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Patterns of Expenditure on Health Care in India and Punjab

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Abstract: This paper presents a descriptive analysis of expenditure patterns on health care in India and the state of Punjab, with special reference to preventive health care. The need to analyse arises from the persistent, unresolved paradox between stagnant, inadequate financial inputs in the union and state budgets for healthcare and the increasing challenges posed by the rising incidence of communicable and non-communicable diseases, which demand higher financial inputs. As a result, the disability has increased the number of years of life lost among people, along with adverse effects on their productivity. Hence, to keep pace with socio-economic development and meet the challenges of increasing incidence of disease, both the central and the state governments need to increase financial inputs substantially, beyond the government's proposed 2.5% of the GDP, which, at present, ironically, lags around 1.6%, even below the government's own commitment.

Keywords: Healthcare, Preventive Healthcare, Expenditure, India, Punjab

Introduction

In India and its states, although health care is largely a state responsibility, due to inadequate public-sector facilities, most people, even those from the poorest sections of society, prefer private health care institutions. As a result, most people end up paying more out of their own pockets. Hence, impoverishment also increases in the poorer states in India (Dash & Mohanty, 2019). Given the situation, an analysis of the budgetary provisions and expenditures the state makes becomes significant. First, how much is spent to create institutional structures for the delivery of healthcare; second, how much is spent on training human resources to acquire professional

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competencies; and third, how much people incur when buying health services to maintain good health and their overall well-being. Analytically, state and people's expenditures are distinct categories.

The state expenditure implies one-time 'capital expenditure' incurred in the creation and acquisition of permanent assets and infrastructure, technologies, and skilling of manpower. In addition, the state expenditure includes 'recurring revenue expenditure' for the maintenance of supplies of preventive and curative healthcare. In India, the constitutional mandate of the state is to invest and make expenditure on the creation of permanent assets and their continued maintenance, respectively. The 'household expenditure', on the other hand, implies 'recurring revenue payments' on preventive health care and curative health that households incur on the maintenance of their good health to prevent any type of socio-economic losses due to Disability- Adjusted Life Years (DALY). This is also called Out of Pocket Expenditure (OOPE) that the citizens incur in buying health insurance, primary prevention, immunization and secondary prevention as well as on buying curative health care for the treatment of non-communicable and communicable diseases.

Theoretical Assumptions underlying Health Expenditure

A question may arise here as to why the state and the people invest and incur expenditure on healthcare. It is argued that investments and expenditures, besides covering the costs of prevention and productivity gains, also involve manifold considerations. Primarily, the overall economic implications for society and the household concerned are that, worldwide, the incidence of communicable and non-communicable diseases is extremely high. As a result, a phenomenal, continuous increase in the costs society, households, and individuals bear for maintaining and restoring good health has been taking place. This is detrimental to the primary developmental objectives of the society, maintaining high standards of health, and realization of optimum productivity potentials of the population. The reason being association between public health expenditure and economic performance indicates considerable productivity, performance, strengthening human capital and overall economic development of society and people (Raghupathi & Raghupathi, 2020). However, one must be sceptical about the role of multiple factors related to productivity in negatively associating with health and economic performance. On the contrary, in specific economic spheres, such as labour productivity, personal spending, and GDP growth, the association has been found to be positive.

The underlying assumption here being investments and expenditure on health have instrumental value in the realisation of socio-economic development, essential for greater equality, equity and distributive justice for all. There are also two crucial preconditions: first, launching 'timely, acceptable and affordable quality health care provisions'; and second, pertaining to the relational dimensions of health-promoting components. The latter includes 'safe and potable drinking water, sanitation, food, affordable housing, creation of knowledge and awareness about health, and gender equality' (WHO, 2006, *cited in* Gigimon & Mathew, 2023: 109). Both being essential, the state contributes to the State resources in many ways. Even the Preamble of the World Health Organisation, dated July 22, 1946, executed since April 7, 1948, enjoined upon 61 signatory countries to make budgetary allocations for the implementation of health policies, programmes, and adequate health measures (WHO, 1946: 1). Evidently, worldwide health has been incorporated into the state functions by respective governments.

Consequent upon the WHO's above stated resolution, in the democratic republics, health has been declared a State subject, but the regulation and execution of health policies and programmes have been complex, marked by differential financial allocations and expenditures among the constituent states by the federal governments. For instance, the United States' health system is, perhaps, the world's largest, but it is a highly complex regulatory apparatus involving multiple stakeholders. The complexities emanate from the very structure of American Government- federal and states, private and self-regulations that creates differential controls; paradoxically, "physicians are regulated by the licensing laws of the states, but professors carry considerable influences on medical education and practice; hospital regulations are dominated by industry; health insurance under state control but drugs regulations remain with the federal government; all together constituting symbiosis of public-private collaborations," (Field, 2017). The United States' experience with COVID-19 shifted the focus of its broader framework for internationalising public health policy under the influence of the World Bank and the World Health Organisation. The result is an increase in centralisation of health under the federal-executive confluence (Sahoo, 2024). The impact of these consequences is also evident in health policies and programmes in developing countries, including India.

