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An estimation of public expenditure on health & family welfare in Punjab

Harjeet Singh[1], Kulwinder Singh[2]
[1] Research Scholar, Department of Economics, Panjab University, Chandigarh, Punjab, India
[2] Assistant Professor of Economics, University Business School, Panjab University, Chandigarh, Punjab, India

Abstract
This research paper examines the pattern of government expenditure on the health and related sectors, particularly family welfare and child development, by the Punjab state government. The paper delves into the significance of public spending on healthcare. In India, health is a state-owned responsibility, and each state allocates funds to the health sector through annual budgets. The research highlights the current state of public health spending in India, revealing that private sector spending dominates over public spending, raising concerns about the potential impact of economic reforms on public healthcare funding. The study utilizes data on public expenditure on health in Punjab from 1981 to 2020, classifying it into revenue and capital expenditure categories. The findings show that the majority of the health sector budget is allocated to revenue expenditure, covering recurring expenses like salaries, administrative costs, and maintenance. In contrast, the share of capital expenditure is significantly lower, accounting for only about 2% on average. The research underscores the importance of increasing the budgetary allotment to the health sector, suggesting a target of 3% of GDP, up from the current 2.5%. Global spending on health has shown a significant increase over the years, reaching 9.8% of the global GDP by 2019. In light of the growing average life expectancy and healthy life expectancy worldwide, it becomes imperative for governments to invest more in the health sector to support the well-being and longevity of their populations. Ultimately, this research serves as a call to action for the Punjab state government and policymakers across India to prioritize the health and family welfare sector, taking into account the potential benefits for public health outcomes, economic growth, and overall societal well-being. By increasing public spending on health, governments can better address healthcare challenges, enhance access to quality medical services, and contribute to the attainment of national and global health goals.

Keywords: Public expenditure, health sector, non-communicable diseases, health infrastructure, life-expectancy

Introduction

Governments are coming under more and more pressure to allocate more money to social sectors. One of them is health and family welfare sector. Recently, it has been suggested that the government raise its budgetary allotment to the health sector to 3% of GDP, currently it is near about 2.5% of GDP. In India, health is a state-owned responsibility, therefore a lot depends on the capacity of the state governments to increase fiscal support for the health sector. All states and union governments are providing a budgetary proportion to health sector through annual budgets. Public health spending is tackling serious diseases including Covid-19, HIV/AIDS, TB, malaria, and reaching Millennium Development Goals (MDG) targets and also reducing poverty as well as essential for a nation's industrial and economic growth (WHO, 2022).

In India, the responsibility for the health sector lies with the state governments, and they allocate funds for health-related programs as part of their budget. Additionally, the Central government provides assistance to state governments through centrally funded programs. This means that the majority of funding for healthcare comes from the government, both at the state and central levels (RBI, 2016). Hence, public spending plays a crucial role in financing healthcare services and programs in the country. The public spending on the health sector in India is more influenced by supply-side factors than demand-side factors. Supply-side factors refer to the factors that affect the availability of healthcare services and resources, such as the number of healthcare facilities, medical professionals, medical equipment, and medicines. In India, public spending on health primarily focuses on improving the supply-side aspects of healthcare, including building and upgrading healthcare infrastructure, providing training to healthcare professionals, and procuring medical equipment and medicines. The emphasis is on enhancing the capacity and availability of healthcare services to meet the needs of the population. On the other hand, private sector spending on healthcare is more influenced by "demand-side factors," which primarily revolve around the choices and preferences of individual consumers. In the private healthcare system, individuals have more agency in deciding where, when, and how to spend on healthcare. Demand-side factors include: a. Affordability and Wealth: Private healthcare services are often associated with out-of-pocket expenses. Individuals with higher incomes or better financial stability may be more willing to spend on private healthcare services. b. Perceived Quality and Access: The perceived quality and accessibility of private healthcare services also influence demand. Some individuals may opt for private healthcare due to perceptions of better quality or shorter waiting times. c. Insurance Coverage: Private health insurance plays a crucial role in demand-side factors. People with health insurance coverage may be more likely to seek private healthcare services since their expenses are partially or fully covered (Bhat, 2000) [1].

