Finances for Health in India: Are New Sources the Way to Go?

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ABSTRACT

The Government of India has proposed the National Health Assurance Mission (NHAM) to move the country rapidly towards universal health coverage (UHC), by providing all citizens with specified drugs, diagnostics, and services. Currently, India's public spending on health is one of the lowest in the world. Recent pronouncements from the government indicate a further cut in the health budget, indicating a serious discrepancy between policy intentions and necessary financial provisions. Against this backdrop, this paper offers two broad options to enhance fiscal space for health in India: (a) superior utilisation of the existing resource envelope through reprioritisation and reallocation within the social sector, including pooling of fragmented allocations; and (b) identification of new revenue handles for the health sector and choice of the most sustainable of these.

Keywords: Health financing, fiscal space, absorptive capacity, innovation, corporate social responsibility, health cess

JEL classification: H51, H60, I18

1 INTRODUCTION

The Government of India is preparing to launch the National Health Assurance Mission (NHAM) to provide its citizens universal health coverage (UHC). The NHAM promises to deliver an assured health package, including essential drugs and diagnostics. While treatment for the poor would be free, there would be an insurance component for the remaining population. The aim is to make 50 essential drugs with a package of diagnostics and about 30 AYUSH[1] drugs available to all citizens at government hospitals and health centres countrywide (Ministry of Health and Family Welfare (MoHFW) 2014a). The MoHFW estimates that the NHAM will cost $181.62 million (Rs 11,400 million annually, almost double the current health allocation (Kalra 2014a).

Health spending in India has been deemed inadequate, and much of the recent research has been on the possible costs of launching UHC for the entire population. Most of these studies indicate that any such rollout would need the government to raise health spending from the very low level of 1 per cent of GDP to anywhere between 2–4.5 per cent of GDP (Gupta et al. 2014; Mahal and Fan 2012; Planning Commission 2011; Prinja et al. 2012). The outlook for raising health spending, however, has not been very optimistic, and finances would be a core concern in the context of the NHAM. For example, an analysis of the relationship between income and healthcare expenditure at the state level found the goal of spending 2–3 per cent of GDP on health ambitious (Bhat and Jain 2004). Others argue that such spending has declined over time largely because states[2] have cut social sector expenditure overall; and, despite the improvements since 2005, due mainly to the launch of the National Rural Health Mission (NRHM)[3], India was unlikely to raise target spending to 2–3 per cent of GDP (Berman and Ahuja 2008). These concerns seem plausible given the very low per capita total spending as well as spending on health coverage[4] in India (Gupta and

[1] AYUSH is the acronym for ayurveda, yoga and naturopathy, unani, siddha, and homeopathic systems of medicine.

[2] India is a federal union of 29 states and seven union territories. The seventh schedule of the Constitution of India classifies functions into union list, state list and concurrent list. According to this schedule, health belongs to the state list.

[3] The National Rural Health Mission (NRHM), launched in 2005, is a centrally sponsored flagship programme of the Government of India. It adopts a synergistic approach to health and aims to make the architectural corrections necessary in the basic health care delivery system. Its plan of action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organisational structures, optimisation of health manpower, decentralisation of health programmes, and meeting Indian Public Health Standards in the smallest jurisdictions of the country.

[4] Here, 'coverage' implies additional expenditure that the government incurs on scheme-based health coverage to specific segments of the population e.g. health services of the Ministry of Defence and Railways, Central Government Health Scheme, National Health Insurance Scheme (Rashtriya Swasthya Bima Yojana), Employees State Insurance Scheme, medical reimbursement by state government departments, state government health schemes, etc.

Chowdhury 2014), especially relative to countries that have successfully launched UHC—like Brazil, Colombia, Chile, and Mexico—and to the even lower spending on health coverage.

Fiscal space in the context of health has been defined as the 'ability of governments to increase spending for the sector without jeopardising the government's long-term solvency or crowding out expenditure in other sectors needed to achieve other development objectives' (Tandon and Cashin 2010). The need for raising expenditure from the low 1 per cent of GDP has been heard on many forums, and there has been much recent debate and discussion in India on the issue of fiscal space for health. Such discussion has centred on the implicit assumption that lack of resources might constrain the launch of UHC, and some have even argued for using corporate resources, especially through the mandated[5] corporate social responsibility (CSR) channel (ICICI Foundation, Samhita). Yet others have argued for a health cess, which has found some resonance within the government (Iyer 2014). Finally, earmarked tax and sin tax have always been a favourite in discussions on additional funding for the health sector.

In this paper, we take a look at the issue of public financing for health in India to understand whether lack of finances is the central issue in the context of UHC. We then explore and analyse the possibility of raising additional funding through other innovative sources. Specifically, we ask:

1. Does government health spending reflect the general macroeconomic scenario?
2. How well does the health sector utilise its allocations?
3. What could be the possible optional sources of finance, and how much could they yield?

