No Respite for Public Health

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Health allocations in Budget 2016–17, which show a modest increase in nominal terms, must be viewed against the virtual stagnation of allocations since 2010–11, and the major cuts of 2015–16. Meanwhile, state governments' investments in health grew steadily. The centre has only prioritised initiatives that stimulate private health sector growth. This approach will have immediate adverse effects on availability and quality of public health services and will cause impoverishment due to healthcare costs, compromising economic growth in the long run.

The Union Budget 2016–17 for health sector disappoints again, but does not surprise us. Since 2012, the systematic policy incongruence between what government states as policy, and what it does in terms of budget allocations, has become an established feature of Indian public health policy. The major sections of media remain studiously silent on this, either because they endorse it, or because it is no longer news. To a casual observer, it is not as obvious as to those who have been tracking public health expenditures. It is only the packaging of the bad news that seems to change.

Centre and State Allocations

In Budget 2016–17, total allocation on health through various ministries and departments is ₹39,571 crore, as against an allocation of ₹32,742 crore for 2015–16. This is a 20% increase in nominal terms. As against ₹34,956 crore in the revised estimates it works out to a 14% increase. Usually, the revised estimates are significantly lower than the allocations in the budget proposals, so when next year's allocations are compared to the revised estimates, it makes the increase look greater than it actually is. But last year, rather unusually, the revised estimates had to be increased, not decreased. The budget proposals were such a sharp cut, that even routine activities and commitments could not be pursued, and a mid-term increase in budgets became essential.

The real picture emerges only when we look at changes in actual expenditure in real terms (Table 1 and Figure 1, p 40) over a longer time period. Prices have increased faster than health budgets since 2012–13. If we factor this in, then in real terms both allocation and expenditure went down over this period. The actual expenditure for 2014–15 was lower than the expenditure during 2011–12. We do not know what will be the cuts into revised estimates or actual expenditures this year, and so we need to compare the current budgetary allocations with corresponding budgetary allocations made earlier. In such a comparison, this year's budget proposal is lower than what was allocated in 2014–15. It is only the sharp decline of the previous year that makes this year's budget look better than it really is.

The budgetary allocation and expenditure trends since 2012–13 are in sharp contrast to the period from 2004–05 to 2011–12 when considerable expansion of union government expenditure took place. The growth of union government spending in real terms between 2004–05 and 2009–10 was 13.85% (Figure 2, p 40). In the subsequent period, from 2010–11 to 2014–15, the growth in public health expenditure plummeted to -0.31%, a

Table 1: Budget Allocations

Year	Current Prices				Constant (2004–05) Prices		
	Allocations	Revised Estimate	Actual Expenditure	% Difference between Allocation and Expenditure	Allocations	Revised Estimate	Actual Expenditure
2005–06	10,687	10,040	9,650	9.7	10,253	9,632	9,259
2006–07	12,994	11,758	10,948	15.7	11,675	10,564	9,837
2007–08	15,855	14,974	15,048	5.1	13,389	12,645	12,707
2008–09	18,123	18,476	17,661	2.5	14,037	14,311	13,680
2009–10	22,641	21,680	20,982	7.3	15,600	14,938	14,457
2010–11	25,154	25,055	24,450	2.8	15,695	15,633	15,256
2011–12	30,456	28,353	27,199	10.7	17,541	16,330	15,665
2012–13	34,488	29,273	27,885	19.1	18,016	15,291	14,567
2013–14	37,330	30,847	30,135	19.3	18,071	14,933	14,588
2014–15	37,930	31,038	32,154	15.2	17,247	14,113	14,620
2015–16	32,742	34,956	–	–	14,068	15,019	–
2016–17	39,531	-	–	–	16,505	–	–

Source: Expenditure Budget, Vol 2; Union Budget, various years, www.indiabudget.nic.in, viewed on 25 March 2016; All India Average Consumer Price Index (industrial workers), Labour Bureau, http://labourbureau.nic.in/indexes.htm, viewed on 25 March 2016; price base: 2001.