In the Indian context, it is pertinent to submit here three background conditions laying foundations of health care: First, Bhore Committee Report of 1946 that laid

down the foundation of contemporary three tiered health care system for preventive and curative health care to rural and urban areas; Second, while the Constitution of India and its Seventh Schedule ensured health for all irrespective of their socio-economic status, the fast growing population and not so growing capacity of the public health care system to provide access to quality health care witnessed simultaneous development of private health care providers that added to the cost of obtaining health care; and third, lack of overall health policy between the launching of first National Population Programme in 1951 and the first National Health Policy 1983 that aimed at providing health for all by 2000 (Chokshi et al., 2016). Under the given conditions, it is important to clarify that economics and expenditure on public health care, in general, operate within multiple value systems. Along with a focus on ethnic public health issues, many states also implement global public health programmes in accordance with directives from international agencies such as the WHO, the World Bank, and the United Nations. The roots of which are traceable to the process of colonisation and to the post-World War II formation of the World Health Organisation in 1946, which has been implemented since 1948 in 61 countries.

It may appear irrelevant to describe it as a process of unannounced reassertion of economic colonialism in crucial spheres, such as education, health, agriculture, and industrial development programmes of the newly declared independent nation-states. However, the way annual budgetary allocations are made for public health policies and programmes in India reflect upon the influences of the World Bank and the World Health Organisation. There are, of course, advantages that India has enjoyed due to the internationalisation of public health, as evidenced by the grants-in-aid it has received since independence to address epidemics and eradicate communicable diseases (Chokshi et al., 2016). In brief, while India enjoyed the benefits of financial and valuable scientific expertise of international linkages, at the same time, like the United States, despite health being a state subject, the domination of the central government has created dependency relationships between the centre and the states in India, especially with reference to financial allocations from the central government.

It is also worthwhile to mention here that the dependency of the states on the centre is an outcome of the Constitution of India's Seventh Schedule, which allocates powers and functions between the centre and states. Accordingly, the public health, sanitation, management and maintenance of hospitals and dispensaries are explicitly

assigned to states, and the disproportionate powers over health portfolios held by the central government. The legislative and executive powers in the field of health are exercised by the centre through the Union and Concurrent lists. The primary power pertains to policy design and financing; lucrative sources, such as taxes and national programmes, are dominated by the centre (Sahoo, 2024). Ironically, despite central support for scientific and technological interventions in the health sector, including public health, the gaps in health outcomes have widened, as evidenced by the growing incidence of communicable and non-communicable diseases. One reason, perhaps, has been low investment in the primary health sector, resulting in inadequate health infrastructure, including human resources, and, consequently, slow improvement in key health indicators (Rao, 2023).

The per capita government expenditure on health, as per statistics released by the World Health Statistics Report (2015) and World Bank Data (2015), was just US $75 in comparison to China ($420), Sri Lanka ($127) and Brazil ($947), indicating that it was much lower. In reference to per capita Out of Pocket Expenditure (OPE), it was US$89.2 in India, but lower in China ($72.3), Pakistan ($86.8), Brazil ($47.2), and Nepal ($79.9). The reference to comparative data suggests that when state per capita health expenditure is high, per capita household out-of-pocket expenditure tends to be low, and vice versa.

The prevailing proposition holds that a state's per capita increase in health expenditure is associated with a decrease in households' per capita out-of-pocket expenditure. By implication, it signifies that it is a necessity of the state to incur high expenditure on health to bring down per capita household out-of-pocket expenditure. A study by the Economic Research Foundation (ERF, 2006) with reference to 'high private expenditure on health indicated inadequate public spending that creates negative externalities on account of two reasons. First, due to socially underprovided financial inputs from private players in the health sector; second, due to inadequate access to health care for the poor. These inadequacies have long-term adverse effects on the ongoing social welfare schemes, labour productivity, and harm future growth and development prospects. The study further revealed that two conditions, such as 'externalities' and 'information asymmetries', lead to market failures, which, from the point of view of health care has fatal consequences. In order to avoid the failures, it becomes inevitable for the state to make necessary interventions (ibid.). Under the given backdrop of the necessity for public spending, understanding 'expenditure' is the central focus of this paper.

Methodology and Analysis

The analysis primarily focuses on understanding the system for incurring and managing recurring expenditures to meet the health sector's increasing financial needs due to rising inflation, population growth, and, consequently, the rising incidence of disease in the state. The health is also dependent on other relational externalities, the other expenditures pertain to costs on public health services-nutrition, potable water, sanitation etc. The reason being, as has also been empirically observed, health care utilisation depends on financial allocations and economic provisions provided by the state for preventive and curative health (see Hooda, 2013). Hence, this paper relies on year-wise budget estimates of the central and state governments for the health sector and other related spheres affecting human health, as mentioned above. The analysis uses a comparative historical method.

Patterns of Health Budget Estimates and Current Expenditures: India and Punjab

It is an established fact that health care in India, as already stated, has been, primarily, a state subject, but dominated by the health policy-perspectives and programmes formulated from time to time by the central government. Broadly, these included schemes promoted by WHO or other international agencies aimed at nation-wide eradication of pandemics and epidemics, such as Tuberculosis, Cholera, Smallpox, AIDS, SARS, etc. The other schemes that have been continuously advocated include Reproductive and Child Health and institutions run for defence services and other central forces in different states. At the state level, each state government provided preventive and curative health care services to its people. It is worth noting that, until the 11th Plan, the central government mobilised funds from the likely savings of other health schemes. With the changed political regime and consequent renaming of NRHM as NHM, two major components were designed in the 12th Plan: the National Rural Health Mission and the National Urban Health Mission (NHM, 2013). World Health Statistics Report (2015) and World Bank Data (2015). Subsequently, the pattern of financing shifted to a 90:10 ratio funding by the centre and the states during 2018-19. The flow of finances from the centre to the states depended on decisions taken by the centre, thereby indicating that the states, by and large, remained dependent on the centre for financial inputs.

