Financing Health for All in India

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Abstract

India has set out ambitious goals for itself in the health sector in its Tenth Five Year Plan (2002-07). It is also a signatory to the United Nations Millennium Development Goals. Attainment of these goals which are time-bound will require a massive scaling up of investment in health, especially in public primary health care. We argue for a 'Health for All' initiative on the part of the government akin to the 'Education for All' scheme which was launched nation-wide in 2001. The large amount of resources required for scaling up public investment in primary health need not be the constraint it is purported to be. We discuss several options that are available to the government for generating the necessary funds. Among the options that can generate resources domestically are reform of the government's subsidies regime including implementing life-line tariffs, ear-marking taxes and disinvestment of loss-making public sector units.

Health for All can also be financed by raising more resources via external assistance. Official development assistance to India at present is rather low given India's per capita income and the scale of its needs in human development terms. The scale of official development aid to India should increase several folds and committed use of funds should be made by the government in health and other priority sectors. With the 73rd and 74th amendments to the Indian Constitution which created a third tier of government comprising of elected local bodies at the village and town ward levels, a decentralized system of service delivery will eventually become a reality in India and needs to be a part of any debate on the means and modes of improving human development outcomes in India. The current system of planning and allocation of funds at the sub-national level however needs to be over-hauled if fiscal decentralization is also to become a reality.

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1. Introduction

Health is intrinsically valuable and people value a long and healthy life as an end in itself. Good health is also a means to higher labor productivity and rising living standards. On the other hand, poor health is associated with large losses in labor productivity among working adults (Behrman and Deolalikar, 1988). Infections and malnutrition among children cast a long shadow on their adult lives and their future productivity. Many more mothers die due to pregnancy and child birth related reasons – deaths that can be avoided if there is adequate and convenient access to prenatal care and essential vaccines. In India, where less than 10% of the population has health insurance (mainly government employees and people working in the formal sector), episodes of ill-health can push even initially non-poor households into chronic poverty. Investing in people's health is therefore fundamental for attaining the important societal goals of economic growth, efficiency, equity, and poverty alleviation.

In poor countries including India, more than half the burden of disease is due to communicable diseases. Cross-country differences in life expectancy at birth are largely due to differences in infant and child mortality rates (Schulz, 1999). Provision of immunization and prenatal care can reduce the current levels of very high infant, child and maternal mortality and morbidity quickly. These services are most cost-effectively provided at low level facilities such as sub-centers and primary health care centers in India. Even at low levels of economic development countries such as Sri Lanka, China, Jamaica and Costa Rica, as also the Indian state of Kerala have been able to attain health indicators that are close to those of middle and high income countries by providing an extensive network of primary health care facilities (Mehrotra and Jolly, 1998).

India was a signatory to the Alma Ata Declaration of 1978 and national health policies and plan documents have recognized the importance of preventive and curative primary health care in maintaining and promoting people's health. This was recently reiterated in the approach paper to the 10^{th} Five Year Plan which recommended the provision of essential primary health care services free of cost to all individuals and essential health care service to people below the poverty line (Planning Commission $2002/10^{th}$ plan document). Post-independence, a vast public health infrastructure has been established in India that seeks to provide primary, secondary and tertiary levels of health care through a tiered system with sub-centers located within or close to habitations in rural areas for providing primary health care services, followed by primary health care centers, community health care centers and district hospitals located in urban areas.

Despite this wide-spread network of public health facilities, India's record in health is rather depressing. The infant mortality rate of 63 per 1000 live births and the under-five child mortality rate of 73 per 1000 live births are still rather high. The

maternal mortality rate is as high as 440 per 100,000 live births. Many diseases such as malaria, hepatitis, tetanus, leprosy and others that have disappeared from most countries are still common in India. In fact, India's share in world leprosy is 68% (Dreze and Sen, 2002).

The official rhetoric notwithstanding and despite the economic and social importance of health, India's commitment to health can be gauged from the amount of public resources it devotes to health. India currently spends 5.2% of its GDP on health of which public health expenditure is an abysmal less than 1% of GDP, the rest being accounted for by private expenditure (National Health Policy, 2002). Other developing countries on average spend around 3% of their GDP on health and developed countries around 5% of their GDP (Sachs and Bajpai, 2001). According to the Central Statistical Organization (CSO), in 1998-99, government expenditure on health (excluding expenditure on family welfare) was Rupees 1,058.8 billion or 0.6% of GDP. When Plan and Non-Plan expenditures of twenty six state governments and the Central Ministry of Health and Family Welfare are summed, public expenditure on health was Rupees 1,677.1 billion or a mere 0.95% of GDP. In per capita terms, India spends only $4 per capita annually on public health. According to the World Health Report (2000), only twelve other countries spend less than India on public health, most of them in Africa.

