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SCALING UP HEALTH EXPENDITURE FOR UNIVERSAL HEALTH COVERAGE: PROSPECTS AND CHALLENGES

Indrani Gupta and Samik Chowdhury

The High-Level Expert Group (HLEG) constituted by the Planning Commission of India in October 2010 recommended an increase in public funding of health to a minimum of 2.5 per cent of the gross domestic product (GDP) during the Twelfth Five Year Plan (2012–17) and a minimum of 3 per cent by 2022 (Planning Commission 2011). Other estimates indicate that a fully evolved programme of universal health coverage (UHC) might require a much higher level of public funding of around 4 per cent of GDP (Prinja et al. 2012).

Funding has also been identified as a key constraint by the Planning Commission's Steering Committee on Health for the Twelfth Five Year Plan which states, 'The health care system in the country suffers from inadequate funding' (Planning Commission 2012). The definition of UHC adopted by the Steering Committee is, 'Ensuring equitable access for all Indian residents in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as services addressing wider determinants of health delivered to individuals and populations, with the Government being the guarantor and enabler, although not necessarily the only provider, of health and related services.' This is adapted from the definition of UHC given by the HLEG with some changes to indicate that all residents would be protected once the scheme is fully functional. The UHC is to be

financed by central and state governments on 15:85 sharing basis.

Clearly, both the Centre and the states have to increase the volume of spending on health to make UHC a reality. According to the Planning Commission, '... since expenditure on health by the State Governments is about twice the expenditure by the Centre, the overall targets for public sector health expenditure can only be achieved if, along with the Centre, State Governments expand their health budgets appropriately' (ibid.). The Twelfth Plan also states that general tax revenues would be the principle source of funding for UHC.

For financing the Twelfth Plan, the projections envisage increasing total public funding, plan and non-plan, on core health from 1.04 per cent of GDP in 2011–12 to 1.87 per cent of GDP by the end of the Twelfth Plan, a three-fold increase in absolute terms over the Eleventh Plan levels, and an increase of about 34 per cent annually over this period. With the incentive measures proposed, it is estimated that the states' total funding on health will also increase to three times the Eleventh Plan levels involving a similar annual increase. The share between the Centre and the state may remain the same at 33:67 ratio though the Steering Committee does mention a 15:85 ratio.

Given the ambitious vision of expansion of funding for UHC and in the Twelfth Plan, an important question is whether such expansion is feasible and possible in the near future, especially given that the states are to

shoulder a greater fiscal responsibility for implementing UHC.

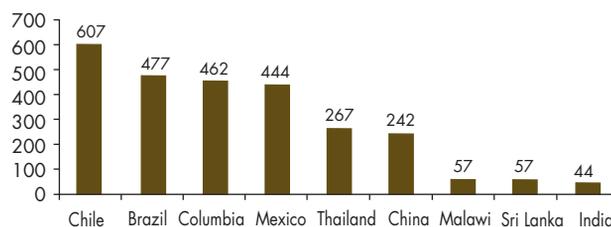
In this analysis we assess the states' fiscal situation, spending on health and possibilities of expansion to meet UHC needs in light of the projections. We divide states into three categories based on their progress vis-a-vis two of the health Millennium Development Goals (MDGs)—Infant Mortality Rate (IMR) and under-five mortality-rate (U5MR). We also undertake an expanded analysis comparing all states wherever necessary. Based on a variety of data, evidence and information, we club states based on their ability to roll out UHC. We also look at the Centre's potential to increase health spending to the extent mentioned in the Plan document. We conclude by presenting the implications of the results and possible options left to India to move forward on the UHC agenda.

CENTRALITY OF PUBLIC SPENDING IN UHC

The UHC initiation begins with raising resources for health. While efficacy of spending is an important part of financing, sufficiency of resources would remain a necessary—though not a sufficient—condition for countries planning to move towards UHC, irrespective of the path adopted. As the 2010 World Health Report of WHO (WHO 2010) indicates, every country could raise additional domestic resources for health. UHC is a public initiative and needs to be funded mostly by public funds. While mechanisms like pre-payment and pooling¹ would save resources, and effective public-private partnerships (PPPs) would also additionally be useful in the developing countries, UHC will remain almost totally a publicly funded and provided process. This is mainly due to the small size of the organised sector and large pools of socio-economically vulnerable populations who would require subsidised care. Whether the process is going to be entirely tax funded or otherwise, public funding has to be the cornerstone of a successful UHC.

The international experience indicates that public spending has been an important tool in the implementation

FIGURE 4.1 Per Capita Public Spending in Purchasing Power Parity (National Currency Unit/US\$), 2011



Note: Data represented in this figure corresponds to 2011.
Source: WHO Global Health Expenditure Database.²

of successful UHC. Figure 4.1 presents the per capita public spending on health of selected countries that have already moved or are in the process of moving towards UHC. India is also included in Figure 4.1 to present a comparative position vis-à-vis these countries.

Countries that have successfully launched UHC like Brazil, Columbia, Chile and Mexico demonstrate relatively higher public spending on health per capita, more than 10 times that of India's level. Closer home, Thailand and Sri Lanka have UHC, though the processes have been different, with Sri Lanka depending entirely on tax-based financing. Recently, however, Sri Lanka has also been dealing with high out-of-pocket (OOP) spending driven mostly by increasing incidence of non-communicable diseases (NCDs). China is also rapidly moving towards spreading universal coverage. Even a poor country like Malawi has recently been able to extend essential health package to its poor, though with support from external sources. Its per capita public expenditure on health is also higher than that of India.

