

Priorities in Budgetary Allocations for Health during the Fourteenth Finance Commission: Evidence from Five States

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Abstract

The aggregate government health spending in India is one of the lowest in the world in terms of its share in GDP. Since most of the functions of the health system are undertaken by the states, it is important for states to mobilize enough funds to sustain existing activities and undertake new ones in the health sector. A major departure from the past in the fiscal architecture took place following the acceptance by the government of the 14th Finance Commission (FFC) recommendations. A key question in this context is whether these significant changes created a disruption in the state health finances and consequently, impacted on state spending patterns across key components. This is examined for 5 selected states in the country – Bihar, Himachal Pradesh, Tamil Nadu, West Bengal and Uttar Pradesh. A brief review of the health systems indicates wide variations in inputs and outcomes, with Tamil Nadu quite far ahead in terms of health outcomes, and Bihar and Uttar Pradesh requiring significant catch up. While health spending did increase somewhat for all the states in the FFC period in real terms - most noticeably for Bihar - states seem to have little maneuvering space for new investment due to high shares of salaries and emoluments. Among other results, states have been investing reasonably on primary care, but the public health component continues to get low priority even during the FFC period for these states. The share of prevention and control of diseases in total health spending has declined for all states in these four years. Overall, while these five states have maintained their total health spending, there has been no re-prioritization within the health budget and no significant departures – transformative or detrimental - from the usual patterns of allocation during the FFC period.

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1. Introduction

The aggregate government health spending in India is one of the lowest in the world in terms of its share in GDP. The government spends about 1 percent of the country's GDP on health according to the National Health Accounts 2019¹.

Health being a state subject, much of the onus of spending remains on the states, and of the total government spending on health, the average share of the states and union territories came to slightly less than 70 percent of the total for 2016-17¹. However, public health spending has been generally low in the states as well, with significant disparities across regions.

Given that most of the functions of the health system are undertaken by the states, it is important for them to be able to mobilize enough resources to sustain activities in the health sector and also to undertake newer activities.

In this context, an important factor has been the adoption of key recommendations pertaining to inter-governmental fiscal transfers that potentially impacted on states' capacity to mobilize resources. A recent study finds that government expenditure on health in India has been pro-cyclical, and economic growth, revenue generation, and central transfers have had positive and significant effects on public health spending among the states.²

A major departure from the past happened following the 14th Finance Commission (FFC) recommendations and its subsequent acceptance by the Government of India. The FFC increased the tax devolution to states from the divisible pool and adopted a new formula for the inter-se distribution of the shareable proceeds between states. Simultaneously, the Union government reduced the Plan outlay to states from the Union budget in order to accommodate this increased tax devolution. The reduction in Plan outlay was operationalized by doing away with grants that used to flow from the erstwhile Planning Commission, and an altered sharing pattern of expenditure for the Centrally Sponsored Schemes (CSS), with the states now required to contribute a larger share in these CSSs than before.

These significant changes in inter-governmental fiscal architecture affected each states budgets, differently. For some it meant higher levels of untied funds in general, while for some states it led to a fiscal squeeze. While the actual impact on overall state finances will only be clear at the end of the FFC period, social sector allocations in these four years have been studied in extensive detail by scholars to indirectly infer about the implications of the altered fiscal architecture on state

spending patterns.³ A key question, therefore, in this context is whether these significant changes created a disruption in the quantum and composition of finances for the health sector at the state level or alternatively, allowed for transformative changes to take place in the budget allocations.

This paper examines this question for 5 selected states in the country – Bihar, Himachal Pradesh (HP), Tamil Nadu (TN), West Bengal (WB) and Uttar Pradesh (UP). This selection of the states is on purpose – two (Bihar and UP) from the Empowered Action Group (EAG) of states considered in need of special focus, one hilly state (HP) with geographical challenges, one middle income state (WB) which has been doing moderately well on selected health indicators, and one state (TN) which has been in the forefront in terms of health outcomes.

We first review the basic health systems of each of these five states to understand the context in which health financing takes place. We then analyse state budget data of these 5 states to observe if there have been any major departures from the past trends in allocations to health and among different key items of health. We conclude by offering possible explanations for the results and indicate some key implications.

