Although health is a state subject in India – the Central government accounted for only 30 percent of total government health expenditure in 2014-15 – there are measures which the Union Ministry of Finance can take to keep the nation healthy not only through higher allocations, but also targeted tax exemptions, given that our out-of-pocket health expenditure is one of the highest in the world. We need more money in our pockets to spend on our health. This, however, does not absolve states and UTs of their primary responsibility vis-à-vis the health of their citizens, and all of them need to do much more than they are currently doing – even health-advanced states like...
Kerala and Tamil Nadu spent less on health than the miniscule national average as percent of their GSDP (2012-13).

*Here are some policy recommendations that the Union Ministry of Finance could consider:*

1) **Income brackets:** A stratified approach could be developed to make provisions for health care instruments. For example, households without an earning member or those with annual income of 5 lakhs should be provided comprehensive health insurance coverage with the total premium shared between Centre and state / UT governments on a 25:75 basis. Likewise, for those annual income between 5 and 10 lakhs should bear 25 percent of the premium on their own, with the remaining shared between Centre and state as per the same ratio. Similarly, the co-payment of premium can keep increasing according to defined income brackets, with households having an annual income of 30 lakhs and above paying the entire premium themselves.

2) **Tax benefits:** The limits of medical reimbursement and exemption under Section 80D should be raised from the present 15,000 each to, at least, 1 lakh each per household. There should be provisions for further tax exemptions based on the household burden of disease and disability. We know too well, for instance, how cancer treatments drain out entire family resources, even in developed countries. Where is that money going to come in our pockets? A government in need is a government indeed! Preventive health instruments beyond simple check-ups should also be part of reimbursements and exemptions.
3) **Alternative financing sources:** Following mechanisms may be considered for expanding the existing pool of financial allocations for health in our country:

**a. Surcharges on alcohol and tobacco:** This is increasingly gaining traction in many parts of the world, including India, and should be continued. The current base of excise revenue could be further expanded if unfiltered cigarettes, bidis, chewing tobacco and like are brought under the standard purview of tobacco taxation.

**b. Health Impact Assessment Index (HIAI):** Industries should be incentivized or disincentivized as per their impact on individual / public health. Those which have a negative impact should be taxed, while those which have a positive impact should be given some sort of tax exemption. An HIAI should be created to determine level of impact and concomitant level of tax liability / incentive. It is important to highlight here that until health taxes are earmarked for the health sector, such taxes will neither make us healthy nor carry legitimacy among the taxpayers.

**c. Corporate Social Responsibility (CSR):** A certain percentage of CSR should be earmarked for health. Companies should be allowed to use CSR for funding the health care of their own staff. They should have the option to fund Central / state / local health interventions that they deem desirable. This would incentivize governments to improve governance and compete for CSR funds, especially if pooled and managed centrally, for instance by industry associations. However, they should not be used to gain favours from governments.

4) **Import tariffs / duties:** All import tariffs / duties on health care (drugs, surgicals, equipment, etc.) should be completely removed if their manufacture / production within the country is not feasible for whatever reasons. These tariffs and duties are straightaway passed on to customers. If the government is not paying for health care, it should at least not make it more expensive.
5) **Prioritization of health expenditures**: Chronic diseases have assumed pandemic proportions in India. Sixteen million people died prematurely due to NCDs in 2012, 21 percent (3.4 million) of them in India alone, the highest in any country. Unlike other countries, however, the problem in India is not just about low priority to health among citizens and governments alike, but about lower priority accorded to chronic diseases within already miniscule health allocations. Figure 1 shows that, despite some improvements recently, the share of NCD expenditure in NHM was only 2.6 percent. Further, it should be noted that NHM NCD budget also includes outlays for health conditions like blindness, deafness, burns, mental and oral health, elderly and palliative care and tobacco control, and only 42 percent of the approved outlay under it in 2015-16 went for NPCDCS, the main program that focuses on core chronic diseases in the NHM framework.

6) **Budget shrinkages and inefficiencies**: A glimpse into the budget of National Health Mission (NHM) shows some major challenges with regard to health budgets in general and prevailing allocations in particular. For instance, in 2014-15, funds allocated to the National Program for Prevention and Control of Cancer, Diabetes, CVD and Stroke (NPCDCS) shrank in phases – from the proposal to the approval stage and then in terms of actual expenditure. Approval rates ranged from 7 percent in a health-advanced state like Tamil Nadu to 35 percent in the case of another, Kerala. Spending rate in a backward state like Uttar Pradesh was 20 percent.

Although public health spending in India is one of the lowest in the world, an ironic reality is that public health systems are unable to utilize the meagre budgets allocated to them. A major proportion of these finances remain unutilized not because they are...
in excess, but due to the skill shortage of health personnel and infrastructural inadequacies. Not only do health departments have to give up unused funds, their allocations in consecutive years are determined in accordance with the funds actually spent in the last year. By the end of a financial year, health-backward states like Uttar Pradesh and Rajasthan are able to utilize only about eighty percent of allocated funds. The corrective measure should be to enhance the technical / absorptive capacity of their health systems rather than to punish poor citizens through reduced allocations.

7) Health system strengthening: As a follow-up from above, the existing 27 percent allocation to health system strengthening under NHM should be used to enhance technical and absorptive capacity of state health systems. International donor organizations like the GIZ should be roped in for this purpose, given their competence in technical capacity-building.

(The article has been authored by Ali Mehdi. He is Project Leader. Co-authored by Divya Chaudhry who is Research Associate with the Health Policy Initiative at ICIER)
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