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The Policy Brief series is aimed at stimulating policy discussion on specific issues by summarising results of research carried out in-house at NIPFP and elsewhere on the broad theme of ***Financing Human Development***. Dissemination of these is a part of the research programme currently underway at NIPFP on the same theme, supported by the Planning Commission and UNDP.

PUBLIC SPENDING ON HEALTH IN LOW-INCOME STATES AND CENTRAL TRANSFERS

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The level of public expenditure on health in India is among the lowest in the world. As per the UNDP Human Development Report 2004, India ranks 173 among 177 countries in terms of public expenditure on health. At 0.9 percent of GDP, public expenditure on health in India is also the lowest among South Asian countries. Keeping this in view, some of the major policy statements in recent years have stressed the need for increasing the level of public expenditure on health in the country. The National Health Policy, 2002, the 2004 Common Minimum

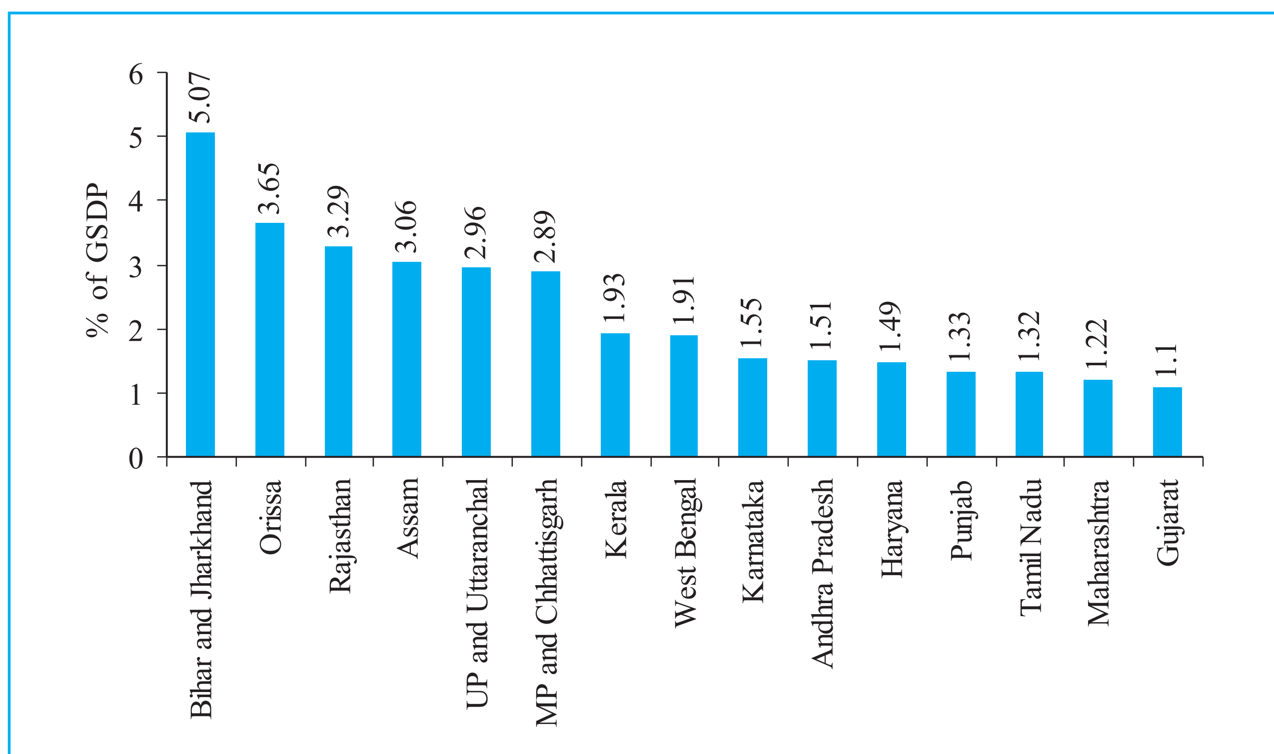

Figure 1. *State-wise requirement of resources for providing basic health services by 2009-10 (as percent of GSDP)*

Programme of the Government of India, and the National Rural Health Mission, 2005, have all endorsed the need to increase health expenditure to about 2 to 3 percent of GDP by 2010.

