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The Trend of Health Expenditure in India and Odisha and Its Relationship with Health Status

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Abstract: ***India, especially Odisha, has a long way to go in providing basic health care to the people. The persistence of deficits in the health outcomes of a majority of the country's population is rooted in the poor state of public provisioning of healthcare. Public expenditure accounts for a small share in total expenditure on healthcare in India, which reflects the low priority accorded to health sector in the government budgets of the country. When compared to the developed and many developing countries, the share of public expenditure in the country's total expenditure on healthcare appears to be very low for India. Further, India ranks sixth from the bottom, amongst all countries in the world, in terms of public expenditure on healthcare as a proportion of the Gross Domestic Product (GDP). On the basis of the above discussion, it is felt that health sector would require a significant strengthening of the regular and sustained government interventions, which would inevitably require a much higher magnitude of public expenditure on health than what is still prevailing in India and Odisha. Therefore, as an immediate action, at least the following issues must be addressed in the Union and State Budget. Overall allocation for the health sector should be in increased in the union budget 2016-17, to fulfill the Government's commitment to increase the health expenditure to 2-5 % of GDP. Overall allocation on Medical Education and Training has to be raised. In the context that post graduate medical education needs to be prioritized to fulfill requirement of the specialist doctors, allocation on this should be increased. At the same time, the Union Finance Minister's proposal for Annual Health Survey to prepare District Health Profile for all districts (which was slated to begin from 2010) is a welcome step; but the government would need to allocate adequate funds for this purpose. We may note here that no allocation towards this has been made in Union Budget 2014-15. We would expect that adequate funds will be allocated in the Union Budget 2016-17.***

Keywords: Health, Odisha, IMR, Immunization

1. Introduction

Public expenditure on health is an essential prerequisite for human welfare since it leads to better health outcome, greater equity, more consumer satisfaction and lower cost of service. The three rationales for government intervention in the health sector - provision of public goods, reduction of poverty and market failure correspond roughly to three different kinds of services, namely, public health, clinical health and health insurance. 'Public Health' includes the services provided to the population at large or to the environment such as housing, drinking water and sanitation. 'Clinical Services' are highly cost-effective services which improve the health of the poor. Since poor people cannot buy such care for themselves, there is a case for public finance. The government cannot finance all medical care for which health insurance is desirable[1].

Alleviation of poverty provides a straight forward rationale for public intervention in health. Reduction of poverty requires two strategies – promoting labour productivity which is the most important asset of the poor and increasing their human capital through access to basic health care, education and nutrition. Investing in the health of the poor is an economically efficient and politically acceptable strategy for reducing poverty[2].

Health is treated as public goods and due to externalities inherent in it, government intervention is justified. Externalities, or spillovers of benefits or losses from one individual to another leads to market failure and government intervention becomes indispensable. Failures in markets for health care and health insurance provide a third rationale for government action to improve efficiency and equity. Efforts to obtain valuable information about risks add to the cost of insured health care without improving health outcomes and the market is shy to share the cost.

2. Global Health Expenditure

World spending on health is about 8 per cent of the global income in 2014. Of this; governments have spent nearly 60 per cen[3]t. The role of government varies from country to country but every government plays an important role. There is a glaring disparity in the health expenditure between established market economies like USA, UK, Canada etc. and India. While the percentage of world population residing in these market economies is 15 per cent, in India alone resides 16 per cent. However, according to an estimate in 2014, the total health expenditure in these market economies is $1483 billion whereas that in India it is only $18 billion. It is also observed that while these economies share a staggering 87 per cent of the total world health expenditure, India shares only 1 per cent. These disparities are prevalent despite the fact that India needs better health care facilities than these developed countries.

3. Role of Government

Human development has assumed considerable importance in the development process and has attracted worldwide attention in recent times. In case of developing countries, government expenditure on health plays an important role in ensuring total reasonable level of human development. In India government spending on health is smaller than the world average. It was 6.0 per cent of the GDP in 1999-2000. According to a recent Report in *The Times of India*, India ranks 171st out of 179 countries in government health spending. In contrast, it ranks at impressive 18th in terms of private spending on health[4]. Government expenditure on health is important in India for two reasons. The first is that,

the magnitude of deprivation in the country is too large to be left to market forces alone to tackle and secondly a higher proportion of the poor population utilizes government facilities[5]. The bulk of government spending is routed through the State Governments since the Indian Constitution specifies that a large number of health related activities belong to the ambit of individual states. The central government spends most of the remaining share, with local governments such as Municipalities. A recent analysis by the World Bank concludes, "the hospitalized Indian spends more than half of his total annual expenditure in buying health care: more than 40 per cent of hospitalized people borrow money or sell assets to cover expenses and 35 per cent fall below the poverty line[6]."

