CHAPTER III

Public Spending on Health at the Level of States
States play a significant role in provisioning health services in India. As laid out in the Constitution, major responsibilities of creating, maintaining and managing health institutions rest with the States. The Centre's role remains limited to family planning, health policy making and research. Centre and States jointly provide public health services and take care of medical education. Discussion in the previous chapter has revealed that in terms of responsibilities in spending, more than two-third is done by the States and remaining one third is carried out by the Centre. We have observed significant interstate variations in the level of spending, even though the overall level is very low in the country. The three sample States are also quite diverse not only because of their diverse health outcomes but also due to their spending levels and priorities. For instance, Kerala has achieved health outcomes comparable to many developed countries. Tamil Nadu and West Bengal have achieved considerable progress in some health outcomes in last three decades but lags behind Kerala in many respects. The common thread that binds them is that in some period of history these states have shown considerable commitments in social sector spending including health. Kerala's history of public spending on health dates back to early years of Independence with the Left parties coming to state power. Government's commitment for the delivery of social services in Tamil Nadu is also linked to the influence of Dravidian Movement in the State. West Bengal also had considerable progress in health spending during the early years of Left rule in the State.

At the national level, as discussed in the previous chapters there have been considerable cutbacks in public spending on health. The focal point of this chapter is to try to capture the consequences of economic reforms in state spending on health. We would like to see if our study States could take up the challenge of fiscal conservatism under economic reforms and maintain their levels of spending. Let us start with some understanding of the level, trends and priorities at the State level. Following the discussions in the previous chapters we would like to examine the various subcategories of health services to understand the changes and the consequent effect on service delivery.

As put forward in the last chapter, health expenditure as a share of Net State Domestic Product is a good measure of trend in spending. Let us consider the expenditure by the
State governments, which include Grants in Aid (GiA) from the Centre. All-State average spending has remained around 1.5 per cent of Net State Domestic Product during the entire period under consideration (Figure III.1). The level of spending in Tamil Nadu has consistently been higher than the other two States or all-States average level. But during the early years of 1990s, one could observe substantial decline in the state which was followed by a phase of recovery and a subsequent decline. From around 2.5 per cent of NSDP spent on health during early 1990s, it declined to 1.7 per cent in 1997-98. Since then it increased to reach 2.5 per cent again in 2004-05, however in subsequent period there was some decline. In Kerala one can observe a secular decline in spending. From 2.1 per cent in 1990-91, spending on health in Kerala reduced to 1.3 per cent by 2004-05. The level of spending in West Bengal is much below the other two States and even the all-State average. During the later half of 1990s there was some recovery, however it was short lived and declined since 2000-01.

Figure III.1: Public Expenditure on Health by States as Per cent of NSDP

SOURCE: Public expenditure data is from RBI (2010), "State Finances: A Study of Budgets". NSDP figures are from CSO.

Expenditure on health services, which means the spending done by departments of Health and Family Welfare, received a sharper decline in early 1990s than the decline in total health. For instance, in Kerala, the share of public spending in GDP fell from 1.57 per cent in 1990-91 to 0.84 per cent in 2002-03 and remained almost at the same level for the remaining period (Table III.1). Similar kinds of decline could be observed in case of Tamil Nadu and West Bengal. The all India average level of

PUBLIC SPENDING ON HEALTH AT THE STATE LEVEL
spending was much lower than these states to start with, and fell down further by mid
1990s. The all India average spending remained almost at the same level for the
remaining period of time. In case of Tamil Nadu and Kerala we observe continuous
decline in share of health expenditure in NSDP. There was some sort of marginal
reversal during the early 2000s in West Bengal, but since then there was a steep
decline. It must be noted here that the three states were spending significantly higher
amount than the other states, which got reflected in their share of NSDP being higher.
However, after the reforms process Tamil Nadu & West Bengal have gradually
reached a lower level of spending compared to national average, whereas Kerala
remains little ahead. Apart from all other things, what this convergence of level of
spending shows is that the limited independent policy space which was earlier
available to states got further reduced in the reforms era.

Table III. 1: Expenditure in States on Health Services as percentage of NSDP

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>1.57</td>
<td>1.08</td>
<td>0.95</td>
<td>0.84</td>
<td>0.91</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>1.24</td>
<td>0.92</td>
<td>0.81</td>
<td>0.77</td>
<td>0.73</td>
</tr>
<tr>
<td>West Bengal</td>
<td>1.32</td>
<td>0.85</td>
<td>1.05</td>
<td>0.77</td>
<td>0.74</td>
</tr>
<tr>
<td>All States</td>
<td>1.01</td>
<td>0.74</td>
<td>0.77</td>
<td>0.70</td>
<td>0.78</td>
</tr>
</tbody>
</table>

*Source: Public expenditure data is from RBI (2010), “State Finances: A Study of Budgets”. NSDP figures are from CSO.*

Growth in Expenditure:

During 1975-89, States’ total expenditure on health care at constant prices grew at an
impressive rate of 9.2 per cent per annum. This growth rate was higher than the
growth in total public expenditure of the States, and GDP growth rate (Tulasidhar
1992f). During 1980s, the growth rate in health care expenditure decelerated, along
with a slow down in overall public expenditure, in States during the latter half of the
period (1982-89). Compared to this, public expenditure on health at constant prices
grew at an annual average rate of 6.1 per cent during 1990s and recovered slightly to
7.7 per cent during the following decade. During the first five years of the 1990s in all
States taken together expenditure grew at a rate of 6 per cent which climbed up to 7
per cent in the later period.

There is considerable level of variation in growth among the three States. For
instance, in Kerala for the three quinquennial periods namely, 1990-94, 1995-99 and
2000-04, corresponding growth rates were 4.2 per cent, 7.9 per cent and 11.6 per cent.
Clearly an increasing trend in growth could be observed. In Tamil Nadu, though a similar trend of increasing growth is seen, rates were much lower compared to Kerala. During early 1990s total health expenditure grew only at 2.1 per cent, it marginally improved to 3.1 per cent in the later half of the decade and then jumped to 6.1 per cent in early period of 2000s. Growth rates in West Bengal have excessive fluctuations which deserve further probing. Cutbacks in expenditure during early days of economic reforms, was clearly visible by the negative growth during that period. However, there was a sudden jump in spending during later half of the decade: a growth of 14.8 per cent was observed. This fell down to 3.8 per cent in early 2000s. As it is the case with the national trends, both in Kerala and Tamil Nadu growth rates were higher in 2000s, compared to 1990s. West Bengal however defies the trend as health expenditure grew at higher rate in the 1990s compared to 2000s. In fact, health expenditure almost stagnated in the 2000s in West Bengal. It would be important for our analysis to find out the causes of such stagnation.

Figure III. 2: Growth Rate in Health Expenditure (at constant prices)

![Graph showing growth rate in health expenditure](image)

Source: Public expenditure data is from RBI (2010), "State Finances: A Study of Budgets".

Per Capita Expenditure:

With population growth the need for greater health care also increases. It is important that one takes out the impact of population growth from expenditure trends. It would be worthwhile here to look at trends in per capita expenditure. Per capita expenditure on health was Rs. 27 in 1974-75. By 1991-92 it went upto Rs. 62 (Figure III.3). It hovered around that level during entire first half of the 1990s and picked up during the later period. During 2006-07 per capita expenditure on health went up to Rs. 131.
During the period of 1974-75 to 1989-90 per capita expenditure increased at a rate of 6.8 per cent per annum (Reddy 1993). Compared to this, between 1991-92 and 1999-2000, per capita expenditure increased only at a rate of 4.8 per cent. During the subsequent decade per capita expenditure grew at a rate of 5.9 per cent. Clearly the growth rate was higher during pre reform days compared to the reform period.

![Figure III.3: Per Capita Expenditure on Health (at constant prices)](image)

Source: Author's calculation based on Expenditure data from RBI State Finances, Finance Accounts of States. Reddy (1994)

All the States do not have similar levels of per capita expenditure on health. From figure III.2, it can be observed that Kerala had high levels of per capita expenditure during the pre reform decades. But by the early 1990s, per capita expenditure in Tamil Nadu was higher compared to other States under consideration. Similarly West Bengal showed higher per capita expenditure during later half of the 1990s.

In figure III.4 we have tried to observe the trends in the share of Plan expenditures in the total expenditure. If total health spending is considered, it is observed that the share of Plan expenditure has increased for the three sample States as well as for all States taken together. However, when only Medical and Public Health is considered, share of Plan expenditure declines for all the study States. When other sub-sectors excluding Medical, Public Health and Family Welfare are considered we see a general increasing trend in share of Plan expenditure for all the three States. This implies that new initiatives in health sector have largely come from other sub-sectors whereas in health services Plan expenditures have declined in general. It is also worthwhile to
note that for Tamil Nadu, Plan expenditure as a percentage of total health spending has almost doubled between 2001-02 and 2005-06. This has happened largely due to increase in Plan expenditure on Nutrition and Social Security and Welfare. Among the States, Tamil Nadu has been spending more on Plan expenditure than Kerala and West Bengal.

Figure III. 4: Share of Plan Expenditure in Total Health Spending

Source: Calculated from RBI (2010), "State Finances: A Study of Budgets".

Revenue and Capital Expenditure:

Within the health sector, government spends on different items. It pays salaries to health personnel, it may provide drugs to the patients, conduct immunisation programmes, it builds hospitals, buys equipments, privatizes some hospitals etc. These expenditures can be demarcated into two distinct categories. In some of these activities governments asset position changes and in some it does not. For instance if the government builds a new hospital or health centre, it adds to the asset base of the
CHAPTER III
government. Such items are called ‘capital expenditure’. Paying salaries or distributing drugs do not affect government’s asset position. These items are classified as ‘revenue expenditure’. Revenue expenditures are generally meant for running the systems, like paying salaries, rents, maintenance charges, drugs and consumables. As government creates new assets through capital expenditure it needs support systems to maintain those assets and hence need to incur revenue expenditure. A proper balance between revenue and capital expenditure is crucial for the health sector to meet increasing need for health services.