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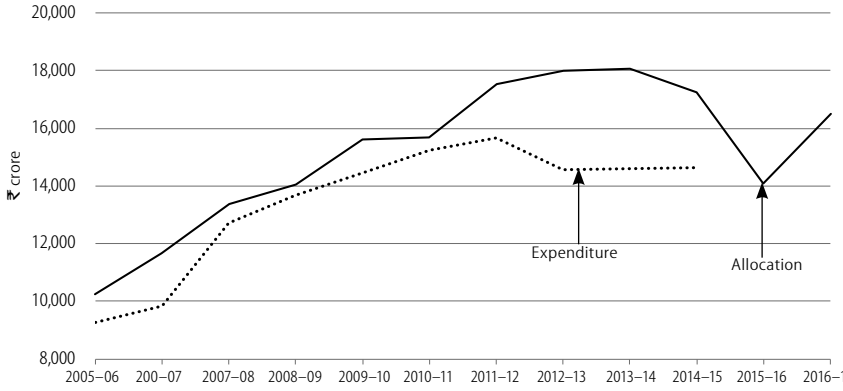
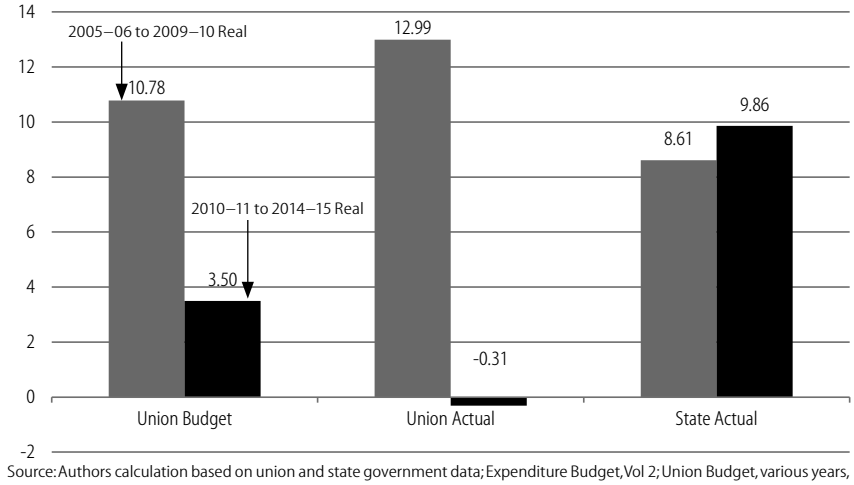
Figure 1: Allocations and Expenditure on Health by Union Government (Constant 2004–05 Prices)



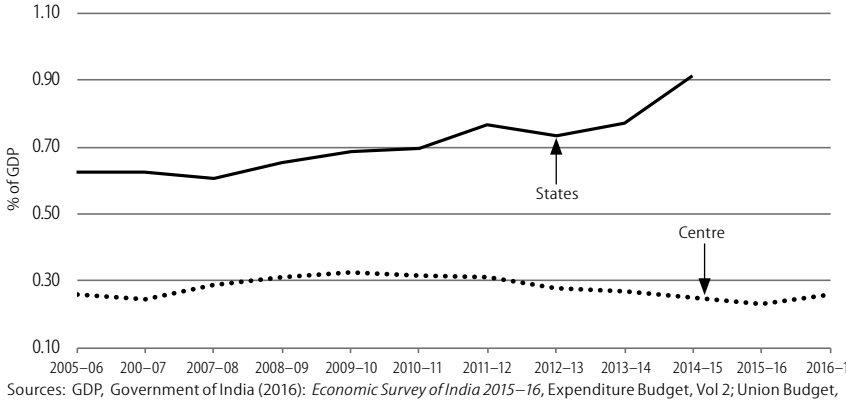
Source: Same as Table 1.

Figure 2: CAGR of Allocation and Expenditure, Current and Constant Prices (2004–14 prices)



Source: Authors calculation based on union and state government data; Expenditure Budget, Vol 2; Union Budget, various years, www.indiabudget.nic.in; viewed on 25 March 2016; *State Finances: A Study of Budgets*, Reserve Bank of India; various years.

Figure 3: Union and State Government Expenditure on Health as % of GDP and SGDP



Sources: GDP, Government of India (2016): *Economic Survey of India 2015–16*, Expenditure Budget, Vol 2; Union Budget, various years, www.indiabudget.nic.in, viewed on 25 March 2016; *State Finances: A Study of Budgets*, Reserve Bank of India; various years.

decline in expenditure in real terms. It has been argued that since states do not have the capacity to spend, additional money allocated remains unutilised and hence an increase in budgets is unwarranted. The gap between allocations and expenditures for most of the period from 2005–06 to 2010–11 has been lower than that for the latter years (Figure 1). Therefore, we need to examine more closely the argument of low absorptive capacities of the states and see its linkages with the changes in financing policies being practised.

