

# Public Expenditure on Healthcare in India and Tamil Nadu: Five-Year Plans

Elango J. Parimalam<sup>1</sup>, V. Sathishkumar<sup>1</sup>, R. Rajanbabu<sup>2</sup>

<sup>1</sup>Assistant Professor, Department of Economics, Loyola College, Chennai, India, <sup>2</sup>Assistant Professor, Department of Economics, Manonmaniam Sundaranar University, Tirunelveli, Tamil Nadu, India

## Abstract

**Background:** Health is both an input and an outcome of broader social and economic development. It is also well known that achievements in health do not simply depend on the health sector, other than arise out of improvements in education, standard of living, social stability, housing, water supply, sanitation and other environmental factors. These are amenable to change by actions taken by households, communities and governments and are typically outside the domain of the health system.

**Objective:** The present paper attempts to estimate the extent of public health expenditure in India and Tamil Nadu over the period under review with reference to five-year plans.

**Methodology:** The particulars regarding the total plan investment outlay, health and family welfare expenditures in India and Tamil Nadu have been collected from the published source which is presented beneath the respective table. To carry out the research, straightforward tabular statements were prepared for working out the percentage and average value.

**Conclusion:** From the analysis, it's evident that the total expenditure on health and family welfare of the central and state government shows a steady increase over the plan periods. It's clear from that the plan outlay on both the health and family welfare has increased from first plan (1951-56) to twelfth plan (2012-17) in absolute terms. However it has been always low sharing to the total plan investment outlay of the country. In Tamil Nadu, almost in all the plan periods, the approved outlay was less than incurred actual expenditure.

**Keywords:** *Public Expenditure, Health and Family Welfare, Public Expenditure on Health.*

## Introduction

The public investment in health and health outcomes often does not exhibit any relationship. However, analysis of differences in health expenditure assumes significance and eventually is the starting point

in any attempt to describe the differences in the health outcomes (World Bank, 1993). Health as conceived by WHO (World Health Organization) is a “state of physical, mental and social well-being and not just the absence of disease or infirmity”. According to Amartya Sen, health contributes to a person’s basic capability to function, to choose the life he/she has reason to value (Sen, 1985), health is not just an attribute of individual; it is also a reflection of the social environment in which an individual experiences life. How a society values and understands health will determine in great part how the individual person experiences life. Even more, it will determine what society and individuals can do

---

### Corresponding Author:

**R. Rajanbabu**

Assistant Professor, Department of Economics  
Manonmaniam Sundaranar University, Tirunelveli  
Tamil Nadu, India

E-mail: rajaneco@rediffmail.com; rajeneco@gmail.com

about health— how health will be measure and how the society’s medical care services will be evaluated. Health, in other words, is thought to be influenced by relative income suggesting that levels of health can be regarded as a signal of the socio-economic development within which people live, as well as to how rich or poor the society is on average.

### Significance of Health

It is now widely recognized that health is both an input and an outcome of broader social and economic development. It is also well known that achievements in health do not simply depend on the health sector, other than arise out of improvements in education, standard of living, social stability, housing, water supply, sanitation and other environmental factors. These are amenable to change by actions taken by households, communities and governments and are typically outside the domain of the health system.

Moreover, good health also improves educational attainment and promotes economic growth and political participation. Yet unhealthy behaviour, sickness, malnutrition and high fertility are also significant causes of poverty. Health and health services have a major influence on the well- being of individuals and societies and are an important part of a nation’s politics and economy. Sick health and poor health services are increasingly recognized as major dimensions of poverty in their own right, so that efforts to battle poverty ought to consider the role of health. Good health is universally acknowledged to be of intrinsic value and, therefore, constitutes an integral element of development. One can be rich but sick enough to, not to enjoy any opportunities that wealth opens up and poor health may translate into worsening economic opportunities as well. There are numerous factors that influence health like hereditary factors, environmental factors, life style, adequate housing, basic sanitation and socio-economic conditions including income, education, availability and quality of health infrastructure and per capita health expenditure.

### Determination of Health Status Indicators

The health status indicators are as follows: (i)

Mortality Indicators (ii) Morbidity Indicators (iii) Delivery Indicators (iv) Indicators of Utilization rate (v) Indicators of Social and Mental Health (vi) Environmental Indicators (vii) Socio-economic Indicators (viii) Health Policy Indicators and Indicators for quality of life.

