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HEALTHCARE EXPENDITURE IN INDIA -AN ANALYSIS

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Abstract

Health is an important constituent of human resource development. Good health is real wealth of society. It not only increases human efficiency but also decreases private and public expenditure on sickness and diseases. Health has been declared as a fundamental human right. The present concern in both developed and developing countries is not only to reach the whole population with adequate healthcare services but also to secure an acceptable level of health for all through the application of primary healthcare programmes. Healthcare services help to reduce infant mortality rate, check crude death rate, keep diseases under control and raise life expectancy.
***Keywords**: healthcare services, infant mortality rate, death rate, life expectancy, job security, economic growth*

Introduction

Good health is both the means and end of development. A healthy population is a pre-requisite for economic growth; in turn this income growth can channeled to improve human lives through the provision of a decent education, good healthcare facilities, increased job opportunities, improved job security, good governance and all other requirements for human well being. Thus improvement in health is an important engine of economic growth. If economic growth of a country is to be sustained, the provision of healthcare has to be more accessible and qualitatively better. India has made a lot of progress since independence in the field science and technology and has achieved a place of prominence among the developed countries in same respects but in the field of health sector particularly rural health, the picture is pretty grim.

Long gestation period for health also cannot justify slow outcomes in the health sector, as rural health is still a distant dream even after 59 years of independence.

With this background the present paper made an attempt to examine the following issues which are given in the objectives of the study

Objectives of the Study

- To examine the need for health care in India.
- To evaluate the healthcare spending in India.
- To make an interstate comparison of health expenditure in India.

Need for Healthcare

Health is the basic ingredient of welfare. It affects every aspect of life, our ability to work, to plenty to enjoy our families or socialize with friends, all depend crucially upon our physical well-being. And ill-health which leads to death makes all sources of satisfaction irrelevant. In pure economic term, as the World Bank put it "improved health reduces production losses caused by worker illness, permits the use of natural resources that had been totally or nearly inaccessible because of disease, increases the enrollment of children in school and makes them better able to learn and frees for alternatives uses of resources that would otherwise have to be spent on treating illness. The economic gains are relatively greater for poor people". Because their income depends exclusively on physical labour and they have no saving to cushion the blow. Thus, spending on health is considered a productive investment, which raises the income and reduces the toll of human suffering from ill health. An integrated plan, in which investment , which raises the income and reduces the toll of human suffering from ill health. An integrated plan, in which investment in certain key areas in health fields, is essential for reversing the vicious circle of poverty and sickness in developing countries like India.

Economics of health plays a vital role in improving quality of life as well as quality of labour input and in India the main reasons for the inferior quality are poor health and malnutrition. Although adequate empirical data are not available to support the contribution of health to the process of economic development, yet "it is a common place idea that poverty, illiteracy, ill health and low productivity go together". (Dewatt & Wadhwan, 1985)

The National Common Minimum Programme of the government plans to raise public spending on health from level of 0.9% to 2 to 3% of GDP in the next five years with focus on primary health care. The plan allocation for 2004-05 was enhanced from the initial allocation of Rs. 1800 crore to Rs. 2208 by the Planning Commission. It has further been increased to Rs. 2908 crore in the annual plan for 2005-06. Over and above this, there are also other funding agencies. It is a well-known fact that governments are responsible for a substantial share of public spending on health. The share of public expenditure for health is as high as 60 to 75% in high-income countries. Developing countries spent only about $170 billion or 4% of the amount spent by rich countries. For the world as a whole public and private expenditure on health services was about $2000 billion of 8% of total world product. The total annual spending ranged from less than $10 per person in low income countries to more than $1000 per person in high-income countries. Since the share of GNP devoted to health tends to rise with income, rich countries differ from poor ones even more in health expenditure than in income (Meenakshi, R. 2005). In India the role of private sector cannot be underestimated. This sector has two types of organizations, firstly the charitable with no profit no loss basis secondly, private with profit basis. Almost 75% of the total health care load is carried out by the private sector. The current annual per capita public health

expenditure in the country is no more than Rs.200. Given statistics, it is no surprise that the reach and quality of public health services has been below the desired standard. Here it is a shocking piece of information in terms of public spending on health. India ranks 171st out of 175 countries. In contrast, it ranks an impressive 18th in terms of private spending on health. Public spending on health in India is mere 0.9% of GDP whereas only four countries Nigeria, Indonesia, Sudan and Myanmar spend less than India. In China, with which India is often compared, the government spends 2% of GDP and ever Nepal1.5% and Bangladesh 1.6% spend on health according to UN data. Health Secretary J V R Prasad Rao spells out what this means. "With funding so low we can either fund doctors or get medicines or give support services. We can't care of all this". (Times of India, 29 July 2004).

