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Health Care Budgets in a Changing Political Economy

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A meaningful analysis of recent health budgets can only be made in the context of the direct and indirect encouragement given by the state to the growth of the private sector in health services. First, the slowing down of state investment in the hospital sector and the subsidies, soft loans and duty and tax exemptions offered; second, the creation of a market for modern health care through the setting up of PHCs and cottage hospitals in the rural areas; and third, the consistent expansion in highly qualified medical personnel who could not be absorbed in the state sector.

WHILE the 1980s saw the beginning of a process for economic change towards greater liberalisation and privatisation of the Indian economy, the 1990s have accelerated the pace of change under the umbrella of structural adjustment. This has also meant increase in borrowings with the debt burden burgeoning and making interest payments a rapidly increasing proportion of the state budget. This state of the economy has its bearing on state spending, and social sectors are the first to get the axe. The little hope which remained of a welfare state evolving in India is now fading away.

It must be indicated at the outset that India has always had a very large private medical sector, especially for non-hospital care. While the colonial state developed the hospital sector at a slow pace, individual private practice expanded without any state intervention. Investment in the private hospital sector was very small until the mid-1970s, after which it spread like an epidemic (Table 1). While the reasons for this historical moment are quite complex two facts stand out. Firstly, the slowing down of state investment in the hospital sector was in itself a signal to the private sector, and the state supported this by giving subsidies, soft loans, duty and tax exemptions, etc. Secondly, the earlier introduction of modern health care in the rural areas by the state through the setting up of PHCs and cottage hospitals had paved the way for the private sector, by creating a market for modern health care in the peripheral regions. Also, by the mid-1970s the number of specialists being churned out had increased tremendously and their demand in the west was comparatively reduced and this too may have played a role in private hospital growth because most specialists prefer hospital practice.

Apart from individual practitioners and hospitals the private pharmaceutical industry has provided considerable support for the expansion of the private health sector. We can clearly see the organic link between the two as they both expanded together at a fast pace post-mid-1970s (Table 1). In more recent years the new medical technology has added another dimension to this private sector expansion with the increasing participation of the corporate sector in health care. This is a clear indication of growth towards a monopoly capitalist character with health care now fully commodified thanks to the new genre of medical technology [Jesani et al 1993]. This coupled with the coming in of insurance multinationals, whose entry has only been delayed due to the political crisis, completes the circle of global market

TABLE 1: PATTERNS OF HEALTH SECTOR GROWTH IN INDIA 1951-95

Year	1951	1961	1971	1976	1981	1986	1991	Latest Year
Hospitals	2694	3054	3862	4465	6805	7764	11174	13692 (1993)
Per cent rural	39	34	32		27	21		31
Per cent private				14	43	44	57	67
Hospital beds	117000	229634	348655	448866	504538	594747	664135	696203 (1993)
Per cent rural	23	22	21		17	18		20
Per cent private				18	28	26	32	35
Dispensaries	6600	9406	12180	11696	16745	25871	27431	27403 (1993)
Per cent rural	79	80	78		69	53		40
Per cent private					13	45	60	63
PHCs		2695	5131	5373	5568	14145	22243	23009 (1993)
Subcentres			27929	37931	51192	98987	131098	131479 (1993)
Doctors								
All systems	156000	184606	450000	628000	665340	763437	920000	110000@ (1994)
Per cent allopathic	39	45	34	34	40	42	43	38
Per cent private Allopathic			62		71	73		
Nurses	16550	35584	80620	113455	150399	207430	311235	340208 (1992)
Medical Colleges	30	60	98	106	111	125	128	146 (1993)
Allopathic								
Per cent private	7	4	9	9	10	17	19	29
Non -allopathic						222		
Per cent private						65		
Outturn of medical graduates	1600	3400	10400	11982	12170	11970	12086	12000@ (1994)
Postgraduates		397	1396	2265	3833	5427	3139	
Non- allopathic						4000		
Pharmaceutical production (Rs bn)	0.2	0.8	3.0	4.3	14.3	21.4		60.5 (1995)
Government health expenditure (Rs bn)	0.22	1.08	3.35	6.78	12.86	29.66	50.20	113.13 (96-97)

