Public Financing for Health Coverage in India

Who Spends, Who Benefits and At What Cost?

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Any discussion on universal health coverage in India is premature without a comprehensive understanding of public financing of health coverage in the country. This article analyses the government's share of financial resources for health across different agents, with particular focus on resources for health coverage. An attempt is made to separate spending for health in general and health coverage in particular, and to examine the issue of equity. The analysis indicates that the present health coverage system is inadequate and iniquitous, with various systems running at different costs. It suggests consolidating finances and moving towards a more unified system to realise the benefits of efficiency gains.

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1 Introduction

Given the current global focus on universal health coverage (UHC), government spending on health from domestic sources increasingly takes on a central role. While government allocations to health goods and services could in principle be based on ethical (poverty, horizontal and vertical equity, and the rule of rescue), political, and efficiency (public goods, externalities, catastrophic cost, and cost-effectiveness) criteria (Musgrove 1999), the UHC agenda, to begin with, calls for a much higher quantum of spending by the government. Any discussion on UHC is, therefore, somewhat premature in the absence of a comprehensive understanding of the public financing aspects of health coverage in the country. The amount and composition of public resources for health comprise an important policy factor that determines adequacy as well as fairness in financing of healthcare.

While raising sufficient resources is critical, the other two functions of a sound health financing system are pooling of funds to spread risks, and the purchase/provision of services in an efficient and equitable manner (Carrin et al 2008). These are equally relevant in a context of suboptimal resource availability and inefficient allocation of resources. Thus, without a proper analysis of "what is", one cannot venture into a discussion of "what can be" or "what needs to be done".

Most of the studies pertaining to health coverage in India focus on the high out-of-pocket spending by households, with far fewer studies on government finances. One major reason for this could be the lack of exhaustive and comparable information on government health finances available in the public domain. First, there has been no recent account of health spending in India based on national health accounts (NHAs). The first NHA was for the fiscal year 2001-02, followed by another NHA for 2004-05 (GoI 2005b, 2009). Despite its importance, the NHA has not been updated since 2004-05.

Second, information on public expenditure on health in India suffers from definitional ambiguities, making research on public financing of health a somewhat daunting task. For example, the Reserve Bank of India (RBI) provides data on public expenditure on health both at the central and state levels. However, this expenditure corresponds to the expenditure incurred only by the Ministry of Health and Family Welfare (MoHFW; departments in the case of state governments), and ignores expenditures on health made by other ministries and departments, the major ones being the Ministry of Labour and Employment (MoLE), Ministry of Defence (MoD), and Ministry

of Railways (MoR). The RBI statistics are not comparable with the health expenditure reported by *Indian Public Finance Statistics* (IPFS), an annual publication of the Ministry of Finance, which includes water and sanitation in its definition of health expenditure.

There have been estimates of total health expenditure, including government financing, by the National Commission of Macroeconomics and Health (GoI 2005a); the High Level Expert Group on UHC (GoI 2011); the Planning Commission (GoI 2013); and the World Health Organisation (WHO) Global Health Expenditure Database. These and a few other studies (Choudhury and Amarnath 2012) indicate that the centre and states together spend between 1% and 1.5% of the gross domestic product (GDP) on health, although the composition of this is not available in the public domain for most of the estimates. The discussion on public financing for health coverage is far sparser. How much does the government spend on extending coverage, and who gets covered? How many separate models exist, and how do these models compare with each other, especially on costs?

This article attempts to answer these questions. At the outset, it analyses government financial resources for health in India across different agents, with an additional focus on resources for health coverage. In particular, we focus on aggregate government finances for health across sources and levels of government. Further, an attempt is made to separate spending for health in general and health coverage in particular.

2 Public Finances for Health

Public financing for health is done by all the three tiers of government – central, state and local. The central government ministries that spend on healthcare include the MoHFW, MoLE, MoR and MoD. These ministries are mentioned in most discussions on health spending in India. In addition, all central ministries/departments also spend on the healthcare of their employees in the form of medical reimbursement or an allowance, which comes under the Central Government Health Scheme (CGHS), a key health coverage programme for central government employees.

Health being a state subject, a major proportion of expenditure is at this level. The state departments of health and family welfare are key spenders. Analogous to the CGHS, all departments of state governments reimburse medical expenses to their employees, though the specific modalities differ across states.

