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BUDGET

Health budgets – Changing the story

Our budgetary allocations for health have not changed very significantly over the years. If at all they reflect a shrinking trend. At 8 per cent per annum rate of economic growth the allocations are distressing, writes Ravi Duggal.

AT the national level for the last three years there has been a lot of talk about the National Rural Health Mission (NRHM) and now even the Urban Health Mission. Prior to NRHM the state and central governments together spent 0.9 per cent of GDP on health and they had targeted via the Mission to raise this to up to three per cent of GDP. It is four years of the UPA government and its promise in the Common Minimum Programme, but we are still sailing at 0.9 per cent of GDP; and there is mounting evidence to show that the public health system is unable to meet even very simple primary healthcare demands of the country's citizens.

The central government claims to have expanded its resources substantially via NRHM and this is perhaps also true (For instance 2006-07 to 2007-08 budget allocations of the Central Health Ministry increased by 21 per cent whereas those of all state governments combined increased three times less at a mere seven per cent for the same period.), but we must not forget that health is a state subject and three-fourths to four-fifths of the budget comes from the state governments. In 2007-2008, the national public health expenditure was budgeted at Rs. 420.43 billion and of this the state governments accounted for 75 per cent, one of the lowest proportions ever. For the latest year 2008-09, the increase in the central health budget is a mere 14 per cent in sharp contrast to the overall increase in central government expenditure of 20 per cent revenue increase of 25 per cent, direct tax revenue increase of 36 per cent and defence spending increase at 24 per cent. This clearly indicates the inadequate weightage given to health in the central government's budget this year, despite tax-payers contributing increasing proportions to the state exchequer.

In the Table, we have provided a summary of public health budgets from the pre-NRHM year and it is quite evident that budgetary allocations have not changed in any

significant way. If at all, a shrinking trend is visible, and this would look worse if we had to use a price deflator. With a rapidly growing economy at over eight per cent growth per annum the health budget allocations at best are shameful. What is worse is that invariably budgeted figures are on the higher side as compared to revised estimates and then actual expenditures are even lower. What is also visible in the Table is that the Centre's own budget is growing more rapidly and its grants to the states are declining which is indicative of an increased central control rather than promoting fiscal devolution. Further, the states' own budgetary commitments to health are also declining as a proportion of their total expenditures.

Thus it is clear that the flagship approach of the UPA government has been a failure as far as the health sector and its budgetary allocations are concerned. The architectural corrections which the NRHM talks about are nowhere in sight. The deficiencies of the public health system continue and this is largely due to its gross under-financing at one level, and at the other level the policy initiative being commandeered by the Union government. This has left the state governments being unconcerned about public health.

In the mid eighties the Minimum Needs programme was a great success in strategising the Health For All strategy. It provided the resources to expand the much neglected rural health system and that was the period when the governments' health spending peaked at 1.5 per cent of GDP. That was the period of primary healthcare consolidation driven by the 1982 health policy and the Alma Ata Declaration. But at the turn of the nineties the public health system turned turtle under the new economic reforms and the Structural Adjustment Programme driven by the World Bank. That began a period of compression in health spending and we saw a declining trend not only in terms of

Table : Ministry of Health and Family Welfare Budgets in Rs. Crores

Category	Actuals 2004-05	BE 2005-06	RE 2005-06	BE 2006-07	BE 2007-08	BE 2008-09
1. Central Health, FW and Ayush	8086.46	10733.54	10086.26	13081.82	15856	18123
2. Of which Grants to States and UTs including NE component	3775.09 [0.75]	4969.12 (968.20) [0.97]	3780.15 (880.00) [0.74]	5078.98 (1168.80) [0.90]	5196 (1436) [0.75]	6113 (1653) [0.81]
3. Net Health Central Govt. (1-2)	4311.37 [0.86]	5764.42 [1.12]	6306.11 [1.24]	8002.84 [1.41]	10660 [1.53]	12010 [1.60]
4. State/UT Govt. Health and FW (including 2)	21465.19 [4.32]	24336.63 [4.57]	25479 [4.19]	29137 [4.36]	31383 [4.10]	34500* [4.2]
5. Total Health (3+4) as % GDP@	25776.56 0.82	30101.05 0.84	31785.11 0.89	37139.84 0.90	42043 0.90	46510* 0.92