Source: CEHAT Database; Original Source: Health Statistics/Information of India, CBHI, GOI, various years; for pharmaceutical production: OPPI literature, various years; for health expenditure: from Demand for Grants of various state governments, respective years; @ data estimated by author, # data is revenue + capital and for both central and state governments, excluding water supply and sanitation (see Duggal et al *EPW*, 1995).

consolidation of the health sector in India. This is like Alisha Chinai's 'Made in India' which had busted all popularity charts and supposedly given Indians a pride in the 'Made in India' label but most are not aware that this album was produced and recorded in London, UK! This is what globalisation of India is in reality – the label will become Indian but the surplus will be appropriated by the new genre of imperialists.

Apart from private sector expansion and corporatisation, another strong and undesirable character of the health sector in India is its neglect of rural areas where still over 70 per cent of the population resides. Today there are over 11 lakh registered medical practitioners of various systems in the country of which 60 per cent are located in cities. In case of modern system (allopathy) practitioners as much as 75 per cent are located in cities and especially metropolitan areas. For instance, of all allopathic medical practitioners registered with the state medical council in Maharashtra 55 per cent are in Mumbai city alone which has only 12 per cent of the state's population. The main reason, thus, for the underdevelopment of health care in rural areas is this vast rural-urban gap in the provision of and location of health care resources. With rural areas being underserved two things have happened – a large number of unqualified people have set up medical practice and the rural population exerts pressure on facilities in the cities and towns thus affecting the efficiency and capacity of the latter. In spite of planned development over the last 45 years the state has failed in narrowing the rural-urban gap, and in fact at the behest of imperialist influence it has promoted strategies for rural health care which cause more harm than good for the health of the people. Under the umbrella of community health the state has given rural areas third rate health care through its PHCs and that too only preventive (immunisations) and promotive (family planning) care; curative care which is the main demand of the people has been ignored in terms of investment and allocations and hence people in rural areas are left to the mercy of the exploitative private health sector which more often than not in rural areas comprises unqualified providers. It is important to see the health budgets in the above context for making a meaningful analysis.

While there is a lot of talk about the latest budget (1997-98) being remarkable, it has not really diverted from the path it has been traversing now for a number of years. While the salaried class and the bourgeoisie may have a lot to cheer in terms of saving taxes and having larger disposable incomes, there is nothing in the budget to bring cheer to the toiling masses. Social sector interventions like health care, education, housing, etc. which are regarded as important social levellers and help blunt inequities in society continue to be neglected. This despite the promise of the current government of assuring basic minimum services by 2000 AD, which include 100 per cent coverage for safe drinking water in rural and urban areas, 100 per cent coverage of primary health care services in rural and urban areas, universalisation of primary education, etc. among other basic needs [GOI 1997]. It must be noted here that all the basic minimum needs being talked about are state subjects and the allocation of the centre is a very small proportion. Hence even real increases in allocations by the centre (often linked to new schemes) may have a negligible impact, unless the state governments take some radical measures on their own. (This is not to say that the centre has no influence; in fact with a small proportion of funding the centre dictates policies in terms of advocating and supporting programmes it considers to have national importance, and with control over a major chunk of tax revenues it can twist arms of the states to accept its policies and programmes.)

