International Journal of Research in Economics and Social Sciences (IJRESS)
Available online at: http://euroasiapub.org
Vol. 7 Issue 7, July- 2017
ISSN(o): 2249-7382 | Impact Factor: 6.939 | Thomson Reuters Researcher ID: L-5236-2015

A Comparative Study of Private & Public Expenditure in India

Dr. Anupama Verma, Associate Professor, Economic Department, Tilak P.G. College, Auraiya

Ensuring that public spending on health care and other services is pro-poor is an important objective of many national governments and international agencies. It is central to the mission of the World Bank and is a key component of the Heavily Indebted Poor Countries Initiative and the International Monetary Fund's Poverty Reduction and Growth Facility. Under lying the objective is the contention that distributional concerns, to a large extent, justify public spending on health care. The ultimate targets may be reduced health inequality and greater equity in the distribution of health care. Public spending on health care may also be justified as an instrument for the redistribution of welfare. In low-income countries, where information and administrative constraints are particularly binding, in-kind transfers, such as public health care, are more feasible and potentially more efficient than cash transfers in alleviating poverty and reducing inequality.[1]

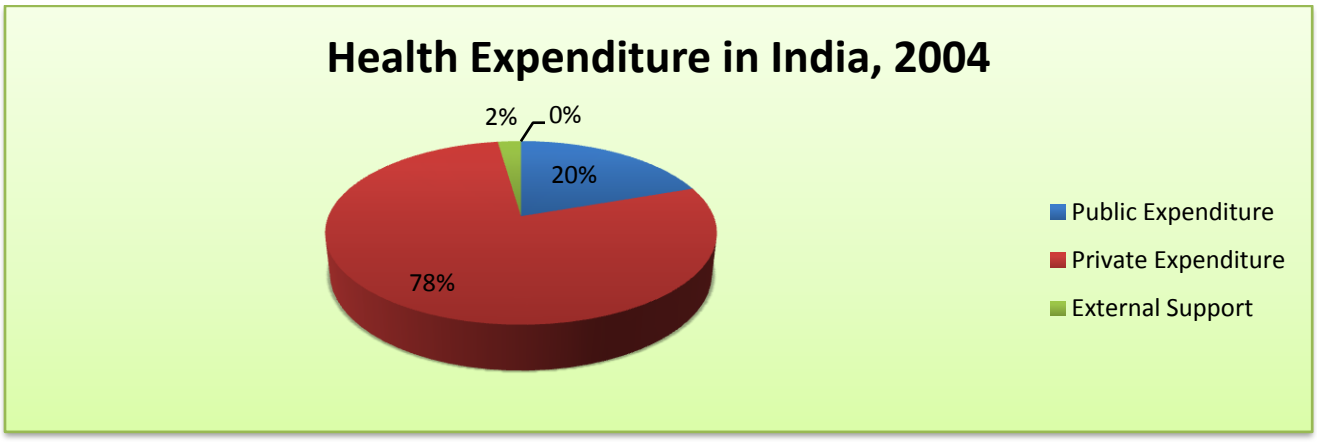
Health expenditure is highly unequal across the globe. In most developed countries public financing for around 80 per cent of all health expenditure whether through state revenues and/or social insurance has been the critical component in realizing universal access with equity. In contrast, in most of the developing countries the reverse is true, i.e. 70-80 per cent of the health expenditure is private.

In terms of commitment to improve the health services too, India's performance is not very impressive. Public expenditure on healthcare including spending on water supply and sanitation at 1.3 percent of GDP in 2002, was one of the lowest, although it was higher than the expenditure in other south asian countries except Srilanka. Of 174 countries for which information was presented in the Human Development Report (UNDP, 2005), India's rank inproportion of health expenditures to GDP was 159 and only 15 countries incurred lower expenditure than India. In fact, public expenditure on health was just about 1.3 percent of GDP whereas private health expenditure was almost 4.8 percent or 3.7 times the public expenditure.

