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EDITORIAL ANALYSIS

Spend Better, Not Only More: Public Health Money and the Governance Multiplier

THE HINDU

3 August 2026 · SOCIAL ISSUES · ECONOMY · GS2 · GS3

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Spend Better, Not Only More: Public Health Money and the Governance Multiplier

The Hindu 3 August 2026 GS2 GS3

INTERVIEW ANGLE

"If public health spending produces measurably better outcomes where bureaucratic quality is higher, the implication is that governance reform is a health intervention. How would you persuade a health ministry to spend part of its budget on something that is not, on its face, health at all?"

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THE LIFT LINE

A budget line is not a health outcome. Between the two sit procurement, staffing, supply chains and the honesty of everyone handling the money, and that gap is where most of the difference between countries actually lives.

WHY THIS EDITORIAL MATTERS FOR YOUR EXAM

Health financing is a standing GS2 theme, and most answers reach for the same figure, India's health spending as a share of GDP, and stop. This editorial supplies the second half of the argument, that the return on that spending is conditional on governance, which converts a familiar statistic into an analytical claim a candidate can actually build on.

GS Paper 2: Issues relating to development and management of Social Sector/Services relating to Health; government policies and interventions; important aspects of governance.

GS Paper 3: Government budgeting; inclusive growth.

For **Prelims**, fix the National Health Policy target, the distinction between budget allocation and utilisation, and the main health-financing terms.

CONCEPT	MEANING	WHY UPSC TESTS IT
Budget execution rate	The proportion of allocated funds actually spent within the financial year	The first-order constraint; allocation without utilisation produces nothing
Out-of-pocket expenditure (OOPE)	Health spending borne directly by households at the point of care	India's principal health-financing equity problem; drives catastrophic health expenditure
National Health Policy, 2017	Sets a target of public health expenditure at **2.5 per cent of GDP**, and of more than 8 per cent of each State's budget	The benchmark against which India's actual spending is measured
Development assistance for health (DAH)	External finance for health in low- and middle-income countries	The variable now contracting, which reframes the entire strategy

BACKGROUND AND CONTEXT

Development assistance for health rose steadily for two decades and peaked at about **US$80.3 billion in 2021**, before falling to roughly $50 billion in 2024 and a forecast **$39.1 billion in 2025**, a fifteen-year low and roughly half the peak, on IHME's *Financing Global Health 2025*. The contraction reflects announced reductions in overall foreign assistance across major donors, with the United States alone cutting more than $9 billion in 2025. For recipient health systems, this removes a cushion that had allowed domestic reform to be deferred.

A distinction worth carrying into an answer: the gap between low- and middle-income and high-income health expenditure has **narrowed as a share of GDP**, from 2.05 to 1.68 percentage points between 2000 and 2023, while **widening in per-capita terms**, from about US$1,118 to US$3,528 over the same period. Both statements describe the same data. The ratio converged because low- and middle-income economies raised health's share of a growing GDP; the absolute gap widened because the base was so much smaller to begin with. Quoting only the first makes progress look better than it is; quoting only the second makes it look non-existent.

LEVER	QUESTION IT ANSWERS
Execution	Is appropriated money actually spent?
Allocation	Is it spent on the interventions with the highest health return?
Governance	Does the system convert spending into services without leakage or capacity failure?

THE CORE ARGUMENT / ISSUE

Execution comes before allocation

There is no point optimising the composition of a budget that is not being spent. Execution typically runs at 85 to 90 per cent in health budgets, below general budget execution rates, and the shortfall is not evenly distributed: wage lines are fully executed while goods-and-services lines, which buy the drugs and equipment, are consistently under-spent. Under-utilisation is driven by identifiable, fixable causes: procurement processes that cannot complete within the financial year, district-level absorptive capacity that has not been built up to match increased allocations, and fund-release patterns that concentrate disbursement late in the year when it cannot be spent well. These are administrative problems with administrative solutions, which is precisely why they are neglected in favour of the more visible argument about the headline number.

The prevention-versus-treatment allocation problem

Prevention and primary care deliver more health per rupee than tertiary curative care, and this is not seriously disputed among health economists. The reason allocation nonetheless skews toward the latter is political rather than technical: a new hospital is visible, attributable and inaugurable, while an immunisation programme that prevents an outbreak produces no observable event at all. Its success looks exactly like nothing happening. Any serious reallocation therefore has to overcome an accountability asymmetry, not merely an analytical one.