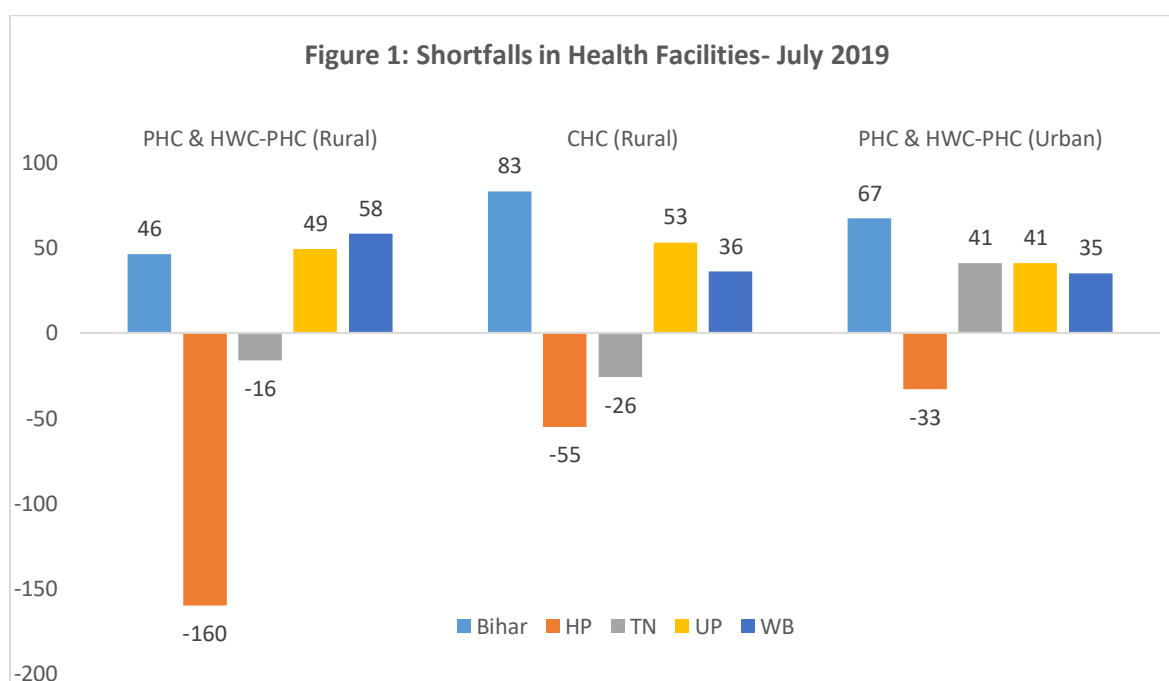
2. Health system in selected states: a brief overview

Table 1 shows that the health outcomes vary significantly across these states, with TN, WB and HP doing reasonably well compared to Bihar and UP in all the 3 health outcomes –IMR, U5MR and MMR. For institutional deliveries and immunization - indicators considered as key indicators of a functional health system – the differences are less stark and the ranking varies. However, on all 5 indicators, UP and Bihar are at the bottom of the list. To benchmark these numbers, Thailand’s U5MR and IMR are 9 and 8 respectively and for Sri Lanka these numbers are 7 and 6 respectively⁴. Clearly, even for a well-performing state like TN, there is scope for further improvements.

Indicators	Bihar	WB	UP	TN	HP
Infant Mortality Rate (IMR) *	48	28	64	20	34
Maternal Mortality Rate (MMR) #	149	98	197	60	85
Under-five mortality rate (U5MR) *	58	32	78	27	38
Institutional births (%) *	63.8	75.2	67.8	98.9	76.4
Children 12-23 months fully immunized (%) *	61.7	84.4	51.1	69.7	69.5

Source: * NFHS-4 (2015-16) # SRS (2016-18)

The resilience of health systems come from adequate and functional health system inputs – infrastructure, personnel, health products & services, governance and financing. In Figure 1, we indicate some key indicators for infrastructure, and find that apart from HP and to a lesser extent TN, there are significant shortfalls in Primary Health Centres (PHC), Health & Wellness Centres (HWC) and Community Health Centres (CHC) in the other states, with the most marked shortfall being in Bihar for CHC and urban PHC-HWC. Even WB has significant shortfalls. According to the norms of the Indian Public Health Standards (IPHS), which sets infrastructural and human resource standards for public health institutions in India, for personnel and infrastructure, the shortfall is defined as required minus in-position.