So, it is well known that health sector spending in India is dominating by private sector spending rather than public. This is why the perspectives that public spending on health has been further diminished during the period of economic reforms create concern, and need to be investigated. This research aims to examine the real pattern of government expenditure on health and related sectors (especially, family welfare and child development) by Punjab state government.

Public health expenditure

The expenditure on health sector is divided into two components revenue expenditure and capital expenditure, like other social and economic sectors. The sum of two components became budgetary allotment to health sector. These two sectors carrying different roles, implication and utilization at different places. Revenue account consists the part of spending which are committed every year to run the system like salaries, administrative expenditure, maintenance, scholarships, hospital expenses, pharmacy expenses, ambulances etc. on the other hand capital account spending on buildings, infrastructure, laboratories, research and development etc. In 2015-16 Punjab's public health expenditure by revenue expenditure was 99.92% and by capital expenditure was just 0.08% (MoHFW, 2018).

People are living longer and staying healthy for longer. Globally, the average life expectancy at birth rose from 66.8 years in 2000 to 73.3 years in 2019, while the healthy life expectancy (HALE) increased from 58.3 years to 63.7 years. Global spending on health more than doubled in real terms between 2000 and 2019, reaching 9.8% of the global gross domestic product (World health statistics, 2022).

Literature Review

Jani (2022) conducted a study on fiscal marksmanship and health expenditure in Indian states, which is an area that has received less attention in previous research. The study aims to provide evidence of the disparities between budget estimates and actual figures, focusing on their impact on developmental initiatives, particularly in the healthcare sector. Auld (1970) [2] examined fiscal marksmanship in Canada and highlighted its significance in long-term development and short-term stabilization. Zakaria and Ali (2010) [13] explored the need for improved fiscal marksmanship in Pakistan's national government to support rational expectations in the economy. Dholakia (2015) [3] emphasized that a budget's credibility relies on how closely projected figures align with actual outcomes by the end of the year. Additionally, studies by Shreshtha and Chakraborty (2019) and Jacob and Chakraborty (2020) focused on the fiscal marksmanship of subnational governments in Kerala and Karnataka, India. These studies revealed systematic resource transfers from medical to other developmental expenses and a high degree of error in capital spending compared to revenue expenditure in state governments. They underscored the need for fiscal discipline in state government health expenditures and analyzed its impact on health indicators from both short and long-term perspectives. The role of fiscal marksmanship in stabilization and human development was also discussed.

Rajpal and Joe (2018) critically assessed methods for measuring health expenditure in countries with significant data gaps, like India. The study also highlighted distressed financing, where households are compelled to borrow or sell assets to afford healthcare, leading to delayed or forgone treatments for those with low ability to pay. Bhat and Jain (2004) explored the connection between health expenditure and income at individual and national levels. Previous research, including Abel Smith (1963, 1967), Newhouse (1977), and Gerdtham *et al*. (1992) [5], established GDP as a significant determinant of health expenditure after accounting for factors like inflation, exchange rates, and population. Healthcare financing in India has been Duggal (1996) [4] and Bhat (1996, 2000) [1] explored public-private partnership optimization in India's health sector. These studies stress the importance of investigating individual states' public health expenditure, considering their unique structural and political contexts, especially in decentralized countries like India.

Objectives

1. To study the trends in public expenditure on health sector in Punjab.
2. To study the public health infrastructure in Punjab.
3. To examine the incidence of non-communicable and communicable diseases in the state.

Methodology

Data pertaining to fiscal indicators and health expenditure, including revenue expenditure, capital expenditure, State Domestic Product (SDP), and SDP per capita, has been gathered from various reputable sources like EPW Research Foundation, State Finances: A Study of Budgets, Reserve Bank of India (RBI) - Handbook of Statistics on Indian Economy, RBI - Statistical Abstract of Punjab, Government of Punjab, and Economic Survey of Punjab, Government of Punjab. The collected data will be subjected to analysis using descriptive statistical methods such as ratios, percentiles, averages, and growth rates. The paper provides valuable insights through charts and tables, showcasing the historical trends of public health expenditure in Punjab. It demonstrates the need for a more substantial allocation of funds towards the health sector, emphasizing the importance of addressing supply-side factors and demand-side considerations in healthcare spending decisions.

