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Health Satellite Account, 2017–18, Himachal Pradesh

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Health Satellite Account, 2017–18 Himachal Pradesh

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Foreword

Health expenditure is one of the two significant social expenditures, other being education, for an economy. In India, public expenditure on health is incurred by central government as well as state and local governments, with state being the primary provider of both finances and healthcare facilities. Additionally, households end up spending a notable amount on direct healthcare expenditure and also on indirect expenditure such as payments towards health insurance schemes. A combination of the two - public and private expenditure - presents the financial status of the health sector in the state economies.

In this context, Health Satellite Account assumes great significance as it provides the information on financial flows related to healthcare in a systematic framework. This framework, based on the internationally accepted System of Health Accounts (SHA-2011), provides a standard for classifying health expenditures according to consumption, provisions and financing. To be specific, the HSA presents the health expenditure (public and private) by four different classifications, namely, sources of finance, financing schemes, healthcare functions and providers of healthcare facilities.

The present study, undertaken by the National Council of Applied Economic Research (NCAER), uses the methodological framework of the SHA-2011 to prepare the first Health Satellite Account for the state of Himachal Pradesh. This study also draws its methodology from the National Health Accounts–Guidelines for India, 2016, prepared by the Ministry of Health and Family Welfare, Government of India.

I take this opportunity to thank Mr Prabodh Saxena, IAS, Additional Chief Secretary (Finance, Personnel, Planning, Economic and Statistics) and Mr Akshay Sood, IAS, Secretary (Finance, Planning, Economics & Statistics, Cooperation, Housing), Government of Himachal Pradesh for initiating this important study. In the same vein, I express my gratitude to Dr Vinod Rana, Economic Adviser, Department of Economics and Statistics, Government of Himachal Pradesh, for the valuable insights and constant cooperation he offered to the NCAER team through the course of the study. I also wish to thank Dr B.B. Katoch, Director and Mr Mohinder Kumar, Assistant Director, Department of Health and Family Welfare, Government of Himachal Pradesh for their useful inputs and suggestions. Besides, on behalf of the NCAER team, I wish to thank all the officials of Department of Economics and Statistics, Shimla and its district offices for actively participating in the Capacity Building sessions organised by NCAER as part of the study. The report benefitted immensely from their important inputs.

I express my gratitude to all the members of the NCAER study team, including Dr Poonam Munjal, Team Leader; Dr Palash Baruah, Senior Research Analyst; Ms Elizabeth Lyn, Mr Animesh Sharma and Mr Rahat Hasan Khan, Research Analysts, for their efforts in

completing the study amidst the challenge of the pandemic in the country. I hope that the study will provide useful insights to the policy makers in the health sector and will also prove to be a useful contribution to the literature on health for the State of Himachal Pradesh, in particular, and the country, as a whole.

New Delhi
September 2021

Dr. Poonam Gupta
Director General, NCAER

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Executive Summary

I. Introduction

According to the World Health Organization (WHO), health is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The role of health as an engine of economic growth is not entirely unsubstantiated, as an investment in health care leads to better, healthier lives for the populace, which in turn, increases productivity, and creates an efficient workforce, thereby significantly adding to the social and economic progress of any country.

Universal health care has also been stressed by the UN under its Sustainable Development goal#3 which states "Ensure healthy lives and promote wellbeing for all at all ages" by 2030. The health sector includes a very diverse set of activities that not only includes services that detect diseases but also its prevention and awareness. The health sector thus in India due to its overlapping features, function, and objectives is quite vast and provides a rich source of revenue as well as employment generation for the economy. Heath Satellite Account, conceptualised by the WHO, is a globally recognized framework to measure health expenditure and the flow of funds in the country's health sector.

Health Satellite Account helps in making explicit, the implicit data in this area, thereby aiding policymakers in analysis and/or decision making in the health sector. This report presents the first ever Health Satellite Account for the state of Himachal Pradesh.

II. State Profile

As per the 2011 Census, the total population of Himachal Pradesh is 68,64,602, including 34,81,873 males and 33,82,729 females. Almost 90 per cent of the State's population lives in rural areas. The sex ratio, as per the Census, stood at 972 females per 1000 males, higher than the national average of 943 females per 1000 males, showing an increase from 896 in the 2001 Census. According to the latest annual Employment-Unemployment Survey, the "Periodic Labour Force Survey (PLFS)", conducted by NSSO during 2017-18, in the rural areas 45.2 per cent, 68.5 per cent, and 63.5 per cent of the total population within the age group of 15-29 years, 15-59 years, and 15 years and above, respectively, are either currently employed or are seeking employment. The corresponding figures for the urban areas are estimated to be 44.4 per cent, 56.2 per cent, and 52.9 per cent, respectively.

The State's economic growth, in terms of the year-on-year growth in Gross State Domestic Product (GSDP), has been faster than the national growth for most of the years since the inception

of the new GDP series, that is, 2011-12 (Central Statistics Office, Ministry of Statistics and Programme Implementation). The GSDP growth for 2019-20 is 4.9 per cent, higher than the national growth of 4.0 per cent. In 2020-21, when India's GDP suffered a loss of 8.0 per cent resulting from the pandemic and several lockdown restrictions, the State's GSDP fell by a comparatively lower rate of 6.2 per cent.

The State has a road network of 28,208 km, including eight National Highways (NH) accounting for a total road length of 1,234 km and 19 state highways with the total length of 1,625 km. Some roads are, however, closed during the winter and monsoon seasons due to snow and landslides. There are three domestic airports in the State, namely the Gaggal airport in Kangra district, Bhuntar airport in Kullu district, and Shimla airport in Shimla district.

Himachal Pradesh has reflected rapid improvement and taken rapid strides in its health care with its life expectancy index exceeding the all India average and has performed exceedingly well on other health indicators of fertility and immunization while lagging on some indicators with a wide variety of inter-district variations.

Some of the key health related characteristics of the state are as follows:

- Himachal Pradesh has performed consistently well in promoting the health advances in the state with the state's life expectancy at birth of 72.6 years exceeding the All India average of 69 years in 2013-17 by over 3 years.

- According to the National Family Health Survey (NFHS-4, 2015-16) data, the total fertility rate in Himachal Pradesh witnessed a sharp decline from 3.0 to 1.9 between 1992-93 and 2005-06, which remained unchanged for another one decade, till 2015-16 and further decline to 1.7 in 2019-20.

- Himachal Pradesh is among a few states that despite having a 90 per cent rural population has no shortfalls of PHCs, CHCs, and sub-centres that provide the most essential primary health care to the general populace. The state has 91 community health centres, 576 primary health centres, and 2084 sub-centres which reflect the capability of the state in providing primary health care in the scarcely populated state

- There are about 8.39 PHCs in the state per lakh population which exceeds the norm of one PHC per 20,000 populations in hilly or tribal regions (HP HDR Report, 2002).

- In Himachal Pradesh, 88.2 per cent of the deliveries are carried out in institutional centres which paint a favourable picture for maternal health and child health in the state. In 6 out of 12 districts, the proportion of institutional deliveries exceeding the state average

- With regard to immunization, about 89.3 per cent children in the age group of 12-23 months had received basic immunization against six major childhood illnesses (tuberculosis, diphtheria, pertussis, tetanus, polio, and measles), as per NFHS, 2019-20.

III. Public Health Expenditure

- Total public health expenditure constitutes of the revenue and capital accounts. Most of the expenditure is incurred on revenue account, which comprised of around 89 percent of the total health expenditure.
- Maximum allocation of revenue account is towards state Medical Education, Training and Research,, which accounts for 33 percent of total current expenditure of Department of Health and Family Welfare (DoHFW)

III.1. Public Health Current Expenditure by Healthcare Financing Schemes

- Of the total public health expenditure of Rs. 1461.8 crore, state government's share is the highest, at 71.1 percent, during 2017-18.
- The Union government contributed 20 per cent and the Local government accounted for just 1.9 per cent.
- The share of government based voluntary insurance schemes in total public expenditure stood at 6.8 per cent.
- The share of Social health insurance, comprising of Employees State Insurance schemes, in total public expenditure stood at 0.2 per cent.

III.2. Public Health Current Expenditure by Revenues of Financing Schemes

- Of the total public health expenditure of Rs. 1461.8 crore, most of the revenue is sourced from the state government's Internal Transfers and Grants, which accounts for 74.8 percent of total expenditure.
- This is followed by transfers from Union government on 100 percent centrally sponsored schemes like National AIDS Control Programme, Prevention and Control of Blindness, Family Welfare Centres in Rural and Urban areas; or 90 percent centrally sponsored schemes like National Rural Health Mission, 10 percent of which is allocated under state government transfers.
- Besides these, there are government-sponsored insurance schemes which are other sources of revenue . These are the Himachal Pradesh Universal Health Protection Scheme (HPUHPS), Rashtriya Swasthya Bima Yojna (RSBY), and centrally sponsored National Health Insurance Schemes. Based on the scheme guidelines, the expenditure incurred on

these schemes are allocated to Internal Transfers of Union government, state government, and voluntary prepayment by individuals or households towards these government insurance schemes. The expenditure is equally divided among these source categories if the breakup is not available.

- Hence derived value of voluntary prepayment by individuals/households is estimated to be 2.4 percent of total public health expenditure.
- Another important source of revenue for Public health expenditure in the state of Himachal Pradesh is Social Insurance contributions. These have a financing arrangement that ensures access to health care based on payment of non-risk payment by on or behalf of eligible persons. These contributions are mostly wage-related and are shared between employers and employees and by the government. Social health insurance contributions include payments made through the employment state insurance scheme implemented by the employment state insurance corporation. Thus, the share of social insurance contributions accounted for a negligible share of 0.1 per cent of the total public health expenditure.

III.3. Public Health Current Expenditure by Healthcare Functions

- Inpatient curative care has the highest share in public health spending, accounting for 35.9 per cent. Outpatient care (16.1 per cent) accounted for the second-highest public expenditure in the state, further followed by Governance and Health system and Finance Administration (14.3 per cent).
- The Reporting Item, "Traditional, Complementary and Alternative Medicines" contributed to 12.7 per cent of total public expenditure while the "Total pharmaceutical expenditure" accounted for 8.1 per cent of total public spending.
- Importantly, the Other health care services n.e.c accounted for 13.4 per cent of the total public health expenditure followed by preventive care (12 per cent) and medical goods (7.5 per cent).
- Ancillary services accounted for 0.7 per cent of total public expenditure.

III.4. Public Health Current Expenditure by Healthcare Providers

- The highest public spending was incurred on General hospitals that accounted for about 38.8 per cent of total public expenditure.
- Other health care providers, which include health providers within boundaries of autonomous universities, research institutions, and international organizations, accounted for about 25.6 per cent of total public expenditure.
- Ambulatory health care centres, which include establishments that provide a wide range of outpatient services accounted for 15.7 per cent of total public health expenditure followed closely by providers of health care system administration and financing that received an allocation of 11.2 per cent of total public expenditure.

- Total public expenditure on specialised hospitals accounted for 4.2 per cent followed by other government health care practitioners (2.5 per cent), providers of preventive care (0.7 per cent) and provider of ancillary services (0.7 percent).
- Retailers and providers of medical goods are estimated to have a share of 0.3 per cent of the total public expenditure. Also Government mental hospitals had a share of 0.1 per cent of total public expenditure in the state.

III.5. Total Public Health Expenditure by Factors of Provision

- In terms of Public health expenditure by Factors of provision, employee remuneration (comprising of wages and salaries, social contribution, and other allowances or other costs related to employees) emerged as the largest input in health care service provisioning in Himachal Pradesh accounting for a total of 67.4 per cent of total public health expenditure.
- Among the constituents of staff remuneration, salaries account for 66.3 percent of total public health expenditure, social contributions being 1.1 per cent, and other costs related to employees accounting for 0.01 per cent.
- Fixed capital accounts account for the second-largest share after wages and salary at about 14.4 per cent of total public health expenditure. This includes capital expenditure for the creation of assets and major works involving construction and expansion.
- Non-Health care services account for 11.3 per cent of the total public health expenditure. Non-healthcare services include office expenses, maintenance of vehicles, payment for consultancy, publication, advertisement, guest expenses, food expenses, etc.
- Health care goods, like hospital equipment, medicine, and chemicals, materials, and supplies, etc. constitute only 2.7 percent of total public health expenditure. Health care services constitute just 1.6 percent of total public health expenditure followed by other items of spending which account for 1.2 per cent of total public spending
- Non-health care goods contributed to 0.8 per cent of the total public health expenditure. This factor of provision includes general goods used for health care production not specifically related to health care. Examples-Office supplies, kitchen supplies, transport, electricity, water, etc.

IV. Private Health Expenditure

IV.1. Private Health Current Expenditure by Healthcare Financing Schemes

- The total value of private health expenditure incurred by the households as their out-of-pocket expenditure is estimated at Rs. 2252.7 crore. This is households' direct payment for healthcare goods and services.

- Other primary coverage schemes or households' prepayment for health insurance schemes and premiums amounts to Rs. 16.4 crore, as per state-wise data on the premium paid, published by IRDA.
- Of the total private health expenditure of Rs. 2269.2 crore in Himachal Pradesh for 2017-18, 99.3 percent is on account of OOPE, or the direct payment by households. The remaining 0.7 percent is spent indirectly through health insurance policy premiums.
- Of the total Private Final Consumption Expenditure of the state, estimated at Rs. 70,209 crore, the expenditure on healthcare goods and services is 3.23 percent.

IV.2. *Private Health Current Expenditure by Healthcare Functions*

- Outpatient curative care has the highest share of total private spending accounting for 58.9 per cent of total private expenditure followed closely by Inpatient curative care that accounted for 27.9 per cent of total private health expenditure.
- Expenditure on medical goods has a share of 2.2 per cent of the total private expenditure. Ancillary services captured 8.8 per cent of the total private spending.
- Preventive care services accounted for 1.8 per cent of total private spending while home-based curative care has a share of 0.02 per cent of total private expenditure. Another important health care provider was governance and health system and financing administration that had a share of 0.4 per cent in the total private expenditure.
- The reporting item, TPE, constitutes 90.2 per cent of total private health expenditure. TCAM constitutes 89.5 percent of the same.

IV.3. Private Health Current Expenditure by Healthcare Providers

- Of the total private health expenditure of Rs. 2269.2 crore, Retailers and other providers of medical goods constitute the largest share of 68.3 per cent, followed by Providers of ancillary services with a share of 17.7 per cent. Providers of ancillary services include laboratory and imaging services, patient's transportation, part of pre-natal and post-natal care.
- Private Hospitals account for about 8.3 per cent of total private spending while 4.6 per cent of total private expenditure is spent on Public hospitals
- Each of the remaining healthcare providers accounts for less than 3 percent of total private health expenditure, together constituting about 1.2 percent only. These include Offices of general medical practitioners-Private (with the share of 0.5 per cent), Public and Private Specialized hospitals (0.1 per cent each), Governance and health system and finance administration (0.1 percent), providers of preventive care (0.2 per cent), and other health care providers (0.04 per cent).

V. Total Health Expenditure

- The state's total health expenditure is estimated at Rs. 4351.9 crore, of which public expenditure constitutes 47.9 percent and private households (comprising out-of-pocket expenditure and voluntary prepayments for insurance schemes) account for the remaining 52.1 percent. The higher the proportion of public expenditure, the lesser is the dependence on household out-of-pocket expenditure. At the same time, the higher the proportion of private expenditure, the higher is the extent of financial protection available for households towards healthcare payments.
- Total current health expenditure, Rs. 3731.0 crore refers to only recurrent expenditure on healthcare, net of all capital expenditure. This indicates the operational expenditure which impacts the health outcome of the state. The current health expenditure works out to be 85.7 percent of the total health expenditure of the state.

- Public Health insurance expenditure refers to the finances allocated by the government towards payment of premiums for health insurance schemes or reimbursements of government employees' health expenditure. At, Rs. 102.3 crore, public health insurance expenditure is just 2.4 percent of total health expenditure.
- On the contrary, private health insurance expenditure is much lower at 0.4 percent of total health expenditure. This indicates the lower intent of households to opt for voluntary prepayment plans.
- Of the total general government expenditure for the year 2017-18, at Rs. 34811.21 crore, expenditure on healthcare stood at 5.98 percent.
- Public expenditure on AYUSH (Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy) or TCAM (Traditional complementary and alternative medicine) is 8.90 percent of the total public expenditure.
- The percentage distribution of Total Health Expenditure by Healthcare Financing Schemes reveals that 60.4 percent of the total expenditure is on account of households' out-of-pocket expenditure. State government schemes constitute another 27.8 percent while union government schemes account for 7.9 percent of the total health expenditure in the state.
- The percentage distribution of Total Health Expenditure by Revenues of Healthcare Financing Schemes reveals that 60.4 percent of the total expenditure is on account of revenues from households. The state government's share is 29.3 percent and the union government spends about 8.2 percent through various grants and schemes.
- Further, the percentage distribution of Total Health Expenditure by Healthcare Functions, shows that 31 percent of total health expenditure is incurred on in-patient curative care, while 42.1 percent is incurred on out-patient curative care. Preventive care accounts for 5.8 percent. Total expenditure on pharmaceuticals, primarily referring to over-the-counter expenses, accounts for 4.3 percent of total health expenditure, and close to 60 percent of the total expenditure is incurred on non-allopathic or TCAM treatment
- Lastly, the percentage distribution of Total Health Expenditure by Healthcare Providers, shows that the largest healthcare provider receiving healthcare revenues is "Retailers and

other providers of medical goods". These account for 41.6 percent of total expenditure. General public hospitals account for 17.4 percent while general private hospitals account for about 5.6 percent.

I. Introduction

I.1. Context of the Study

"The Ultimate resource in economic development is People. It is people, not Capital or Raw materials that develop an economy" – by Peter Drucker

Health is described as the 'real wealth' of human beings and the enjoyment of highest attainable standards of health is one of the most fundamental rights of any human being without any distinction on the basis of race, gender, religion, political beliefs, economic or social condition. Universal health care has also been stressed by the UN under its Sustainable Development Goal number 3 which states "Ensure healthy lives and promote wellbeing for all at all ages" by 2030.

According to the World Health Organization, health is defined as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."* The role of health as an engine of economic growth is not entirely unsubstantiated as an investment in health care leads to better, healthier lives for the populace. This in turn increases productivity, and creates an efficient workforce thus significantly adding to the social and economic progress of any country.

The health sector includes a very diverse set of activities that not only includes services that detect diseases but also its prevention and awareness. The health sector thus in India due to its overlapping features, function, and objectives is quite vast and provides a rich source of revenue as well as employment generation for the economy. The need to raise additional public resources for expanding insurance coverage, improving the efficiency of spending, and ensuring the effective performance and sustainability of health systems, among others requires preparation of a good database that can help the government for optimum utilization of resources on health, identifying resource gaps and potential areas for capturing efficiency in resource mobilization. Heath Satellite Account, conceptualised by the WHO, is a globally recognized framework to measure health expenditure and the flow of funds in the country's health sector.

Realising the importance of the Health sector in the economy, the Government of Himachal Pradesh has decided to prepare its first Health Satellite Account.

I.2. Health Satellite Account

Health Satellite Account is a new concept for India and is not common in an international context as well. It helps in making explicit, the implicit data in this area, thereby aiding policymakers in analysis and/or decision making in the health sector. The review of literature shows that in the

past two Health Accounts have been prepared at national level and a few at state level for states like Tamil Nadu and Punjab. Internationally, the Healthcare Satellite Accounts are sporadically available for the US and a few EU countries.

To systemise the information on financial flows related to health care, OECD published its first System of Health Accounts (SHA 1.0) in 2000. Following this, based on many revisions, SHA 2011 was laid out to provide a standard for classifying health expenditures according to consumption, provisions, and financing.

The World Health Organisation (WHO) and the Pan American Health Organisation (PAHO) prepared the first Manual on Health Satellite Accounts in 2005. The primary aim of the HSA is to broadcast/inform public policies and decision making on programmes and projects related to the health sector and link the health branch to macroeconomic growth and development in the economy.

According to the first version of the PAHO's Manual, the principal characteristics of the SHA are given in Figure.I.1.

Figure I.1: Characteristics of Health Accounts

It provides additional information on the health sector, for example, tables showing expenditure by financing units and users/beneficiaries.
It uses more detailed concepts, classifications, and tables related to health, that are complementary or alternative to those in the SNA, for example by including ancillary units, changing the coverage of the sector, or disaggregating products, among others.
It extends and details the coverage of production, costs, and benefits of human health activities, for example by including volunteer work and domestic work related to the care of patients within a household.
It extends data analysis through the use of specific aggregates and indicators and facilitates analysis of the health sector in the context of the global economy, considering, for , the share of the health sector in the economy (percentage of GDP), and health expenditure per capita, among others.
It enhances the analysis of monetary data by including physical data, such as the number of beds, number of outpatient consultations, and number of surgical interventions, among others.

Source: PAHO first Manual on Health Satellite Account, 2005.

I.3. Objectives of the Study

The broad objective is to prepare the Health Satellite Account for Himachal Pradesh for the year 2017-18 and to develop the capacity of the DES officials for the preparation of the Health Satellite Account of the state. The other objectives of the study are as follows:

a. Functional classification of health care system prevailing in the state.
b. An analysis of health care provider units functioning in the state.

c. Information on expenditure on health care through different sources of finance.
d. Information about the funding of health care through different sources.
e. Derive health indicators such as share of health expenditure to GSDP, per capita expenditure etc.

I.4. Experiences of Other Countries

Some countries that have produced health accounts are listed in Table I.1.

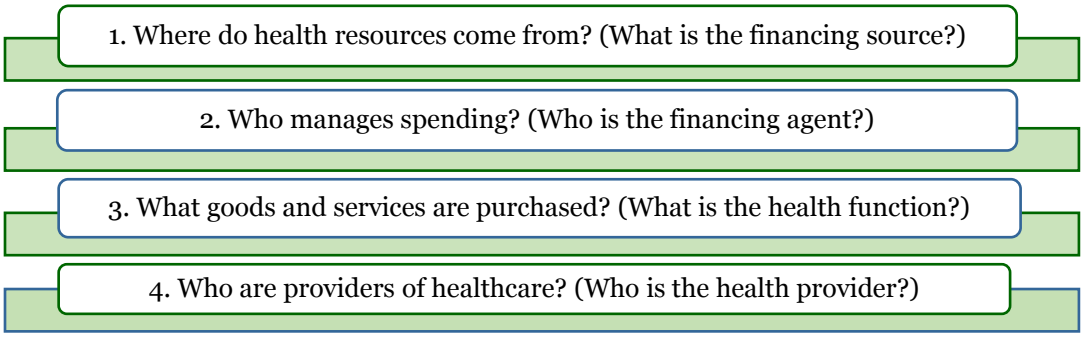
Table I. 1: List of countries which have Health Accounts

Countries					
1. Benin	8. Liberia	15. Zambia	22. Vietnam	29. Egypt	36. Lebanon
2. Georgia	9. Mali	16. India	23. Mexico	30. Australia	37. St Kitts & Nevis
3. Bhutan	10. Namibia	17. Thailand	24. Peru	31. Lao	38. Afghanistan
4. Kenya	11. Niger	18. Indonesia	25. Barbados	32. Turkey	39. Philippines
5. Ethiopia	12. Rwanda	19. Malaysia	26. Dominica	33. United States	40.Bangladesh
6. Malawi	13. Tanzania	20. Botswana	27. Jordan	34. Sri Lanka	41. Seychelles
7. Portugal	14. South Africa	21. Burkina Faso	28.Democratic Republic of Congo	35. United Arab Emirates	42. Republic of Korea (South Korea)

Source: NCAER Research.