[1]AparnaaSomanathan,Who benefits from public spending on health care in Asia?, Forum 9, Mumbai, India, 12-16 September 2005

The low level of public expenditures is not the only concern; an overwhelming proportion of health spending is on curative rather than preventive healthcare. Spending on preventive healthcare has a pro-poor impact. This is because, affluent sections of population have already access to facilities like protected water supply and immunization and additional spending enhances the coverage of the facilities to hitherto uncovered areas and provides greater access to the poor . Preventive health care also has greater impact in enhancing "capabilities" of the poor.[2]

In India, the population is 1210.2 million in 2011. The size of the rural and urban population is 68.84 per cent and 31.16 per cent respectively. The decadal growth rate of population had declined from 21.5 per cent in 2000 to 17.6 per cent in 2011. The per capita public health spending in India is low and as a percentage of GDP, it has declined from 1.3 per cent in 1990 to 0.9 per cent in 1999 and increased marginally to 1.1 per cent by 2009. The estimates from the National Health Account (NHA) for the year 2004-05 showed that total expenditure in the country was Rs 133776 crores, accounting for 4.25 per cent of its GDP. Of the total expenditure, the share of private health expenditure accounted for 78.05 percent; public expenditure constituted 19.67 per cent of external support was 2.28 per cent. The share of public health expenditure has increased from 0.96 per cent in 2005-06 to 1.10 per cent in 2008-09. The Eleventh five year plan document had suggested that the public spending on health should be increased from 0.9 per cent of GDP to 2-4 per cent of GDP.[3]



[2] M. Govinda Rao &Mita Choudhury, Inter-State Equalisation of Health Expenditures in Indian Union, National Institute of Public Finance and P olicy New Delhi, January 2008, pg- 1-46.
[3]R.Maya, Financing Health Carre in India,Indian economic Journal,2011, pg.609-616)

To examine the trend in health expenditure, the data regarding medical and public health expenditure (revenue and capital) incurred by centre, states and union territories for the period 1986-87 to 2009-10. For analysis the period has been divided into two parts as follows:-

1986-87 to 1995-96

1996-97 to 2005-06

The combined (revenue and capital) expenditure on medical and public health increased absolutely from Rs. 4068 crore to Rs. 76012 crore during the period 1986-87 to 2009-10, showing a compound annual growth rate of 13.1 per cent per annum. The growth rate was observed to be higher during the period 1986-87 to 1995-96 (13.0 per cent per annum) as compared to period 1995-96 to 2005-06 (10.4 per cent per annum). Though the revenue and capital expenditure of centre, states and union territories on medical and public health increased tremendously from 1986-87 to 2009-10, but as per cent of total expenditure and as per cent of GDP it has declined. It was 4.41 per cent of total expenditure and 1.57 per cent of GDP during 1986-87, but it declined to 4.23 per cent and 1.22 per cent respectively during 2009-10. The public expenditure on family welfare was Rs. 570 crore during 1986-87, which increased 12885 crore during 2009-10, showing a compound growth rate of 13.4 per cent per annum. In this case too, the growth rate was observed to be higher during the period 1986-87 to 1995-96, (13.2 per cent per annum) as compared to the period 1995-96 to 2005-06 (11.4 per cent per annum). The expenditure of centre, states and the union territories on family welfare increased manifold, and as per cent of total expenditure it increased marginally from 0.61 per cent to 0.72 per cent during 1986-87 to 2009-10, while as per cent of GDP it was witnessed a slight decline from 0.22 per cent to 0.21 per cent during the corresponding period.[4]

The level of public expenditure by the centre and state health department as a share of Gross Domestic Product (GDP) has not significant risen between 1950-51 and 2003-04. This has primarily been due to the austerity measures in the late 1980s, which negatively affected sectors such as health. Below table depicts the trends in public health expenditure as per cent of GDP from 1950-51 to 2003-04 in India. It reveals that public spending on health in India gradually

[4]ViplaChopda and Bharti Kapur, Public Expenditure on Health in India: An Analysis, IEJ 2011, pg. 659-

accelerated from 0.22 per cent in 1950-51 to 1.05 per cent during the mid- 1980s, and stagnated at around 0.9 per cent of the GDP during the year later years. Moreover, health sector suffered more during post-liberalization period. In the pre-liberalization period of independent India, the health expenditure as percentage of the GDP rose as a whole from 0.22 per cent in 1950-51 to 0.96 per cent in 1990-91. However, it has seen a steady decline ever since in the post-liberalization period from 0.96 per cent in 1990-91 to 0.91 per cent in 2003-04.