In India poor public health expenditures remain the predominant cause of the unsatisfactory performance of the health system. Also, inefficient utilization of available resources also contributes substantially to poor health outcome. The policy which declared the state to provide free universal health care to the entire population is far from reality. India has one of the highest levels of private financing with out-of-pocket expenses, estimated to be very high. In a poor country like India, out of pocket payment is the most regressive method of health finance as it aggravates poverty.

4. Healthcare Expenditure by Government

Central Government

Health care expenditure refers to the amount defrayed towards health care by the Central, State and Union Territory governments[7]. It excludes expenditure by local bodies, public sector enterprises and autonomous and semi-autonomous institution[8]. The different components of government expenditure are: i) Medical and Public Health ii) Family Welfare iii) Nutrition iv) Water supply and Sanitation and v) Social Security and Welfare.

State Government

In the government sector, provision of health care is the responsibility of the State government. The states account for over 90 per cent of the aggregate health expenditure of central and state governments. Their share in the aggregate spending has increased in past years. Involvement of the central government in states budget is confined mainly to family planning and certainly centrally sponsored disease control programmes.

National programme on control of leprosy, immunization scheme for children and ICDS are some of the examples of centrally sponsored schemes. Centre's allocation of funds to these schemes in different states is guided by their needs, ability to absorb grants and spend them efficiently. There is a fair degree of uniformity in the levels of spending of similarly placed states. But such uniformity is absent in the case of states' expenditure on their areas of responsibility such as medical relief, public health, medical education, water supply and sanitation and states own schemes in nutrition.

Ability of the states to make sufficient level of allocation of money to different component of health depends on a number of factors. Important among these are: states capacity to raise revenues from the taxes assigned to them, the statutory share they get in central taxes and upgradation grants they get from the centre. Besides their own sources of revenue, states get a share in the non-corporate income tax and union excise duties from the centre[9].

Table 1: Combined Expenditure of Center and State on Health and Family Welfare (Rs in Cr)

	Center's Expenditure on Health and Family Welfare*	State's Expenditure on Health and Family Welfare	State's Expenditure as% of Total Budgetary Expenditure on Health and Family Welfare	Total Expenditure (Center+ States) as % of GDP
2003-04	7249	12529	70.7	0.90
2004-05	8086	18721	69.9	0.85
2005-06	9650	22031	69.5	0.88
2006-07	10948	25375	69.9	0.90
2007-08	14410	28908	66.7	0.88
2008-09	17661	38579	68.6	1.02
2009-10	21680	43848	66.9	1.06

Source: Compiled by CBGA from Union Budget, Govt. of India, various years.

Despite the gradual stepping up of Union Budget allocation for Health & Family Welfare since 2005-06, Centre's expenditure on health still accounts for a very small magnitude as compared to the overall level of public spending on health recognized as necessary for the country. In 2009-10, the combined budgetary allocation (i.e. the total allocation from both Union Budget and State Budgets) for health sector stands at a meager 1.06% of GDP, which is far below the promised level of public expenditure on health. The table shows that a major chunk of India's public spending on health comes from the State Budgets[10]. In 2003-04, the expenditure on Health & Family Welfare

incurred from the State Budgets accounted for almost 71% of the country's total public expenditure on health; this proportion has shown a marginal decline over the last three years and reached 67% in 2009-10. Thus, although the Union Budget allocation for Health & Family Welfare has been increased gradually since 2005-06, it still accounts for only one-third of the total public expenditure on health in the country. The expenditure on Health & Family Welfare from the State Budgets has increased at a much slower pace over the last six years. As a result, the combined expenditure of Centre and States on Health and Family Welfare has increased very slowly from 0.9% of GDP in 2003-04 to 1.06% of GDP in 2009-10.

5. Characteristics of Health Expenditure

India is characterized by relatively low expenditure on health, which is estimated to be 0.9 per cent of GDP. The percentage is almost equal to the expenditure incurred in other Asian Countries such as China, Indonesia, Thailand and Sri Lanka. But these countries have better health outcome than India[11].The private sector accounts for over three-quarter of the expenditure implying the share of government is confined to a mere 25 per cent. On the basis of a survey of 18,000 households conducted by NCAER[11], it is found that 39 per cent of household expenditure was incurred on government doctors and 56 per cent on private practitioners in both rural and urban areas. This situation is totally different from that prevailing in developed countries. In these countries public sector accounts for more than 60 per cent of the total health expenditure[12].