Health accounts preparation is much more regularly pursued than the education accounts and many countries have taken steps to document their health care expenditure either consistently (in 1 to 3 years) or at least every four years. According to USAID, almost 41 countries have produced Health Accounts regularly while 79 countries have prepared these accounts every 4 years.

Health care expenditure data can be dated back to the 1950-1970s when the Organization for Economic Co-operation and Development (OECD) countries regularly began estimating their private and public health expenditures (e.g. France & Netherlands). In more recent years, there have been two efforts that have been done to systemize the collection of information on financial flows related to health care. SHA-1.0 was prepared by the OECD in 2000 that includes the international classification of health accounts and the combined efforts of WHO, USAID and the World Bank in 2003 that led to the publication of the *NHA producers' guide*. Building on SHA 2000, the OECD worked with the World Health Organization (WHO) and Eurostat to publish a system of health accounts, 2011 edition (SHA 2011). The SHA framework is the most widely-used reference for health expenditure accounting. Health Accounts classify health expenditure by addressing four basic questions namely:



The process for India to institutionalize National Health Accounts was envisaged in National Health Policy, 2002, and the National Health Accounts Cell (NHA Cell) was established in the Ministry of Health and Family Welfare, Government of India. NHA Cell produced health accounts estimates for FY 2001-02 and FY 2004-05. NHA team has until 2016 conducted three rounds of national health account estimates following the SHA 2011 methodology in 2013-14, 2014-15, and 2015-16 and plans to consistently generate these accounts. These accounts are defined within the framework of National Health Accounts Guidelines for India, 2016 (with refinements where required) and adhere to System of Health Accounts 2011 (SHA 2011).

I.5. AYUSH Policy, 2019

The vision statement of the proposed policy is "To establish a strong and well-designed network of AYUSH services in the state providing easily accessible, affordable and equitable healthcare delivery system to the general population and to set up a benchmark of all the best AYUSH practices in the nation by promoting highest standards of AYUSH education, research and treatment, and public outreach of AYUSH interventions and endeavouring to ensure significant sector contribution to the state's economy by 2025".

Policy objectives

- To provide cost effective AYUSH services with universal access through upgrading AYUSH hospitals and dispensaries, so that AYUSH system of medicine becomes the preferred choice of treatment in primary health care. It is envisioned to increase penetration of Ayurveda Health care by providing one AHC for a population of 2000.
- To strengthen and upgrade the secondary and tertiary level of healthcare in AYUSH system of medicine.
- To carry out effective research and evaluation in the system so as to introduce evidence based medicine and standardisation of treatment modalities besides providing a world class treatment facility in Ayurveda to the people of the state and the country as a whole.
- To strengthen the various AYUSH educational institutes so as to improve the quality of Ayurvedic education.
- To improve the quality of ASU & H drugs by introducing an effective ASU & H drug control mechanism enabling an uninterrupted perennial medicine supply to all the health

institutions under the system by utilizing and maximising the potential of three Government Ayurvedic Pharmacies.

- To support cultivation of medical plants by adopting good agricultural practices so as to provide sustained supply of raw materials.
- To develop strong alliance with other departments for the sustainable growth and development of the department.
- To promote E-governance by introducing complete office automation, MIS in the directorate and all sub-offices to introduce online licensing and formulation approval system of ASU & H drugs.
- Implementation "Ayushman Bharat" w.r.t. AYUSH by incorporating AYUSH system of medicine in Welness Centers and utilising the preventive aspect of treatment as a public good.
- To promote Himachal Pradesh as preferred AYUSH destination.

I.6. Structure of the Report

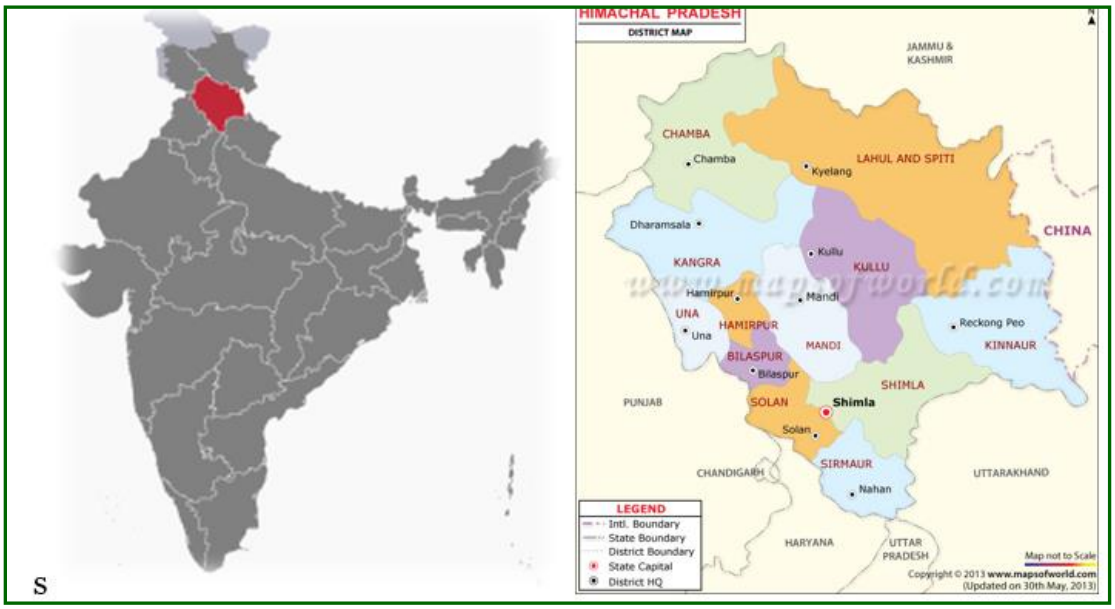
The report is structured as follows. This chapter presented the context of the study, brief note on Health Satellite Account, its relevance to the policy makers, broad objectives of the study, literature review and State Ayush Policy. Chapter 2 provides the demographic, economic and infrastructural profile of the state. Chapter 3 gives the state health profile covering the basic health characteristics and also the physical health infrastructure in the state. Chapter 4 provides the methodological details of HSA, along with some key findings from the primary as well as secondary data sources. Chapter 5 presents the HSA tables and accounts in detail. The concluding chapter summarises the key results of the HSA, including the contribution of health to the economy.

II. Himachal Pradesh: The Land of Snowy Mountains

The State of Himachal Pradesh has derived its name from the great Himalayan Ranges and is also known as the "Land of Snowy Mountains." Himachal Pradesh is home to scenic mountain towns and resorts situated in the northern part of India among the western Himalayas. Host to the Dalai Lama, this snow-laden province has a strong Tibetan presence, which can be prominently seen in the Tibetan New Year celebrations.

Himachal Pradesh was made a full-fledged State on 25 January 1971. The State is bounded by Jammu & Kashmir to the North, Punjab to the West, Haryana to the South, Uttarakhand to the South-east, and by the Tibet Autonomous Region of China to the East (Figure II.1). Its diverse geographical terrain features lofty snow-clad mountains, deep gorges, thickly forested valleys, large lakes, terraced fields, and cascading streams. The capital of the State is Shimla.

Figure II.1: Map of Himachal Pradesh



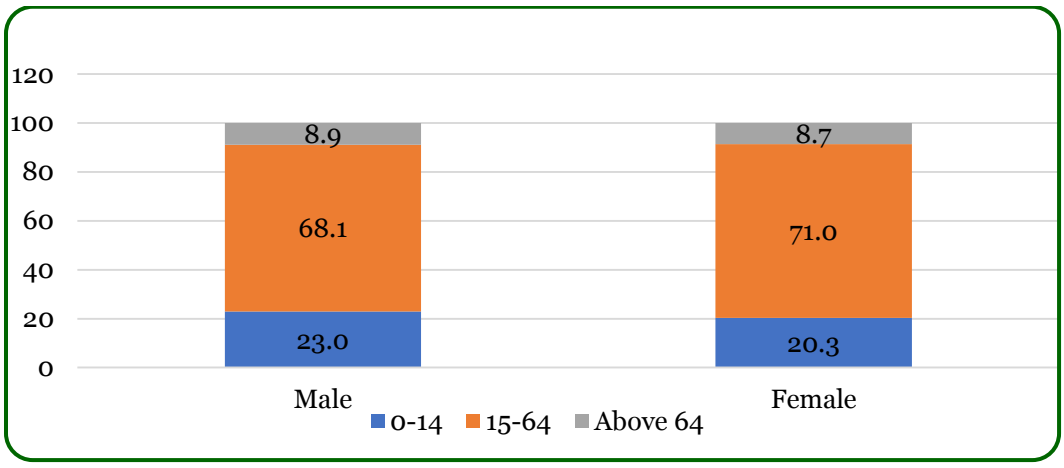
Source: *District map of Himachal Pradesh (mapsofindia.com).*

II.1. Demographic Profile

As per the 2011 Census, the total population of Himachal Pradesh is 68,64,602, including 34,81,873 males and 33,82,729 females. Almost 90 per cent of the State's population lives in rural areas. The sex ratio, as per the Census, stood at 972 females per 1000 males, higher than the national average of 943 females per 1000 males, showing an increase from 896 in the 2001 Census.
The population density of the State is 123 per sq. km, which is lower than the national average of 368 per sq. km., placing the State at the 21st position on the population chart. The literacy rate of the State population is 82.8 per cent, with 89.53 percent for males and 75.93 per cent for females.

More recent data on the demographical details of the State may be obtained from the survey conducted by NSSO during 2017-18 on "Household Social Consumption: Education and Health". Figure II.2 illustrates the distribution of the State's population by broad age group and gender, for the year 2017-18. The proportion of young people in the age group of 0-14 years is estimated at 23.0 per cent for males, and 20.3 per cent for females. About 68 per cent of the total male population falls in the age group of 15-64 years, whereas only 9 per cent fall in the age group of above 64 years. The proportion of people aged 15-64 years, among the female population, is slightly higher, at 71.0 per cent, than the corresponding figure for the male population.

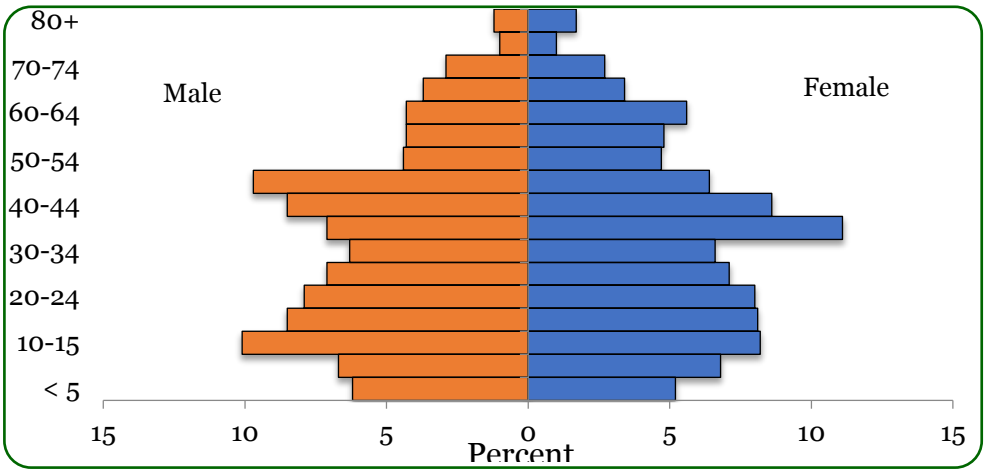
Figure II.2: Distribution of Population by Broad Age Category and Gender (%)



Source: *"Household Social Consumption: Education", NSSO, 2017-18.*

Figure II.3 depicts the age structure of the State population presented in the form of a population pyramid for the year 2017-18. An examination of this population pyramid reveals a noticeable larger young male population (aged 0-29 years) as compared to the female population in the same age group. On the other hand, an analysis of the older population (aged 45 years and above) indicates that the female population is found to be larger than the male population in the same age group.

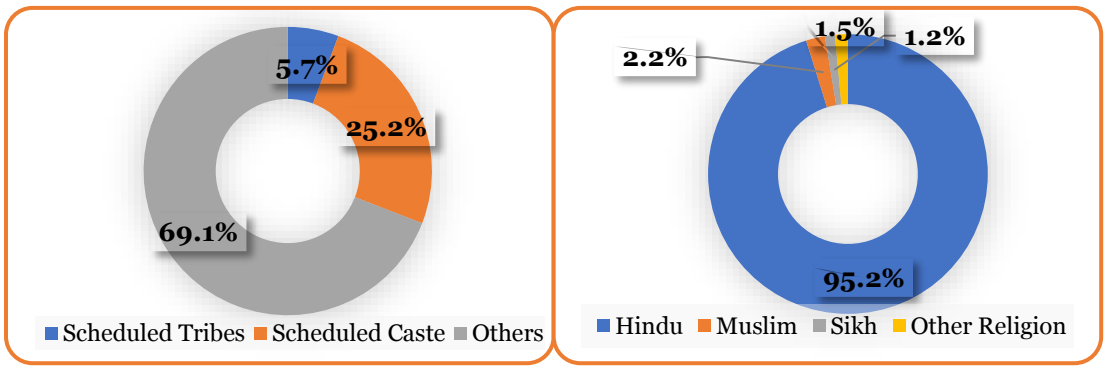
Figure II.3: Population Pyramid (%)



Source: "Household Social Consumption: Education", NSSO, 2017-18.

Figure II.4 shows the percentage distribution of the population by social group and religion. As per the 2011 Census, the Scheduled Tribes (STs) and Scheduled Castes (SCs) constitute 6 per cent and 25 per cent of the population, respectively, in the State. An assessment of the religion-wise population distribution indicates that those following the Hindu religion account for 95.1 per cent of the population, followed by Muslims, accounting for 2.2 per cent, while those following other religions account for around 2.7 per cent of the total population.

Figure II.4: Distribution of Population by Broad Social Group and Religion (%)



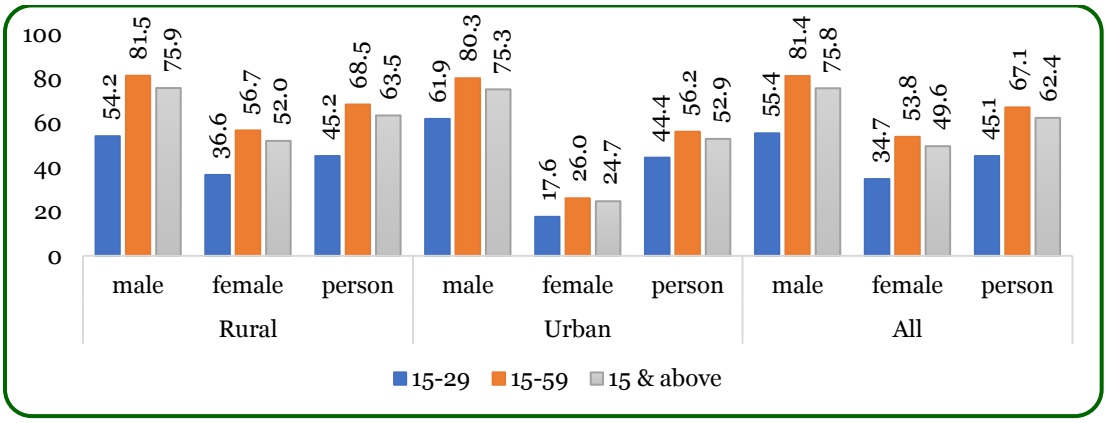
Source: *"Household Social Consumption: Education", NSSO, 2017-18.*

II.2. Employment

Figure II.5 shows the labour force participation rate by broad age categories, gender, and regions for the period 2017-18. According to the latest annual Employment-Unemployment Survey, the "Periodic Labour Force Survey (PLFS)", conducted by NSSO during 2017-18, in the rural areas 45.2 per cent, 68.5 per cent, and 63.5 per cent of the total population within the age group of 15-

29 years, 15-59 years, and 15 years and above, respectively, are either currently employed or are seeking employment. The corresponding figures for the urban areas are estimated to be 44.4 per cent, 56.2 per cent, and 52.9 per cent, respectively. This proportion is estimated at 75.9 per cent for males and 52.0 per cent for females in the rural areas, and 75.3 per cent for males and 24.7 per cent for females in the urban areas for the age group of '15 and above' years.

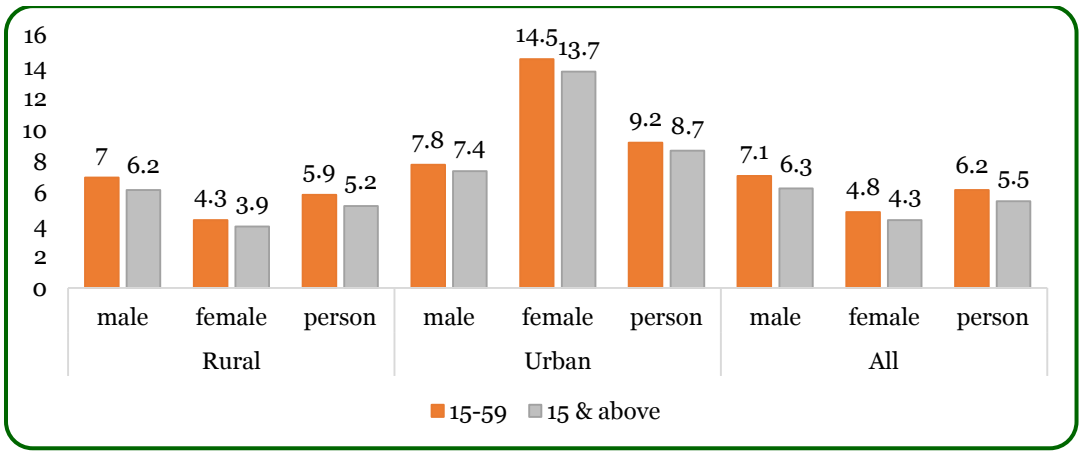
Figure II.5: Labour Force Participation Rate (LFPR) by Region and Gender



Source: *"Periodic Labour Force Survey", NSSO, 2017-18.*

The unemployment rate in the State was found to be around 5.5 per cent for those aged 15 years and above for the year 2017-18. The unemployment rates were 6.3 per cent for males and 4.3 per cent for females (Figure II.6). The unemployment rate among the population in the age group of 15-29 years was found to be higher as compared to that for the other age groups.

Figure II.6: Unemployment Rate (UR) by Region and Gender



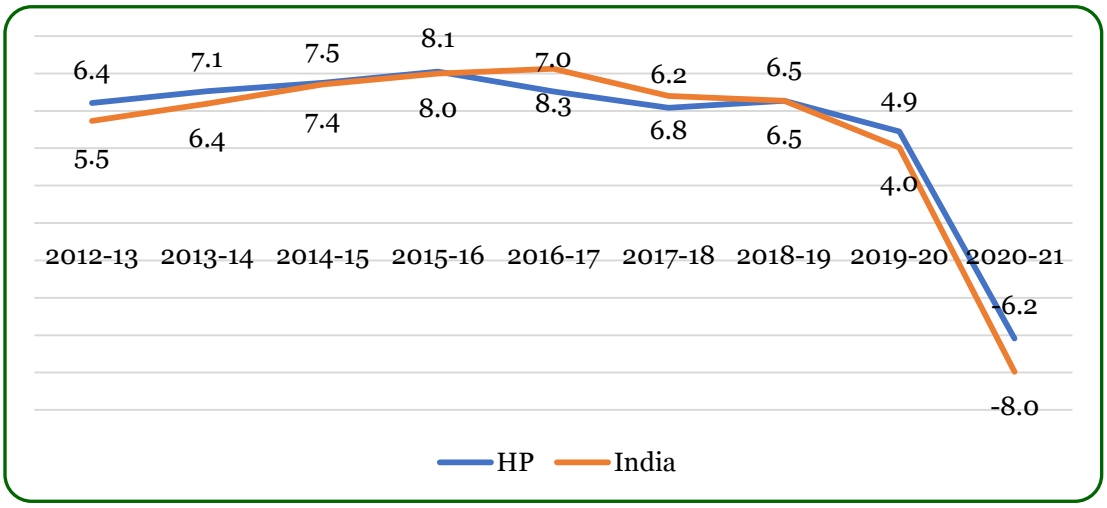
Source: *"Periodic Labour Force Survey", NSSO, 2017-18.*

II.3. Economic Profile

The State is doing very well with respect to economic growth, especially that driven by the growth of industry and tourism. In addition, agriculture, horticulture, and hydropower are also traditionally important constituents of the State's economy. The State is particularly known for the abundant production of off-season vegetables, exotic fruits and vegetables, and various varieties of flowers and carnation.

The State's economic growth, in terms of the year-on-year growth in Gross State Domestic Product (GSDP), has been faster than the national growth for most of the years since the inception of the new GDP series, that is, 2011-12 (Central Statistics Office, Ministry of Statistics and Programme Implementation). The GSDP growth for 2019-20 is 4.9 per cent, higher than the national growth of 4.0 per cent (Figure II.7). In 2020-21, when India's GDP suffered a loss of 8.0 per cent resulting from the pandemic and several lockdown restrictions, the State's GSDP fell by a comparatively lower rate of 6.2 per cent.

Figure II.7: Growth in Gross State Domestic Product (Constant Prices)



Source: Central Statistics Office.

II.4. Infrastructure Profile

The State has a total area of 55,673 sq km, and a common border with many Indian States. Its rivers are perennial and are fed by snow and rainfall. These are Chandra Bhaga or the Chenab, the Ravi, the Beas, the Satluj, and the Yamuna. The landscape of the State is predominantly hilly, which renders many of its areas difficult to reach. However, in recent years, roads have been built and many bridges have been constructed to make these areas more easily accessible to travellers.

Himachal Pradesh has good connectivity through developed roadways and also airways. The State has a road network of 28,208 km, including eight National Highways (NH) accounting for a total road length of 1,234 km and 19 state highways with the total length of 1,625 km. Some roads are, however, closed during the winter and monsoon seasons due to snow and landslides. There are three domestic airports in the State, namely the Gaggal airport in Kangra district, Bhuntar airport in Kullu district, and Shimla airport in Shimla district.

Himachal Pradesh has two railway lines—broad-gauge and narrow-gauge lines. The broad gauge railway line, which was electrified in 1999, connects the Una Himachal railway station to Nangal Dam in Punjab and runs up to Daulatpur. The narrow-gauge railway line, which runs between Kalka and Shimla and is popular among tourists, is one of the UNESCO World Heritage Sites. This train passes through many tunnels and bridges. Another narrow gauge line between Pathankot and Jogindernagar runs through a maze of hills and valleys. The total length of the narrow railway track is 259 km.

Overall, the total route length of the operational railway network in the State is 296.26 km.

II.5. Tourism Profile

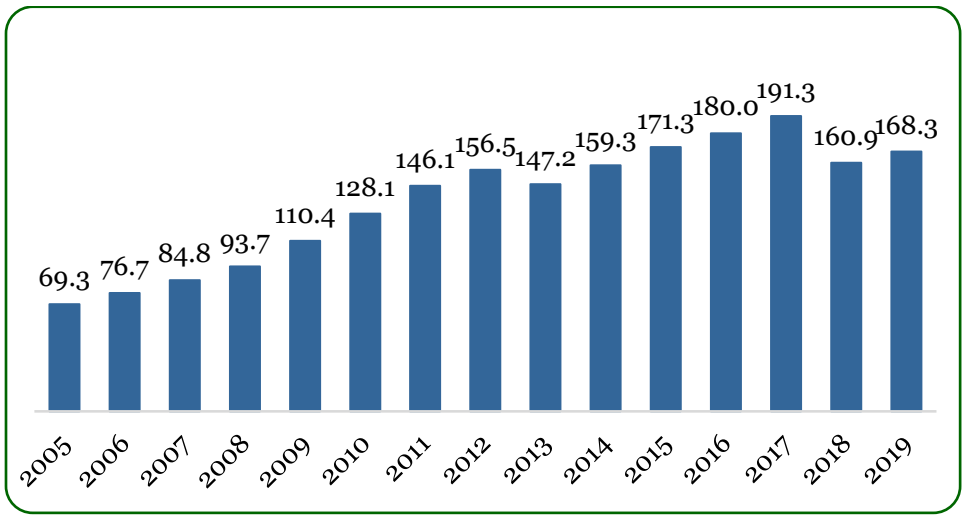
With the direct and indirect contribution of 7.8 percent in the state's GDP, tourism sector of Himachal Pradesh has emerged as one of the important and major contributor in the state's economy. The natural scenic beauty, thickly forested valleys, snow-capped mountains, perennial snow-fed rivers, clean and peaceful environment and sacred shrines makes the state a perfect tourist destination.