*Mortality Indicators:* Mortality indicators are the traditional measure of health status which includes the following. Infant mortality rate (IMR), Child mortality rate 1-4 yrs. (CMR), Maternal Mortality Rate (MMR), Crude Death Rate (CDR) and Disease specific mortality rate.

*Morbidity Indicators:* Incidence and prevalence of morbidity, Notification rates, Attendance rate at our – patient department health centres etc., Admission, readmission and discharge rates, and Duration of stay in hospital, and absence from work or school.

*Health care Delivery Indicators:* Doctor–population ratio, Doctor-nurse ratio, Population per health centre/ sub-centre, Population–bed ratio and Population per traditional birth attendant.

*Indicators of Utilization Rates:* Proportion of pregnant women who receive antenatal care, Proportion of infants who are fully immunized against the diseases, Proportion of population using the various method of family planning, Bed-occupancy rate (i.e., average daily inpatient /average number of beds), Average length of stay (i.e. days of care rendered), and Bed turnover ratio that is discharge/average beds.

*Indicators of Environment:* Population of air, water, radiation and noise, Solid waste, Exposure to toxic substances in food or drink, and having access to safe water and sanitation.

*Social Economic Indicators:* Per capita GNP, Level of unemployment, Dependency ratio, Literacy rates, (specially, female literacy rate), Family size, Housing (Number of persons in a room), and Per capita calorie availability.

*Policy Makers Indicators:* This indicator is a political commitment. Which are following as

proportion of GNP spent on health services, Proportion of GNP spent on health related activities (water supply, sanitation, housing, nutrition), and Proportion of total health resources devoted to primary health care.

The main objective of the study is to estimate the extent of public health expenditure in India and Tamil Nadu over the period under review with reference to five-year plans.

### Methodology and Data

This study is based on secondary information, which satisfies the objectives chosen for the study. It was mainly related to public health expenditure. The particulars regarding the total plan investment outlay, health and family welfare expenditures in India and Tamil Nadu have been collected from the published source which is presented beneath the respective table. The data on total plan investment outlay, health and family welfare expenditures have been collected for the five-year plan periods (1951-56 to 2012-17). The data have been collected from Annual Financial Statements of various years, budget documents, various reports of Planning Commission of India and Tamil Nadu. Straightforward tabular statements were prepared for working out the percentage and average value.

### Five-Year Plan Outlays on Health and Family Welfare

The table 1 depicts that the pattern of central allocation of five year plan outlays on health and family

welfare. The First five-year plan where the total plan investment outlay for all heads of development was Rs.1960 crores and the outlay on health and family welfare was just Rs.65.3 crores which was just a meagre (3.3 per cent) of the total plan investment. The Second five-year plan period, the outlay on health increased to Rs.145.8 crores but the outlay on health as a percentage of the total plan investment decreased even further to 3.1 per cent. Third plan where the outlay on health increased to Rs.250.8 crores, but the outlay on health as a percentage of the total plan investment decreased even further to 2.9 per cent. The outlay on health as a per cent age of the total plan investment increased slightly under the annual plans and the fourth five plans where it was 3.2 and 3.9 per cent respectively.

Fifth five-year plan, the outlay on health expenditure increased to Rs.1252.6 crores as the government in an attempt to eradicate poverty and also realising the failure of coercive methods to control population, stressed on health family planning and nutrition as a component of the minimum need programme etc., although the outlay on health as percentage of the total plan investment again declined to 3.2 per cent. The government decided to discontinue the fifth-five year plan in 1978 and brought an annual plan in 1979-80 with new priorities and programme. Yet, under this annual plan where the totally expenditure on health was Rs.341.6 crores, the per cent of outlay on health as a percentage of the total plan investment was the lower (2.8 per cent).

**Table 1: Central Allocation of Five-Year Plan Outlays on Health and Family Welfare**

(Rs. in Crore)

Sl. No.	Five-Year Plan	Period	Total Plan Investment Outlay (all heads)	Health Sector	Family Welfare	Sub-Total	Percentage of Outlay
1	First Plan	1951-56	1960.0	65.2	0.1	65.3	3.3
2	Second Plan	1956-61	4672.0	140.8	5.0	145.8	3.1
3	Third Plan	1961-66	8576.5	225.9	24.9	250.8	2.9
4	Annual Plans	1966-69	6625.4	140.2	70.4	210.6	3.2
5	Fourth Plan	1969-74	15778.8	335.5	278.0	613.5	3.9
6	Fifth Plan	1974-79	39426.2	760.8	491.8	1252.6	3.2
7	Annual Plan	1979-80	12176.5	223.1	118.5	341.6	2.8

