Changing Health Budgets

Why Budgets are Important?

The trajectory of public health budgets is a good predictor of what is happening to the public health system. For instance post Alma Ata, where India signed the Health For All by 2000 Declaration, huge investments were made in the public health sector, especially in rural areas under the Minimum Needs Programme. This raised public health spending up to 1.5% of GDP by mid-eighties and increased access to public health services as shown by the 1987 NSSO data on morbidity and utilisation. Subsequently health outcomes like Infant Mortality Rate and Life Expectancy also showed good improvements and the rural-urban gap also began to narrow. But the neo-liberal economic reforms beginning 1991 set in a process of declining allocations for public health sector and reversed this process.

Thus public health budgets in a scenario of a neglected and declining public health system become key instruments for public health advocates.

Collapse of Public Health System: Declining Expenditure Cause of Concern

There is a growing interest in discussion and analysis of health budgets and health expenditures for two reasons.

Firstly, the economic reforms of the nineties have created a trajectory of public health spending that shows a downward trend both in terms of share of the Government's budget as well as a proportion of the Gross Domestic Product. Prior to economic reforms in the mid-eighties (1986-87) public health expenditures had peaked 1.6% of the GDP and was 3.95% of government's budget. By 2001 these figures read a dismal 0.9% and 2.7%, respectively, and further down to 0.9% and 2.4% in 2005 budget estimates. What was worse was the decline in new investments by the Ministries of Health as reflected in the decline in capital expenditures from a robust 12% in 1986-87 to a mere 4% in 2000-01 and only a slight improvement in 2004-05 at 5%[1].

Secondly, the use of the public health system during the decade of 1987 and 1996, for which national data is available via the 42nd and 52nd Rounds of the National Sample Survey (NSS) of the Government of India, shows a shocking decline of over 30% in proportion of patients seeking care in public health institutions.[2] This decline in use of public health facilities was precipitated by the neglect and subsequent collapse of the public health system due to its under-financing in the nineties.

The two reasons are closely linked. The declining investment and expenditures in the public health domain have created a scenario where people, especially the poor, have moved away from the public health system because the latter cannot meet their needs and they often have had to face denial of health care in public health institutions. Further, since 1998 with user fees being charged in many states under the so called health reform policies dictated by World Bank and allied agencies, the access to public health care for a vast majority of the poor became even more difficult. The NSS data also indicates that between the two rounds the rate of non-utilisation for seeking health care for illness increased by one-fifth and for nearly half the hospitalisations patients had to either obtain loans or sell assets to seek health care.

Thus reviewing health budgets can become an important tool for monitoring performance and deficiencies of the public health system and then use that analysis to bring in changes, which would strengthen the public health system.

Trends in Public Health Spending

Table 1 shows a historical trend of public and private health expenditures in India. It is evident that private financing, largely out-of-pocket burden of households, has been the predominant source of financing health care, though during the eighties public financing picked up substantially and did show the potential for taking the public health sector to new heights. But at the turn of the nineties the World Bank led economic reforms (1991 onwards) set in a trend where the private sector has taken control of the health sector in India at the cost of the public health sector. The private sector in health post-nineties is indeed very different. The small element of philanthropy has completely disappeared and corporate control of the health sector is evident – pharmaceuticals, corporate hospitals, privatisation of public hospitals, medical tourism etc.

This is contrary to global experience. For example in the OECD countries all of which, except USA and Turkey, have universal access with equity for health care, the proportion of public spending is between 70 and 80 per cent and in these countries the entire population gets access to basic health services, including referral care and drugs, without any payment at the point of delivery. In all these countries all health care resources are pooled and spent rationally under a regulated environment. In India public health expenditure has always been less than one-fourth as a proportion of total health spending; presently estimated at an all time low of 16%. Out-of-pocket burden on households has been the main source of financing health care in India and this has led to a lot of indebtedness and pauperisation in the country.

Box No. 1 Countries Spending Lowest on Public Health: India at Rock Bottom

Serial No.	Bottom of the Public Health Expenditure	Public Expenditure on Health % of Total 2002
1.	Guinea	15.5
2.	Iraq	16.9
3.	Cambodia	17.1
4.	Myanmar	18.5
5.	Sudan	20.7
6.	India	21.3

Source: 2005 /World Development Indicators, The World Bank.

As depicted in the above box no.1, India ranks sixth from the bottom in terms of public health spending amongst all countries.

Increasing Out-of-Pocket Expenditure: Pauperisation of Masses

Until 1991 public health budgets moved in a gradual upward trajectory gradually expanding access to public health care. But budgets after 1991 have set in a linear downward trend and this has drastically impacted the public health system, has affected adversely the vast majority of the poor who are the main users of the public health system and have forced them to migrate to the private health sector which often pushes them into the vicious trap of indebtedness. At the other end of the spectrum the private health market is booming, partly fueled by private health insurance which is experiencing presently a growth rate of over 30% per annum, and India is becoming a major international destination for what is disgustingly referred to as medical tourism[3].