The need to raise the level of expenditure is particularly high in some states of the country. Recently, some estimates of resource requirements for providing minimum health services in the health sector were provided by a study conducted for the National Commission on Macroeconomics and Health, Ministry of Health and Welfare.[1] Minimum health services include providing access to health facilities in the rural areas (both in the form of physical facilities and manpower), providing all households with access to safe drinking water and toilets, providing nutritional supplements to all children in the age group of 6 to 71 months, and to all pregnant and lactating mothers below the poverty line.

Estimates suggest that in a number of low income states of the country, the requirement of resources for providing even the minimum health services is much more than 2 to 3 percent of their GSDP. In Bihar (including Jharkhand), Orissa, Rajasthan, and Assam the requirement is more than 3 percent of GSDP (*Figure 1*). In Madhya Pradesh (including Chhattisgarh) and Uttar Pradesh (including Uttaranchal), the requirement of resources is very close to 3 percent.[2] Sixty percent of the total shortfall in expenditure requirements to provide basic services in the health sector in 15 major states has been found to be in the states of Bihar, Uttar Pradesh, and Madhya Pradesh, alone. If one included West Bengal, Orissa, and Rajasthan, the additional requirement of resources is nearly 80 percent. On the whole, additional resource requirements

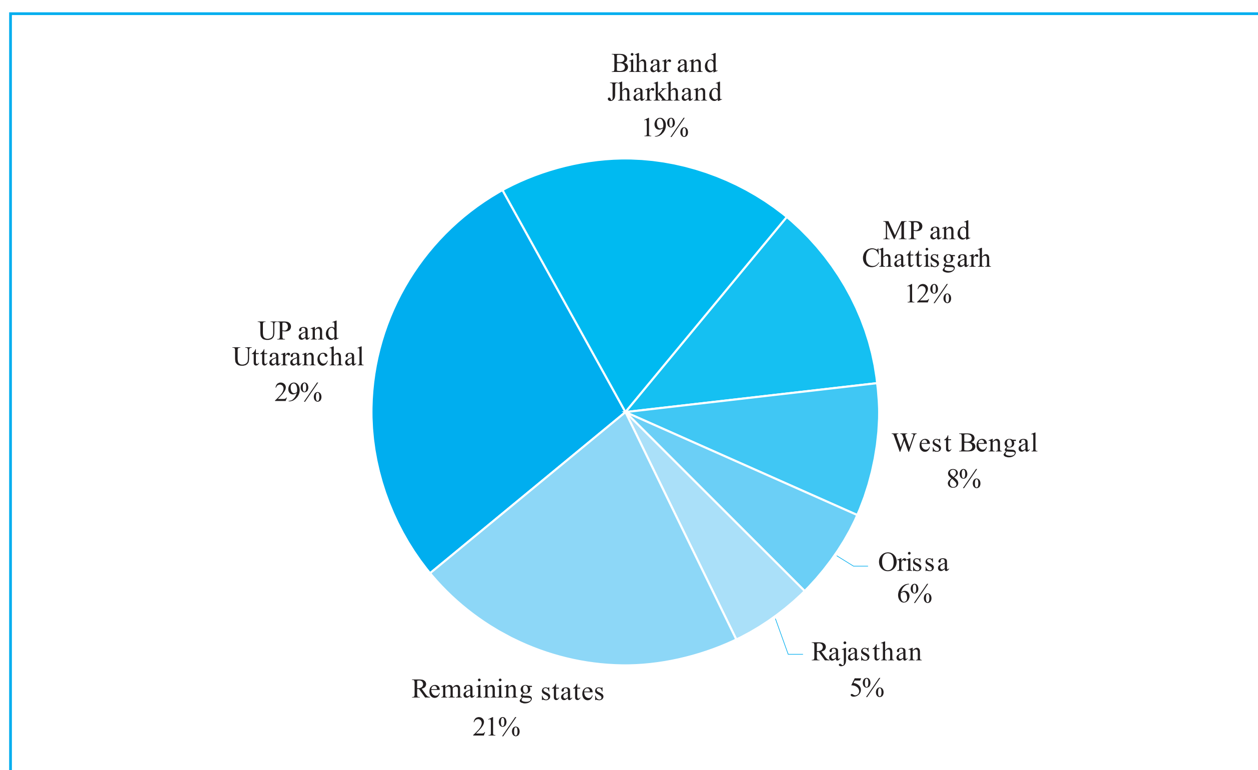

Figure 2. *Distribution of additional requirement of resources across States for meeting basic health services by 2009-10*