In addition to the state and central government, financing of the health sector by local self government is important in large urban areas. The health expenditure of municipal bodies varies between 30 to 50 per cent of their total expenditure. In rural areas the status of public health provided by local self government bodies like the Panchayats is very poor. It is due to fact that the local bodies lack the financial autonomy. The higher expenditure incurred by poor households on private sector facilities are more in the nature of unavoidable expenditure on curative care. This is a reflection of non-availability and under utilization of public sector facilities. The anomalous situation in the country is evident in the fact that health infrastructure constructed at public cost remain grossly underutilized. The Primary Health Centre in rural areas treat less than 5 per cent of the total illness episodes. This is a clear indication of the poor quality of service, provided at the public sector health facilities[13].

The public provisioning of infrastructure is concentrated a large hospital-based curative facilities in urban areas. Nearly four-fifth of the infrastructure facilities in the country is located in urban areas. The rural areas are neglected both by the public sector as well as the private allopathic sector. The rural areas which account for three fourth of the population had only 32 per cent of the hospitals and 20 per cent of the hospital beds[13].

Trends in State Govt. Health Expenditure

Health is a state subject and state governments have a major responsibility for providing adequate funding for health services. There exist wide disparities across states in terms of health infrastructure, expenditure and attainment. The coefficient of variation in real per capita expenditure incurred in health has increased over the years. This is likely to aggravate the existing disparities in the provision of health infrastructure across strates[17].

An analysis of the budget of Odisha from 1991-92 to 1998-99 shows the same trend. In 1991-92 the proportion of health expenditure in the budget was 4.6 per cent of the total budget expenditure and it was only 1.23 per cent of GSDP during the same period. Further a serious point to be noted is that in 1998-99 the per cent of health budget declined to 4.49 per cent as a percentage of state budgets and 1.12 per cent of GSDP during the same period. The low expenditure on health by the state governments is being affected by their stringent financial position since the initiation of adjustment at the central level from 1991[14]. Several measures undertaken by the Union Government have implied a deceleration in revenues for the states, plan and non-plan grants. Despite the more equitable arrangement for sharing of revenues suggested by the Tenth Finance Commission, the budget did not bring about any fundamental change in the arrangements for sharing revenues. The states during this period reacted to fiscal stringency with a deceleration in health expenditure[15].

Trends in different Plan Period

The pattern of investment in health has been rather bleak in the Five Year Plans. While the 1st Five Year Plan had 3.3 per cent of the total plan outlay reserved for the health sector, the Ninth Five Year Plan had only 2.31 per cent reserved for the same. The percentage of expenditure in Family Welfare is also not very encouraging. While 0.1 per cent of the total plan outlay was reserved in the 1st plan, only 1.76 per cent of the net expenditure was allocated for the same.

The plan wise real per capita health expenditure shows a great deal of variation from the 5th Five Year Plan to 9th Plan in different states. The coefficient of variation value was only 26 per cent across the states in 5th Five year Plan which increases to 40 per cent during the 9th Five Year Plan period. Odisha needs more per capita expenditure for its poor health status.

Health Expenditure as a Percentage of Social Sector Expenditure

The expenditure by the Central and the State governments on public health, water supply and sanitation has been declining over the years despite the fact that the cost of health services has increased exponentially. It is evident from the analysis of health expenditure as a percentage of social sector expenditure, total government expenditure and GDP from the year 1974-75 to 2002-03. While the percentage share in social sector expenditure for health is 22.56 per cent in 1974-75 it has decreased to 22 per cent for the year 2002-03. The same trend can be seen in the percentage share in total government expenditure over the same period where the percentage of health expenditure has only marginally increased from 4.1 per cent to 4.6 per cent. The percentage share of health expenditure in GDP has also

shown an insignificant increment from 0.85 per cent to 1.4 per cent over the year.

By analyzing the per capita expenditure on education, health and social security in Orissa from 1985 to 2000 it is obvious that the health sector expenditure is by and large neglected among the social sector expenditure. While the per capita expenditure on education in 1985-86 is Rs.72.18, it is only Rs.39.35 for health during the same period. The bleak performance of Odisha in terms of its health status is the result of low per capita health programme.

