NATIONAL COUNCIL OF APPLIED ECONOMIC RESEARCH

Working Paper

Addressing Key Issues in the Light of Structural Adjustment Programme (SAP) in Health and Family Welfare Sector in India

(With special reference to centrally-sponsored projects (CSPs)

By:
Samir K. Mondal & Vineeta Kanwal

March 2006

CONTENTS

Abstract

The cutback in public investment in social sector including health is an inevitable consequence of the financial crises faced by both developed and developing countries since late seventies. In India, the dismal performance and several deficiencies of the public health services rather added fuel to the fire. Circumstances made it pertinent to mobilise additional resources from within the health sector itself, as contained in the structural adjustment programme, for financing the health sector. Thus, the involvement of private parties, NGOs, PRIs, co-operatives etc. for delivery of health services started gaining ground gradually. However, this trend is considered as a retreat from socialistic norms and counterproductive for the economically disadvantaged class. The policies including that of 'World Bank' and the recent 'Indian Health Report (WHO) 2000', now recognise the importance of investing in health & also providing for a 'safety net' for the poor and vulnerable to promote economic development and reduce poverty. So, there is an urgent need to address several issues to revamp the entire health sector in India. The paper, apart from an extensive review of India's health scenario also identifies the potential areas where further studies need to be undertaken for accelerating the reforms process in the desired direction.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANM	Anganwadi Nurse Midwife
BOD	Burden of Disease
BOP	Bureau of Planning
BMS	Basic Needs Programmes
CAG	Comptroller and Auditor General
CGHS	Central Government Health Scheme
CHCs	Community health Centers
CMH	Commission on Macroeconomics and Health
CSPs	Centrally Sponsored Projects
DALYs	Disability Adjusted Life Years
EBD	Expenditure Based Disbursement
FY	Financial Year
HHs	Households
ICDS	Integrated Child Development Programme
IHR	Indian Health Report
MNP	Minimum Needs Programmes
MRS	Medical Relief Society
NGO	Non Government Organization
NHA	National Health Accounts
NPP	National Population Policy
PHCs	Primary Healthcare Centers
PRI	Panchayati Raj Institutions
PSU	Public Sector Undertaking
RCH	Reproductive Child Health
RKS	Rogi Kalyan Samity
SAP	Structural Adjustment Program
SCs	Sub-centers
SOE	Statement of Expenditure
SWAP	Sector Wide Approach
UNICEF	United Nations International Children's Emergency Fund
WCD	Women and Child Development
WDR	World Development Report
WHO	World Health Organization

1. Background Story

With the advent of 'fiscal crises' in the economy of most countries in late seventies, welfarism suffered a setback with investment in social sectors especially health and education being viewed as 'unproductive'. The developing countries including India which accepted IMF funding under 'Structural Adjustment Programme (SAP)' in early nineties had to adhere to the world bank policy of cutback on social welfare expenditure especially health to cope up with the situation. This approach no longer views healthcare as a 'need', but begins viewing it as a 'demand' defined by consumer's ability and willingness to pay. Accordingly, Bank advocated - mobilising additional resources from within the health sector itself, tapping households for payments, introduction of user-fees in public hospitals, and devising mechanisms for risk-sharing through insurance schemes as options. The understanding was that the public investment focus on 'preventive programmes' and 'cost recovery mechanisms' be better suited for curative services.

But from the subsequent analysis by the World Bank on the effect of the adjustment policies in the countries, which implemented these since around 1980 was rather disappointing. The fact that leapt the eye was the 'roll-back' of many gains of the previous decades in the areas of health and education as a result of the adjustment policies at the behest of the Bank in many of those countries that drastically reduced resource allocation in these areas. As observed by the UNICEF, "for the first time the modern era, a subcontinent is sliding back into poverty. The numbers of families in sub-Saharan Africa who are unable to meet their most basic needs have doubled in a decade. The proportion of children who are malnourished has risen". Under these circumstances, the World Bank realised that if SAP has to succeed, it is necessary to provide 'a safety net' for the poorest and vulnerable who bear the brunt of these policies the most acutely and, therefore, selective investment needs to be made in health and allied sectors (Sengupta 1994)

Also it is heartening to know that the importance of investing in health to promote economic development and reduce poverty has been well recognized by the World Health Organization's Commission on Macroeconomics and Health (CMH). in 'the Indian Health Report (IHR)',2000 (Bajpari 2004). The CMH found that extending the coverage of crucial health services, including a relatively small number of specific interventions could save millions of lives each year, reduce poverty, spur economic development and promote global security.

The IHR says." …If the state (India) has universal healthcare and poverty alleviation as its basic objective; if there have been gains, however patchy and inadeuate; if there are systems in existence though not actually thriving, why is the current health scenario so bleak? The IHR points out that the biggest problems with the Indian health system are the lack of government spending in the health sector (0.9 per cnet of GDP against an average of 2.2 per cent by lower-middle income countries) and the ineffeciencies and misuse of the meagre resource that are available.