[1] Rao, M.Govinda, Mita Choudhury, and Mukesh Anand, 2005, "Resource Devolution from Centre to States: Enhancing Revenue Capacity of States for Implementation of Essential Health Interventions" in *Financing and Delivery of Health Care Services in India: Background Papers*, National Commission on Macroeconomics and Health (NCMH), Ministry of Health and Family Welfare, Government of India.

[2] This is the case despite the fact that the study mentioned above underestimates the resource requirements.

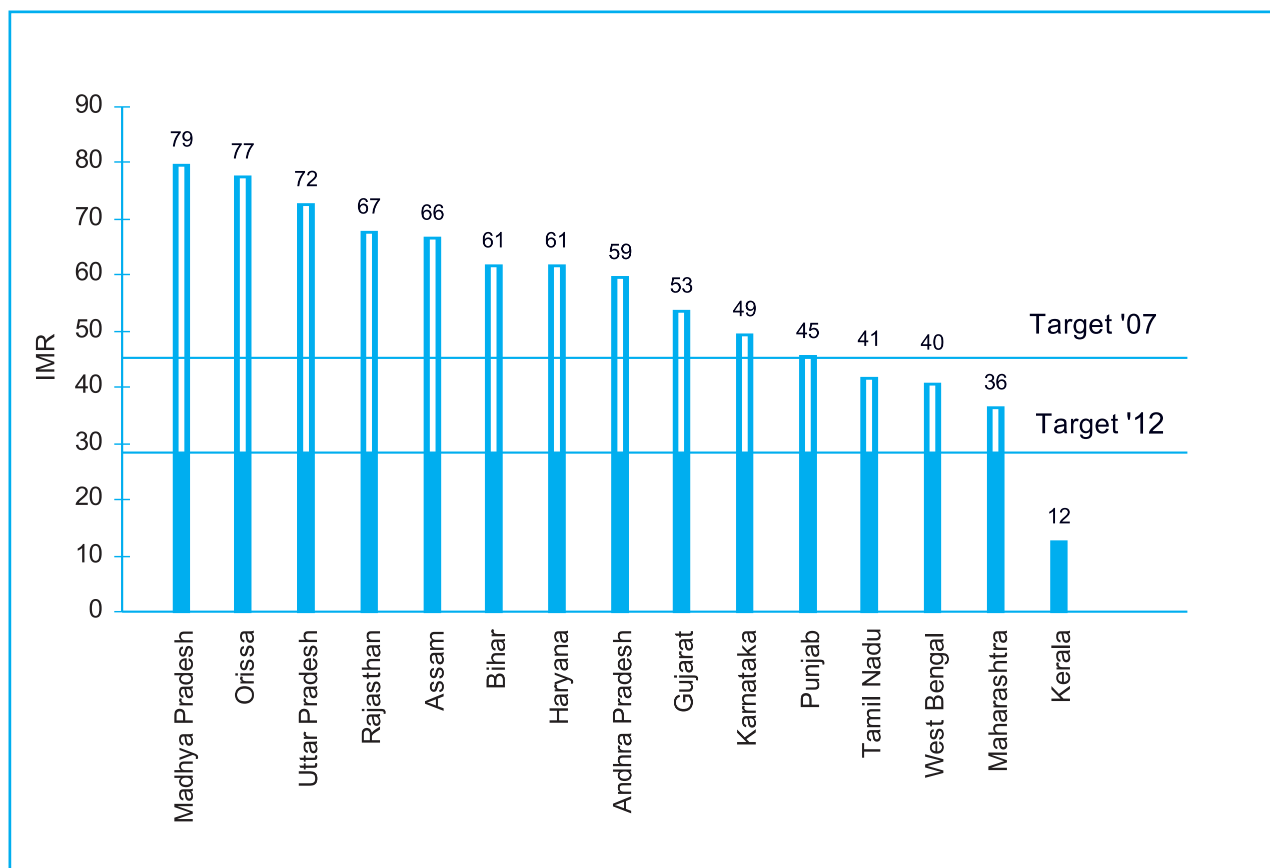

Figure 3: *Statewise Infant Mortality Rate and their gap from the Tenth Plan Goals, 2004*