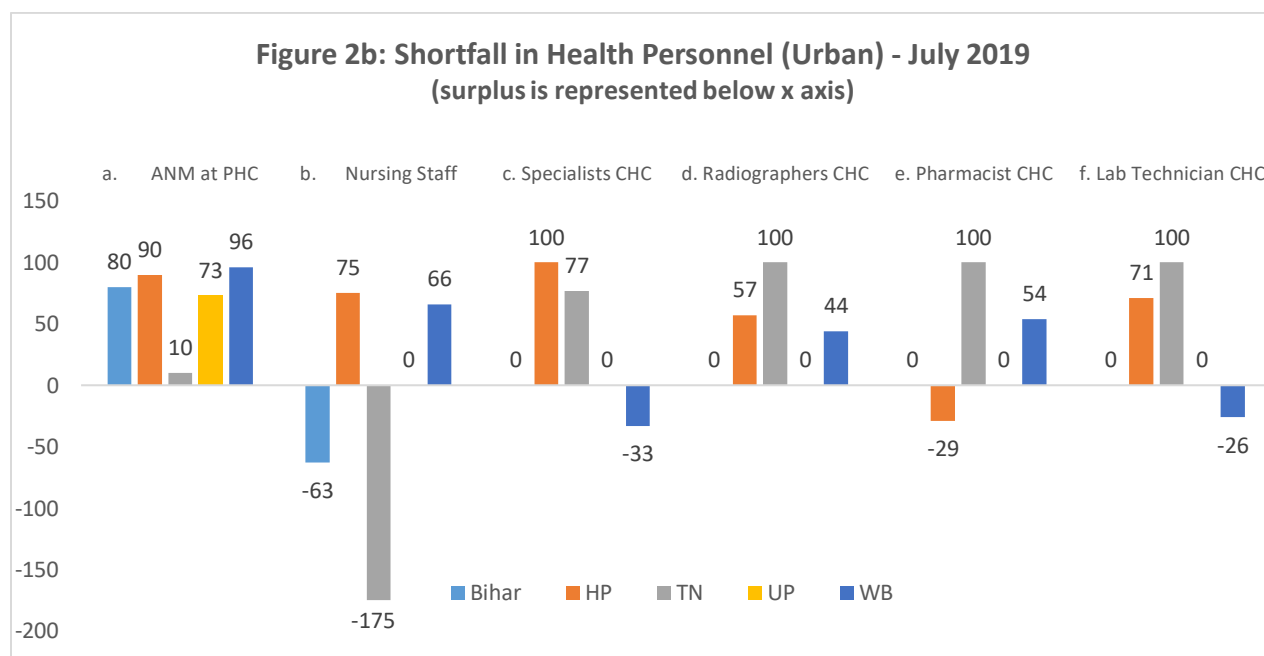
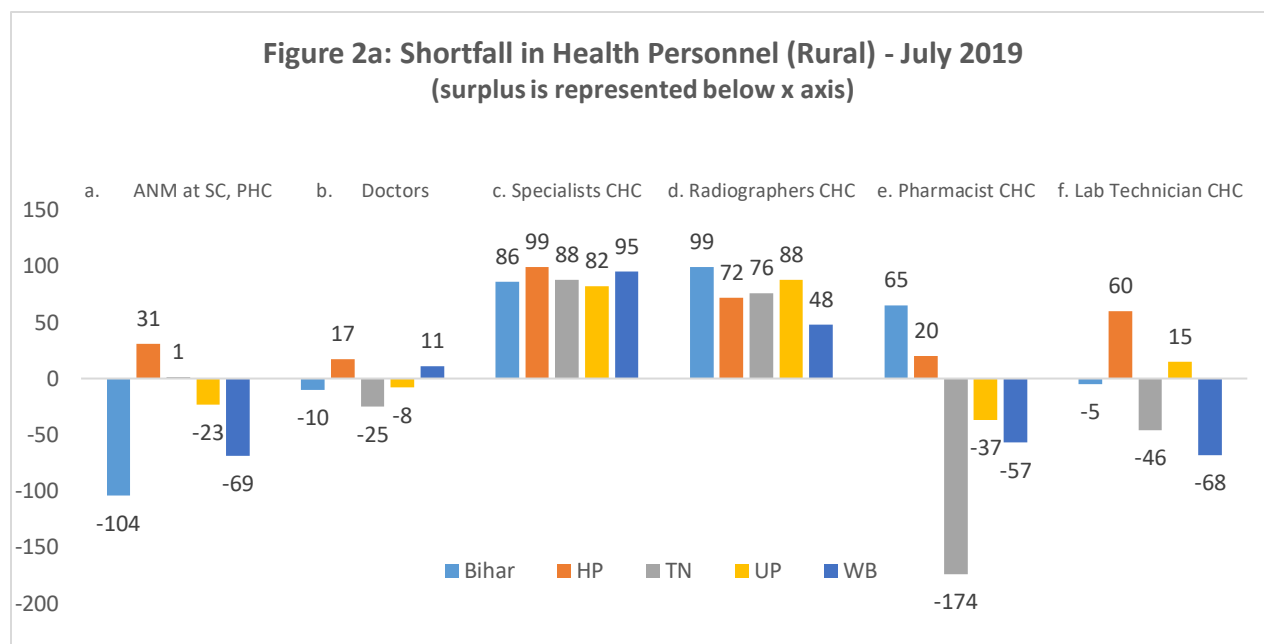


Source: **Rural Health Statistics 2018-19**

Figure 2a and Figure 2b give the shortfalls in a variety of personnel category, and shows that there are serious shortages across states in most of these categories. The shortages are starker for rural areas compared to urban areas, and much more prevalent for UP and Bihar.

A third of the rural population in the state of UP is deprived of primary healthcare infrastructure, according to the norms of the Indian Public Health Standards (IPHS).⁵ The state is 40 % short of sub centres and HWC-SC's, 49 % short of PHC's and HWC PHCs and 53 % short of CHCs,

according to RHS-2018-19 data⁶. A study found acute shortages of specialists which was more than 80 percent of the requirement in the state of UP⁷.



Source: **Rural Health Statistics 2018-19**

The distribution of specialists across CHCs has also become progressively uneven over the study period, as shown by the rise in the Gini index (from 0.41 in 2002–2004 to 0.74 in 2012–2013). Other studies have documented the disappointing health infrastructure situation in Bihar as well⁸.

For example, the number of sub-centres per one lakh population experienced a decline from 2004 to 2009, and then improved marginally after that, but again declined between 2014 and 2018. The National Health Profile (2018) indicates that the number of PHCs per lakh population for Bihar, experienced a decline between 2014 and 2018⁹. However, even this rise in the number of PHCs per lakh population does not help the state to match the national average.

The close connection between health inputs and health outcomes cannot be over-emphasized and health financing, therefore, remains a critical control knob for policymakers. In the recent past, requirements for enhanced financing has gone up because all the states included in the study - except West Bengal - have adopted and contributed to the financing of the two initiatives of the recently launched Ayushman Bharat: the Prime Minister's Jan Arogya Yojana (PMJAY) - which aims to cover 40 percent of the vulnerable population with publicly funded health insurance - and the Health and Wellness Centre (HWC) initiative which aims at providing comprehensive primary health care by transforming existing sub-centres and primary health centres. The PMJAY scheme was launched with the goal of reducing out-of-pocket payments for hospitalization, which continue to be very high in our country leading to impoverishment of the poor population. Combined with the HWC initiative, Ayushman Bharat was positioned as India's significant move towards attaining Universal Health Coverage (UHC).

UP tops in terms of the number of beneficiaries under PMJAY but has been slow to step up daily treatments. One concern for both UP and Bihar has been the low empanelment of both public and private hospitals under this scheme¹⁰.