It is now widely recognized that investment in health fields contributes to economic growth of a country by stimulating growth in human capital formation and by preventing economic loss due to sickness, disability, premature death and cost of treatment.

Health Care Spending

Health care is primarily financed by the state governments and the state allocation on health is usually affected by any economic stress they encounter. The major chunk of public expenditure (almost 60 percent) on health care sector comes through the state's budget. Nevertheless, state governments also have certain degree of dependence on the funds of the Central Government. The funding from Central Government enables the states to run the family planning programs and centrally sponsored schemes especially national disease control programs, immunization, nutrition schemes and the components of minimum need program of the centre. The central government either provides complete grant or partially through matching grant, where contribution of the states has to be added. The central government provides the complete grants for medical research and education in the centrally sponsored institutions (Purohit, 2010)

India's share of both health expenditure in Gross Domestic Product (GDP) and public spending on health is low as compared to developed countries. While, its health expenditure percent of GDP is higher than Asian economies i.e. China, Malaysia, Sri Lanka, Thailand, Pakistan and Bangladesh, but public spending as percent of total health expenditure is significantly lower than all these countries except Pakistan (GOI, 2009). Results from National Health Accounts for the year 2004-05 shows that the total health expenditure in the country was Rs. 1,337,763,206 (USD 29,603,080 @ I Rs. 45.19 in the year 2006) accounting to 4.25 percent of GDP, which is very low.

The contribution to the total health expenditure comes from two major players' i.e. public sector and private sector. Public sector expenditure constituted only 19.67 percent (Central Government, and State government's share is 6.78 percent and 11.97 percent respectively), whereas the contribution of private sectors accounted to 78.05, percent of total expenditure. The total external flow during 2004-05 was Rs. 30,495 million

with a major portion having been routed through the Central Government. It indicates that the Indian healthcare industry is pre-dominantly catered by private sector of the private sector, household's out of pocket expenditure was 72.3 percent of total healthcare expenditure incurred in India. This includes out of pocket payments borne by individual households for treatment and insurance premium contributed by individual in health insurance schemes. Of the total out of pocket expenditure by household in 2004-05, Rs. 578,998 million was spent. Of this, 62 percent was spent by the rural households and the balance 38 percent was spent by the urban households for availing different health care services. The per capita health expenditure for India in 2004-05 was Rs. 1201 of which the share of public was Rs. 242 (20.2 per cent) and of private was Rs. 959 (79.8 per cent).

In sum, the existing level of government expenditure on health in India is about 1 percent of GDP, which is very low. Moreover, there has been a decline in this above proportion from 1992-93 till now. However, the Eleventh Five Year Plan aims to increase this proportion to 2 percent by the end of plan period with the help of innovative health financing mechanism, (PCI, 2007).

The World Bank reported in 2000 that "Irrespective 4 income class, one episode of hospitalization is estimated to account for 8 percent of per capita annual expenditure, pushing 2.2 percent of the population below poverty line. It is because of this reason that a single episode of major illness is enough to eat away the life savings of most individuals in India (Ananthakrishnan, 2005): Even more disconcerting is the fact that 40 percent of those hospitalized has to borrow money or sell off assets". Studies also show that the disadvantaged group including poor spends a large proportion of their income on health as compared to their Counterpart. The burden of treatment increases during inpatient care (Visaria and Gumber, 1994; Gunther 1997). Component analysis of private sector expenditure shows that 66 per cent was spent on outpatient care, followed by 23.48 percent on inpatient care, 3.43 per cent on, delivery and 2.83 percent on family planning services. In per capita terms Rs. 564 was spent on outpatient care which was the highest among all the services (GOI, 2009).

Inter State Analysis of Health Care Spending

The health care sending of 14 major states in the county has been examined here. It is also important to mention here that public spending in India is one of the lowest and as per the national health accounts 2001-02 spending by the health departments of both centre and state accounts for 0.9 per cent of GDP. Fiscal pressure has resulted in the compression of state expenditure and steady decline in social expenditure. The combined expenditure of the states in the 1990s on health, water supply sanitation and family welfare programme declined from 8.4 per cent of total expenditure in 1990s to 7.2 per cent in 2001-02 (GOI, 2005).