Trend of Health Expenditure in India

Year	Health Expenditure as % of the GDP			Per- Capita Expenditure on Health (Rs.)
	Expenditure	Capital	Aggregate	
1950-51	0.22	NA	0.22	0.61
1955-56	0.49	NA	0.49	1.36
196061	0.63	NA	0.63	2.48
1965-66	0.61	NA	0.61	3.47
1970-71	0.74	NA	0.74	6.22
1977-76	0.73	0.08	0.81	11.15
1980-81	0.83	0.09	0.91	19.37
1985-86	0.96	0.09	1.05	38.63
1990-91	0.89	0.06	0.96	64.83
1995-96	0.82	0.06	0.88	112.21
2000-01	0.86	0.04	0.90	184.56
2001-02	0.79	0.04	0.83	183.56
2002-03	0.82	0.04	0.86	202.22
2003-04	0.86	0.06	0.91	214.62

Note: GDP is at market price, with base year 1993-94, NA-Not Available

Source: 1. Report on Currency and finance, RBI, Various Issues, 2. Statistical Abstract of India, Govt. of India, Various Issues, 3. Handbook of Statistics of India, RBI, Various Issues.

PRIVATE EXPENDITURE ON HEALTH CARE SERVICES

It is well known that health expenditure in India is dominated by private spending. To a large extent this is a reflection of the inadequate public spending that has been a constant if unfortunate feature of Indian development in the past half century. This is particularly unfortunate because of the large positive externalities associated with health spending, which make health spending a clear merit good. The greater reliance on private delivery of health infrastructure and health services therefore means that overall these will be socially underprovided by private agents, and also deny adequate access to the poor. This in turn has adverse outcomes not only for the affected population but for society as a whole. It adversely affects current social welfare and labor productivity, and of course harms future growth and development prospects.[5]

Of those seeking treatment, 78 percent rural and 81 per cent urban patients are availing private non-institutional facilities and 58 per cent rural and 62 per cent urban patients are going to private hospitals (NSSO 2004).We also find that the dependence on the private sector is significant across all income ranges from the poorest to the richest, and utilization for public facilities is only very marginally higher among the poorest segments.[6] A related fact is that nearly 75 per cent of health-related expenses are out of pocket and occur at the point of service delivery.[7]

Contribution of private sector in health care expenditure in India is around 80 per cent and is one of the highest in the world.[8] Almost 94 per cent of this amount (which covers both financing and provision aspects) comprises of out-of-pocket expenditure on health. The remaining 6 per cent is the expenditure on provision, which accounts for the private sector contribution to 60 per cent of all in-patient care and 78 per cent of total number of visits in

[5] Government Health Expenditure in India: A Benchmark Study, Economic Research Foundation,New Delhi, August 2006, pg. 1-42.
[6]Laveesh Bhandari and Siddhartha Dutta, HEALTH INFRASTRUCTURE IN RURAL INDIA, India Infrastructure Report 2007, pg. 265-285.
[7] ABHIJIT DAS, Public-private partnerships for providing healthcare services, Indian Journal of Medical Ethics Vol IV No 4 October-December 2007, pg. 174-175.
[8] CII, KMOL(2009),policy paper "The Emerging role of PPP in Health care".

outpatient care.[9] In addition the private sector today provides 58 per cent of the hospitals and 81 per cent of the doctors in India.[10]

The private sector expenditure on health sector has increased dramatically, particularly during the post- liberalization period. The share of government expenditure accounted for about one-third of the total health expenditure. The share of health expenditure to the total expenditure on health by the private sector and public sector is presented in table below.