The total value of the health sector in India today is over Rs.2150 billion or US$ 49 billion. This works out to about Rs.2000 per capita which is 6.5 per cent of GDP. Of this 16 per cent is financed by Central and State Governments, 4 per cent is from social insurance, 1 per cent private insurance and the remaining 79 per cent being out of personal resources as user fees and purchase of medical commodities and services (95 per cent of which goes to the private sector). Two-thirds of the users are purely out-of-pocket users and 70 per cent of them are from the poorest sections. The tragedy is that in India, as elsewhere, those who have the capacity to buy health care from the market most often get health care without having to pay for it directly (like employees of the government or

most employees of the organised sector), and those who are below the poverty line or living at subsistence levels are forced to make direct payments (daily wage earners, peasants and agricultural labourers, petty vendors etc.) often with a heavy burden of debt, to access health care from the market. We need to change this situation and this can only be done under a public mandate which pools together all the health resources and organises the health sector into a regulated entity, whether public or private, to serve common interests. India spends a lot of money on health care, over 6% of GDP. Since 80% of this is out-of-pocket and mostly on the private sector a substantial chunk is wasted in a wide range of irrational medical practice. We need to reign in these resources into a common pool and reorganise the entire health system for the common good. After all health is a public good or social good and we must not forget this.

Disparities in Public Health Spending

Another discerning issue is rural-urban disparities in public health spending. At one level the overall allocations to rural areas is grossly disproportionate to its population and at another level the activities and programmes to which the small rural health expenditures are allocated is highly skewed in favour of family welfare and against medical care. This is reflected in the type of health care facilities one sees in rural and urban areas – the former have PHCs, which focus on preventive and promotive programmes, and the latter have dispensaries and hospitals, which are mainly curative oriented. Disaggregating public health expenditure into rural and urban is not easy because of the way in which health budgets are structured. In Table 1a we have done this exercise for one state from each region of the country as an illustration using the functional knowledge of how each programme operates in these states.

Table1: Growth of Private Health Expenditures in India in Comparison to Public Health Expenditures 1951-2006

		1951	1961	1971	1981	1986	1991	1995	1998	2000	2003	2004	2006 BE
Health Expenditure Rs. Billion	Public	0.22	1.08	3.35	12.86	29.66	53.50	85.65	126.35	172.16	201.21	216.19	301.21
	Private		3.65	10.99	52.84	90.54	146.98	278.59	459.00	835.17	1282.8	1450.0	1850.0
Health Expenditure as per cent of GDP	Public	0.25	0.71	0.84	1.05	1.19	1.04	0.93	0.91	0.88	0.89	0.85	0.91
	Private		2.25	2.60	4.06	3.61	2.88	3.04	3.30	4.76	5.69	5.75	5.61
Private: Public ratio (times)		__	3.4	3.3	4.1	3.1	2.8	3.3	3.6	5.4	6.4	6.7	6.2

Source: Public expenditures from Finance Accounts of State and Central Governments except 2004 and 2006 which is from CMIE – Public Finance 2005, and private expenditures from National Accounts Statistics of CSO, GOI, various years; for 2004 and 2006 private sector estimated by author; BE=Budget Estimate