Table 1: Year-wise Percentage of Per Capita Healthcare Spending - 2000-2022

Year	*Per Capita (US $)*	*% of GDP*	*Year*	*Per Capita (US $)*	*% of GDP*
2000	$18	4.03%	2012	$49	3.33%
2001	$20	4.26%	2013	$56	3.75%
2002	$20	4.24%	2014	$57	3.62%
2003	$22	4.01%	2015	$58	3.60%
2004	$25	3.96%	2016	$60	3.50%
2005	$27	3.79%	2017	$57	2.94%
2006	$29	3.63%	2018	$58	2.86%
2007	$36	3.52%	2019	$61	2.94%
2008	$38	3.51%	2020	$57	2.96%
2009	$38	3.49%	2021	$0	0.00%
2010	$45	3.27%	2022	$0	0.00%
2011	$48	3.25%	-	-	-

Source: Macrotrends LLC2010-2024 (www.macrotrends.net/global-metrics/countries/IND/india/healthcare-spending - Accessed on 22.08.2024)

A look at the centre's yearly spending on health (Table 1) suggests a paradoxical pattern. It is obvious from the fact that while the population of the country increased along with an increase in the incidence of communicable and non-communicable diseases, the percentage of central budgetary allocations continuously decreased. However, per capita health spending increased due to increasing volume of national income and GDP, as well as an increase in the per capita income of people.

Table 2: Key Health Financing Indicators for India

Year/Expenditure Head	*Year/ Expenditure Head*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*
Total Health Expenditure (THE)	In crores	4,83,259	5,28,484	5,81,023	5,66,644	5,96,440	6,55,882
Total Health Expenditure (THE)	% of GDP	3.9	3.8	3.8	3.3	3.2	3.3
Total Health Expenditure (THE)	Per capita in Rs	3826	4116	4381	4297	4470	4863
Current Health Expenditure	% of THE	93.4	93.7	92.8	88.5	90.6	90.5

Capital Health Expenditure	% of THE	6.6	6.3	7.2	11.5	9.4	9.5
Government Health Expenditure (GHE)	In crores	1,39,949	1,61,863	1,88,010	2,31,104	2,42,219	2,71,544
Government Health Expenditure (GHE)	% of THE	29	30.6	32.4	40.8	40.6	41.4
Government Health Expenditure (GHE)	% of GDP	1.13	1.18	1.2	1.35	1.28	1.35
Government Health Expenditure (GHE)	% OF GGE	3.94	4.07	4.4	5.12	4.81	5.02
Government Health Expenditure (GHE)	Per capita in Rs	1108	1261	1418	1753	1815	2014
Social Security Expenditure	% of THE	5.7	6.3	7.3	9	9.6	9.3
Household's Out of Pocket Expenditure (OOPE)	In crores	3,02,425	3,20,211	3,40,196	2,76,532	2,87,573	3,40,916
Household's Out of Pocket Expenditure (OOPE)	% of THE	62.6	60.6	58.7	48.8	48.2	47.1
Household's Out of Pocket Expenditure (OOPE)	% of GDP	2.4	2.3	2.2	1.62	1.52	1.54
Household's Out of Pocket Expenditure (OOPE)	Per capita in Rs	2394	2494	2570	2097	2155	2289
Private Health Insurance Expenditure	% of THE	3.7	4.2	4.7	5.8	6.6	6.9

Note: Gross Domestic Product (GDP), General Government Expenditure (GGE)

Source: National Health Accounts Estimates for various years

In continuation of the above, per capita per annum spending on health care by the central government, the national health accounts annual reports based on the health accounts system of 2011, provide detailed key financing indicator-wise data on total health expenditure estimates and the current expenditures incurred by the Union Government of India (Table 2). The total health expenditure for the financial year 2014-15 was estimated at Rs. 4,83,259 crores, constituting 3.89 per cent of the GDP, and per capita expenditure was estimated at Rs. 3,826. The total combined current and capital expenditures incurred by the government and private sources, which include funds donated by external sources or donors. Of the total expenditure, the current health expenditure was Rs.4,51,286 crores, constituting 93.4 per cent, and capital expenditure was Rs.31,973, accounting for only 6.6 per cent. Of the total health expenditure, central government health expenditure, which also included capital expenditure, was Rs. 1,39,949 crores, accounting for 29 per cent of the GDP and 1.13 per cent of the GDP per capita. The per capita expenditure was Rs. 1,108, which comes to 3.94 per cent of general government expenditure. While the central government contributed 37 per cent of the total, the state government spent 63 per cent.