The governance interaction is the sharpest claim

The strongest and most testable proposition here is that the effect of health spending on outcomes is **conditional** on governance quality rather than independent of it. The canonical evidence is Rajkumar and Swaroop, *Public Spending and Outcomes: Does Governance Matter?*, which estimates that a one percentage-point rise in public health spending as a share of GDP cuts under-five mortality by about 0.32 per cent under good governance, 0.20 per cent under average governance, and by nothing measurable under poor governance.

Two honest caveats belong in any answer that uses this. The interaction result is **contested**: replication work using similar cross-national designs has failed to find support for it. And the evidence base is child and infectious-disease mortality; the effect on reproductive, maternal and newborn health is much weaker, so the claim should not be stretched to cover maternal outcomes. Argue it, do not assert it.

If the interaction does hold, then two countries spending identically will not obtain identical results, and the difference is not explained by health policy at all. This reframes anti-corruption work and administrative capacity-building as health interventions in their own right, which is an uncomfortable conclusion for a health ministry, because the lever sits outside its department.

Why the argument must not become an excuse

The efficiency argument has an obvious misuse, and a good answer should pre-empt it. India's public health spending stands at **1.43 per cent of GDP** on National Health Accounts 2022-23, up from 1.15 per cent in 2013-14 but against a National Health Policy 2017 target of 2.5 per cent. Its out-of-pocket expenditure share is **43.4 per cent** of total health expenditure, and it has moved in the wrong direction, up from 39.4 per cent the previous year and far above the National Health Policy's aim of 35 per cent. The global average is around 18 per cent. At those levels the binding constraint in many districts is straightforwardly the absence of staff, drugs and equipment, and no governance improvement conjures a paediatrician into a facility that has no post sanctioned. "Spend better" is a valid argument for reform and an invalid argument against resourcing.

HOW TO THINK ABOUT THIS (ANALYTICAL FRAME)

When an input produces variable outputs across contexts, look for the interaction term rather than treating the input as ineffective. Health spending, education spending and infrastructure investment all show wide variation in outcomes across countries at similar spending levels, and the temptation is to conclude either that the spending does not work or that the differences are cultural. The more productive move is to identify the conditioning variable, here governance quality, because a conditioning variable is something policy can act on. Apply this interaction-term thinking whenever an intervention appears to work well in some settings and not others.

THE DIAGRAM IN WORDS

Picture health spending as water poured into a channel that runs from the treasury to a village clinic. The volume poured in at the top is the budget, and most public debate is about that volume alone. But the channel has three features that determine how much arrives: a valve near the top that is often only partly open, which is budget execution; a fork midway where most of the flow is diverted toward a large tertiary hospital rather than toward the many small primary channels, which is allocation; and, along the whole length, the porosity of the channel walls, which is governance. Two countries pouring the same volume at the top can deliver very different quantities at the clinic, and the difference is not in the pouring.

WAY FORWARD

1. **Raise public health expenditure toward the National Health Policy 2017 target of 2.5 per cent of GDP**, treating the level and the quality of spending as complements rather than as competing priorities.
2. **Publish budget execution rates by state and by programme**, since utilisation shortfalls are invisible in allocation figures and cannot be fixed while they remain unmeasured.

3. **Rebalance allocation toward prevention, primary care and public health functions**, and build accountability mechanisms that can credit averted disease rather than only constructed facilities.
4. **Treat administrative capacity at district level as health infrastructure**, funding procurement capability, financial management and data systems explicitly rather than assuming they exist.
5. **Reduce out-of-pocket expenditure as the headline equity metric**, since it measures what households actually bear rather than what governments intend.

PYQ LINKAGE AND PRACTICE

UPSC has repeatedly tested health financing, Ayushman Bharat, out-of-pocket expenditure and the National Health Policy target in GS2, and this editorial's governance-interaction argument supplies the analytical step that distinguishes a strong answer from a recitation of figures.