Clearly, for the successful implementation of both these initiatives, the state governments have to raise more finances for running the schemes as well as to strengthen the respective health systems to enhance the performance of these new programmes¹¹.

In an apparent contradiction, very little of the 88.5 crore given by the Centre to Bihar in 2018-19 could be spent to upgrade its existing primary health centres (PHCs) and health sub-centres¹². Bihar spent just Rs 27 crore that it had got under Ayushman Bharat on the key component of upgrading existing PHCs into HWCs. UP has performed much better on the same parameter spending nearly Rs 99 crore out of the Rs 176 crore allocated to it. UP managed to do transform

and operationalise more than 2,000 centres while Bihar managed to do so for only 600 of its existing PHCs. This indicates complex complementarities in funding sources among other state-specific reasons.

The public health facilities in Bihar are already overburdened and evidence indicates significant inequality in the availability of health care facilities - both public and private - across villages in Bihar¹³. For example, the total number of inhabited villages exceed the total number of health facilities in the rural areas, and extreme concentration of these facilities is observed in just a few areas as a result of which there is a lack of health care facilities of any type in almost two-third villages of the state. On several parameters of preventive and promotional healthcare services, the record of the state government in the last 15 years has remained far from satisfactory¹³.

According to the NITI Aayog's Health Index Report (2019), Bihar comes second on the Health Vulnerability Index in 2017-18¹⁴. There was further deterioration between 2015-16 and 2017-18 primarily due to poor performance in parameters like total fertility rate, birth weight, sex ratio at birth, TB treatment success rate, quality accreditation of public health facilities, and time-taken for NHM fund transfer. Not only was the average score of health status low in Bihar, the inter district variation in health status was quite high. Another study attempted to measure the extent of inequality in health status and health care services in Bihar and UP¹⁵, and found that the overall performances of Bihar in terms of health attainment, health status and health infrastructure is dismal.

A similar situation exists in UP, which is the worst performing state in terms of the NITI Aayog's Health Index Report (2019)¹⁴. The performance related to low birth weight, TB treatment success rate, average tenure of key positions at state and district level and level of birth registration accounted for the deterioration between base year (2015-16) and reference year (2017-18).

Both Bihar and UP have been receiving assistance from a variety of sources to improve their health systems. For example, to improve public healthcare infrastructure and management, the UP government has partnered with the World Bank and launched the Uttar Pradesh Health System Strengthening Project (UPHSSP)¹⁶. The Bill and Melinda Foundation (BMGF) has supported several public health projects and programs under its 2012 agreement with the Uttar Pradesh state

government to improve health, agriculture and financial services to the poor. In 2010, BMGF had a tri-partite collaboration with the Bihar government, the private sector and community organizations with the objective of increasing women and children-centric health care¹⁷. Other initiatives to improve access to medicine by the UP government include collaborations with organizations like *World Health Partners*, to create public service health delivery networks including telemedicine centres, across selected villages in the state¹⁸. However, the reach of these centres across such a large and populous state as Uttar Pradesh remains limited.

The hilly state of HP is comparatively doing much better than Bihar and UP despite facing geographical challenges of delivering health to every corner of the state. Its hilly terrain and extreme climatic conditions hamper healthcare delivery services and availability of health care personnel. However, even with 90 percent of HP's population residing in rural areas, the state has ranked among the top three states in India's Child Well-Being Index, and in the top 10 for improved health index scores in NITI Aayog's Health Index Report (2019)^{19,14}.

Generally, the overall availability of existing health services in HP has been found to be adequate as compared with the standard norms of hill states of India, but the distribution of these services remained skewed²⁰.

High out-of-pocket healthcare expenditure among patients attending secondary health care facility in HP justifies HP joining PMJAY in 2018²¹. Himachal Health Care Scheme- HIMCARE is being implemented since Jan 1st, 2019 for the vulnerable population that have been left out of PMJAY. It includes the BPL workers, the registered street vendors and those who were employed under MNREGA for a minimum of 50 days during previous or current financial year provided none of them are covered under AB²². Both the AB and HIMCARE seem to be faring well.

West Bengal – like HP – is relatively better off in terms of health outcome, but there is a serious shortage of healthcare resources. As per the WHO standards there should be a 1:1000 ratio of doctors and population served but for West Bengal this ratio is 1: 10401 according to the previous National Health Profile (2018)²³. However, this is still better than the ratios for UP and Bihar given in the same report which is 1: 28031 and 1:19962. West Bengal has outsourced tertiary and

secondary care such as ambulance, catering and laundering services, diagnostics and dialysis of patients to private partners²⁴.

The WB State Health Scheme is a state-level health insurance scheme for cashless treatment at hospitals which was originally launched in 2008 and was revamped and renamed the “West Bengal Health for All Employees and Pensioners Cashless Medical Treatment Scheme” in 2014²⁵. The other important scheme is the West Bengal Swasthya Sathi scheme which till recently had over 7 million people covered under it who could avail free hospitalization²⁶. West Bengal in November 2020 announced that the entire state would be covered under it²⁷. West Bengal is one of the few states that did not join Ayushman Bharat along with Delhi, Telangana and Odisha, though Delhi has indicated that it will join from fiscal year 2021-22²⁸.