The state has 28 Wildlife Sanctuaries and five national parks. The presence of these national parks and wildlife centuries shows a huge potential for wildlife and natural tourism in the state. Number of heritage buildings like Bahadurpur port, war memorials, etc. are few other tourist attractions in the state. UNESCO in 2008 added the Kalka-Shimla railway which is popularly known as 'toy train' as a world heritage site.

Realizing the potential of the sector and putting it in the high priority, the state government has developed an appropriate infrastructure for its development. The efforts of these development plans has translated into a significant rise in the domestic as well as foreign tourist inflows in the state in the last few years.

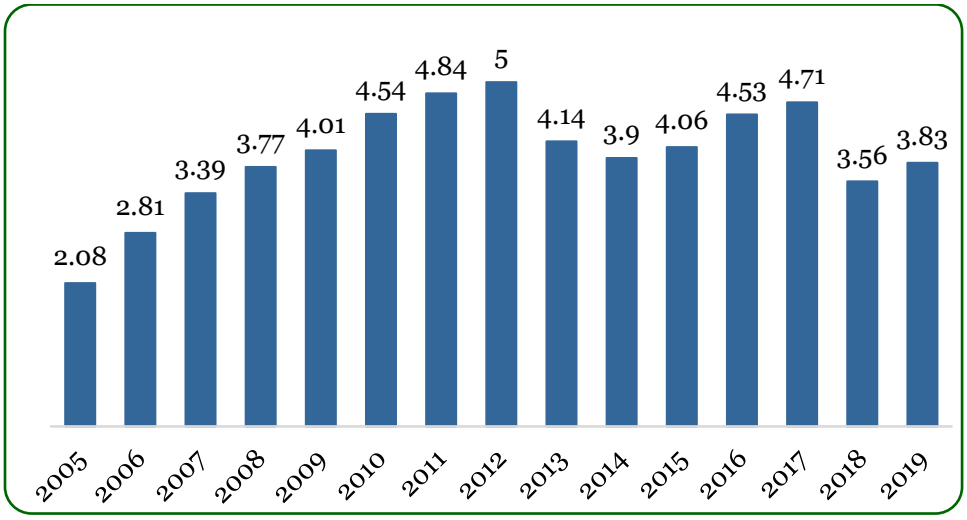
In 2019, approximately 168.29 lakh domestic tourists visited the state. This implied an increase of 143 per cent (from 2005 to 2019), as 69.28 lakh domestic tourists had visited the state in 2005. During the same period, foreign tourist arrivals increased from 2.08 to 3.83 lakh, implying a jump of 84.1 per cent. According to DES, Himachal Pradesh, there were 3679 registered hotels/guest house in the state, in December 2019.

Figure II.8: Total Domestic Tourist Arrivals (in lakhs)



Source: DES, HP.

Figure II. 9: Total Foreign Tourist Arrivals (in lakhs)



Source: DES, HP.

Among the districts, Kullu tops the tourist footfalls in the state with almost 18.3 percent of total tourist footfall, followed by Shimla (18.2%) and Kangra (13.5%). Kullu and Shimla are known for its mountains and scenic beauty and are among the most popular hill stations in northern India. While, Kangra is most notably famous for its temples.

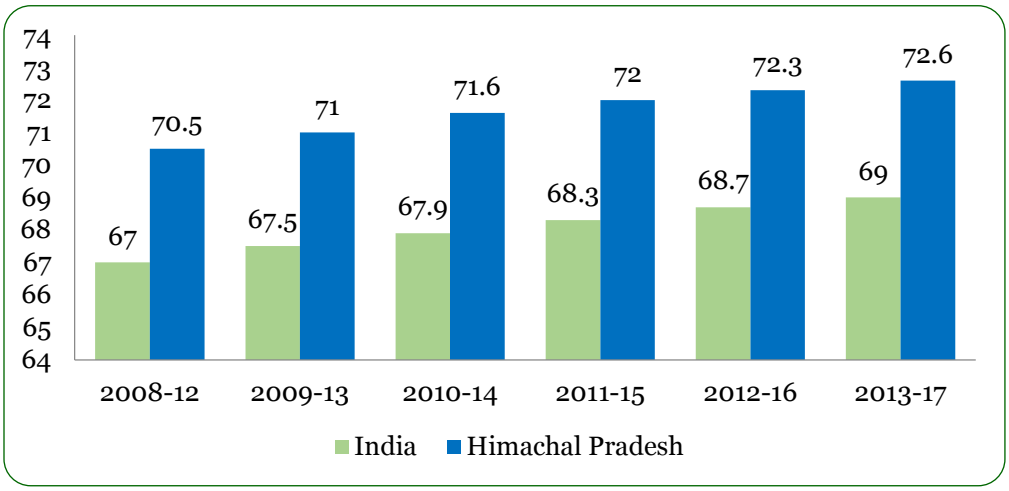
III. State Health Profile

Himachal Pradesh has reflected rapid improvement and taken rapid strides in its health care with its life expectancy index exceeding the all India average and has performed exceedingly well on other health indicators of fertility and immunization while lagging on some indicators with a wide variety of inter-district variations. This chapter discusses the health profile of the state of Himachal Pradesh and its 1. 2 districts.

III.1. Life Expectancy

Life expectancy at birth is taken as "the number of years a newborn infant could expect to live if prevailing patterns of age-specific mortality rates at the time of birth were to stay the same throughout the child's life," (UNDP, 2010). Himachal Pradesh has performed consistently well in promoting the health advances in the state with the state's life expectancy at birth of 72.6 years exceeding the All India average of 69 years in 2013-17 by over 3 years (Figure III.1). The state's life expectancy at birth has managed to be higher than the All India rate for almost a decade from 2009-17 which can be attributed to the state's high expenditure on health and strong health infrastructure that has a greatly prolonged life expectancy. Life expectancy at birth depends on age-specific mortality patterns thus the higher life expectancy of the state reflects the functioning of the health facilities in the state. Higher life expectancy at birth is usually perpetuated by low child, infant and adult mortality rates which the state reflects in the sample registration system data.

Figure III. 1: Life expectancy at Birth (In years)



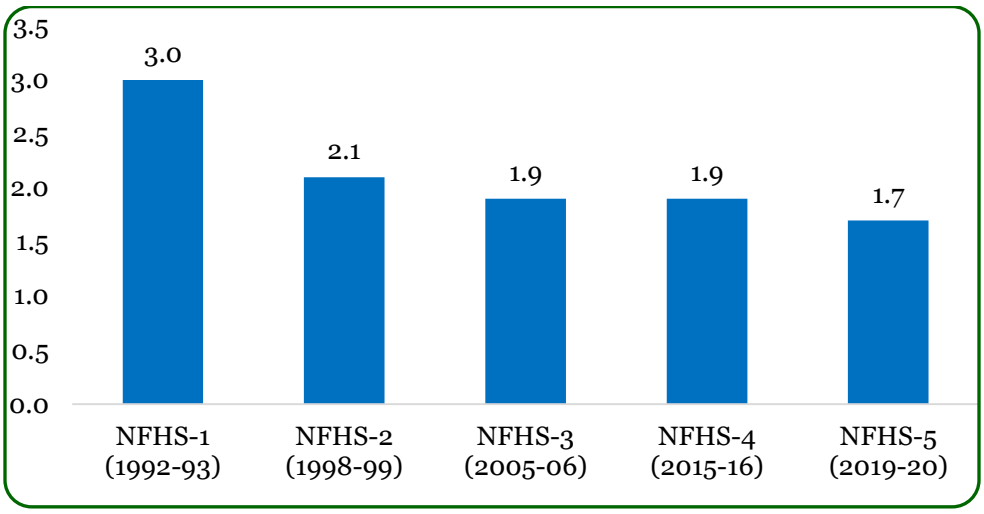
Source: NITI Aayog, Sample Registration System.

Life expectancy at birth disaggregated by sex pointed out that women across the state have a higher life expectancy at birth than males with a lifespan of approximately 6 years more than males. At the state level, females have a life expectancy at birth of 75.6 years while for males it is 69.8 years for the period of 2013-17. It also validates the fact that given similar access to health care and nutrition women tend to have lower age-specific mortality rates than men. Himachal Pradesh's life expectancy for both males and females is higher than the national average for the period 2000-17. The life expectancy at birth at all India level was 67.8 years for males and 70.4 years for females from 2013 to 2017. Female life expectancy at birth in the state has increased by 9 years while for males the rate has increased by 3 years reflecting gender gap in the provision of health facilities. The state's high number of health facilities (Family Welfare Centres) that focus on maternal health and health care schemes focusing on women can be one of the reasons for the wide gap between the life expectancy of females *vis-a-vis* male. (Annexure Table A1)

III.2. Fertility and Mortality

The total fertility rate in Himachal Pradesh witnessed a sharp decline from 3.0 to 1.9 between 1992-93 and 2005-06, which remained unchanged for another one decade, till 2015-16 and further decline to 1.7 in 2019-20. This change reflects a growing preference towards a small family size as well as improved access to schooling for women leading to a sharp dip in fertility rates (NFHS-5 report, 2019-120). Fertility had declined by 0.2 children between NFHS 4 and NFHS 5. (Figure III.2).

Figure III. 2: Trends of Total Fertility Rates (births per woman)



Source: NFHS -5 report (2019-20).

III.3. Health Infrastructure

Himachal Pradesh is a mountainous state with both low hills and plain regions and High mountain regions and areas that make infrastructural development a challenge. Himachal Pradesh's rugged topography, varying population density and challenging climatic conditions make the cost of creation and maintenance of health infrastructure extremely high. Himachal Pradesh with 66.53 per cent of legally defined forests (Forest Survey of India, 2003) has one of the richest biodiversity in the country with a wide variety of wild medicinal plants and herbs that are essential for allopathic and especially non-allopathic medicine. The creation of a separate AYUSH department has helped in strengthening the quality and scope of AYUSH services which is reflected in a large number of AYUSH hospitals and dispensaries in the state. The state has 1213 Ayurvedic institutions, 3 Unani dispensaries, and 14 Homeopathic dispensaries that specialize in providing natural remedies to the people. (Table III.1)

Himachal Pradesh is among a few states that despite having a 90 per cent rural population has no shortfalls of PHCs, CHCs, and sub-centres that provide the most essential primary health care to the general populace. The state has 91 community health centres, 576 primary health centres, and 2084 sub-centres which reflect the capability of the state in providing primary health care in the scarcely populated state.

In terms of the number of health institutes, the districts of Kangra (567) and Mandi (420) have the highest share of health institutes in the state while Kinnaur (64) and Lahaul and Spiti (57) have the least proportion of hospital & health institutes (Annexure Table A2).

At the district level, almost all of the districts had a significant presence of AYUSH centres with Kangra (251) and Mandi (177) having the highest share of AYUSH centres while Lahaul and Spiti (22), Bilaspur (71), and Kinnaur (30) having the least number of such centres. The AYUSH centres in the state include Ayurvedic, Unani and homeopathic hospitals and dispensaries (Annexure Table A3).

Table III. 1: Health Profile of the State 2017-18

Institutions	Number of Institutions
A. Medical Institutions (Allopathic)	
Hospitals	86
Primary Health Centres	576
Community Health Centres	91
E.S.I dispensaries	16
Sub-centres	2084
Total	2853
B. Medical Institutions (Ayurvedic)	
Hospitals	33
Nature Cure Hospitals	1
Dispensaries	1175
Ayurvedic Pharmacies	3
Research Institutions	1
Total	1213
C. Unani Dispensaries	3
D. Homeopathic Dispensaries	14
E. Family Welfare Centres	89

Source: Himachal Pradesh in Figures, Economic & Statistics Department HP.

Kangra (13) and Mandi (10) had the highest share of family welfare centres among all the 12 districts having the infrastructure required in providing essential child and maternal health care services in the state. Lahaul and Spiti was the only district that had the least proportion of hospitals/health institutes, family welfare centres, and AYUSH centres in the state reflecting the poor status of health infrastructure in the district while Kangra had the highest proportion of health institutes in the state indicating a strong capability of the state to provide accessible and affordable health care to the people. (Annexure Tables A3).

Kangra, Mandi and Shimla are the best performing districts in terms of treated patients (Internal) to the tune of 39.15 lakh, 28.18 lakh and 20.52 lakh resprectively. These three districts also have the highest number of beds in the health institutes revealing adequate infrastructural facilities and capacity of the districts in the treatment of patients. The total number of beds in Kangra , Mandi and Shimla were 2269, 1284 and 2225 respectively (Annexure Table A4).

Kinnaur (3.01 Lakhs) and Lahaul and Spiti (1.58 Lakhs) were the least performing districts in terms of treated patients (both internal and external) as well as the lowest number of beds (194 and 204 respectively) in the health institutes revealing inadequate infrastructural facilities and capacity of the districts in the treatment of patients (Annexure Table A4).

III.4. Health Personnel

The availability and access of physicians, doctors, surgeons, and various other health personnel serves an important role in providing appropriate medical aid to the general populace enhancing the longevity and health conditions of the people. Primary health care centres, by providing essential curative and preventive care services serve as the most important link between the people they serve especially in harsh terrain as that of Himachal Pradesh. Despite its hilly and inaccessible terrain, Himachal Pradesh has more PHCs, CHCs, and sub centres than many more states in the plain areas which is an indicator of the state's capacity to provide both advanced and basic health care services to its people. There are about 8.39 PHCs (Table III.2) in the state per lakh population which exceeds the norm of one PHC per 20,000 populations in hilly or tribal regions (HP HDR Report, 2002). The coverage of primary health care institutions has distinctly improved in the last half a decade which reflects good accessibility and fewer burdens on health institutions across the state. There has been a relatively slow growth in the coverage of AYUSH medical institutions in the state in last 5 years which can indicate a gap in spending between allopathic and AYUSH institutions (Table III.2).

Table III.2: Availability of Health Facility per One Lakh Population

(As on 31st March)

	Health Personnel/Facility	2014	2015	2016	2017	2018
1	Allopathic Hospitals	0.88	0.93	1.08	1.09	1.27
2	Ayurvedic Hospitals	0.44	0.44	0.45	0.47	0.48
3	Primary Health care centres	7.12	7.28	7.55	7.84	8.39
4	Community Health care centres	1.14	1.14	1.15	1.30	1.31
5	Sub centres	30.13	30.08	30.17	30.34	30.35
6	Allopathic Dispensaries	0.16	0.16	0.17	0.25	0.23
7	Ayurvedic dispensaries	16.16	16.21	16.20	16.77	17.12
8	Homeopathic Dispensaries	0.20	0.20	0.20	0.20	0.20
9	Total (1 to 9)	56.23	56.45	56.97	58.26	59.36

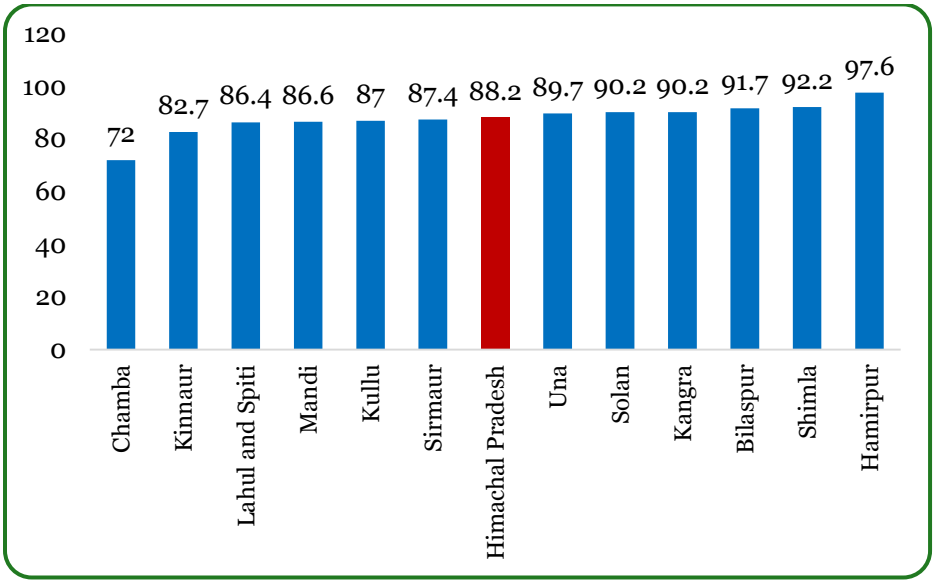
Source: Health & Family Welfare Department, HP

III.5. Maternal & Child Health

Maternal and childcare services are one of the most essential health care services that ensure not only the health of the mother i.e. the primary caregiver but also her offspring to ensure that they live a healthy life. Maternal and child health parameters are governed by access, availability, utilization of health services, the proportion of institutional & home deliveries, immunization rates for children, and utilization of health services to provide pre and post-natal health care services to women. Maternal and child health are integral to human development and the place of birth as well as the access to and availability of institutional care and trained attendants at the

time of delivery have important bearings on maternal and child survival. It is revealed that most of the districts of Himachal Pradesh prefer government institutional centres for delivery rather than home deliveries which indicate that the benefits from programmes like the Matri Seva Yojana and Himachal Pradesh Universal health protection scheme launched in 2016 are reaching women from all income groups and are promoting government institutional deliveries (Figure III.3).

Figure III.3: District-wise Institutional Deliveries (%), 2019-20

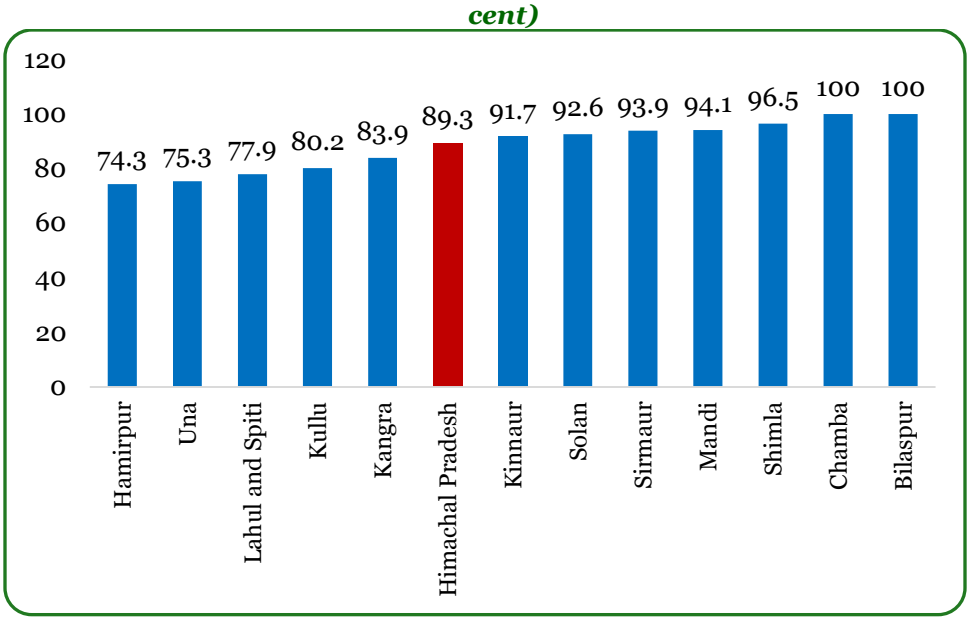


Source: NFHS -5 report (2019-20).

In Himachal Pradesh, 88.2 per cent of the deliveries are carried out in institutional centres which paint a favourable picture for maternal health and child health in the state. In 6 out of 12 districts, the proportion of institutional deliveries exceeding the state average. Hamirpur recorded the highest proportion of institutional deliveries (97.6 percent) while Chamba has the lowest proportion of institutional deliveries (72 percent) representing huge inter-district variations in institutional deliveries. The shortfalls in the Chamba district could be either due to lack of access or the underutilization of existing institutional facilities for deliveries (Figure III.3).

With regard to immunization, about 89.3 per cent children in the age group of 12-23 months had received basic immunization against six major childhood illnesses (tuberculosis, diphtheria, pertussis, tetanus, polio, and measles), as per NFHS, 2019-20. At the district level, 7 of the 12 districts fared better than the state figures with Bilaspur and Chamba recording the highest proportion (100 per cent) of immunized children and Hamirpur with the lowest proportion of immunized children (74.3 percent) (Figure III.4).

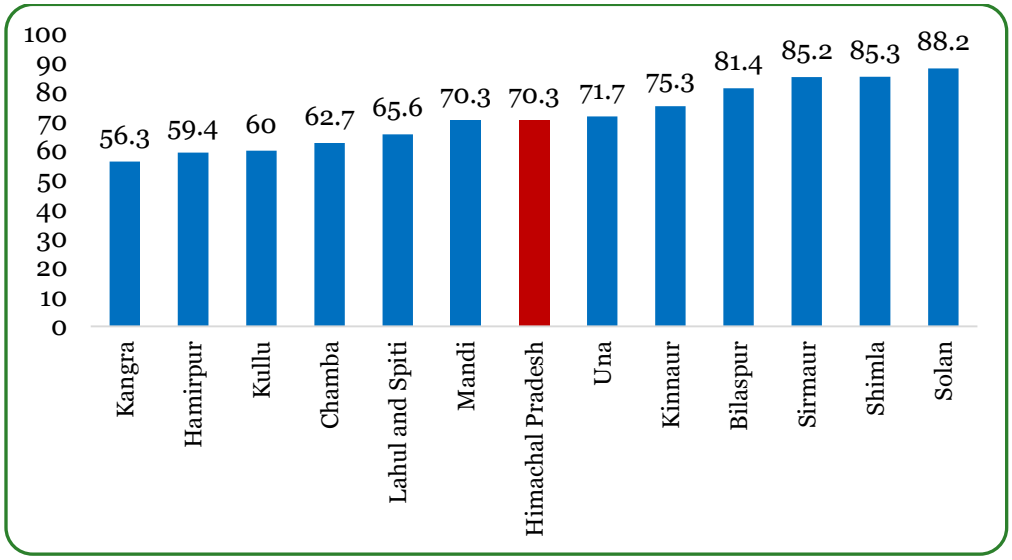
Figure III.4: Coverage of all basic vaccinations of children between 12-23 months (in per cent)



Source: NFHS -5 report (2019-20).

Poor nutritional status during pregnancy and after delivery increases women's susceptibility to health hazards and reproductive problems which makes Antenatal check-ups and immunization essential for women. In terms of maternal health in the past 5 years, about 70.3 per cent of women had 4 or more antenatal care visits for their last births in the state with half of the districts lagging behind the state average. At the district level, Solan (88.2 percent) recorded the highest proportion of women who had 4 or more antenatal care visits followed by Shimla (85.3 percent) and Sirmaur (85.2 percent). Kangra (56.3 percent) and Hamirpur (59.4 percent) were the least performing districts and recorded the least proportion of women who had 4 or more antenatal visits. (Figure III.5)

Figure III.5: Four or More Antenatal Care Visits (% of last births in the past five years)



Source: NFHS -5 report (2019-20).