GRAPH 1

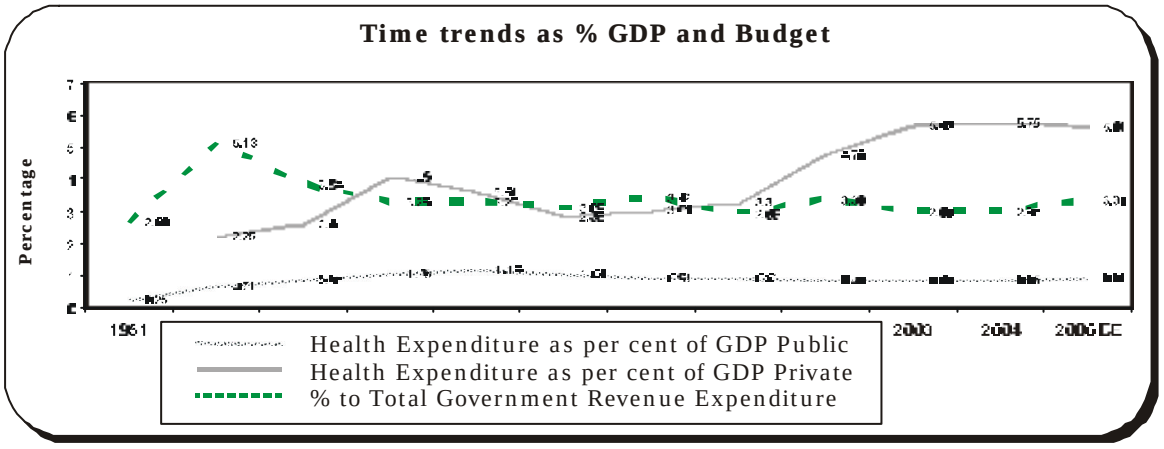
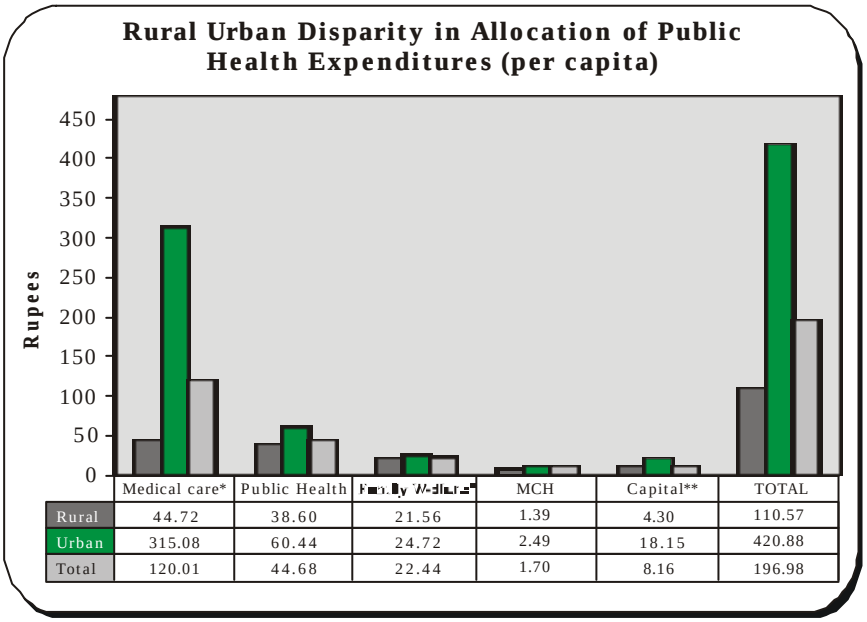


Table 1 a: Rural – Urban Inequities in Public Health Expenditures for Selected States – Percentages, and Totals in Rs. Millions for 2002-03 Actuals

States/ Type of Expenditure (Row Total fig. in Rs. millions)		Medical care*	Public Health	Family Welfare#	MCH	Capital **	TOTAL
Maharashtra	Rural	5.71	60.00	49.97	60.00	0.78	32.51
	Urban	94.29	40.00	50.03	40.00	99.22	67.49
	Total	**7581.82**	**7461.46**	**1305.36**	**207.99**	**960.83**	**17517.48**
Mizoram	Rural	51.90	51.00	63.87	51.00	100.00	55.68
	Urban	48.10	49.00	36.13	49.00	0.00	44.32
	Total	**497.36**	**95.20**	**64.88**	**5.96**	**41.03**	**704.44**
Orissa	Rural	46.89	80.00	90.20	80.00	53.45	58.89
	Urban	53.11	20.00	9.80	20.00	46.55	41.11
	Total	**3082.14**	**787.32**	**697.47**	**28.90**	**378.24**	**4974.07**
Punjab	Rural	42.47	66.00	65.46		0.00	45.40
	Urban	57.53	34.00	34.54		100.00	54.60
	Total	**5331.71**	**411.81**	**359.87**	**0**	**1.31**	**6104.71**
Tamil Nadu	Rural	18.96	54.00	73.07	54.00	75.01	35.01
	Urban	81.04	44.00	26.49	44.00	24.75	64.66
	Total	**8181.76**	**1316.74**	**2192.25**	**186.83**	**483.35**	**12360.95**
Madhya Pradesh	Rural	39.47	73.00	72.80	73.00	90.66	50.03
	Urban	60.53	27.00	27.17	27.00	9.34	49.96
	Total	**5425.96**	**1161.96**	**1018.05**	**0.10**	**182.93**	**7789.02**

* includes health services both allopathy and other system of medicines, minor head includes ESIS, Medical education Dep. Drug manufacture;
# excluding MCH Programme
** Includes capital expenditure of Medical, Public Health and Family Welfare
Note: For about two-thirds of the expenditure there is a clear rural-urban indication in the budget; for the rest we have used our functional knowledge of programme implementation to allocate proportions to rural and urban areas
Source: Finance Accounts 2002-03, respective states.

GRAPH 2



Source: Finance Accounts 2002-03, respective states; proportions of rural-urban expenditures of selected states used to extrapolate for the country as a whole

When the United Progressive Alliance (UPA) government came to power in mid 2004 a new hope emerged because the manifestoes of both the Congress and the CPI(M) talked about increasing public health investments and this even got reflected in the Common Minimum Programme (CMP) of the UPA coalition.