The detailed health expenditure data pertaining to 2015-16, based on the same criteria, Systems of Health Accounts (2011), the total Government of India estimated expenditure that included current and capital expenditure by government and private sources was 5,28484 crores, 3.84 per cent of the GDP, and Rs. 4,116 per capita. Of the total, the current health expenditure was Rs.4,95,190 crores, 93.7 per cent, whereas the capital expenditure was only Rs.33,294 crores, just 6.3 per cent of the total expenditure estimates. The contribution to capital expenditure from all government sources was Rs. 9,269 (27.83 per cent), whereas the state government contributed Rs. 23,953 (71.94 per cent). The external donor's contribution was only Rs.72 crores (0.21 per cent). The government health expenditure of Rs.1,61,863 crores constituted 30.6 per cent of the total health expenditure and only 1.18 per cent of GDP, with an estimated per capita expenditure of Rs. 1261. In relation to the total general government expenditure, it constitutes 4.07 percent while the contribution of the union government is 35.6 per cent, and the state contributed 64.4 per cent.

The 2018-19 data indicated a total estimated health expenditure of Rs. 5,96,440 crores, accounting for 3.16 per cent of the GDP and Rs. 4,470 per capita. Of this, 90.58 per cent of expenditure was incurred by the government, and the remaining 9.42 per cent, constituting the capital expenditure, came from different sources,

such as the Union Government (32.86 per cent), State Government (66.69 per cent), and external donors (0.44 percent). In comparison to the estimates, the government health expenditure was Rs. 2,42,219 crores, constituting 40.61 per cent of the total health expenditure, 1.28 per cent of GDP, Rs. 1,815 per capita, which accounted for 4.81 per cent of the General Government Expenditure. The Union Government contributed only 34.3 per cent, whereas the state government incurred 65.7 per cent of the expenditure.

In contrast to 2018-19, the National Health Accounts estimates for 2019-20 indicated total health expenditure of Rs. 6,55,822 crores, accounting for 3.27 per cent of GDP, and per capita expenditure of Rs. 4,863. Out of the said total, Rs.5,93,659 (90.52 per cent) constituted current health expenditure. The capital expenditure estimates were Rs 62,163 crores (9.48 per cent) of the total. The Union Government contributed Rs. 22,923 crores (36.87 per cent), whereas the State Government contributed Rs. 38,951 crores (62.65 per cent), and private donors contributed Rs. 289 crores (0.46 per cent). Against the given estimates, total government health expenditure, which also included capital expenditure, was Rs.2,71,544 crores (41.41 per cent), constituting 1.35 per cent of the GDP and Rs.2,014 as per capita expenditure. The data also indicated that expenditure on health accounted for just 5.02 per cent of the government's total expenditure. During this year, the central government contributed 35.8 per cent of the total, and the state governments spent 64.2 per cent.

Table 3: Head-wise Distribution of Union Government Health Expenditure (in Crores)

Year/ Government Health Expenditure	*2014-15*	*2015- 16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*
National Health Mission	20199	20907	21839	25465	30578	40482
Govt. Health Schemes	2300	2531	3285	3668	4060	4852
Railway Health Services	2111	2213	3183	3508	4606	5043
Defense Medical Services	6695	6645	10485	32118	12852	14690
Ex-Serviceman Contributary Health Scheme	2243	2563	2914	3869	3226	5180
Govt. Financed Insurance Scheme		5064	7705	9446	12680	13809

Source: National Health Accounts Estimates for various years

The head-wise distribution of Union Government Health Expenditure (Table 3) revealed that in 2014-15 was Rs. 20,199 crores for the National Health Mission.

The provisions increased substantially by over double (Rs. 40,482) in 2019-20. Between 2014-15 and 2016-17, the increase was marginal, whereas it increased substantially in 2017-18 to 2019-20. The second major beneficiary of the Union Government Health expenditure grant (Rs. 6,695 crores) was the Defence Medical Services. The expenditure grant between 2014-15 and 2015-16 did not show any substantial increase. However, it increased substantially in 2016-17 and almost tripled (Rs. 32,118) in 2017-18. After which, it declined considerably to less than half (Rs. 12,852) in 2018-19 and Rs. 14,14,690 in 2019-20. In other words, there has been a lack of consistency in the distribution of funds for defence services. The financial provisions for the smooth running of Union Government Health Schemes in the state were Rs 2300 in 2014-15, which were subsequently increased to Rs 2531 in 2015-16, and then to Rs 3285 in 2016-17. After which the increase was greater, finally reaching Rs. 4852 in the year 2019-20. The provisions for meeting the health needs of railway employees in the state, the Union Government provided Rs. 2,111 crores for Railway Health Services, successively increasing to Rs. 2,213 crores in 2015-16. After which the financial contribution of the Union Government in each successive year rose to Rs. 3183, Rs. 3508, Rs. 4,606, and Rs. 5043 in 2016-17, 2017-18, 2018-19, and 2019-20, respectively. The contribution of the Union Government to the running of ECHS services in the state was Rs.2243 crores in 2014-15, after which it was substantially increased to Rs.2563 crores in 2015-16, and then to Rs.2914 crores. Subsequently, in 2017-18, the amount was increased to Rs.3869. However, in 2018-19, the grant was reduced to Rs. 3226, but increased further to Rs. 5180 in 2019-20. Another area worth mentioning here is the insurance coverage amount, which rose from Rs.5064 in 2015-16, then to Rs.7705 in the subsequent year, then to Rs.9446, Rs. 12680, and Rs.13809 in the subsequent years.