IV. Concepts and Definitions

This chapter presents the broad concepts and specific definitions of terminology used in the state-specific Health Satellite Account, prepared here for the state of Himachal Pradesh. These are based on "System of Health Accounts, 2011" (SHA-2011), prepared collaboratively by World Health Organisation (WHO), Organisation for Economic Cooperation and Development (OECD) and EuroStat. The SHA framework is meant to provide the systematic description of financial flows related to healthcare and provides a common guideline so as to enable international as well as national comparisons.

IV.1. Health Satellite Account

The satellite accounts typically are the presentation of additional dimensions of an economic sector, which is also of great social interest, in a flexible manner and without overloading the integrated structure of the System of National Accounts (SNA). These are prepared to allow the expansion capacity in sectors like tourism, health, education, culture and environment etc.

The Health Satellite Account (HSA) is a coherent, systematic and integrated set of accounts and tables based on the SNA concepts and definitions. The terms Health Satellite Account or National Health Accounts may be used interchangeably as both present the health related demand and supply structure. From the demand side, health accounts present the expenditure by sources and by financing schemes through which expenditures are made. From supply side, these accounts identify the healthcare service providers and their services utilised.

Following the System of Health Account (SHA-2011) framework, the health expenditures are disaggregated into current and capital. The details of current health expenditures are presented according to the classifications as given in Figure IV.1.

***Figure* IV. 1: Classifications to present Current Health Expenditure**

Revenues of Healthcare Financing Schemes	•entities that provide resources to spend for health goods and services
Healthcare Financing Schemes	•entities receiving and managing funds from financing sources to pay for health goods and services
Healthcare Providers	•entities receiving finances to produce / provide health goods and services
Healthcare Functions	•describe the use of funds across various health care services

The following sections present the appropriate classifications of healthcare functions, financing schemes, healthcare providers and factors of provision.

IV.2. Functional Classification of Healthcare System (HC)

The functional classification of healthcare refers to groups of healthcare goods and services consumed by final users (i.e. households and also collectively by the community) with a specific health purpose. Clearly, there is no one-to-one relationship between health care functions and the providers and also the financing sources of health care. The same type of health care goods and services, like curative care or rehabilitative care or medical goods, etc., can be consumed from different types of providers, like hospitals, clinics, medical shops, etc. At the same time, these can be purchased under various financing schemes, like health insurance, central or state government sponsored schemes etc.

The functional classification in the health accounting framework focuses on the estimation of current spending and involves the contact of the population with the health system for the purpose of satisfying health needs. This classification is broadly based on The International Classification for Health Accounts – Health care (ICHC-HC), as recommended in SHA-2011.

The functional classification classifies the healthcare goods and services at one, two and three-digit levels and aims to distribute health consumption according to the type of need of the consumer (e.g. cure, care, prevention, etc.). The first-digit level is divided into 8 categories, each of which are further classified into 2 and 3 digit level categories.

However, for the sub-national level health accounts, information on health expenditure by each of these categories of functional classification are difficult to obtain. Hence, the classification is restricted to 2-digit categories only, to the extent possible.

The functional classification of health care, as recommended by SHA-2011 and followed by National Health Accounts of India, are presented in Table IV.1.

Table IV. 1: Functional Classification of Health care

Codes	ICHA-HC description
HC.1	Curative care
HC.1.1	Inpatient curative care
HC.1.3	Outpatient curative care
HC.1.4	Home-based curative care
HC.2	Rehabilitative care
HC.3	Long-term care (health)
HC.4	Ancillary services (non-specified by function)
HC.4.3	Patient transportation
HC.4.4	Laboratory and Imaging services
HC.5	Medical goods (non-specified by function)
HC.5.1	Pharmaceuticals and Other medical non-durable goods
HC.5.2	Therapeutic appliances and Other medical goods
HC.6	Preventive care
HC.6.1	Information, education, and counselling (IEC) programmes
HC.6.2	Immunisation programmes
HC.6.3	Early disease detection programmes
HC.6.4	Healthy condition monitoring programmes
HC.6.5	Epidemiological surveillance and risk and disease control programmes
HC.6.6	Preparing for disaster and emergency response programmes
HC.7	Governance and health system and financing administration
HC.7.1	Governance and Health system administration
HC.7.2	Administration of health financing
HC.8	Other healthcare services not elsewhere classified (nec)
HC.RI.1	Total Pharmaceutical expenditure
HC.RI.2	Traditional complementary and alternative medicine (TCAM)

Source: SHA-2011 and National Health Account – Guidelines for India.

The categories used for the State Health Account, as presented in Table IV.1 are described as follows:

1. Curative Care

Curative care comprises health care contacts during which the principal intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury, or to protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function. This means the treatments and therapies provided to a patient with the principal intent of fully resolving an illness and trying to bring the patient to their status of health before the illness presented itself. The several components of curative care are listed below.

- Establish a diagnosis
- Formulate a prescription and therapeutic plan
- Monitor and assess the clinical evolution
- therapeutic means like pharmaceuticals and other medical goods (e.g. orthoses such as glasses and prosthetic appliances such as artificial teeth or limbs)
- therapeutic procedures such as surgical procedures that require additional follow up
- Routine administrative procedures such as completing and updating patient records

The main purpose of curative care remains the same in case of inpatient, outpatient and home-based curative care, only the technology and place of provision changes.

Inpatient curative care: Healthcare contacts that involve an overnight stay in a healthcare facility.

Outpatient curative care: Healthcare contacts that involve no overnight stay in a healthcare facility.

Home-based curative care: Healthcare contacts that involve the consumption of services at the patient's place of residence.

2. Rehabilitative Care

Rehabilitative care aims at empowering persons with health conditions who are experiencing or are likely to experience disability so that they can achieve and maintain optimal functioning, a decent quality of life and inclusion in the community and society. Rehabilitation services include consumption of services aimed at reaching, restoring and/or maintaining

- optimal physical (e.g. complementing body structure through a prosthesis)
- sensory(e.g. complementing hearing recovery with a prosthesis)
- Intellectual (e.g. recovering memory capability after a stroke)
- psychological (e.g. reducing depression and stress through supported learning to use a prosthesis)
- social functional levels (e.g. by re-establishing control of basic functions such as swallowing and speaking after a stroke)

3. Long-term Care (health)

Long-term care (health) consists of a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency. This care is aimed at the dependent population with chronic or recurrent psychiatric conditions, such as

physically disabled people and mental health and substance abuse patients. The various components of long-term care (health) can be distinguished as given below:

- Medical or nursing care that ensures a high level quality of life assurance regardless of the type of health ailment
- Personal care services provided in response to limitations in self-care primarily due to disability and illness i.e. help with activities of daily living like eating, bathing, washing, dressing etc.
- Assistance services relate to care that enables a person to live independently in a house or apartment i.e. providing assistance with tasks of household management like shopping, laundry, vacuuming, cooking etc.
- Other social care services involve community activities and occupational support given on a continuing or recurrent basis to individuals, such as activities whose primary purpose is social and leisure.

4. Ancillary Services

Ancillary services are frequently an integral part of a package of services whose purpose is related to diagnosis and monitoring. This category is further divided into Patient transportation and Laboratory and imaging services.
Patient transportation: This item comprises the transportation of patients to a health care facility on medical recommendation or as a necessary inter-facility transfer to complement a package of health care services.

Laboratory and imaging services: This item comprises a variety of tests of clinical specimens aimed at obtaining information about the health of a patient and also variety of services that employ imaging technology, such as X-rays and radiation for the diagnosis and monitoring of patients.

5. Medical Goods

Medicines and other medical goods are frequently a component of a package of services with a preventive, curative, rehabilitative or long-term care purpose. Medical goods are further divided into pharmaceuticals and other medical non-durables and therapeutic appliances and other medical goods.

- Pharmaceuticals and other medical non-durable goods
    - Prescribed medicines.
    - Over-the-counter drugs (OTC).
    - Other medical non-durable goods (for e.g. first-aid kits, bandages, hot water bottles etc.)

- Therapeutic appliances and other medical goods
    - Glasses and other vision products
    - Hearing aids
    - Other orthopaedic appliances and prosthetics(for e.g. orthopaedic shoes, artificial limbs, surgical shoes etc.)

6. Preventive Care

Prevention is any measure that aims to avoid or reduce the number or the severity of injuries and diseases, their sequelae and complications (Pomey et al., 2000). This includes a wide range of expected outcomes, which are covered through a diversity of interventions, organised as primary, secondary and tertiary prevention levels

Primary prevention: The goal of primary preventive measures is the reduction of risks before they generate some effect, e.g. via vaccination.

Secondary prevention: Secondary prevention involves specific interventions aimed at the detection of disease and then starting the therapy as early as possible, e.g. via screening (for e.g. screening for diseases such as TB, diabetes and breast cancer).

Tertiary prevention: Tertiary prevention aims at reducing the negative impact of an already established disease or injury by an attempt to avoid worsening and complicating, such as early surgery on a joint damaged by burns
The breakdown of prevention includes the following classes.

- Information, education and counselling programmes
- Immunisation programmes
- Early disease detection programmes
- Healthy condition monitoring programmes
- Epidemiological surveillance and risk and disease control programmes
- Preparing for disaster and emergency response programmes

7. Governance, and Health System and Financing Administration

These services focus on the health system rather than direct health care, and are considered to be collective, as they are not allocated to specific individuals but benefit all health system users. This classification is further divided into government and health system administration and administration of health financing.

- Governance and health system administration
    - Formulation and administration of government policy

- Setting the standards
- Regulation, licensing or supervision of providers/producers
- Management of fund collection
- Administration, monitoring and evaluation of resources

- Administration of health financing: This class involves a subcomponent specific to health financing, regardless of its public and private origin or its public and private provision. It contains the management of the collection of funds and the administration, monitoring and evaluation of such resources.

8. Other Healthcare Services not elsewhere classified (nec)

This item includes any other health care services not classified in 1 to 7.

Reporting items

Total Pharmaceutical Expenditure (TPE)

Total measurement of the pharmaceutical consumption is of major relevance in a healthcare functional approach. The total figure for expenditure on pharmaceutical consumption is obtained by adding the explicitly reported pharmaceutical component within treatment packages, notably as part of the interaction within the contact for curative care, which is expected to be not just the largest amount, but also part of rehabilitative care and long-term care. There may also be amounts incorporated as part of outpatient care from prescribing physicians.

Traditional, Complementary and Alternative Medicines (TCAM)

TCAM has been identified as policy relevant in many countries due to either its cultural importance or its high growth rate, both in high and middle per capita income countries. Due to the mix of purposes and practices and financing profiles, TCAM systems, therapies and disciplines (including the related medical goods) are a de facto sub-class of hospitals, ambulatory care services and retailers and have to be specially extracted and summed up, to be included here as an important policy item.

IV.3. Classification of Healthcare Financing Schemes (HF)

Healthcare financing schemes are the structural components of the healthcare financing systems. They are the main types of financing arrangements through which the people obtain health services. These can be broadly classified as follows.

1. **Government schemes, social insurance schemes**: Schemes aimed at ensuring access to basic healthcare for the whole society, specific population groups determined and mandated by law or by the government are categorized under this.

- **Government Schemes**: Healthcare services provided by the union, state and local governments (urban and rural local bodies) across the country are categorized as government schemes. According to the Constitution of India, predominant responsibility of providing healthcare services is of the state governments. However all the three levels of government finance and provide healthcare services.

- **Compulsory contributory health insurance schemes**: Compulsory health insurance involves financing arrangements that ensure access to healthcare for specific population groups through mandatory participation and eligibility based on the payment of health insurance contributions by or on behalf of the individuals concerned.

    - Union Government schemes
    - State Government schemes
    - Local Government schemes
    - Compulsory contributory health insurance schemes

2. **Voluntary Health Insurance Schemes**: Voluntary health insurance is taken up and paid for at the discretion of individuals or firms. Voluntary health insurance may also be purchased by the employer. It is usually purchased from private insurance organisations (both for-profit and non-profit), although in some cases it may also be purchased from public or quasi-public bodies.

    - Employer-based Voluntary schemes
    - Government-based Voluntary schemes
    - Public Enterprise Financing schemes
    - Private Enterprise Financing schemes

3. **Direct out-of-pocket payments by households:** Majority of financing of healthcare in India is through household out of pocket payments. There are three main types. One, where the household makes a payment at point of service at a private or public facility. Two, where the household pays at point of service as part of cost sharing when enrolled in a government scheme (user fees) or compulsory contributory insurance schemes. And the third is through cost sharing (co-payments, deductibles, etc.) when enrolled in voluntary insurance scheme.

IV.4. Classification of Revenues of Financing Schemes

1. **Transfers from government domestic revenue (allocated to health purposes)**

- Internal transfers and grants: This category refers to transfers within the union government, state and local government towards health purposes.
    - revenues from tax and non-tax sources allocated to government schemes
    - the budget of national health services,
    - government health programmes
    - insurance programmes implemented by the government

2. Transfers distributed by government from foreign origin

- Transfers distributed by Union Government from foreign origin
- Transfers distributed by State Government from foreign origin

3. Social insurance contributions

- Social insurance contributions from employees
- Social insurance contributions from employers

4. Voluntary prepayment

- Voluntary prepayment from individuals/households
- Voluntary prepayment from employers.

5. Other domestic revenues (not elsewhere classified)

- Other revenues from households
- Other revenues from corporations
- Other revenues from NPISH

6. Direct foreign transfers

- Direct foreign financial transfers
- All direct foreign financial transfers
- Direct foreign aid in kind
- Direct foreign aid in goods
- All direct foreign aid in goods
- Direct foreign aid in kind

IV.5. Classification of Healthcare Providers (HP)

Healthcare providers are the organisations and actors that provide healthcare as their primary activity or one activity among other activities. This classification enables linkage between healthcare functions (HC) and healthcare financing (HF). The classification of healthcare

providers, as recommended by SHA-2011 and followed by National Health Accounts of India, along with the classification which is adopted for the state health account, are presented in Table IV.2.

Table IV. 2: Classification of Health care Providers

Codes	ICHA-HP description
HP.1	Hospitals
HP.1.1.1	General Hospitals - Government
HP.1.1.2	General Hospitals - Private
HP.1.2.1	Mental Hospitals - Government
HP.1.2.2	Mental Hospitals - Private
HP.1.3.1	Specialised Hospitals - Government
HP.1.3.2	Specialised Hospitals - Private
HP.3	Providers of Ambulatory or Out-patient Healthcare
HP.3.1	Offices of medical practitioners and specialists (private)
HP.3.3	Other Healthcare Practitioners (Government)
HP.3.4	Out-patient Healthcare centres like Family Panning (government)
HP.4	Providers of ancillary services
HP.4.1	Providers of patient transportation and emergency rescue
HP.4.2	Medical and diagnostic laboratories
HP.4.3	Others
HP.5	Retailers and Other providers of medical goods
HP.6	Providers of preventive care
HP.7	Providers of healthcare system administration and financing

Source: SHA-2011 and National Health Account – Guidelines for India.

7. Hospitals

Hospitals comprise licensed establishments that are primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing and other health services to inpatients and the specialized accommodation services required by inpatients. Although the principal activity is the provision of inpatient medical care they may also provide day care, outpatient and home healthcare services as secondary activities. They are further classified into:

- General Hospitals
    - General Hospital government: includes medical college hospitals, district hospitals, sub district hospitals and CHCs.
    - General hospitals private: include nursing home.
- Mental health hospital(government):cater in-patients who suffer from
    - severe mental illness
    - substance abuse disorders
- Specialized hospitals(public and private)

- Speciality hospitals like cancer, TB and lung diseases, cardiology, neurology etc.
- Hospitals of AYUSH
- Healthcare units exclusively providing maternal and child health

8. Providers of ambulatory healthcare

Primarily engaged in providing healthcare services directly to out-patients who do not require in-patient services

- medical practices
- dental practices
- other healthcare practitioners
- ambulatory healthcare centers

9. Providers of ancillary services

This category comprises establishments that provide specific ancillary type of services directly to out-patients under the supervision of health professionals and not covered within the episode of treatment by hospitals, nursing care facilities, ambulatory care providers or other providers.

- patient transportation and emergency rescue
- medical and diagnostic laboratories
- dental laboratories
- Other providers of ancillary services. e.g hearing testing services (except by offices of audiologists), pacemaker monitoring services, Physical fitness evaluation service.

10. Retailers and other providers of medical goods

Primary activity is the retail sale of medical goods to the general public for individual or household consumption or utilisation

- Pharmacies
- Retail sellers and other suppliers of durable medical goods and medical appliances
- All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods. e.g. Cartridges, sale of fluids (e.g. for home dialysis)

11. Providers of preventive care

This category comprises organizations that primarily provide collective preventive programs and campaigns/ public health programs for specific groups of individuals or the population-at-large, such as health promotion and protection agencies or public health institutes as well as specialized establishments providing primary preventive care as their principal activity.

- ASHA
- Multi-Purpose Health worker

- Community health workers and volunteers under national Public health programs for communicable and non-communicable diseases.

12. Providers of healthcare administration and financing

This item comprises establishments that are primarily engaged in the regulation of the activities of the agencies that provide healthcare and in the overall administration of the healthcare sector, including the administration of health financing

- Government health administration agencies
- Social health insurance agencies
- Private health insurance administration agencies
- Other administration agencies

IV.6. Classification by Factors of Provision

1. Compensation of employees

The compensation of employees refers to the total remuneration, in cash or in kind, paid by an enterprise to an employee in return for work performed by the latter during the accounting period. It measures the remuneration of all persons employed by providers of healthcare in public and private sector, irrespective of whether they are health professionals or not. It includes the following:

- Wages and salaries of employees:
  - include remuneration both in cash and in kind
- Social contributions:
  - payments to social security or any form of insurance on behalf of the employees.
- All other costs related to employees

2. Self-employed professional remuneration

Self-employed income refers to the final consumption payments made by patients or healthcare beneficiaries typically at practitioner's office and quasi corporations. Measurement has been approached through surveys and through records from providers.

3. Materials and services

This category consists of the total value of goods and services used for the provision of healthcare goods and services (not produced in-house) bought in from other providers and other industries of the economy. All the materials and services are to be fully consumed during the production activity period.

- Healthcare services: Services consumed usually refer to general services provided by non-health industries:
    - Security
    - payments for the rentals of buildings and equipment
    - Maintenance and cleaning.
- Expenditure on healthcare goods
    - Pharmaceuticals
    - Other healthcare goods. for e.g. cotton, wound dressings, protective clothes and uniforms
- Non-healthcare services
    - staff training
    - operational research
    - transport, housing
    - meals and drinks
    - services for infrastructure
- Non-healthcare goods
    - office supplies
    - hospital kitchen supplies
    - transport
    - electricity
    - water

4. Consumption of fixed capital

The consumption of fixed capital is a cost of production. It may be defined in general terms as the cost for a given accounting period, of the decline in the current value of the producer's stock of fixed assets as a result of physical deterioration, foreseen obsolescence or normal or accidental damage. It excludes losses associated with damage caused by war or natural disasters.

5. Other items of spending on inputs

- Taxes
- Other items of spending
    - property expenses, fines and penalties imposed by government
    - interest rates and costs incurred for the use of loans
    - non-life insurance premiums and claims.

V. Health Expenditure

Health accounts provide a systematic description of the financial flows of health care goods and services and is used as a standard to classify health expenditures on the basis of consumption, financing and provision. It aims to capture and identify the sources of finance for health expenditure, the financing schemes that enable resource mobilisation on health care, the various mediators through which funds are routed, services provided by the health care system and lastly recognition of health care providers who are primarily engaged in provision of health care.

Health Satellite Accounts present health expenditure by sources of finance, financing schemes, functions and providers of healthcare facilities. The total health expenditure of the state comprises the following

1. **Revenue Expenditure**
   This is defined as final consumption expenditure of resident units on health care goods and services and is a part of current health expenditure. Health Revenue expenditure of the state is recurring in nature and includes:

   a. Household Out of Pocket Expenditure on Out-patient and In-patient (Medicines, doctor fees, bed charges, diagnostic, Preventive & Rehabilitative services, Traditional Systems of Medicine (AYUSH), ambulance and allied services, Health Enhancing Drugs/products (such as vitamins with/ without prescription) at Public/ Private health facilities and pharmacies
   b. All Government Health Expenditure (Budgets to health facilities, procurement of drugs and consumables, health programmes - Disease Control, Family Welfare & Reproductive Child Health Programme, National Nutrition Mission, Immunization, Antenatal Care, Delivery, Postnatal Care, Abortion, etc.)
   c. Health Administration, Health Insurance, Medical benefits to employees by government/private entities.

2. **Capital Expenditure**
   It is measured by total value of fixed asset that health care providers have acquired during the accounting period and that are repeatedly used for more than one year in the provision of health care services.
   a. Expenditure on buildings & Construction excluding minor repairs
   b. Medical education, research and pre-service training

The financing agents and the healthcare providers are broadly classified into:

1. Public Health Expenditure
2. Private Health Expenditure

V.1. Public Health Expenditure

Public expenditure on health in the state includes expenditure incurred by the State Government, the Central Government and the local bodies. Within the state government, the major expenditure on healthcare is done by Department of Health and Family Welfare (DoHFW). The details of expenditure incurred by DoHFW were obtained from the Detail Demand for Grants (DDG) submitted by the line department to the Department of Finance.
Besides, within the state government, other than the department of health and family welfare, there are several other departments that spend on the healthcare of the employee, their dependents or general population, mostly in the form of medical reimbursements. In order to obtain these expenditures incurred by other departments on healthcare, the Detailed Demand of Grants (DDGs) of all the departments were carefully scrutinised to identify the heads under which health expenditure is incurred.

Thus, three different sets of information from DDGs of all government departments with health expenditure are as follows.

1. Major heads reflected in the DDG of State Department of Health and Family Welfare.
2. Major heads under which different departments of the state have incurred expenditure on health.
3. Major heads under which respective departments have paid medical bills of the state government employees in the form of medical reimbursements.

A DDG for a financial year presents the total provisions required for a service, including revenue and capital expenditure, grants and loans relating to that service. The DDG for a particular year gives item-wise details of government expenditure for three consecutive years, that is, Budget estimates (BE) for that year, Revised Estimates (RE) for the previous year and Actual Expenditure for year before previous year. Hence, for this study, DDG for 2019-20 has been referred to, which provides actual expenses for 2017-18, the reference year of Health Satellite Account.

Each DDG is divided into sectors (Education, Health, Finance etc.), which may in some cases be further divided into sub-sectors (Education, Sports, Culture under Education; Medical and Family Welfare under Health etc.). The main unit of classification in accounts is the major head, which is further divided into sub-major head, each of which is then divided into minor heads, each of which has a number of sub-ordinate heads, generally known as sub-heads. The sub-heads are further divided into detailed heads and object heads. Major Heads generally correspond to 'Functions' of government while minor heads identify the programme undertaken to achieve the objectives of the function represented by the major head.

In order to prepare the tables and accounts for Health Satellite Account, depicting the health expenditure by Financing Schemes, Revenue of Healthcare Financing Schemes, Healthcare Providers and Healthcare Functions, all the budget heads were mapped with the SHA-2011 classification. However, all the budget heads do not necessarily correspond with the SHA classification on a one-to-one basis and therefore require apportioning their values into more than one category. For example, Hospitals and Dispensaries" correspond with two healthcare

functions, that is, Inpatient Curative care and Outpatient Curative care; and also with two healthcare providers, that is, General Hospitals and Ambulatory Healthcare systems.