As for local governments, despite the 74th constitutional amendment that envisages a greater role for the third tier of government, their contribution to health spending is insignificant, barring a few large urban local bodies. Also, there are substantial variations in local government expenditure across states, depending on the extent of devolution of functions, funds, and functionaries in particular states.

While it is relatively straightforward to access expenditures by the central ministry and state departments of health through published sources such as the MoHFW budget and the RBI database, it is more difficult to find expenditures on health by other departments – centre and state – in any single location. As for local bodies, the only source of comparable data on finances of local bodies is the finance commission, which is, however, too aggregated to be useful in such an analysis. Yet another complexity is the possibility of double counting arising from intergovernmental transfers in a federal set-up – the centre provides grants and loans to state governments and these appear in both the centre's and states' budget figures. It is important to net these amounts out from one or the other aggregate to arrive at the correct figure.

An Annex (p 63) presents the major sources of public finance in health, with information on coverage, financing arrangements, and the source of data. For estimating local government expenditure on health, we have computed the ratio of local government to state government spending from the NHA (2004-05) and applied it to the state government's total spending for the current year.

3 Public Spending

To understand health coverage spending by the government, we first estimate total public financing for health in the country. Table 1 gives the total public finances for health in 2010-11.[1] It was Rs 80,155 crore or $17.6 billion – about 1.03% of GDP at current prices. The bulk of the spending (64%) came from state governments, with the centre spending about 31%. The MoHFW spends only 21% of the total amount. Clearly, it is not the major player as far as public spending on health in the country is concerned. The only other ministry that spends a substantial amount on health is the MoD (7.4%) through its elaborate system catering for employees of all the three services.

Table 1: Government Spending on Health (2010-11)

Financing Source	Total Spending (Rs Crore)	Share (%)
Centre	25,019 (5.5)	31.2
Ministry of Health and Family Welfare	16,891 (3.7)	21.1
Ministry of Labour and Employment	512 (0.1)	0.6
Ministry of Defence	5,914 (1.3)	7.4
Ministry of Railways	1,433 (0.3)	1.8
All other ministries (CGHS reimbursement)	269 (0.1)	0.3
State	51,206 (11.2)	63.9
Local bodies	3,930 (0.9)	4.9
Total	80,155 (17.6)	100

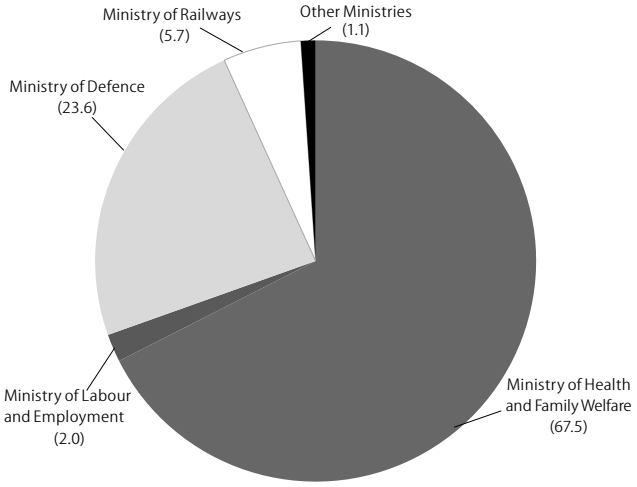
* Figures in parentheses are the equivalent expenditures in billion dollars. The average exchange rate of the Indian rupee for a US dollar in 2010-11 was Rs 45.5768, according to the RBI.

Figure 1 (p 61) shows the sources of funding of the central government expenditure on health. The MoHFW contributes 68% of all central government funds for health, followed by the MoD (24%). The railways contributes a significant amount (6%) of total central spending on health, followed by the MoLE (2%), which spends on health through its national health insurance scheme (Rashtriya Swasthya Bima Yojana, or RSBY) for below the poverty line (BPL) households.[2]

4 Public Spending on Health Coverage

How does the total expenditure of the government distribute itself between health coverage-related spending and all other spending? While the entire public sector health infrastructure

Figure 1: Composition of Central Government Expenditure on Health (%)



is designed to provide subsidised or free care, and can be thought of as some form of "coverage," we do not include such services in definitions of health coverage here. Instead, we focus on the additional expenditure that the government incurs in running special schemes for extending health coverage to specific groups of the population.