In recent months the political economy of health care has generated the hope of bringing about some significant changes. The Common Minimum Programme of the UPA coalition at the Centre had envisaged raising public health expenditure in the next few years to between 2% – 3% of GDP from the current 0.9% with a strengthened focus on primary health care. The first budget of the UPA government failed to address this issue. In the meanwhile the *Jan Swasthya Abhiyan* with the support of the National Human Rights Commission brought into focus the issue of health care as a right and highlighted the denial of health care within the public health system through public hearings conducted across the length and breadth of the country between June and December 2004.

While this exercise was happening and states were being criticised for their failure to deliver basic health care to the people, the Central Government came up with the idea of a National Rural Health Mission (NRHM) to address the primary health care needs of the rural masses. The National Advisory Council made this a priority issue and pushed the Government to expedite the commitments made in the CMP. A number of consultations were held where experts from across the country deliberated the strategies for making this mission a success. The key elements of the discussion focused on comprehensive primary health care, village/hamlet level health worker christened as ASHA (Accredited Social Health Activist) and decentralisation via panchayats. The process of implementing this has begun in a few states and we have to track and see what happens at the ground level. The *Jan Swasthya Abhiyan*, the Indian chapter of the Peoples' Health Movement, which has been interfacing closely with government through the NRHM and the NHRC has set up a NRHM Watch and is closely monitoring its progress in a number of states.

Populist Provisions in the Budget?

The Finance Minister in the 2005-06 Budget speech[4] said that the increase (Rs. 1860 crores) over the previous budget will finance the NRHM component. This overall increase of 24% in the budget appeared substantial and if it were to be divided equally among all PHCs then each PHC would get additionally about Rs. 8 lakhs, an amount adequate to solve the problems of the average PHC. However the budgetary allocations belie this fact when we see that the increase for the HIV/AIDS programme was 105% from Rs. 232 crores in 2004-05 to Rs. 476.5 crores in 2005-06. Similarly for the RCH programme the increase was a whopping 94% from Rs. 710.51 crores to Rs. 1380.68 crores, for medical education also a high of 50% from Rs. 912.82 crores to Rs. 1360.78 crores and as much as 80% for Indian Systems of Medicine and Homoeopathy (AYUSH) from Rs. 225.73 crores to Rs. 405.98 crores. Just these four programmes account for Rs. 1543 crores (or 83%) of the increased amount of Rs. 1860 crores. Except for the RCH programme the others have very little relation to the NRHM provisions.

Thus the Finance Minister's statement in the budget speech was clearly a populist pronouncement and like all such pronouncements of past budgets similar to the various versions of health insurance packages of different finance ministers, sickness assistance funds etc. is a mirage.

The overall budget of the Ministry of Health and Family Welfare for the year 2004-05 and 2005-06 is outlined in Table 2.

Table 2: Demand for Grants of Ministry of Health and Family Welfare (Rs. Crores)

Category	Budget 2004-05	Budget 2005-06
Medical and Public Health	3103.12	4253.84
AYUSH	225.73	405.98
Family Welfare	6696.37	7769.01
Gross Total Health	10025.22	12428.83
Grants to States and UTs	4663.00	5158.00
Total Health Central Govt.	5362.22	7270.83
Less recoveries	(-)1587.10	(-)1741.72
Net Health Central Govt.	**3775.12**	**5529.11**

Source: Budget 2005-06, Demand for Grants, Demand Nos. 47, 48, 49, Ministry of Finance, GOI, New Delhi, 2005

Table 3: Health Expenditure of State Governments as a per cent of Total Government Expenditure 1981-2006