The real per capita health expenditure (1993-94 prices) and its share from the state expenditure have been presented in this section. As observed from the table 2.9 Punjab

with Rs. 132.5 has the highest real per capita spending during 1991-92 to 2005-06 whereas Bihar spends the least. The poor states like Orissa, Madhya Pradesh and Uttar Pradesh stand at I1th, 12th and 13th respectively. Kerala with better HDI occupies second position among 14 major states of the country. But as a share of state expenditure, West Bengal makes highest budgetary spending towards health sector. The average share is 5.68 per cent during 1990-91 to 2005-06 against 3.08 per cent for Haryana which is the lowest in the country. The high income states like Punjab, Haryana and Gujarat allocate relatively lower share of state expenditure towards the health sector in comparison to poor states like Bihar, Orissa and Uttar Pradesh (Table 1). In spite of a lower share of the state budget the per capita health care spending of these states is found to be more in comparison to the poor states. In case of Kerala which performs significantly better in most of the health indicators the rank in the share of state expenditure and per capita health spending is same during the period. It is also important to look in to whether the state governments have maintained the same level of expenditure as earlier or reduced the share towards health sector due to the financial crisis. As observed from the Table 2, except Haryana, all the states have reduced the share towards health after the onset of financial crisis during 1998-99 onwards.

Table 1 Real per Capita Health Spending and its Share in State Expenditure

State	Average Real Per Capita Health spending	Rank	Average Share in State Expenditure (1990-91 to 2005-06)	Rank
Andhra Pradesh	92.32	**8**	4.47	**8**
Bihar+	53.38	14	5.17	3
Gujarat	96.01	6	3.81	13
Haryana	86.43	10	3.08	14.
Karnataka	102.35	4	4.74	**6**
Kerala	130.08	2	5.46	2
Madhya Pradesh	67.38	12	4.42	9
Maharashtra	95.59	7	3.96	12
Orissa	72.02	11	4.25	10
Punjab	132.5	1	4.03	11
Rajasthan	96.97	5	5.16	4
Tamil Nadu	113.6	3	5.02	5
Uttar Pradesh+	61.75	13	4.58	7
West Bengal	89.67	9	5.68	1

+ indicates undivided states.

Source: Compiled from Handbook of Statistics on State Government Finances, 2004/05, **State Finances**: A Study of Budgets of 2005/06 RBI.

The highest decline is observed in case of undivided Bihar followed by Uttar Pradesh and West Bengal. In case of Bihar the decline is 1.52 per cent, for Uttar Pradesh it is 1.44 and it is 1.19 per cent for West Bengal (Table 2). This indicates the poor states have reduced their share towards the health sector after the onset of the financial crisis. Another important revelation is that Gujarat is the only state among the high income states which has declined its share by 1.01 per cent in the post crisis period.

Table 2 Inter-State Comparison of Health Sector Expenditure

States	Share of Health Expdrs. to Total Expdr. 1991-92 to 1997-98	Share of Health Expdrs. to Total Expdr. 1998-99 to 2005-06	% Change over the period
1	2	3	4 (3-2)
Andhra Pradesh	4.67	4.04	-0.63
Bihar+	5.78	4.28	-1.50
Gujarat	4.23	3.22	-1.01
Haryana	2.83	2.94	0.11
Karnataka	5.05	4.22	-0.83
Kerala	5.68	5.01	-0.67
Madhya Pradesh+	4.57	3.85	-0.72
Maharashtra	4.21	3.51	-0.70
Orissa	4.59	3.82	-0.77
Punjab	4.02	3.70	-0.32
Rajasthan	5.54	4.67	-0.87
Tamil Nadu	5.33	4.51	-0.82
Uttar Pradesh+	5.25	3.81	-1.44
West Bengal	6.02	4.83	-1.19

+ indicates the undivided states

Source: Compiled from Handbook of Statistics on State Government Finances, 2004/05,
State Finances: A Study of Budgets of 2005/06, RBI.

The extent of disparity among various category of states and the improvement in real per capita expenditure on medical and public health and family welfare during 1991-92 to 2005-06 has been presented in the Table 3. It is found that during 1991-92. Punjab's per capita health spending was highest and that of Madhya Pradesh was the lowest. In this period the disparity between the highest spending and lowest spending state was 1:2.05. The situation of Madhya Pradesh improved during 1996-97 and stood 12th position and the per capita health spending of Bihar was lowest while Kerala occupied the first position during the same period. During this period the disparity between highest and lowest spending state increased and reached to 1:2.92. In 2001-02 again Punjab spent highest in per capita terms and Uttar Pradesh had lowest spending. But in 2005-06 Kerala and Bihar were the highest and lowest spending states respectively. So the point to mention here is