As per SHA-2011, it is important to keep the current expenditure and capital expenditure separately. While the Budget has separate Revenue (or current) and Capital Outlay Account, but according to the SHA classification, some of the heads within Revenue account also qualify to be classified under capital expenditure or capital formation. The expenditure items which are outside the boundary of current expenditure and are included in capital formation are the following:

1. Machinery and equipment are capital goods. Besides, materials used over more than one production period are also classified as capital (equipment and related), for example tools which can be repeatedly used
2. Infrastructure related, like major renovations, reconstruction or enlargement of fixed assets are capital expenditures
3. Provision of education and training of health personnel, including the administration, inspection or support of institutions providing education and training of health personnel unless the trainings are on the job trainings, which is included in current health expenditures.
4. Research and development programs directed towards the protection and improvement of human health is also a part of the capital account.

In the case of Himachal Pradesh, following budget line items of the Revenue Account have been classified as Capital Formation.

Table V. 1: Budget line Items classified under Capital Formation

Major Head (Code)	Sub Major Head	Minor Head	Sub Minor Head	Description Sub Minor Head
2210	05	101	01	Ayurvedic College
2210	05	101	03	Research In Indian System Of Medicine
2210	05	101	05	National Ayush Mission
2210	05	105	01	Indira Gandhi Medical College, Shimla.
2210	05	105	03	Training In Various Health Cources
2210	05	105	04	Dental College
2210	05	105	05	Directorate Medical Education And Research
2210	05	105	06	Dr. Rajendra Prasad Medical College Tanda.
2210	05	105	07	Upgradation Of Govt. Medical Colleges
2210	05	105	08	Pradhan Mantri Swasthya Suraksha Yojna-Ii
2210	05	105	12	Dr. Yashwant Singh Parmar Goverment Medical College, Nahan
2210	05	105	13	Dr. Radhakrishnan Government Medical College, Hamirpur
2210	05	105	14	Pandit Jawahar Lal Nehru Government Medical College, Chamba
2210	05	105	15	Lal Bahadur Shastri Government Medical College & Hospital At Ner Chowk
2210	05	105	16	Capacity Development For Developing Trauma Care Facilities In Hospitals Located On Government National Highways
2211	00	003	01	Training Of Auxiliary Nurse Midwife/Dais/Lady Health Visitor Supervisor Etc.
2059				**Public Works**

Source: Detailed Demand for Grants, Department of Health and Family Welfare, Government of Himachal Pradesh.

Further, expenditure incurred by local government on healthcare is also taken into account of public health expenditure and this is also divided into current and capital expenditure. Over and above the expenditure incurred by DoHFW and local government, expenditures of other state government departments, primarily on "Medical Reimbursement" and "Medical Facilities" are included in the Current Public Health Expenditure. The following table summarises the different heads of Public Health Expenditure:

Table V. 2: Total Public Health Expenditure of the state

S. No.	Heads	Expenditure (Rs. crore)
1 (2+3)	**DoHFW Revenue Account** (2210 + 2211+2059+2216+2235)	1552.3
2	- Current Expenditure	1132.3
3	- Capital Formation	420.0
4	**DoHFW Capital Account (4210)**	188.1
5	Local Government Health Expenditure	27.5
6 (7+9)	**Other State Departments – Revenue Account**	314.7
7	- Medical Reimbursements and Recovery- All Departments	150.9
8	- Medical Reimbursements and Recovery- All Departments (Excluding the department of Planning and Backward Area Sub-Plan, Tribal Development and Scheduled Caste Sub-Plan)	150.4
9 (11+15)	- Medical & Public Health component (net of Medical Reimbursement) in:	163.8
10	- Current Expenditure	151.6
11 (12 + 13 +14)	- Current Expenditure (Excluding Reimbursement))	151.1
12	Planning and Backward Area Sub-Plan	23.2
13	Tribal Development	40.2
14	Scheduled Caste Sub-Plan	87.7
15 (16 + 17 +18)	- Capital Formation	12.7
16	Planning and Backward Area Sub-Plan	0.0
17	Tribal Development	3.2
18	Scheduled Caste Sub-Plan	9.5
19 (20 + 21 + 22)	**Other State Departments – Capital Account (4210)**	74.74
20	Planning and Backward Area Sub-Plan	3.57
21	Tribal Development	21.50
22	Scheduled Caste Sub-Plan	49.67
19 (1 + 4 + 5+ 6 + 19)	Total Public Health Expenditure	2158.04
20 (2 + 5 + 8 + 10)	- Current Expenditure	1461.8
21 (3 + 4 + 15 + 19)	- Capital Formation	695.64

Source: Detailed Demand for Grants, Department of Health and Family Welfare, Government of Himachal Pradesh.

The compilation of Total Public Current Health Expenditure reveals its value to be amounting to Rs. 1461.8 crore and the Total Public Health Capital Expenditure stands at Rs. 620.8 crore for Himachal Pradesh, for 2017-18.

The total public health expenditure or the expenditure on Medical and Family Welfare by the DoHFW of the state, for 2017-18, stood at Rs. 1740.4 crore. This constitutes of the revenue and capital accounts of the following five major heads.

1. Medical and Public Health
2. Family Welfare
3. Public Work
4. Housing
5. Social Security and Welfare

At Rs. 1552.2 crore, Medical and Public Health accounts for 79.7 percent of total public health expenditure, in 2017-18. Most of the expenditure is incurred on revenue account, which comprised 89.1 percent of the total health expenditure. Table V.3 presents the values of expenditure incurred by state government's DoHFW on these heads, by revenue and capital accounts.

Table V. 3: Public Health Expenditure by DoHFW

Codes	Budget Heads	2017-18
Revenue		(Rs. crore)
2059	Public Works	9.8
2210	Medical and Public Health	1237.5
2211	Family Welfare	303.2
2216	Housing	1.4
2235	Social Security and Welfare	0.10
	Total Revenue Account	1552.2
Capital		
4210	Capital Outlay on Medical and Public Health	188.1
4211	Capital Outlay on Family Welfare	-
	Total Capital Account	188.1
Total		1740.4

Source: Detailed Demand for Grants, Department of Health and Family Welfare, Government of Himachal Pradesh.

The sub-major heads of Revenue Account of Medical and Public Health are the following.

1. Urban Health services - Allopathy
2. Urban Health services – Others systems of medicine
3. Rural Health services - Allopathy
4. Rural Health services – Others systems of medicine
5. Medical Education, Training and research
6. Public Health

Among these heads, the maximum allocation is towards Medical Education, Training and Research, which accounts for 33.0 percent of total current expenditure of DoHFW (Figure V.1). This is followed by Rural Health Services and Urban Health Services accounting for 27.0 percent and 22.8 percent respectively. On the other hand, other systems of medicine, including Ayuvedic and Homeopathy, account for 13.0 percent of the total expenditure, of which over 53.8 percent is

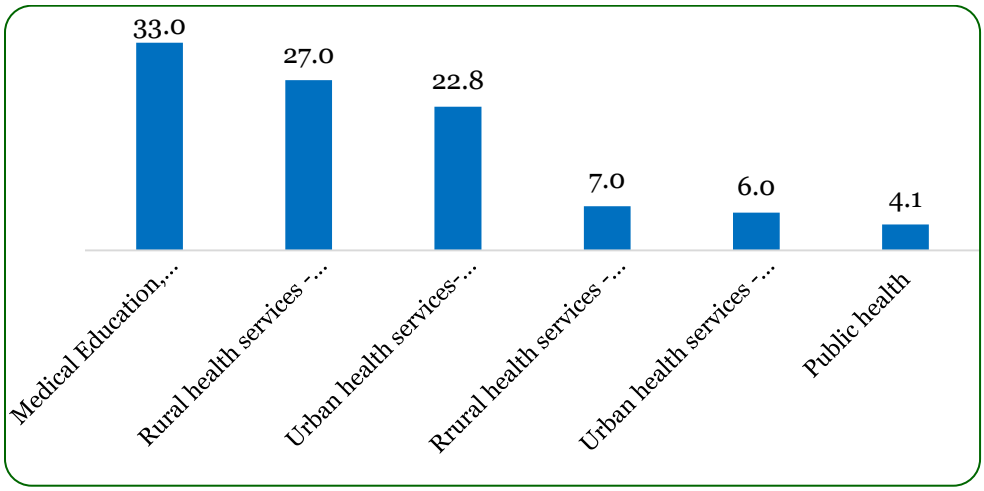
incurred on Rural Health Services while the remaining is incurred on Urban Health Services (Table V.4 and Figure V.1).

Table V. 4: Components of Revenue account of Medical and Public Health

	Budget Heads	Amount (Rs. crore)
1	Medical and Public Health	1237.56
2	Urban Health Services-Allopathy	282.31
3	Urban Health Services -Other Systems of Medicine	74.38
4	Rural Health Services -Allopathy	334.45
5	Rural Health Services -Other Systems of Medicine	86.76
6	Medical Education, Training & Research	408.66
7	Public Health	50.99

Source: Detailed Demand for Grants, Department of Health and Family Welfare, Government of Himachal Pradesh.

Figure V. 1: Composition of Revenue Account of DoHFW Medical and Public Health Expenditure (% distribution)



Source: Detailed Demand for Grants, Department of Health and Family Welfare, Government of Himachal Pradesh.

The sub-major heads of the capital account of Medical and Public Health are the following.

1. Urban Health Services
2. Rural Health Services
3. Medical Education, Training and Research
4. Public Health

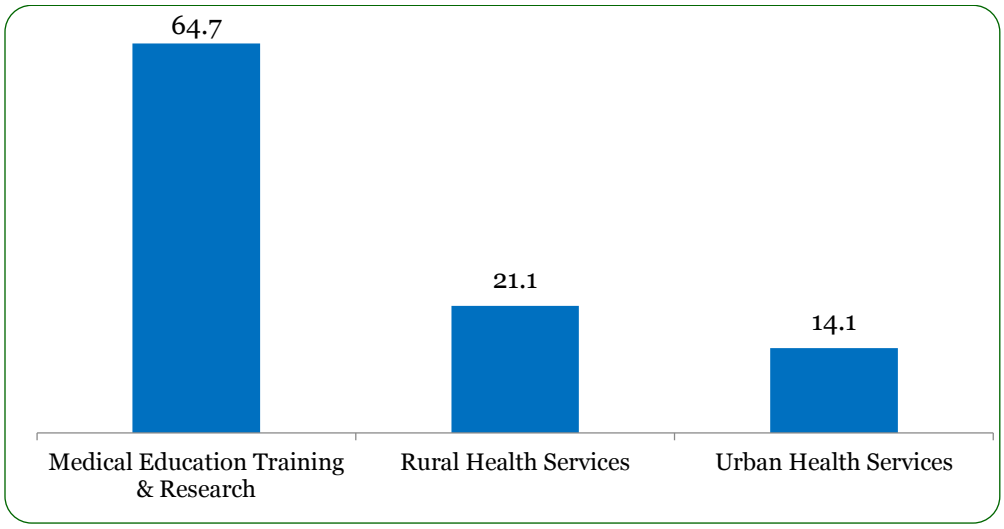
The allocation towards Public Health is nil for 2017-18. The values of expenditure and the percentage distribution of budget allocation towards these heads is presented in Table V.5 and Figure V.2 below.

Table V. 5: Components of capital account of Medical and Public Health

	Budget Heads	**Amount (Rs. crore)**
1	Medical and Public Health	**188.13**
2	Urban Health Services	26.60
	Hospitals & Dispensaries - Major Works	*26.6*
3	Rural Health Services	39.73
	Hospitals & Dispensaries - Major Works	*39.7*
4	Medical Education Training & Research	121.80
	Ayurveda	*7.7*
	Medical College	*17.2*
	Dental College	
	Dr. Rajendra Prasad Medical College Tanda.	*4.0*
	Construction of medical college at Nahan	*15.8*
	Construction of medical college at Hamirpur	*33.9*
	Construction of medical college at Chamba	*43.2*
5	Public Health	0.00

Source: Detailed Demand for Grants, Department of Health and Family Welfare, Government of Himachal Pradesh.

Figure V. 2: Composition of Capital Account of DoHFW Medical and Public Health Expenditure (% distribution)



Source: Detailed Demand for Grants, Department of Health and Family Welfare, Government of Himachal Pradesh.

Among the other state departments, the following departments show expenditure under the major head 2210, that is, Medical and Public Health; and under the head 4210, that is, Capital Outlay on Medical and Public Health. These are:

- Planning and Backward Area Sub-Plan
- Tribal Development
- Scheduled Caste Sub-Plan

The following table presents the details of their health expenditure (including Medical Reimbursements) by sub-major heads:

Table V. 6: Details of health expenditure by other departments

	Other Departments	Rs. crore
	Planning and Backward Area Sub-Plan	
1 (2 to 4)	Revenue - Medical and Public Health	23.4
2	Rural Health Services –Allopathy	12.3
3	Rural Health Services -Other Systems of Medicine	10.5
4	Public Health	0.6
5	Capital outlay - Medical and Public Health	3.6
	Tribal Development	
5 (6 to 9)	Medical and Public Health	43.6
6	Rural Health Services –Allopathy	26.6
7	Rural Health Services -Other Systems of Medicine	9.0
8	Medical Education, Training & Research	3.2
9	Public Health	4.8
10	Capital outlay - Medical and Public Health	21.5
	Scheduled Caste Sub-Plan	
10 (11 to 13)	Medical and Public Health	97.3
11	Rural Health Services –Allopathy	76.1
12	Rural Health Services –Other Systems of Medicine	11.6
13	Medical Education, Training & Research	9.5
14	Capital outlay - Medical and Public Health	49.7

Source: Detailed Demand for Grants of respective departments, Government of Himachal Pradesh.

The following sections present Public Current Health Expenditure by the four dimensions of the Health Satellite Account, that is, by sources of finance, financing schemes, functions and providers of healthcare facilities.

V.1.1. Public Health Current Expenditure by Healthcare Financing Schemes

This section presents the public healthcare current expenditure of the state by healthcare financing schemes. Each of the budget line items of expenditure has been classified into the

Healthcare Financing Schemes, described in chapter IV. The classification is based on the SHA-2011 framework.

Health care financing schemes are the main types of financial arrangements through which people obtain health care services. A Financing scheme may raise its revenue from several sources, and it can be operated by more than one financial agent. As far as states are concerned, they are largely independent in matters relating to the delivery of healthcare to the people (National Health Accounts – Guideline for India-2016). Each state has developed its own system of healthcare delivery, independent of the central government. However, they receive funds from the central government and implement some of the central government programmes. Some examples of Health care financing schemes, at the state level, include government schemes (central, state, and local), Social insurance, voluntary insurance and direct out-of-pocket payments to buy health care services.

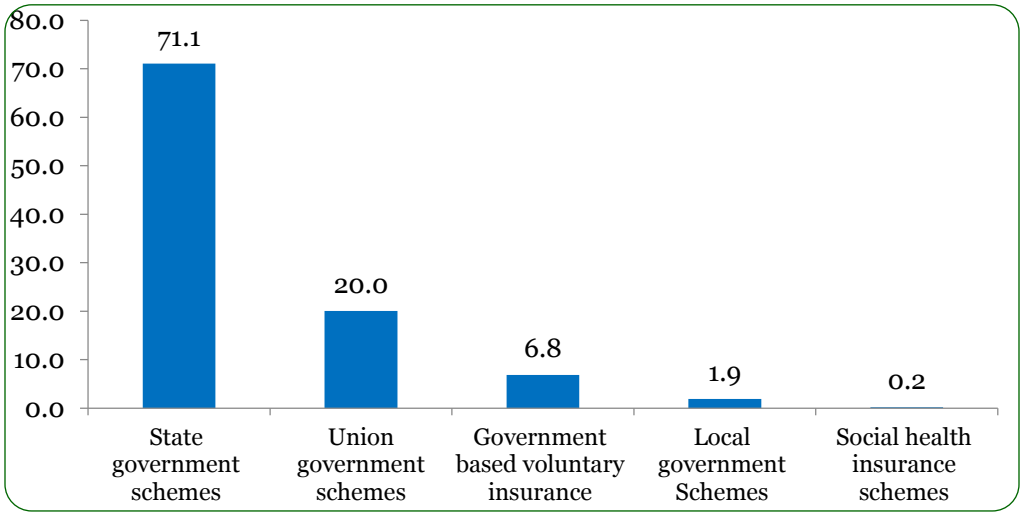
Table V.7 presents the Public Expenditure by Financing Schemes and Figure V.3 presents its percentage distribution.

Table V. 7: Public Health Current Expenditure by Financing Schemes

SHA Code	Classification of Financing Schemes (HF)	Expenditure (Rs. crore)
(HF 1.1.1)	Union government schemes	293.1
(HF 1.1.2.1)	State government schemes	1039.0
(HF 1.1.2.2)	Local government Schemes	27.5
(HF 1.2.1)	Social health insurance schemes	2.7
(HF 2.1.1.2)	Government based voluntary insurance	99.6
	Total	1461.8

Source: NCAER computation

Figure V. 3: Distribution of Public Health Current Expenditure by Financing Schemes (%)



Source: NCAER computation

Key Findings:

- Of the total public health expenditure of Rs. 1461.8 crore, state government's share is the highest, at 71.1 percent, during 2017-18.

- The Union government contributed 20 per cent and the Local government accounted for just 1.9 per cent.
- The share of government based voluntary insurance schemes in total public expenditure stood at 6.8 per cent.

- The share of Social health insurance, comprising of Employees State Insurance schemes, in total public expenditure stood at 0.2 per cent.

V.1.2. Public Health Current Expenditure by Revenues of Financing Schemes

In order to present the public health expenditure across revenues of financing schemes, each of the budget line item of expenditure has been classified into the following categories, based on the SHA-2011 framework:

- Internal transfers and grants-Union Government
- Internal Transfers and grants- State Government
- Internal transfers and grants - Local government
- Voluntary prepayment from individuals/households
- Social Insurance contributions

The revenues of financing schemes describe the revenue sources for each financing scheme given in the previous section. These indicate how the funds under different schemes are mobilised. The sources of revenue are government budgets, household's contributions to social security, or direct payments of households for health services. Hence, the health accounts not only aim at understanding the health expenditure but also analyse the revenue-raising mechanism, giving details of the origin of funds, the destination of fund flows, and nature of these flows.

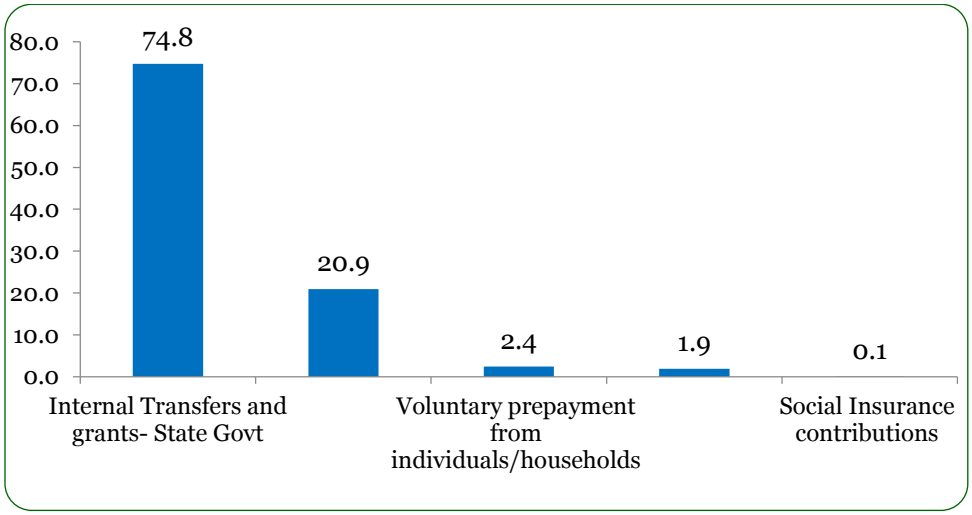
Following the SHA 2011 manual and based on data availability, the classification of revenues of health care financing schemes used for the state Health Satellite Account is as provided in Table V.8, which also presents the Public Expenditure by Revenues of Financing Schemes. Figure V.4 presents their percentage distribution.

Table V.8: Public Health Current Expenditure by Revenues of Financing Schemes

SHA CODE	Classification of Revenues of Financing Schemes (FS)	Expenditure (in crores)
(FS 1.1.1)	Internal transfers and grants-Union Government	305.5
(FS 1.1.2)	Internal transfers and grants- State Government	1092.8
(FS 1.1.3)	Internal transfers and grants - Local government	27.5
(FS 3)	Social insurance contributions	0.9
(FS 5.1)	Voluntary prepayment from individuals/households	35.2
	Total expenditure	1461.8

Source: NCAER computation.

Figure V. 4: Distribution of Public Health Current Expenditure by Revenues of Financing Schemes (%)



Source: NCAER computation.

Key Findings:

- Of the total public health expenditure of Rs. 1461.8 crore, most of the revenue is sourced from the state government's Internal Transfers and Grants, which accounts for 74.8 percent of total expenditure.

- This is followed by transfers from Union government on 100 percent centrally sponsored schemes like National AIDS Control Programme, Prevention and Control of Blindness, Family Welfare Centres in Rural and Urban areas; or 90 percent centrally sponsored schemes like National Rural Health Mission, 10 percent of which is allocated under state government transfers.

- Besides these, there are government-sponsored insurance schemes which are other sources of revenue (See Box 1). These are the Himachal Pradesh Universal Health

Protection Scheme (HPUHPS), Rashtriya Swasthya Bima Yojna (RSBY), and centrally sponsored National Health Insurance Schemes. Based on the scheme guidelines, the expenditure incurred on these schemes are allocated to Internal Transfers of Union government, state government, and voluntary prepayment by individuals or households towards these government insurance schemes. The expenditure is equally divided among these source categories if the breakup is not available.

- Hence derived value of voluntary prepayment by individuals/households is estimated to be 2.4 percent of total public health expenditure.

- Another important source of revenue for Public health expenditure in the state of Himachal Pradesh is Social Insurance contributions. These have a financing arrangement that ensures access to health care based on payment of non-risk payment by on or behalf of eligible persons. These contributions are mostly wage-related and are shared between employers and employees and by the government. Social health insurance contributions include payments made through the employment state insurance scheme implemented by the employment state insurance corporation. Thus, the share of social insurance contributions accounted for a negligible share of 0.1 per cent of the total public health expenditure

Box 1: Health Insurance Schemes in Himachal Pradesh

Himachal Health Care Scheme (Himcare)

Himachal Health Care Scheme (Himcare) is a state government scheme, which takes forward the central scheme of Ayushman Bharat, to cover many more families under the scheme and take benefit of health insurance. Ayushman Bharat is a flagship scheme of Government of India which was launched to achieve the vision of Universal Health Coverage (UHC). Himcare aims at providing health insurance cover of Rs. 5 lakh per year per family, which is being provided on family floater basis. In case of more than five members, the remaining members are being enrolled as a separate unit subject to the capping of five members for each such additional unit. This scheme is being implemented on co-payment basis. Under this scheme, differential premium rates have been decided based on the categories. Since the scheme started in 2019, this scheme is not covered in the Health Satellite Account, 2017-18.

Rashtriya Swasthya Bima Yojna (RSBY)

Rashtriya Swasthya Bima Yojna (RSBY) is a government-run health insurance scheme for the household identified by the Government of Himachal Pradesh. This scheme is being implemented in the Himachal Pradesh since 2008 initially covering only two districts i.e. Shimla and Kangra, later it was implemented on all over the state from 1st March, 2010. It provides cashless health benefits for hospitalization in empanelled public and private hospitals. It is a cashless scheme provided through smart cards. The scheme is designed by GOI, Ministry of Labour & Employment provides health insurance coverage of R 30,000 on family floater basis (maximum five members are covered) in a policy period to all the RSBY smart card holders by covering more than 1100 diseases. The premium is being shared between centre and state in the ratio of 75:25.

Himachal Pradesh Universal Health Protection Scheme (HPUHPS).