Findings and Analysis

Table 1 presents the availability of public funds allocated to the health sector by the Punjab government. It shows the health expenditure from both the revenue and capital accounts for the period from 1981-82 to 2020-21. Notably, the data reveals that the government's expenditure from the capital account is significantly lower compared to the revenue expenditure side. This indicates that the majority of the health and family welfare sector's expenses are directed towards current expenses such as salaries, maintenance, and

other ongoing costs. Consequently, only a negligible portion (averaging around 2%) of the capital account is utilized for health sector investments. The data further demonstrates that the amount of money allocated to Medical and Public Health services from revenue expenditure has shown a consistent increase over the years, rising from 5,646 lakhs in 1981-1982 to 330,933 lakhs in 2020-2021. Similarly, capital expenditure for Medical and Public Health has also experienced steady growth, going from 409 lakhs in 1981-1982 to 19,793 lakhs in 2020-2021. However, it is concerning that the table indicates no capital expenditures on Family Welfare throughout the entire mentioned period, suggesting that most of the funds are allocated to revenue expenditure rather than long-term investments in this sector. Additionally, there were specific years, such as 2001-2003, where the capital expenditure on health services was negligible, for example, only 13 lakhs per year. The lowest capital expenditure was observed in 2014-15, with only 7 lakhs, which was nearly zero percent of the revenue expenditure on health services.

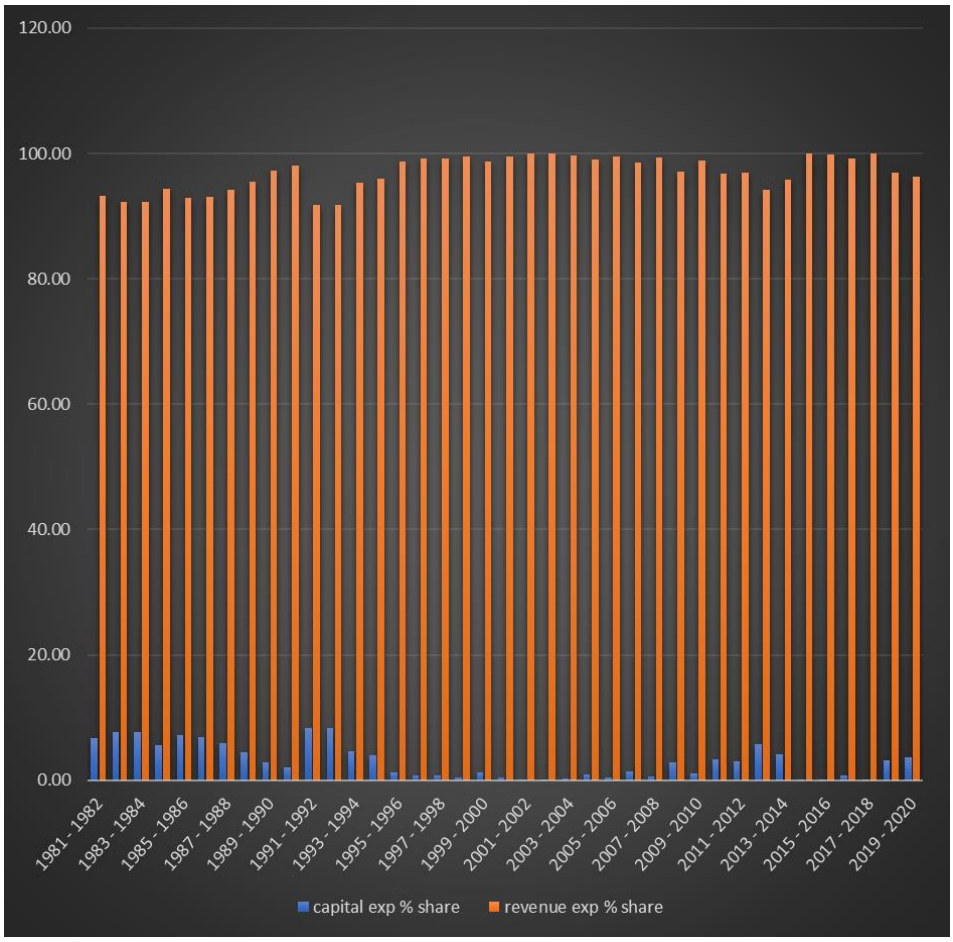
Table 1: Total Public Expenditure on Health Sector in Punjab (1981-2022) (in 000 lakhs)