Figure III. 5: Share of Capital Expenditure in Health Budget (Per Cent)

![Graph showing share of capital expenditure in health budget for different states.]

Source: Calculated from RBI (2010), "State Finances: A Study of Budgets".

It is also important to note that revenue expenditures are downward sticky, meaning that it is not easy to reduce revenue expenditures once they are made. For instance, salaries in government set up in India cannot be easily reduced, because of the nature of employment and organized workers’ movements. In contrast to this, capital expenditures are mostly one time in nature and decisions to raise capital expenditure are discretionary in nature, often resultant of conscious policy decisions.

The most important observation that we could make from figure III.5 is that in all the three study States, share of capital expenditure remained stagnant at less than 5 per cent of total health budget for the entire 1990s. The levels are less than half of what was prevailing at all the States. The share is found to increase in the later decade. In Kerala, we see the prevalence of low levels of capital expenditure in the entire period of two decades. In West Bengal, the declining trend observed during 1990s seems to
have reversed during the later decade. Compared to the share of around 1 per cent during the late 1990s, capital expenditure jumps to reach almost 10 per cent by mid 2000s. For all States the share of capital expenditure almost doubles in the 2000s compared to 1990s. Surprisingly steep increase in share of capital expenditure is seen in Tamil Nadu since 1999-2000, mainly on account of an increase in expenditure in water supply and sanitation.

When the health service sector is looked into we find stagnancy prevailing during the entire period, with some increase during the later years. With some variations across the years, States are spending around 3-6 per cent of budget of health service sector on capital expenditure. Such low levels of expenditure are not enough even to take into account the rate of depreciation, not to speak of creating new facilities. The trend in Tamil Nadu is quite surprising. We have seen previously that there was a spurt in capital expenditure on total health in Tamil Nadu 1999-2000 onward. In contrast to this when capital investments in health services is considered the trend reverses and share goes down after 1999-2000. There is a sudden jump 2005-06 onward. In West Bengal, the share declines during the entire 1990s, recovers abruptly during 2000-02, only to nose dive again. Investments through externally aided projects in West Bengal during 2000-02 may be attributed to this sudden increase. We need to look at these aspects in details.

Low levels of capital expenditure in health during 1990s remained a major cause of concern for all the three States. The situation improved to some extent in the later period. Capital expenditure remained higher for all States compared to the study states. During 1990s there was a marginal decline and it improved then on. However, if we disaggregate total spending and look specifically at the health services we observe that for the three states level of capital expenditure increases a bit but the trend remains more or less the same. Share of capital expenditure on health services for all states is much lower compared to total health. This implies two important things. Firstly, high capital expenditure for all states is mainly due to high spending on water supply and sanitation. Of the total social sector capital expenditure for all states, water supply and sanitation consisted almost 40-60% during 1990s and 2000s. The increase happened largely at the cost of medical and public health. The other implication of this is the low capital expenditure on health services, essentially
meaning that new health facilities are not being created or existing facilities are not maintained.

Bulk of the rural health infrastructure has been created during 1980s. Since then we see a disturbing stagnation. Between sixth and seventh Plans there was a 60% growth of Sub-Centres, PHCs and CHCs taken together. But since then number of PHCs, SCs and CHCs have grown by only 16.3%. In Kerala, the corresponding growth rate was 145% between sixth and seventh Plan, but for the rest of the period there is a decline in actual number. Similarly, for TN the there was 60% growth in 1980s but since then facilities have grown only by 1%. In WB, number of facilities grew 26% during sixth and seventh Plan period and in the subsequent period also there is a growth of 26%. However most of this growth is during Tenth Plan and that too in number of SCs. In fact during the last two decades, total number of PHCs and CHCs has gone down by 6% in the State. This is in contrast to other states, which have converted many SCs into PHCs and PHCs into CHCs and thus number of PHCs and CHCs have increased (GoI 2010). It may well be the case that some of the CHCs have been upgraded to rural hospitals and sub-divisional hospitals. Figure 6.2 shows the trend in population served per government bed. Both in Kerala and Tamil Nadu, there is a sudden jump in population served per bed between 1994 and 2005. However, in case of West Bengal, there is a decline in the ratio. This is definitely a sign of improvement and may serve as an explanation why there is high dependence on government hospitals in cases of hospitalisation in the State. According to estimates by Health Information of India, nationally there is a gradual decline in number of beds per lakh population.

![Figure III.6: Population Served per Government bed](image)

Source: Data on bed is from Health Information of India, various years. Population data is from Census population projection.
There are huge gaps in required health institutions and that are in position in government sector. However, both Kerala and TN has more PHCs and CHCs against the Indian Public Health Standard (IPHS). The gap is quite high in case of WB. There is a shortage of 1084 PHCs and 150 CHCs in WB. This gap can be fulfilled only through substantial jump in capital expenditure.

**Priority on Health in State Budgets:**

Given the significant levels of development deficits in the country, and poor health indicators, it is important that health is given adequate priority in policy making and spending in the country. Health being largely a State subject, it is imperative that the State governments would accord substantial priority towards health. It implies that out of the total expenditure of the government a significant share should go towards health. Like health, major responsibility of providing social sector rests with the States. During early 1990s, States spent around 85 per cent of the combined expenditure on social sector and 90 per cent of expenditure on rural development. These shares declined significantly by the end of 1990s (Dev and Mooij 2002).

![Figure III. 7: Share of health expenditure in the total budget](source: Calculated from RBI (2010), "State Finances: A Study of Budgets").

The diagram above (fig III. 7) suggests that share of health in the budgets of all-States almost remain the same for 1990s and 2000s. However there are state level variations. Tamil Nadu spends highest proportion of its budget on health compared to other States. The gap between other States and Tamil Nadu seems to diminish over time as
there is a fall in the share of the State in its budget. During 1990-91, Tamil Nadu used to spend around 15.6 per cent of budget on health, which got reduced to 10.6 per cent in 2006-07. During 1990-91 Kerala spent around 12 per cent of budget on health. By 1999-2000 it went down to 8.7 per cent and hovered around that level for the later years. Health expenditure as a proportion of total budget went through periodic ups and downs in the last two decades. From a level of above 11 per cent during early 1990s it went down below 9 per cent by mid 1990s and recovered in the later half of the decade, only to slide further down during 2000s. Overall, compared to 1980s where health was given greater priority and expenditure on health grew more than the rate of growth of total government expenditure thus increasing the share, the trend seems to have got reversed during the reforms period. It would be worthwhile to find out the reasons for such lower priority and identify areas where States have spent more. It would also be interesting to find out reasons for this fluctuating trend in share of health in West Bengal.

Sub-Sectors of Health:

The definition of health used so far includes water supply, sanitation, family welfare nutrition, handicapped and child welfare apart from medical and public health. However, the conventional definition of health care used for health financing purpose includes spending on medical, public health and family welfare. These are considered the core elements of health care and others play supportive role. The World Health Report, published by the WHO includes only these core elements in its international comparison of health expenditure. National Health Accounts, in its reports includes spending on medical, public health and family welfare leaving out other interventions. It is important for our analysis to look at the trends and patterns in spending among these broad categories. A detailed analysis of the core elements of health services would be taken up later.

The relative emphasis on different broad elements of health sector helps us to identify the policy thrust of the governments. As has been discussed earlier, following Bhore Committee recommendations, the Government emphasized setting up of health infrastructure in the form of big hospitals, medical colleges etc., little attention was paid on rural health services, issues of water supply, sanitation, nutrition etc. As a result an urban centric health infrastructure based on curative care in big hospitals was
taking shape in the country during the first three decades after Independence, whereas rural areas remained grossly underserved. When we look at the impact of these trends in terms of financing we find that medical and public health department consumed the majority of the resources and very scanty amounts are being spent on child and handicapped welfare and nutrition. More than two thirds of the spending in all States went in to medical and public health in 1974-75. The trend was somewhat reversed during VI Five Year Plan, which was largely influenced by the Alma Ata Declaration of 'Health for All by 2000 AD'. The plan stressed that vertical and horizontal linkage has to be established among all the interrelated programmes, like water supply, environmental sanitation, hygiene, nutrition, education, etc. (Duggal 2005). This change in gear was clearly evident in the spending priorities during the 1980s. The share of medical and public health in total spending got reduced to half by 1990-91. During this period spending on nutrition, handicapped and child welfare and water supply and sanitation increased considerably. From little more than one fourth of the total spending, water supply and sanitation went on to occupy more than a third of the total spending. There was also a marginal increase in the share of family planning.

![Figure III. 8.a: Share of Broad Elements of Health in Total Spending - All States](source)

Source: Calculated from RBI (2010), "State Finances: A Study of Budgets".

The decline in share of medical and public health in total spending on health further accentuated in the 1990s- in the year 1995-96 its share went down to 41 per cent. The declining trend continued through the later period, barring a few odd years in late 1990s when there were marginal increases. Share of water supply and sanitation decreased to some extent during the initial years of the 1990s.
Trends in Kerala are completely different from what we observe at the level of all States. In contrast to a decline in share of medical and public health in total expenditure at all States, in Kerala there was an overall increase in its share—both during pre reform and post reform periods. During 1974-75 the share of public health was only 46.5 per cent. It remained almost at the same level till 1990-91. However, during the same period share of water supply and sanitation went down significantly. During mid-1970s water supply and sanitation was accorded almost similar level of priority in spending; but by 1990-91 its share went down to a fourth of total spending. The declining trend continued during the decade to reach its lowest in 2000-01 when the share was even less than 12 per cent. Though there was a reversal in the subsequent period, it didn’t last long. The share of family planning increased during 1980s— in 1990-91 more than a fifth of total health expenditure was being earmarked for family planning. However, there was a subsequent decline in share in the 1990s. Somewhat similar to what we observe at the all State level, the share of handicapped and child welfare increased during the entire period under consideration. One significant observation regarding Kerala is complete absence of spending on Nutrition. A careful look at the measures adopted by the State government to ensure food security in a perpetually food deficient State would be important. The issue needs to be seen also in the context of nutritional status of children in the State.