Himachal Pradesh Universal Health Protection Scheme (HPUHPS) implemented by the Government of Himachal Pradesh to improve access of enrolled beneficiaries and their families to quality healthcare for cashless treatment of diseases involving hospitalization through empaneled healthcare providers. In the family maximum five members can be enrolled in a smart card so if the family is more than five, one additional card is given to the family. There is no family cap. Coverage of health services is provided on a day care basis and benefit is provided through only smart card.

Employees State Insurance Scheme (ESIS)

The Employees' State Insurance Scheme is an integrated measure of social insurance embodied in the Employees' State Insurance Act and it is designed to accomplish the task of protecting employees as defined in the Employees' State Insurance Act, 1948 against the impact of incidences of sickness, maternity, disablement and death due to employment injury and to provide medical care to insured persons and their families. The ESI Scheme is financed by contribution from employers and employees. The rate of contribution by employer is 4.75% of the wages payable to employees. The employees' contribution is at the rate of 1.75% of the wages payable to an employee. In the beginning, the ESI Scheme was implemented at just two industrial centres in the country in 1952, namely Kanpur and Delhi. Keeping pace with the process of industrialization, the scheme today, stands implemented at over 843 centres in 33 States and Union

V.1.3. Public Health Current Expenditure by Healthcare Functions

The system of health accounts (SHA 2011) defines health care functions as groups of health care goods and services that are consumed by households. The main purpose of these services is to improve, maintain and prevent the deterioration of the health status of the person, and mitigate the consequences of ill-health through proper medical, nursing, and paramedical knowledge which can include modern medicine and traditional, complementary, and alternative medicine. These health care functions can be consumed at individual level or group level. Collective services are aimed at the whole population and include services such as monitoring and evaluation of specific disease control programmes and governance and administrative services that improve the efficiency of the overall health system that in turn benefits all health care recipients.

Other than the major healthcare functions, the classification also includes two reporting items. These are:

- HC.RI.1 indicates the expenditure under the line item related to Total Pharmaceutical Expenditures (TPE). This code is useful, to sum up, all the expenditures that belong to pharmaceutical expenditures from various data sources in this section and elsewhere.

- HC.RI.2 indicates that the expenditure under the line item is related to Traditional Alternative Complementary Medicine (TCAM). This code is useful, to sum up, all the expenditures that belong to TCAM from various data sources in this section and elsewhere. The purpose of reporting TCAM separately is because of its policy relevance due either to its cultural importance or its high growth rate. Mainstreaming of AYUSH has been prominent under government health expenditures and social health insurance schemes make it very important in the Indian context more so now by the establishment of a separate Union Ministry for AYUSH.

Expenditures reported in the budget document, when mapped against the SHA 2011 classifications, results in multiple revenue sources, healthcare providers, and healthcare functions. This calls for the given line item's expenditures to be apportioned or split among the related classification codes. Arriving at proportions of these splits is called the development of allocation keys. Such splits under any of the classifications can be arrived from the existing data sources, say, NSS 75th round of survey on "Household Consumption on Health: 2017-18". For example, the budgetary allocation towards hospitals, dispensaries or clinics is a mix of allocation towards Inpatient and Outpatient curative care. This is because, in general, hospitals, dispensaries, or clinics are providers of both inpatient and outpatient healthcare, as also as preventive care and medical goods. Hence, in such cases of multiple mapping, allocation ratios have been used to apportion the expenditure into different healthcare functions. The NSS survey data has been used to arrive at the following allocation ratios (Table V.9).

Table V. 9: Allocation Ratios for Healthcare Functions

Healthcare Functions	Allocation Ratios	
Inpatient curative care	0.84	1.00
Outpatient curative care	0.16	
Inpatient curative care	0.50	1.00
Governance and health system and financing administration	0.50	
Governance and health system and financing administration	0.50	1.00
Preventive Care	0.50	

Source: NCAER computation.

In the cases, where NSS data, being a household survey, is unable to provide the allocation ratios, the value of expenditure has been equally distributed across the mapped healthcare functions. For example, the healthcare insurance schemes correspond to the combination of two healthcare functions, that is, Inpatient Curative Care (HC.1.1) and Governance and Health System and Financing Administration (HC.7).

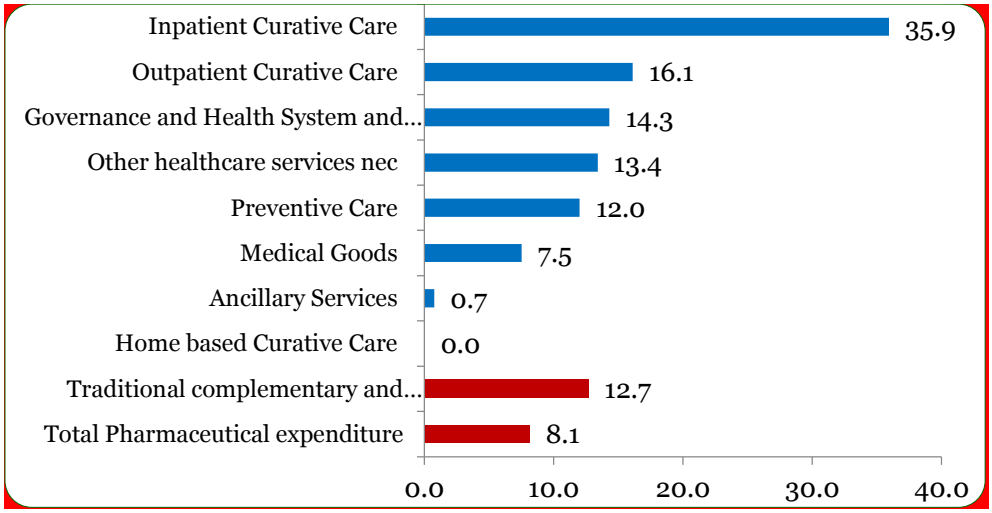
As done for Financing Schemes and Revenues of schemes, each line item of the budget is mapped with the healthcare functions. The public health expenditure classified according to the healthcare functions is presented in the Table V.10. Figure V.5 presents the percentage distribution of the same.

Table V.10: Public Health Current Expenditure by Healthcare Functions

SHA CODE	Classification of Health care Functions (HC)	**Expenditure** (in Rs. crore)
(HC.1.1.)	Inpatient Curative Care	525.3
(HC 1.3)	Outpatient Curative Care	235.5
(HC 1.4)	Home-based Curative Care	0.0
(HC 4)	Ancillary services	10.9
(HC 5)	Medical Goods	109.9
(HC 6)	Preventive Care	175.6
(HC 7)	Governance and Health System and Financing Administration	209.2
(HC 9)	Other healthcare services nec	195.4
	Total	**1461.8**
(HC.RI.1)	Total Pharmaceutical expenditure	118.8
(HC.RI.2)	Traditional complementary and alternative medicine (TCAM)	185.4

Source: NCAER computation.

Figure V. 5: Distribution of Public Health Current Expenditure by Healthcare Functions (%)



Source: NCAER computation.

Key Findings:

- Table V.10 reveals that Inpatient curative care has the highest share in public health spending, accounting for 35.9 per cent. Outpatient care (16.1 per cent) accounted for the second-highest public expenditure in the state, further followed by Governance and Health system and Finance Administration (14.3 per cent).
- The Reporting Item, "Traditional, Complementary and Alternative Medicines" contributed to 12.7 per cent of total public expenditure while the "Total pharmaceutical expenditure" accounted for 8.1 per cent of total public spending.
- Importantly, the Other health care services n.e.c accounted for 13.4 per cent of the total public health expenditure followed by preventive care (12 per cent) and medical goods (7.5 per cent).
- Ancillary services accounted for 0.7 per cent of total public expenditure.

V.1.4. Public Health Current Expenditure by Healthcare Providers

Health care providers are the final recipient of health care funds. They include such organizations which are involved in the provision of health care as one of their primary activities or one activity among other activities. According to the SHA 2011, health care providers can be divided into primary and secondary providers. Primary health care providers are those providers whose principal activity is to deliver health care goods and services.

Some examples of primary providers include general and specialist physicians, emergency and ambulance services, hospitals, health centres, laboratories, nursing care facilities, and

pharmacies. Secondary providers include providers of health care system financing and administration and households as the provider of health care services.

Like healthcare functions, some of the budget line items are mapped with multiple healthcare providers. Such value of expenditures is also apportioned using the allocation ratios, as obtained from NSS 75th round of the survey. These allocation ratios are presented in Table V.11.

Table V.11: Allocation Ratios for Healthcare Providers

Healthcare Providers	Allocation Ratios	
General Hospital – government	0.9734	1.0000
Ambulatory Healthcare Centres	0.0266	
Providers of Preventive care	0.5000	1.0000
Providers of healthcare system administration and financing	0.5000	

Source: NCAER computation.

In the cases, where NSS data, being a household survey, is unable to provide the allocation ratios, the value of expenditure is equally distributed across the mapped healthcare providers. For example, Indira Gandhi Balika Suraksha Yojana corresponds to the combination of two healthcare providers, that is, Providers of Preventive Care (HP.6) and Providers of Healthcare System Administration and Financing (HP.7). The value of expenditure for this line item is equally distributed across HP.6 and HP.7.

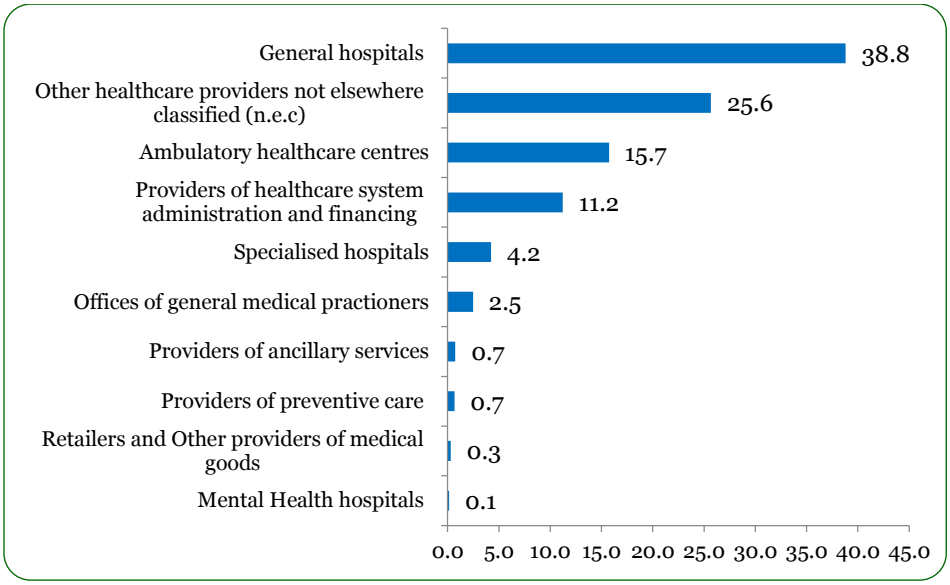
Each line item of the budget is mapped with the healthcare providers. The public health expenditure classified according to the healthcare providers is presented in the Table V.12. Figure V.6 presents the percentage distribution of the same.

Table V.12: Public Health Current Expenditure by Healthcare Providers

SHA CODE	Classification of Health care Providers (HP)	Expenditure (In Rs. crore)
(HP.1.1)	General hospitals	567.5
(HP 1.2)	Mental health hospitals	2.1
(HP 1.3)	Specialised hospitals	62.0
(HP 3.1)	Offices of general medical practioners	36.1
(HP 3.4)	Ambulatory healthcare centres	230.0
(HP 4)	Providers of ancillary services	10.9
(HP 5)	Retailers and other providers of medical goods	4.3
(HP 6)	Providers of preventive care	9.9
(HP7)	Providers of healthcare system administration and financing	164.1
(HP 10)	Other healthcare providers not elsewhere classified (n.e.c)	374.9
	Total Public Expenditure	**1461.8**

Source: NCAER computation.

Figure V. 6: Distribution of Public Health Current Expenditure by Healthcare Providers (%)



Source: NCAER computation.

Key Findings:

- The highest public spending was incurred on General hospitals that accounted for about 38.8 per cent of total public expenditure.

- Other health care providers, which include health providers within boundaries of autonomous universities, research institutions, and international organizations, accounted for about 25.6 per cent of total public expenditure.

- Ambulatory health care centres, which include establishments that provide a wide range of outpatient services accounted for 15.7 per cent of total public health expenditure followed closely by providers of health care system administration and financing that received an allocation of 11.2 per cent of total public expenditure.

- Total public expenditure on specialised hospitals accounted for 4.2 per cent followed by other government health care practitioners (2.5 per cent), providers of preventive care (0.7 per cent) and provider of ancillary services (0.7 percent).

- Retailers and providers of medical goods are estimated to have a share of 0.3 per cent of the total public expenditure. Also Government mental hospitals had a share of 0.1 per cent of total public expenditure in the state.

V.1.5. Total Public Health Expenditure by Factors of Provision

Factors of provision are the valued inputs that are used in the provision of health care. Factors of provision include a mixture of factors of production –Land, capital, materials and supplies, and externally produced services. It includes both health and non-health specific inputs that are needed to generate health care services. Some of the common factors of provision laid out by the SHA 2011 are:

- Personnel involved in Healthcare, IT, Repairs and Maintenance, Security, and other services
- Capital consumed, which includes the use of buildings, Vehicles, and medical and office equipment
- Medical materials and supplies such as serum, syringes, pharmaceuticals, cotton, wound dressings as well as non-medical goods such as electricity, water, stationery, and cleaning supplies
- Externally purchased services which include Laboratory and imaging services, patient transportation, renal analysis, dialysis, and any outsources support services such as food preparation for patients, cleaning, washing, security and garden services, repair and maintenance, and other administrative services

As mentioned in previous sections, for classifying the budget expenditure by healthcare financing schemes, revenues of financing schemes, healthcare functions, and healthcare providers, mapping is done with each line item of the budget major, sub-major, minor and sub-minor heads. However, for classifying the budget expenditure by factors of provision, each object head under each sub-minor head is mapped with the different factors of provision. The object code is the sixth tier of the 6-tier coding system of a DDG.

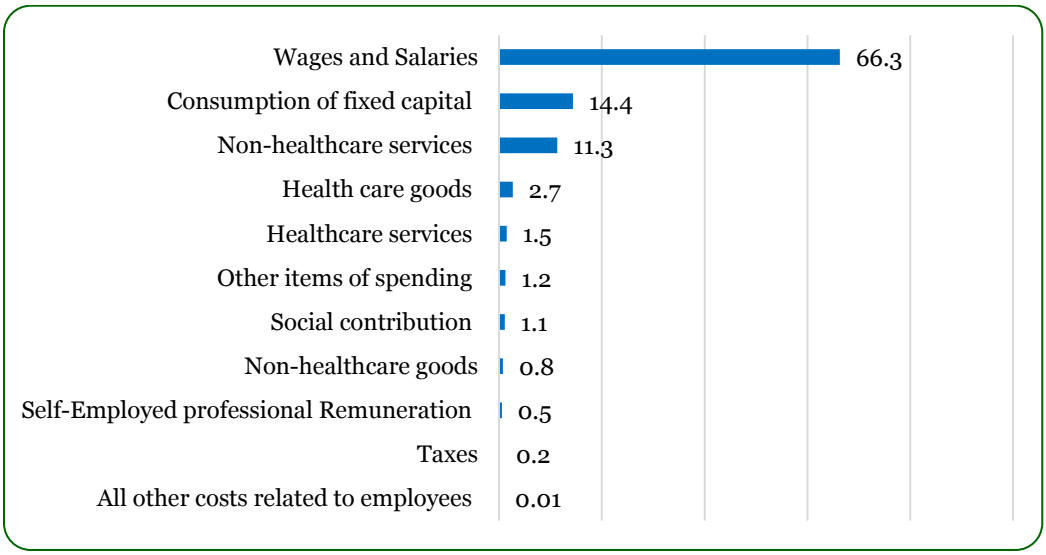
The public health expenditure classified according to the factors of the provision is presented in the Table V.13. Figure V.7 presents the percentage distribution of the same. It may be noted that since factors of provision comprise both labour and capital cost, total public expenditure in Table V.13 is the combination of both current and capital expenditure, that is, Rs. 1740.4 crore.

Table V.13: Total Public Health Expenditure by Factors of Provision

SHA Code	Factors of Health care Provision	Expenditure (Rs. crore)
FP.1	Compensation of employees	1173.1
FP.1.1	Wages and Salaries	1153.7
FP.1.2	Social contribution	19.1
FP.1.3	All other costs related to employees	0.2
FP.2	Self-Employed professional Remuneration	9.5
FP.3	Material and Supplies	282.8
FP.3.1	Healthcare services	25.6
FP.3.2	Health care goods	46.8
FP.3.3	Non-healthcare services	197.1
FP.3.4	Non-healthcare goods	13.3
FP.4	Consumption of fixed capital	250.5
FP.5	Other items of spending on inputs	24.6
FP.5.1	Taxes	3.3
FP.5.2	Other items of spending	21.2
Total	**Total (FP 1+FP2 +FP3 +FP 4 +FP5)**	**1740.4**

Source: NCAER computation.

Figure V. 7: Distribution of Total Public Health Expenditure by Factors of Provision (%)



Source: NCAER computation.

Key Findings:

- In terms of Public health expenditure by Factors of provision, employee remuneration (comprising of wages and salaries, social contribution, and other allowances or other costs

related to employees) emerged as the largest input in health care service provisioning in Himachal Pradesh accounting for a total of 67.4 per cent of total public health expenditure.

- Among the constituents of staff remuneration, salaries account for 66.3 percent of total public health expenditure, social contributions being 1.1 per cent, and other costs related to employees accounting for 0.01 per cent.

- Fixed capital accounts account for the second-largest share after wages and salary at about 14.4 per cent of total public health expenditure. This includes capital expenditure for the creation of assets and major works involving construction and expansion.

- Non-Health care services account for 11.3 per cent of the total public health expenditure. Non-healthcare services include office expenses, maintenance of vehicles, payment for consultancy, publication, advertisement, guest expenses, food expenses, etc.

- Health care goods, like hospital equipment, medicine, and chemicals, materials, and supplies, etc. constitute only 2.7 percent of total public health expenditure. Health care services constitute just 1.6 percent of total public health expenditure followed by other items of spending which account for 1.2 per cent of total public spending

- Non-health care goods contributed to 0.8 per cent of the total public health expenditure. This factor of provision includes general goods used for health care production not specifically related to health care. Examples-Office supplies, kitchen supplies, transport, electricity, water, etc.

V.2. Private Health Expenditure

Private health expenditure is the expenditure incurred by private households on healthcare goods and services. This expenditure is incurred either through direct out-of-pocket expenditure or indirectly through prepayments as health insurance contributions and premium.

Out-of-pocket expenditure (OOPE) refers to the payments made by an individual or a household at the point of service directly, where the cost of the health goods or services is either not covered under any social protection or insurance scheme or is partially covered. Himachal Pradesh has a very high household health expenditure. OOPE includes expenditure on healthcare functions like inpatient care, outpatient care, family planning, immunization, drugs, diagnostics, medical non-durables, therapeutic appliances from various healthcare providers.

The data sources which have been used to estimate the private health OOPE are the following:

- "Household Social Consumption: Health", a household survey conducted by the National Sample Survey Office (NSSO), during 2017-18, as part of the 75th round of its surveys. The survey was aimed at generating basic quantitative information on the health sector. It

captures the details of household expenditure on various heads of healthcare goods and services.

- "Household Consumption Expenditure Survey", a household survey conducted by NSSO, during 2011-12, as part of the 68th round of the survey. The survey collected details of household expenditure on all items of expenditure. For this study, the values of expenditure of those healthcare goods and services have been taken into account, which NSSO's 75th round does not cover. These are family planning devices and therapeutic appliances like contact lenses, hearing aids, and orthopaedic equipment.

- National Family Health Survey (NFHS), a household survey conducted by the Ministry of Health and Family Welfare, in its fourth round conducted during 2015-16. The survey is a national and state representative and provides details on health parameters and also captures healthcare expenditure. For this study, the values of expenditure incurred on family planning services or sterilisation, adopted by men and women, have been taken into account.

- While the reference year for NSS 75th round is 2017-18, which is also the reference year of this study, but the other two data sources, that is, NSS 68th round (2011-12) and NFHS-V (2015-16), have to be extrapolated for 2017-18. For the population adjustment, per person, health expenditure obtained from these sources have been applied to the estimated population for 2017-18. The state-level population estimates or projections are obtained from "Population Projections for India and States, 2011-2036", Report of the Technical Group on Population Projections, National Commission on Population.

- Further, the values of expenditure are price adjusted using the retail inflation of health services for the state of Himachal Pradesh. Retail inflation is inflation based on the Consumer Price Index.

- For indirect household health expenditure through prepayments of health insurance schemes and premium, data is sourced from Insurance Regulatory and Development Authority (IRDA), which provides state-wise Gross Direct premium paid by individuals.

The National Health Accounts – Guideline for India identifies the boundaries for OOPE. These have been considered for the present study as well. According to these boundaries:

- Out of pocket (OOP) expenditures on inpatient and outpatient healthcare, on medicines, doctors' fee, diagnostics, bed charges, surgeries, patient's transportation, and ambulance and other therapies are included

- Medicines/Ancillary services that are purchased or availed independently without prescription from a health professional in the case of self-prescriptions or self-diagnosis such as over the counter medicines are also included as health expenditures.

- Loss of household income has been considered outside the boundary of health.

- Other miscellaneous expenditures incurred by the relatives or friends of the patient like transport cost, food expenditures, lodging charges, wage/labor, etc. are not considered as household health expenditures.

The expenditure line items which have been considered for estimating the private health expenditure, including OOPE and indirect expenditure through prepayments for health insurance schemes or premium, are given in the Table V.14.

Table V. 14 Expenditure line items for Private Health Expenditure

Code	Expenditure Line Items
Out-of-Pocket Expenditure	
HH01	Inpatient care
HH02	Outpatient care
HH03	Over the counter medicines
HH04	Laboratory and Imaging services (Diagnostics)
HH05	Patient's transportation
HH06	Prenatal Care
HH07	Postnatal Care
HH08	Family Planning
HH09	Therapeutic appliances and other medical goods
HH10	Immunization
HH11	Vitamins and minerals
	Delivery at Home
Gross Direct premium	
Private Insurance	Other primary coverage schemes (Individual voluntary health insurance)

The expenditure on "Delivery at Home" is not part of SHA-2011 classification, but given its prominence, it has also been added to OOPE.

While estimating the OOPE from the NSS surveys, it may be noted that:

- Some of the households also report medical reimbursements on expenditure by employers or insurance firms. These were estimated and subtracted from the total medical expenditure.

- The values of expenditure for inpatient care are collected for the 365-day reference period, in the NSS survey. These are taken as it is. However, for expenditure on out-patient care, the reference period is 15 days. These are annualised, as given in NHA-Guidelines of India, by deriving the per-day expenditure and multiplying it by 365.

- Further, since the NSS population is an underestimation, the values are population-adjusted by multiplying the per-capita OOPE by the estimated population for the state for the year 2017-18.

V.2.1. Private Health Current Expenditure by Healthcare Financing Schemes

The entire OOPE is classified under the health financing scheme, HF.3.3, that is, All Households out-of-pocket payments. This is the direct expenditure by households. The indirect expenditure through prepayments for health insurance schemes or premiums (referred to as Individual Voluntary Health Insurance – Premiums or Reimbursements) is classified under HF.2.1.1.3, that is, other primary coverage schemes.

Table V.15 presents the mapping of household expenditure line items with the healthcare financing schemes.