State/Year	1981	1987	1991	1996	1998	2001	2003	2005	2006
Andhra Pradesh	5.80	7.88	5.53	4.65	5.44	4.74	3.96	3.53	3.57
Arunachal Pradesh	5.91	9.77	4.89	4.66	5.04	NA	4.68	4.45	3.19
Assam	3.96	10.21	NA	5.84	5.87	4.66	3.69	3.06	3.67
Bihar	3.78	8.49	5.10	5.79	5.24	4.01	3.17	3.24	3.47
Chhattisgarh	-	-	-	-	-	4.13	3.99	3.74	3.89
Goa, Daman & Diu	7.19	13.45	8.70	5.39	4.89	3.90	4.02	3.27	3.87
Gujarat	4.38	9.58	5.03	4.70	4.57	3.38	3.21	3.05	2.98
Haryana	4.33	8.25	4.11	2.95	3.27	3.26	2.88	2.59	3.11
Himachal Pradesh	6.63	13.50	3.32	6.16	7.04	5.64	4.50	5.08	4.90
Jammu & Kashmir	3.79	12.50	5.56	5.50	4.97	4.89	5.30	4.78	4.79
Jharkhand	-	-	-	-	-	NA	4.18	3.65	7.25
Karnataka	3.79	8.23	5.40	5.28	5.85	5.11	4.17	3.49	3.73
Kerala	6.56	9.85	7.21	6.53	5.68	5.25	4.74	4.71	5.08
Madhya Pradesh	4.94	10.11	5.16	4.81	4.57	5.09	4.11	3.39	3.84
Maharashtra	4.85	9.38	5.13	4.56	4.29	3.87	3.71	3.51	3.55
Manipur	2.60	12.61	4.38	4.83	4.48	4.82	2.89	3.72	3.36
Meghalaya	6.25	13.25	6.26	6.19	6.86	5.65	5.88	5.23	5.24
Mizoram	7.89	11.85	3.50	4.18	NA	4.96	5.01	3.96	4.25
Nagaland	5.39	10.88	5.96	5.95	5.68	4.87	4.65	4.68	4.64
Orissa	5.17	8.50	5.13	5.16	4.82	4.15	3.75	3.90	4.34
Pondicherry	9.05	10.01	7.82	0.03	0.04	NA	NA	NA	NA
Punjab	3.67	10.52	6.73	4.62	4.93	4.54	3.54	3.10	3.31
Rajasthan	4.85	14.48	6.50	5.70	7.97	5.16	4.24	3.94	4.65
Sikkim	4.49	6.44	7.89	2.72	1.92	3.67	2.03	2.56	2.50
Tamil Nadu	6.18	10.04	6.91	6.29	6.28	4.86	4.10	4.20	4.76
Tripura	2.51	7.37	5.18	14.74	4.79	4.04	3.79	3.79	5.76
Union Government	0.22	0.29	0.56	0.46	0.52	0.77	0.76	0.83	1.12
Uttar Pradesh	4.69	9.08	6.31	6.03	1.74	3.98	3.75	4.49	4.94
Uttaranchal	-	-	-	-	-	3.08	3.77	4.34	4.49
West Bengal	6.30	9.73	8.37	6.43	NA	5.63	4.95	3.94	4.78
All India	**1.52**	**3.95**	**2.93**	**2.01**	**1.75**	**2.77**	**2.41**	**2.42**	**2.77**

Sources: Up to 1987 is Combined Finance and Revenue Accounts, Comptroller and Auditor General of India GOI, respective year; For year 2001 is State Finance A Study of Budget of 2002-03, RBI; For year 2003 - 2006 is Public Finance CMIE, 2005 and State Finances, RBI, 2006.

But this is only a small part of the story, infact only one-sixth of the story. It is the state governments which account for the remaining five-sixths. We often forget this fact when looking at national health budgets and public health spending and hence focus a large part of our energies on advocating with the Central Government. While this may have worked to some extent given the fact that in the last few years the Central health budget has moved from a share of 12% of total public health spending to over 16% presently, this does not have an impact on the national health situation significantly.

States Worst Affected

The situation of state governments is getting from bad to worse where their health budgets are concerned (see Table 3) and this is largely because we have ignored state health ministries in our advocacy strategies, except for few sporadic instances. Thus the major impact on public health spending policies can be analysed when we focus our attention on tracking state health budgets. So let us be cautious in our approach and strategy of budget advocacy.

Table 3 clearly demonstrates that without exception state governments are neglecting public health as is evident with the declining trend of health expenditures post 1991. However the commitment of Central funding shows an upward trend but we need to be cautioned here as this upward movement is to a fair extent fuelled by aid and debt, which is also showing an increasing trend.

How Can We Change The Forthcoming Budget ?

What should we advocate for the next fiscal year?

CMP's Social Commitment

We need to work at two levels. First we should continue to use the CMP mandate of the UPA to demand progressive increase for health allocations to 2% of GDP in the next fiscal year. We should raise this issue prominently to assess the forthcoming health budget. We must demand from the Centre as to how they plan to reach that level of financing and how they will get the state governments to more than double their commitments as per the CMP promise.