Level of Health Expenditure by the Private and Government sector in India (in %)

Year	Private Expenditure	Government Expenditure
2003	79.6	20.4
2004	79.1	20.9
2005	77.6	22.4
2006	75.0	25.0
2007	73.8	26.2
2008-09	71.6	26.7

Source: GOI, "National Health Profile 2010", Ministry of Health and Family Welfare, New Delhi.

The share of government expenditure on health to the total health expenditure was 20.4 per cent in 2003 and it increased to 26.2 percent in 2007. Even though the share of private expenditure on health witnessed a declining trend, it still accounts for about two-thirds of total health expenditure. National Health Profile 2010 reveals that the OPP expenditure plays significant role in the health expenditure. The estimate shows that OPP expenditure on health has come down from 92.4 per cent in 2003 to 89.9 per cent in 2007.

However, the per capita health expenditure in India has significantly period it was increased Rs. 0.61 in 1950-51 to Rs. 64.83 in 1990-91. During the liberalization period it was increased dramatically and reached Rs. 214.62 in 2003-04. The per capita public health

[9] NSSO,2008.
[10] Govt. of India.

expenditure is comparatively low (Rs. 242) when compared with the private per capita health expenditure (Rs. 955) in 2004-05.[11]

Private health care may be classified into various levels, based on the scale of operations and the range of services provided. Some of these are listed below

- Individual private practitioners providing medical prescriptions and basic healthcare services;
- Small nursing homes with bed capacity ranging from 5-100 beds primarily concentrated in urban areas
- As per the 52nd Round of National Sample survey Organization, 81% of the outpatient care and 56% of inpatient care is being provided by the private sector in the country.
- Large hospitals run by trusts or corporates that are located primarily in cities and towns across the country. The 1990s have seen significant entry of Indian companies in medical care. Most of these players have focused on large, single or multi-specialty facilities located in large cities. These include Apollo, Fortis, Max, Wockhardt and Escorts, among others.
- Leveraging India's IT strengths, telemedicine is being tried out at a few hospitals. This holds promising potential for providing quality medical care even in remote parts of the country.[12]

PUBLIC-PRIVATE PARTNERSHIP IN HEALTH EXPENDITURE

Public-Private Partnership or PPP in the health sector can be an instrument for improving the health of the population if adopted judiciously in India. PPP should be seen in the context of viewing the whole medical sector as a national asset with health promotion of all sections of society especially the poor as goal of all health providers, private or public. PPP however would not mean privatization of the health sector system. Partnership is not meant to be a substitution for lesser provisioning of government resources nor an abdication of government responsibility but as a tool for augmenting the public health system.[13]

[11] P. Anbalagan, Equity Aspects of Healthcare with Reference to Health Insurance for the poor in India, IEJ, 2011, pg. 739-756.
[12] www.mohfw.nic.in
[13] Prem Vijoy, amrindrakumar Singh & Rajeev Kumar, Health, Education and Inclusive Development, IEJ 2011, pg. 679-685.

Enthusiasts of public-private partnership such as the World Bank believe these partnerships could help address specific cost and investment challenges faced by governments and improve efficiency and quality of health services. Others like the WHO and several pharmaceutical companies think public-private partnerships can contribute to improving equity in access to essential drugs while enhancing research into some of the world's forgotten diseases such as trypanosomiasis, buruliulcer, tuberculosis and malaria, all of which predominantly affect the poor.[14]

Percentage of Hospitalised Treatment by type of Hospital during 2004, 1995–96 and 1986–87

Type of hospital	Rural			Urban		
	2004 (60th)	1995–96 (52nd)	1986–87 (42nd)	2004 (60th)	1995–96 (52nd)	1986–87 (42nd)
Government	41.7	43.8	59.7	38.2	43.1	60.3
Non-government (Private)	58.3	56.2	40.3	61.8	56.9	39.7

Source: NSSO (2004)

The objectives of PPP mechanism should be clearly defined so as to bring about universal coverage and equity in health care. The main objectives should be:

- Inclusion of all sections of the society, especially the poor, under the health care system;
- Improving quality, accessibility, availability, acceptability and efficiency of health services;
- Exchange of skills and expertise between the public and private sector;
- Mobilization of additional resources;
- Improving the efficiency in allocation of resources and additional resource generation;
- Strengthening the existing health system by improving the management of health within the;
- Government infrastructure;
- Widening the range of services and number of services provided;

[14]AUGUSTINE D ASANTE &, ANTHONY BZWI, Public-private partnerships and global health equity: prospects and challenges,Indian Journal of Medical Ethics Vol IV No 4 October-December 2007,PG. 176-180.