Figure III. 8.b: Share of broad elements of health in total spending: Kerala

Source: Calculated from RBI (2010), "State Finances: A Study of Budgets"

Health system seems to have undergone major changes in Tamil Nadu since mid 1970s. At least changing spending priorities suggest so. From a system highly
dominated by medical and public health in the mid '70s, Tamil Nadu has shifted to a more balanced distribution of resources among the major sub-sectors. In 1974-75 more than three quarters of the resources were being devoted to medical and public health, whereas each of family planning, water supply sanitation and nutrition were provided with less than ten per cent of the resources. Within a span of little more than a decade, medical public health, water supply sanitation and nutrition started receiving almost similar amount of budgetary resources. However, during the decades under economic reforms, share of water supply sanitation and medical public health went down further while share of nutrition increased.

Figure III. 8.c: Share of Different Sub-Sectors in Health Spending: Tamil Nadu

Source: Calculated from RBI (2010), "State Finances: A Study of Budgets".

West Bengal has consistently devoted much greater proportion of resources towards medical and public health. However, during 1980s there was some consistent increase in the share of water supply, sanitation and nutrition, and consequently the share of medical public health decreased as share of total expenditure fell down. The share of water supply and sanitation was almost maintained throughout the study decades. However, spending on nutrition went down significantly. Given that West Bengal has high levels of under-nourishment among women and children, the trend needs to be reversed. By mid 2000s almost half of the resources were devoted towards medical and public health, which is much higher, compared to the other study States or even the all State average. We need to probe whether this has resulted in a better health care infrastructure or better implementation of public health programs or in the contrary, inadequate focus on other services like water supply and nutrition.
From the above discussion we find some divergent pattern of financing in the three States and some common trends. We see that in all States aggregate, there is a decline in priority on medical and public health since mid 1970s. Kerala has defied this trend as share of medical and public health has increased between 1974-75 and 1990-91. During the same period we could notice considerable increase in spending on water supply and nutrition, a trend which can be clearly attributed to Alma Ata declaration. 1990-91 onward, the decline in share of medical public health seems to have been accentuated. Surprisingly during this reforms period, share of handicapped and child welfare seems to have increased in all the States. Among the three States, Tamil Nadu seems to offer a balanced picture in terms of share in spending among different categories, whereas Kerala and West Bengal assign greater emphasis on medical and public health. In both these States expenditure on nutrition has been neglected considerably.

![Figure III. 8.d. Share of Different Sub-Sectors in Health Spending: West Bengal](image)

Source: Calculated from RBI (2010), "State Finances: A Study of Budgets".

Let us now analyze the growth of these sectors for the period 1974-75 to mid-2000s, breaking it into two broad categories- pre-reform and reform periods. We have noticed earlier that during the pre-reforms period (mid '70 onward) health sector grew significantly, even faster than the growth in overall revenue generation. Compared to this growth rates in reforms period have been less. However the extent of slowdown is not uniform across the states as there are significant variations among states.
Earlier when we were observing the growth rates of total health expenditure, we found out that in 1990s, there was considerable decline in growth compared to the previous decades. We also saw that during the 2000s, there was a slight improvement in growth rates. Variations in States were also observed. It would be worthwhile to analyze the pattern of different sectors of health to develop a better understanding about the patterns. During the above discussion we saw that among the different sub-sectors, share of medical and public health has gone down significantly since the 1990s. This suggests that it has grown slower than the other sub-sectors. Let us now look at the pattern of growth in the different sub-sectors.

**Figure III. 9.a: Growth in Expenditure of Different Subsectors of Health in all States: pre-reforms**

![Chart showing growth in expenditure of different subsectors in all States during 1975-1989. During this period medical and public health grew at a rate of 6.24 per cent. Both Family Welfare and Water Supply and Sanitation grew at around 10 per cent rate, whereas nutrition grew at 19 per cent. During 1975-81 growth in medical and public health was almost around 10 per cent; it fell to less than four per cent during 1980s. Similarly, water supply and sanitation grew slower during 1980s compared to 1970s, whereas growth of nutrition and family welfare was faster during 1980s compared to 1970s. The trends show that preventive health expenditure received significant attention during the fifteen years prior to the introduction of economic reforms. Particular emphasis was also given at the national level on at least one source of clean drinking water in all the villages and on providing supplementary nutrition to pre-school and primary school children. It would be clearer if we identify the sources of these funds- whether these are driven by higher spending on CSS or had state...
specific emphasis. It has to be kept in mind here that this did not happen at the cost of medical and public health which also grew in real terms.

There are inter-State variations in growth rates among the different sub-sectors. Spending on Medical and Public Health has almost stagnated over the 1990s in all States as well as the three sample States. Growth rates have remained lesser than the previous decade, much lesser than total growth of health sector during the decade. West Bengal and Kerala had 3.5-4 per cent growth rates during 1990s and in Tamil Nadu it was merely 1.5 per cent, something comparable to all States average and lesser than even population growth rates.

Figure III. 9.b: Growth in different sub-sectors: post-reforms

Water supply and sanitation had grown robustly during 1980s. As it is the case with other sub-sectors, during 1990s growth rates fell, even though it grew faster compared to medical and public health. In Kerala it fell between 1990 and 2005-06. Similarly, we observe negative growth rates in Tamil Nadu during 1990s and in West Bengal.
during 2000s. In Social Security and Welfare we see a steady growth in almost every State during the entire reforms period. When all the States are taken together, spending on nutrition shows steady growth, similar level of growth is also found in West Bengal. However, in Kerala there is a steep decline in spending on nutrition.

When we look at States various patterns emerge. In Tamil Nadu and Kerala, we see a situation of stagnation in all sub-sectors except Social Security and Welfare during the reform period. West Bengal defied stagnation of 1990s and all the sub-sectors grew at a healthy rate. But the momentum could not be sustained during the 2000s and there is absolute decline in expenditure on medical and public health and water supply and sanitation. This may be linked to worsening fiscal situation in West Bengal during 2000s.

**Growth in Plan Expenditure:**

Let us now focus on the growth of plan expenditure on health. During the period 1990-91 to 1991-92, due to Balance of Payment crisis, the Central Govt. could not allocate enough funds for five year plan (FYP) and hence annual plans were implemented. For the next fifteen years three FYPs were implemented- VIII Plan (1992-97), IX Plan (1997-2002) and X Plan (2002-2007). During this entire period the three sample States show significant variations in the growth rate in Plan expenditure on total health (at constant prices). Kerala had a healthy growth of 8.6 per cent during VIII FYP but in subsequent times there is absolute decline in spending.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>1.6</td>
<td>8.6</td>
<td>-2.8</td>
<td>-2.4</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>15.6</td>
<td>1.4</td>
<td>17.2</td>
<td>8.9</td>
</tr>
<tr>
<td>West Bengal</td>
<td>-4.7</td>
<td>10.8</td>
<td>23.7</td>
<td>3.9</td>
</tr>
<tr>
<td>All States</td>
<td>27.8</td>
<td>4.6</td>
<td>7.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Sources: Calculated from RBI (2010), "State Finances: A Study of Budgets".

Tamil Nadu, on the contrary, had a very sluggish growth rate in the Plan expenditure in health during the VIII FYP; however, during the consecutive plans growth was healthy. West Bengal had considerably high growth rates during the VIII and IX FYPs, whereas the growth rates slipped during the later period. When all the States
are taken together there is only a marginal variation in growth rate, though there is not a significant growth in spending. When medical public health and family welfare is considered there seems to be similar pattern of fluctuation for all the three States. For instance in Kerala like the pattern observed for total health spending, here we see higher growth rate for the VIII FYP, and in subsequent periods there is considerable decline in growth rates. However it has to be noted that the rates are higher for all the three periods. In contrast to Kerala, in West Bengal we observe that the general trend in fluctuation remains the same but magnitude becomes less. This implies that other sectors in West Bengal grew faster than MPHFW, which was not the case in Kerala, where growth is led by this sector.

Figure III. 10: Growth in Plan expenditure on Medical Public Health and Family Welfare

Source: Calculated from RBI (2010), “State Finances: A Study of Budgets”.

Functional Classification:

The distinction between preventive and curative medicine is an old fashioned distinction based on the early history of preventive medicine when sanitary measures and immunisation were classed as being preventive while other activities such as amputation were classified as curative medicine. The modern concept of preventive medicine is much broader than environment sanitation and immunisation. In addition to measures designed to prevent diseases it also includes activities designed to minimize disability, to stop progression of disease and to achieve satisfactory rehabilitation (Sorkin 1976). According to Lucas, the issue is not whether to do preventive or curative medicine but how best to allocate resources to different levels
of prevention in dealing with particular health problems. Curative service by its nature is much more expensive treatment and requires hospital care. Although curative services must be made available for everyone, curative medicine must not siphon-off funds from the provision of preventive services. Ideally a good preventive service would eventually reduce the burden of curative services as lesser number of people would fall ill and require treatment.

It is with this perspective that we aim to classify health expenditure according to functions. A greater emphasis on curative care would imply that there is a reliance on medical establishments like hospitals and dispensaries, whereas preventive and public health services would mean emphasizing on prevention of communicable and non-communicable diseases, family planning and immunisation services. This category includes expenditures on services specifically intended to enhance the health status of the population or specific population subgroups, as distinct from the personal medical services, which repair health dysfunction. Many of these expenditures on these services may be provided in an integrated fashion by general medical institutions as part of their normal activities.

Services of curative care include expenditure on teaching hospitals, specialty hospitals, ESI dispensaries, homeopathic hospitals and dispensaries, Ayurvedic hospitals and dispensaries, Primary Health Centres, Community Health Centres and expenditure on dental care etc. Rehabilitative care includes expenditure on rehabilitative centres for TB and leprosy patients, institutes for rehabilitation of physically handicapped, drug de-addiction programmes, etc. Ancillary services related medical care includes expenditure on blood banks, blood transfusion council, regional diagnostic centres, ambulance related expenditure, medical store depot etc. Preventive and Public Health services included expenditure on disease control programmes, family planning services, prevention of food adulteration and drug control etc.