Not only is the level of public health spending very low, the utilization of available resources is also highly inefficient resulting in a public health system that is dysfunctional. So much so that it is the much larger and the largely unregulated private sector that has become the de facto provider of health care services in India. 79% percent of all out-patient visits are made in the private sector where over three-fourths of the qualified medical practitioners work (Planning Commission, 2001). The poor too prefer to use the much costlier services provided by private practitioners even when they have access to subsidized or free public health care. The low levels of utilization of public health care services is both due to lack of a public health facility at a convenient distance for a significant section of the population but more importantly due to the very low quality of health care provided by the public sector.

To improve both access as well as the quality of care provided under the public health system, greater investment in public health care is a pre-requisite. Given the current level of public health expenditure in India, it is unlikely that India will be able to make any significant progress towards the attainment of the Millennium Development Goals (MDGs) to which it is a signatory or its even more ambitious health targets as stated in the 10th Five Year plan 2002-07 (Table1 in the Appendix). The National Common Minimum Program adopted by the United Progressive Alliance in 2004 after it formed the government at the centre agreed to increase public expenditure on health to 2-3% of GDP. The central government's budget estimates for 2005-06 for outlays on health and family welfare shows an increase of 22% over last year, from Rupees 84.20 billion to Rupees 102.80 billion. These are intentions and actions on the right path, but they are not enough, given the size of the task, and the urgency with which it needs to be faced. It has become commonplace, however, to cite the weak fiscal position of both the central and the state governments as the binding constraint that is keeping the government from

committing to the resource requirements for expanding and improving the primary health care system in the country.

In this paper, we propose various options that are available to the government to generate the necessary resources to strengthen the system of primary health care in the country: to increase access and to make it more efficient, equitable, and responsive to the demand for health care in the country. Not all these options are entirely original, but the fear that they will not pass muster given the political history of the country have kept them away from being given serious consideration. However, India has currently shown refreshing willingness to be bold and to experiment. It seeks a leader's position in the new world economy. Like the Indian cricket team, it has to learn to 'plan for success' (Bajpai et al, 2005) and to create and generate the necessary political consensus for its plans.

The paper is organized as follows. Section 2 discusses the role of the government in investing more resources in the public health care system. Section 3 lists and elaborates on the various options that are available to the government for generating more resources which can then be used for health. In Section 4, the role of planning and allocation at the sub-national level is briefly discussed and Section 5 concludes.

2. Role of the Government: Higher Public Spending

The very low level of public health expenditure remains a root cause of the poor performance of the health system in India. The wasteful and inefficient utilization of available resources further aggravates the delivery of primary health care services which when they are provided are of poor quality. With more than 80% of health care expenditure being financed privately, India has one of the highest levels of out-of-pocket expenditure for health care in the world. Only Cambodia, the Democratic Republic of Congo, Georgia, Myanmar and Sierra Leone have higher out-of-pocket expenditures (Misra, 2003). Moreover, it is the poor who suffer the most as a result who have to bear the double burden of poverty and ill-health. According to the 52nd round of the National Sample Survey 1995-6, out-of-pocket expenditures for the bottom quintile of the income distribution accounted for nearly 12% of household income and for the top quintile around 14%. With thin and/or missing health insurance markets, illness can result in chronic poverty as households bear the costs of illness by selling off productive assets or taking on debilitating loans.

Given widespread poverty and the very sharp health inequalities that exist in India by income class, the provision of health care, especially primary health care has to be a social concern and primarily the responsibility of the state. Primary health care has to be financed by public spending and in order to provide basic health care coverage to all; per capita expenditure on health care in India needs to rise by much more than is currently the case, and in a relatively short period of time. This is essential for improvement in health outcomes from its current harsh levels. It is also necessary if the health targets envisioned in the 10th plan are to be reached.

Public spending per capita has to rise from $4 to at least $30 per capita which will be around 6% of GDP for resources to be adequate for expanding coverage and improving quality on a sustainable basis. According to the estimates of the Commission on Macroeconomics and Health which stimulated the cost of essential services that the state must provide, public spending per capita in low income countries will have to be within the range of $30-$45 per capita (CMH, 2001). Along with increased finances, governance and institutional reforms will have to be undertaken to ensure a well-functioning and efficient health system that is transparent and accountable.

In the current policy environment of pro-market reforms and in the face of persisting fiscal imbalances both at the central and state levels of government, state presence in health matters is being debated, influenced to some extent by corporate India's opinions (Dreze and Sen, 2002). The notion taking root is that the state should reduce its presence in the health care sector and allow the private sector a greater role in the financing and provision of health services. The debate is, to say the least, lopsided as it does not pay attention to the reasons why health and especially primary health care should essentially be a public concern. Nor does it see the fundamental conflict of such a stance with the other social goals of poverty alleviation and equity. Moreover, historical experiences of present day advanced countries before their take-off into economic growth and of current low-income countries that have successfully made the health transition show that health attainments in these countries have categorically been the result of greater public intervention, not less. Contemporarily too in advanced industrial countries, health care is largely a social concern with universal socialization of medicine and health care in many countries.