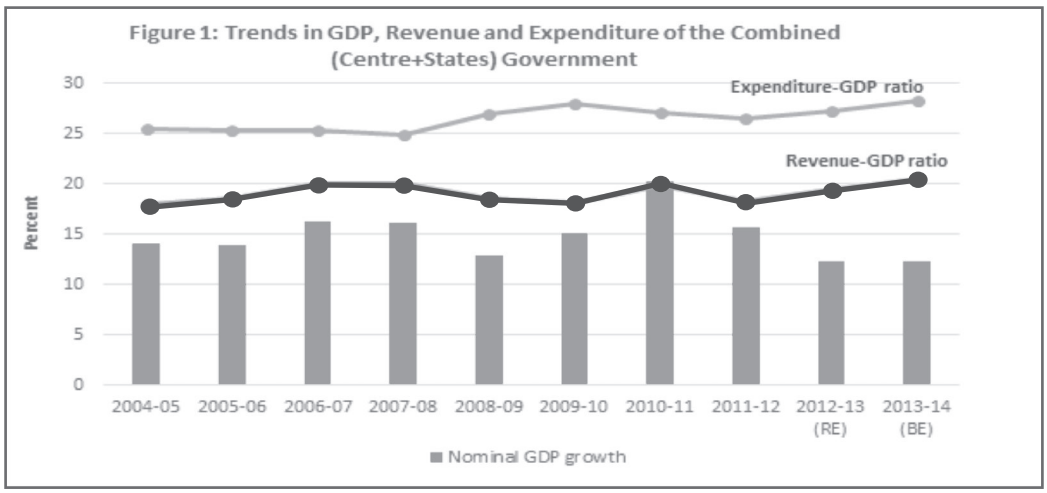
2 PUBLIC FINANCING FOR HEALTH IN INDIA

Of the total health spending (4 per cent of GDP), the government spends around 1%; the remainder is private spending, mostly household out-of-pocket spending (Gupta and Chowdhury 2014; Kumar et al. 2011).

Regarding the public financing issue, there are two questions:

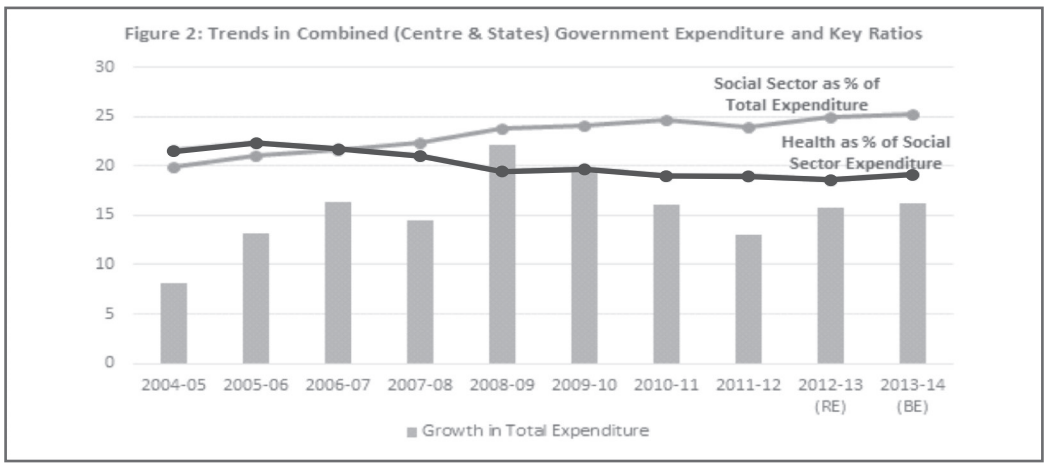
- Can it be raised?
- Does the evidence indicate a willingness to raise finance?

[5] With the enactment of the Companies Act, 2013, India has initiated spending on corporate social responsibility (CSR) activities through a statutory provision. While many corporate houses have been traditionally engaged in voluntary CSR activities, the new CSR provisions put formal and greater responsibility on companies in India to set out clear framework and processes to ensure strict compliance.



Source: Indian Public Finance Statistics, relevant years. GDP from Central Statistical Organisation.

As far as the first question is concerned, Figure 1 gives the trends in nominal GDP growth and the share of total revenue and expenditure during the past decade. India's nominal GDP has been growing at 15 per cent per annum on average. The revenue-to-GDP ratio rose and the expenditure-to-GDP ratio fell during the first half of the decade, until 2006-07. This coincides somewhat with the high growth phase of the economy. Between 2007–08 and 2009–10, the initial years of the meltdown, the revenue-to-GDP ratio plunged while the expenditure-to-GDP ratio increased, which indicates a fiscal stimulus financed largely through borrowing. Thereafter, the ratios have been displaying a largely parallel trend. During the entire period, both revenue and expenditure as a share of GDP have remained more or less constant. While total expenditure had a share of 25–28 per cent, revenues had a share of 17–20 percent.