State balance sheets reveal a different story. Between 2005–06 and 2014–15, expenditure by states increased by 19.24%; after adjusting for rise in prices, this comes to a healthy 9.25%. Fund absorptive capacity also gradually increased. But what is notable is that during the period of 2010–11 to 2014–15, when union government spending virtually declined, spending by states actually grew at close to double-digit rates (9.86%). However taken together we are still far short and worsening with respect to the commitment made by the erstwhile Planning Commission, reiterated in the recent draft National Health Policy (MHFW 2015; Planning Commission 2011, 2012), to reach 2.5% of the gross domestic product (GDP) (Figure 3). The states can certainly do more, and indeed the state share of the National Health Mission (NHM) budget has been increased from 25% to 40%. But it is unrealistic to expect the states to take the major part of the burden of reaching the minimal levels of public health expenditure that is urgently required.

The union government's spending on health as percentage of GDP is the lowest since 2005–06 (Figure 3). The only explanation for this is the push for fiscal consolidation, the burden of which is borne by a reduced investment in health and education. Public expenditure for creation of physical capital—with private ownership in areas like infrastructure and defence—has become an acceptable option and investment for the future, but increasing investments for the creation of social capital is perceived or projected as part of fiscal profligacy which can be cut back to reach fiscal consolidation targets.

Routing via Private Partnership

The only context when any pro-poor public expenditure in social sectors seems acceptable in this economic regime is when they are routed through the private sector—giving further fillip to the runaway growth story of the private healthcare industry—unmindful of the serious adverse consequences this has had in increasing inequity and impoverishment. Thus, the only three specific "new initiatives" mentioned in this year's budget proposals, the National Dialysis Services Programme, a proposed National Insurance Programme, and the expansion of Jan Aushadhi scheme, would all fit snugly into such an understanding.

No further funds are to be provided for the National Dialysis Services, but part of existing NHM funds are to be rerouted through private partnerships. Dialysis machines are to be given exemptions from duties. Dialysis services are a matter of great urgency as many states report considerable increases in chronic kidney disease. However, dialysis is only one procedure, in a long chain of nephrology (kidney-related) services. A combination of various kind of measures for prevention from kidney disease which delay the onset of requirement for dialysis in those affected, alongside managing the co-morbidities that are invariable, and provisions for renal transplantation where required are essential for effective management of kidney-related conditions.

The Ministry of Health's proposals have always rooted for a major scheme to strengthen all services in a district hospital in an integrated fashion. Within such an approach, dialysis services, even if assumed to be outsourced, would be useful and viable. But there is no such larger commitment visible, only the eager leveraging of one more "public private partnership opportunity."

The current proposal for a new insurance scheme is similar. There is no such scheme ready for launch, and it is unlikely that within a year, the institutional mechanisms to create a national scheme, and the complex negotiations that would be needed with many states that already have fairly large publicly-funded insurance schemes of their own, would be completed. Further, a number of studies have failed to show the effectiveness of publicly-funded health insurance as a vehicle of financial protection (Virk and Atun 2015; Ghosh 2014; Nandi et al 2013; Selvaraj et al 2015). Rather, most studies point to concerns with respect to publicly-financed insurance: especially supply-driven service utilisation, lack of awareness of entitlements, and out-of-pocket outpatient care which forms the bulk of expenses. Raising the cap on sum assured is not the first priority.

Current financial cover under Rashtriya Swasthya Bima Yojana (RSBY) is about ₹30,000, which is proposed to increase to ₹1,00,000, with additional benefits for the elderly. This would definitely shoot the premium significantly upward. Thus, the funds provided, about ₹1,500 crore, would be inadequate to cover the current RSBY's requirements and are nowhere near the minimum required for such an expansion.

In many states formal or informal ceiling of number of hospitals empanelled has been one way of rationing services to curtail the runaway costs that are always associated with most insurance schemes. Those hospitals that are already empanelled may have the tendency to charge more in order to benefit from enhanced coverage. But it is uncertain whether effective coverage in terms of reduction in out-of-pocket expenditure, which is the central problem, would be substantial.

There is yet another side of the insurance schemes, which is much talked about but much less studied empirically: what are the mechanisms in place to control supplier-induced demand? This is a vexing question and every country that has adopted the insurance model (publicly- or privately-financed) has wrestled with this issue with varying degrees of success. In every closed door meeting with concerned stakeholders, the discussion often and soon turns to this question. We are of the view that with lack of progress on regulation of the private sector, insurance per se is not the right public policy option to pursue in the current context in India. Government money can and should be spent more wisely.