Health for All: A Sarva Swasthya Abhiyan for India

Health is a state subject in India which means that the primary responsibility of financing and providing health care rests with the state governments. The central government's role has been to fund centrally sponsored schemes, to develop policies and guidelines and to provide statutory grants or general transfers to the states. However, the quantity and quality of health care provision varies widely across states reflecting their widely varying levels of economic development, their health sector priorities and their current and past investments in health. Similarly, there are wide variations in health outcomes across states, across socio-economic groups and across rural and urban areas. In 2002, infant mortality rate varied from a low of 14 per 1000 live births in Kerala to 97 per 1000 live births in Orissa[1]. The maternal mortality rate in Uttar Pradesh was as high as 707 per 100,000 live births in 1996-97. The total number of malaria positive cases in 2000 was 2.2 million of which more than half were in the two states of Madhya Pradesh and Orissa. The rural infant mortality rate was 75 per 1000 live births in 2002 compared to 44 per 1000 live births for urban areas (NHP, 2002). Given these very sharp divisions across states, the central government could take the initiative of providing an umbrella program that would reduce the inequalities in health outcomes across states.

[1] Regions with high IMR and child mortality have high fertility rates as households tend to have larger number of children and vice versa Sachs (2005). Orissa and Kerala are striking examples in this regard.

The National Health Policy 1983 (NHP 1983) had proposed a "Health for All by the Year 2000" program through the provision of comprehensive primary health care services. While the year 2000 has come and gone, the need for a nation-wide health for all program has become more urgent than ever. The NHP (1983), however, did not spell out any concrete steps as to how such a program will be implemented. In November 2001, the government of India (GOI) launched its ambitious centrally sponsored scheme for the universalization of elementary education (***Sarva Shiksha Abhiyan*** *or SSA*) to attain the goals of universalization of primary education by the year 2007 and universalization of elementary education by the year 2010.[2] The total project cost of the SSA has been estimated at $3.5 billion of which $1 billion has been pledged by three donors, namely the World Bank, DFID and the EC. Education in India is on the 'concurrent' list. This means that both the central and the state governments share responsibilities with respect to the financing and provision of education. However, in practice, it is the state governments that have the major role in financing and providing education. But as the case of the SSA shows, a political consensus towards a nation-wide program with clear benefits can be generated and implemented in partnership with the state governments. In a similar vein, a Health for All program (***Sarva Swasthya Abhiyan***) could be launched in India building on the grounds created by the SSA (Bajpai and Sachs, 2004). The modalities of financing and implementing the program can be modeled along the lines of the SSA with appropriate modifications in program design and implementation strategies that are pertinent to the health sector and the health needs and priorities of the people. The SSA experience can be further valuable in terms of deriving lessons in terms of what works and what does not.

3. Options for mobilizing resources for financing public health

As is amply evident, India grossly under-invests in the health sector whereas if it wants to meet its development goals of economic growth and human development, both the central and the state governments need to commit larger amounts of public resources to health, and specifically to primary health care. To raise resources for financing a health for all initiative, the government has to move beyond current perceptions that the already large fiscal deficits of the central and state governments will make it hard if not impossible to raise the required quantum of resources and politically commit to higher levels of expenditure on social services. The case of SSA shows that it is possible to build a broad-based consensus on a large nation-wide human development program when its high social benefit is recognized. To mobilize additional resources for financing public health, various options are available, some of which of we discuss below.

To raise the additional 5% of GDP for increased public spending on health, both the governments at the centre and the state levels will have to reorient and restructure their fiscal policies. Currently, India's fiscal deficit is around 10% of GDP as a result of fiscal profligacy and mismanagement since the late 1980s. By bringing down the fiscal deficit and by reallocating funds from sectors such as infrastructure where the private sector can come in, India can generate the additional resources required for expanding and

[2] Elementary education in India refers to the first eight years of schooling, of which the first five grades belong to the primary level of schooling.

improving the public health system. Moreover, the fiscal deficit should be reduced by cuts in existing expenditures rather than by raising taxes. Current government expenditures (centre and states combined) are already at very high levels at more than a third of GDP and further increases in expenditure that are financed by general tax revenues would be very difficult to implement (Sachs and Bajpai, 2001).

The fiscal deficit should be reduced by reducing expenditure on certain items of the government budget such as wasteful and inefficient explicit and implicit subsidies. These public savings can then be used for financing essential social development initiatives including a universal health for all program. Instead of general tax revenues being used to finance spending programs, special taxes could be earmarked to do so. India has recently implemented a 2% cess on certain taxes, revenues from which are to be specifically used for education. Assistance from abroad is another attractive policy option for governments of developing countries compared to the option of borrowing from the market, both of which tend to crowd out private investment while increasing the market rate of interest. External assistance funds are generally in the form of grants and any loan component is provided at very low rates of interest, the principal to be returned after a long period of time. We discuss these options in further detail below.