Tamil Nadu has been in the forefront among states in health outcomes, and has been able to sustain its position despite moderate levels of public financing for health. It is said to have a model public health system and has provided quality health services at affordable costs especially to the rural people with great success²⁹. In 1939 a Public Health Act was enacted by the state which was the first of its kind to be enacted in India. The state also has the distinction of having an efficient public health cadre at the district level²⁹. Tamil Nadu has undertaken significant reforms in its health sector which dates back to 1980s which saw rigorous expansion of rural health infrastructure in the state besides deployment of thousands of multipurpose health workers as village health nurses in rural areas. The Tamil Nadu Health System Reform Programme (TNHSRP) was launched by the State Government with the objective of improving the quality of healthcare, reducing NCDs and filling the gaps in reproductive and child health services to make it more equitable. The scheme is being implemented with financial support from the World Bank³⁰.

The state government has also signed up an agreement with the Japan International Cooperation Agency (JICA) to receive a substantial loan to improve the quality of urban healthcare services in Tamil Nadu³¹.

TN has been implementing the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) for extensive health coverage quite successfully. However, it has decided to join the PMJAY, has merged it with CMCHIS and a combined programme has been rolled out in September 2018, with a mixed mode of implementation (trust and insurance)³² like UP, unlike Bihar and Himachal Pradesh which have opted for the Trust mode of implementation for PMJAY⁹.

This brief review points to significant variations across states in health outcomes as well as inputs and points to different approaches for strengthening health systems. Clearly, health financing plays a key role in making the connection between inputs and outputs tighter. Experts recommend that governments should spend at least 5 percent of GDP on health if they want to move towards UHC³³. Given the very low current spending, the National Health Policy 2017 has aimed for a very modest goal of 2.5 percent of GDP for the country as a whole by 2025³⁴. Since the major share of total government health spending come from states, this implies that the states will have to significantly step up investments in their respective health sectors as well.

Below, we will analyze to what extent states have been able to move towards this goal during the FFC period.

3. Health spending trends across 5 states through the 14th Finance Commission (FFC) period

In this section, we attempt to answer the following questions:

- Has health spending increased in real terms in the FFC period?
- Given the central role of public health spending, what do the state budgets reflect in terms of the priority accorded to this function in the FFC?
- Do states display a pattern in health expenditure by economic classification? Are these patterns uniform across states, invariant of their general rankings on health outcome? Has the FFC brought any alterations in these patterns?
- Do states display a pattern in health expenditure by levels of health-care like primary, secondary and tertiary care (PST), investment on education and research, social security and administration? Do these patterns correspond well with selected indicators that govern these investments?

We look at the trends in these key components for a five year period i.e. 2014-15 to 2018-19.

a. Total health expenditure

HP had the highest per capita real expenditure in 2018-19 at Rs 1,905. However, over the 5 years, Bihar showed the highest compound growth in per capita real total expenditure, followed by HP (Table 2). WB's growth was the lowest. While Bihar with a per capita real total

expenditure Rs. 445 spent around a quarter of what HP (Rs. 1905) did in 2018-19, this difference was greater in 2014-15. In 2014-15, Bihar's per capita real public expenditure on health was only 20 percent of HP. For other states, the gap (relative to HP's per capita expenditure) was much narrower in 2014-15, and it seems to have narrowed further over the years, indicating a slow trend towards convergence.

States	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate (%)
BIH	263	315	362	387	445	13.4
WB	553	651	652	670	696	5.0
UP	438	450	508	521	541	5.9
TN	858	893	849	1000	1148	7.2
HP	1333	1373	1668	1763	1905	10.1
Max/Min	5.1	4.4	4.6	4.6	4.3	

b. Expenditure on public health

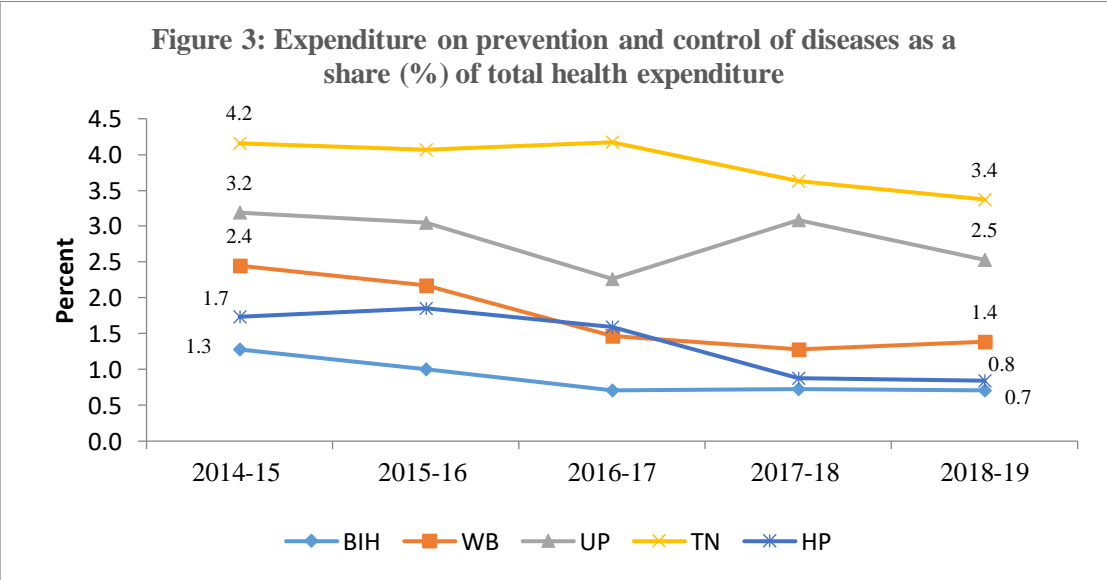
In view of the COVID-19 pandemic and its devastating impact on countries, the public health component of health budget will remain an area of focus in the coming days. The public health component largely comprises drug control, food safety and standards, manufacture of vaccines, prevention and control of diseases, prevention of food adulteration, public health education and public health laboratories. Public health interventions have been universally successful in dealing with the threat of communicable diseases. So, it can be expected that states in the initial stages of epidemiological transition would direct more resources towards public health.