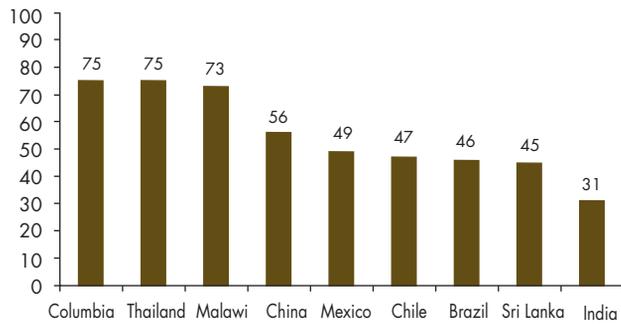
The role of government in financing is clearer from Figure 4.2, which shows the share of the government in total health spending.

By and large the more robust of the UHC systems have a much higher share of government spending in total spending. India's share (of 31 per cent) is much less than its immediate neighbour Sri Lanka which is at 45 per cent; Sri Lanka has been struggling with high OOP spending in any case, indicating the need for stepping up government investment in health. One core indicator of UHC is OOP spending by households; whatever

¹ Pre-payment refers to resources for health services that are collected prior to the health event requiring intervention, e.g. general taxes, compulsory insurance contributions (payroll taxes), voluntary insurance premiums, etc. Pooling refers to accumulation of financial resources for health with the objective of spreading risk so that no individual carries the full burden of paying for care; effectively the healthy subsidise the sick, young subsidise the old, and the rich the poor. Pools are fragmented when multiplicity of schemes targeting different groups create barriers to the redistribution and efficient use of pre-paid funds (WHO 2010).

² See <http://apps.who.int/nha/database/DataExplorerRegime.aspx>, accessed on 30 December 2013.

FIGURE 4.2 Share (%) of Public Spending in Total Health Spending, 2011



Note: Data represented in this figure corresponds to 2011.

Source: WHO Global Health Expenditure Database³

the route to achieve UHC, a country with increased health coverage would be bound to show a decline in OOP spending. The centrality of public spending can be further verified if one finds significant association between OOP spending and public spending. To verify that this is indeed so, we ran a simple regression for 149 countries with percentage of OOP spending in total health expenditure as the dependent variable. The independent variables used in the regression are per capita GDP and per capita public health expenditure of all levels of government, both in log forms. The only other variable included in the regression is percentage immunised under DPT3, to capture the quality of health system. The results are indicated in Table 4.1.

The results confirm that a higher per capita public spending is an important determinant of OOP spending across countries, and higher the per capita public spending on health, lower is OOP spending. The results also indicate that higher GDP would tend to increase OOP spending, which may be interpreted as the income effect. Controlling for these two variables—quality of health systems—

TABLE 4.1 Determinants of OOP Spending

Independent variable	Regression co-efficient	t statistic
Log per capita GDP	2.0	3.8
Log per capita public health spending	-7.1	-9.2
Percentage immunised for DPT3	.07	0.71
N=149		R ² = 0.46

Note: OOP Spending is dependent variable.

Source: Authors' calculation.

captured here by the extent of DPT3 immunisation, does not seem to have any significant impact on OOP spending.

The inference that can be drawn here is that health spending by government would remain a key policy tool for achieving low OOP spending on health. The seventh schedule of the Indian Constitution puts health on the State List, although the central government's contribution to the sector in the form of central sector and centrally-sponsored schemes (CSSs) is also an important part of total resources. The next section, therefore, analyses recent evidence on health spending in India, across states and Centre in the context of UHC.

PUBLIC EXPENDITURE ON HEALTH IN INDIA: SOME RECENT EVIDENCE

Public health expenditure in India has been historically rather static and inadequate. One of the earliest evidence on this is provided by the Bhole Committee (1946), which stated that the per capita private expenditure on health was Rs 2.50, compared to a state per capita health expenditure of just Rs 0.36 in the 1940s. More recent studies have also demonstrated the continuing predominance of private health expenditure in the Indian health system. Berman et al. (2008) examined trends in government health spending in light of the government's commitment to enhance public spending on health to 2–3 per cent of GDP. Their analysis shows that public health spending has been declining till 2004. This decline has been largely a result of a decline in the overall social sector expenditure by the states. The health sector received a boost after the launch of the National Rural Health Mission (NRHM) in 2005. Although this almost reversed the trend of declining public health expenditure, the authors opined that it would still be insufficient to achieve the target of 2–3 per cent of GDP. The authors also indicated two important concerns. First, while the CSSs are well-intentioned, one must look into the ability of the states to finance a predominant part of these schemes. The second issue is that of the ability of the states to spend—or their absorptive capacity—alongside increased allocations.

In another study (Bhat et al. 2004), the authors analysed the state-level public health expenditure data to examine the feasibility of the government's commitment to spend 3 per cent of GDP on health. The paper examines the relationship between income and healthcare

³ See <http://apps.who.int/nha/database/DataExplorerRegime.aspx>, accessed on 30 December 2013.

expenditures at state-level and estimated the elasticity of health expenditure at 0.68. Based on current levels of spending and the fiscal position of the state governments, the goal of spending 2 to 3 per cent of GDP on health, according to the authors, looked very ambitious.