Table V.15: Expenditure line items mapping with Healthcare Financing Schemes

Code	Expenditure Line Items	SHA Code	Financing Schemes
Out-of-Pocket Expenditure			
HH01	Inpatient care	HF.3.3	Household OOP
HH02	Outpatient care	HF.3.3	Household OOP
HH03	Over the counter medicines	HF.3.3	Household OOP
HH04	Laboratory and Imaging services (Diagnostics)	HF.3.3	Household OOP
HH05	Patient's transportation	HF.3.3	Household OOP
HH06	Prenatal Care	HF.3.3	Household OOP
HH07	Postnatal Care	HF.3.3	Household OOP
HH08	Family Planning	HF.3.3	Household OOP
HH09	Therapeutic appliances and other medical goods	HF.3.3	Household OOP
HH10	Immunization	HF.3.3	Household OOP
HH11	Vitamins and minerals	HF.3.3	Household OOP
	Delivery at Home	HF.3.3	Household OOP
Gross Direct premium			
Private Insurance	Individual voluntary health insurance	HF.2.1.1.3	Other primary coverage schemes

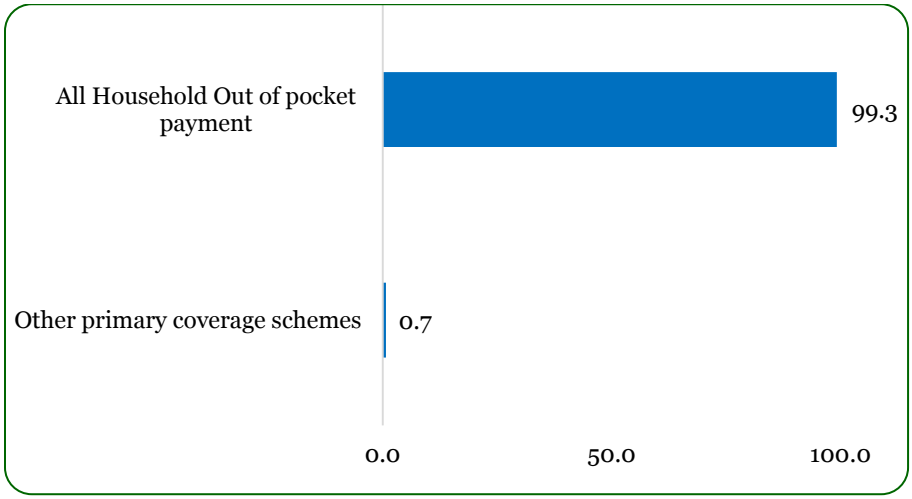
The value of private health expenditure classified by healthcare financing schemes is presented in Table V.16 and the percent distribution is given in Figure V.8.

Table V. 16 Private Health Expenditure by Healthcare Financing Schemes

SHA CODE	Classification of Financing Schemes (HF)	Expenditure (In crores)
HF 3.3	All Household Out of pocket payment	2252.7
HF 2.1.1.3	Other primary coverage schemes	16.4
	Total	**2269.2**

Source: NCAER computation.

Figure V. 8: Distribution of Private Health Expenditure by Healthcare Financing Schemes (%)



Source: NCAER computation.

Key Findings:

- The total value of private health expenditure incurred by the households as their out-of-pocket expenditure is estimated at Rs. 2252.7 crore. This is households' direct payment for healthcare goods and services.

- Other primary coverage schemes or households' prepayment for health insurance schemes and premiums amounts to Rs. 16.4 crore, as per state-wise data on the premium paid, published by IRDA.

- Of the total private health expenditure of Rs. 2269.2 crore in Himachal Pradesh for 2017-18, 99.3 percent is on account of OOPE, or the direct payment by households. The remaining 0.7 percent is spent indirectly through health insurance policy premiums.

- Of the total Private Final Consumption Expenditure of the state, estimated at Rs. 70,209 crore, the expenditure on healthcare goods and services is 3.23 percent.

V.2.2. Private Health Current Expenditure by Revenue of Healthcare Financing Schemes

With respect to Revenues of healthcare financing schemes, the entire OOPE is classified under FS.6.1 or other revenues from households (not elsewhere classified, n.e.c). The indirect household expenditure or insurance payment is classified under FS.5.1 or Voluntary prepayment from individuals or households.

Table V.17 presents the mapping of household expenditure line items with the revenues of healthcare financing schemes.

Table V. 17: Expenditure line items mapping with Revenues of Healthcare Financing Schemes

Code	Expenditure Line Items	SHA Code	Revenues of Healthcare Financing Schemes
Out-of-Pocket Expenditure			
HH01	Inpatient care	FS.6.1	Other revenues from households(nec)
HH02	Outpatient care	FS.6.1	Other revenues from households(nec)
HH03	Over the counter medicines	FS.6.1	Other revenues from households(nec)
HH04	Laboratory and Imaging services (Diagnostics)	FS.6.1	Other revenues from households(nec)
HH05	Patient's transportation	FS.6.1	Other revenues from households(nec)
HH06	Prenatal Care	FS.6.1	Other revenues from households(nec)
HH07	Postnatal Care	FS.6.1	Other revenues from households(nec)
HH08	Family Planning	FS.6.1	Other revenues from households(nec)
HH09	Therapeutic appliances and other medical goods	FS.6.1	Other revenues from households(nec)
HH10	Immunization	FS.6.1	Other revenues from households(nec)
HH11	Vitamins and minerals	FS.6.1	Other revenues from households(nec)
	Delivery at Home	FS.6.1	Other revenues from households(nec)
Gross Direct premium			
Private Insurance	Individual voluntary health insurance	FS.5.1	Voluntary prepayment from individuals/households

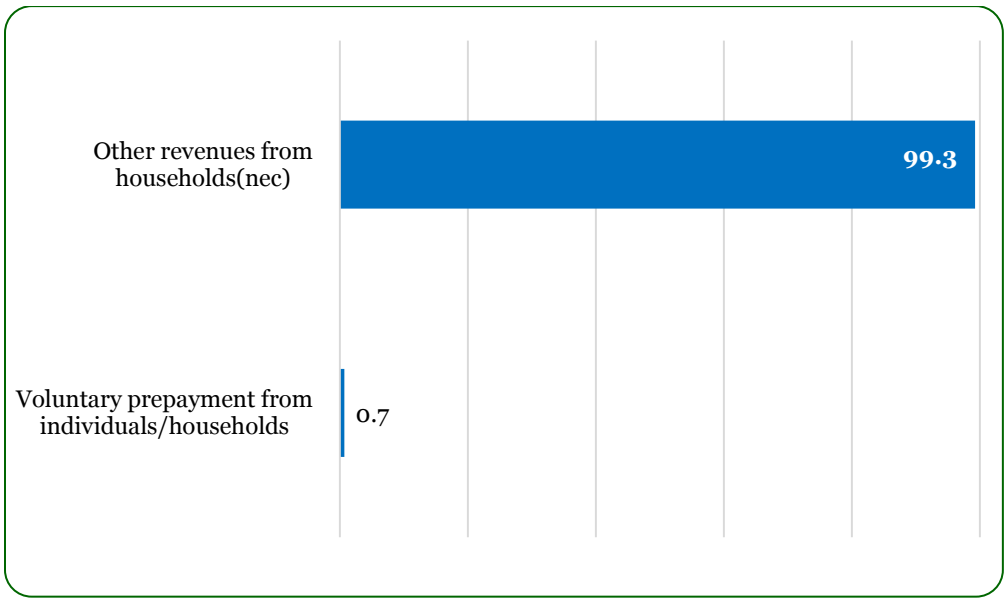
The value of private health expenditure classified by revenues of financing schemes is presented in Table V.18 and the percent distribution is given in Figure V.9.

Table V. 18: Private Health Expenditure by Revenues of Healthcare Financing Schemes

SHA CODE	Classification of Financing Schemes (HF)	Expenditure (In crores)
FS 6.1	Other revenues from households(nec)	2252.7
FS 5.1	Voluntary prepayment from individuals/households (FS 5.1)	16.4
	Total	**2269.2**

Source: NCAER computation.

Figure V. 9: Distribution of Private Health Expenditure by Revenues of Healthcare Financing Schemes (%)



Source: NCAER computation.

V.2.3. Private Health Current Expenditure by Healthcare Functions

The functional classification of private healthcare expenditure is based on the SHA-2011 framework. The values of expenditure by households on healthcare goods and services, obtained from various sources, as discussed before, relate to the expenditure on hospitalization and non-hospitalization treatment. These are classified into inpatient and curative care, respectively. The hospitalization cost or the expenses on inpatient care includes package as well as the non-package component. The following points have to be noted to classify the household OOPE with the Healthcare Functions:

- The items that are included in the non-package component are Doctor's or surgeon's fee, medicines, diagnostic tests, bed charges, excluding the total amount reimbursed by medical insurance company/employer. Also, other medical expenses (attendant charges, physiotherapy, personal medical appliances, blood, oxygen etc.) are included as part of inpatient curative care.
- Classification of OOP expenditures under rehabilitative, long term care, and day care has not been done in the absence of suitable data and the absence of a suitable method for apportioning the available data.
- Expenditure incurred during the last 15 days, not as an in-patient of the medical institution, is classified as Outpatient curative care. This amounts to the sum of expenditure incurred on doctor's or surgeon's fee, medicines (AYUSH and others),

diagnostic tests and other medical expenses (attendant charges, physiotherapy, personal medical appliances, blood, oxygen, etc.).

- Almost all line items also have elements of Total Pharmaceutical Expenditure (TPE) as well as Traditional, Complementary, and Alternative Medicines (TCAM) expenditure, both of which are separately classified under Reporting items. These reporting items are important from a policy perspective. TPE includes expenses incurred for treatment of members as an inpatient, outpatient, and expenses incurred on over-the-counter medicines. TCAM expenditure or the medical expenses on Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy (AYUSH) includes the total medical expenditures when the nature of treatment was AYUSH from the inpatient, outpatient, ante-natal, and post-natal treatment.

- While there is an overlapping of TPE and TCAM with other functions across many expenditure line-items, but these are not allocated using any allocation ratios. Instead, the entire value of expenditure is classified under these reporting items. Hence, these are placed separately in the classification by functions, although these are included in other line-items.

- Expenditure on Preventive Care (HC.6) includes expenditures under Immunization programmes (HC.6.2) and Healthy condition monitoring programmes (HC.6.4). Expenditure on immunization is classified under HC.6.2. Pre-natal and post-natal care are classified under HC.6.4.

Table V.19 presents the mapping of household expenditure line items with the revenues of healthcare functions.

Table V. 19: Expenditure line items mapping with Healthcare Functions

Code	Expenditure Line Items	Healthcare Functions and their codes
Out-of-Pocket Expenditure		
HH01	Inpatient care	Inpatient curative care (HC 1.1), Total Pharmaceutical expenditure (HC RI.1), TCAM (HC RI.2)
HH02	Outpatient care	Outpatient Curative care (HC 1.3), Total Pharmaceutical expenditure (HC RI.1), TCAM (HC RI.2)
HH03	Over the counter medicines	All pharmaceuticals and other medical non-durable goods (HC 5.1.4), Total Pharmaceutical expenditure (HC RI.1), TCAM (HC RI.2)
HH04	Laboratory and Imaging services (Diagnostics)	Laboratory and Imaging Services (HC 4.4)
HH05	Patient's transportation	Patient Transportation (HC 4.3)
HH06	Prenatal Care	Healthy condition monitoring programmes (HC 6.4), Total Pharmaceutical expenditure (HC RI.1), TCAM (HC RI.2)
HH07	Postnatal Care	Healthy condition monitoring programmes (HC 6.4), Total Pharmaceutical expenditure (HC RI.1), TCAM (HC RI.2)
HH08	Family Planning	All Therapeutic appliances and other medical goods (HC 5.2.4)
HH09	Therapeutic appliances and other medical goods	All Therapeutic appliances and other medical goods (HC 5.2.4)
HH10	Immunization	Immunization programmes (HC 6.2)
HH11	Vitamins and minerals	All pharmaceuticals and other medical non-durable goods (HC 5.1.4)
	Delivery at Home	Home-based curative care (HC 1.4)
Gross Direct premium		
Private Insurance	Individual voluntary health insurance	Inpatient curative care (HC 1.1), Providers of healthcare system administration and financing (HC 7), Total pharmaceutical expenditure (HC.RI.1)

The overlapping of functions is seen in the case of Individual Voluntary Health Insurance. The multiple functions against this line item are HC.1.1 and HC.7. The expenditure is allocated into these two functions in equal halves.

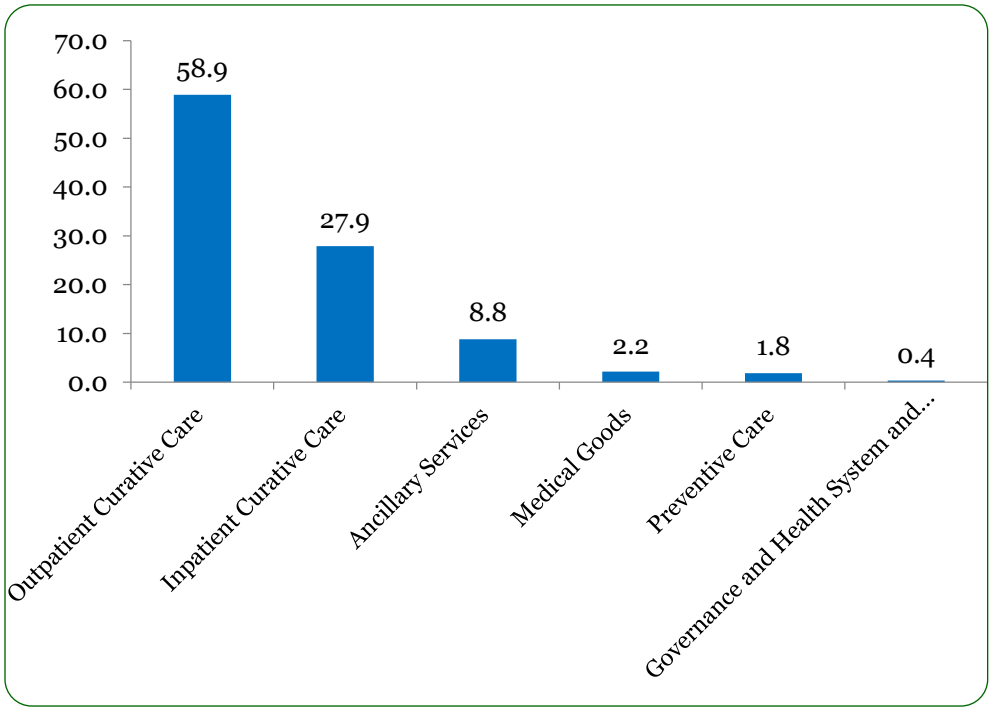
The value of private health expenditure classified by healthcare functions is presented in Table V.20 and the percent distribution is given in Figure V.10.

Table V.20: Private Health Expenditure by Healthcare Functions

SHA CODE	Classification of Health care Functions (HC)	Expenditure (Rs. crore)
(HC.1.1.)	Inpatient Curative Care	633.3
(HC 1.3)	Outpatient Curative Care	1337
(HC 1.4)	Home-based Curative Care	0.5
(HC 4)	Ancillary Services	199.7
(HC 5)	Medical Goods	48.8
(HC 6)	Preventive Care	41.7
(HC 7)	Governance and Health System and Financing Administration	8.2
(HC 9)	Other healthcare services nec	0.0
	Total Private Health Expenditure	**2269.2**
(HC.RI.1)	Total Pharmaceutical expenditure	2046.6
(HC.RI.2)	Traditional complementary and alternative medicine (TCAM)	2030.2

Source: NCAER computation.

Figure V. 10: Distribution of Private Health Expenditure by Healthcare Functions (%)



Source: NCAER computation.

Key Findings:

- Outpatient curative care has the highest share of total private spending accounting for 58.9 per cent of total private expenditure followed closely by Inpatient curative care that accounted for 27.9 per cent of total private health expenditure.

- Expenditure on medical goods has a share of 2.2 per cent of the total private expenditure. Ancillary services captured 8.8 per cent of the total private spending.

- Preventive care services accounted for 1.8 per cent of total private spending while home-based curative care has a share of 0.02 per cent of total private expenditure. Another important health care provider was governance and health system and financing administration that had a share of 0.4 per cent in the total private expenditure.

- The reporting item, TPE, constitutes 90.2 per cent of total private health expenditure. TCAM constitutes 89.5 percent of the same.

V.2.4. Private Health Current Expenditure by Healthcare Providers

The private healthcare expenditure is classified by healthcare providers on the basis of the information collected in the NSS survey on "level of care" as the following categories:

- Government or public hospital (including health sub-centre/Primary Health Centre/Community Health Centre etc.)
- Charitable/Trust/NGO run hospital private hospital
- Private doctor/clinic
- Informal health care provider

Table V.21 presents the mapping of household expenditure line items with the healthcare providers.

Table V.21: Expenditure line items mapping with Healthcare Providers

Code	Expenditure Line Items	Healthcare Providers and their codes
Out-of-Pocket Expenditure		
HH01	Inpatient care	General Hospitals-govt (HP 1.1.1), General Hospitals-Pvt (HP1.1.2), Medical and diagnostic Laboratories (HP4.2), Pharmacies(HP 5.1)
HH02	Outpatient care	General Hospitals-govt (HP 1.1.1), General Hospitals-Pvt (HP1.1.2), Offices of general medical practitioners Pvt-(HP 3.1.1), Medical and diagnostic Laboratories(HP4.2),Pharmacies(HP 5.1),Other healthcare providers n.e.c (HP 10)
HH03	Over the counter medicines	Pharmacies (HP 5.1)
HH04	Laboratory and Imaging services (Diagnostics)	Medical and diagnostic Laboratories (HP4.2)
HH05	Patient's transportation	Providers of Patient transportation and emergency rescue (HP 4.1)
HH06	Prenatal Care	Medical and diagnostic Laboratories (HP4.2), Pharmacies (HP 5.1), Providers of preventive care(HP 6)
HH07	Postnatal Care	Medical and diagnostic Laboratories (HP4.2), Pharmacies(HP 5.1), Providers of preventive care(HP 6)
HH08	Family Planning	Retail sellers and other suppliers of durable medical goods and medical appliances (HP.5.2)
HH09	Therapeutic appliances and other medical goods	Retail sellers and other suppliers of durable medical goods and medical appliances (HP.5.2)
HH10	Immunization	Providers of preventive care (HP 6)
HH11	Vitamins and minerals	Pharmacies (HP 5.1)
	Delivery at Home	Other healthcare providers not elsewhere classified (n.e.c) (HP 10)
Gross Direct Premium		
Private Insurance	Individual voluntary health insurance	General Hospitals - Government (HP.1.1.1), General Hospitals - Private(HP.1.1.2), Specialized hospitals (Other than mental health hospitals)- Government(HP.1.3.1), Specialized hospitals (Other than mental health hospitals) - Private(HP.1.3.2), Providers of healthcare system administration and financing (HP.7)

There are instances of multiple providers classified against single expenditure line-items. In these cases, the expenditure is apportioned by each healthcare provider using the allocation ratios. These allocation ratios are derived from the NSS survey data by estimating the proportion of expenditure of each provider in the combination of providers, as required. The allocation ratios, required to classify the expenditure line-items by healthcare providers, are presented in Table V.22.

Table V.22: Allocation Ratios for Healthcare Providers

Healthcare Providers	Allocation Ratios	
Inpatient		
General Hospital – Government	0.1220	1.0000
General Hospital – Private	0.2509	
Medical and Diagnostic Laboratories	0.1670	
Pharmacies	0.4599	
Outpatient		
General Hospital – Government	0.0180	1.0000
General Hospital – Private	0.0206	
Offices of general medical practitioners Pvt	0.0092	
Medical and Diagnostic Laboratories	0.0702	
Pharmacies	0.8814	
Other healthcare providers n.e.c	0.0002	
Pre-natal Care		
Medical and diagnostic Laboratories	0.0718	1.0000
Pharmacies	0.9013	
Providers of Preventive Care	0.0267	
Post-natal Care		
Medical and diagnostic Laboratories	0.0718	1.0000
Pharmacies	0.9013	
Providers of Preventive Care	0.0267	

Source: NCAER computation.

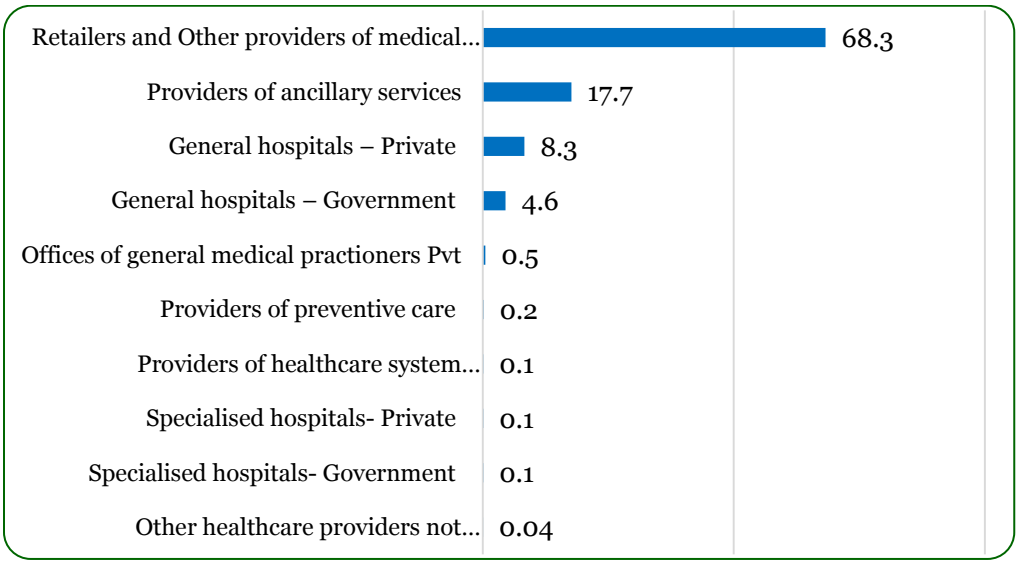
The value of private health expenditure classified by healthcare providers is presented in Table V.23 and the percent distribution is given in Figure V.11.

Table V. 23: Private Health Expenditure by Healthcare Providers

SHA CODE	Classification of Health care Providers (HP)	Expenditure (Rs. crore)
(HP.1.1.1)	General hospitals – Government	103.7
(HP 1.1.2)	General hospitals – Private	187.8
(HP 1.3.1)	Specialised hospitals- Government	3.3
(HP 1.3.2)	Specialised hospitals- Private	3.3
(HP 3.1.1)	Offices of general medical practitioners Pvt	12.4
(HP 4)	Providers of ancillary services	400.8
(HP 5)	Retailers and Other providers of medical goods	1549.4
(HP 6)	Providers of preventive care	4.3
(HP7)	Providers of healthcare system administration and financing	3.3
(HP 10)	Other healthcare providers not elsewhere classified (n.e.c)	0.9
	Total	**2269.2**

Source: NCAER computation.

Figure V. 11: Distribution of Private Health Expenditure by Healthcare Providers (%)



Source: NCAER computation.

Key Findings:

- Of the total private health expenditure of Rs. 2269.2 crore, Retailers and other providers of medical goods constitute the largest share of 68.3 per cent, followed by Providers of ancillary services with a share of 17.7 per cent. Providers of ancillary services include laboratory and imaging services, patient's transportation, part of pre-natal and post-natal care.

- Private Hospitals account for about 8.3 per cent of total private spending while 4.6 per cent of total private expenditure is spent on Public hospitals

- Each of the remaining healthcare providers accounts for less than 3 percent of total private health expenditure, together constituting about 1.2 percent only. These include Offices of general medical practitioners-Private (with the share of 0.5 per cent), Public and Private Specialized hospitals (0.1 per cent each), Governance and health system and finance administration (0.1 percent), providers of preventive care (0.2 per cent), and other health care providers (0.04 per cent).

