Public Health Spending in India

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For BBL session on February 16, 2010
## Health Care Spending: A Comparative Picture in 2005

<table>
<thead>
<tr>
<th>Countries</th>
<th>% of GDP</th>
<th>Govt. Share</th>
<th>Per-capita PPP ($)</th>
<th>Per-capita Ex. Rate ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>2.8</td>
<td>29.1</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>India</td>
<td>5.0</td>
<td>19.0</td>
<td>19</td>
<td>7</td>
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<tr>
<td>Nepal</td>
<td>5.8</td>
<td>28.1</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2.1</td>
<td>17.5</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>4.1</td>
<td>46.2</td>
<td>88</td>
<td>24</td>
</tr>
<tr>
<td>South East Asia</td>
<td>4.0</td>
<td>29.0</td>
<td>29</td>
<td>9</td>
</tr>
</tbody>
</table>
Health Care Financing in India: A snapshot in 2004-05

- Households: 71%
- State Govt.: 12%
- Local Bodies: 1%
- Firms: 6%
- Social Ins.: 1%
- Ext Funds: 2%
- Central Govt.: 7%
Diversity Across States

• Significant variation in public and private financing mix across states
  – e.g., share of public financing in Himachal Pradesh is 42% while it is just 10% in Kerala
  – among the major states, 5 states (Assam, Gujarat, Karnataka, Orissa, and Rajasthan) have public share > 20%.
  – significant variation across states in the level and share of total health expenditure as well as and public health expenditure
Govt. Spending by Type of Care
2004-05

- Primary Care: 41%
- Secondary Care: 15%
- Tertiary Care: 23%
- Others: 21%
Govt. Health Expenditure as % of GDP

% GDP

Centre
States
Total (Centre & States)


1.20
1.00
0.80
0.60
0.40
0.20
0.00
Share of Govt. Health Exp. in Total Govt. Exp.

- Centre
- States
- Total (Centre & States)

Year Range: 1999-2000 to 2004-2005

- Share of Govt. Health Exp. in Total Govt. Exp.
  - 0.00 to 6.00

- Graph showing trends over time.
Commitment to Increase Government Health Financing

• Increasing public health expenditure from 1% of GDP to 2-3% of GDP

• Reprioritization of social programs, including health program
  – political change
  – acceleration in economic growth and the consequent increase in government revenues

• Central government’s focus on health is likely to continue

• NRHM to be the principal vehicle for stepping up public health spending
NRHM launched in 2005

• NRHM is designed as an umbrella program – consolidating existing programs as well as adding some new ones – with a flexible, bottom-up perspective whereby district and village level health plans are aggregated up to the state level which are then annually submitted to and financed by the centre, with some proposed matching of funds by the states to be introduced during the course of the implementation of the program.
Health Care Financing Strategy

• Increased central funding for health is mainly through NRHM
• This increase is to be centre-led as the centre would increase its share in total govt. health spending from less than 30% to 40% by 2012
• The centre would increase its allocation of NRHM by 30% per year for the first two years of the program and 40% per year thereafter until 2012
• States to increase their own health spending by at least 10% every year
Growth in Health Spending

[Graph showing the growth in health spending from 2000-01 to 2007-08 for Centre and Groups A, B, and C.]
Planned Versus Actual Central NRHM Allocations

- **Planned central NRHM allocations**
- **Actual central NRHM allocations**

The graph illustrates the comparison between planned and actual central NRHM allocations from 2005-06 to 2011-12. The planned allocations show a steady increase over the years, while the actual allocations appear to lag behind, particularly in the later years.
Utilization of NRHM funds as % of Releases

- **Group A**
- **Group B**
- **Group C**
Some Observations on NRHM

• NRHM expenditure being used for variety of purposes/activities which were either unfunded or underfunded prior to NRHM demonstrating at least the intent that these expenditures be additional

• Since NRHM activities are largely complementary to the pre-existing service delivery programs, the intent is clearly to increase the effectiveness of government health service delivery

• Specifically, all three types of innovative grants viz., untied grants, maintenance grants, and grants to facility level “patient welfare committees,” are currently based on input-related norms

• NRHM could improve the linkage between increased spending and results by tying expenditures more to measured increases in outputs and outcomes
Concluding Observations

• Fulfilling the commitment realizing the goal of 2-3% of GDP would require that states on aggregate would need to increase spending on average by 22-38% per year to attain this target

• Achieving this target is unlikely, both because of the fiscal implications of such large increases as well as the difficulties in actually spending rapidly increased budgets

• Increasing the effectiveness of public spending through NRHM
Thank You!