The graphic presentation (Figure 1) depicting the percentage distribution of current healthcare expenditure across different functions revealed that more than one-third of current expenditure is incurred on the provision of curative care to indoor patients, or on patients hospitalised for treatment of various health issues. It is observable from the figure that, from 2014-15 to 2019-20, except for minor variations in expenditure in each successive year, it remains consistently around 35 per cent. In comparison to inpatient curative care expenditure, the expenditure on outdoor patients ranges between a minimum of 16.2 percent to 19.29 percent which has progressively increased successively. Expenditure on pharmaceutical and other medical goods and services has declined from 29 per cent in 2014-15 to 22.09

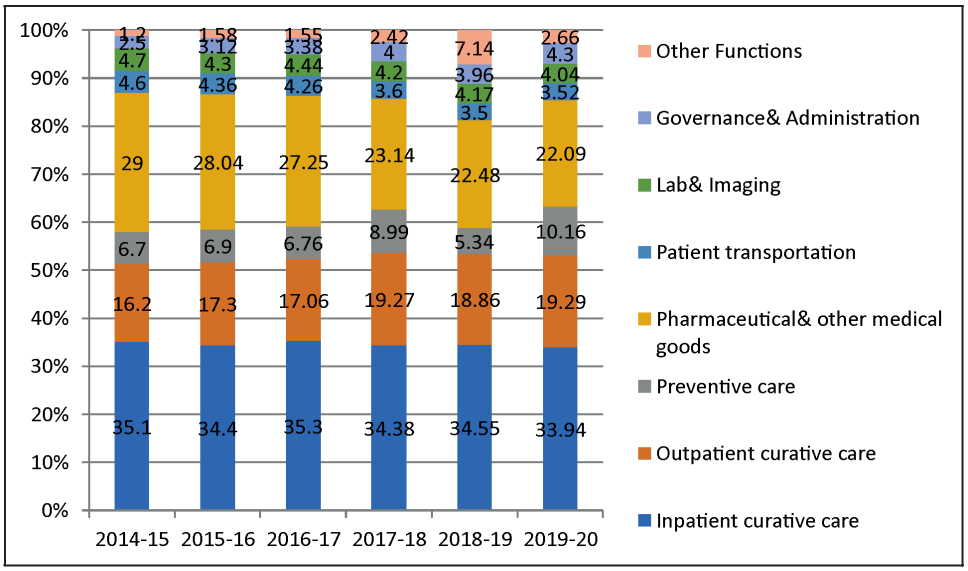

Fig. 1: Percentage of Current Health Expenditure on Healthcare Functions

Source: National Health Accounts Estimates for various years

per cent in 2019-20. Expenditure on preventive health care has been increasing year after year. It was just 6.7 per cent of the total current expenditure in 2014-15, increased to 8.99 per cent in 2017-18, then declined to 5.34 per cent in 2018-19. After which, preventive health care increased substantially to 10.16 per cent of total current expenditure. The rest of the functions, including lab and imaging services, administrative and governance, and other functions, have been at a minimum percentage of current expenditure, ranging between 1.2 percent to 7.14 per cent on other functions, around an average 4.0 per cent on lab and imaging, etc. The major proportion of the expenditure is on inpatient and outpatient treatment, the provision of pharmaceutical and related medical services, patient transportation, and lab and imaging services, etc. The remaining current expenditure is for governance, administration, and other functions of healthcare providers.

Table 4: Current Health Expenditure on Preventive Health Care Programs in crores

Preventive Care	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*
Information, education & counseling (IEC) Programs	3065 (0.7)	3824 (0.77)	3735.93 (0.69)	2770 (0.55)	3702 (0.69)	3540 (0.60)
Immunization Programs	3526 (0.8)	4317 (0.87)	6748.51 (1.25)	6362 (1.27)	6618 (1.22)	7989 (1.35)

Preventive Care	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*
Early Disease detection Programs	295 (0.1)	727 (0.15)	663. 82 (0.12)	342 (0.07)	428 (0.08)	394 (0.07)
Healthy condition monitoring programs	14081 (3.1)	13832 (2.79)	12885.54 (2.39)	23704 (4.72)	23479 (4.35)	29911 (5.04)
Epidemiological surveillance and risk and disease control programs	8543 (1.9)	11239 (2.27)	12346.91 (2.29)	11865 (2.36)	16691 (3.09)	16472 (2.77)
Preparing for disaster and emergency response programs	40 (0.01)	94 (0.02)	100.53 (0.02)	83 (0.02)	73 (0.01)	1944 (0.33)
Total	29550 (6.7)	34033 (6.9)	36481.24 (6.76)	45126 (8.99)	50991 (5.34)	60250 (10.16)

Parentheses represent the percentage of the total current expenditure allocated for preventive health care

Regarding current expenditure incurred on preventive health care programmes presented above (Table 4) and percentage of the total current preventive health care expenditure presented below (Figure 2) revealed that the total current expenditure is spent on information, education and counselling programmes. The expenditure indicates a lack of a uniform pattern. In 2014-15, it was only 0.7 percent whereas in the subsequent year, it increased marginally, then declined in the next two financial years (0.69% and 0.55%). After which it again increased to 0.69 in 2018-19 and declined to 0.60 in 2019-20. In the case of the immunisation programme, the data indicate progressively increasing expenditure from 0.8 per cent in 2014-15 to 0.87 per cent in 2015-16, and then to 1.25 per cent in 2016-17 with a marginal increase to 1.27 per cent in 2017-18.