The statement on expanding Jan Aushadhi stores is similar. All official policy statements, including the Draft National Health Policy (MHFW 2015) have been pushing to make free drugs and diagnostics available through public health facilities. This provides the most effective and immediate relief against the costs of care. Though many states have already moved in this direction, the Budget Speech fails to mention or expand funding for this. Instead it calls for an expansion of the Jan Aushadhi scheme, which is the establishment of government-run pharmacy stores selling generic drugs against private sector prescriptions. Since private sector has strong interest in prescribing only branded drugs, this token gesture towards making care in the private sector more affordable is likely to have minimal impact.

But the real danger does not lie in all these aspects. The real danger is that these powerful signals to the private sector are accompanied by a squeeze of the NHM's financing. As per the Budget Speech, NHM allocation in this year's budget is ₹20,037 crore. This would mean a mere 0.3% increase in allocation in constant prices. But the budget figures do not add up to ₹20,037 crore; rather we calculate it at ₹19,037 crore. This would mean a reduction of 4.7% at constant prices.

Another development this year is the allocation of ₹400 crore to the department of ayurveda, yoga & naturopathy, unani, siddha and homeopathy (AYUSH) under NHM. Subsequently the National AYUSH Mission has no allocation. Even if we add this component of AYUSH, the total budget for NHM is ₹19,437 crore, which means a reduction of 2.7% compared to previous year. The turnaround of many essential public services and the strengthening of public health systems, which NRHM had triggered in states, would be halted by these cuts. Anecdotal reports and newspaper articles suggest that, serious gaps, especially in the already weak situation in human resources for health, have begun to worsen again.

New Schemes, No Finance

In this period many new schemes have been launched. For example, the National Urban Health Mission increases geographic and population coverage greatly; vaccines in the immunisation system have been increased; and now the National Dialysis Services has been announced, without a corresponding increase in additional financing. The consequent belt-tightening of core requirements means more work but with reduced human resources. Without adding to the workforce at every level the problems of quality of care and availability of services is only likely to worsen.

Two arguments that are used in different platforms to justify these cuts need to be examined further. The first of these relates to poor absorption of

funds. In response, one must begin by noting that poor absorption is first and foremost an accurate indicator of very poor governance. Any government must hold itself accountable for it. Second, when funding is sub-threshold, with provision for some components but a failure to fund essential corollaries—the most important being a well-trained and skilled workforce, with adequate numbers of capable mid-level managers—funds given for new services and schemes would necessarily fail to get absorbed.

Unfortunately public policy is driven by an obsession with keeping public employment low and this combined with inappropriate human resource management policies and skills leads to less than optimal value for money. And third, institutional mechanisms of public financing are so poorly constituted with high transaction barriers that holding mid-level managers responsible for what is clearly a governance failure at the highest levels will not solve the issue. Finally, it is likely that at least part of the poor absorption is failure to release budgeted funds on a number of administrative technicalities, but essentially driven by the need to achieve targets for reducing fiscal deficit.

The second argument is the rationale advanced for routing public investments through the private sector, based on a claim that the latter makes more efficient use of resources. There is little evidence to support such a claim, and much evidence that contradicts it. But even if it were to be true, there are many vital roles that relate to health as a public good—disease surveillance and epidemic preparedness, for example, or the prevention of the rising tide of non-communicable disease—where the private sector cannot substitute for an effective public health system.

As a result, despite a huge growth in the private sector-based health services, age-standardised mortality rates for non-communicable diseases are now far higher in India than in any developed nation and there is still no universal primary healthcare programme in the public sector that addresses this rising tide. Nor is there any effort to expand the very selective packages of care that fund-constrained district health systems are providing currently. The National Health Policy draft admits that current district and sub-district health services address less than 15% of all morbidities, and this, more than any other single factor, forces the public to seek care either in the private sector or in the overcrowded mega public health hospitals.

One of the lessons that nations need to learn from the Ebola crisis of Western Africa is that when nations fail to invest in public health systems, they lay themselves open to deadly epidemics that could threaten the health security and economy of a nation. The Ebola crisis ravaged precisely those nations in Africa which had seen a decade of structural adjustment-driven reforms which had left their public systems understaffed and dysfunctional.

The damage to industry and growth rates that such an epidemic would do is mind-boggling. The finance ministry is apparently responsive only to the needs of the industry, defence and economic growth rates. Without sounding alarmist, it would be useful to remind the ministry that chronic and sustained under-financing of public health systems over the last four years has now reached such critical levels, that there is a serious threat to health security of the nation as well as to its economic growth—not only in the long run, but also in the immediate—not only for the poor, but for everyone.

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