Editorial

Government financing of health in India

India is a welfare State in which the government has a responsibility to ensure that citizens have access to healthcare. We are also a federal State, with multiple levels of government, each with its own responsibility. The sixth item in the State list in the Constitution of India vests responsibility for 'Public health and sanitation, hospitals and dispensaries' on the state governments. Items 20 and 20A, on Economic and Social Planning and Population Control in the Concurrent list permit both the states and the Union to function in these areas. But much that is innovative comes from the Union, and its role is therefore important. States must be able to build on this innovation.

An understanding of health financing, therefore, must focus on the state governments. The Union can certainly help, but health is not its main responsibility. Today, <20% of all government spending on health comes from the Union government. And government spending is <25% of spending on health; private spending is the major chunk. Ambitious goals have been proclaimed—from the Alma Ata Declaration to the Millennium Development Goals. Right to health is seen as a universal one for all citizens. However, health indicators such as maternal mortality are still at alarming levels and show how far India has yet to go. The government seems to believe that privatization may lead to better outcomes. Tax holidays for private corporate hospitals, tax breaks for citizens buying health insurance, etc. show that we are moving in this direction.

Data on health financing for all states is difficult to come by and even more difficult to analyse because of the way accounts are maintained. Therefore, I focus on a typical state: Karnataka. While Kerala and Tamil Nadu are generally accepted as doing better, Karnataka is fairly representative of the other states—and perhaps better than some in the Hindi heartland.

There are other problems for those who want to understand funding in detail. The way the accounts are kept, there is a major head for health and family welfare (codes 2210, 2211 for revenue account and 4210 and 4211 for capital account). Since nutrition is important in health, we can add code 2236 which is money under the Integrated Child Services Programme. Transfers from the Union to the states are revenue expenditures for the Union, even if the states use them for capital expenses. And after 2005, we have money spent under the National Rural Health Mission—a fairly large sum. In addition, there is a Plan and Non-Plan classification that the government uses. Economists consider it meaningless but the classification continues. For specific details, we have to look at local accounts. These are poorly maintained, scattered across the country, and certainly not reliable. For meaningful analysis, data management at this level must be improved.

Audit takes place at the level of the Health department. At lower levels, audit is poor and even when undertaken, there is no follow up action. Improving the accounting system, to include unit level accounting and audit, and action on audit, must be a prerequisite to any change in the health delivery system in India.

The Karnataka budget for 2000–01 allocated ₹120 821.1 lakh for health, and this grew to ₹268 050.4 lakh in 2008–09. The actual expenditure was lower at ₹112 897.6 lakh and ₹232 886.5 lakh. We should ask why money allocated was not spent. Does

the demand, voiced by many, for increased allocations, make sense when we do not have the capacity to spend even what has been allocated? How can we increase the absorptive capacity of health departments?

If we look at figures adjusted for inflation (using 1990–2000 as a base) then we get allocations for these years at ₹106 984.8 lakh and ₹155 317.6 lakh. Inflation is eroding the health budget significantly. By using numbers unadjusted for inflation, the state government has given the impression that allocations are actually increasing. Citizens must be vigilant.

As a percentage of Karnataka's gross state domestic product, the trend for health is declining, from 1.11% in 2000–01 to 0.99% in 2008–09 for allocations and 1.04% and 0.86% for expenditures.

In inflation-adjusted terms the percentages are 1.06% and 0.66% for allocations and 0.99% and 0.57% for actual expenditures.

At a time when the state's income is increasing, its percentage expenditure on health is declining. This would be understandable if the state indicators were excellent. Since they are not, we need to know why health is declining in importance—or as a priority for expenditure. And this happened when the stated policy is to improve health conditions by increasing spending on this sector. This was the major reason given for the large Structural Adjustment loan from the World Bank in the early 2000s. However, experience tells us that the loan did reduce the state's fiscal deficit because expenditure on the social sectors was cut, as the data above show.

Nonetheless, there is a silver lining. Unspent balances in the state have been dropping in the National Rural Health Mission (NRHM). In Karnataka they have dropped from ₹14 291.13 lakh or 76% in 2005–06 to ₹2357.13 lakh or 5% in 2009–10. We must understand how this happened, and strengthen those forces. The NRHM has also introduced flexibility into the financing mechanism by decentralizing procedures. Village health and sanitation committees can spend up to ₹10 000 per year on healthcare, and primary health centres (PHCs), community health centres (CHCs) and taluk and district hospitals have also been given access to united funds. Electronic fund transfer, creation of flexi pool funds, and the increasing use of cash transfers in the *Janani Suraksha Yojana* are other innovations brought in by the Union. But unless the states restructure their working, these innovations will not translate into improved outcomes. There is much to be done yet institutionally at local levels. This is our weak link. The capacity to use these funds properly has not been built up.

The figures above are aggregates. Let us look at the picture in a typical district. We choose Shimoga, where the Centre for Budget and Policy Studies has been researching this question.

The actual expenditure on health in Shimoga rose from ₹1455 lakh in 2002–03 to ₹2339 lakh in 2008–09. In inflation-adjusted terms (2002–03 prices) the actual expenditure on health in Shimoga was ₹1809 lakh.

Total expenditure in the district has been fluctuating, beginning with ₹17 362 lakh in 2002–03 and remaining roughly the same at ₹17 504 lakh in 2008–09. Adjusting for inflation, the figure for 2008–09 was ₹13 539 lakh; inflation has eroded a lot of value. In percentage terms, the expenditure hit a low of 8% in 2002–03 and a high of 19% in 2005–06. Such volatility in expenditure is perturbing and needs an explanation. We do not have one.

While improving health conditions requires that money be spent, it also requires that many others things are done. For money to be spent properly there must be controls at the spending level that are not just administrative procedures. Elected representatives must have the right to ask questions, to suggest local changes and monitor work as it is being done. Social audit, of the kind that has been made mandatory in the Rural Employment Guarantee programme, is one way in which this can be ensured. Letting local governments—the appropriate level of the *panchayats* or municipality—monitor health projects on the ground is essential, and now constitutionally mandated. Encouraging the setting up of Village Health and Sanitation committees that are distinct and separate from the *gram panchayats* creates multiple agencies locally with turf wars that reduce the effectiveness of both.

While healthcare provision is the major responsibility of health professionals, local administration need not be loaded on them. Doctors posted in PHCs and district offices must be enabled to focus on medical work, not on attending meetings and filling forms. Unfortunately, paper pushing is given social stature, and doctors in clinics are not seen to be as important as Block Development Officers.

Fiscal reforms, if not accompanied by structural changes in our local governmental set up, are not likely to lead to improvements in health indicators, even if more money is spent. This is the lesson from the field.

The medical profession, the civil servant, and of course politicians must change. The initiatives from the Planning Commission for universal access to healthcare, through insurance programmes, need to be debated. Is the insurance route, with private provision, superior to direct government provision of services? Insurance by its nature will not be universal—as the US experience clearly shows. This subject needs more debate.

Ultimately, it is not how much we spend that matters—although it is not unimportant—but how we spend it that is critical.

VINOD VYASULU
Centre for Budget and Policy Studies
Jayanagar
Bangalore
Karnataka
India
vyasulu@gmail.com