Source: Economic Survey of India, relevant years.

The more relevant issue here is to understand what has happened to social sector[6] expenditure in general and to health expenditure in particular. Figure 2 presents the trend in total expenditure; social sector expenditure as a share of total expenditure; and health expenditure as a share of social sector expenditure. The trends indicate that while the share of social sector in total government expenditure has been increasing, particularly after 2007–08, the health sector has not benefited. In fact, public spending on health as a share of social sector spending declined steeply after 2005–06 and steadied somewhat, though at a lower level, after 2010–11. Clearly, the increase in the share of social sector spending has come from non-health sectors. Table 1 indicates the annual average growth rates in the components of social sector expenditure. It is apparent that the slowest growth has been in health sector spending, and the maximum increase in social security and welfare. Spending on health, rural development, and education has seen the least growth. While India spends less on social and welfare policies than many countries in the Asia-Pacific region (Jha 2013), it does not preclude the possibility of internal reallocations within social sector spending. This simple analysis indicates that there is scope for the government to increase allocations to health even in the current scenario. Clearly, then, the issue of prioritisation is the more relevant one in the context of health spending. This is further evident from the recent slash in the health budget: the government has ordered a cut of nearly 20 percent in its 2014–15 healthcare budget due to fiscal strain. Reportedly, over Rs 60 billion has been slashed from the health budget allocation for the financial year ending on 31 March 2015 (Kalra 2014b).

Table 1 Growth of Social Sector Expenditure by Government (Centre and States)

Sectors	Annual Average Growth Rate (%) 2003-04 to 2013-14
Education	17.7
Housing	21.7
Urban development	25.9
Labour and Employment	20.6
Social security and welfare	28.7
Rural development	17.1
Health	16.5
Social sector	18.6

Source: Expenditure data on health has been taken from Economic Survey of India. For all others, Indian Public Finance Statistics data has been used

Note: Social sector as classified by Indian Public Finance Statistics is slightly different from that of Economic Survey (Figure 2). However the key components are the same.

[6] Social sector includes education, sports and youth affairs, health and family welfare, water supply and housing, information and broadcasting, welfare of vulnerable classes, labour and employment, social security and welfare and nutrition, north eastern areas and other social services.

Another important point to keep in mind while discussing health finances is the absorptive capacity of states: the current central allocations to states often go unspent, due to poor absorptive capacity. Figure 3 gives the expenditure as share of Plan outlay for select components of the National Health Mission[8] (NHM) and total non-NHM expenditure of the MOHFW. Overall, 77 per cent of the Plan[9] outlay of the MOHFW was spent in 2012–13 and 2013–14. The utilisation was higher for NHM components than for non-NHM components. Less than 50 percent of the Plan outlay was spent by the national programmes for communicable diseases, iodine deficiency, tobacco control, deafness, mental health and blindness. The Pulse Polio Immunization Programme had the highest expenditure–allocation ratio. Expenditure as a percentage of total releases has also dropped in the last three years. In FY 2009–10, over 100 percent of total releases (GOI and state share) was spent. This dropped to 84percent in FY 2012–13. Until December 2013, 63 percent of the total release was spent (Accountability Initiative 2014).

The aggregate unspent balance or financial saving (Plan + non-Plan) of the MOHFW for the year 2012–13 was $869 million (Rs. 54,570 million). The key reasons reported for such under-spending across schemes are low receipt of financial proposals, availability of unspent balances with the implementing agencies at the state level, and low absorbing capacity and infrastructure, particularly in the North-Eastern states (MoHFW 2014a).

The problem of under-spending is more severe at the state level. During 2007–08, just four states (Andhra Pradesh, Bihar, Gujarat, and West Bengal) made the desired contribution under the NRHM from their budget, while 14 others did not contribute at all (CAG 2010). More recently (FY 2013–14), Bihar released 65 per cent less than their required share and Andhra Pradesh 49 percent. There also exist wide variations in actual expenditure patterns across states. In FY 2012–13, while Kerala spent more than its available funds (opening balance and total releases), Uttar Pradesh, on the other hand, spent a mere 42 percent (Accountability Initiative 2014). In fact, the recent budget cuts have also been attributed to under-spending by state governments (*The Hindu* 2015).