Although expenditure declined marginally in the next financial year, in 2019-20 it increased to 1.35 per cent of total expenditure. The maximum expenditure was on health condition monitoring programmes, which have also fluctuated (3.1% in 2014-15, 2.79% in 2015-16, and 2.39% in 2016-17). However, from 2017-18 onward, the percentage expenditure increased to 4.72 per cent, then declined to 4.35 per cent in 2018-19, and then increased to 5.04 per cent in 2019-20. The expenditure on epidemiological surveillance and risk and disease control programmes ranged from 1.9 per cent in 2014-15 to 3.09 per cent in 2018-19, registering a progressive increase. However, in 2019-20 it declined to 2.77 per cent, suggesting a lack of uniformity in the pattern of expenditure increases. Expenditure on early disease detection programs and on disaster and emergency response programs has been

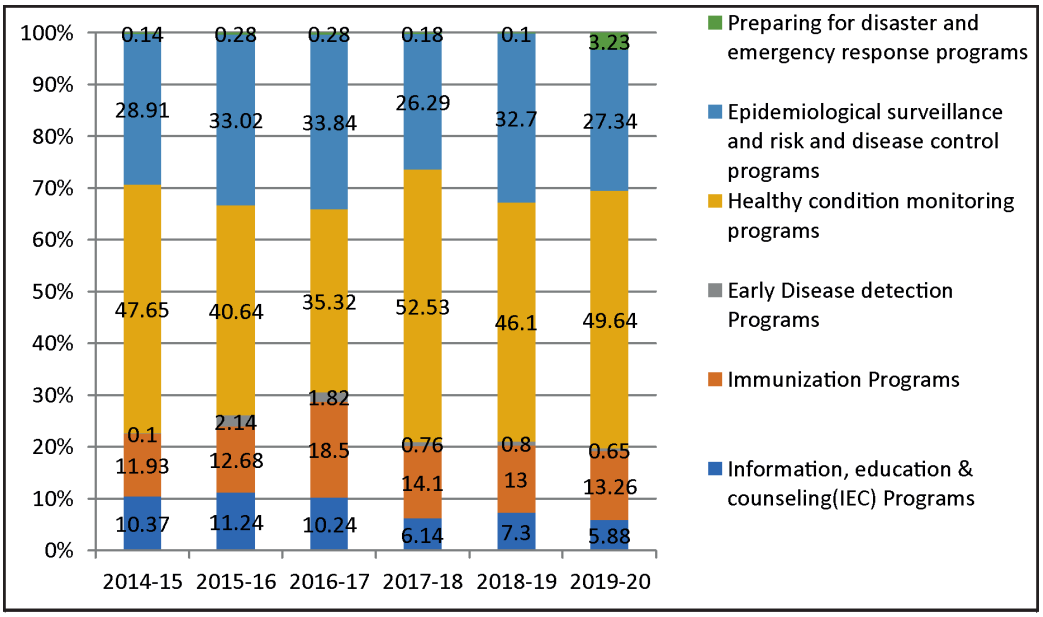

Figure 2: Programme-wise Percentage of the Preventive Health Expenditure

less than 1 per cent from 2014-15 to 2019-20. The data showed that expenditure on preventive health care across different heads had been minimal, suggesting that preventive health care is not a top priority in health care. At this juncture, it is worthwhile to briefly discuss the sources of federal health care funding that flow to the states.

At this juncture, it is important to refer to two critical issues. First, in the introductory chapter, it was argued that, due to limited public-sector outreach in health care delivery, private players have recently entered the sector in a big way. Second, as observed in this chapter, due to successive declines in the financial allocations, the preventive health care remains limited. The data from the National Health Accounts for 2014-15 to 2019-20 show that the private sector has been more proactive in investing in the health sector than the public sector. During the financial year 2014-15, government hospitals incurred Rs. 64,685 crores (14.3%) in expenditure, while private health care entrepreneurs and hospitals incurred Rs. 116,943 crores (25.9%). In comparison, while government health expenditure in 2018-19 increased to Rs. 93,689 crores (17.34 per cent), current health expenditure increased only to Rs. 93,689 crores (17.34 per cent), while private hospitals' current expenditure increased to Rs. 1,55,013 crores (28.69 per cent) (Government of

India, 2018: 5-6). In the financial year 2019-20, the government's current health expenditure increased to Rs.1,02,579 crores (17.20%), and, private hospitals' expenditure reached Rs.1,69,194 crores (28.50%) (Government of India, 2023: 4). It is obvious from the government data that private investments in the health sector increased more than the public sector investments. In a neoliberal state, the private sector is more concerned with curative health care than preventive care. As noted, the public sector spends only 10 per cent of its total allocations on health care.