- Clearly defined sharing of risks;
- Community ownership; and
- Equitable spread in rural and urban areas, with emphasis on rural and backwards areas.

Funds Flow to Health Sector 2004-05

Source of Funds	Expenditure (in million)	Percentage Distribution
A-Public Funds		
Central Govt.	90667	6.78
State Govt.	160171	11.97
Local Bodies	12292	0.92
Total-A	263130	19.67
B- Private Funds		
Households	951538	71.13
Social Insurance Funds	15073	1.13
Firms	76643	5.73
NGOs	879	0.07
Total-B	1044133	78.05
C- External Flows		
Central Govt.	20884	1.56
State Govt.	3272	0.24
NGOs	6337	0.47
Total-C	30493	2.28
Grand Total	1337756	100.00

Source: 1. Demand for grants MOHFW & Other Central Ministries (2006-07), GOI

2. Demand for grants DOHFW & Other Central Ministries (2006-07), State Govt.

3. NSSO 60th Round

Considerations for Public-Private Partnership at Primary and Secondary levels:

1. Contract for outreach services and package of primary care interventions for underserved areas to NGO's or other medical groups. These could be area specific and could be paid on an estimated per capita basis. Performance could be measured on targets achieved and results of indicator surveys.

2. Contact for marketing of specific health products to build both demand and supply, especially in remote areas. These could be for products generally sold in chemists or kirana shops, such as Oral Contraceptives, condoms ORS, IFA tablets, disposable delivery kits, vitamin A and others. Contracts could be to social marketing firms, NGO's or commercial groups. Marketing activities tend to succeed more than plain IEC campaigns because they are persuasive in nature and also show a definite outcome in terms of stocking of products and in sales. Sales generally mean use.

3. Improve the quality of both public and private medical services in tandem. This can be done through accreditation of doctors and pare-medical personnel, along with training in latest practices in reproductive and child health. Including the medical associations in this effort will ensure sustainability. A promise of publicity for services and possibly discounted supplies (eg.Free vaccines) may encourage private doctors to take up preventive services.

4. Consider schemes for sharing of services and supplies between private and public facilities-eg, contracting private doctors for outreach services, public doctors to perform procedures like sterilization in private nursing homes, public health centers for dual private /public clinic use with fee-sharing.

5. Develop alternative sources for health financing for client services - community financing schemes, health insurance for special groups, user fees for all but the poorest joint ventures with private medical facilities or employer groups.[15]

[15] Rita Leavell, PUBLIC AND PRIVATE SECTOR PARTNERSHIP IN HEALTH CARE.

References

1. Alam, Moneer (1977). "Health Financing by States : An Exploration". Demography India 27(2): 177-205.
2. Musgrove P. (1999) "Public Spending on Health care : How are Different Criteria Related?", Health Policy 47(3): 207-23, 2 May.
3. Reddy, K. N. and V. Selvaraju (1994), Health Care Expenditure by Government of India 1974-75 to 1991-91. New Delhi : Seven Hills Publications.
4. Word Bank (1995), India : Policy and Finance strategies for strengthening primary health care services, Report No 13042-IN, May 15,
5. Word Bank (1997), http: //www.worldbank.org/poverty/impact/health
6. WHO (2003a). http://W3.whosea.org/cntryhealth/india/index.htm.
7. WHO (2003b). Shaping the Future : World Health Report 2003.
8. WHO (2005). Country Profile. http://W3.whosea.org/cntryhealth/india/index. htm. country Empirical Study.