Resource Mobilisation

It is not very difficult to raise additional resources if the government has some commitment to the social sectors. A health cess of 2% on sales turnover of health degrading products like alcohol, tobacco products like cigarettes, *guthka*, *beedis*, *paan masalas* etc. which together have a turnover estimated at Rs.1000 billion[5] would itself generate Rs. 20 billion which is 8% addition to the existing health budgets of central and state governments combined. Similarly, the financial transaction tax (Tobin Tax) introduced by the Finance Minister in 2005 needs to be expanded and earmarked for social sector expenditures only (this should be an additional allocation and should not entail reductions from existing allocations out of present tax revenues). India is a rapidly growing financial sector economy and daily transactions in securities (Government, stock market and forex) alone are estimated at Rs. 350 billion per day and other cheque and financial instruments another Rs. 250 billion daily[6] and a 0.1% Tobin tax on this would generate Rs. 60 crores daily for social sector budgets. And this would not hurt those transacting as it would be merely Re. 1 per Rs. 1000 transacted. Apart from this there are other transactions like credit card transactions, commodities trading etc. which can contribute substantially. There are also other avenues for raising resources for the health sector, for example a health tax similar to profession tax, a health cess on land revenues and agricultural trade so that the rural economy can also contribute to revenues for public health, health cess on personal vehicles using fossil fuels, on luxury goods like air conditioners, on house rents and property taxes above a certain value or size etc. The bottom line is that these additional resources should be strictly earmarked for the health sector and should not find their way into the general pool – with this caveat and evidence of its use for strengthening social sectors like health and education people will not protest against such levies. Further any attempts to raise revenues through user fees should be resisted, as they are regressive and anti-poor. There is

evidence from the states which have introduced user fees via the health sector reforms projects that the user fees contribution has failed to improve the efficiency of the public health system and also utilisation of public health facilities have declined due to user fees impacting adversely access of the poor to public health services[7].

Secondly, we need to advocate with both ministries of health and finance for making structural changes in the way in which both resources are allocated as well as how the health system is organised and structured. The present mechanism of allocating resources to health facilities is very inefficient and also ineffective. It does not allocate resources on the basis of the requirements of the health care facility to meet its goals but on an ad hoc basis of what the governments are able to procure and provide. That is, a PHC or a Hospital is not given resources in terms of the services it is mandated to provide but on the basis of staff it is able to employ or drugs that it is able to procure etc. Hence the way resources are allocated needs restructuring.

Restructuring Resource Allocation

Resources must be provided to health facilities whether hospitals or health centres on a block funding or per capita basis. Thus hospitals, for instance, should get funds @ Rs. 300,000 per bed because that is what it requires to run a reasonable district or rural hospital, and a health centre providing comprehensive health care should get Rs. 150- 200 per capita for the 30,000 or 20,000 population it serves to provide a reasonable level of primary health care. This mechanism of financing will factor in rationality and efficiency in allocation of resources for public health. Further, on a longer term basis (3 – 5 years down the line) the health care system both public and private needs to be restructured into a regulated system – this would involve creating a multi-stakeholder national health authority which pools together all health resources public and private, makes payments to health care providers on the basis of defined and structured costs and monitors and regulates such a health care system. This reorganisation must be done within the framework of universal access and equity using the right to health approach and here linking with the *Jan Swasthya Abhiyan's* right to health campaign will be important to synergise efforts in budget advocacy.

It is only such changes that will strengthen and universalise access to health care and create equity in health. Thus the forthcoming budgets of Central and State governments need to proactively pursue the goal of doubling resource allocations for public health and allocate these using principles of global budgeting and per capita basis for allocations, as relevant. Hence the Public Health Budget for next fiscal year with additional resources raised as suggested above should look something like the projection made below:

Table 4: What Public Health Budgets Should Look Like in Contrast to What Exists Presently?

Source	What it Should Be		What it is Presently	
	Amount Rs. Billion	Percent of GDP	Amount Rs. Billion	Percent of GDP
Central Government	100	0.33	55.29	0.19
Grants to States/UTs	100	0.33	51.58	0.18
State/UT Governments	300	1.00	194.37	0.69
Local Governments	100	0.33	30	0.10
Total	**600**	**1.99**	**331.24**	**1.16**

To conclude, the above resources should not be too difficult to raise but what is more important is the political will of the government to take such an initiative. And more importantly the Ministries of Finance and Health have to change the way resources are allocated because the present mechanism leads to a lot of waste of the limited resources which are provided leading to allocative inefficiencies. We have worked out an illustration of how allocations can be made for the above projected resources to strengthen the public health system. (see Annex 1)

To summarise we need to take the following actions:

- Demand raising of resources to 2% of GDP for public health.
- Advocate for changes in budget commitments also at the state level.
- Suggest ways in which additional resources can be raised.
- Advocate for changing mechanisms of how resources are allocated to health facilities.
- Work out details of rational and efficient budgetary allocations for different components of health care provision.
- Strategise how the health care system can be reorganised, restructured and regulated.
- Work towards bringing in a national legislation mandating right to health and health care.
- Synergise actions with the *Jan Swasthya Abhiyan*'s right to health care campaign.