The way Indian Constitution divides responsibilities between the Centre and the States, elements of curative care are largely taken care off by the State governments whereas Centre has a greater share in Preventive and Public Health services. According to NHA calculations, sum of Rs. 107,772 million was spent on curative care in 2004-05, which accounted for 42.67 per cent of health expenditure. Between
Centre and States, the States spent 47 per cent on curative care, while the Centre spent 22.16 per cent. Preventive and Public Health Services were found to be major health care function for the central government wherein 42 per cent of the health expenditure was incurred against 16.45 per cent by the State governments. Overall 10 per cent was spent on Health Administration (Gol 2009).

From the above classification it is clear that each of the categories have their own functions in delivering health care. Curative health services constitute the expenditure on hospitals, dispensaries and they play important role in controlling mortality. Public health services like disease control programs are mostly preventive in nature. In the developing country context, these expenditures play a significant role in reducing the burden of communicable diseases. Family planning services, immunisation programs have also significant role in preventing morbidity and mortalities. It has to be noted however that this distinction between curative and preventive services are merely notional at times and often play interchangeable roles. For instance, in the case of communicable diseases, early treatment often plays the role of preventive services.

Let us now look at the State level variations in the share of these different functional categories. Here we would consider a time period of 1987-88 to 2004-05. We can definitely identify a general pattern of distribution between the different functions albeit some variations across States. Curative services consume more than half to two third of the total spending, whereas a sixth of the expenditure being spent on...
preventive and public health services and around a tenth being spent on medical education, training and research. In Kerala, almost two third of spending was going towards curative services during 1987-88, a sixth on preventive and public health services and one eighth on education. Administrative expenses were significantly low (2.4 per cent) in Kerala. During 1990s the share of public health and preventive services grew constantly, mostly at the cost of other ancillary services; it almost consumed a fifth of the total expenditure by 1999-2000. Later on, we see an increase in spending on medical education and subsequent decline in the share of public health services. High spending on curative services in Kerala may be linked to high incidence of geriatric problems due to higher share of older people.

Figure III. 11.b & c: Functional Classification of Health Services: Tamil Nadu & West Bengal

Source: Detailed Demand for Grants, State Budget, Tamil Nadu and West Bengal, various years.

In Tamil Nadu and West Bengal the share of curative care was less compared to Kerala. There was an initial decline in the share of curative services in Tamil Nadu, however since mid-1990s the share increased. Compared to other States, Tamil Nadu spends much more on preventive and public health services. Though it has a significant component of family planning services, spending on disease control programmes was also high, so was the spending on maternity and child health services. Apart from a marginal increase during 1993-95, administrative expenses remained around 3 per cent in Tamil Nadu throughout the period. The jump in expenses during mid 1990s was largely on account of increasing expenditure on medical education and training. This may be due to emphasis on medical education in the state during that period.
Administrative expenses are significantly higher in West Bengal compared to other States, as is the category of miscellaneous expenses. It hovered around 6-6.5 per cent during the 1990s, though it fell to less than 5 per cent subsequently. Whether high expenses on administration have implied better implementation and financial management of services is another matter to see. Miscellaneous expenses cover different outreach services, special plans for tribal areas, medical stores etc. Up to mid-1990s these expenses were quite high. This was also the period when West Bengal had decent growth in overall expenditure. But in the later period, when there was a general cutback in expenditure, these miscellaneous expenses suffered significantly. Interestingly, during the entire period we see a gradual increase in share of curative services and a decline in share of preventive and public health services. The above discussion would be more meaningful when we look into economic classification and analyze specific schemes and programmes.

Different levels of health services:

Health service provisioning is generally demarcated into three levels of care based on the nature of care provided: primary, secondary and tertiary level care. Distinguishing health care services is difficult due to accounting practices which do not allow us to distinguish between the different levels of services provided by the same institution. For instance a tertiary hospital may serve as the first contact point of patients and provide primary level services to a large number of patients. This happens because of two reasons. First of all the referral system does not work in India for all practical purposes. Then a district hospital or medical college hospital may be the only functioning health facility in the locality. This results in a lot of patient influx into these big hospitals. The fundamental issue is whether we can have a well-functioning health system that works most efficiently to cater to peoples' requirements and fulfill the public health commitments.

Let us now analyze the composition of health expenditure in our study States and analyze the changing patterns. In Kerala during 1987-88, almost half (49.4 per cent) of the total fund was being devoted towards tertiary level, little more than a third (33.7 per cent) towards primary level and less than a sixth towards secondary level care (14.8 per cent). Within a span of two years the composition changed
significantly. The share of tertiary care fell to 41.3 per cent making way for secondary care which rose to 25 per cent. The share of tertiary care fell largely due to a fall in expenditure on hospitals and dispensaries which constitute the biggest part of the spending on curative care. However, this would require a detailed investigation to get a better understanding of the nature of change. The shares remained almost static during the entire 1990s. However, during 2000s, we can identify a change in composition in favour of tertiary care at the cost of secondary care.

Figure III. 12.a: Levels of Health Care: Kerala

When Plan expenditure is classified into different levels of care, we see a clear cut dominance of primary level care. During the late 1980s we find almost three quarter of Plan funds being devoted towards primary health care. Share of plan investment declined continuously during 1990s and we find a corresponding rise in investment in tertiary level care. Plan investment in secondary care remained crucially low to start with and it declined further later on. Low level of Plan investment in secondary level care means that there has been little new initiative at this level. Secondary level care signifies the rural hospitals, Community Health Centres, the ESI facilities. These facilities play crucial role in providing hospital services to the rural people and urban industrial workers. Cutback in plan investment in basic hospital services would definitely have adverse impact on medical emergencies, critical maternal and child health care. Again low levels of plan investment in tertiary level and high overall investment would definitely mean that expenditures at tertiary level are of the nature of non-Plan and recurring, which are required to maintain the systems.

In Tamil Nadu, during the entire period under consideration we can identify several changes. During 1987-88 almost half (48.7 per cent) of the total spending was
devoted towards tertiary level care, a little less than two-fifth (40 per cent) in primary level care and a tenth in secondary level. Since then there has been a change in priority between tertiary and primary level cares. By mid 1990s share of primary level care rose to 45 per cent, whereas 41 per cent in tertiary level care, the share of secondary also declined a bit. But since mid 1990s again we see an increase in share of tertiary care and a fall in primary level care. During 2004-05 half of the total spending was going to tertiary level, two fifth to primary level. When we consider Plan investments in different levels of care we find high levels of investment at the primary level. At the same time investments at the secondary level seems to vanish over time. Higher priority in favour of primary level care clearly shows the focus of the State Government to enhance primary level care.

**Figure III. 12.b: Levels of Health Care: Tamil Nadu**

![Graph showing levels of health care in Tamil Nadu](image)

*Source: Detailed Demand for Grants, State Budget, Tamil Nadu, various years.*

During late 1980s, the distribution among different levels of care was much more balanced in West Bengal. A third of the total expenses was going towards primary level, less than two fifth towards tertiary level and 23 per cent in secondary level care during 1987-88. During the entire period we see a squeeze in spending on secondary level care, at the cost of increasing tertiary level care. By 2004-05 almost half of the spending got devoted towards tertiary care, and 12 per cent towards secondary level care. Share in primary level rose during 1990s only to fall marginally later on. When Plan spending is categorised into levels of care we see the dominance of primary level, albeit a declining share since mid 1990s. Interestingly, there is an increase in the share of tertiary level in plan spending during the same period. This trend is accompanied by complete absence of secondary level care in Plans.
Among the three States under consideration we see a convergence in the share devoted to each level of care during this period. Most overwhelming commonality that emerges is the decline in share of secondary level care. It may have serious implications for the delivery of curative health services. Community health services, which are part of the secondary level care, are the entry points for hospitalisation services in the government system. This is also the level at which minor operations would be done, emergency obstetric care services would be available, neo-natal illnesses are addressed, basic tests and procedures would be conducted. Secondary level care would also ease out the pressure of tertiary level institutions. A decline in the secondary level care would hamper the availability of these extremely important elements of health care and thus compromise on quality of health services. Complete absence of Plan investment in secondary level care shows that no new initiative being taken to strengthen these. However, the limitation of the above analysis is that it does not include capital expenditure and thus contain only revenue expenses. Inclusion of capital expenditure is not possible because the information presented in the budget of States does not allow us to make such classifications.

Changing nature of Plan financing and spending priorities:

The other important issue that needs to be addressed here is how the nature of Plan financing and spending priorities has changed over time. There are two main sources of Plan funds which are relevant for health. States receive funds from Central Plan, through the implementing Ministries, which is devolved as Grants in Aid (GiA) to State departments. These are generally the Centrally Sponsored Schemes (CSS). For instance the Reproductive and Child Health Programme, different national disease
control programmes like Revised National Tuberculosis Control Programme (RNTCP), National Blindness Control Programme etc. Apart from these CSS, States have their own Plan interventions which are generally called the State Plan Schemes. CSS are conceptualized and implemented keeping the national level priorities like maternal health and child survival or eradication of important nationally prevalent diseases and those which needs to be tackled nationally. But in a diverse country like India, where there are wide ranging variations across States in the level of health achievement and disease profile, State specific issues and priorities are extremely important and hence State plans are needed. State Plan Schemes also shows the ability of the States to be able to mobilise resources according to their own priorities.

Figure III. 13: Share of Centrally Sponsored Schemes in Plan Spending in States

Source: Detailed Demand for Grants, State Budget, Kerala, Tamil Nadu and West Bengal; various years.

Figure III.13 shows the share of CSS in Plan spending in the States. All the three States show different pictures. In Kerala, the share of CSS in total plan has declined consistently since 1990-91; the declining trend continues till late 1990s, since then there is some recovery. In complete contrast to this, in Tamil Nadu, the share of CSS increases consistently till mid-1990s and since then it moves on with consistent cyclical fluctuations. In West Bengal, during the initial phase of '90s there is some increase in the share, but since then there is continuous decline. However, the decline becomes steeper since 1997-98. From a peak of more than 80 per cent of plan funds coming from CSS, by late 1990s it plunged to hover around 40-50 per cent in West Bengal. In the other two States, the share remains within 60-70 per cent range. We had observed earlier that Plan expenditure on MPHFW had grown extremely rapidly.
during IX Plan period (1997-2002) in West Bengal (table III. 4). This coupled with decreasing share of CSS in plan spending implies that the increase has been largely on account of State Plan Schemes of Government of West Bengal.