The Economic Research Foundation (2006) did a preliminary study on the broad patterns of government spending on health and related areas in India in the recent past, and attempted to link them to observed health outcomes. The analysis was conducted both at the central government level and for 14 major states. The analysis of state budgets indicated wide variations across states, not necessarily synchronous with the state domestic products. The gaps between states in terms of per capita spending increased during the period of study.

Rao et. al. (2012), in their paper, analyse the nature of public spending on health and its impact on health infrastructure and health status of the population. In view of the recent reform attempts to augment spending on healthcare through specific-purpose transfers to states, the paper looked into the fiscal space for healthcare expenditure at the state-level and the stimulation and substitution effects of central transfers for health. The research concluded that not only is public spending on healthcare in India too low, but its distribution across the country is very uneven. Taking NRHM as a specific purpose transfer programme, the authors' find that the objective of increasing the expenditures to 2 per cent of GDP has not been fulfilled, partly because the low-income states could not avail the grants, as they could not afford to pay their own component of spending.

Berman et al. (2010), in continuation of their earlier (2008) study, found that realising the goal of 2–3 per cent of GDP would require that the states on aggregate increase spending on average by 22–38 per cent per year to attain this target. The authors conclude that this seemed unlikely, firstly because of the low fiscal capacity of states and secondly because of the lower ability of states to scale up the pace of programmes like NRHM leading to low absorptive capacity. The paper had some word of caution on the unintended consequences of the NRHM's dependence on central grants, one of them being the possible substitution of the state government's own health expenditure by these grants.

HEALTH SPENDING BY THE CENTRE AND THE STATES: SOME RECENT EVIDENCE

Since a significant amount of literature now exists to indicate how states have fared over the years, we look at more recent evidence of health spending for the states.

To anchor the discussion on health outcomes, we divide the states into three categories based on whether or not they have met their MDG goals of IMR and U5MR. The category I states are the best performers with respect to the two indicators and include Arunachal Pradesh, Delhi, Goa, Kerala, Maharashtra, Manipur, Nagaland, Sikkim, Tamil Nadu, West Bengal and Tripura. Category II states include Andhra Pradesh, Gujarat, Haryana, Himachal Pradesh, Karnataka, Mizoram, Punjab, Jammu and Kashmir and Uttarakhand. Category III states are the worst performers in the chosen indicators, and include Assam, Bihar, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, Chhattisgarh and Meghalaya.

The ability of governments to increase health spending is closely linked with their GDP or in the case of states, to Gross State Domestic Product (GSDP); a comfortable level of per capita income and an increasing income of the state would in principle allow a larger share to be put away for health. In Table 4.2, we present per capita health spending inclusive of central transfers and per capita GSDP for 2009–10 and growth rate in spending between 2001–02 and 2009–10. We also show the percentage of GSDP that is allocated to health for these three groups of states.

Clearly, MDG outcomes have a positive association with GSDP as well as per capita health spending, with Category III states spending the least on health. In other words, higher the GSDP and per capita health spending better are the MDG outcomes. The last columns indicate that the proportion spent on health has come down for all the groups over these years. A comparison of health expenditure and GSDP growth indicates that incomes have outpaced health spending; in other words, states have not been able to put proportionately the same or a higher amount out of their increasing income into health, and this is true of states in all three categories.

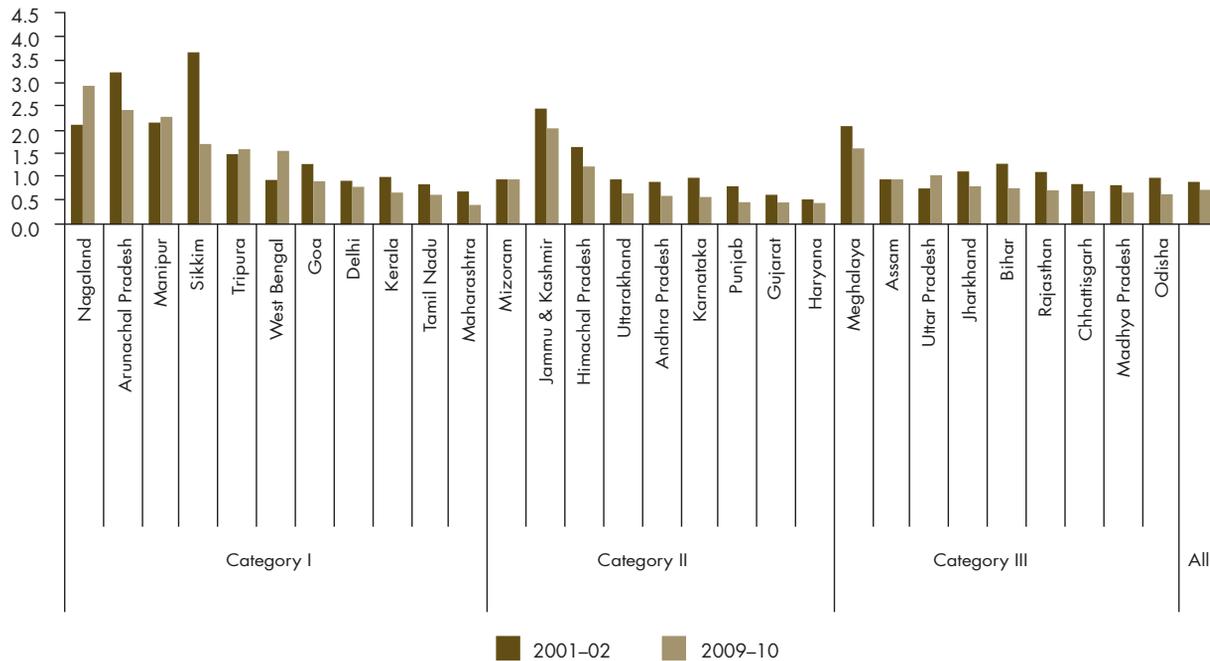
Figure 4.3 displays states in decreasing order of health share in GSDP for the year 2009–10. A few observations may be made. First, on an average the states spend just 0.6 per cent of their GSDP on health and family welfare. The share remains below 1 per cent for all the three categories, with Category II states spending much less than the other two groups (see Table 4.2). Second, some of the larger and economically developed states like Andhra Pradesh, Karnataka, Punjab, Gujarat, Haryana and Maharashtra, rank lowest in terms of the share of health in their GSDP. Third, all North-eastern states spend a relatively higher proportion of their GSDP on health. Finally and most importantly, there has been a decrease in the average share of health in GDP for all categories (Table 4.2),