Figures in parentheses is NE (Northeast Region) component and in square brackets % to respective Total Budget or Expenditure. BE = Budget Estimate, RE= Revised Estimate; @ GDP at market prices from RBI – Handbook of Statistics, RBI, Mumbai, 2007; * projected by author

Source: *Expenditure Volume of Budget 2006-07, 2007-08 and 2008-09 (Demand Nos. 46 and 47 and 2008-09 also Demand No. 48) Ministry of Finance, GOI, New Delhi, 2006/2007/2008. For 2004-05 actuals - Annual Financial Statement 2006-07. For State/UT governments from RBI – State Finances 2005-06, 2006-07, 2007-08, RBI, Mumbai, 2007/2008*

GDP bottoming out at 0.8 per cent per cent but also in terms of health expenditure as a proportion of total government spending. And this declining budget support culminated into the 2002 health policy which batted for privatisation and larger private investments in health. The 2002 health policy became the nail in the coffin of the public health system. This led to the collapse of the public health system with continued underfinancing, until civil society pressure and the changing politics with the UPA regime brought in the NRHM as a rescue operation under the Bharat Nirman programme, similar to the MNP of the eighties but so far the NRHM has not shown very significant changes, only perhaps some tinkering.

If the public health sector has to become vibrant again as it was in the mid-eighties, and if we have to move in the direction of atleast three per cent of GDP being devoted to health from the budget, then the state governments and

their budgets have to play a much larger role. In recent years there is only one example of a state, Mizoram, which had achieved 2.7 per cent of SDP (State Domestic Product) and we have the outcomes to see for ourselves. Mizoram has one of the best health outcomes in the country and this was made possible with the large budgetary allocations devoted to the health sector. In the last couple of years Mizoram's health budget has been threatened and is witnessing a declining trend and this may arrest the health progress the state achieved in the last 5-10 years.

Whenever we think budgets, we always look at the Union budget. While the Union budget is important, we have to focus our larger attention on state budgets if we want to change the story of health in India. Healthcare is best delivered in a decentralised way and this also means that control over budgets has to be devolved to local governments. Politically, we have Panchayat Raj but fiscally the latter has

no powers and control over the resources. Budgets are not only about allocations, it is more importantly about being able to decide how to use the allocations and this is best done not from Delhi or Mumbai or Chennai or Kolkata but from Mehrauli, Nandurbar, Pudukkottai and Puruliya.

Another dimension that we ignore when discussing budgets is the revenue or income side. If governments have to spend adequately on the development sector then they need to raise adequate volume of resources. If we look at any country which has good social security for its citizens then we see that their Tax:GDP ratio is in the range of 30 per cent to 40 per cent. Thus countries like UK, Canada, Sweden, Australia, Germany etc. are able to have excellent social security for its citizens. In recent years South Korea, Costa Rica, Brazil, Malaysia, Thailand have progressed in that direction. Post SAP India's Tax:GDP ratio was down to 13 per cent and presently it is about 17 per cent. With a booming economy netting in more of the GDP in taxes is quite feasible provided there is a strong political will for social action. India cannot change the story towards better health and education if we do not improve the Tax: GDP ratio because that is the only way of bringing in more resources for the social sectors.

Finally, in our understanding of budgets we should not ignore the household burden in meeting healthcare costs. In a predominantly poor country like India this is very crucial. It is a contradiction that for a public good like healthcare, people (including the poor) have to depend on the market. Market failures in healthcare are well documented globally and hence most OECD (Organisation for Economic Co operation and Development) countries, except USA, have publicly financed healthcare systems. In India, 80 per cent of health financing is out-of-pocket and a very large proportion of this is financed not from current incomes but through indebtedness and sale of assets, especially for hospitalisations. In the Urban Health Mission the key strategy being discussed is insurance as a means of financing healthcare for the urban poor. We must rethink this because poor cannot contribute to insurance, they have to be directly supported by the state.

To conclude budget discussions are not only about allocations but they are about decision making, about governance and about equity and these achieve synergy only when political will for progressive change leads the way. ■



The writer is an independent researcher and health activist and is associated with the medico friend circle and the Jan Swasthya Abhiyan.