When the central government presents its budget there is a lot of euphoria and expectation – reliefs in taxes, excise and customs duties, defence spending, interest burden, subsidies. The middle classes and business look forward to the budget eagerly but the same enthusiasm is not shown in the case of state and local-government budgets/expenditure which affect their lives more closely. In fact there is a complete lack of concern for the social sector allocations. Even the media ignores this and highlights only special schemes or concessions which the finance minister announces in his budget speech like the 'cheap' hospitalisation policy for the low income groups announced in the 1996-97

TABLE 2: AN OVERVIEW OF CENTRAL AND STATE HEALTH BUDGETS 1989-97

(In rupees billion)

Category	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96 RE	1996-97 RE
1 Total central health budget	10.12	10.28	12.73	13.82	17.22	21.48	22.95	26.08	28.72
2 GOI's own expenditure	3.78	4.47	4.92	5.56	6.33	7.43	9.47	12.77	14.71
3 Disbursement to states and UTs (1-2)	6.34	5.81	7.81	8.26	10.89	14.05	13.48	13.31	14.01
4 Health expenditure of states #	34.77	39.60	45.86	50.83	56.62	66.69	74.28	85.38	94.42
5. Per cent central component in state budget # (3/5 x 100)	18.2	14.7	17.0	16.2	19.2	21.1	18.1	15.6	14.8

Notes: # The state government expenditures are only from 25 states (excluding UTs) and exclude capital expenditures, hence the actual percentage of central component should be less by about 0.5 to 2 .

Source: 1 *Expenditure Budget 1996-97*, Vol 1, GOI, July 1996, 2 and 4 *Report on Currency and Finance*, RBI, various years.

TABLE 3: SELECTED PUBLIC HEALTH EXPENDITURE RATIOS, ALL INDIA, 1981-95

Year	1980-81	1985-86	1991-92	1992-93	1993-94	1994-95	1995-96 RE	1996-97 BE
Health expenditure as per cent to total government expenditure	3.29	3.29	3.11	2.71	2.71	2.63	3.29	3.29
Expenditure on medical care as per cent to total health expenditure	43.30	37.82	26.78	27.66	27.46	25.75	NA	NA
Expenditure on disease programme as per cent to total health	12.96	11.69	10.59	10.84	10.41	9.51	NA	NA
Capital expenditure as per cent to total health expenditure	7.54	8.45	7.78	4.03	4.47	4.27	3.66	4.00
Total health expenditure (Rs bn) - Revenue	11.89	27.15	52.01	62.04	71.83	78.67	97.93	108.60
Including capital expenditure	12.86	29.66	56.39	64.64	75.18	82.17	101.65	113.13

Source: CEHAT Database; Original Source: up to 1985-86, Combined Finance and Revenue Accounts, Comptroller and Auditor General of India, respective years, other years, Demand for Grants, respective states, various years. The percentage for capital expenditure is based on revenue + capital total whereas for others it is as a per cent of revenue expenditure. NA = not available, RE = revised estimate.

udget or the opening up of health insurance
a the private sector in this year's budget.

It is important to note that the central
ealth budget in itself has a very limited
cope. It includes expenditures on central
overnment-owned hospitals, dispensaries,
e CGHS (health insurance for central
overnment employees and their families),
edical research (support for ICMR and
lied institutions) and medical education
entral government colleges). Apart from
is the budget also includes the centre's
ntributions and grants to various health
ogrammes of national importance like
ntrol and eradication of communicable
seases like malaria, tuberculosis, leprosy,
IDS, as well as support for the family
anning programme (almost entirely
ntrally funded) immunisation, blindness
ntrol, etc. The larger part of health care
dgets come from state and union territory
overnments' own resources or from their
are of revenues disbursed by the centre.
n an average during the last decade the
e's contribution (grants and plan fund
s of special programmes) has been
out 17 per cent to the overall state health
dgets. Table 2 gives an overview of
dgets for the last one decade.

It is evident from Tables 2-6 that state
overnments are clearly the dominant
nders on various health care programmes.
owever, given the lamentable state of
irs of public health services/institutions
d their inability to meet demands of
izens, it is also clear that allocations to
e health sector are both inadequate and
efficient. Further, it is also evident that
re is a declining trend in public health
penditures and when this is viewed in the
ntext of the introductory remarks above
becomes apparent why the private health
tor has such a strong hold of the health
re market.