TABLE 4.2 Per Capita Health Expenditure

Categories of states	Per capita health expenditure (Rs)		Per capita GSDP (Rs)		Health expenditure/GSDP ratio	
	2009–10	Growth 2001–02 and 2009–10	2009–10	Growth rate 2001–02 and 2009–10	2001–02	2009–10
I	584	11.7	80882	14.6	0.84	0.72
II	439	10.2	77213	15.0	0.86	0.57
III	285	12.7	34720	13.3	0.92	0.82
All states	406	11.6	57902	14.3	0.87	0.70

Sources: Health expenditure by the states from 'State Finances: A Study of Budgets', RBI 2003–04 and 2011–12. Population Projections—Census 2001 used for population figures for the corresponding year. GSDP from Press Releases and Statements, National Accounts Statistics, Central Statistical Organisation, Ministry of Statistics and Programme Implementation, Government of India.

FIGURE 4.3 Health Spending in GSDP in 2001–02 and 2009–10



Source: Same as Table 4.2.

when compared to 2001–02. Except for the North-east states (except Meghalaya and Sikkim), Tripura, West Bengal and Uttar Pradesh, all the other states show a decline in the share of expenditure on health in GDP. Paradoxically, despite the decline in share of health in GDP, the Category I states have been able to meet their MDG goals, indicating that there are definitely other factors at work, as contained in the rich literature on the social determinants of health (WHO 2008).

Among the major states and outside of the North-eastern states, West Bengal and Uttar Pradesh are the only two states that seem to have increased their health spending. The North-eastern states have generally been

doing well, except Assam and Meghalaya, and are now catching up after a long period of repressed growth in income and social indicators.

The variance across states in health spending has also been going up over the years except for the Category III states as indicated by the co-efficient of variation in per capita health spending across the three categories in Table 4.3. This indicates a lack of convergence among most states that are at similar levels in terms of health outcomes, in turn indicating a lot of noise in the determinants of health spending. In other words, health spending is being influenced by a variety of state-specific factors over time, which would have implications about

TABLE 4.3 Co-efficient of Variation (CV) in Health Expenditure

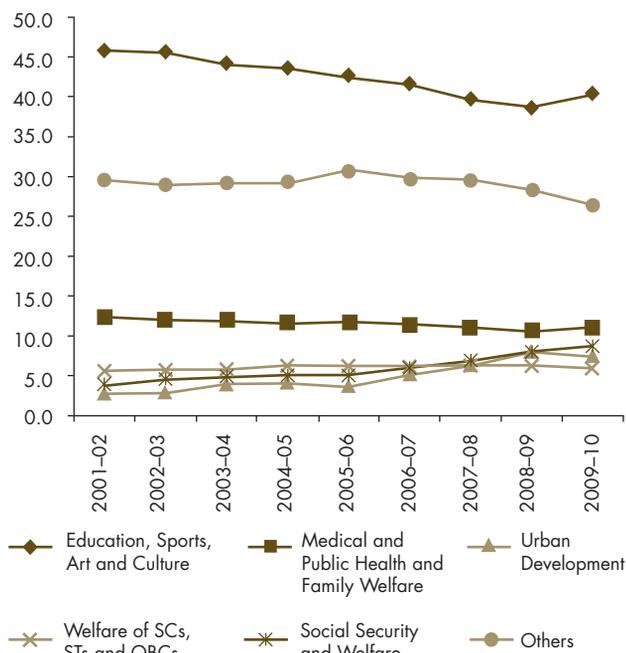
Categories of states	Per capita health expenditure		Health expenditure as a % of GDP	
	2001-02	2009-10	2001-02	2009-10
I	0.53	0.58	0.62	0.60
II	0.71	0.86	0.77	1.07
III	0.63	0.52	0.37	0.38
All States	0.70	0.80	0.64	0.75

Source: Same as Table 2; Authors' calculations.

the ability of a centrally directed programme of UHC to ensure adequate spending at the state-level.