(1) Public Expenditure Restructuring: Subsidy Reform

Among the options available to the government to raise resources to finance publicly provided primary health care is the gradual reduction and/or elimination of wasteful and inefficient subsidies. Subsidization by the government of the provision of goods and services is justified when there are large positive externalities present. In such a situation, without government intervention, society will either not provide the good or service or the provision will be lower than what is socially optimal. Governments also subsidize the provision of goods and services to attain redistributive and equity goals. Examples include food subsidies to populations below the poverty line and price support for farm output. A third reason for providing subsidies is the provision of merit goods – when a certain good or service, such as vaccination, is considered essential for the well-being of the population. However, in the case of India, more than 50% of the subsidization cannot be rationalized on the basis of the criteria listed above.

Explicit Subsidies

In 1999-2000, subsidies accounted for 14.3% of the central government's revenue receipts. This was a little less than 1.5% of GDP. A large share of these subsidies was for goods and services which do not match either any externality associated efficiency or equity criteria. These included subsidies to goods and services such as manures and fertilizers, oilseeds and pulses, milk, fish, power, transport, iron and steel, sericulture, chemicals, textiles, paper and newsprint, atomic fuels, railways etc.[3] In these sectors no significant externalities exist and their subsidization cannot be justified either on efficiency or equity grounds. On the contrary, their subsidization leads to allocationary

[3] The government also directly provides hotel and tourism services for which no justification for either government financing or government provision can be made.

distortions creating waste and inefficiency. Moreover, these subsidies have led to large fiscal deficits at both the central and state levels of governments. As a matter of fact, fiscal mismanagement has become the hallmark of fiscal management in India. Starting from the mid-1980s onwards, the trend of gross fiscal imbalance has continued all the way to the present, slowing down moderately only for a short while after the economic reforms of 1991 but then deteriorating again. In 1990-91, the combined fiscal deficit of the central and state governments was 9.6% of GDP. With fiscal restraint as part of the reform process, the combined fiscal deficit[4] declined to 7.4% of GDP in 1992-3. In 1998-9, however, the fiscal deficit had climbed up again to its pre-reform level and stood at 9.5% of GDP (Report of the 11th Finance Commission, GOI, 2000). As a result human development has suffered with under-investment in critical areas of health and education as both the central and state governments have cut back on capital expenditures while continuing their large scale subsidization.

Implicit Subsidies: Reforming State Electricity Boards

Very poor cost-recovery in public sector units leads to very large levels of implicit subsidies. Subsidies are implicit when publicly provided goods and services are priced below the cost of providing them. They are the unrecovered costs – excess of aggregate costs over returns – of providing public goods and services, especially social and economic services (Srivastava and Bhujang Rao, 2004). According to the Report of the 11th Financial Commission, for the central government, for the years 1995-96 and 1996-97, cost recovery was as low as 8.4% for social services and 16.6% for economic services, implying 91% and 83% of implicit subsidization (NIFPF, 1997). For the state governments, cost-recovery was even lower at 2.15% for social services and 10.75% for economic services for the years 1994-99.

In India, almost 85% of investment in state-level public enterprises is on electricity utilities. The State Electricity Boards (SEBs) are responsible for generating and distributing power, setting tariffs and collecting revenues. Instead of generating a minimum of 3% return on investment as stipulated by the Electricity Supply Act of 1948,[5] the SEBs have been incurring humongous financial losses every year for over two decades.[6] In 1999-2000, the value of fixed assets of the electricity utilities was Rupees 68,000 which should have generated a minimum return of Rupees 20.40 billion. Instead, the SEBs registered a financial loss of Rupees 230 billion which was nearly 34% of the

[4] Fiscal deficit is the total borrowing requirements. It is total expenditure minus total revenue plus capital receipts. Revenue deficit is revenue expenditure minus revenue receipts. Primary deficit is fiscal deficit minus interest payments.

[5] The Electricity Supply Act 1948, Section 49 states that 'the Board shall, after taking credit for subvention from the state government under section 63, carry on its operations and adjust its tariff so as to ensure that the total revenues in any year of account shall, after meeting all expenses, leave such surplus as is not less than 3% or such higher percentage as the state government may specify.'