This approach can be rationalised by posing a counterfactual – would the public health facilities in schemes such as the CGHS and RSBY have existed if these schemes were not there? The answer is yes. These schemes use the same public health infrastructure that was created in the country with the vision of catering for citizens through free or subsidised care.[3] The existence of these schemes, therefore, has not directly resulted in new spending on personnel and infrastructure. However, the same cannot be said of the defence and railway health infrastructure that was created to cater for the relevant sub-populations.

We classify, therefore, the expenditures of the CGHS and RSBY under health coverage, without adding the expenditure on the public health infrastructure that is used to run these schemes. However, we include the entire expenditure of the defence and railways ministries as expenditure under health coverage. In Table 2, we include under central schemes the CGHS (inclusive of medical reimbursements by other central ministries), defence and railways health services, and the RSBY. For state governments, we categorise the portions of the RSBY and Employees State Insurance Scheme (ESIS) that are state-financed, and the reimbursement for state employees as coverage expenditure.

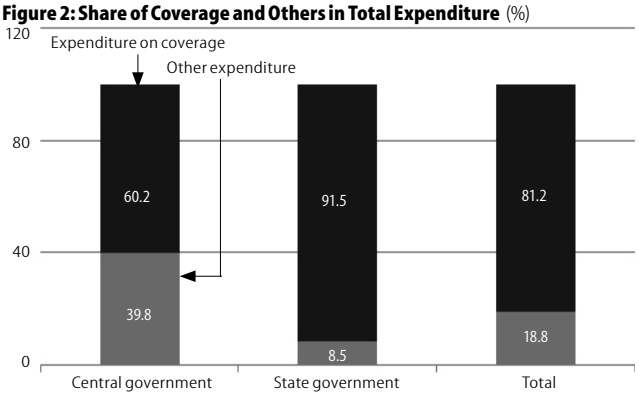
Table 2: Government Spending on Health Coverage by Source

Source	Expenditure on Coverage (Rs Crore)	Percentage Composition
Central government	9,965	69.6
Ministry of Health and Family Welfare	2,106	14.7
Central Government Health Scheme[a]	2,106	14.7
Ministry of Labour and Employment	512	3.6
Rashtriya Swasthya Bima Yojana	512	3.6
Ministry of Defence	5,914	41.3
Ministry of Railways	1,433	10.0
State governments/state contribution	4,354	30.4
Department of Health and Family Welfare	1,882	13.1
Employees State Insurance Scheme	416	2.9
Rashtriya Swasthya Bima Yojana	171	1.2
Other departments (medical reimbursement/allowance)	1,886	13.2
Local governments	0	0.0
Total	14,320	100.0

The centre-state division on expenditure on health coverage is now 69:31, with the centre spending the major share. The major contribution comes from the MOD. The CGHS contributes 12% to total spending for coverage if one includes the medical reimbursement under this scheme from other ministries. Thus, while states spend relatively more on total health, the centre spends more in total spending for health coverage.

Figure 2 shows the percentage of government spending between coverage and other expenditures. Since expenditures by local bodies are based on the assumptions mentioned earlier, and not actual figures, we do not include them in the analysis.

Figure 2: Share of Coverage and Others in Total Expenditure (%)

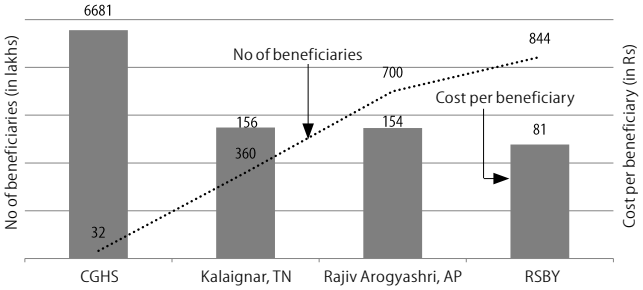


Overall, around 19% of all government health funds go specifically into spending for health coverage. The remaining is spent on the operation and maintenance of the general health system. Between the centre and the states, the centre spends about 40% and the states about 9% of their respective total expenditures on direct health coverage.

5 Comparing Models of Health Coverage

It needs to be mentioned that the schemes discussed here are quite disparate in terms of coverage, the level of care or the "benefit package", and geographical reach. Self-contained health schemes such as the ones offered by the MOD and MOR, and the CGHS are truly comprehensive in terms of the level of care (primary, secondary or tertiary) and type of services (outpatient and inpatient) provided. This is not so for some of the state-level health schemes and the RSBY, which includes inpatient treatment only within their ambit. Another issue is that of geographical presence – the CGHS facilities are available in only 25 cities in India, whereas the RSBY is universal in terms of its presence. The state-run schemes are by definition only valid for those residing in specific states. The management of the various schemes is non-uniform, with different parts of the government being involved in operationalising them.