In the backdrop of the above discussion based on Union Government health accounts, the following significant inferences emerge. First, the estimates and current expenditure incurred on health services indicated that the share of the states was more than the contribution made by the union government; Second, the expenditure incurred by the private hospitals was more than the government hospitals; and third, the curative care of the indoor patients and outdoor patients was much higher than the expenditure incurred on the preventive health care in India as a whole. It is worth noting that the budget estimates and current expenditure, when compared with the growing population and the increasing incidence of both communicable and non-communicable diseases, further highlight the critical financial inadequacies in India's health system. It was also clear that the Government of India partially provided funds for health care expenditure to different states, including the state of Punjab. This funding was primarily for centrally sponsored schemes from time to time, such as Tuberculosis, Reproductive and Child Health, and other significant areas, including Union Government Military and Other Central Forces stationed in Punjab.

It may also be mentioned here that the state government's expenditure comes from the government's own sources, including Municipal Corporations, and even Panchayats financing up to 35 percent, and ESI health insurance cover extended by public and private undertakings for their employees (see Garg, 2001; Mahal et al. 2001; World Bank-RSA, 2005; Singh et al., 2018). The other reality, specifically for the Punjab state, is that, compared to the country, it was once the most prosperous state, with the highest per capita income and the highest per capita expenditure on health. It also had relatively better health indicators than the national averages. Ironically, by the beginning of the present century, Punjab witnessed an increased incidence of non-communicable diseases, resultantly more heart attacks and deaths. The other challenge that confronted the state during this period pertained to a low percentage of institutional deliveries (only 37 per cent), of which 37.4 per

cent were not attended by health professionals; 25 per cent of the children suffered malnutrition; and the lowest sex ratio (World Bank-South-Asia Region, 2005). The same report further noted that the emerging health scenario certainly called for increased spending on health. The reason is that at that time, the state spent only 4 per cent of its annual budget on health care, of which almost 55 per cent was on primary health care. Ironically, even after allocating more than half of the budget to primary health care, the functioning of PHCs and Sub-centres remained ineffective. As a result, 80 per cent of the 'Out of Pocket' expenditure was incurred by people seeking health care services in private clinics (ibid.).

The rising cost of treatment and inadequate budgetary provisions have made people meet 70 per cent of the 'out of pocket expenditure' from their own sources. The existing situation suggests that families, while meeting their basic needs, forego treatment, resulting in the loss of productive lives (Venkateswaran 2016). The estimates, based on national health accounts of 2013-14, indicate that total expenditure on preventive health care is just 9.6 per cent of the total budget layout, which has witnessed in the latest report has declined to 4.55 percent (see Government of India, 2023: 4). Although there has been emphasis laid on public-private partnership in meeting the health needs, the analysis point out that the preventive care is provided only by the public health institutions. The entire expenditure on national health programmes, such as the National Disease Control Programme, is borne by the government (Venkateswaran 2016), which also covers preventive health. The fact remains that the private sector, being entirely commercial, is least involved in the preventive healthcare delivery.

Besides the least involvement of the private sector in providing preventive care, there are many challenges due to rural-urban differentials marked by inequalities and inequities in favour of the urban rich. In addition to the meagre expenditure layouts provided by the central government on preventive healthcare, the public sector health facilities are also inadequate. Private-sector health services have also expanded considerably and are now accessible to rural areas, but high-cost private services remain beyond the reach of most rural folks. The evidence suggests that till 2013, the health infrastructure status in rural Punjab not only indicated a lack of adequate health facilities to treat the patients suffering from terminal diseases, like cancer, but also lacked diagnostic facilities to diagnose the disease (Akhzer 2016), compelling people either to forego health or to go to the urban areas and spend more. A PGIMER- Public Health Foundation Report, while indicating little disease

awareness among people, also reveals that only 6 per cent of all health expenditure in the public and private sectors is spent on preventive care, which is, in fact, provided only at government-run institutions. The report also indicates that about 77 per cent of health expenditure is incurred by households and individuals from their own sources, whereas the government's contribution is around 20 per cent. The irony of the situation is that, rather than improving, the inadequacies of the health system impoverish 3.3 per cent of people in the state each year (ibid.).

Table 5: Key Health Financing Indicators for Punjab

Year/Expenditure Head	*Year/ Expenditure Head*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*
Total Health Expenditure (THE)	In crores	15138	16234	17285	12692	14047	15353
Total Health Expenditure (THE)	% of GSDP	4.1	4.1	4.0	2.7	2.7	2.9
Total Health Expenditure (THE)	Per capita in Rs	5220	5598	5960	4231	4682	5118
Government Health Expenditure (GHE)	In crores	2578	3245	3421	3258	4082	4624
Government Health Expenditure (GHE)	% of THE	17.0	20.0	19.8	25.7	29.1	30.1
Government Health Expenditure (GHE)	% of GSDP	7.0	0.8	0.8	0.7	0.8	0.9
Government Health Expenditure (GHE)	% OF GGE	5.2	6.1	5.7	5.0	5.2	4.9
Government Health Expenditure (GHE)	Per capita in Rs	889	1119	1180	1086	1361	1541
Out of Pocket Expenditure (OOPE)	In crores	12001	12563	13362	8805	9196	9940
Out of Pocket Expenditure (OOPE)	% of THE	79.3	77.4	77.3	69.4	65.5	64.7
Out of Pocket Expenditure (OOPE)	% of GSDP	3.3	3.2	3.1	1.8	1.8	1.9
Out of Pocket Expenditure (OOPE)	% OF GGE	--------	----------	-------	13.6	11.8	10.6
Out of Pocket Expenditure (OOPE)	Per capita in Rs	4138	4332	4608	2935	3065	3313

Note: Gross State Domestic Product (GSDP), General Government Expenditure (GGE)

Source: National Health Accounts Estimates for India, 2014-15, 2015-16, 2016-17, 2017-18, 2018-19 and 2019-20.