For health sector new initiatives can be of various forms- one may plan to set up a new hospital in a place which is hitherto uncovered or start a new department in a hospital, bring new equipments etc. It may also involve running special immunisation programme, giving some special initiatives for institutional delivery or family planning. Expenditures of such diverse nature can be plan expenditure - it includes those which are one-time expenditures, it may also include those which are recurrent - capital and revenue expenditures. The relative share of revenue and capital expenditures shows the nature and emphasis of plan expenditure.

In figure III.14 we are looking at the relative share of capital expenses in plan spending. In Kerala we observe a continuous decline in share of capital expenses since late 1980s. In West Bengal, though there is some increase in the share of capital expenditure within Plan during late 1980s, steep decline can be observed during 1990s. During late 1990s however, there is some increases in share of capital expenditure. The declining and low share of capital expenditure in Plans shows that there is hardly any new investment towards creation of new facilities or strengthening those, whereas items where spending is more in the nature of entitlements or reimbursements get prioritized.

**Figure III. 14: Share of capital expenditure in Plan Spending of States**

![Graph showing share of capital expenditure in Plan Spending of States](image)

*Source: Detailed Demand for Grants, State Budget, Kerala, Tamil Nadu and West Bengal; various years.*
The declining share of capital expenses is also linked to the question of spending on different departments. For instance greater spending on medical and public health would be required to have greater capital investment in creating new hospitals, however if family welfare is prioritized we can assume that most expenses would be of the nature of revenue expenses. Among the three States, Tamil Nadu had lower share of FW, though it increased since 1997-98. During the same period we observe a continuous decline in the share of FW in West Bengal. This can be linked to the declining share of CSS in West Bengal since 1997-98. Since much of the FW activities are financed by central plan, declining share of CSS has resulted in decline in the plan spending on FW. However we need to also take into account the CSS which are bypassing State budgets. For instance, the Reproductive and Child Health (RCH) scheme budgets were directly sent to the RCH societies, bypassing State budgets. RCH which is part of the FW, would not form the part of plan expenses in the present analysis.

**Figure III. 15: Share of Family Welfare in Plan Spending of States**

Source: Detailed Demand for Grants, State Budget, Kerala, Tamil Nadu and West Bengal; various years.

**Communicable and Non-Communicable Diseases**

India is characterized by a dual burden of disease. The situation is quite unique in the sense that prevalence of chronic diseases has increased without substantial reduction of communicable diseases. Thus a large number of people suffer from diseases like Tuberculosis, Malaria, Diarrhea etc. and at the same time the prevalence of Cancers, Hypertension and other cardio-vascular disease, Diabetics, etc. are increasing. A
balance in spending between communicable and non-communicable disease would be crucial. Here we have tried to find out how much attention does communicable and non-communicable diseases get in the health budget of the States. In taking up the exercise we have tried to identify disease specific interventions for diseases like malaria, tuberculosis, filaria, leprosy etc. At the same time we have identified spending on disease specific hospitals. Interventions are required to improve surveillance of diseases, tackle epidemics, special laboratories for these diseases. We have classified the diseases into two categories- communicable disease and non-communicable diseases. It has to be kept in mind that this exercise to find out what is the total spending on these diseases is little difficult and the adopted methodology is partial in nature. This is largely because some of the interventions which are crucial in reduction in the treatment of diseases do not figure in the detail demand for grants in the budget as independent items. For example all medical college hospitals and many district hospitals would have departments of cardiology, gastroenterology etc which are part of general budgets of these hospitals. As a result, in the Budget of States or Centre there would not be any separate head for these items. In case of most of these diseases there is no national program with separate budget, they are often integrated with the general hospital system. Hence they cannot be distinguished separately. However, if there is any plan investment to improve any specific department of a tertiary hospital, the object is mentioned separately and it is added in our exercise.

Among the three States, Kerala being the most advanced in terms of epidemiological transition has high prevalence of chronic diseases. It is expected that there would be considerable investment on the diseases like diabetics, hypertension etc. During early 1990s we find a marginal increase in the share of non-communicable diseases, but subsequently there was a gradual decline though at a very slow pace. In 1987-88, only 2.1 per cent of total budget on Medical, Public Health and Family Welfare (MPH&FW) was spent on non-communicable diseases. It increased marginally to 2.7 per cent in 1995-96, then the share continuously declined to 1.7 per cent in 2002-03. However in 2006-07, some reversal is observed, mainly due to the introduction of NRHM and the share reaches to 3.1 per cent.
In the case of communicable diseases, since 1995-96 we observe a continuous decline in its share. In 1995-96 in terms of share in total budget 5.8 per cent was spent, which was much higher than what was spent during 1987-88 (4.8 per cent). But since then there has been continuous decline and during 2006-07 only 2.75 per cent was being spent on communicable diseases, which is even lower than the share of non-communicable disease. When we add the two categories together, we find that during 1987-88 around 7 per cent was spent, which reached a peak of 8.5 per cent in 1995-96 but since then there has been continuous decline. In 2006-07, only 5.6 per cent is being spent.

Let us now disaggregate the spending on communicable diseases to see which of these are being taken up seriously by the State and which are largely ignored. We have made a sub-categorisation and clubbed all vector borne diseases like Malaria, Filaria, Japanese encephalitis, Dengue. We are considering tuberculosis and leprosy separately and all other communicable diseases have been put under the category 'other'. During 1987-88 almost half of the spending was on vector borne diseases; Tuberculosis and leprosy received a quarter of the expenses, other diseases were given almost negligible share. During the early 1990s, we observe a decline in the share of VB diseases and corresponding increase in share of leprosy. Let us also remember here that this was the phase when overall share of communicable diseases was increasing. In absolute terms, between 1987-88 and 1995-96 spending on VBDs
increased less than twice but spending on leprosy increased more than four times. This development can be seen in the context that during this phase DALY was introduced to ascertain the burden of disease and leprosy was given greater emphasis nationally. Expenditure on tuberculosis, on the other hand, faced a cutback in absolute terms during early 1990s but subsequently increased. But during late 1990s again we see a decrease in share of tuberculosis. From more than a fourth of share in budget, it was marginalized to almost less than a fifth by 2006-07. This is in sharp contradiction with the resurgence of tuberculosis nationally. The other important issue is complete marginalization of other communicable diseases and the spending on tackling epidemics and disease surveillance programs. During the early 1990s there is decline in spending on these items in absolute terms. In a State like Kerala, where the economy is dependent largely on trade and there is considerable migration, neglect of disease surveillance could expose people to risk of transmitting diseases outside the country as well as bringing in diseases from outside.

**Figure III.16.b: Share of major diseases in total communicable disease kitty: Kerala**

![Graph showing share of major diseases in total communicable disease kitty: Kerala](image)

*Source: Detailed Demand for Grants, State Budget, Kerala, Tamil Nadu and West Bengal; various years.*

Tamil Nadu spent more than a eighth of total budget on MPHFW on disease control programs during 2006-07. This is a sharp decline from the share during 1990-91, when a fourth of the total spending was on disease control programmes. Though 1990-91 seems to be an exceptional period, the current level is even lower than what prevailed during late 1980s or even early 1990s (more than 15 per cent). Much of the decline is due to a decline in spending on communicable diseases. Spending on non-communicable diseases remained almost static at a very low level of less than 2 per
cent, occasionally touching two. This is much lower than share of Non-communicable diseases in Kerala. Of late, there seems to a renewed interest on communicable disease as its share increases since introduction of NRHM.

Figure III. 17.a: Share of Communicable and Non-communicable Disease in Total Health Budget of Tamil Nadu

Source: Detailed Demand for Grants, State Budget, Tamil Nadu, various years.

Share of different diseases within the total spending on communicable disease varied widely across time in Tamil Nadu. Till mid 1990s almost 80 per cent of the spending was made in vector borne diseases. But in subsequent time there was continuous decline in its share. Leprosy got increasingly higher share in spending. During 2006-07 only a fifth of the total spending went to vector borne diseases, whereas leprosy received almost half of the funds. Tuberculosis received very little attention in Tamil Nadu, though the share increased marginally. In fact, after the introduction of NRHM there seems to be some improvement in spending on tuberculosis. In the category of 'others' considerable share is on bacteriological lab, control and surveillance of epidemic preparedness. As it was the case with Kerala, in Tamil Nadu also there is some decline in share of others during 1990s, this is largely to do with the general negligence shown towards these extremely sensitive issues of disease control. Since the introduction of NRHM, there is higher attention given to these diseases.
In West Bengal, the share of diseases control programs increased considerably during early 1990s compared to what was being spent during late 1980s. The share more than doubled between 1989-90 and 1990-91. Throughout the 1990s the share remained stable around 16 per cent, in fact it increased to some extent during late 1990s and early 2000s. However since 2001-02, there is continuous decline, which continued even after NRHM was introduced. Most of the spending on disease control program was on communicable diseases. There was almost no expenditure on non-communicable disease during 1980s. During early 1990 some specialty hospitals to treat cancer was set up and strengthened and hence there was some increase in share.
We break up the communicable diseases into sub-categories like vector-borne disease, tuberculosis, leprosy, water borne diseases and club all other diseases into one category. Most significant difference of West Bengal with other States is that the share of tuberculosis is much higher compared to other States. Correspondingly leprosy and vector borne diseases received relatively less attention in the State. One reason for the higher share of tuberculosis may be because of presence of tuberculosis hospitals and sanitariums in the State. However, a relatively low share of leprosy is quite strange considering the fact that it has a high burden of diseases. In fact the share reduced significantly 2001-02 onward and made way for greater spending on vector borne diseases. Spending on water borne diseases was very marginal throughout and over time, schemes were completely withdrawn from budget.