Figure 3: Cost Per Beneficiary of Selected Health Coverage Schemes



How much does it cost to run the various health coverage schemes? In Figure 3, we estimate spending per beneficiary as an indicator of the relative cost of some of the major government-run health coverage schemes. The CGHS costs are presented along with other programmes that run through existing public sector facilities (and private as well) such as Kalaignar (Tamil Nadu), Rajiv Arogyasri (Andhra Pradesh), and the RSBY. All except the CGHS are mainly for tertiary care and hospitalisation, and targeted at BPL people. The CGHS includes outpatient care and covers all central government employees across economic classes. We indicate the size of population covered using a dotted line.

The first point to note is that the CGHS is much more costly than the other programmes. While inclusion of outpatient care might be cited as a reason, it is not clear that this should necessarily increase per beneficiary cost. It can be argued that since the other schemes are for tertiary care, focusing on tertiary in the CGHS will only increase costs. In any case, the differences in costs are too much for this alone to be the reason.

Similarly, if we compare self-contained schemes (not shown here), the costs per beneficiary of the railways (Rs 2,254) and defence (Rs 5,938) ministries are much higher than the ESIS per beneficiary cost (Rs 552). While defence should be treated differently, it is not immediately clear why the ESIS and railways costs are different unless this can be explained by the kind of people covered and the services they avail themselves of (the ESIS covers blue-collar factory workers and the railways cover all employees).

What do these various numbers indicate? Clearly, costs could vary depending on a variety of conditions, an important one being scope of coverage. For those with similar coverage, the cost differences could be due to efficiency issues. If we believe that all the schemes have similar reach and are able to meet the objective of reaching the people they are targeting, then the more inexpensive schemes offering similar services are clearly more efficient.

Figure 3 indicates that there may be economies of scale in health coverage programmes – the larger the coverage, the lower the cost.

This brings us to another important issue. A key policy concern with government resources for healthcare is whether they are well targeted and reach the most needy (WHO 2005a). The dotted line in Figure 3 indicates that the CGHS covers a very small sub-group at very high costs, whereas the other programmes, which are targeted at the poor, cover more people at lower costs. While a proper benefit-incidence analysis is required to understand who benefits from government subsidies, our analysis indicates that the current system of public health financing for health coverage is quite iniquitous.

6 Summary and Implications

The MOHFW spends only about 15% of the total public health expenditure in the country. This raises concerns about its ability to increase its spending to the level required for moving towards UHC. Any move towards UHC needs to be implemented with the active and willing participation of state governments, who are the major spenders. The inability of states to raise their expenditures to any significant extent has been discussed elsewhere (Gupta and Chowdhury 2013). The recent increase in centrally-designed and sponsored schemes such as the National Rural Health Mission (NRHM), which require matching contributions from the states, have imposed a burden of committed expenditure on already resource-starved state governments. In spite of this, a UHC blueprint cannot, and should not, be drawn up solely by the central government or the MOHFW.

Second, the article raises important concerns on the roll-out of UHC. There has been much debate and discussion on UHC in India in the recent past. In October 2010, the Planning Commission constituted a High Level Expert Group (HLEG) on UHC with the mandate of developing a framework for providing easily accessible and affordable healthcare (GOI 2011). However, since the vision is not accompanied by any costing, it avoids the public finance implication of a new comprehensive system of health coverage in the country. Our analysis indicates that the government spending on health is now only about 1% of GDP. Of this, a very small percentage goes into supporting health coverage (19%). The current system of coverage by the government is fragmented and costly, with costs driven by schemes operated by the defence, CGHS and railways, in that order. If we exclude the coverage by the defence ministry, the expenditure on coverage falls substantially. From the viewpoint of efficiency, schemes with larger pools have lower per beneficiary costs. From the viewpoint of equity, the present schemes of the government are really problematic, with low-cost schemes covering the BPL and high-costs schemes covering the non-BPL. The centrally-run schemes cater for relatively better-off people and cover all kinds of care – primary, secondary and tertiary, including high-end specialised care and surgery. The other schemes have a narrower coverage. This makes the equity question even more important.