What happened to the Punjab government's 'free preventive health check-up scheme for 30 years plus age' people (Debnath 2016) launched in 2016 with the promises to: create health consciousness, conduct diagnostic tests, and provide treatment to cure the diseases detected during the free check-ups. While making the announcement, the then Chief Minister of Punjab, which coincided with Punjab Assembly elections, remarked that, "the majority of the people, especially Punjabis by nature, were least health conscious and the scheme would be instrumental in changing their mindset to stay healthy through regular check-up and medical tests." Since the announcements also require corresponding financial inputs, the expenditure incurred before and after 2016 has been limited, which has been a challenge.

Table 5 depicts the total health expenditure, that included government, private, and contributions by other agencies, the percentage of GSDP and out-of-pocket health expenditure from the financial year 2014-15 to 2019-20 in respect of Punjab. The data indicate an increase in expenditure from 2014-15 to 2015-16 and to 2016-17, after which it declines considerably in 2017-18. After which, the expenditure begins to increase continuously. In 2019-20, it increases little above the level of 2014-15. Consequent upon the said pattern of expenditure, the percentage GSDP also followed a similar pattern. It remained constant at 4.1 per cent between 2014-15 and 2015-16, and then marginal decline to 4.0 in 2016-17.

After which it drops down to 2.7 in the subsequent year, and remains constant for another year, and then marginally to 2.9 in 2019-20. The per capita health expenditure incurred by the government indicates a marginal increase in the subsequent financial year, from Rs.5,220 in 2014-15 to Rs.5,598 in 2915-16, and to Rs.5,960 in 2016-17. After which it declined substantially to Rs.4,231 in 2017-18, and again registered an increase to Rs.4,682 in 2018-19 and further to Rs.5,118 in 2019-20. In other words, the health expenditure did not follow a continuous pattern, keeping pace with the increasing population and the incidence of diseases.

The expenditure incurred by the government, like the total expenditure indicate a similar pattern of growth between 2014-15 and 2016-17, but afterwards a decline. However, in the financial year 2018-19, it increased substantially from Rs. 3,258 in 2017-18 to Rs. 4,082 crores, then to Rs. 4,624 crores in 2019-20. Government health expenditure constituted only 17 per cent, 20 per cent, 19.8 per cent, 25.7 per cent, 29.1 per cent, and 30.1 per cent of the total health expenditure, respectively, for the financial years 2014-15 to 2019-20. It is intriguing to find that the percentage of

GSDP accordingly registered a continuous decline from 2014-15 to 2019-20. In the case of percentage GGE, the trend showed an initial rise from 5.2 in 2014-15 to 6.1 in 2015-16, followed by a decline. The per capita government health expenditure, however, indicated an encouraging sign with continuous increase, though it also registered a decline during 2017-18.

The data on total out-of-pocket expenditure has been considerably high, increasing from Rs. 12,001 crores in 2014-15 to Rs. 12,563 crores in 2015-16 and to Rs. 13,362 crores in 2016-17. It declined substantially to Rs. 8,805 in 2017-18, but again began rising in the subsequent financial years and remained lower than the amount in 2014-15. The percentage out-of-pocket expenditure, however, constituted a very high proportion of the total health expenditure, highest 79 per cent to 64.7 per cent. The trend, however, discerned a continuous decline. Accordingly, the percentage GSDP declined marginally from 1.8 in 2018-19 to 1.9 in 2019-20. The per capita out-of-pocket expenditure, which was Rs.4.138 increased substantially to Rs. 4,332 and then to Rs. 4,608, respectively, between 2014-15, 2015-16 and 2016-17. After which, it registered a decline to Rs.2,935, but started rising in the subsequent financial years. Perhaps the lack of a health policy, insufficient financial inputs, inconsistent data across various dimensions of health, and inadequate planning account for the current health situation in the country and across states, including Punjab.

Summary and Conclusion

Both curative and preventive healthcare constitute the two significant dimensions of the overall healthcare delivery system in human society. Health, being a constitutional commitment of the state to its people it is integral to socio-economic development, and good physical and mental health and complete well-being of citizens. However, given the fluctuating and inconsistent budgetary allocations, even when increased, they faced the implications of a low GDP share, inadequate public health infrastructure, and an increasing burden of out-of-pocket expenditure on citizens. The existing scenario has caused financial hardships for people, or else people from low socio-economic backgrounds go without healthcare. Agarwal et al. (2024) argued that the increase in expenditure has, in fact, been marginal (0.9% to 1.6% of GDP), remaining below the NHP set target (2.5%). Consequently, the challenges of high Out-of-Pocket expenditure have remained unresolved. Hence, there is a need to enhance health expenditure beyond 2.5% of GDP to at least 3% of GDP. The situation in Punjab is even worse, as the out-of-pocket expenses are

higher than the national average (Kumar, 2024). Thus, Punjab requires an even more robust plan with adequate budgetary provisions to make health for all a reality.

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