Declining Health Expenditures

The state's commitment to provide health
for its citizens is reflected not only in
adequacy of the health infrastructure
t low levels of financing but also in declining
pport to various health care demands of the
ople, and especially since 1980s from when
gan the process of liberalisation and opening
of the Indian economy to the world
rkets. Medical care and control of
mmunicable diseases are crucial areas of
ncern both in terms of what people demand
priority areas of health care as well as
t existing socio-economic conditions
mand. As with overall public health
nding allocations to both these subsectors
n show declining trends in the 1980s and
90s. This increasing disinterest of the
te in allocating resources for the health
tor is also reflected in investment
penditure with very large decline in capital
penditures during the 1990s.

Further, when we look at expenditures

Table 4: Revenue Expenditure on Health by States 1985-96
(Per Cent of Total Government Revenue Expenditure)

Year	1985-86	1991-92	1992-93	1993-94(RE)	1994-95 (BE)
Union government	0.52	0.45	0.42	0.45	0.42
Major States					
Andhra Pradesh	6.61	5.82	5.87	5.75	5.63
Assam	6.75	5.23	5.57	5.14	6.00
Bihar	5.68	5.66	5.87	6.24	6.89
Gujarat	7.51	5.42	4.79	5.09	5.21
Haryana	7.00	4.19	4.56	3.60	2.90
Jammu and Kashmir	7.61	6.37	6.87	7.71	6.20
Karnataka	6.60	5.96	6.44	6.56	6.39
Kerala	7.85	6.92	6.29	7.13	7.44
Madhya Pradesh	6.69	5.78	5.48	5.65	5.55
Maharashtra	5.97	5.25	5.33	5.34	4.67
Orissa	7.38	5.94	5.63	6.00	5.00
Punjab	7.24	4.32	5.78	5.32	5.33
Rajasthan	8.11	6.85	6.64	6.34	6.97
Tamil Nadu	7.70	6.72	5.73	6.64	6.59
Uttar Pradesh	9.75	6.00	5.81	5.48	5.38
West Bengal	8.92	7.31	7.55	7.15	6.58
Other States					
Arunachal Pradesh	5.85	6.28	6.37	5.64	6.39
Goa, Daman and Diu	8.22	8.33	8.10	7.87	7.52
Mizoram	6.80	5.21	5.10	4.97	4.99
Pondicherry	9.11	8.91	7.93	8.07	8.03
Himachal Pradesh	7.89	7.24	7.73	8.08	8.19
Manipur	6.15	5.74	6.01	5.24	4.54
Meghalaya	9.20	6.73	7.19	7.51	7.33
Nagaland	6.96	4.17	*	5.39	4.78
Sikkim	4.03	6.01	6.81	6.10	6.78
Tripura	6.53	5.54	4.90	5.16	5.10
All India	3.29	3.11	2.71	2.71	2.63

Notes: * = Not available, RE = Revised Estimate; BE = Budget Estimate
Source: CEHAT Database: Original Source: Same as Table 3.

Table 5: Expenditure on National Disease Programmes by States
(As Percentage of Total Health Expenditure)