Quasi-government institutions do not perform any better in this regard. In 2011–12, the net surplus of the Employees State Insurance Corporation (ESIC), which runs the only social

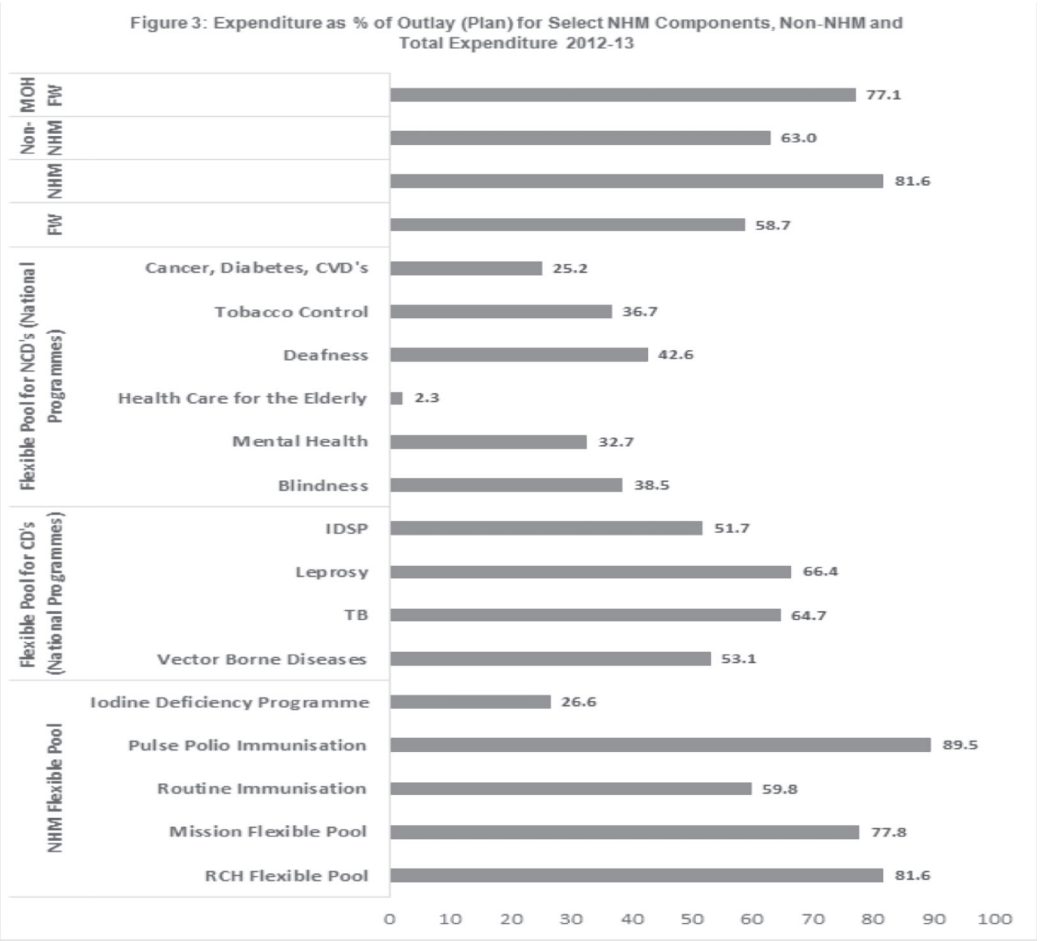
[7] Social sector as classified by Indian Public Finance Statistics is slightly different from that of Economic Survey (Figure 2). However, the key components are the same.

[8] The NRHM has been subsequently renamed as the NHM after including urban areas within its ambit. The NHM forms a major component of expenditure by the MoHFW.

[9] Total government expenditure might be classified into Plan and non-Plan expenditure. Plan expenditure is allocated under the direction of the Planning Commission. Non-plan revenue expenditure is accounted for by interest payments, subsidies (mainly on food and fertilisers), wage and salary payments to government employees etc. that are more in the nature of committed expenditure.

health insurance scheme[10] in India, was $658 million (Rs 41,310 million). In a truly risk- and income-pooled SHI, funds could be better utilised. The ESIC has been consistently generating an excess of income over expenditure (ESIC 2014). While there is some indication that low operation costs generate such surpluses (Srinivas 2009), it is possibly not the sole explanation for such huge savings. In any case, it clearly adds to the instances of inefficient use of funds due to lack of pooling across agents of health spending (Gupta and Chowdhury 2014).