Most of these schemes involve the private sector in the delivery of healthcare services to the target population. While the private health sector in India today is too big to ignore, the issues of unregulated private providers and unevenness in price and quality require policy focus in any discussion on UHC. The central question is how and to what extent the private sector should be co-opted to extend publicly run coverage programmes, and what effect this could have on costs and quality – of both public and private healthcare, but especially the former, where providing right provider incentives has always been a major concern.

The analysis raises two important concerns that need to be addressed if India wants to move to a path of inclusive health coverage, either via UHC or an essential health package (EHP). Government subsidies are now not targeted well. They even promote inequity by covering a small segment of the population that needs much less support than those with less ability to pay. Given the tight public finance situation on health, it is imperative that the pool be broadened and schemes merged for efficiency gains. It is important to consider subsequent merging of all publicly-financed schemes, or at least review how else one can reduce subsidies missing those who should be their real beneficiaries. The merging of finances should also be accompanied by a consideration of whether – under a proper administrative and management system – the fragmented supply situation can be consolidated as well.

The decision to pool is not a politically easy one because it requires dismantling a system that has been delivering subsidised care for a considerable period and at considerable costs to a small section of the population. But good ethics demands that we openly acknowledge the absence of efficiency and equity in the current health coverage system; examine how those outside such a system can be brought in; and how health subsidies can be appropriately distributed across the entire population.

NOTES

1 An important aspect of health resources of the government, which is often overlooked, is the contribution by beneficiaries. For example, an estimated $126 million was collected in 2010-11 as payroll contributions from employees under the CGHS. There is a one-time contribution of Rs 30 from cardholders under the Rashtriya Swasthya Bima Yojana (RSBY) as well. Since adjusting for these amounts do not make too much of a difference, we present the unadjusted amounts in the calculations. This information was difficult to collect for all state health schemes, and we do not attempt such adjustments to state spending figures as well. However, for the Employees State Insurance Scheme (ESIS), the key source of funds is contribution by employees and employers, which was deducted from total expenditure on the ESIS to arrive at the state government's contribution to the scheme.

2 Although the ESIS is also under the MoLE, it is largely a self-contributory scheme, with the state governments contributing one-eighth of the expenditure of medical benefit with a per capita ceiling of Rs 1,500 per insured person per annum.

3 The CGHS also has its own network of allopathic dispensaries, polyclinics, AYUSH dispensaries, yoga centres, and dental units across 25 cities in India

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Annex

Sources of Expenditure	Coverage	Financing Arrangement	Data Source
Central Government Health Scheme	Active employees and pensioners of central government ministries, departments, autonomous institutions, etc.	MoHFW of the central government Contribution from employees based on pay	The DGs of the MoHFW, annual report of the MoHFW, DGs of the various ministries for medical reimbursement under the scheme.
State Government Employees Health Scheme	Employees of state government departments and institutions	State government	DGs of all state government departments.
Rahstriya Swasthya Bima Yojana	BPL families and other unorganised sector workers like railway coolies, hawkers, domestic workers, rag pickers, rickshaw pullers, etc.	Expenditure is borne by the centre and states in the ratio 75:25. Minimal one-time fee for the RSBY card from beneficiaries.	Central government contribution is obtained directly from the DG of MoLE. The states' share is indirectly computed by applying the ratio to the centre's contribution.
Defence medical services	Active employees and ex-servicemen under the Ministry of Defence.	Ministry of Defence	Report on performance audit of medical establishments in defence services
Railway medical services	Active employees and ex-servicemen under the Ministry of Railways.	Ministry of Railways	Relevant DGs of the budget of the Ministry of Railways
Employees State Insurance Scheme	Employees of any firm employing more than 10 people who earn up to Rs 15,000 per month, and their families.	Covered employees contribute 1.75% of their wages and employers 4.75% of it. Employees earning up to Rs 100 a day are exempt. State governments contribute one-eighth of the expenditure of medical benefit within a per capita ceiling of Rs 1,500 per insured person per annum.	Annual report of the ESIC
State-specific schemes and state-supported community health schemes	BPL households and other categories that are state-specific.	States' financial contribution to schemes launched by them or run by non-government bodies.	State government websites "Government Sponsored Health Insurance in India", Gerard La Forgia and Somil Nagpal, World Bank, 2012

DG – Demand for Grants, MOHFW – Ministry of Health and Family Welfare, MoLE – Ministry of Labour and Employment, ESIC – Employees State Insurance Corporation, BPL – Below Poverty Line, AYUSH – Ayurveda, Yoga, Unani, Siddha, and Homeopathy.