The actual scenario, however, belies expectation. Table 3 shows that Bihar and UP which have a disproportionate burden of communicable diseases have some of the lowest expenditures per capita on public health. In these five years, the lowest trend growth in per capita real expenditure on public health also occurred in case of Bihar and UP, which was in the range of 3 - 4%. HP registered a phenomenal growth of 24 percent in this component, overtaking TN in 2018-19 in absolute terms. The relative difference of expenditure (max/min) on this component, among the selected states also increased in these five years indicating divergence.

Table 3: Per capita real expenditure (in Rs.) on public health						
States	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	5	5	5	6	6	3.4
WB	21	24	61	47	20	5.2
UP	16	16	16	19	17	3.7
TN	46	50	51	52	56	4.5
HP	27	32	33	52	62	24.1
Max/Min	8.7	9.2	12.3	9.2	10.3	

In 2016, Communicable Maternal Neonatal and Nutritional Diseases comprised 42.6 %, 40.5%, 24.8%, 23.1% and 20.4% of total disease burden (Disability Adjusted Life Years or DALYs) in Bihar, UP, WB, HP and TN respectively³⁵. This indicates that states like Bihar and UP must invest suitably on the public health component and especially communicable diseases to avoid further burden. Prevention and control of diseases is arguably one of the most crucial components within expenditure under the public health head, and would impact directly on a state’s ability to fight communicable diseases.

However, Figure 3 shows that the share of this component in total health expenditure was very low for all the five states. It was highest for TN at 3.4% but lowest for Bihar at 0.7%. Also, the share of this component has gone down almost steadily for all the five states during this period.



c. Expenditure by economic classification

Expenditure on salaries, wages and establishment is a crucial component of government spending. However, since resources are limited and claims on them competitive, a higher share of this component in the total budget translates into lower share on materials and supply, primarily because establishment costs are non-negotiable. For example, for the Department of Health and Family Welfare this could mean a lower share of drugs and consumables.

Table 4 shows that per capita real expenditure on salary/wages and establishment - although low for Bihar - constitutes 80 per cent of total health expenditure. The highest growth in this component was also registered by Bihar during the FFC period. HP again is an outlier with a level of salary/wage and establishment expenditure at least five times that of Bihar, which spends the least per capita on this component. This could be on account of HP being a hilly state and the associated cost disabilities with respect to other states. However, real per capita expenditure on the other component of health expenditure i.e., materials, supply, machinery & equipment was also the highest for HP with a 29% growth during the FFC period (Annexe 1a).

Table 4: Per capita real expenditure (in Rs.) on salaries/wages and establishment and its share in total health expenditure						
States	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	217 (83)	214 (68)	301 (83)	331 (85)	354 (80)	15.2
WB	282 (51)	289 (44)	311 (48)	331 (49)	430 (62)	10.3
UP	237 (54)	243 (54)	263 (52)	297 (57)	308 (57)	7.6
TN	449 (52)	459 (51)	481 (57)	501 (50)	585 (51)	6.4
HP	1206 (90)	1170 (85)	1304 (78)	1446 (82)	1538 (81)	7.2
Max/Min	5.6	5.5	5.0	4.9	5.0	

Note: Figures in parentheses are the shares (%) in total health expenditure

Among the other states, TN (-2.6%) and WB (-0.1%) registered a negative growth in this component followed by UP (1.1%) and Bihar (8.1%) (Annexe 1a). A key finding that emerges from this analysis is that except HP, all other states had a higher growth in expenditure on salaries/wages and establishment when compared to spending on materials, supply, machinery and equipment. The possible fallout of this in the long run could be greater privatization of health care

as stocks of essential consumables and equipment run dry in public facilities, even if the workforce might be in place.

d. Expenditure by levels of health-care

Disaggregating health expenditure across primary, secondary and tertiary health services enables us to determine state-specific priorities within the health sector. We applied an original methodology³⁶ of reclassification of state budget line items, leading to six categories of type of care. - These categories are primary, secondary, tertiary, medical education, social security and administration. Social security includes items of expenditure on health coverage schemes including health insurance by the state governments, while the other categories are self-explanatory.