If we look at all states combined, how does health fare among other social sector expenditures of the government? Figure 4.4 indicates the percentage composition of social sector expenditure over all states combined. Health's share has come down over the years (from 12.3 to 11 per cent), as has been the case with education. This is in spite of the launch of NRHM during 2005-06, which shows up as a substantial jump in the central government expenditure, discussed later in the chapter. While education has had an increase in recent years this has not happened with health. The share of urban development has more than doubled when compared with the pre-Jawaharlal Nehru National Urban Renewal Mission (JNNURM) period. Marked increases in shares of social security and welfare and

FIGURE 4.4 Percentage Composition of Social Sector Spending over 2001-02 and 2009-10

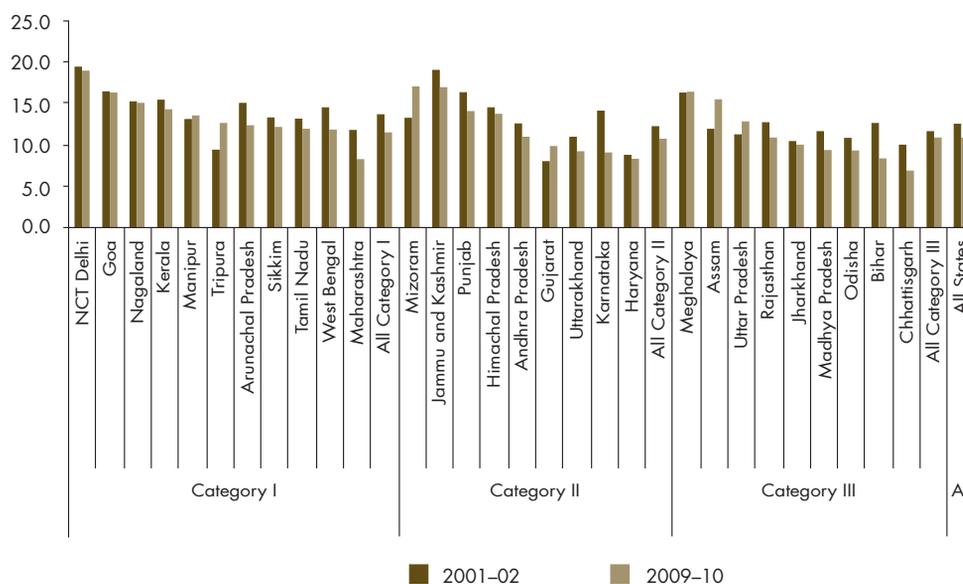


Source: 'Appendix Table 7, Composition of Social Sector Expenditure 'State Finances: A Study of Budgets 2013-14', RBI.

welfare of Scheduled Castes and Tribes (SCs/STs) and Other Backward Classes (OBCs) are also noticeable.

Figure 4.5 shows the share of Medical and Family Welfare in total social sector expenditure of states.

FIGURE 4.5 State Health (Department of Health and Family Welfare) Spending in Total Social Sector Spending (%)



Source: State Finances: A Study of Budgets 2013-14, RBI.

The states are arranged in order of decreasing share for the year 2009–10. A few important observations emerge from the figure. First, the percentage share varies between a low 7 per cent for Chhattisgarh to 19 per cent for Delhi. Second, all North-eastern states have a higher than average share of health in social sector expenditure. Third, three of the most economically developed states in India, i.e. Gujarat, Haryana and Maharashtra spend less than the average (all states) share of social sector expenditure on health and family welfare. Fourth,

most states have shown a decline in the share of public health spending in total social sector spending, with the exception of the North-eastern states, Gujarat and Uttar Pradesh.

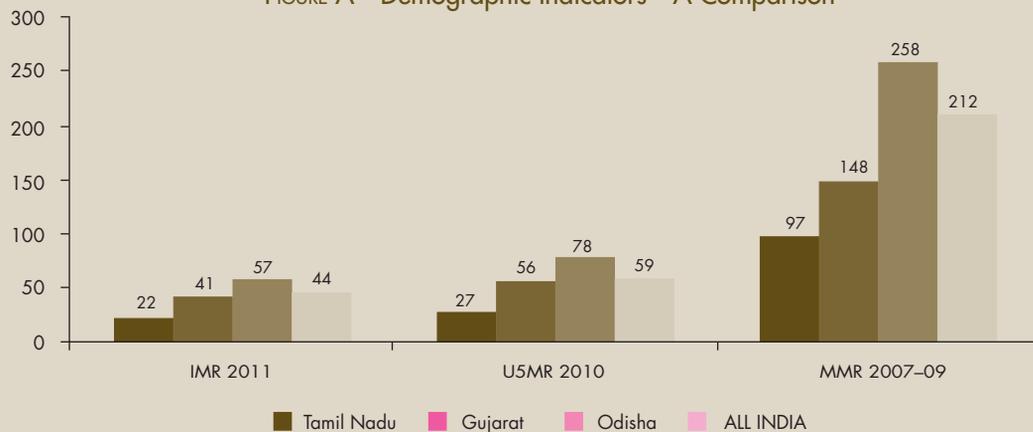
Clearly, health spending by the states has been getting relatively lower priority in social sector spending over the years.