Key Questions and Suggestions:

1. The CMP has committed raising public health expenditure to up to 3% of GDP. The current budget is still below 1%. Will the forthcoming public health budget reflect any serious intent of achieving this goal? We strongly feel that the forthcoming health budgets should achieve at least 2% of GDP in order to show that the government is serious about what they have committed.
2. Raising additional resources is critical to meet the health goals set out in the CMP and subsequently in the NRHM Mission document. How does the government propose to raise these additional resources and earmark it for public health programmes? Some suggestions given below:
    - Health cess (sin tax) on sales turnover of health degrading products like alcohol, cigarettes, tobacco products, *guthka, beedis, paan masalas* etc.
    - Tobin tax on all financial transactions - Government, stock market and forex; bank and credit card transactions; commodities trading and futures etc.
    - A tax similar to profession tax can be put in place as a health tax.
    - A health charge on land revenues, agricultural products, vehicles using fossil fuels, luxury goods like air conditioners and luxury cars etc., health cess on house rents and property taxes of a certain value and size etc.
3. Rural – urban disparity in health care access and resource allocation is very severe. Seventy per cent of the population lives in villages but the resources allocated, as a proportion to population is one-third in rural areas in comparison with urban areas. How does the government propose to reduce this gross neglect of rural India without affecting the present level of urban health expenditures, which are also under stress? We suggest that the allocations of the health budget must be made on a per capita or block funding basis. (See Annexure 1 for an illustration).
4. Health is a state subject and hence the Union Government alone cannot make a difference. How does the government propose to help State Governments achieve the CMP goals and commitments? We suggest that the Union Government engages actively the State Governments on these issues of resource allocations and help strengthen both curative and preventive health care across the country.

Annexure 1

Calculation for Comprehensive Health Care in India[8]

Note: To provide comprehensive health care the entire health system needs to be organised into a regulated system in which private provisioning and financing is also included under a health care system which is under public domain like in the OECD countries as well as a number of developing countries like Sri Lanka, Costa Rica, Jamaica, Brazil etc. The framework and financing for such an organised health care system has been discussed by the author elsewhere[9]. Here we present an illustration of a calculation of how a comprehensive health care system should be financed at different levels of health care.

1. Primary health care (Family Medical Practitioners+PHC) with following features:

- Staff composition for each PHC-FMP unit to include 4 doctors, 1 PHN, 2 nurse midwives, 8 ANMs (females), 4 MPWs (males), 1 pharmacist, 1 clerk/stat asst., 1 office assistant, 1 lab technician, 1 driver, 1 sweeper – this adds up to salaries and benefits/capitation of **Rs. 3,200,000** (salary structures across states may be different and hence this could vary). The doctors (FMPs) and nurses need not necessarily be employees and work for salaries– they could be given the option of being contracted in as is done by NHS in UK for example and serve a fixed number of families and paid a contracted amount as negotiated.
- 10 beds per PHC
- Average rural unit to cover 20,000 population (range 10-30 thousand depending on density); average urban unit to cover 50,000 population (range 30-70 thousand population depending on density)
- Non-salary costs separately for rural and urban units per unit cost as per table below:

Line item	**Rate**	**Rural (20000 popn. per unit)**	**Urban (50000 popn. Per unit)**
Medicine and other clinical consumables	Rs. 25 per capita per year	Rs. 500,000	Rs. 1,250,000
Travel, POL etc.	Rs. 6000 pm rural; and Rs. 3000 pm urban	Rs. 72,000	Rs. 36,000
Office expenses, electricity, water etc.	Rs.10 and 12 thousand for rural and urban, respectively	Rs. 120,000	Rs. 144,000
Maintenance of building and equipment etc.		Rs. 100,000	Rs. 200,000
Rent and/or amortisation		Rs. 144,000	Rs. 240,000
CHW honorarium	Rural 1 CHW per 500 population @Rs. 1000 pm per CHW; Urban 1 CHW per 1500 population @ Rs. 1250 pm per CHW	Rs. 480,000	Rs. 495,000
Total Non-salary		**Rs.1, 416,000**	**Rs.2, 365,000**
Total Primary care Cost per unit		**Rs. 4,616,000 (Rs. 224 per capita)**	**Rs.5, 565,000 (Rs. 109 per capita)**
Total Primary care cost for country	**Rural: 700 million population needing 35,000 PHC/FMP units; and urban 300 million population needing 6000 units**	**Rs. 162 billion**	**Rs. 33 billion**

2. First level Referral Care

In **rural areas** for every 5 PHCs there would be one 50 bedded hospital and this would cost Rs. 225,000 per bed per annum or Rs. 11.25 million per such hospital. As per this ratio we would need 7000 rural hospitals and this would translate into **Rs. 79 billion** for the country as a whole.

In **urban areas** for each 10 PHCs one 200 bedded hospital would be needed and this would cost Rs. 250,000 per bed per year or Rs. 50 million per hospital. As per this ratio 600 such hospitals would be needed and this would translate into **Rs. 30 billion** for the country as a whole.