Year	1985-86	1991-92	1992-93	1993-94(RE)	1994-95 (BE)
Union government	4.47	5.41	6.56	4.93	$
Major States					
Andhra Pradesh	17.00	17.29	16.85	18.09	18.79
Assam	18.77	9.90	*	9.41	7.26
Bihar	10.90	*	11.55	11.75	10.34
Gujarat	14.09	11.91	12.24	13.04	13.76
Haryana	20.75	15.17	14.58	15.95	15.33
Jammu and Kashmir	3.10	*	*	*	*
Karnataka	10.02	5.37	5.28	5.96	5.58
Kerala	12.33	3.78	4.57	5.29	5.98
Madhya Pradesh	11.25	10.63	9.90	9.34	8.84
Maharashtra	16.03	11.95	11.81	11.26	11.87
Orissa	15.84	12.84	12.46	11.33	10.98
Punjab	13.55	8.53	10.18	6.48	6.90
Rajasthan	11.91	9.10	8.89	8.66	8.18
Tamil Nadu	2.89	12.13	11.61	11.65	6.20
Uttar Pradesh	13.52	18.60	18.83	16.51	17.35
West Bengal	8.14	9.93	9.37	9.20	9.18
Other States					
Arunachal Pradesh	23.82	9.98	13.21	17.66	11.73
Goa, Daman and Diu	6.92	4.85	5.67	5.60	5.13
Mizoram	13.67	11.00	11.19	12.81	11.83
Pondicherry	9.90	8.96	8.84	8.70	8.97
Himachal Pradesh	12.86	10.92	13.04	11.40	11.24
Manipur	16.88	18.38	*	*	*
Meghalaya	13.06	14.32	4.50	3.10	4.04
Nagaland	13.88	16.16	*	12.66	16.62
Sikkim	10.38	8.68	9.32	7.64	8.66
Tripura	16.20	6.23	9.49	8.86	9.42
All India	11.69	10.59	10.84	10.41	9.51

Notes: * = Not available, RE = Revised Estimates; BE = Budget Estimates; $ = 1994-95 (BE) union government breakup not available.
Source: CEHAT Database; Original Source: Same as Table 3.

across states not one state shows a significantly different trend in spite of the fact that health care is a state subject under the Constitution! This only goes to show how strongly the central government influences the state's financing decisions and that too with average grants of less than 10 per cent of the state's health budgets, very similar to how international agencies with even smaller grants exert large ideological influences. This lack of initiative on part of state governments to meet demands of the people is in part due to the tight grip that the centre has over Plan resources, which are also largely investment expenditures. Thus the mechanism of 'planned' development is used by the centre to make states tow their line even when the states may have opposition governments in power.

Under structural adjustment since 1991 there has been further compression in government spending in its efforts to bring down the fiscal deficit to the level as desired by the World Bank. The impact of new economics unleashed on people comes via income and prices and affects people through final consumption and/or employment, and for the poorest sections the development expenditures like IRDP, JRY, health care, education, housing and other welfare are crucial in the context of the existing overall life chances available to such sections. There is clear evidence that expenditures on such social programmes are declining in real terms and its benefits are accruing to fewer people. For instance the GOI budget expenditures have declined from 19.8 per cent of the GDP in 1990-91 to 16.58 per cent in 1993-94 and the central health sector has been even more severely affected [Tulasidhar 1993]. The states' share in health expenditure has increased and that of the centre declined drastically, and especially so for the centrally-sponsored disease control and other national programmes which are mostly of a preventive nature. If the states do not pick up the added burden of allocating additional resources for these programmes then tuberculosis, malaria, AIDS, leprosy, etc, would be plaguing the Indian people more severely.

The situation regarding medical care expenditures, which are the responsibility of state governments, is even worse. The decline in these expenditures have been much more severe and this has affected particularly the poorer sections of the urban population. The cutbacks within this account are on commodity purchases such as drugs, instruments and other consumables. Patients in public hospitals are now increasingly being given prescriptions to purchase drugs from outside at their own cost and this too against the background of drug prices having increased two to three times during the last two to four years. In many states small amounts of user charges have been introduced. Anecdotal accounts from various states, as well as data from the performance budget of the ministry of health in Maharashtra reveal that the net impact of introduction of user-charges and issuing of prescriptions to purchase drugs, injections, syringes, bandages, etc, from outside have reduced public hospital utilisation in most districts – and these would of necessity mean the poorest. All this ultimately pushes the poor to increasingly use private health providers, often at a cost of personal indebtedness, and makes public health institutions restricted to those who can exert influence to grab the restricted but quality services.