for meeting the basic health services are concentrated in six states namely, Bihar, Orissa, Rajasthan, Assam, Madhya Pradesh, and Uttar Pradesh (*Figure 2*). These states are also the ones which have the poorest health indicators in the country and therefore drag down the level of health achievement for the country as a whole (*Figure 3*). With the mid-term appraisal of the Tenth Plan highlighting that India is off-track in terms of attaining the Millennium Development Goals (MDGs) and Tenth Plan objectives, increasing the level of expenditures in these states has assumed significant importance.

These states are however low-income states with limited capacity to generate additional resources for meeting the expenditure requirements. Most of the existing resources of the states are used up for meeting their committed liabilities towards wages, salaries, interest payments, and pensions. In Bihar, Orissa, and Assam, the entire revenue is used up in meeting the committed liabilities. Similarly, more than 95 percent of the revenues in Rajasthan and 85 percent of revenues in Uttar Pradesh are used up in meeting committed liabilities. Even in Madhya Pradesh, the corresponding percentage is more than 75 percent. This leaves very little room for any reprioritisation of expenditures in these states towards the health sector. Besides, most of these states have now passed the Fiscal Responsibility and Budget Management (FRBM) Acts, which require these states to reduce fiscal and revenue deficits within a specified period of time. This would constrain the states from bringing about any increase in the expenditure levels. Given the commitment to FRBM, the extent of committed liabilities and the limited capacity in generating additional resources, these states are not in a position to meet the additional requirement of health expenditures from their own resources.

This makes it necessary for the centre to step in and provide additional central transfers to these states to

facilitate increase in expenditure for providing basic health services in these states. The equalisation grants in the health sector provided by the Twelfth Finance Commission (TFC) has been a positive step in this direction. The TFC provided the equalisation grants to states whose per capita health expenditure was lower than the average per capita health expenditure of all states separately for special and non-special category states. By this classification, the states receiving additional grants, namely, Assam, Bihar, Jharkhand, Madhya Pradesh, Orissa, Uttar Pradesh, and Uttaranchal are specifically the states which require additional central transfers to meet the expenditure required to provide basic health services. The TFC grants, however, covered only 30 percent of the gap between the state's per capita health expenditure and the average per capita health expenditure, separately for general and special category states and are grossly inadequate for meeting the additional requirement of health expenditure in these states. A much greater amount of central transfers is required in these states to provide basic health services and improve the health indicators.

While the centre has pledged to increase its annual budgetary outlays over existing outlays by 30 percent every year under the National Rural Health Mission, it is important that these additional outlays are primarily directed towards specific states where these transfers are most required for providing basic health services. At present, the National Rural Health Mission (NRHM) focuses on eighteen states, which include these six low-income states. Redirecting additional outlays under NRHM towards these six states is important if one is hoping to put the country on the track towards meeting MDGs. Additionally, reprioritising the existing expenditures of the central government in favour of the health sector and targeting part of it towards these low-income states could well act as a booster for significantly improving the health indicators in these states.

Equally important is the mode of transfer of resources from the centre to the states. These have to be in the form of specific purpose transfers targeted at the health sector. While general-purpose transfers would also increase the resource availability at the state-level and enhance their capability to spend on the health sector, these would not be earmarked for the health sector and may not be used for augmenting health expenditures in these states. In fact, the equalisation grants for the health sector awarded by the TFC are specific purpose transfers with a reasonable monitoring mechanism. However, given that the TFC transfers are inadequate relative to the requirement of resources in the health sector of these states, these have to be supplemented with additional specific purpose transfers through centrally sponsored or central sector schemes with suitable safeguards to avoid fungibility of these funds.

In sum, there are two factors that make additional central transfers for reinforcing health services essential: (a) while the prescription of spending 3 percent of GDP on health may be an appropriate objective for the nation as a whole, in some of the states, the requirement is substantially higher and (b) it is specifically these states where the likelihood of additional expenditure on health from their own resources is small. Ergo, if India has to make substantive progress towards meeting the MDGs in the area of health, additional central transfers targeted towards these states is a policy imperative.