
2004-05	4311.37	108.90	3242209	39.59	13.30
2005-06	6684.49	110.60	3693369	60.44	18.10
2006-07	8325.66	112.20	4294706	74.20	19.39
2007-08	10726.78	113.80	4987090	94.26	21.51
2008-09	13750.50	115.40	5630063	119.16	24.42
2009-10	15888.84	117.00	6477827	135.80	24.53
2010-11	18641.47	118.60	7784115	157.18	23.95
2011-12	19447.67	121.00	8832012	160.72	22.02
2012-13	10823.06	121.70	9988540	890.00	1.08
2013-14(RE)	13105.02	123.30	11345056	1064.00	1.16
2014-15(RE)	15949.02	126.70	12653762	1280.00	1.26

Source: Public Expenditure on health from "Health Sector Financing by Centre and States/UTs in India", National Health Accounts Cell, MOHFW< GOL.@ GDP from CSOPopulation from "Population Projections for India and States 2001-2026", RGI Census, GOI.

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IX. FIVE YEAR PLAN OUTLAYS ON HEALTH AND FAMILY WELFARE

The table no: 3 shows the pattern of central allocation of five year plan outlays on health and family welfare.

Table: 3 :- Central Allocation of Five Year Plan Outlays on Health and Family Welfare (Rs In Crores)

S.No	Period	Total Plan Investment Outlay of Country	Health Sector	Family Welfare
1	First plan (1951-56)	1960.0	65.2 (3.3)	0.1 (0.1)
2	Second Plan (1956-61)	4672.0	140.8 (3.0)	5.0 (0.1)
3	Third Plan (1961-66)	8576.5	225.9 (2.6)	24.9 (0.3)
4	Annual Plans (1966-69)	6625.4	140.2 (2.1)	70.4 (1.1)
5	Fourth Plan (1969-74)	15778.8	335.5 (2.1)	278 (1.8)
6	Fifth Plan (1974-79)	39426.2	760.8 (1.9)	491.8 (1.2)
7	Annual Plan (1979-80)	12176.5	223.1 (1.8)	118.5 (1.0)
8	Sixth Plan (1980-85)	109291.7	2025.2 (1.8)	1387.0 (1.3)
9	Seventh Plan (1885-90)	218729.6	3688.6 (1.7)	3120.8 (1.4)
10	Annual Plan (1990-91)	61518.1	960.9 (1.6)	784.9 (1.3)
11	Annual Plan (1991-92)	65855.8	1042.2 (1.6)	856.6 (1.3)
12	Eighth Plan (1992-97)	434100.0	7494.2 (1.7)	6500.0 (1.5)
13	Ninth Plan (1997-02)	859200.0	19818.4 (2.31)	15120.2 (1.76)
14	Tenth Plan (2002-07)	1484131.3	31020.3 (2.09)	27125.0 (1.83)
15	Eleventh Plan (2007-12)	2156571.0	136147.0 (6.31)	3988.0 (0.18)
16	Twelfth Plan (2012-17)	-	75145.29	10044.00
17	Annual Plan (2012-13)	-	6585.00	990.00
18	Annual Plan (2013-14)	-	8166.00	1069.00
19	Annual Plan (2014-15)	-	8233.00	1069.00
20	Annual Plan (2015-16)	-	6254.00	1008.00

Source: Planning Commission of India.

It has been evident from the table that the plan outlay on both the health and family welfare has been increasing from First Plan to Annual Plan 2015-16 in absolute terms. In the First Plan the actual plan outlay on health and family welfare were Rs.65.2 crore and Rs.0.1 crore respectively. In the Tenth plan the total outlay on these were Rs. 31020.3 crore and Rs.27125 crores respectively. Later in the Eleventh plan actual plan outlay on health and family welfare were Rs.6.31 crore and 0.18 crore respectively. Likewise, in the Twelfth plan actual plan outlay on health and family welfare were Rs. 75145.29 crores and Rs. 10044.00 crores respectively. The annual plan 2015-2016 in the twelfth plan period shows actual plan outlay on health and family welfare were Rs.6254.00 crores and Rs.1008.00 crores respectively.

Similarly, as a percentage of total Five-Year Plan outlays, that on health showing a decreasing trend up to the Seventh Plan, i.e., from 3.3 per cent in First Plan to 1.7 per cent in Seventh

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Plan. From the Annual plan 2015-16, it has been started to increasing from 1.56 percent to 6.31 per cent in Eleventh Plan. In the Twelfth Plan 2012-17 shows there is a decrease in the plan outlay on health and family welfare.

On the other hand, in the case of family welfare, as a percentage of total plan outlays, it shows an increasing trend in all the five Year Plans and Annual Plans. Hence, it is evident from the table that, even though there is a decrease in the plan outlay on health, that on family welfare has not been affected.

X. POLICY IMPLICATIONS

Adequate number of doctors, hospital visitors and other field staff should be commissioned into service, particularly in rural areas. For this the government should allocate more funds, which will improve the health conditions of the people in the country. Hence, expenditure on health should be one of the prime importance of the government activity, which will give more productive capacity and there by develop the economy.

XI. CONCLUSION

From the above finding, it can be understand that the total expenditure on health and family welfare of the central and state governments shows a steady increase over the study period. Likewise plan allocations on health and family welfare also showing a steady growth rate. The analysis of the determinants of the government expenditure on health revels that the variables like population, per capita income and number of hospitals have positively influenced the government expenditure on health.

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