If states have so far been unable to increase their spending, there are two other sources for sustaining total health spending: Centre's own spending on health

BOX 4.1 Tamil Nadu

Tamil Nadu has recently emerged as a public health model which has yielded results in terms of improved health outcomes; the state is much ahead of the national average in terms of the core health indicators, as also of the economically more developed states. Tamil Nadu's health outcomes are comparable to only Kerala, which has had a long history of organised healthcare even before the state came into being in 1956 (Kutty 2000). Tamil Nadu, on the contrary, has experienced phenomenal improvements in health outcomes in the last three decades or so. Between 1980 and 2005, Maternal Mortality Ratio (MMR) and IMR in Tamil Nadu declined by more than 60 per cent. In terms of coverage, 90 per cent of all deliveries are attended by skilled birth attendants, almost 25 per cent deliveries take place in primary health facilities and 81 per cent infants are fully immunised (Balabanova et al. 2013). What are the factors that have contributed to such massive improvements in health outcomes?

FIGURE A Demographic Indicators—A Comparison



Source: Demographic Indicators, www.data.gov.in, accessed on 21 October 2013.

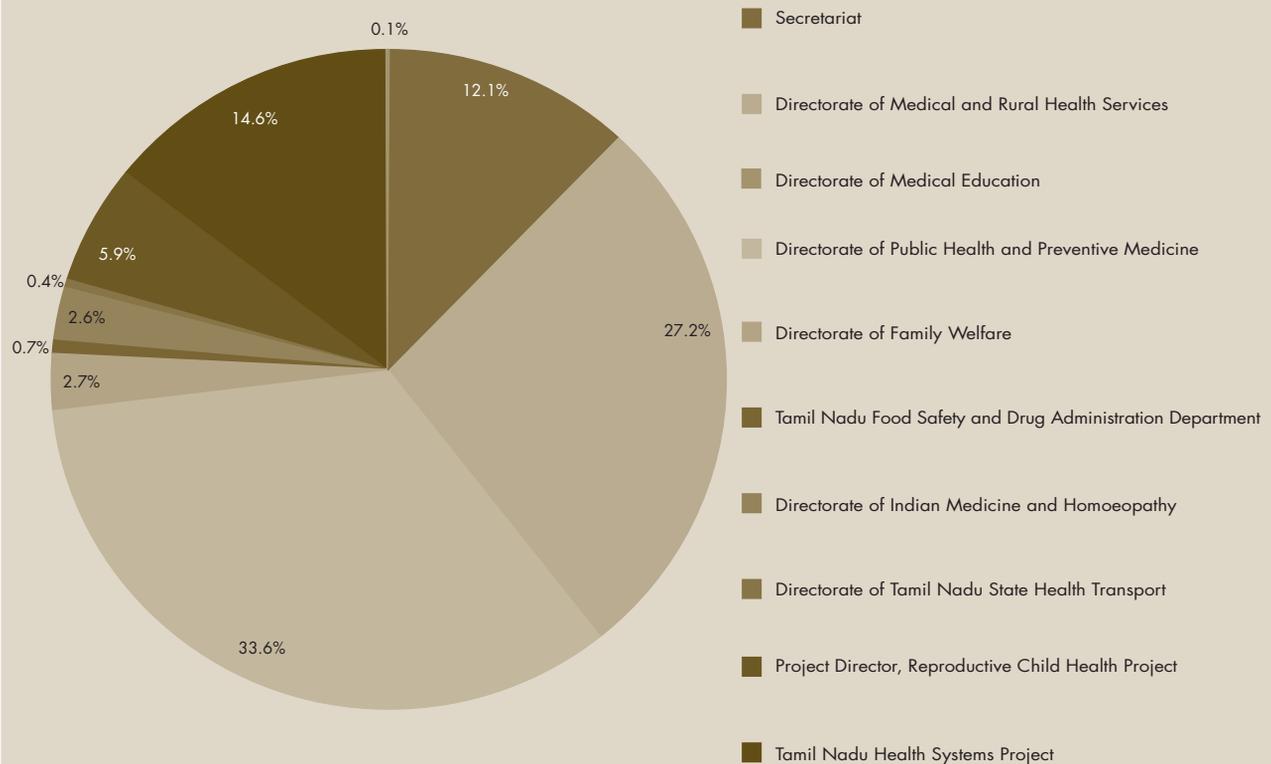
Tamil Nadu ranks fifth among the states in terms of per capita health spending. Health spending as a proportion of GSDP is quite low, and like most other states, it has declined between 2001 and 2002 and 2009 and 2010. Clearly, the level of spending has not been as important as the quality of spending, i.e. efficacy of public spending in Tamil Nadu has made the difference. Unlike most other states in India, Tamil Nadu has a separate Directorate of Public Health (instead of a merged Medical and Public Health) with a dedicated budget, workforce and a clear mandate for proactive planning and disaster management. It is run by trained public health managers along with technical staff like entomologists and statisticians.

Also, the share of public health and preventive medicine in the total budget for the health sector of the state is the highest (see Figure B). The other three larger shares correspond to that of medical education, health systems project and medical and rural health services respectively.

(contd...)

(Box 4.1 contd...)

FIGURE B Composition of Health Budget of Tamil Nadu



Source: Computed from Government of Tamil Nadu (2013–14).

Another key aspect is that the state has a Public Health Act that provides a legislative basis for the functioning of the Department of Public Health and Preventive Medicines (DPHPM). The Act contains implementable norms/rules with respect to hygiene, inspection, regulation, public health nuisance, etc. Such an Act is non-existent in most other states.