**Cont... Table 1: Central Allocation of Five-Year Plan Outlays on Health and Family Welfare**

8	Sixth Plan	1980-85	109291.7	2025.2	1387.0	3412.2	3.1
9	Seventh Plan	1985-90	218729.6	3688.6	3120.8	6809.4	3.1
10	Annual Plan	1990-91	61518.1	960.9	784.9	1745.8	2.8
11	Annual Plan	1991-92	65855.8	1042.2	856.6	1898.8	2.9
12	Eighth Plan	1992-97	434100.0	7494.2	6500.0	13994.2	3.2
13	Ninth Plan	1997-02	859200.0	19818.4	15120.2	34938.6	4.1
14	Tenth Plan	2002-07	1484131.3	31020.3	27125.0	58145.3	3.9
15	Eleventh Plan	2007-12	2156571.0	136147.0	3988.0	140135.0	6.5
16	Twelfth Plan	2012-17	7669807.0	75145.3	10044.0	85189.3	1.1

Source: Planning Commission of India.

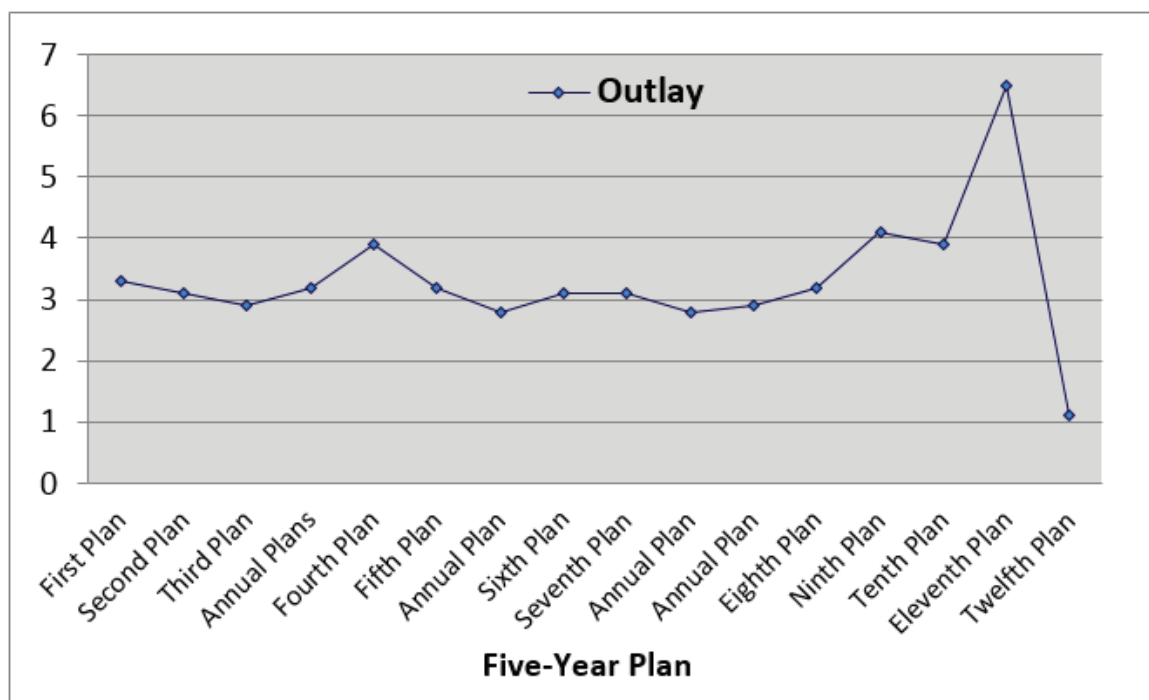
In the Sixth and Seventh plans the expenditure on health was Rs.3412.2 crores and Rs.6809.4 crores respectively and outlay on health as a percentage of the total plan investment was similar at 3.1 per cent. The eight-five year plan could not take-off due to the fast changing following situation at the centre and it was decided that 1990-91 and 1991-92 would be treated as separate annual plans. Again under both Annual plans the per cent of outlay on health as a percentage of the total plan investment was the low at just 2.9 per cent.