Year	Revenue Expenditure		Capital Expenditure	Total
	Medical and Public Health	Family Welfare	Medical and Public Health	
1981-1982	5646	0	409	6055
1982-1983	5898	0	492	6390
1983-1984	7860	0	651	8511
1984 - 1985	8802	0	519	9321
1985 - 1986	8367	0	643	9010
1986 - 1987	8998	0	666	9664
1987 - 1988	10644	0	660	11304
1988 - 1989	12308	0	573	12881
1989 - 1990	15688	0	448	16136
1990 - 1991	16629	0	339	16968
1991 - 1992	18119	0	1629	19748
1992 - 1993	19795	0	1782	21577
1993 - 1994	22291	0	1082	23373
1994 - 1995	22617	0	940	23557
1995 - 1996	21888	3797	333	26018
1996 - 1997	26888	4596	232	31716
1997 - 1998	34647	3676	284	38607
1998 - 1999	47451	4158	222	51831
1999 - 2000	50489	3967	716	55172
2000 - 2001	59275	4484	255	64014
2001 - 2002	57788	4029	13	61830
2002 - 2003	57435	3598	13	61046
2003 - 2004	55630	5215	164	61009
2004 - 2005	55092	5287	561	60940
2005 - 2006	62981	6605	296	69882
2006 - 2007	62198	6705	964	69867
2007 - 2008	68355	7292	482	76129
2008 - 2009	75102	7820	2406	85328
2009 - 2010	88356	9711	1083	99150
2010 - 2011	107080	11904	4021	123005
2011 - 2012	139810	15269	4759	159838
2012 - 2013	162256	17132	10936	190324
2013 - 2014	171222	17429	8267	196918
2014 - 2015	216991	19426	7	236424
2015 - 2016	240753	19666	209	260628
2016 - 2017	267095	19683	2245	289023
2017 - 2018	253395	21250	139	274784
2018 - 2019	290596	23742	10047	324385
2019 - 2020	315843	23185	12847	351875
2020 - 2021	330933	22679	19793	373405

Source: EPWRF database, 2022 and Author's calculations.

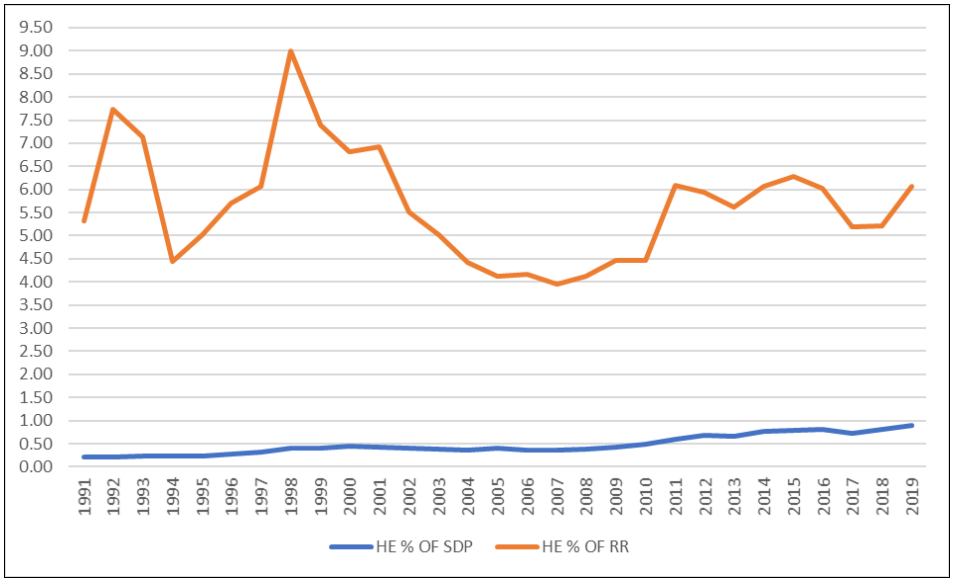
Overall, the data highlights the spending trends for Medical and Public Health under both revenue and capital expenditure categories. The significant increase in revenue expenditure signifies the government's focus on enhancing healthcare and public health services over time. However, the minimal allocation of capital funds indicates that long-term investments in the health sector may not be given as much priority. This raises concerns about the sustainability and development of healthcare infrastructure and services in Punjab.