While summing up the discussion on disease control programme, it is important to highlight that there is a clear decline in its share during the entire period of 1990s and 2000s, for all the three States. To a great extent this has to be linked to decline in share of communicable diseases. Non-communicable diseases received very little attention, though it was slightly higher in case of Kerala. Among the communicable diseases, Leprosy received higher attention in Kerala and Tamil Nadu but not in West Bengal. Though in most parts of the country there is steep decline in disease load in leprosy, in West Bengal, the load is still around unity, which is highest in the country. Tuberculosis received considerable attention in Kerala and West Bengal, but got very little attention in Tamil Nadu. Given the resurgence of tuberculosis along with increasing prevalence of HIV&AIDS, it is expected that it would get greater attention.
Tamil Nadu, which has highest number of HIV patients in the country, would be expected to spend more on tuberculosis. It has to be kept in mind that all expenditures on disease control could not be captured in our exercise, especially the spending on non-communicable diseases. This is because of the fact that a considerable amount of spending is done as part of the general expenditure on hospitals and dispensaries and the accounting system needs to be changed. Ideally this is desirable as control of many diseases can be done effectively if they are integrated in to the general system of health service delivery. However, the way health system is structured currently in India, this is hardly a case. Most of the control programs have vertical administration for implementation. There are efforts under NRHM to integrate disease control programs, but desired results are yet to be seen.

**Spending on Big Hospitals**

It is important to look at the pattern of spending on tertiary, super-specialty and medical college hospitals in States. These hospitals are, generally, the most important institutions for the delivery of quality curative health care, with high dependence of people on them. At the same time most of these hospitals are medical college hospitals, producing the doctors for their respective States as well as the entire country. On the other hand, these hospitals eat up major share of total spending of States. The example of All India Institute of Medical Sciences can illustrate the point well. For the year 2011-12 a total of Rs 1100 crores were allocated to AIIMS, this is more than the total health budget of many States, including Himachal Pradesh, Haryana, Chhattisgarh etc. There is no denial that there is immense requirement to improve quality of health care in these hospitals, but in the context of stringent cut back measures, it is quite likely that majority of resources are consumed in maintaining these institutions.

Let us now look at the situation in the three States vis-à-vis their priority towards big hospitals. Let us first look at the pre-1990s situation. There is sharp contrast between Tamil Nadu and other States, in terms of share in MPH&FW budget. In Tamil Nadu more than two-third of the total spending were consumed by the big hospitals. Subsequently there is some decline in priority towards 1990s. But for the remaining period the share remained around 46 per cent. In case of Kerala only a fourth was spent on big hospitals during 1987-88. Consequently there was some increase in
share, however it remained at a level less than one third. To start with, West Bengal was spending only around 12 per cent on MPHFW, much less than the other two States. Till mid 1990s, though the same level was maintained, a sudden jump occurred during early phase of 2000-01. In fact in 2001-02, share touched more than half of total MPHFW budget. However to get a clearer picture we need look at further desegregation and trace out the how much of the so called service was spent on the new initiatives.

![Figure III. 19: Share of big hospitals in total spending on MPH&FW](image)

Source: Detailed Demand for Grants, State Budget, Kerala, Tamil Nadu and West Bengal, various years.

**Spending on Maternal and Child Health**

Kerala, Tamil Nadu and West Bengal are among the best performing States in terms of maternal health indicators. Though Kerala is far ahead, Tamil Nadu and West Bengal along with Maharashtra are other better performing States. All these States are characterized by relatively low IMR and MMR. It would be worthwhile to find out the budget on maternal health for these States. The Union government intervenes on maternal health through three major schemes. Two of them are under the Ministry of Health and Family Welfare (MHFW); the most important one being the Reproductive and Child Health (RCH) programme, the other being the Rural Family Welfare scheme. Supplementary Nutrition Programme (SNP) implemented by the Ministry of Women and Child Development (MWCD) also focuses on maternal health. The State governments run hospitals specifically for maternity purposes and train health professionals and workers. Some States also have special incentive schemes for institutional deliveries.
There are broadly two types of interventions. Some are initiated by the Centre as Centrally Sponsored Schemes (CSS) while the others are State interventions. The financial architecture of the CSS is not unique and involves two broad channels. For some CSS, States are provided funds, which would then appear in the State budgets. Rural Family Welfare Service is one such scheme. Interestingly, one cannot locate RCH in the budget of the States. This is because under RCH, the Centre bypasses the State budget and transfer funds to the State Health Societies (SHS). States have their own State Plan Schemes and non-plan interventions. In the State budget, there would be three major forms of interventions – the CSS routed through the State budget, the State Plan Schemes and the non-plan interventions. For the total expenditure on maternal health in the State, it is necessary to add CSS funds bypassing the State budget and funds that appear in it. However, there are difficulties in getting the disaggregated data unless one looks at the audit statements of the State Health Societies. The problem is that these Statements are not available online. The level of disaggregation that is available from the NRHM website of Ministry of Health and Family Welfare (MoHFW) is not enough for our analysis. It provides spending on RCH flexible pool\(^9\) and Janani Surakshya Yojana within RCH. The RCH flexible pool includes spending on family planning and other items which should not be part of the maternal and child health budget. To a large extent this shortcoming would be overcome as item wise data on spending across all States is provided by MoHFW since 2008-09.

To resolve the issue we would adopt an indirect methodology. From the available data for 2008-09 we would identify the family planning and other components which are not supposed to be part of the MCH budget. We compute the ratio of family planning activities to the total RCH Flexi pool funds. Assuming that the share of family planning activities would be more or less the same for other years we would derive the deductible amount for other years. Thus we can obtain the MCH component by deducting these items. It should be noted here that this assumption may not hold as evidences suggest that the share of family planning activities under NRHM remained higher during the initial phase of NRHM (Indranil 2010).\(^{10}\) However, given the fact that the difference would be marginal and in the context of total maternal health budget it would form insignificant proportion, we can safely use this methodology.
Let us first look at the aggregate level of spending on maternal health. There is significant variation in the share among the States. But the most significant observation that comes out of the fig III. 20 is that since the introduction of NRHM there is considerable increase in the share in case of Kerala and West Bengal. Among the three States, Tamil Nadu really stands out. In 1987-88, it spent around 4.3 per cent of health budget on MCH, however it reduced to half (2.3 per cent) by 1995-96. There is continuous increase in the share since then. During 2003-04 Tamil Nadu spends around 6.2 per cent of health budget on MCH, way above of what is being spent by other States. 2006-07, when NRHM funds are included the share reduces to some extent to 5.6 per cent. Compared to Tamil Nadu, the MCH budget of other States seems to be extremely tiny. Kerala used to spend around 3 per cent of health budget on MCH during 1990-91. Over time this share reduced and 2003-04 it spent less than one per cent of budget on MCH. In 2006-07, due to introduction of NRHM, the share jumps to 2.6 per cent. The situation in West Bengal is even worse; in 2003-04 it spent as little as 0.14 per cent on MCH. However, the share increases to 2.3 per cent after introduction of NRHM. The higher share of Tamil Nadu in MCH shows its commitment on maternal and child health issues. Even before the introduction of NRHM, Tamil Nadu had initiated several programs on safe motherhood which were replicated by other States and nationally. A better understanding can be developed when we look at the details of schemes and programs. Let us look at the per capita spending on maternal and child health in order to make a better comparison.
Let us first explain the methodology of calculating the per capita expenditure on maternal and child health. Most of the maternal and child health interventions are meant for the children below five years of age and women in the reproductive age group, i.e. 15-44 years. We have deflated the total budget figures with the population in these two groups. The population figures are from Population Census of 1991. There are two reports that are used. The data for year 1990-91 are taken from the child-women ratio of Census (RGI, 1991). For the remaining years, Population Projections 1996-2016 India and States, has been used (RGI, 1995). In order to control for the changes in prices, we have used the NSDP deflators, calculated from NSDP data provided by CSO. The per capita real expenditure data would help us to understand whether there is any increase in spending over time, though it would underestimate the absolute level of spending.

**Figure III. 21: Per capita expenditure on Maternal and Child Health (constant 1981 prices)**

![Graph showing per capita expenditure on Maternal and Child Health for Kerala, Tamil Nadu, and West Bengal.](image)

*Note: In order to take per capita expenditure, population below five years of age has been added to female population in reproductive age group (15-44 years). This is based on the understanding that most of the interventions considered in the MCH budget cater to people of these groups. Real per capita expenditure has been obtained by deflating with NSDP deflator at 1980-81 prices.*

*Source: Population figures are from Census (1991): Population Projections of India and States, RGI. NSDP deflator is derived based on CSO data.*

Let us first look at the absolute level of per capita expenditure in current prices. Tamil Nadu spent Rs58 per capita on maternal and child health in the year 2006-07. This is more than three times to what West Bengal spent (Rs. 18) and significantly higher than that of Kerala (Rs. 33). This would include spending on the States on NRHM. Fig III.21 shows the trend in per capita spending since 1990-91 at constant prices. We see that for all the three States, there is continuous decline in spending after 1990-91.
For Kerala and West Bengal, the decline continues till 2000-01, however in case of Tamil Nadu there was some recovery in 2000-01. Compared to other States, the level of spending in West Bengal was much low to start with and it went down further, only to increase after the introduction of NRHM. Though the level of spending in Tamil Nadu is much higher, it cannot be seen as a benchmark. The simple reason is still substantial number of maternal and infant deaths taking place in the State even though the coverage of immunisation, Ante-natal check ups and institutional delivery is very high. The low level of investment in West Bengal can be linked to its poor performance in institutional delivery and ANC. Some further break down of MCH budget into the nature of interventions would be required to develop a better understanding of policy and priorities of the States on the issue of safe motherhood and child survival.