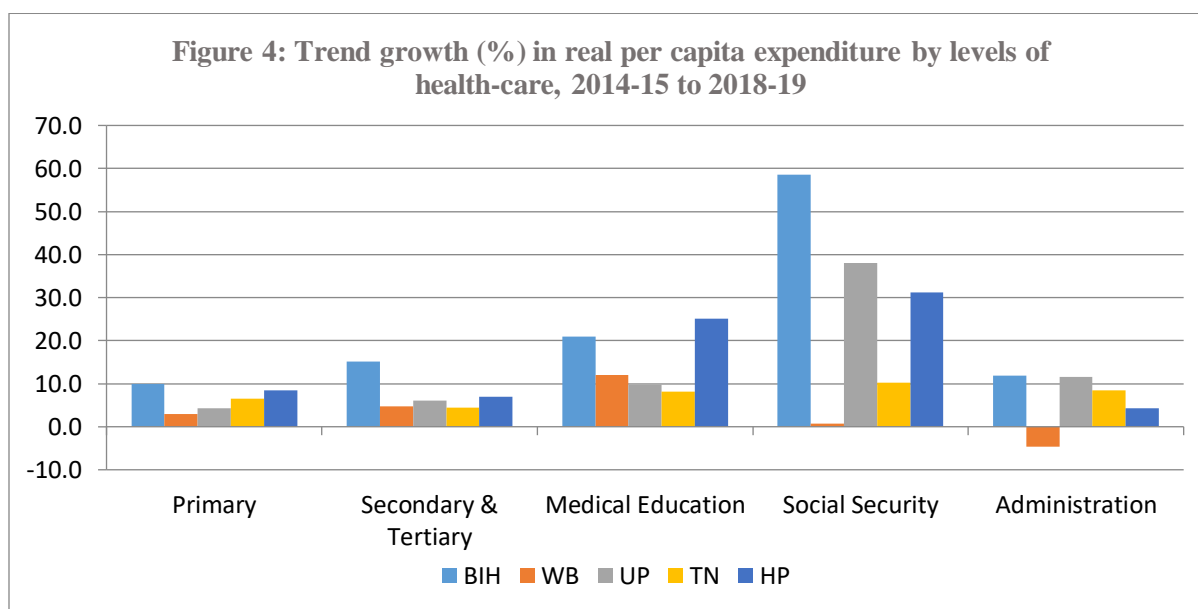


Figure 4 presents a summary of the growth in expenditure between 2014-15 and 2018-19 on all these categories for the five states. There are a few significant observations to be made.

First, on an average, social security received the biggest thrust in terms of public spending in all but one state. The outlier state, West Bengal, however, had increased its investment on this significantly to support its Swasthya Sathi programme over the years, and only in the last year the allocations went down drastically. *Second*, even though this component registered some of the highest growths in the FFC period, the absolute real per capita expenditure on social security was quite low for all states, except Tamil Nadu (See Table 5). *Third*, there is huge disparity among the

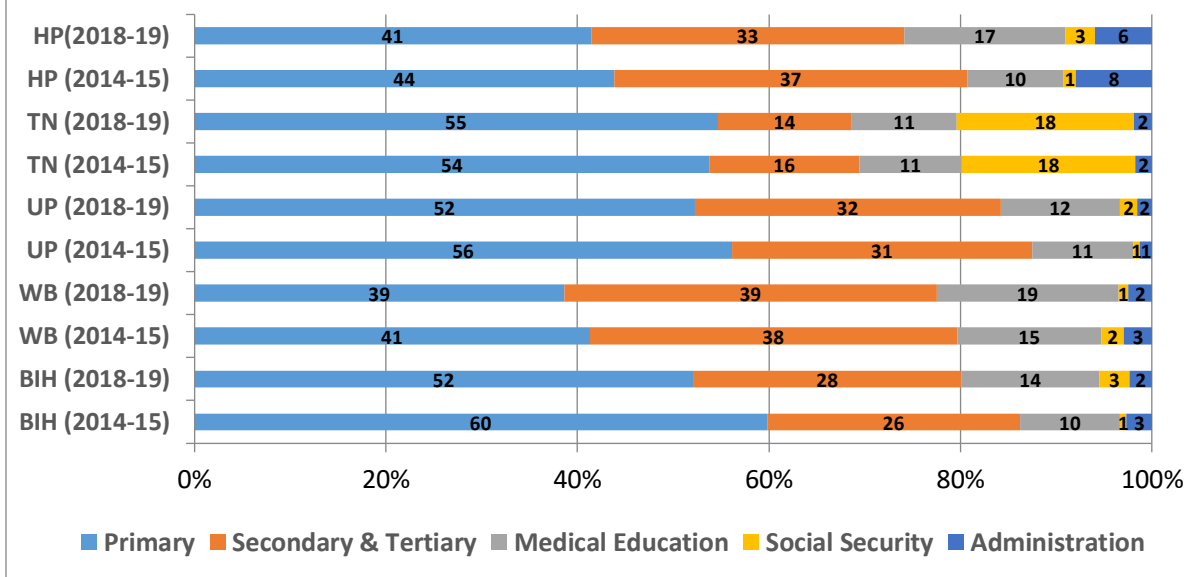
states in social security expenditure, but this difference seems to be declining rapidly (Table 5) over time.

Table 5: Per capita real expenditure (in Rs.) on social security						
States	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	2	4	6	6	14	58.5
WB	13	13	52	44	7	0.6
UP	3	2	2	4	10	38.1
TN	155	165	154	233	212	10.2
HP	17	26	29	33	58	31.3
Max/Min	85.3	89.3	95.8	56.7	29.7	

Fourth, the next biggest increase in expenditure on an average happened for medical education. *Fifth*, Bihar has registered a higher growth than the other states in all the components except medical education (see Annexe 1b). So, the higher growth of per capita total health expenditure in real terms for Bihar (see Table 2) seems to be uniformly distributed across all categories rather than the result of extreme values in a few. This indicates a conscious multi-pronged approach to resource allocation in the state of Bihar in recent times, to rectify the long-standing issues of the health sector.