[6] The SEBs finance their excess expenditure primarily by transfers from the state governments, bonds and debentures raised either on their own or through state government guarantee and by withholding payments on their purchase of power, fuel and equipment from suppliers, especially public sector suppliers. In 2001, the total debt of SEBs to power sector companies was Rupees 289.39 billion of which 59% was principal (Sankar, 2004).

fixed value of assets and nearly 1.15% of GDP. In 2000-2001, the losses of the SEBs incurred by the SEBs were over Rupees 260 billion of which only Rupees 6,000 was accounted for in the state budgets as explicit subsidies. These losses were equivalent to 1.2% of GDP. Irrational pricing policies, losses due to theft of power called transmission and distribution losses (T & D) and inefficient power supply mechanisms have resulted in a public sector utility that is a considerable drain on state finances. In the face of large financial deficits and due to general economic mismanagement, the SEBs neglect maintenance of assets, neglect preventive maintenance, take poor investment and technical decisions and in general produce a poor quality product at a very high cost.

There is immediate need to reform the SEBs and plug the draining of resources from the state budget. The SEBs need to rationalize their tariff structure and bring pricing in line with costs incurred, ensure universal metering, bring transmission and distribution losses under control allowing the state governments to eventually withdraw their support and enable private investors to enter the electricity market on a larger scale. The savings generated from reforming SEBs have the potential of freeing up resources – nearly 1.2% of GDP – that are more than India's current public expenditure on health.

Life-Line Tariffs

Subsidy reforms can also take the form of 'life-line tariffs': charging highly subsidized initial prices for lower levels of consumption, and higher prices for higher units of consumption (Bajpai et al, 2005). People living below the poverty line in rural India can be given fixed and limited quantities of water, electricity and fertilizer at zero cost. For any consumption above this basic fixed package, the consumer will be charged an unsubsidized price that would fully cover the cost of supplying the service. Life-line tariffs can therefore generate large budgetary savings while also ensuring that the basic infrastructural needs of poor, rural households are met. They also make targeting easier. The savings realized from life-line tariffs can be invested in health (and other social sectors).

(2) Earmarked Taxes

Earmarking taxes for an identified specific program are easier to implement politically than a general new tax which can give rise to much public and political resistance. These taxes can be imposed either at the central or the state levels of government. India recently imposed a 2% cess on income tax, corporation tax, excise and customs duties and service tax, the revenues from which have been earmarked for primary education, including the provision of mid-day meals in schools. This cess is expected to yield Rupees 40-50 billion, around 0.1% of GDP. There are risks associated with earmarked taxes as given the fungibility of funds; the possibility of diversion of funds for other than primary health care always exists. To this end adequate safeguards will need to be built. International experience suggests that if properly administered, earmarked funds can be used to raise additional resources for funding education and health. Indiana, Arkansas and South Carolina in the United States used earmarked taxes for educational financing purposes. Similarly, Korea introduced a five year education tax

on liquor, tobacco, interest and dividend income and on banking and insurance industries raising 15% of its education budget in this manner. Earmarked taxes have also been used in Latin America and Africa. Brazil used a federal levy on financial transactions which was used to finance health care funding.

(3) Disinvestment of Public Sector Units

The central and state governments could work on major programs of disinvestment of central and state public sector units (PSUs) and announce that the proceeds would be spent on the health sector. For the central PSUs, all the sitting members of Parliament (Lok Sabha) could be given a share of the disinvestment proceeds, (those constituencies which are predominantly urban could be given a lower share) but with the specific purpose of the funds being used ONLY on primary health care given their respective constituency's needs and priorities. Similarly, for the state PSUs, such proceeds could be for all the sitting members of the respective State Legislative Assemblies.

This will, of course, require strict monitoring, preferably from the Prime Minister's office for the central PSUs and from the Chief Ministers' in the case of the state PSUs so as to ensure that the funds are being utilized for the purpose they were meant for. Such a scheme is likely to bring together the Members of Parliament/Members of State Legislative Assemblies from across party lines since they will be able to see the gains for themselves as well as for their constituencies. This could possibly unite them to support disinvestment plans on the floor of the House. Securing political accountability to such an idea at the level of Members of Parliament/Members of State Legislative Assemblies is likely to help a great deal in dealing with the opposition to disinvestment plans from trade unions and others traditionally opposed to them. This might seem like a long shot, but should such a scheme work, it will not only help the government withdraw relatively easily from the loss-making public sector, from running textile mills to steel plants, from managing hotels to operating airlines and a variety of other sectors, but will also divert resources towards primary health care.

(3) External Assistance

Development assistance from abroad can supplement resources raised domestically to finance public investment, especially if the options available to governments to raise resources through domestic savings are limited and are likely to have adverse effects on the economy by crowding out resources available to the private sector and raising the market interest rate. Development assistance from abroad can therefore add to domestic savings without adversely affecting domestic investment which is essential for economic growth.

The high concessionality of external assistance is a particularly attractive characteristic of external assistance for financing public investment in goods and services that have public goods characteristics. The benefits of such goods and services are widely

dispersed and the costs cannot be captured. If such public investment was made out of market borrowings, repayments on the basis of returns from such investment would not have been possible. On the other hand, external assistance with public investment of a social nature allows governments to retain the social returns generated.