Most of these changes have been at the behest of World Bank whose *World Development Report (1993)* focused on 'Investing in Health'. This report is directed at third world governments to reorient public health spending for selective health programmes for targeted populations where it clearly implies that curative care, the bulk of health care, should be left to the private sector. In keeping with this, the Andhra Pradesh government set up an autonomous body called the Andhra Pradesh Vaidya Vidhan Parishad to make the functioning of taluka level hospitals independent of the government and flexible to accommodate interaction with the private sector and is making further 'reforms' with assistance from World Bank. Punjab, West Bengal and Karnataka governments have followed suit to reform the public health sector under the guidance of World Bank [World Bank 1996]. In fact Punjab has gone one step further and set up a corporation for managing public hospitals with private sector participation. In many states the first steps towards privatisation have been taken through contracting out certain services in the hospital to private bodies. In Maharashtra two municipal hospitals in Mumbai are being considered for handing over to private medical colleges on a lease contract. In a number of states PHCs and selected programmes in selected districts are being handed over to NGOs to run them more 'efficiently'. All in all, the state is gradually abdicating responsibility in the health sector and that too under the garb of a progressive slogan, 'peoples' health in peoples' hands'.

TABLE 6: EXPENDITURE ON MEDICAL CARE BY STATES
(As Percentage of Total Health Expenditure)

Year	1985-86	1991-92	1992-93	1993-94(RE)	1994-95 (BE)
Union government	18.49	13.76	14.61	11.90	*
Major States					
Andhra Pradesh	42.23	31.73	32.03	34.72	31.31
Assam	45.22	28.39	24.53	15.75	9.24
Bihar	48.17		15.07	13.14	12.79
Gujarat	32.85	26.86	29.34	26.62	26.46
Haryana	21.59	20.24	19.88	19.18	17.98
Jammu and Kashmir	52.65	*	*	*	*
Karnataka	43.65	24.32	20.93	24.34	22.91
Kerala	51.28	39.11	42.17	44.61	42.14
Madhya Pradesh	37.69	28.51	28.58	24.34	25.16
Maharashtra	24.99	25.25	26.61	28.07	26.15
Orissa	42.46	25.34	24.60	21.85	24.17
Punjab	50.86	23.21	35.36	30.72	30.56
Rajasthan	40.78	28.09	27.59	27.37	25.09
Tamil Nadu	57.46	36.44	35.87	43.42	43.52
Uttar Pradesh	25.80	28.69	30.09	32.33	32.33
West Bengal	44.65	37.86	38.93	36.25	37.18
Other States					
Arunachal Pradesh	62.67	71.63	74.00	68.85	60.41
Goa, Daman and Diu	68.22	49.54	53.23	53.35	54.62
Mizoram	63.73	21.72	19.64	19.54	23.17
Pondicherry	71.58	66.22	57.85	55.07	53.30
Himachal Pradesh	40.52	25.87	24.89	10.14	26.04
Manipur	50.72	20.88	*	*	*
Meghalaya	50.88	34.79	36.62	34.63	33.86
Nagaland	60.15	42.93	*	38.30	37.01
Sikkim	46.73	53.03	49.45	51.48	46.26
Tripura	66.45	43.76	41.92	36.39	36.28
All India	37.82	26.78	27.66	27.46	25.75

Notes: * = Not available, RE = Revised Estimates; BE = Budget Estimates.
Source: CEHAT Database; Original Source: Same as Table 3.

References

Duggal, Ravi, S Nandraj and A Vadair (1995): 'Health Expenditure Across States' (Special Statistics), *EPW*, April 15 and 22.

GOI (1997): *Economic Survey 1996-97*, Ministry of Finance, Government of India, New Delhi.

Jesani Amar, and S Ananthram (1993): 'Private Sector and Privatisation in the Health Care Services', *FRCH*, Bombay.

Tulasidhar V (1993): 'Structural Adjustment Programme – Its Impact on the Health Sector', *NIPFP*, Delhi.

World Bank (1996): 'India – A Comparative Review of Health Sector Reform in Four States: An Operational Perspective', Report No 15753-IN (Draft Version), Washington.