Eighth-five year plan the outlay on health increased to Rs.13994.2 crores, which reflect on the outlay of health as a percentage of the total plan investment increased slightly to 3.2 per cent. There was improvement in outlay of health under the Ninth-five year plan which was increased to Rs.34938.6 crores, still the outlay health as a percentage of the total plan investment was 4.1 per cent.

Health expenditure increased to Rs.58145.3 crores under the Tenth-five year plan but the outlay on health as a percentage of the total plan investment decreased to 3.97 per cent. Later in the Eleventh plan actual plan

outlay on health and family welfare were Rs.136147 crores and Rs.3988 crores respectively. Similarly, in the Twelfth plan actual plan outlay on health and family welfare were Rs.75145.29 crores and Rs.10044 crores respectively.

Health and family welfare expenditure by the centre and states, both plan and non plan, will have to be substantially increased by the end of the Twelfth five-year plan. The twelfth-five year plan projections visualize increasing total public funding, both plan and non-plan, on core health from 1.04 per cent of GDP in 2011-12 to 1.87 per cent of GDP by the end of the twelfth five-year plan. From 0.94 per cent of GDP in the tenth-five year plan it has already increased to 1.04 per cent in the eleventh five-year plan. Under the twelfth five-year plan, the principle source of finance for publicly delivered health services would be from the general tax revenues and these are to be supplemented by partnership with private sector, as well as corporate contributions as a part of their corporate social responsibility. In all, the analysis of the data reveals that the central allocation has drastically increased over the plan periods.



**Fig.1: Percentage of outlay to the total plan investment outlay in India**

**Five-Year Plans in Tamil Nadu**

It is very essential to know the plan outlay and its expenditure over the plan period after independence. It will be very helpful to review the health sector status of Tamil Nadu. The power of political leaders and official authorities made to plan and execution of five year plans.

The table 2 portrays that central assistance over the period was varied, which reveals the cooperation /

support of central and state for the betterment of Tamil Nadu economy. In the last plan period, the receipt of central assistance was 31.08 per cent which was the lowers over the plan period. The highest central assistance received by Tamil Nadu was in the eight plan period that is 137.49 per cent. Almost in all the five-year plan periods, the grant outlay was not as much of as incurred actual expenditure.

**Table 2: Five-Year Plans Total Outlay and Expenditure in Tamil Nadu**

(Rs. in Crore)

S. No.	Plan	Period	Approved Outlay	Actual Expenditure	Percentage of Expenditure
1	First Plan	1951-56	86.00	80.00	93.02
2	Second Plan	1956-61	186.19	188	101.08
3	Third Plan	1961-66	342.33	342	101.46
4	Annual Plans	1966-69	266	266	100.00
5	Fourth Plan	1969-74	552	559	101.27
6	Fifth Plan	1974-79	1122.32	1165	103.83
7	Annual Plan	1979-80	343	380	110.79

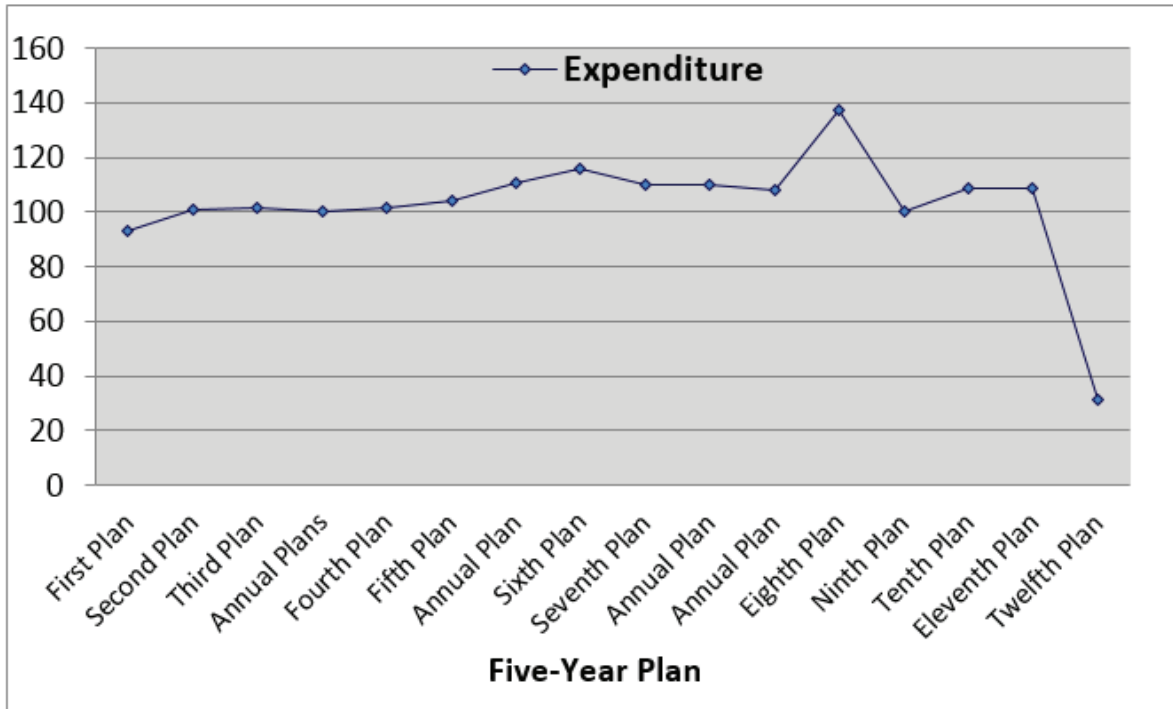
**Cont... Table 2: Five-Year Plans Total Outlay and Expenditure in Tamil Nadu**