On the part of the donors, development assistance can be justified as the financing of global public goods of which health of populations in poor countries afflicted by infectious diseases is a part. If health is a global public good, developing countries on their own will not have the incentives to provide adequately for it.

The federal government's 'Education for All' project (Sarva Shiksha Abhiyan, or SSA) is an excellent example of how additional public investments could be mobilized to enhance the quality and quantity of primary education for all[7]. This is a really good project and model of aid for India -- a national project on social priorities, and a few big donors that pool their resources. Currently, India receives $1.4 billion in the form of official development assistance. This amounts to approximately $1.40 per Indian and is far below what some other countries with India's level of income receive (Bajpai et al, 2005). The level of official development assistance to India should increase at least four- to five-fold. India's credit-worthiness should generate the necessary trust among the donors for this amount of assistance. In order for India to end extreme poverty, we are of the view that India should receive as much as $4 - $7 billion per year of budgetary aid for high-priority well-targeted, mainly rural social and infrastructure spending.

The IDA of the World Bank should be a major focal point for expanding the aid flows to India. IDA is now the single largest source of donor funds for basic social services in the poorest countries. In the 12 months to June 30, 2003, IDA's support for projects was targeted at human development such as education, health, social safety nets, water supply and sanitation (44%), infrastructure (26%), and agriculture and rural development (11%).

IDA does a number of important things. First, it provides the world's single largest flow of low-cost development assistance to poor countries, though not enough of it and not at low enough cost. A concessional loan typically carries no interest and offers a much longer grace period and maturity than other forms of financing could provide. IDA's standard concessional loan (called a 'credit') does not require principal repayments until 10 years after it is signed, with a final maturity of 40 years. Second, it directs its outlays towards the priorities identified by the recipient countries. Third, IDA harmonizes donor resources. Third, in the case of IDA, the donor governments agree, wisely, to pool their resources into a single basket that can back the specific strategy of

[7] As part of this project, three agencies -- the World Bank, UK's Department for International Development and the European Commission -- are providing $1 billion for this project. World Bank's International Development Association will provide $500 million, while the DfID will contribute $300 million and European Commission $200 million. The project is estimated to cost $3.5 billion. The Centre and state governments would provide the remaining $2.5 billion for the project that aims to achieve universal enrollment and completion of elementary education of children of 6-14 years of age by 2010.

the recipient country. Fourth, IDA commits its resources over a three-year time horizon rather than the one-year donor budget cycle typical of bilateral aid. Finally, it aims to base its allocations on good performance, using indicators for governance and economic management.

A back of the envelope accounting

To reduce the fiscal deficit to generate the additional resources required for funding health care, the following prime areas of potential expenditure reduction over a three year period can be considered. These items of expenditure reduction include options other than subsidies and SEBs, items that are also unnecessary drain on the Indian exchequer.

Central Expenditures	
Percent of GDP	
Reduction in subsidies	0.75
Central power sector undertakings support to SEBs	0.8
Reduced infrastructure investments, taken over by private sector projects	1.3
Reduced interest payments on account of contractionary fiscal measures	1.0
Disinvestment of PSUs	0.3
State level Expenditures	
SEB commercial losses (excluding explicit subsidies)	1.0
Water sector reform including rise in water tariffs	0.3
Transport reform including rise in transport tariffs	0.4
Reduced infrastructure investments, taken over by private sector projects	0.2
Disinvestment of state-level PSUs	0.6
Total	6.3

The above table shows that given the political will to take hard but essential decisions, it is possible to raise domestically additional resources to finance human development in India. Moreover, earmarked taxes and external assistance from abroad can further supplement the government budget for its social spending programs with an additional 1-1.05% of GDP. We emphasize that these are rough and suggestive estimates. The purpose of doing such an accounting exercise is to point to possibilities that have so far not found any place on the debate informing the financing of human development in India, especially health and education.

4. Sub-national planning and allocation

In India, health is a ‘state’ subject. This means that the primary responsibility of financing and provision of public health services rests with the state governments. The central government plays the role of an overseer by providing directives and guidance through the formulation of national policies and by the transfer of funds via its plan expenditure largely for centrally sponsored schemes (CSS) and other central schemes which are either wholly subsidized by the central government or are co-financed by the central and the state governments. States account for nearly three quarters of all public

expenditure on health, the rest being central government expenditure and tied grants to the state. While, plan expenditure dominates the central government's budget, non-plan expenditure dominates the budgets of the state governments as they are responsible for recurrent costs. The central government makes all the decisions regarding new investment and programs and central funds dominate the financing of new primary health care facilities in the states through plan investments, jointly sponsored public health schemes and centrally sponsored family welfare programs (Berman, 1998). The size of the states' non-plan expenditure is also determined by the quinquennial awards made to the states by the Finance Commission for recurrent costs of past investment. State budgets are therefore, significantly shaped by central-state fiscal relationship and concomitant transfer of funds. And state level planning and budgetary allocations with respect to the health sector is not independent of the complex division of responsibilities between the central and state governments.