3. Secondary and Tertiary care / Teaching Hospitals

One such hospital per 2.5 million population, that is 400 hospitals of 500 bed each at a cost of Rs. 350,000 per bed per year translating into Rs. 175 million per hospital or **Rs. 70 billion** for the country as a whole.
Primary + First Referral + Secondary/Tertiary = Rs. 373.95 billion

4. Other costs

Capital @ 10% or Rs. 37.39 billion
Research and Data systems @ 4% or Rs. 14.96 billion
Admin costs @ 4% or Rs 14.96 billion
Audit costs @ 2% or Rs 7.48 billion

Grand Total would be Rs. 448.74 billion or Rs. 450 per capita and this works out to 1.5% of GDP. This calculation excludes medical education and medical research, which would be 15% and 10% of the total health care cost, respectively, amounting to an additional Rs.112 billion.

Summary Table

Type of Cost	Amount in Rupees billion
1. Primary care	195
2. First Referral Rural	79
3. First Referral Urban	30
4. Secondary/Tertiary care	70
SUBTOTAL	**374**
5. Capital @ 10%	37
6. Research and data systems @ 4%	15
7. Admin @ 4%	15
8. Audit @ 2%	7
TOTAL Health Care Cost	**448 or 1.5% of GDP**
Medical Education and Research	**112**
Grand Total	**560 or 1.9% of GDP**

References

1 The percentages have been worked out from the Finance Accounts of respective years; for the latest year the budget estimates from the Reserve Bank of India were used; national income data was taken from the Economic Survey.

2 NSSO -1996: Report No. 441 – 52nd Round, NSSO, GOI, New Delhi, 1998.

3 Rao C S : Indian Insurance Industry – New Avenues of Growth, Oct, 18 2004 www.ficci.com accessed 20-2-2006.

4 Budget Speech of Finance Minister – Budget 2005-06, Ministry of Finance, GOI, New Delhi 2005.

5 MoHFW, 2004: Tobacco Control in India, www.mohfw.nic.in; and www.tobaccojournal.com accessed 20-2-2006.

6 RBI Bulletin September 2005.

7 Mahal Ajay and Veerabhraiah N, 2005, User Charges in India's Health Sector - an Assessment, in Financing and Delivery of Health Services in India, National Commission on Macroeconomics and Health, GOI, 2005, New Delhi.

8 This calculation was originally done for a Jan Swasthya Abhiyan discussion on the National Rural Health Mission. It is now updated to 2005 prices. The parameters / benchmarks used are based on experience of costs and expenditure patterns of optimally run health care facilities in the government and NGO sector. This illustration is approximate and further details will have to be worked out when such a plan is implemented.

9 Duggal Ravi, 2004: Operationalizing Right to Healthcare in India, ICFAI Journal of Healthcare Law, August 2004, Vol2, No. 3, pgs 13-42.

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Note: This macro analysis is the first part of the budget analysis and a second part on disaggregated analysis of budget data will follow soon.

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CEHAT, in Hindi means "Health". CEHAT is the research centre of Anusandhan Trust and is actively involved in research, action, service and advocacy on health and allied themes. Our projects are focused on four themes, (1) Health Services and Financing (2) Health Legislation, Ethics and Patients' Rights (3) Women's Health and (4) Investigation and Treatment of Psycho-Social Trauma. We have a multi disciplinary team with experience in Medicine, Social Sciences, Social Work, Journalism and Law, which undertakes research and advocacy for betterment of disadvantaged masses of our society, for strengthening people's health movements and strives towards realising right to health and health care.

Related Publications:

1. Duggal, Ravi, Dilip T.R and Raymus Prashant ***Health And Healthcare In Maharashtra – A Status Report,*** **October 2005,** [**Rs. 100/-**] ***pgs. 79.***
The book has six chapters which focus on socio-economic and demographic profile of Maharashtra, the organisational structure and systems of public health care services at various levels in urban as well as rural areas, the physical infrastructure for delivery of health care services and the wide rural-urban disparity in access to these services, review of healthcare facilities available in public sector in the state, analysis of declining public expenditure on health care services including curative care as well as preventive and promotive programmes and some indicators of health status such as infant mortality, child mortality, life expectancy, morbidity and hospitalisation, nutritional status, water supply and sanitation in Maharashtra. The discussion in all chapters is analytic and backed by strong evidence in 46 tables with time-series data on a wide range of health and related issues.

2. Gangolli, Leena V; Duggal, Ravi and Shukla, Abhay ***Review of Healthcare in India***, **January 2005 [SB Rs.250/-] [HB Rs.500/-] pgs. 400**
This volume contains 18 chapters and discusses such varied topics ranging from the state of the preventive health and nutritional services for children to the community health worker programme and the public health system. In addition to the articles, the book contains an appendix of statistical data, a valuable tool for researchers and activists.

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