8	Sixth Plan	1980-85	3150	3645	115.71
9	Seventh Plan	1985-90	5750	6316	109.84
10	Annual Plan	1990-91	1450	1591	109.72
11	Annual Plan	1991-92	1600	1726	107.88
12	Eighth Plan	1992-97	10200	14024	137.49
13	Ninth Plan	1997-02	25000	25036	100.14
14	Tenth Plan	2002-07	40000	43568	108.92
15	Eleventh Plan	2007-12	85344	92655	108.57
16	Twelfth Plan	2012-17	211250	65656*	31.08*

Source: State Planning Commission, Govt. of Tamil Nadu

\*Expenditure computed for two years (2012-13 & 2013-14)

The Tamil Nadu government is trying to enhance the health status of people through various health programmes. Health programmes become successful when people’s cooperation and participation are solicited and ensured. Meagre incurring huge health expenditure will not bear fruit. Health consciousness has to be created in the minds of the people. Health education has to be important and health habits have to be inculcated. Thus promotional health care delivery indirectly plays an important role in achieving better health status of people in the state.



**Fig.2: Percentage of expenditure to the approved outlay**

## Conclusion

From the analysis, it's evident that the total expenditure on health and family welfare of the central and state government shows a steady increase over the plan periods. It's clear from that the plan outlay on both the health and family welfare has increased from first plan (1951-56) to twelfth plan (2012-17) in absolute terms. However it has been always low sharing to the total plan investment outlay of the country. In Tamil Nadu, almost in all the plan periods, the approved outlay was less than incurred actual expenditure.

**Ethical Clearance** – Secondary dataset, available in public domain.

**Source of Funding** – Self

**Conflict of Interest** – Nil

## References

1. Berman P, Rajeev Ahuja. Government health spending in India. *Economic & Political Weekly*. 2008 Jun; 43(26/27): 209-216.
2. Brijesh C Purohit. Household expenditure on health care. *Economic & Political Weekly*. 1994 June; 29(26): 155.
3. Brijesh C Purohit, Tasleem A Siddiqui. Utilisation of health services in India. *Economic & Political Weekly*. 1994 Apr; 29(18): 1071-1080.
4. Eldhose AM. Health status and health care expenditure in India – an analysis with a focus on Kerala state. *International Journal of Education & Applied Sciences Research*. 2015 Jan; 2(1): 45-56.
5. Mohammed Ashfaq Ahmed, Honakeri PM. Public expenditure on health sector in India – recent trends. 2014 May: 1-11. Retrieved from <https://www.researchgate.net/publication/255968818> access on 7 March 2021.
6. Ravi Duggal. Challenges in financing healthcare. *Economic & Political Weekly*. 2012 Sep; 47(35): 22-23.
7. Santhanalakshmi S, Malathi S. A Study on Public Expenditure on Health Sector in India. *International Journal of Innovative Science and Research Technology*. 2017, May; 2(5): 443-450.
8. Selvaraju V, Vinod B Annigeri. Trends in public spending on health in India. 2001 May: 5-26. Retrieved from <https://www.researchgate.net/publication/235995185> access on 7 March 2021.