Figure 3: Expenditure as % of Outlay (Plan) for Select NHM Components, Non-NHM and Total Expenditure 2012-13



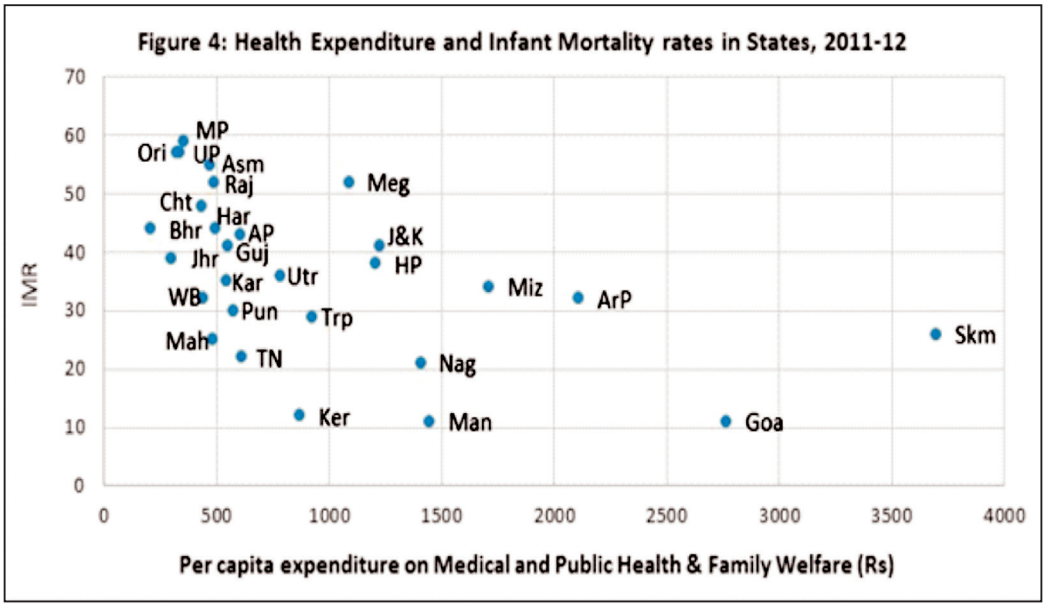
Source: Based on Outcome Budget, MOHFW, GOI, 2012-13 and 2013-14.
Note: The figures for Flexible Pool for NCDs correspond to 2013-14 while the rest correspond to 2012-13.

[10] The ESIC administers the Employees State Insurance Scheme (ESIS). It is a comprehensive social security scheme that delivers social protection to workers against the events of sickness, maternity, disablement, and death due to employment injury. It also provides medical care to insured employees and their family. It is funded primarily through designated contributions from employees and employers, with partial support from state governments.

Finally, there is significant variation in health outcomes across states at a similar level of health spending. Figure 4 shows per capita health spending and IMR to show that states with similar per capita health spending have different health outcomes, which indicates the presence of other determinants of health outcome, besides spending. Such determinants indirectly impact on spending efficiency as well. An analysis of state health spending and outcomes using the stochastic frontier approach for the years 2000–09 indicates that efficiency is around 73 percent, indicating that health outcomes can be improved without additional resources (Prachitha and Shanmugam 2012). Yet others have pointed out significant inefficiencies in spending in India and possible increases in effective fiscal space through efficiency gains (Tandon and Cashin 2010).

While the reasons for inefficiency could be varied and different across states, improving health outcomes with current spending levels by improving spending efficiency will be one important way of addressing the resources issue. This, however, is often missed in discussions on health spending, which centre mostly on the requirement of additional revenue.

Figure 4: Health Expenditure and Infant Mortality rates in States, 2011-12



Source: IMR from SRS Bulletin, October 2012, Health Expenditure from RBI State Finances

Note: The states are Andhra Pradesh (AP), Assam (Asm), Arunachal Pradesh (ArP), Bihar (Bih), Chhattisgarh (Cht), Goa (Goa), Gujarat (Guj), Jharkhand (Jhr), Haryana (Har), Himachal Pradesh (HP), Jammu & Kashmir (J&K), Karnataka (Kar), Kerala (Ker), Madhya Pradesh (MP), Maharashtra (Mah), Manipur (Man), Mizoram (Miz), Meghalaya (Meg), Nagaland (Nag), Odisha (Ori), Punjab (Pun), Rajasthan (Raj), Sikkim (Skm), Tamil Nadu (TN), Tripura (Trp), Uttar Pradesh (UP), Uttarakhand (Utr), and West Bengal (WB).

3 NEW SOURCES OF HEALTH FINANCING

Globally, innovative financing for health has been seen as an effective mechanism to mobilise funds, and most of the discussion on such financing has focused on how the global community can help the health sector in developing countries meet its needs (Fryatt et al. 2010; Le Gargasson and Salomé 2010). There have been instances of international organisations and coalitions working together to raise funds for contributing to pools, such as the Global Fund for HIV, TB and Malaria (GFATM) and Gavi (the Vaccine Alliance), etc.

Innovative revenue generation has been attempted at the national level too, but these efforts have been restricted mostly to developed countries. For example, Italy has proposed the 'de-tax' approach that would require earmarking a share of VAT revenues for health, and France has been advocating voluntary contributions for a while now and moving away from the tax-based approach (Hecht et al. 2010). Other suggestions have been a very low rate tax on internet traffic (WHO 2012), a global currency transactions tax (CTT) and financial transactions tax (FTT) on the sale of shares, bonds, and derivatives (Health Poverty Action 2012; Policy Cures 2015).