Chart 1: Percentage Distribution of Public Health Expenditure by Revenue & Capital Expenditure from 1981-2020



Source: EPWRF database, 2022 and Author's calculations.

Chart 2: Percentage share of Health expenditure in SDP and revenue receipts from 1991 to 2019



Source: EPWRF database, 2022 and Author's calculations.

Public health infrastructure in the state

The expansion of public health facilities in Punjab saw significant growth until the mid-1980s, primarily driven by increased central funding to the state's health sector and the state's focus on rural development. However, after that period, the allocation of public funds to the state's health services declined substantially. Despite the surge in patient load due to the increase in non-communicable and communicable diseases, there has been no substantial improvement in the public health infrastructure since the mid-1980s in the state. The implementation of new economic reforms in India in 1991 led to a significant influence of international institutions on the country's health sector. Both the World Bank and the World Health

Organization took the lead in piloting health sector schemes and reforms in India, with a significant focus on promoting private sector initiatives. These reforms emphasized the involvement of non-governmental bodies and alternative organizational structures in the delivery and management of healthcare services. The paradigm shift in health policy that involves cutbacks in public health expenditure and an increased role for the private sector in health care has adversely affected the functioning of primary health centres (PHCs) across Indian states (Qadeer, 2000) [8].

Table 2: Classification of Public Medical Institutions in Punjab by Type of Institutions from 1991 to 2019

Year	Rural Area					Urban Area					Total
	Hospitals	**PHCs**	**Disp.**	**Others**	**Total**	**Hospitals**	**PHCs**	**Disp.**	**Others**	**Total**	**Total**
1991	88	419	1249	43	1799	131	23	224	27	405	2204
1992	79	418	1237	66	1800	126	16	237	38	417	2217
1993	73	422	1220	60	1775	132	24	242	44	442	2217
1994	73	422	1220	60	1775	135	24	242	44	445	2220
1995	73	422	1220	60	1775	135	24	242	44	445	2220
1996	73	422	1220	60	1775	135	24	250	44	453	2228
1997	73	422	1220	61	1776	135	24	250	44	453	2229
1998	73	421	1220	62	1776	135	24	249	45	453	2229
1999	72	418	1217	69	1776	135	22	248	48	453	2229
2000	72	418	1217	69	1776	135	22	248	48	453	2229
2001	72	418	1217	69	1776	134	22	248	48	453	2229
2002	73	416	1223	64	1776	147	25	259	39	470	2246
2003	73	416	1221	64	1774	146	25	258	39	468	2242
2004	73	416	1221	64	1774	146	25	258	39	468	2242
2005	73	416	1221	64	1774	146	25	258	39	468	2242
2006	73	416	1214	68	1771	146	25	239	44	454	2225
2007	73	416	1207	68	1764	146	25	247	46	464	2228
2008	73	416	1207	68	1764	146	25	247	46	464	2228
2009	46	383	1207	77	1713	92	12	208	52	364	2077
2010	3	423	1207	77	1710	89	23	207	52	371	2081
2011	3	423	1207	95	1707	88	21	207	54	370	2077
2012	6	412	1207	94	1717	93	16	224	57	390	2107
2013	6	412	1205	90	1713	92	15	233	60	400	2113
2014	6	412	1205	90	1713	92	15	235	60	402	2115
2015	6	412	1205	90	1713	92	15	235	60	402	2115
2016	6	412	1205	90	1713	92	15	235	60	402	2115
2017	6	412	1205	90	1713	92	79	185	63	419	2132
2018	6	416	1203	88	1713	92	79	185	63	419	2132
2019	6	416	2967	89	3478	93	115	173	63	444	3922
CAGR											
1991-2019	-8.84	-0.02	3.02	2.54	2.29	-1.17	5.70	-0.88	2.96	0.31	2.00
1991-2000	-2.21	-0.03	-0.29	5.4	-0.14	0.33	-0.49	1.14	6.6	1.25	0.13
2001-2010	-29.75	0.13	-0.09	1.23	-0.42	-4.44	0.5	-1.99	0.89	-2.19	-0.76
2010-2019	9.05	-0.21	11.9	-0.81	9.3	0.69	23.68	-2.22	1.95	2.31	8.27