Practice question: "The return on public health expenditure is conditional on the governance environment through which it passes." Examine this claim, and assess whether it argues for spending better, spending more, or both, in the Indian context. (250 words, 15 marks)

Interview angle: If public health spending produces measurably better outcomes where bureaucratic quality is higher, the implication is that governance reform is a health intervention. How would you persuade a health ministry to spend part of its budget on something that is not, on its face, health at all?

Sources: The Hindu, Ministry of Health and Family Welfare, World Health Organization

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KEY ARGUMENTS AT A GLANCE

With development assistance for health contracting sharply, the strategy of simply raising health budgets has become insufficient, and the more consequential lever is the quality of spending: budget execution, allocation toward prevention and primary care, and the governance environment through which the money passes, since evidence suggests the same expenditure produces significantly better outcomes where corruption is lower and bureaucratic quality higher.

✓ SUPPORTING

- Donor retrenchment has removed the option of substituting external finance for domestic reform, with major donors announcing steep cuts to foreign assistance, which means health systems in low- and middle-income countries must extract more from budgets that will not grow proportionately.
- Budget execution is a first-order problem before allocation is even reached: money appropriated but unspent produces no health outcome at all, and execution rates in low- and middle-income health budgets typically run in the region of 85 to 90 per cent, with wage lines fully executed while goods-and-services lines are consistently under-spent.
- The interaction between spending and governance has an empirical basis rather than a merely rhetorical one: Rajkumar and Swaroop find that a one percentage-point rise in public health spending as a share of GDP lowers under-five mortality by about 0.32 per cent under good governance, 0.20 per cent under average governance and by no measurable amount under poor governance, though a replication literature contests the interaction and the evidence is strongest for child mortality and infectious disease rather than for maternal health.

⚠ COUNTER

The “spend better” framing can be co-opted as an argument against spending more at all, which would be a serious misuse: India spends well below its own stated policy target as a share of GDP, and at very low absolute per-capita levels there is no efficiency gain available that substitutes for the missing money, since a district hospital without staff or drugs cannot be governed into producing outcomes.

→ WAY FORWARD

> Treat spending quality and spending level as complements rather than alternatives: raise public health expenditure toward the National Health Policy target while simultaneously fixing execution, rebalancing allocation toward prevention and primary care, and investing in the administrative capacity that determines whether the additional money produces anything.

✍ MAINS ANSWER FRAMEWORK

QUESTION

Examine the claim that the binding constraint on health outcomes in low- and middle-income countries is the quality of public health spending rather than its quantity, and assess the implications for India. (250 words)

INTRODUCTION

The conventional prescription for health systems in low- and middle-income countries has been to raise health budgets, but with development assistance for health contracting sharply after its recent peak, that strategy has become insufficient on its own, and attention has shifted to the quality of spending: whether appropriated money is actually spent, what it is spent on, and the governance environment it passes through.

BODY

Three levers define the quality question. The first is budget execution.

Money appropriated but unspent produces no outcome whatever, and execution shortfalls in low- and middle-income health budgets are substantial, arising from procurement delays, weak absorptive capacity at district level and mid-year fund-release patterns that make timely spending difficult. The second is allocation.

Spending concentrated in tertiary curative care produces fewer aggregate health gains per rupee than spending on prevention, primary care and public health functions such as surveillance, yet the political economy of health consistently favours the visible hospital over the invisible immunisation programme.

The third, and the most analytically interesting, is governance.

Rajkumar and Swaroop find an interaction effect rather than a simple additive one: a one percentage-point rise in public health spending as a share of GDP reduces under-five mortality by about 0.32 per cent where governance is good, 0.20 per cent where it is average, and by no measurable amount where it is poor. The result is contested in the replication literature, and the evidence is stronger for child mortality and infectious disease than for maternal and reproductive health, so it should be argued rather than asserted.

If the interaction does hold, governance reform is not adjacent to health policy; it is a determinant of the health return on every rupee spent. The necessary caution is that this argument can be misused.

India spends 1.43 per cent of GDP on public health, on National Health Accounts 2022-23, against a National Health Policy 2017 target of 2.5 per cent, and at low absolute levels no efficiency gain substitutes for absent resources.

CONCLUSION

Spending level and spending quality are therefore complements, not alternatives: India needs to move toward its own stated expenditure target while simultaneously fixing execution, rebalancing toward

prevention and primary care, and building the administrative capacity that determines whether additional money translates into health at all.

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