There are fewer examples of innovative financing for health in developing countries. Thailand has imposed a 2 per cent surcharge on alcohol and tobacco excise tax for its Health Promotion Foundation (Thai Health) in 2001 (Adulyanon 2012). Similarly, the Philippines and Indonesia also have earmarked tobacco and alcohol taxes for the health sector. Some countries like Ghana and Chile have used a levy in addition to existing VAT rates to fund health sector activities. For example, an additional 2.5 percent levy on the VAT in Ghana funds the National Health Insurance Scheme. Other examples include Gabon, which has levied 1.5 percent on the post-tax profits of companies that handle remittances and a 10 percent tax on mobile phone operators to be directed towards health care of the low-income groups (Policy Cures b).While taxing foods that are detrimental to health have been advocated from time to time, earmarking such taxes for health has also been suggested. (Jacobson and Brownell 2000; Thow et al. 2011).

Historically, India has financed health care from traditional revenue sources. However, enhanced funding requirement for the NHAM makes a discussion on alternative revenue handles both opportune and interesting. We explore additional domestic sources for raising revenues, keeping in mind that the size of the government budget is only one dimension of the financing question; enhanced allocations and efficiency of spending are the other key dimensions pertinent to any resource mobilisation exercise.

Below, we discuss three such sources: the private corporate sector through mandated CSR spending, earmarked taxes for health, and a levy on airline tickets.

a. Corporate social responsibility

A provision of CSR is incorporated in the new Companies Act of 2013 under Section 135. It states that every company with a net worth of $80 million (Rs 5,000 million or more), or turnover of $159 million (Rs 10,000 million or more), or a net profit of $0.80 million (Rs 50 million or more) during any financial year shall spend at least 2 percent of the average net profits of the company made during the three immediately preceding financial years, in pursuance of its CSR Policy (GOI 2013).The range of CSR activities are to be guided by Schedule VII of the 2013 Act that broadly identifies the areas of CSR spending.

The possibility of a substantial sum of money entering the social sector has generated some fresh interest in the financial profiles of Indian companies. Although numbers ranging from $1.59 billion to $2.39 billion (Rs 100 billion to Rs 150 billion) have been mentioned, it is hard to endorse them, as they are not accompanied by citations of the background research (Shrivastava 2014). Clearly, there is no consensus on this and therefore it calls for some analysis.

Table 2 Top 20 Companies in terms of Expected CSR Spending 2013-14 ($ million)

Rank	Company Name (Standalone basis)	Expected CSR spending, 2013-14 (in $ million)	Rank	Company Name (Standalone basis	Expected CSR spending, 2013-14 (in $ million)
1.	Oil & Natural Gas Corpn. Ltd.	73	11	N M D C Ltd.	22
2	Reliance Industries Ltd.	65	12	I T C Ltd.	22
3	State Bank Of India	41	13	Hindustan Zinc Ltd.	20
4	Tata Consultancy Services Ltd.	38	14	H D F C Bank Ltd.	19
5	N T P C Ltd.	35	15	Tata Steel Ltd.	19
6	Coal India Ltd.	28	16	Bharti Airtel Ltd.	17
7	Infosys Ltd.	28	17	Wipro Ltd.	16
8	Cairn India Ltd.	24	18	Punjab National Bank	15
9	ICICI Bank Ltd.	24	19	Bank Of Baroda	15
10	Bharat Heavy Electricals Ltd.	22	20	Axis Bank Ltd.	15

Source: Computed from Prowess data

We use Prowess[11] to arrive at the expected CSR pool, applying the clauses mentioned in the Act. For the year 2013, 13,951 companies satisfied the CSR criteria. The aggregate of their average net profit (profit after tax) for the three preceding years was $60.73 billion (Rs 3812.28 billion). At 2 percent at least, the CSR liability thus works out to $1.21 billion (Rs 76.25 billion), about 1 percent of the current social sector expenditure in India. Table 2 shows the top 20 companies in terms of expected CSR spending.

[11] The Centre for Monitoring Indian Economy compiles Prowess, a database of the financial performance of listed and unlisted Indian companies, principally from the annual reports of these companies.

How much of this would go towards health or health promotion is difficult to foretell. A recent survey of the top 40 companies by global consulting firm Mercer reveals that among CSR activities, education tops the chart—81 percent adopted it as their mandate—followed by 64 percent focusing on community-based developmental activities and 61 percent adopting environmental sustainability within their own companies (*The Economic Times* 2014).