Note: Others refer to community health center (CHC)
Source: Statistical Abstract of Punjab, Various Issues.

Table 2 provides data on the classification of public medical institutions in Punjab, India, based on the type of institutions (Hospitals, Primary Health Centres (PHCs), Dispensaries, and Others) from the years 1991 to 2019. The data is further divided into rural and urban areas, along with the total number of each type of institution. In 1991, there were 88 hospitals, 419 PHCs, 1249 dispensaries, and 43 other medical institutions in rural areas. In the same year, there were 131 hospitals, 23 PHCs, 224 dispensaries, and 27 other medical institutions in urban areas, resulting in a total of 2204 medical institutions for Punjab. Although the total number of medical institutions in Punjab increased from 2204 in 1991 to 3922 in 2019, this rise was primarily due to an increase in the number of dispensaries in rural areas. It is evident from the compound annual growth rate (CAGR) of medical institutions from 1991 to 2019 that the absolute number of hospitals, both in rural and urban areas, has declined over the years. Moreover, the highest decline in the number of hospitals in rural areas was registered in the decade of 2001-2010. Surprisingly, the CAGR of rural dispensaries from 1991 to 2019 was 3.02%, indicating a positive growth trend in the number of rural dispensaries over the years. On the other hand, the CAGR for urban areas during the same period was -0.88%, signifying a decline in the number of urban dispensaries over the same timeframe.

Increasing incidence of non-communicable/ communicable diseases in Punjab

Table 3 shows the number of institutional cases of indoor patients due to non-communicable and communicable diseases in the state of Punjab for the years 1991, 1995, 2000, 2005, 2010, and 2015. The diseases are categorized into two main groups: Communicable Diseases (Infectious and Parasitic Diseases) and Non-Communicable Diseases (all other diseases listed in the table). The number of indoor patients due to infectious and parasitic diseases in Punjab has fluctuated over the years. The highest number of cases was observed in 1995 with 68253 patients, while lowest

number of cases was observed in 2005 with 35567. The highest number of cases of neo plasms was observed in 2000 with 12658 patients. However, the cases of neo plasms have decreased to 6442 in 2015. Similarly, the number of cases of diseases of blood has increased to three times in 2015 as compared to their number in 1991. However, the number of diseases of nervous system has decreased in 2015 as compared to 1991. The number of indoor patients with pregnancy-related complications has increased to 123958 in 2015 from 84724 in 1991. In 2015, there were 28382 cases of skin related diseases, which increased from 5998 cases in 1991. The number of indoor patients with unspecified diseases has increased to 91929 in 2015 from 51802 in 2010. Overall, the total number of indoor patients due to non-communicable and communicable diseases in Punjab has increased over the years. In 2015, there were 770496 cases, which increased from 621985 cases in 2010 and 416637 cases in 2005.

