Gap between allocations for health, outcomes in States

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The realisation of the full potential of the allocations in the Union Budget for the health sector hinges on many State-level parameters. Many of these allocations are for Centrally Sponsored Schemes (CSS), wherein the States not only share a substantial part of the cost but are also responsible for their implementation. The fiscal space and operational frameworks at the State-level have a strong bearing on the efficacy of the Budget allocations on such schemes.

Currently, two major CSS initiatives are being pursued by the central government to strengthen physical health infrastructure in States: the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), and Human Resources for Health and Medical Education (HRHME). The first is aimed at building health and wellness centres (AB-HWCs), developing block-level public health units (BPHUs), and having integrated district public health laboratories (IDPHLs) and critical care hospital blocks (CCHBs) in each district. The goal is to improve India's preparedness for future emergencies such as pandemics. The second initiative strives to scale up medical personnel by establishing new medical, nursing and paramedical colleges and also increasing seats in colleges. Another important aspect is to also strengthen and upgrade district hospitals and attach them to newly established medical colleges at the district level.

Low fund utilisation

Estimates of central expenditure on these initiatives in the last three Budgets indicate a lacklustre performance in fund absorption. In PM-ABHIM, the ratio of 'Actual' expenditures to 'Budget Estimate' of the CSS component was only around 29% in 2022-23. In 2023-24, the 'Revised Estimate' was about 50% of the Budget Estimate, but is expected to be lower in the 'Actuals'. In HRHME too, the utilisation of funds was only around a quarter of the Budget estimates in both 2022-23 and 2023-24. Interestingly, perhaps due to low utilisation, the Budget allocations for both PM-ABHIM and HRHME have been slashed in the full Budget when compared to the interim Budget.

> Fiscal space and good operational frameworks at the State-level could make a difference to the efficacy of the Budget allocations for health schemes

There could be several factors behind the low utilisation of funds under PM-ABHIM. First, in the AB-HWC component, around 60% of the resource envelope was to be sourced from the health grants recommended by the 15th Finance Commission, as in the scheme's operational guidelines. A recent study by the National Institute of Public Finance and Policy indicates that only around 45% of the 15th Finance Commission health grants were utilised in the period 2021-22 to 2023-24. Discussions with State government officials indicate that the complex execution structure of these grants has posed hurdles in its utilisation. Second, in the component of IDPHLs, States were required to integrate public health laboratories under different vertical programmes to avoid duplication. This entailed extensive reorganisation of the existing implementing structure at the State-level, requiring significant planning, streamlining and coordinated efforts. Third, nearly all components, including the BPHUs and CCHBs, involve construction, where fund absorption is often delayed by rigid procedures. Overlap of funding from multiple sources for certain scheme components with similar activities has created an additional layer of complexity.

Faculty shortage

Under the HRHME, even if allocations for physical infrastructure were better utilised, filling the sanctioned teaching faculty positions could have been challenging. According to a study by the Centre for Social and Economic Progress (CSEP), there is a shortage of over 40% in teaching faculty positions in 11 of the 18 newly created All India Institutes of Medical Sciences in the country. It is even more alarming in State government medical colleges in Empowered Action Group States. As in a CSEP study, in Uttar Pradesh, where 17 government medical colleges were set up between 2019-21, 30% of the teaching faculty positions were vacant in 2022. The shortage of specialists could affect the task of setting up medical colleges or upgrading district hospitals to medical colleges. The challenge also extends to CCHBs under the PM-ABHIM whose guidelines on staffing norms include specialists. As in rural health statistics 2021-22, more than a third of the sanctioned positions of specialists in urban CHCs and two-thirds in rural CHCs were vacant in March 2022.

Fiscal space in States

Notably, State governments will have to bear the recurring costs in maintaining the physical infrastructure built under the PM-ABHIM and HRHME, thus necessitating additional financial commitment. The Union government's support for human resources is only for the duration of the PM-ABHIM scheme, i.e., till 2025-26. The ability of States to plan and support recurring expenses beyond this period is vital for the productivity of the incurred capital expenditure. States need to create the fiscal space required to support these initiatives in addition to contributing to other CSS and their own State health schemes.

In sum, transforming capital expenditure allocations into effective health outcomes depends on several critical factors: the fiscal capacity of States to meet additional recurring expenditures; addressing underlying structural causes of human resource shortages, and improving public financial management processes for executing schemes and grants. These elements will be crucial in ensuring that the budgetary allocations for capital expenditures are productive.