Rural and Urban Differentials:

One of the dichotomies in the delivery of health services in the country is that most of the hospitals and institutions of health service delivery are located in urban areas whereas most of the people live in rural parts of the country. Even the doctors are mostly located in urban areas. Several authors have analysed the reasons of urban centric health service development in the country (Banerjee 1985; Qadeer 2001). When India became a signatory to Alma Ata Declaration, the Union Government pledged to change the situation, lots of emphasis was given to set up rural health infrastructure and gear up public health systems to cater to the needs of the rural people. Emphasis on water supply, sanitation, setting up of PHCs and sub-centres etc. were steps in that direction. How much of it could be actually realized could be found out if, the total spending is disaggregated according to rural-urban differences.

It has to be kept in mind that the issue of rural-urban disaggregation of spending has certain issues about access and methodology. Firstly, let us look at the issue of access. Having a big hospital in a city makes quite some sense. This is because of several reasons. Urban areas are in general better connected in India. Tertiary care institutions are meant for specialty care, which can serve huge population effectively. Urban areas being better connected to a larger number of people, it is quite justified that big hospitals would work more efficiently if located in prominent places. At the same time primary health care should be as accessible to people as possible to be effective.
This requires that public health services, primary level care facilities are located in rural areas. A proper balance of spending between urban and rural areas would be required to serve people's health needs properly. A dis-proportionately higher share expenditure made in urban areas would mean the services are not only urban centric but there is a negligence on public health and primary level care services.

Let us now look at the methodological limitations in this exercise. Certain items in the budget are clearly demarcated between rural and urban areas. For instance, rural family welfare services, programmes for tribal areas, are clearly meant for rural areas. Similarly medical college hospitals, urban FW services, administrative services are located in urban areas. But not all of them are clearly distinguishable. For instance, family planning beneficiaries, public health services are the ones which are not clearly distinguishable. We have adopted different methodologies to derive the rural-urban breakups of these non-distinguishable items. For the family planning beneficiaries, we have taken rural urban break ups of beneficiaries of different family planning services. Similarly for public health services and maternal health services we take the share of rural populations in the respective States. Here we essentially assume that the public health services are evenly distributed across rural and urban population, which is far from reality as most of these services would also be relatively urban centric. Due to unavailability of better data we would adopt this methodology.

Let us first take the share of expenditure in rural areas as a share of total expenditure derived by the above methodology. We consider the time period from 1990-91 to 2004-05. To start with, all the three States have almost similar share in rural...
expenditure- a little more than one third. If we look at the share of rural population in 1990-91, we find huge disparities in spending. In Kerala, although not strictly as germane as in the other states, almost three quarter of population (74 per cent) lived in rural areas in 1990-91. In Tamil Nadu and West Bengal the shares are two third and 72 per cent respectively. By the end of 2004-05, there is no significant decline in rural population share in Kerala, but expenditure on rural areas declines to 30 per cent. In Tamil Nadu, share in rural population declined to little more than half (52 per cent), whereas share in spending goes down to 31 per cent. In case of West Bengal, there is marginal increase in share of rural expenditure (35 per cent) when the population share of rural area remains the same. In Kerala, share in rural expenditure remains stable during early 1990s, but falls subsequently, recovers during late 1990s only to fall down during the later period. In Tamil Nadu, we could observe a continuous decline in the share of rural expenditure till 1997-98, since then it rises for two consecutive years but falls subsequently. In contrast to Tamil Nadu share of rural expenditure in West Bengal increases marginally during most part of the 1990s, however, there is a sudden fall during early years of the millennium which is recovered in the later part.

Now let us look at the differentials in per capita spending in rural urban areas we can probably understand the level of inequalities better. During 1990-91 per capita spending in urban areas was more than five times than that of rural areas for both Kerala (5.26 times) and West Bengal (5.17 times). Compared to these the ratio was only 3.6 times in Tamil Nadu, showing a better parity between rural and urban spending. There is a continuous decline in the ratio for the entire time period, meaning that there is a significant effort from the State to reduce rural urban disparities. However, it may also be linked to rapid urbanization and reduction of rural population share.

Due to increasing urbanization population residing in rural areas has reduced in share. The other important pattern that has emerged is that the attention for family planning initiatives have also spread into rural areas compared to urban belts. These might contribute to decreasing rural-urban disparities in spending. One of the important proxy variables for health infrastructure can be population served per bed. When we refer to table III.5 we find that there is a steep decline in population served per bed in

Public Spending on Health at the State Level
Kerala since 1980s. Here the data is for both public and private sector. Both in TN and WB, the ratio is much higher than Kerala. In case of WB, there is in fact significant increase in population served per bed in rural areas. The same ratio is much less for urban areas. While in rural areas one bed serves more than 12000 people, in urban areas the ratio is 446. Thus there is significant disparity health infrastructure between rural and urban areas. The disturbing aspect is that over the years this disparity has increased in WB. One bed in rural area serves 27 times more people than the population served per bed in urban areas. It has to be kept in mind that this disparity is clearly linked to the growth of private hospitals, which are essentially located in large metros like Kolkata and its suburbs and other relatively affluent urban areas.

<table>
<thead>
<tr>
<th></th>
<th>Population served per bed</th>
<th>Rural/ Urban Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>Kerala 1981</td>
<td>956</td>
<td>223</td>
</tr>
<tr>
<td>Kerala 1991</td>
<td>566</td>
<td>236</td>
</tr>
<tr>
<td>Tamil Nadu 2001</td>
<td>317</td>
<td>354</td>
</tr>
<tr>
<td>Tamil Nadu 1991</td>
<td>8685</td>
<td>428</td>
</tr>
<tr>
<td>West Bengal 2001</td>
<td>4477</td>
<td>385</td>
</tr>
<tr>
<td>West Bengal 1991</td>
<td>6488</td>
<td>403</td>
</tr>
</tbody>
</table>

Source: Data on beds is from Health Information of India, Population data is from Census projections

Economic Classifications:

Economic Classifications of expenditure give extremely important findings about the nature of spending. In the budget document the most detailed breakups depict economic classifications. It means breaking expenditures in to different kinds of spending, like salaries, office and maintenance, drugs, equipments, buildings etc. Human resources are extremely important for delivery of health services, because it is the doctors, the nurses, the ANMs, the paramedical staffs, who run the health services. At the same time provisioning of medicines, good quality of equipments, renovations of old infrastructure and setting up new ones are quite crucial for good quality care. It is important to have some sort of balance in the different classes of spending.
In Kerala, salaries contributed to around 60 per cent of total expenditure in 1987-88, almost a fifth was spent on building and 13.3 per cent on drugs (fig III.23a). By mid 1990s, there was significant change in the pattern. Share of salaries increased whereas that of buildings and drugs decreased. In the context of slowing down in growth of spending this meant that the essential elements of quality care got compromised. During 2006-07, share of medicines increased considerably to 12.8 per cent, along with considerable increase in office expenses. At the same time share in building and equipment reduced further. In West Bengal around two third (65 per cent) of expenditure went to meet salaries in 1987-88. Around 16 per cent was spent on drugs, where as very little was spent on infrastructure and equipments. By mid 1990s, there was increase in share of salaries (72 per cent), whereas share of drugs reduced to 10 per cent. In 2005-06 share of drugs got further reduced, where as salaries also got lower share. However, this may be due to changes in reporting pattern in the State, where salary grants to autonomous institutions were reported as other expenses. In Tamil Nadu between 1987-88 and 1995-96 marginal increase in share of salaries and infrastructure and equipments took place largely at the cost of other spending and drugs. Share of drugs went down to 5.4 per cent from the earlier level of 8 per cent. Spending on infrastructure and equipments increased by one percentage point to 18 per cent. However, there seems to be some rearrangement during 2006-07 when share of building and equipments decreased (9 per cent) where as share of drugs increased (10.7 per cent). The increased emphasis can also be seen in better functioning of the
Tamil Nadu Medical Services Corporation (TNMSC), which has emerged as a model of drug supply in the country.

**Figure III. 23 b & c: Economic Classification of spending: West Bengal & Tamil Nadu**

- **Figure III. 23 b: Economic Classification: West Bengal**
  - 1987-88
  - 1995-96
  - 2006-07
- **Figure III. 23 c: Economic Classification: Tamil Nadu**
  - 1987-88
  - 1995-96
  - 2006-07

Source: Detailed Demand for Grants, State Budget, Tamil Nadu and West Bengal, various years.

Economic classification have been used as an important advocacy tool by international agencies like the World Bank and IMF to show that too much money is being spent on salaries and hence there is a need to cut back spending on salaries and reprioritize on other items. During the early phase of 1990s, when economic reforms were implemented in India, many State government and the Central Government banned recruitments in order to cut back spending and reduce fiscal deficit. In health services, recruitments of doctors, nurses and more importantly paramedical staffs were stopped. Along with emergence of private sector, the recruitment ban fuelled exodus of people from public sector and huge vacancies were created. From the example of Kerala, Tamil Nadu and West Bengal we can make out that share of salaries increased rather than getting decreased during the time of contraction of expenditure in early 1990s. It happens due to downward rigidity of items like salary, which cannot be cut back easily. In such situations, items like drugs, equipments etc which are rather soft are withdrawn. This leads to severe compromise in the quality of service provision. While noting the fact that salaries are quintessential part of health service delivery one may try to distinguish between salaries spent on personnel who are delivering services with those who are engaged in administrative works. Definitely there is a case against excessive expenditure on administrative services, and especially on salaries which essentially promotes bureaucratization of services. The fact that a high proportion is spent on salaries is not a comment on salaries as such but on the inadequacies of the budget.
Let us now turn our attention towards spending on drugs. A large section of out-of-pocket expenses happen on account of drugs. In public sector out-patient services more than four fifth of spending happen on account of drugs. This has happened largely due to gradual withdrawal of provisioning of essential medicines from government facilities, which forces people to buy drugs from open market. Per capita expenditure on drugs at constant prices can be a good indicator of government’s commitments on provisioning of free drugs. In order to control for the effect of prices we have deflated drug expenditures with price index of drugs. Fig III.24 provides a comparative picture on per capita expenditure on drugs. Between 1987-88 and 1995-96, there is hardly any increase in per capita expenditure on drugs for all the three States. However in the subsequent period, there is substantial increase. In the year 2006-07, Kerala spent around Rs. 37 on drugs; Tamil Nadu spent around Rs. 25 and West Bengal spends around Rs. 15 on drugs in 2006-07. It has to be kept in mind that these amounts are miniscule compared to people’s needs resulting in escalation of out-of-pocket expenditures.