While there is scope for further clarity in the new CSR rules (Vaidyanathan and Thacker 2014), it is reasonable to assume that a substantial amount of money will be looking for avenues of socially productive utilisation. Given the insistence of a local area preference for CSR in the Companies Act, companies are expected to design their CSR activities in anticipation of a 'kickback' in the form of higher demand for their products or better human resources for their organisations. If this money is expected to finance social sector programmes of the country in general, the government should think of creating a common corpus to be managed collectively by experienced professionals, with possible representation from the companies. Other than conceivable efficiency gains, it might also bring in some accountability in spending on the social sector.

b Earmarked tax

Currently, there are five revenue handles on tobacco products in India—(1) central excise; (2) surcharge towards the National Calamity Contingency Fund; (3) special excise duties; (4) additional duties; and (5) *bidi*[12] workers' welfare assessment (spent on welfare of *bidi* workers). Additional duties were first imposed in 2005–06 to partly finance the NRHM and is, therefore, practically a health cess, though not as significant as the education cess[13] in magnitude. The revenue from *bidi* workers welfare assessment is spent entirely on the welfare of *bidi* workers. The remaining levies contribute to the general revenues of the government, a fraction of which could arguably be earmarked for the health sector.

In 2011–12, the total central excise duty collected from tobacco products was $2.77 billion (Rs 174.13 billion), which was about 12 percent of the total central excise duty collected (Lok Sabha Unstarred Question No. 5920). In the new budget, the rates have been revised and increased: the increase in excise duty is the steepest in recent times and is in the range of 11–72 per cent for different kinds of cigarettes (Sharma 2014). However, the funds raised are not earmarked for the health sector, and thus go into general revenues. It can be argued that a part of such revenues should flow into the health sector on a sustained basis. Exploring the earmarking of health excise for health sector activities has been recommended earlier as well (Bloomberg 2015). In the context of the UHC, this source might prove to be an important one, obviating the need for any additional new sources for raising funds.

[12] A *bidi* is a small thin hand-rolled Indian cigarette wrapped in a *tendu* leave with a string at one end.

[13] The education cess is a special levy instituted by the Union Government of India since 2004 to fund education infrastructure in the country.

It can be argued that augmenting health's share from budgetary resources is tantamount to spending the current health cess on tobacco products on the health sector, since the government will have to spend out of its other resources for any gap created by augmented health spending. But earmarked sources make for a more transparent and structured approach, because it gives an envelope within which expenditures can take place. It also is intuitively appealing and, in principle, the government can make an accounting adjustment to earmark the health cess as a source of financing. The use of the education cess levied on direct as well as indirect taxes is a good example. In the year 2011–12, the total revenue collected from the education cess was over $4.33 billion (Rs 271.98 billion).[14] It financed more than 50 percent of the expenditure on the landmark universal education programme of the country (Sarva Shiksha Abhiyan) and the Mid-Day Meal Scheme and around 15 percent of the total expenditure on secondary and higher education.

c Airline tax

There have been other innovative channels of raising funds for domestic and global health. Since 2006, UNITAID[15] has been raising funds through the 'air ticket levy' (ATL). In the past five years, more than 50 percent of its funds have been raised through this channel. Nine countries have implemented the ATL: Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger, and the Republic of Korea. Norway allocates part of its tax on carbon dioxide emissions (UNITAID). The funds have remained stable despite global economic turbulence; this proves the robustness of this source.

While the UNITAID financing is an example of global efforts and cooperation, one can think of the ATL as an additional domestic source of financing as well. In that sense, the funds can remain within national boundaries and go directly into a pool set up by the government. Like the UNITAID airline levy, which ranges from US$1 for economy class tickets to approximately US$40 for business and first class travel (ibid.), the domestic airline levy can also be differentiated based on type of travel or distance travelled. The levy would be a simple addition to an existing airport tax, and can be nominal enough to not affect demand.

The volume of air traffic in India has been growing: between January and October 2014 (data for the last two months are yet to be compiled), domestic airlines carried 55.1million passengers, a growth of more than 8.6 percent over the corresponding period of the previous year (50.7 million passengers; Figure 5; Director General of Civil Aviation (DGCA) 2013)