V.3. Total Health Expenditure

The total healthcare expenditure in the state, taking public and private together and also current and capital, is estimated at Rs. 4351.9 crore. The state Gross Domestic Product for 2017-18 is Rs. 1,38,551 crore. Health expenditure, therefore, amounts to 3.14 percent of GSDP. With an estimated population of 72.33 lakh for 2017-18, the per capita health expenditure works out to be

Rs. 6017.6. The per capita Net State Domestic Product (NSDP), indicator of per capita income, for the state is Rs. 1.65 lakh.

The values of the key indicators of health expenditure are presented in the table below:

Table V. 24 Total Health Expenditure in the state

	Indicators	Expenditure (Rs. crore)
1	Current Health Expenditure – Public	1461.8
2	Capital Health Expenditure – Public	620.9
3	Private Household Expenditure	2269.2
4	Current expenditure on health (1 + 3)	3731.0
5	Health Insurance Expenditure – Private	16.4
6	Health Insurance Expenditure – Public	102.3
7	Total Health Insurance Expenditure (5 + 6)	118.7
8	Total Public Health Expenditure (1 + 2)	2082.7
9	Total Health Expenditure (3 + 8)	4351.9

Source: NCAER computation

Key Findings:

- The state's total health expenditure is estimated at Rs. 4351.9 crore, of which public expenditure constitutes 47.9 percent and private households (comprising out-of-pocket expenditure and voluntary prepayments for insurance schemes) account for the remaining 52.1 percent. The higher the proportion of public expenditure, the lesser is the dependence on household out-of-pocket expenditure. At the same time, the higher the proportion of private expenditure, the higher is the extent of financial protection available for households towards healthcare payments.

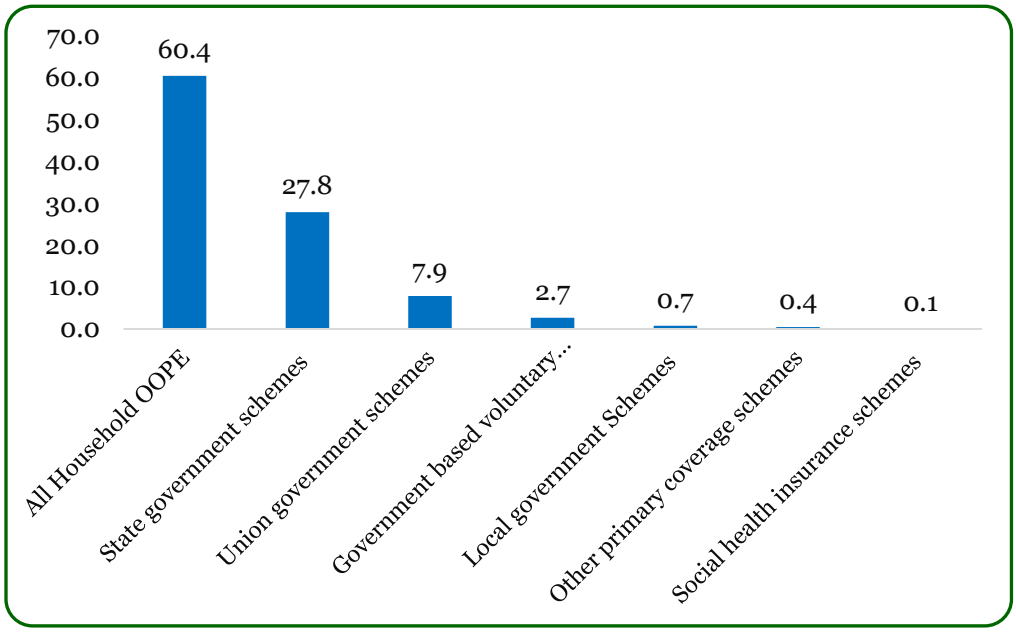
- Total current health expenditure, Rs. 3731.0 crore refers to only recurrent expenditure on healthcare, net of all capital expenditure. This indicates the operational expenditure which impacts the health outcome of the state. The current health expenditure works out to be 85.7 percent of the total health expenditure of the state.

- Public Health insurance expenditure refers to the finances allocated by the government towards payment of premiums for health insurance schemes or reimbursements of government employees' health expenditure. At, Rs. 102.3 crore, public health insurance expenditure is just 2.4 percent of total health expenditure.

- On the contrary, private health insurance expenditure is much lower at 0.4 percent of total health expenditure. This indicates the lower intent of households to opt for voluntary prepayment plans.

- Of the total general government expenditure for the year 2017-18, at Rs. 34811.21 crore, expenditure on healthcare stood at 5.98 percent.
- Public expenditure on AYUSH (Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy) or TCAM (Traditional complementary and alternative medicine) is 8.90 percent of the total public expenditure.
- The percentage distribution of Total Health Expenditure by Healthcare Financing Schemes (Figure V.12) reveals that 60.4 percent of the total expenditure is on account of households' out-of-pocket expenditure. State government schemes constitute another 27.8 percent while union government schemes account for 7.9 percent of the total health expenditure in the state.

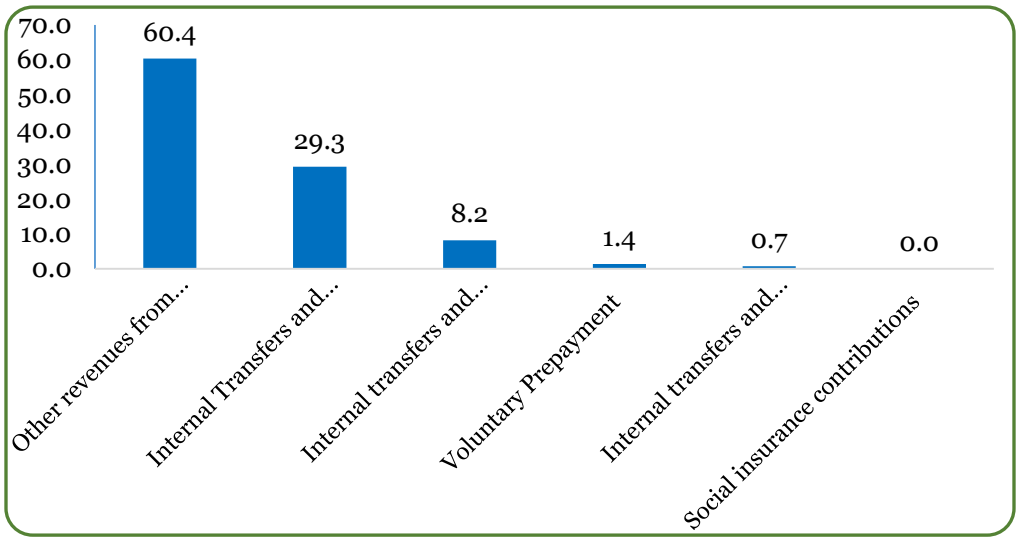
Figure V. 12: Total Health Expenditure by Healthcare Financing Schemes (% distt)



Source: NCAER computation.

- The percentage distribution of Total Health Expenditure by Revenues of Healthcare Financing Schemes (Figure V.13) reveals that 60.4 percent of the total expenditure is on account of revenues from households. The state government's share is 29.3 percent and the union government spends about 8.2 percent through various grants and schemes.

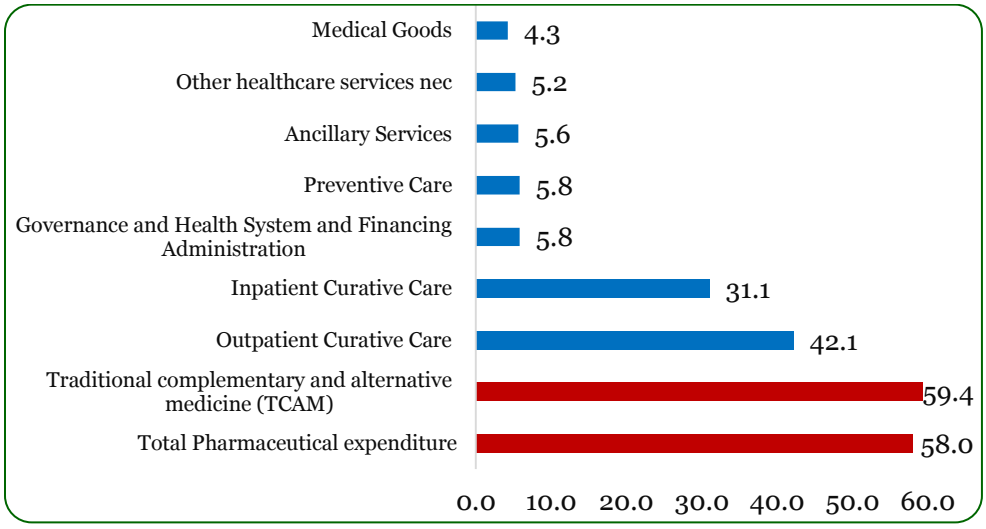
Figure V. 13: Total Health Expenditure by Revenues of Healthcare Financing Schemes (% distt)



Source: NCAER computation.

- Further, the percentage distribution of Total Health Expenditure by Healthcare Functions (Figure V.14), shows that 31 percent of total health expenditure is incurred on in-patient curative care, while 42.1 percent is incurred on out-patient curative care. Preventive care accounts for 5.8 percent. Total expenditure on pharmaceuticals, primarily referring to over-the-counter expenses, accounts for 4.3 percent of total health expenditure, and close to 60 percent of the total expenditure is incurred on non-allopathic or TCAM treatment

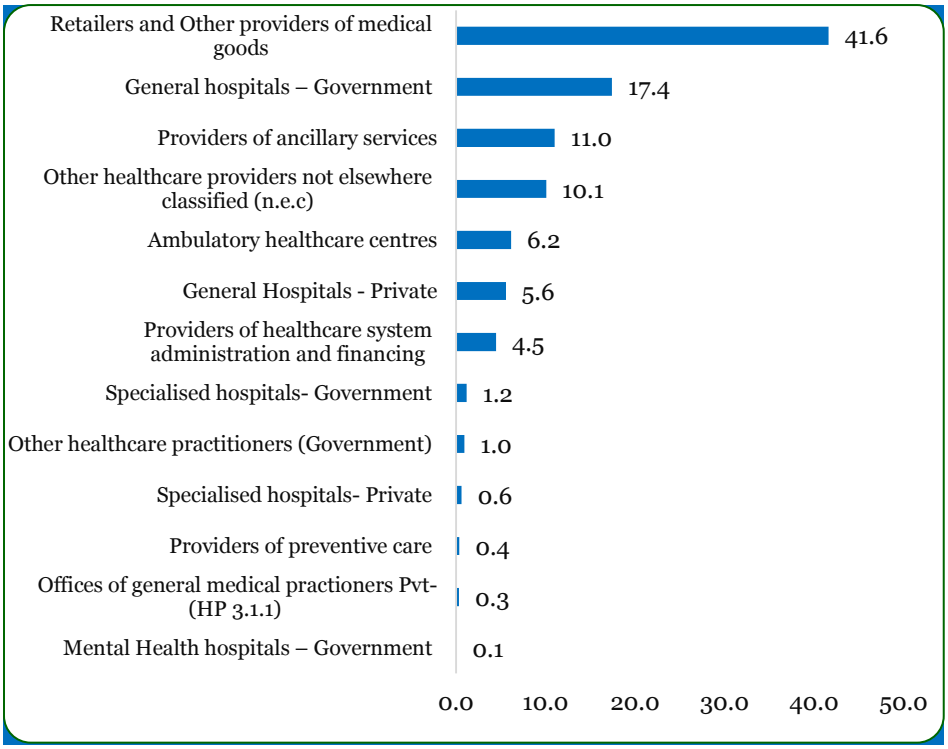
Figure V. 14: Total Health Expenditure by Healthcare Functions



Source: NCAER computation.

- Lastly, the percentage distribution of Total Health Expenditure by Healthcare Providers (Figure V.15), shows that the largest healthcare provider receiving healthcare revenues is "Retailers and other providers of medical goods". These account for 41.6 percent of total expenditure. General public hospitals account for 17.4 percent while general private hospitals account for about 5.6 percent.

Figure V. 15: Total Health Expenditure by Revenues of Healthcare Providers



Source: NCAER computation.

VI. Health Satellite Account Matrices

TableVI.1: Current health expenditures (2017-18) by healthcare functions and healthcare financing schemes (HC X HF matrix)

(Rs. Crore)

	Healthcare Financing schemes		HF.1 Government schemes & contributory healthcare financing schemes				HF. 2 Voluntary healthcare payment schemes		HF 3 Household out of pocket payment	
	NHA Codes		HF.1.1.1	HF.1.1.2.1.	HF.1.1.2.2	HF 1.2.1	HF.2.1.1.2	HF.2.1.1.3	HF.3.3	All HF
	Health care functions	NHA Code Description	Union government schemes	State government schemes	Local government schemes	Social health insurance schemes	Government based voluntary insurance	Other primary coverage schemes	All Household out-of-pocket payment	Total
HC 1 Curative care	(HC.1.1.)	Inpatient Curative Care	0	474.17	0	1.72	54.14	8.22	625.04	1163.3
	(HC 1.3)	Outpatient Curative Care	98.11	137.42	0	0	0	0	1336.95	1572.49
	(HC 1.4)	Home based Curative Care	0	0	0	0	0	0	0.55	0.55
	(HC 2)	Rehabilitative Care	0	0	0	0	0	0	0	0
	(HC 3)	Long term Care(health)	0	0	0	0	0	0	0	0
	HC 4	Ancillary Services	10.92	0	0	0	0	0	199.69	210.61
	HC 5	Medical Goods	0	109.94	0	0	0	0	48.79	158.72
	HC 6	Preventive Care	167.22	8.33	0	0	0	0	41.72	217.27
	HC 7	Governance and Health System and Financing Administration	26.83	102.00	27.48	0.93	45.48	8.22	0	212.69
	HC 9	Other healthcare services nec	0	190.79	0	0	0	0	0	190.79
	All HC	Total	303.99	1023.5	27.48	2.65	99.62	16.43	2252.75	3726.42

Table VI.2: Current health expenditures (2017-18) by healthcare providers and healthcare financing schemes (HP X HF matrix)

(Rs Crore)

Healthcare Financing schemes			HF.1 Government schemes & contributory healthcare financing schemes				HF. 2 Voluntary healthcare payment schemes		HF 3 Household out of pocket payment	
	NHA Codes		HF.1.1.1	HF.1.1.2.1.	HF.1.1.2.2	HF 1.2.1	HF.2.1.1.2	HF.2.1.1.3	HF.3.3	All HF
Health care providers		NHA Code Description	Union government schemes	State government schemes	Local government schemes	Social health insurance schemes	Government based voluntary insurance	Other primary coverage schemes	All Household OOPE	Total
HP.1 Hospitals	HP.1.1.1	General hospitals-Government	0	526.74	0	0.44	19.92	3.29	100.45	650.84
	HP.1.1.2	General hospitals - Private	0	0	0	0.44	19.92	3.29	184.47	208.12
	HP.1.2.1	Mental Health hospitals Government	0	2.07	0	0	0	0	0	2.07
	HP. 1.3.1	Specialised hospitals (Other than mental health hospitals) Government	0	21.30	0	0.44	19.92	3.29	0	44.95
	HP. 1.3.2	Specialised hospitals (Other than mental health hospitals) Private	0	0	0	0.44	19.92	3.29	0	23.65
HP.3 Provided of ambulatory healthcare	HP.3.1.1	Office of general medical practitioners-Pvt.	0	0	0	0.44	0	0	12.38	12.82
	HP.3.3	Other health care practitioners (Govt)	0	35.66	0	0	0	0	0	35.66
	HP.3.4.	Ambulatory health care centres	98.11	131.43	0	0.44	0	0	0	229.99
HP.4 Providers of ancillary services			10.92	0	0	0	0	0	400.81	411.73
HP. 5 Retailers and other providers of medical goods			0	4.32	0	0	0	0	1549.43	1553.74
HP 6 Providers of preventive care			1.54	8.33	0	0	0	0	4.28	14.15
HP. 7 Providers of health care system administration and financing			26.83	102.00	27.48	0	19.92	3.29	0	181.28
HP. 10 Other health care providers not elsewhere classified (n.e.c)			165.68	188.98	0	0	0	0	0.94	357.41
All HP		Total	303.99	1023.5	27.48	2.65	99.62	16.43	2252.75	3726.42

Table VI.3: Current health expenditures (2017-18) by healthcare financing schemes and revenues of healthcare financing schemes (HF X FS matrix)

Expenditure (INR Crore)

			FS.1 Transfers from government domestic revenues (allocated to health purposes)			FS.2 Transfers distributed by government from foreign origin		FS.3 Social Insurance contributions			FS.5 Voluntary Pre-payment		FS.6 Other domestic revenues n.e.c.			FS.7 Direct foreign transfers	
	NHA Codes		FS. 1.1.1	FS. 1.1.2	FS. 1.1.3	FS.2.1	FS.2.2	FS.3.1	FS.3.2	FS.3.4	FS.5.1	FS.5.2	FS.6.1	FS.6.2	FS.6 .3	FS.7.1.4	All FS
	Healthcare Financing	Revenues of health care financing schemes	Internal transfers and Grants-Union govt	Internal transfers and grants –State govt	Internal transfers and grants -Local govt	Transfers Distributed from foreign origin	Transfers distributed by foreign origin	Social insurance employers	Social insurance employers	Other social insurance	Voluntary prepayment from Households	Voluntary prepayment from employers	Other revenues from households n.e.c	Other revenues from corporations	Other revenues from NPISH	All direct foreign financial	
HF.1 Government schemes & compulsory contributory healthcare financing schemes	HF.1.1.1.1	Union government schemes	275.92	27.16	0	0	0	0			0	0	0	0	0	0	303.99
	HF.1.1.2.1.	State government schemes	0	1023.5	0	0	0	0			0	0	0	0	0	0	1023.5
	HF.1.1.2.2.	Local Bodies schemes	0	0	27.48	0	0	0			0	0	0	0	0	0	27.48
	HF 1.2.1	Social health insurance schemes	0.88	0.88	0	0	0	0.88				0	0	0	0	0	2.65
HF. 2 Voluntary Healthcare payment schemes	HF.2.1.1.2	Government based voluntary insurance	29.21	35.21	0	0	0	0			35.21	0	0	0	0	0	99.62
	HF.2.1.1.3	Other primary coverage schemes	0	0	0	0	0	0			16.43	0	0	0	0	0	16.43
HF.3 Household out of pocket payment	HF. 3.3	All Household out-of-pocket payment	0	0	0	0	0	0			0	0	2252.75	0	0	0	2252.75
	All HF		307.64	1086.03	27.48	0	0	0.88			51.64	0	2252.75	0	0	0	3726.42

Annexures

Table A1: Life expectancy disaggregated by sex (In years)

Period	All India		Himachal Pradesh	
	Male	Female	Male	Female
2000-04	62.1	63.7	66.1	66.8
2001-05	62.3	63.9	66.3	67.1
2002-06	62.6	64.2	66.5	67.3
2006-10	64.6	67.7	67.7	72.4
2009-13	65.8	69.3	69.9	73.1
2010-14	66.4	69.6	69.3	74.1
2011-15	66.9	70.0	69.1	75.2
2012-16	67.4	70.2	69.4	75.5
2013-17	67.8	70.4	69.8	75.6

Source: Statistical Abstract 2018-19, DES H.P, as per SRS.

Table A2: Health institutes/ Hospitals and Family Welfare centres in Himachal Pradesh district wise

(In numbers)

Types of Hospital/Institutes	Bilaspur	Chamba	Hamirpur	Kangra	Kinnaur	Kullu	Lahaul &Spiti**	Mandi	Shimla	Sirmaur	Solan	Una
1. Regional hospital	4	1	1	1	1	5		1	1	1	1	1
2. Civil hospital	0	6	5	14	1	0	1	12	11	4	5	4
3. T B Hospital/ clinic	0	2	0	0	0	0		0	0	0	0	0
4. Community health care centre	8	5	2	19	4	4	3	11	8	3	5	8
5.Primary health care centre or hospital	38	45	32	88	24	24	17	77	135	40	41	25
6. Sub Health Centre/Health centre	121	177	153	445	34	99	36	319	242	147	182	136
7.Allopathic Hospital/Dispensary	0	0	0	0	0	0		0	0	4	0	0
8.State Employment insurance scheme hospital	0	0	0	0	0	0		0	0	0	1	0
9. State Employment insurance scheme Dispensary	0	0	0	0	0	0		0	0	0	7	0
Total (1+2+3+4+5+6+7+8 +9)	171	236	193	567	64	132	57	420	397	199	242	174
Family Welfare Centres*	4	9	6	13	5	6	3	10	6	6	6	6

Source: District Profile Reports for latest available years from Himachal Pradesh Health District Portal, GOI
**The data for the district of Lahaul-Spiti was taken from District Statistical Abstract from Himachal Pradesh Health District Portal, GOI
The data from all the districts are taken for the year 2017-18
*The data for the Family welfare centres for all districts is taken from Statistical Abstract 2017-18, DES Himachal Pradesh.

Table A3: AYUSH centres in Himachal Pradesh district wise (In numbers)

Types of AYUSH Centres	Bilaspur	Chamba	Hamirpur	Kangra	Kinnaur	Kullu	Lahaul &Spiti**	Mandi	Shimla	Sirmaur	Solan	Una
1.Ayurvedic hospital	2	2	5	6	1	2	1	2	3	2	2	5
2.Ayurvedic dispensary	67	105	71	244	28	69	21	174	162	83	76	69
3.Homeopathic hospital/ dispensary	2	2	1	1	1	1		1	2	1	1	1
4.Unani dispensary	0	0	0	0	0	0	0	0	0	0	1	0
Total (1+2+3+4)	71	109	77	251	30	72	22	177	167	86	80	75

Source: District Profile Reports for latest available years from Himachal Pradesh Health District Portal, GoI.
**The data for the district of Lahaul-Spiti was taken from District Statistical Abstract from Himachal Pradesh Health District Portal, GoI.
The data from all the districts are taken for the year 2017-18.

Table A4: Number of patients treated and beds in Himachal Pradesh district wise (In Lakhs/Numbers)

Type of patient treated & number of beds	Bilaspur	Chamba	Hamirpur	Kangra	Kinnaur	Kullu	Lahaul &Spiti**	Mandi	Shimla	Sirmaur	Solan	Una
Internal (In lakhs)	13.12	10.61	15.44	39.15	3.02	8.74	1.58	28.18	20.52	11.16	17.62	13.82
External (In lakhs)	0.82	1.19	1.06	2.57	0.16	1.26	0.05	2.90	19.11	0.48	1.33	1.09
Treated Patient* (Internal +External) (In lakhs)	12.30	9.42	14.38	36.58	2.86	7.48	1.53	25.28	1.41	10.68	16.29	12.74
Available Bed*(In numbers)	463	1320	574	2269	194	504	204	1284	2225	370	759	526

Source: District Profile Reports for latest available years from Himachal Pradesh Health District Portal, GoI.
**The data for the district of Lahaul-Spiti was taken from District Statistical Abstract from Himachal Pradesh Health District Portal, GoI.
The data from all the districts are taken for the year 2017-18.
*The treated patients include data for Allopathic, Homeopathic and Ayurvedic Patients for the districts of Bilaspur, Chamba, Hamirpur (External), Shimla, Una, Mandi, and Kullu.
* The treated patients include data for Allopathic and Ayurvedic Patients for the districts of Hamirpur (Internal), Kangra, Sirmaur, Solan, Lahaul & Spiti, and Kinnaur.

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