The public health cadres of the state are trained to imbibe a population-centric approach to health issues rather than assuming a clinical role that caters to specific health issues. After completion of basic medical degree, public health professionals need to acquire a post-graduate diploma/degree in public health within the next four years. Their first assignment is as a health officer in an urban local body after which they are put in charge of an entire district and finally promoted to the directorate. Thus, the directorate consists of professionals who are widely experienced in dealing with urban as well as rural public health issues, at multiple levels of governance. Their career paths are distinct, with more authority and responsibilities and an equal if not faster promotion opportunities than the medical cadres. This keeps them motivated with a resultant impact on public health and disaster management situation in the state (Dasgupta et al. 2010).

Some of the other initiatives taken by Tamil Nadu were an early (in 1980) introduction of the multipurpose health worker scheme, building a vast network of primary healthcare centres and ensuring a reliable supply of essential generic drugs through the Tamil Nadu Medical Services Corporation (Balabanova et al. 2013).

Tamil Nadu's well-organised public health machinery has resulted in reduced demand for curative services, and thereby reduced OOP spending. It also has had a direct impact on health outcomes related especially to maternal and child health and communicable diseases.

Good public health governance coupled with other favourable social determinants of health like high levels of education, especially female literacy rates, have made Tamil Nadu a model for other states to emulate.

and central plan assistance to states and equalisation transfers by the Finance Commission.

HEALTH SPENDING BY THE CENTRE — MINISTRY OF HEALTH AND FAMILY WELFARE

Figure 4.6 presents the trend in central government spending on health (health and family welfare only) over these years.

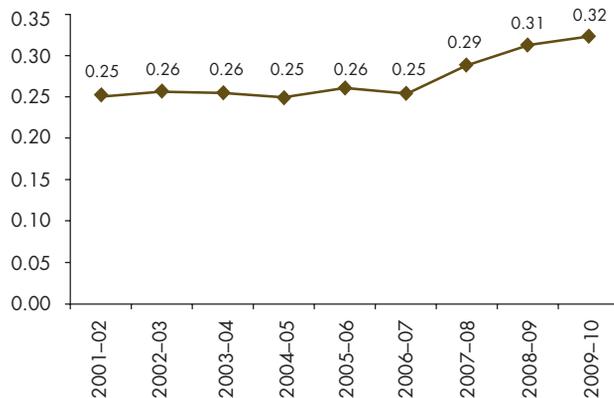
There is an upward trend from 2006–07 attributable to the significant increase in allocation for NRHM. From around 0.25 per cent for about 6 years, the share has increased to 0.32 per cent in 2009–10. The same is true of per capita health expenditure of the MoHFW as shown in Figure 4.7. In fact, per capita expenditure has been steadily increasing over the years and has tripled over 2001–02 and 2009–10.

Clearly, the Centre is playing and will probably need to play a much bigger financial role in the expansion of UHC relative to the states. In case UHC is implemented with a significant share of funding coming from the Centre, it has to be ready with a financial expansion plan with options clearly laid out, more so since the states' funding seem more difficult to garner, based on past trends.

Transfers from Centre to States

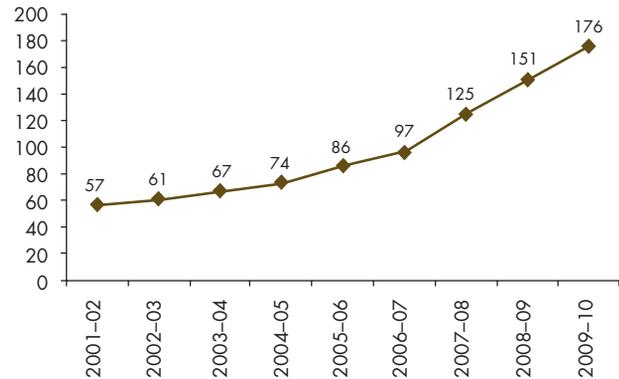
States own revenues are augmented by assignments and transfers—the two channels of resource flow from

FIGURE 4.6 Expenditure by the Central Government (MoHFW) on Health as a Percentage of GDP



Sources: MoHFW expenditure from Union Budget (respective years), GDP from CSO

FIGURE 4.7 Per Capita Expenditure (Rs) on Health by the Central Government (MoHFW)

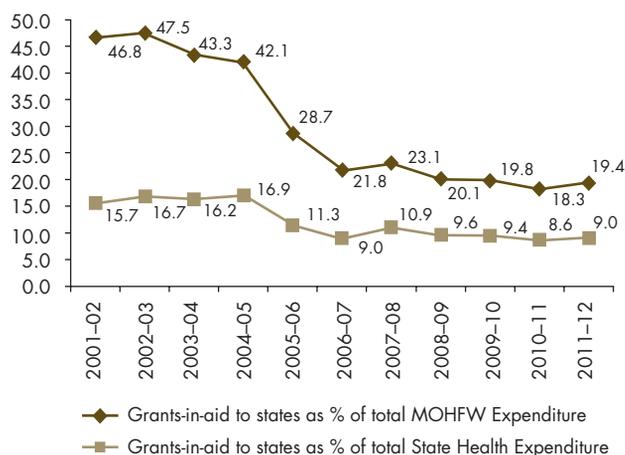


Source: Union Budget (respective years) and Population Projections, Census 2001.

the Centre to the states. States' share in central taxes, also known as tax devolution, is an assignment. As for transfers, these can be non-plan and plan transfers. The non-plan transfers comprise: (a) Finance Commission grants and (b) other non-plan grants. Plan transfers are of four types: (a) State Plan Schemes (normal central assistance and additional central assistance), (b) CSS with funds routed through the consolidated fund of states or state budgets, (c) CSS with funds transferred directly to state/district-level autonomous bodies or implementing agencies, and (d) a small portion of Finance Commission grants treated as plan grants. The normal central assistance for state plans is untied and formula based. However, funds transferred under additional central assistance or CSS are specific to schemes in particular sectors and are subject to central guidelines. Thus, while non-plan transfers follow the treasury route, plan transfers may take either the treasury or the society/direct transfer route.