**Figure III.24: Per capita expenditure on drugs (Constant Prices)**

Source: Detailed Demand for Grants, State Budget, Kerala, Tamil Nadu and West Bengal, various years.

**Conclusion:**

The level of public health service provisioning in India had never reached a level which could ensure universal and comprehensive health services. During late 1970s and early 1980s there was at least a process of building public health infrastructure in the countryside. The central feature of the reforms process is to reverse that gradual process of institution building. Through chronic underinvestment, public health system today is pushed to a severely depleted state and the system is incapable of
delivering quality health care. It has to be noted that though this is the case with major parts of the country, this may not be entirely true in case of Tamil Nadu and Kerala, where there is some standard of government health services could be maintained. The central point in the current exercise is to identify what kind of changes in the budgetary priorities happened during this period. It was also important to understand how the changing prioritization affected the quality of public health service delivery. It seems that there are important state level variations that have taken place within the broad general patterns.

Let us first try to summarize the general trends that emerge. First, there is a general decline in spending on health, when observed in terms of its share in GDP or total budget of States. The decline is stronger when health services are considered. This necessarily implies that within a shrinking space there is further reprioritization against essential health services. Important sectors which have benefited from this reprioritization are water supply and sanitation. High growths of these two sectors have helped to increase their share in national averages as well as state levels. Nutrition, however, did not get adequate attention during reform years. States like Kerala and West Bengal spent very little on nutrition whereas in Tamil Nadu there was improvement in share.

Plan investments were low throughout, limiting the scope of new interventions. Share of plan investment was even lower in case of health services. From a low level, there was some increase in share for plan in total health, but it declined further in case of medical and public health, remained almost at the same level when we include family welfare. Declining share in medical and public health with increase in total health and same ratio for health services essentially mean that share of other areas increased and within health sector changes were in favour of family planning. But at the same time share of Centrally sponsored schemes in plan investment increased in case of most of the states. Similarly, a very low level of spending is done in capital investment, which essentially means that new facilities are not being built adequately and investment on machinery and equipments are not getting adequate attention thus affecting quality of health services.

Secondary health care services which are supposed to provide basic hospitalization services, especially in the rural area getting low priority in the pattern of spending.
This can be seen as one of the reason for deterioration of health services in Community Health Centre and greater pressure on tertiary levels and big hospitals. Big hospitals correspondingly got more importance relatively, thus consuming a large share of total spending on health. Though there is no denial that greater investment is required at tertiary level, but in a context of overall squeeze in spending greater priority on big hospital cannot be interpreted as improvement. There are several factors which could affect this prioritization. Being located in district head quarters or state capitals, there is a tendency among doctors to remain posted in these hospitals and not go to rural areas. The absence of doctors and good quality of care in rural areas in turn push people generally to these better served hospitals and create a demand for these hospitals. An almost complete absence of specialists at CHC level is a proof of this.

Maternal and child health services are extremely important in the case of India. And the persistence of high infant and maternal mortality clearly points out that these services are out of reach for many people. Extremely low level of investment on maternal and child health interventions limit the provisioning of these services. As usual, there was cut back on spending in these interventions during early 1990s. Since the introduction of NRHM there is some improvement in spending. Most important intervention within NRHM is the Janani Surakshya Yojana (JSY) which provides financial incentive for institutional delivery. One of the main reason why JSY could not provide adequate result was because it is cash transfer scheme not backed by improved provisioning of services. Though there is a greater demand for institutional delivery, due to lack of quality care or the ability of the health system to provide good quality care safe delivery is suffering. Moreover overemphasis on JSY has lead decreased coverage on ANC. Until the health service system is thoroughly overhauled, mere fiscal incentive for institutional delivery would not help achieve safe motherhood and child survival.

Declining share of spending on communicable diseases was quite drastic during the post reforms decades, but further disturbing is the near absence of spending on non-communicable diseases. If one looks at the major reasons for hospitalization or treatment in private sector, they are mostly the non-communicable diseases like coronary diseases, hypertension, and diabetics, etc. They way government health
services have been geared up in the last few decades, it seems apparent that there is an attempt to outsource these non-communicable diseases to private sector while limited itself to family planning, pulse polio immunization and to some extent tackling public health emergencies. Frequent outbreak of several communicable diseases and emergence of new ones and complete inability to tackle these situations show that even there gross neglect of the communicable diseases. Authors have pointed out that a lot of the failure to tackle diseases like malaria or tuberculosis is to do with verticalisation of administration, failure to understand the social causes of these diseases (Banerjee 1985; Qadeer 2001). As this present exercise shows, it is also to do with lack of investment, which along with other factors have severely constrained provisioning of services.

A proper balance between spending on different inputs, like medicines, infrastructure and equipments, salaries etc is very crucial for the provisioning of health services. During the process of reforms that balance seems to have been severely compromised. While trying to cutback expenses, governments could not reduce salaries because of several difficulties, they could easily reduce provisioning of drugs, contract out operation and maintenance of equipments and machineries; they also stopped building new infrastructure. All of these lead to squeeze in the share of these interventions. These have got severe cost implications for the people. They are forced to purchase drugs from open market. According to NSSO findings, drugs alone cost four fifth of the total out-of-pocket expenditure for the use of public health services (GoI 2006).

Costs of diagnostic services have also increased significantly.

Let us now try to understand the state specific developments. Kerala has a long history of provisioning of quality public health services. It was spending much more than other states on health in the pre-reforms period. In terms of spending priorities water supply, sanitation and nutrition got significant attention. During 1990s, there was fall in the level of spending, but the fall was more significant in case of other services than on medical and public health. As a result medical and public health received higher priority at times of overall decline. In contrast health system in Tamil Nadu was quite medicalised during mid-1970s and early 1980s. Since then, there seems to be a renewed interest on water supply, sanitation and nutrition. As a result budget on health services was cutback more than other sectors. Both Kerala and Tamil

Public Spending on Health at the State Level

Page 129
Nadu experienced slowdown of growth during early 1990s, where as West Bengal could maintain a certain level of growth during the initial period. The real deterioration happened in West Bengal during later period.

During 1990-91 share of big hospitals in health services budget of Tamil Nadu was around 60 per cent. A substantial part of this was spent on district hospitals. In West Bengal, in contrast only one eighth of the budget was spent on big hospitals and major part of the expenditure went into a few medical college hospitals. Though in subsequent time there was considerable increase in share of big hospitals, attention towards district hospitals increased very little and that too much later. At the same time, spending on secondary level care in West Bengal very remained low. In the absence of good quality care in CHCs and district hospitals, the dependence on Kolkata based medical college hospitals increased severely. The pressure on the big hospitals could be avoided in Tamil Nadu and Kerala through sustained investment at district level with opening of many medical colleges at districts. West Bengal was very late in adopting this strategy.

A few important factors could be identified to show why Tamil Nadu could maintain a good quality of health care during post reforms period. It showed maintained higher level of capital investment than other states, plan investments were balanced between tertiary and primary level cares, higher investment on maternal and child health services, and most importantly, spending on drugs. Kerala and West Bengal on the other hand had low capital investments, greater plan investment on primary with gradual negligence of secondary level care and lower spending on MCH. It must be noted here that in the case of Kerala, where the institutional births is almost universal, there may be lesser requirement for special initiatives to improve maternal and child health. As a result less number of initiatives could be identified, even though there would substantial spending on MCH as part of general budget. This is not true in case of West Bengal, where home births prevail and coverage of ANC and immunization is lower compared to other states. And hence more special attention may be required to bridge the gaps in service provisioning.

The drug delivery system in Tamil Nadu has become a model for the entire country. The fact that per capita out-of-pocket expenditure on drugs is lesser when one uses public services shows that it has been successful to provides drugs to people. It should
be noted however that Tamil Nadu model could not be successfully replicated in other states. Lack of system approach in replicating the TNMSC experienced may be one reason. TNMSC experience cannot be seen in isolation, it has to be linked to the overall health service development in the state. Unlike many other parts of the country, Tamil Nadu could develop relatively strong public health system along with strong growth of private sector. Political commitments towards delivery of social services, long history of social reforms and upliftment of the most backwards social groups are extremely important factors that lead to development of public health services. This is also the case in Kerala. In the context of a well-functioning health service system interventions like TNMSC could yield desired success.

Public expenditure on health declined in the post reforms period compared to the level that could be achieved during the earlier decades. There can be two streams of arguments to explain the decline. It may be argued that it is a conscious political decision to reduce the role of state in health which has been materialized through these cutbacks. However, one need to also see why those states which were either opposed to the reforms or had a strongly positive approach towards provisioning of social services could also not resist the cutbacks in spending. The answer may not be found within the health sector itself. One may need to go beyond health financing and look at the broad macro-economic and financing patterns or may be changes in centre-state fiscal relations.

1 Process of GiA transfer has undergone significant changes since 2001. Earlier all the GiAs were transferred to States and the spending was reflected in State budgets. However, since 2001, GiAs are being transferred to autonomous bodies thus bypassing the budgets and legislative scrutiny of the States. This issue would be taken up later. Total health expenditure here include the spending on medical and public health, family welfare, water supply and sanitation and nutrition. It doesn’t include spending by other departments on health.


5 The framework for WHO’s NHA reporting is based on the System of National Accounts (SNA) of the United Nations and accommodates, to the extent possible, the WHO definition of the boundary of the health system to include all activities involved in the provision of goods and services whose primary intention is to improve the health status of the population.


9 Under NRHM States are being allocated funds as a bulk instead of specific intervention wise allocation which used to be the case with earlier CSS, Funds allocated for RCH is thus called RCH
flexi pool. It is so called because State Health Societies can spend this fund according to their priorities subject to the approval of the National Program Coordination Committee.

10 Indranil (2010), Safe Motherhood, Public Provisioning and Health Financing in India, Report, Centre for Budget and Governance Accountability, New Delhi.

11 Gol (1991), Census of India