In practice, state level plans vis-à-vis the health sector have been largely ad-hoc with plans in one year being updates and revisions of plans from the past. The wide variations across states in the provision of basic minimum services and even within states, wide variations across regions and districts reveals the disconnect between the reality of government plans and policies and their official rhetoric. States and districts with the poorest health status also tend to have the poorest health infrastructure in place. Even when additional funds are provided to fill the existing resource gaps, the practice of the states have been to use the funds in a manner that does not address the problem: for example, constructing more buildings rather than the missing package of basic minimum services for which the funds were made available (Nayar, 1999).

Planning that takes cognizance of people's needs requires a democratic set up for decision-making below the state level. Without such a system in place, state level planning remains over-centralized and removed from the needs and interests of the ultimate beneficiaries. Fiscal decentralization by moving government closer to people can lead to improved service delivery of those services that do not have major spillover effects, greater community participation in governance and hence better accountability on the part of government officials, greater willingness to pay and increased revenue mobilization with broadening of the tax net.

With the 73rd (and 74th) amendments to the Indian Constitution in 1992, the scope for levels of government lower than the state, at the district, block and village levels, to play a larger role in the delivery of basic services to the people has increased. Twenty nine subjects have been devolved to these local bodies of government, known as the Panchayati Raj Institutions (PRIs). They have been assigned taxation powers as well as decision-making authority over expenditures. In most states, the PRIs are now in place. However, there are large inter-state variations in the characteristics of the Panchayats – in their size, composition, methods and norms of elections and the powers devolved to them. This is due to the fact that the implementation of many of the amendment provisions has been left to the state governments.

However, international experience suggests that the share of local governments in expenditure is low and there is reluctance in general on the part of supra-local governments to devolve fiscal powers to local governments. The arguments against fiscal decentralization include the reduced ability of central governments to pursue macroeconomic policy, the lack of local capacity to execute the responsibilities assigned to them and the increased probability of local capture and corruption (Bird, 2001; World Bank, 2004). There is also the potential danger of widening of social inequities as different localities will have a different fiscal base and different preferences for distribution. The central government therefore will need to retain adequate vertical control of the tax system for better redistribution and harmonization of the tax system (Bardhan, 1998).

The experience with decentralization in India since the passage of the constitutional amendments too have been varied, with some states such as Kerala, Karnataka and Madhya Pradesh having made some progress albeit imperfectly,[8] and others where though the local governments are in place but nothing much else has happened. The common major difficulties that have emerged across decentralization experiences in various states are the conflicts between the state and local governments over the transfer of funds resulting in adequate financial devolution, the non-cooperation of bureaucracy with the PRIs, red tapism and corruption. Among the political and wealthy elite there is reluctance to transfer political power to women and backward classes. The most important obstacle in the functioning of the PRIs, however, has been the lack of technical and administrative capacities at the local level and lack of political education among the people about their rights and duties vis-à-vis the Panchayati Raj (Behar and Kumar, 2002). Moreover, there is very little data on the financial status of local government bodies. Proper financial record keeping is lackadaisical or non-existent at the local level.

Bird (2004) identifies a set of necessary and desirable conditions for fiscal decentralization to be successful and comprehensive. Among the necessary conditions are: the council must be locally elected, locally appointed chief officers, a significant set of expenditure and taxation responsibilities, budget-making autonomy, a hard budget constraint and transparency. The desirable conditions include: freedom from excessive mandates and unconditional transfers from higher levels of governments and borrowing powers. Thus, while India has moved in the right direction in terms of bringing government closer to the people, the design and implementation of the decentralization program still has a long way to go. However, given the dismal ground reality of the primary health care system as it currently exists, governance and development from below are a way forward to have an optimally operating public health system.

[8] Kerala has been the most successful among all states though there is a large variation in the performance of Panchayats within the state.

5. Conclusion

In the sections above, we have outlined and discussed various options that will enable the government to raise the resources it needs to create a public primary health care system in the country, with the objective of attaining 'Health for All'. Such a system can be along the same lines as the flagship Education for All program of the central government that has been underway since 2001. The available options include both domestic sources as well as external ones, such as the use of the IDA facility of the World Bank. Arguing for the need to create such a health care system and to invest more resources in publicly provided primary health care, in this paper we have intentionally focused on the means to raise the necessary resources for doing so. This is not to de-emphasize or not consider important the other critical aspect of creating a viable Health for All system of primary health care in the country: the issue of the way in which funds are used. Institutional and governance issues are as important as the adequacy of resources for any system of public provision to deliver efficiently and equitably. Weak accountability, rent seeking and misuse of public funds have resulted in gross wastage of the vast public health infrastructure already in place. However, one of the obstacles that has kept the government from even envisioning an umbrella program, is the concomitant resource requirements. In this paper, therefore, we have tried to show how resources need not be the most binding constraint for investing in people's health. The means are there for the end of 'Health for All'. What needs to be put into place is the will for it.