There are two ways in which one can arrive at the transfers that the state (recipient) receives from the Centre. Central transfers to the health sector of a particular state can be obtained from the health budget of that state. The other source is the detailed demand for grants of the MoHFW, from where the relevant component 'grants-in-aid to state governments' can be obtained. A particular disadvantage of this approach is that only aggregate—not state-specific—central transfers to the health sector of states are given. So, while it would be interesting to see the distribution of these grants across states and over the years, we do not attempt that exercise here.

FIGURE 4.8 MoHFW Transfers as Percentage of Total Health Expenditure of Centre and States



Sources: Union Budget and 'State Finances: A Study of Budgets', RBI.

Almost the entire grants-in-aid to state governments by the MoHFW are in the form of plan expenditure. Figure 4.8 shows transfers from MoHFW as a proportion of total MoHFW expenditure and aggregate state-level health expenditure respectively. MoHFW grants-in-aid to states as percentage of total MoHFW expenditure have been declining steadily since 2002–03. As a proportion of states expenditure on health too, grants have been declining moderately. One major reason is that a large chunk of central transfers to states are occurring through the society route of CSS and, therefore, not being captured in the state budgets. Direct transfers of central plan assistance to autonomous bodies have grown by almost 17 per cent between 2006–07 and 2011–12. Currently, 13 per cent of state governments' health expenditure is financed by MoHFW grants that go through the treasury route.

CONCLUSION

The lack of firm estimates on how much UHC might cost is due to the absence of any tangible consensus on what exactly comprises UHC: specifically, India is still undecided on what to cover, how much to cover, whether to go for compulsory or voluntary system, if all services are to be free for all, etc. In the absence of any fixed point, it is difficult to carry out an exercise in costing of UHC or even a gap analysis. Most importantly—and a point much less discussed and debated—there has been an absence of discussion on pooling of current resources: should a new system

be installed with new funds on the current system or should there be some attempts to pool resources as well as services first in the *existing* system.

The question of consolidation of funds and services is critical in the context of UHC, because this would determine the additional funds that would need to be raised. This is all the more important since the current health coverage system is deemed inefficient as well as inequitable (Gupta and Chowdhury 2013). According to the Steering Committee on Health for the Twelfth Five Year Plan (Planning Commission 2012), '... the health care system in the country suffers from inadequate funding. There are several structural problems too, like, the lack of integration between disease control and other programmes in the social sector, sub-optimal use of traditional systems of Medicines, weak regulatory systems for drugs as well as for medical practice, and poor capacity in public health management.' Such inefficiencies lower the productivity of resource used and lead to wasteful expenditures.

Based on international experience and best practices, it is clear that UHC would require a quantum jump in resources devoted to the health sector. Even a country like Sri Lanka—often lauded for its impressive record of health outcomes at fairly low cost—is now facing the realities of changing disease profile and increasing healthcare costs. Recently, the World Bank has agreed to give a \$200 million loan to recharge its health system (World Bank 2013). Countries like Mexico and Columbia started off with similar health coverage scenarios as India with fragmented and inequitable coverage. In Mexico, with a federal structure, total resources as well as its distribution across provinces improved substantially to enable the gradual roll-out of UHC over a period of nine years (Knaul et al. 2012). Similarly, the healthcare system in Columbia was characterised by 'atomized risk pools, low efficiency, failure of public subsidies to reach the poor, large out-of-pocket expenditures, and significant inequality' (Glassman et al. 2010), but over 10 years of evidence-based and phased roll-out coupled with substantial increases in public health spending, has turned the country into one with one of the lowest OOP spending.

Back home, the Centre has shown its ability to raise resources for health, as evidenced by allocations to NRHM, though the NRHM experience at best has been mixed (Government of Uttar Pradesh 2011). The problems in health system needed more than NRHM in many states. Whether or not the country launches

UHC, there is no denying that strengthening the health system would remain a core factor in improving access. Such improvements cannot take place by Centre's directives or funding alone. It would require much more planning focus from the states themselves, which at this point is not happening. A centrally-implemented UHC is unlikely to work, and states do not seem to be in any particular hurry to come up with operational schemes for UHC. States like Tamil Nadu and Andhra Pradesh have their own schemes which seem to be rather low-

cost and able to deliver to a certain extent. It would be the backward states that would need both health system strengthening and improved health coverage and, therefore a quantum jump in resources.

Raising more resources and/or consolidating and pooling are decisions that are political as well as technical—any decision needs to be backed up by meticulous technical and evidence-based planning, which, it is hoped, India can undertake if it wants to move towards UHC.

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