Table 3: Institutional cases of indoor patients due to non-communicable/communicable diseases in Punjab

Parameter/Year	2015	2010	2005	2000	1995	1991
Infectious and Parasitic Diseases	49545	50814	35567	56067	68253	62440
Neo Plasms	6442	5525	4139	12658	8939	9613
Endocrine, Nutritional and Metabolic disease and immunity disorder	13611	17994	10146	10405	10153	10614
Diseases of Blood and Blood forming organs	32911	12615	12603	8890	8550	10921
Mental Disorders	10346	7961	5160	4496	4673	4646
Diseases of Nervous system and Sense organs	4181	5084	3322	23881	30372	29195
Eye and Odnexa	29568	28678	22189	NA	NA	NA
Ear and Mastoid Process	5746	1689	3124	NA	NA	NA
Diseases of the Circulatory System	33309	29698	24623	30167	26358	26478
Diseases of Respiratory System	37546	4807	24352	33478	31992	32680
Diseases of Digestive System	36690	30727	27886	31755	26918	25936
Diseases of Genito Urinary System	34371	34861	27971	34598	29919	26323
Complications of Pregnancy, child-birth and the Puerperium	123958	30494	63039	68601	81969	84724
Diseases of the Skin and Subcutaneous Tissue	28382	8199	4368	3193	3538	5998
Diseases of the Musculoskelctal System and Connective Tissue	4520	5854	3980	5859	4491	5915
Congenital Anomalies	NA	NA	NA	2404	3084	3482
Prenatal period/Certain causes of Prenatal morbidity and mortality	32678	90247	8450	NA	NA	NA
Certain condition, originating in the period	NA	NA	NA	6592	7702	6264
Symptoms, signs and ill-defined conditions	NA	NA	NA	19730	37422	32337
Congential Malformation deromation Chromosomal Abnormalities	870	28368	942	NA	NA	NA
Injury and Poisoning	NA	NA	NA	89595	82128	66134
Abnormal Laboratory and clinical finding	56000	54542	43998	NA	NA	NA
Injury Poisoning and Conseouenus of external Injuries	64764	57763	44049	NA	NA	NA
External cause of Morbidity and Mortality	73129	64263	46729	NA	NA	NA
Others, Unspecified	91929	51802	0	NA	NA	NA
Total	770496	621985	416637	442369	466461	443700

Source: Economic and Statistical Organisation and Director, Health and Family Welfare, Punjab. NA- Not Available

Table 3 shows the institutional cases of outdoor patients due to non-communicable and communicable diseases in Punjab from 1991 to 2015. The cases of infectious and parasitic diseases show fluctuations over the years, with the highest number of cases (1929814) in 1991 and the lowest number (1094120) in 2005. The number of cases of communicable diseases has decreased in 2015 as compared to the cases in 1991 and 1995. The cases of neo plasms also fluctuate but generally show an increasing trend over the years, with 34207 cases in 2015. The number of endocrine, nutritional and metabolic diseases has increased to 472238 in 2015 from 286298 in 1991. Cases of mental disorders increased over time, reaching 249259 in 2015. Diseases of the circulatory System vary over time, with the highest number (966941) in 2010 and the lowest number (279976) in 1991. Diseases of the respiratory system show fluctuations, but there was an increasing trend, with 2312381 cases in 2015. The cases of complications of pregnancy and childbirth was highest in (1498832) 2010 but decreased to 308387 cases in 2015. The diseases of the skin and subcutaneous tissue have increased over the years, with 1559096 cases in 2015. Likewise, the institutional cases of abnormal laboratory and clinical findings has increased to 1537390 in 2015 from 1369518 in 2005. On the whole, the total number of institutional cases of outdoor patients varies over the years, from 11201193 in 2000 to 15224813 in 2015. There was an overall increasing trend in the number of cases of outdoor patients due to non-communicable diseases in Punjab.