References:

Bajpai, N., Jeffrey Sachs and N. H. Volavka, (2005), *India's Challenge to Meet the Millennium Development Goals*, Paper presented at a seminar in the Planning Commission in New Delhi, India.

Bajpai, N., Jeffrey Sachs, (2004), National Common Minimum Programme of the Congress-led United Progressive Alliance: Policy Reform and Public Investment Requirements, Center on Globalization and Sustainable Development, Columbia University, Working Paper No. 22, New York.

Bardhan, P., (1998), *The Role of Governance in Development: A Political Economy Approach*, Paris: OECD.

Behar, A. and Y. Kumar, (2002), *Decentralization in Madhya Pradesh*, London: Overseas Development Institute.

Behrman, Jere R. and A. B. Deolalikar, (1988), "Health and Nutrition" in *Handbook of Development Economics Volume 1*, H. Chenery and T. N. Srinivasan eds. Amsterdam: Elsevier Science Publishers.

Berman, P, (1998), "Health Care Expenditure in India," in Monica Das Gupta, L. C. Chen and T. N. Krishnan eds. *Health, Poverty and Development in India*, New Delhi: Oxford University Press.

Bird, R., (2001), *Inter-governmental Transfers: Some Lessons from International Experience*, University of Toronto.

Bird, R., (2004), "Inter-governmental Fiscal Relations: Universal Principles, Local Applications," in M. Govinda Rao ed. *Development, Poverty and Fiscal Policy*, New Delhi: Oxford University Press.

Commission on Macroeconomics and Health (CMH), (2001), *Macroeconomics and Health: Investing in Health for Economic Development*, Geneva: World Health Organization.

Dreze, J. and A. Sen, (2002), *Development and Participation*, New Delhi: Oxford University Press.

Mehrotra, S. and R. Jolly eds., (1998), *Development with a Human Face: Experiences in Social Achievement and Economic Growth*, Oxford: Oxford University Press.

Misra, R (2003), *India Health Report*, New Delhi: Oxford University Press.

Nayar, K. (1999), "Health in the Ninth Plan," *Economic and Political Weekly*, Vol. 34(8): 455-457.

Sachs, J. (2005), *The End of Poverty – Economic Possibilities For Our Time*, The Penguin Press, New York.

Sachs, J. and N. Bajpai, (2001), "The Decade of Development: Goal Setting and Policy Changes in India," *CID Working Paper 62*, Harvard University.

Schulz, T P., (1999), "Health and Schooling Investments in Africa," *Journal of Economic Perspectives*, 13(3): 67-88.

National Health Policy 1983. New Delhi: Ministry of Health and Family Welfare, Government of India.

National Health Policy 2002. New Delhi: Ministry of Health and Family Welfare, Government of India.

Report of the Eleventh Finance Commission, (2000), Government of India.

Sankar, T. L., (2004), "Fiscal Impact of Electricity Boards' Overdues on State Finances," in Edgardo M. Favaro and Ashok K. Lahiri eds. *Fiscal Policies and Sustainable Growth in India*, New Delhi: Oxford University Press.

Srivastava, D. K. and C. Bhujanga Rao, (2004), "Government Subsidies in India: Issues and Approach," in Edgardo M. Favaro and Ashok K. Lahiri eds. *Fiscal Policies and Sustainable Growth in India*, New Delhi: Oxford University Press.

Tenth Five Year Plan Document (2000), Planning Commission, Government of India.

The World Bank (2004), *Fiscal Decentralization to Rural Governments in India*, New Delhi: Oxford University Press.

World Health Report 2000. Geneva: World Health Organization.

Appendix:

National Health Policy 2002 Goals		
Goals	Target Year	
Eradicate Polio and Yaws	2005	
Eliminate Leprosy	2005	
Eliminate Kala Azar	2010	
Eliminate Lymphatic Filariasis	2015	
Achieve zero level growth of HIV/AIDS	2007	
Reduce mortality due to TB, Malaria and other vector-borne diseases by 50%	2010	
Reduce prevalence of blindness to 0.5%	2010	
Reduce Infant Mortality Rate to less than 30 per 1000 live births	2010	
Reduce Maternal Mortality Rate to less than 100 per 100,000 live births	2010	
Increase utilization of public health services from the current level of less than 20% to more than 75%	2010	
Establish an integrated system of surveillance, national health accounts and health statistics	2005	

Source: 10th Plan Document, Planning Commission, GOI 2000