Proportion of Revenue and Capital Expenditure

An important feature of the health expenditure incurred by state government in India is that the bulk of expenditure is in revenue account. Between 1994-95 to 2001-02 revenue expenditure constituted over 90 per cent of total expenditure in all major states. There should be an increased level of capital expenditure on health as compared to revenue expenditure, so as to expand the infrastructure which is an essential prerequisite for a better health status. The role of capital expenditure can be well understood from the Implicit Model of Causation between past public spending (Capital Account) and IMR given by Tulsidhar[16]. Infant Mortality Rate (IMR) is influenced by a complex set of factors like past and current spending, access and availability of health care and socio-economic conditions prevailing in the states. Expansion of health services is possible only through expenditure from capital account. A high proportion of revenue account meets the current expenditure which in no way ensures the improvement of IMRs.

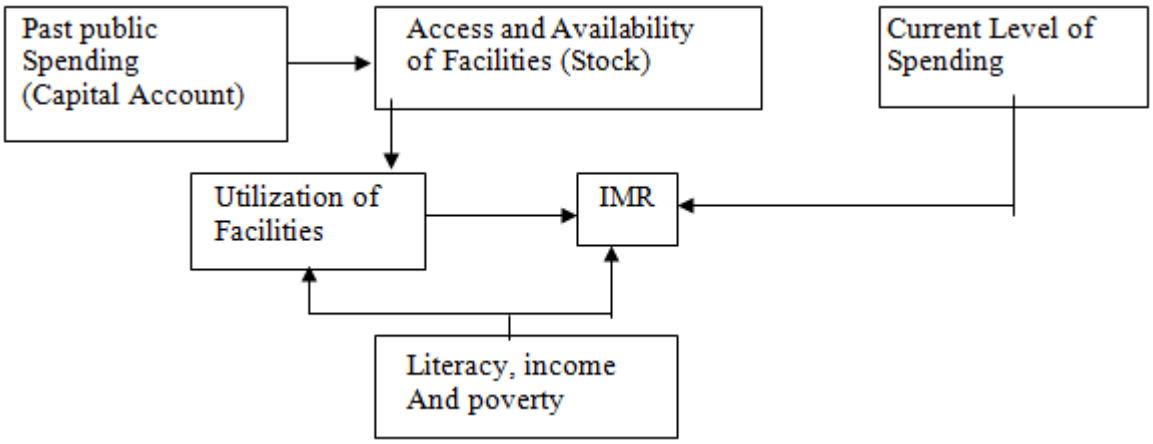

Figure 1: Implicit Model of Causation

The trend of Revenue expenditure and capital expenditure on health in Orissa is similar to other states. The revenue expenditure is meant for salaries, medicine and other accessories. The bulk of capital account is meant for infrastructure. But in a poor state like Orissa capital expenditure is less than 10 per cent of the total between 1986-57 to 2001-02 except in two years. It has also been observed that though there is a serious dearth of health infrastructure in the states a part of the grant from the revenue and the capital account goes unused.

Distribution between Primary, Secondary and Tertiary Care

An analysis of the trend of real per capita public spending on health of major states and their distribution among primary, secondary and tertiary health care shows per capita public spending has increased in primary and secondary level care by 50 per cent between 1985-86 to 1998-99[20] . During this period spending level has increased by more than 100 per cent in the tertiary level care. It has serious implication for both equity and efficiency of the health system. The percentage distribution of budget expenditure in primary, secondary and tertiary level is a matter of grave concern in a health poor state like Odisha where primary health centres in rural sector need a special attention of the government. The primary and secondary health care is neglected by the Orissa budget in the last decade. In the year 1991-92 both these level has only 21 per cent of share each, whereas the tertiary sector grabbed 58 per cent which is meant for major hospitals, allopathy medical education, training and research located in urban areas. Health outcomes depend on the type of expenditure and pattern of spending. The poor health outcomes in Orissa have been attributed to greater emphasis on curative facilities located in urban areas as against preventive measures in rural areas. The poor health attainment of the state is result of the declining share of expenditure in health sector.

6. Conclusion

India, especially Odisha has a long way to go in providing basic health care to the people. The persistence of deficits in the health outcomes of a majority of the country's population is rooted in the poor state of public provisioning of healthcare. Public expenditure accounts for a small share in total expenditure on healthcare in India, which reflects the low priority accorded to health sector in the government budgets of the country. When compared to the developed and many developing countries, the share of public expenditure in the country's total expenditure on healthcare appears to be very low for India. Further, India ranks sixth from the bottom, amongst all countries in the world, in terms of public expenditure on healthcare as a proportion of the Gross Domestic Product (GDP).

On the basis of the above discussion, it is felt that health sector would require a significant strengthening of the regular and sustained government interventions, which would inevitably require a much higher magnitude of public expenditure on health than what is still prevailing in India and Odisha. Therefore, as an immediate action, at least the following issues must be addressed in the Union and State Budget.

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