Increasing Financial Resources for Health

Background:
Public expenditure on health at the end of the 11th Plan period was at 1.04% of GDP. Additionally, 70% of total expenditure on health is out of pocket. Studies show that out of pocket expenditure on health in India may be contributing to increase in poverty by approximately 3.6% for rural and 2.9% in urban areas. World Health Organization (WHO) estimates that low income countries need to spend 60 USD to strengthen health systems and provide essential health services to the population. Current per capita expenditure on health in India is at 61USD, just at the level of the WHO recommendation. Even amongst the BRICS nations, India spends the least on health (Table 1). Additionally, in comparison to other lower-middle income countries such as Kyrgyz Republic which spend 105PPP$ public per capita on health and Vietnam which spends 99PPP$ public per capita expenditure, our level of government expenditure on health is low. Rwanda, classified as a low income country and with a lower GDP, has a system of Universal Health Coverage covering 7.8 million of its 11.8 million population. Rwanda's government expenditure per capita on health is 82.7PPP$.

Table 1. Health expenditure and outcomes in India and other BRICS nations

<table>
<thead>
<tr>
<th>Indicator</th>
<th>India</th>
<th>Brazil</th>
<th>Russia</th>
<th>China</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita public expenditure on health (PPP int$) (WHO, 2012)</td>
<td>51.9</td>
<td>514.6</td>
<td>898.9</td>
<td>268.6</td>
<td>470.5</td>
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<tr>
<td>Tax revenue as a proportion of GDP (World Bank, 2012)</td>
<td>10.7</td>
<td>15.4</td>
<td>15.1</td>
<td>10.6 (data for 2011)</td>
<td>26.5</td>
</tr>
<tr>
<td>Life expectancy (World Bank, 2012)</td>
<td>66</td>
<td>74</td>
<td>70</td>
<td>75</td>
<td>56</td>
</tr>
<tr>
<td>Infant mortality rate (World Bank, 2013)</td>
<td>41</td>
<td>12</td>
<td>9</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>Maternal mortality ratio (World Bank, 2013)</td>
<td>190</td>
<td>69</td>
<td>24</td>
<td>32</td>
<td>140</td>
</tr>
</tbody>
</table>

Concurrently, India's union budget allocation for the Ministry of Health and Family Welfare for 2015-16 has remained at the level of revised expenditure in 2014-15. Following the recommendations of the 14th Finance Commission, more funds are made available to States, and spending is at their discretion.

There is a need to raise more resources for health. Since spending on health need not only be through central government allocations, novel methods for raising additional funds must be explored. Some possible options are listed below.

Options
1. Governmental spending on health
At the end of the 11th Plan, of the total 1.04% of GDP being spent on health, Central spending was 0.35% of GDP.
and State spending was 0.68% of GDP. There has been a prominent demand to raise health spending to 2.5% of GDP, implicitly by raising Central Plan allocation. The demand misses the point that Central plan comprises a mere 3.68% of GDP. Hence, there is only a small window for raising health resources through increase in central plan allocations. Central non-plan resources are committed with little flexibility. Thereby, in order to increase the total spending on health, it is essential for States to increase spending. The fiscal deficit of States is more favourable than of the Centre, and they have more capacity to increase health spending as a proportion of their budgets.

Some measures to encourage higher State spending on health therefore include providing matching Incentive grants as in Rashtriya Krishi Vikas Yojana. The grant may be matched in a defined proportion of the increased State budget in the preceding year. In addition, as recommended in the Twelfth Plan, States could be provided additional incentive grant if they maintain their health expenditure (Plan and non-Plan) as a proportion of their budget at the base level (average of last three years) at the minimum and also prepare a State wide health plan based on District Health Plans.

Since the direct tax base in India is 2.89% of the population, suggestions for expanding the pool of available resources include progressive taxation, ‘Sin tax’ on tobacco and alcohol; the latter can also discourage consumption of these harmful products; a 10% price increase in prices can cause a 8% drop in consumption and a 7% increase in government revenue. Other suggestions include tax on unhealthy foods with high fat, sugar, salt content; currency transaction levy (foreign exchange market in India 34 billion USD, a 0.005% levy on transactions will generate 370 million USD a year; Diaspora bonds (government bonds to nationals living abroad).

Given the funding limitations indicated above, any suggestion on increasing central plan allocations on health should be supported by suggesting the sector from which funds can be diverted

2. Private expenditure

a) Out of pocket expenditure by households is a regressive mode of financing. High levels of out of pocket expenditure at the point of care among the poor leads to catastrophic health expenditure.

Suggested measures:
- Moving away from direct payments to pre-payments and risk pooling
- Starting Health savings accounts such as ‘Medisave’ in Singapore which have shown willingness in uptake among poor populations in pilot projects
- Expanding Insurance options, including a light product to cover basic care

b) Corporate Social Responsibility - The Companies Act mandates that companies (those with a minimum average net profit of 50 million over three years) spend 2% of their annual profits on Corporate Social Responsibility (CSR) activities, of which for which health services is an eligible component. Several companies already involved in health initiatives under their CSR activity. CSR is also mandatory for Central Public Sector Enterprises,

i. These funds may be channeled towards health by making arrangements for public health facilities to directly receive donations from companies, with safeguards to ensure ‘no frills funding’ as suggested in the Twelfth Plan. Health centres in Tamil Nadu are already authorized to enter into MoUs to receive contributions for service provision and maintenance of health facilities.

ii. Companies can also contribute to better management of existing health facilities by temporarily lending the services of their experts; corporate staff can also volunteer services in communities for activities like training, health education, micro-level planning.

c) Private Public Partnerships (PPP) – These are initiatives in which both government and a private entity jointly invest in the delivery of public services. The technical, managerial and human resources of the private
sector may be therefore invested in the achievement of public health outcomes through PPP. This may be done in areas where there public resources are insufficient. These partnerships must be set up within well-structured regulatory frameworks as suggested in the Twelfth Plan. Partnerships with private not-for profit entities can be initiated for creation or management of facilities. In addition, Government can support the creation of specialized entities to build and run institutions which can deliver high quality care in a self-financing manner, as in Sir Ganga Ram Hospital in Delhi. PPP arrangements must include requirements of compliance with regulations, Standard Treatment Guidelines, and lead to delivery of affordable care. Several current PPP arrangements lack a specialized regulatory architecture to ensure prompt redress of conflicts arising from contractual obligations.

References:
4. WHO Global Health Expenditure database. Available at: http://apps.who.int/nha/database/Key_Indicators_by_Country/Index/en
5. Joint Learning Network for Universal Health Coverage. Available at: http://programs.jointlearningnetwork.org/content/mutuelles-de-sante