Table 4: Institutional cases of outdoor patients due to non-communicable/communicable diseases in Punjab

Parameter/Year	2015	2010	2005	2000	1995	1991
Infectious and Parasitic Diseases	1117807	1189776	1094120	1718079	1851472	1929814
Neo Plasms	34207	27376	18878	78919	67482	23605
Endocrine, Nutritional and Metabolic disease and immunity disorder	472238	945407	311102	233789	211958	286298
Diseases of Blood and Blood forming organs	940843	429920	815132	951547	851606	1038394
Mental Disorders	249259	192064	144326	119148	94656	96017
Diseases of Nervous system and Sense organs	94937	109010	76237	1163226	950812	931729
Eye and Odnexa	1017734	30994	872864	NA	NA	NA
Ear and Mastoid Process	537556	8463	408483	NA	NA	NA

Diseases of the Circulatory System	886605	966941	527584	421532	296467	279976
Diseases of Respiratory System	2312381	453436	2231552	2058691	1791685	2041955
Diseases of Digestive System	1517208	792673	1190492	1234186	1017340	1081916
Diseases of Genito Urinary System	493536	2381700	323530	300069	257839	281788
Complications of Pregnancy, child-birth and the Puerperium	308387	1498832	235525	234903	219136	229895
Diseases of the Skin and Subcutaneous Tissue	1559096	1322770	1202791	939722	846548	1151044
Diseases of the Musculoskelctal System and Connective Tissue	661632	664146	534554	441908	388509	350284
Congenital Anomalies	NA	NA	NA	18028	14358	17929
Prenatal period/Certain causes of Prenatal morbidity and mortality	50950	289603	18071	NA	NA	NA
Certain condition, orginating in the period	NA	NA	NA	22003	28977	19532
Symptoms, signs and illdefined conditions	NA	NA	NA	662624	623781	999020
Congential Malformation deromation Chromosomal Abnormalities	3894	502800	2927	NA	NA	NA
Injury and Poisoning	NA	NA	NA	602819	654580	769689
Abnormal Laboratory and clinical finding	1530390	1587378	1369518	NA	NA	NA
Injury Poisoning and Conseouenus of external Injuries	505736	629781	451780	NA	NA	NA
External cause of Morbidity and Mortality	180284	165226	131006	NA	NA	NA
Others, Unspecified	750133	1481381	77701	NA	NA	NA
Total	15224813	15669677	12038173	11201193	10167206	11528885

Source: Economic and Statistical Organisation and Director, Health and Family Welfare, Punjab.

Conclusion

This study highlights the significance of public spending on healthcare and emphasizes the need for increased budgetary allotment to the health sector. The findings reveal that the majority of the health sector budget is allocated to revenue expenditure, covering recurring expenses like salaries, administrative costs, and maintenance. In contrast, capital expenditure accounts for only about 2% on average. This suggests that the focus has been on immediate expenses rather than long-term investments in healthcare infrastructure and services. The research highlights the importance of increasing the budgetary allotment to the health sector, suggesting a target of 3% of GDP, up from the current 2.5%. It also highlights that public spending on health in India has been dominated by the private sector, raising concerns about the potential impact of economic reforms on public healthcare funding. Global spending on health has shown a significant increase, reaching 9.8% of the global GDP by 2019. This underscores the importance of governments investing more in the health sector to support the well-being and longevity of their populations.

This paper serves as a call to action for the Punjab state government and policymakers across the country to prioritize the health and family welfare sector. By increasing public spending on health, governments can better address healthcare challenges, enhance access to quality medical services, and contribute to the attainment of national and global health goals. The study also discusses the state of public health infrastructure in Punjab, noting that there has been no substantial improvement since the mid-1980s. The declining public health infrastructure, on one hand, and the increasing patient load due to the prevalence of non-communicable diseases, on the other hand, have created room for the rapid growth of private healthcare infrastructure in the healthcare sector of Punjab. The government should prioritize increasing funding and investment in public healthcare infrastructure to improve facilities and accessibility. This could include building new hospitals, upgrading existing ones, and ensuring the availability of necessary medical equipment and personnel. Implementing comprehensive health insurance schemes and social support programs can help reduce the out-of-pocket expenditure for healthcare and provide financial assistance to those in need. Overall, the research emphasizes the significance of public expenditure on health and family welfare, urging policymakers to allocate more funds to the health sector to improve healthcare access and outcomes for the population.

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