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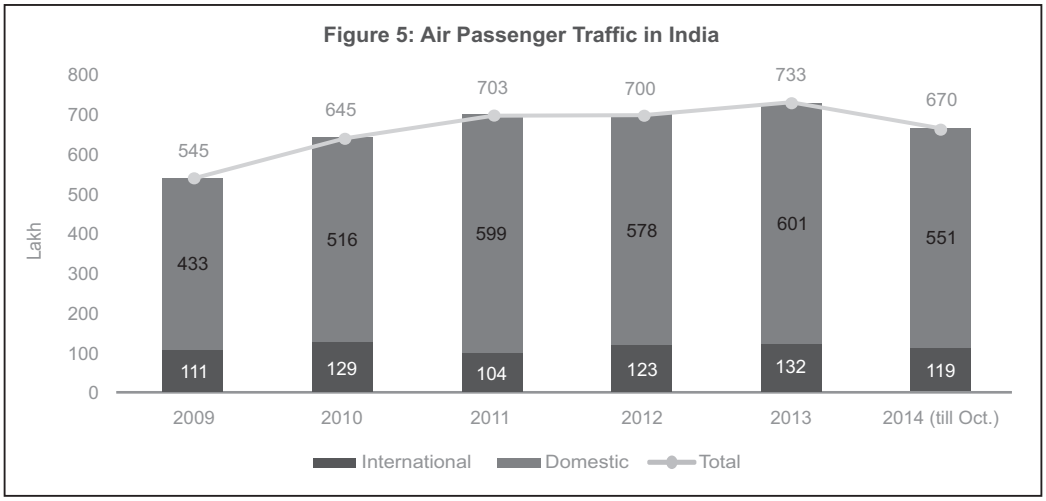
[14] Lok Sabha Annexured Unstarred Question No. 702

[15] UNITAID was established in 2006 by the governments of Brazil, Chile, France, Norway and the UK as the 'International Drug Purchasing Facility'. Today, it is backed by an expanding 'North–South' membership, including Cyprus, Korea, Luxembourg, Spain and the Bill & Melinda Gates Foundation alongside Cameroon, Congo, Guinea, Madagascar, Mali, Mauritius and Niger. UNITAID uses innovative financing to increase funding for greater access to treatments and diagnostics for HIV/AIDS, malaria, and tuberculosis in low-income countries.



Source: Air Transport Statistics, respective years, Directorate General of Civil Aviation, GOI

Assuming similar trends, the total annual traffic by domestic airlines on domestic routes comes to about 67 million for 2014. A small flat levy of Rs 50 (about 80 cents) on all domestic air travel by domestic carriers can raise revenues to the tune of $ 53 million (Rs 3,350 million) in a year. Differential levies based on the class of travel could augment this further. Clearly, a more nuanced approach differentiating luxury travel would yield a different estimate, but this gives an estimate of the magnitude of finances that can be raised through airline levy.

In sum, there are innovative financing mechanisms that can be looked at and more such instances have been discussed and implemented elsewhere (WHO 2012). Table 3 gives an overview of possible finances that can be raised from these various sources.

Table 3 Alternative revenue sources for health

Financing source	Estimated revenue envelope (in $ million)	Comments
Tobacco levies	2,774	For 2011-12. Will be more with newer tax rates. A part already earmarked. Further earmarking would mean health spending would substitute other spending.
CSR	1,215	For 2013. Percentage spent on the health sector cannot be mandated as of now. Decision with the corporate bodies.
Airline tax	53	For 2014, assuming a flat levy of Rs 50 on all domestic tickets on domestic airlines. Can be earmarked by government directive.

4 SUMMARY AND CONCLUSIONS

The discussion on additional sources of financing for the health sector may be somewhat premature. The low current government spending on health, even relative to other social sector components, indicates an issue with prioritisation rather than with finances. Inefficiencies in spending and sub-optimal allocations as well as leakages due to corruption raise questions about how the funds are being used rather than how much more funds are required (Chattopadhyay 2013). It is always possible to allocate additional funds from current revenues, and make some reallocations among different sectors. Clearly, recent further cuts in health budgets indicate that government does not think of the current levels of public spending as cause for concern.

Nevertheless, the ambitious NHAM has been planned to provide some pre-specified health cover to all Indians, and subsidise services for the vulnerable population. This would require substantial resources, and a quantum jump may be called for in resources for the health sector.

Whether the government can allocate a much higher share to health from its revenues is not clear, and past trends are not encouraging. If it plans to augment its resources for the health sector from newer sources, earmarked taxes probably is the most tried and tested way of raising revenues. Additional duties on tobacco products and education cess are successful examples of earmarked resources that can be emulated. Even if the government is averse to the idea of imposing a new tax, it can consider the less contentious option of earmarking a fraction of the total excise collection from tobacco products. Taxes on other sin foods can be considered, but such steps will have to be taken along with sound preventive messages. Apart from tobacco and alcohol, India still does not have a cogent health promotion plan regarding other consumer goods.

Corporate social responsibility has considerable scope, but it is restricted by the government's ability to mandate where and how CSR funds should be spent. Also, given that CSR funds would vary with the fortunes of the corporate sector, it would be akin to exposing social sector spending to market vagaries. Airline taxes can yield a considerable amount as well; a small flat levy is unlikely to affect demand, and can be considered as a viable option. Given that airline traffic has been increasing continually and is unlikely to dip in the future, this source is more stable than the CSR.

However, such additional avenues should be considered only after exhausting all possibilities of raising resources from budgetary sources and consolidation, reprioritisation and reduction in inefficiencies of spending.

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