that the per capita health spending of poor states like Bihar or Uttar Pradesh is found to be lowest in last 15 years. The highest increase in per capita spending is for Kerala in 2005-06 against 1991-92 followed by Andhra Pradesh and West Bengal. In case of Kerala, the rise is 91.11 per cent and for Andhra Pradesh it is 67.74 per cent. The lowest increase in per capita health care spending is for Gujarat. The regional inequality measured in terms of co-efficient of variation among different states is widening over the years. The co-efficient of variation, which was 21.60 in 1991-92, has increased to 29.92 in 2001-02. During 2005-06 it was 26.12. During the process of reforms the gap between the poor and rich states is rising indicating the poor states are not in a position to allocate more and more resources towards health sector. With the rise in national income a higher proportion of income is spent towards health sector. It has been proved in earlier studies that, the ratio of health expenditure to GDP increased as the countries developed economically and socially. [Abel-Smith (1963, 1967) as quoted by Bhat and Jain (2006)]. Again another study found a positive linear relationship between the percentage of health care expenditure to GDP and GDP [Newhouse (1977). as quoted by Bhat and Jain (2006)]. In case of eight states in India the share of health in GSDP is less than one per cent. And for other states it is marginally higher than one per cent varying from 1.08 to 1.15 percent. It is also observed that in the post crisis period the health expenditure as proportion to GSDP has declined in almost all the states except Andhra Pradesh, Orissa and Punjab. But the rise in these three states is marginal. This reveals that the share of GSDP has not increased in the states. Comparing the health care expenditure to GSDP and GSDP in 14 major states it is found that the correlation is found to be negative for all the states in the country. So increasing GSDP doesn't contribute the rise in health care expenditure (Table 4)

Table 3 Real per Capital Health Expenditure

States	1991-92	Rank	1996-97	Rank	2001-02	Rank	2005-06	Rank	% increase in 2005-06 over 1991-92
A.P	66.77	10	8387	8	109.75	6	111.99	5	67.74
Bihar+	36.84	13	39.70	14	61.23	13	70.68	14	24.36
Gujarat	80.62	5	88.06	6	87.36	10	94.55	11	17.28
Haryana	73.3	8	79.04	9	92.06	9	99.93	9	36.33
Karnataka	78.4	7	84.96	7	125.34	3	116.11	4	48.11
Kerala	94.1	2	116.05	1	145.89	2	179.90	1	91.19
M.P+	55.69	14	60.86	12	69.74	12	83.82	13	50.51
Maharashtra	80.75	4	90.38	5	115.03	5	104.31	8	29.18
Orissa	63.70	11	64.37	11	74.60	11	94.86	10	48.91
Punjab	113.95	1	110.18	2	154.51	1	146.55	2	28.62
Rajasthan	79.34	6	100.64	4	106.69	8	106.40	7	34.10
Tamil Nadu	92.55	3	104.63	3	119.83	4	142.36	3	53.82
U.P+	57.24	12	60.11	13	52.83	14	85.04	12	48.58
West Bengal	70.76	9	75.88	10	107.50	7	107.35	6	51.71

+ indicates the undivided states

Source: Compiled from Handbook of Statistics on State Government Finances, 2004/05, State
Finances: A Study of Budgets of 2005/06, RBI.

Table 4 Share of Health Expenditure in GSDP

States	Pre Crisis	Post Crisis	Correlation between of health care expenditure to GSDP
Andhra Pradesh	0.86	0.87	-0.434
Bihar+	2.03	1.53	-0.757
Gujarat	0.7	0.67	-0 583
Haryana	0.58	0.55	0.117
Karnataka	0.92	0.88	-0.500
Kerala	1.08	1.03	-0.820
Madhya Pradesh+	1.08	0.92	-0.805
Maharashtra	0.62	0.60	-0.661
Orissa	1.05	1.08	-0.606
Punjab	0.77	0.87	-0.148
Rajasthan	1.15	1.10	-0.759
Tamil Nadu	0.96	0.86	-0.566
Uttar Pradesh+	1.06	0.89	-0.618
West Bengal,	0.89	0.89	-0.618

+ indicates the undivided states
Source: Compiled from Handbook of Statistics on State Government
Finances: 2004/05, State Finances: A Study of Budgets of 2005/06, RBI.

Conclusion

Inspite of huge budget allocation have been made towards health sector to improve the key health indicators, enormous health problems continued to remain as an unfinished agenda of the economy. Absolute levels of mortality in the state are still unacceptably high. Day by day the size of the population increasing, as a result the state has to face a challenge in providing adequate health facilities which require huge amount of budget allocation. However, it is hereby advise the state to take up a proper road map to meet the challenges of health care services which is a pre-requisite for human development.

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