It is, therefore, interesting to explore the shares of these categories in total health expenditure and their changes over time. That would indicate shifts, if any, in health care financing strategies of the states over time. Figure 5 presents the share of levels of healthcare in total health expenditure for two points of time. The levels indicate that primary health care was - and continues to be - the dominant vehicle for health financing with a share in the range of 39% - 55% of total health expenditure for all states, in 2018-19. There are state level differences in this share with WB spending the least and TN the most in percentage terms, for the current year. Share of primary health care is followed by secondary & tertiary care in all states, except TN: its share of social security in total health spending is next only to primary care, and is way above the rest of the states. This seems to be on account of the Chief Ministers Comprehensive Health Insurance Scheme, the flagship scheme for mass health insurance. Although the growth rate of social security within health spending has been high (Table 5) for almost all states, this has yet to translate into a substantial share of this item in total expenditure.

Figure 5: Share (%) for levels of health-care in total health spending, 2014-15 and 2018-19



Over time a reduction in the share of expenditure on primary health care is noticeable for all states except Tamil Nadu. The share of secondary & tertiary care has remained largely same or increased slightly for some states. The biggest gain in terms of this share has been for medical education, especially for the states of HP, WB and Bihar. For UP and TN, the share of medical education has remained unchanged between 2014-15 and 2018-19.

4. Conclusion

This brief analysis is an attempt to explore whether post FFC, significant changes took place in the quantum and composition of finances for the health sector of five selected states. The brief review of the health outcomes and health systems indicate significant variations across states in health outcomes and state of the health systems, making the role of health financing critical as a policy tool.

The positive news is that health spending increased for all states in the FFC period in real terms, most noticeably for the state of Bihar. However, for states like Bihar and UP, the base was very low, and despite the increases, total spending continues to remain very low.

However, a deeper look at the components of spending indicates that there have been no positive departures from past trends during the FFC period, and some trends that give rise to concerns.

Public health component or the “science and art of preventing diseases” continued to receive very low priority except for the state of HP. However, the share of prevention and control of diseases in total health spending has declined for all states in these four years. This is a sobering finding especially in the current context, which has brought out clearly the need to strengthen the public health dimension of health systems to combat outbreaks, epidemics and pandemics, especially new forms of infectious diseases such as COVID-19. Overall, it seems that states are tied down because of high shares of salaries and emoluments –which has gone up for all but one state – leaving very little maneuvering space for other components of health spending. This feature of the health systems may have led to a deterioration in quality of health systems that require complementary spending on other inputs like drugs and infrastructure and may explain the increasing trend towards privatization of both demand and supply side of health care.

Overall, while the FFC period did not see a de-prioritization of health in terms of total health spending, it did see some worrying trends that do not augur well for the health sectors of the various states and certainly is unlikely to move these states towards universal access to health services in the near future.

Annexures

Annexe 1a

Per capita real expenditure by economic classification - materials,supply, machinery & equipments						
	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	46.0	101.3	61.2	56.4	90.9	8.1
WB	131.2	203.1	165.9	150.5	152.0	-0.1
UP	91.7	101.7	125.7	97.1	99.2	1.1
TN	124.9	98.3	81.4	89.4	114.7	-2.6
HP	126.9	203.0	364.1	317.1	366.2	29.3
Max/Min	2.9	2.1	6.0	5.6	4.0	

Annexe 1b

Per capita real expenditure by levels of health-care - primary care						
	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	157.3	171.5	191.9	203.8	231.9	10.0
WB	228.3	270.2	239.7	260.8	268.9	3.0
UP	245.7	245.5	266.6	282.1	282.6	4.3
TN	461.6	487.1	457.6	499.1	627.3	6.6
HP	584.9	600.2	689.8	737.6	789.0	8.4
Max/Min	3.7	3.5	3.6	3.6	3.4	
Per capita real expenditure by levels of health-care - secondary & tertiary care						
	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	69.4	91.3	106.8	116.3	124.7	15.2
WB	212.2	259.5	245.0	251.7	270.6	4.7
UP	137.1	144.2	158.7	163.7	172.8	6.1
TN	134.0	128.8	122.7	138.8	160.7	4.5
HP	491.5	482.7	574.7	589.4	623.6	7.0
Max/Min	7.1	5.3	5.4	5.1	5.0	
Per capita real expenditure by levels of health-care- medical education						
	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	27.4	41.5	48.3	51.1	64.0	21.0
WB	83.3	77.5	98.1	95.6	132.1	12.0
UP	46.3	52.5	74.1	63.7	67.2	9.8
TN	92.1	94.8	96.3	110.5	126.2	8.1
HP	134.2	164.2	265.6	270.7	320.2	25.1
Max/Min	4.9	4.0	5.5	5.3	5.0	
Per capita real expenditure by levels of health-care- social security						
	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	2	4	6	6	14	58.5
WB	13	13	52	44	7	0.6
UP	3	2	2	4	10	38.1
TN	155	165	154	233	212	10.2
HP	17	26	29	33	58	31.3
Max/Min	85.3	89.3	95.8	56.7	29.7	
Per capita real expenditure by levels of health-care- administration						
	2014-15	2015-16	2016-17	2017-18	2018-19	Compound growth rate
BIH	6.9	7.3	8.9	9.9	10.5	11.9
WB	16.3	30.3	17.4	17.2	17.1	-4.6
UP	5.5	5.7	6.7	7.4	8.3	11.5
TN	14.9	17.6	17.8	19.1	21.5	8.5
HP	105.9	99.7	109.1	132.7	113.4	4.3
Max/Min	19.3	17.6	16.2	18.0	13.7	

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