To finance the much needed expenditure in the health sector, it suggests for the use of the proceeds from the Central and State levies, tobacco tax, property taxes, user fees and also a comprehensive programme of disinvestment in the loss-making public sector units like textile mills to steel plants, from hotels to airlines and divert the much needed resources to the areas of prmary health and education. Though this may appear to be diverting resources, form the loss making economic sector to the much maligned social sector being viewed as 'unproductive,'by the architects of the 'reforms'. In fact, this ultimately gets stranslated into major econmomic gains for the nation. Adequate provision of primary health care (largely preventive) for the rural and urban poor will reduce the incidence of disease and illness that costs havily for the poor in partiular and the country in general. This will also reduce the existing burden on the health infrastructure especially hospitals and dispenseries. It has been amply establised that the poor are increasingly having treatment from private facilities , even for treatment of infectious disease such TB and Malaria, being the primary reponstibility of the public health system. Today, due to increasing commercialization and reduced public investment in health, the public and community health services are being replaced by profit making curative care, 80% of which are in private hands. This has burdened the poor with high cost of medical care which adds to the indebtedness of the poor in rural and urbans areas. Hence higher public expenditure, provision and access to primary health care services, accompanied by poverty allivation programs and universalization of elementary education will enable rise the per capita income of the poor having a cumulative effect in raising the level of national income and improve the quality of life of the people in the lower income brackets.

The reforms process initiated in India is not confined only to social sector but encompasses the gamut of economic sectors as well including agriculture, energy, industry,

transport, communication, etc. Consequently, cut back on public expenditure, disinvestment in Public Sector Undertakings (PSUs), private participation, collaborations have become a common government agenda. This is viewed by many as a gradual 'a retreat from the path of a welfare state and socialistic pattern of society as enshrined in India's constitution and directive principle of state policy. Thus, the time has come to review the policies and programmes and evaluate the status, identify the areas of weaknesses, focus on the priorities, and come out with a blueprint for what needs to be done to address the vital issues raised by expert committees, academicians, and planners in the context of SAP.

A reference to the views expressed on the 'health sector reforms in India' by persons who matter may be quoted (Baru Rama 2003):

"Health Sector Reforms is a group of projects that include Communicable disease, Reproductive and Child Health Programme and Health Systems to promote economic efficiency, quality & reform of public sector", (Senior World Bank Official, Delhi, 2002)

" The World bank is setting the agenda of health sector reforms guided by some North American consultants to introduce privatisation and have designed the components of the health sector reform agenda for the country" Sr. Official, European Commission, March,2002)

"Some academics and researchers (based on recent studies) on health sector reforms regard them as largely driven by the World bank, though accepted by the national government in order to get loans to overcome the fiscal crises, without a corresponding vision of the national government" (Baru Rama 2003)

2. Introduction

India, as a signatory to the Alma Ata Declaration of 1978, was committed to attaining the goal of 'health-for-all' by 2000 through the primary healthcare approach. To achieve these, a huge network of rural health infrastructure comprising primary health centres, community health centres, and sub-centres have been set up throughout the country to provide comprehensive healthcare in the rural areas of the country. The National Health Policy of 1983 further set targets to improve the health status of the people as well as reduce fertility. But this goal, it appears, in all probability, has hardly been achieved and seems to be receding, may be in a decade or two (Kundu 1995). This can very well be visualised from the

prevailing health scenario and can also be affirmed that with the state of affairs we have reached at present, the existing policies, style and structure if pursued further could be disastrous. Among several deficiencies in our healthcare system, the performance of public health services has emerged as the vital issue for determining its future role vis-à-vis the extent of involvement of private parties, NGO's, panchayats and co-operatives in the context of reforms.

In India, healthcare services in the public sector are not adequate in volume and quality to have any significant impact especially with regard to the health status of the unprivileged majority and plagued by many ills like; inaccessibility of public health facilities, the poor quality of their services, and long waiting-period that prompt even the poor to seek expensive private treatment, rising involvement of the private sector is mainly confined to the growth of curative services for a small affluent section of the population even as the goal of provision of basic healthcare for the masses remains elusive; the rural-urban disparity in is evident from the fact that urban areas with 26 per cent of population house, 70 per cent of hospital beds and health infrastructure, and 80 per cent of the doctors. Although a variety of health services are available in cities, all are not benefited from these facilities, the reason being that it suffers from several kinds of inequalities, and deficiencies (Vishwakarma & Mishra 1995).

In the past two decades, despite a massive increase in health inputs in both the public and private sectors, diseases like tuberculosis, leprosy, tetanus, gastro-enteritis, and acute respiratory infections continue their unremitting toll on life and limb; disease for which we now have remarkably effective knowledge and technology for both control and cure. Gradually, the emphasis has been shifted from 'preventive' to 'curative medicine' and that too for diseases like cancer, heart attack and stroke that mostly affect the urban rich, rather than the far more common communicable diseases that continue to plague the rural poor. Preventive and social medicine and family practice have the lowest status in medical education. While 60 per cent of students qualify as super-specialists in increasingly narrow and abstruse subjects, the general surgeon or general physician as of the past is no more produced. Those educated in government medical collages prefer to emigrate to greener pastures or work for profit in the private sector (Ministry of Health and Family Welfare, 1999-2000).

Studies by FRCH in Jalgaon (1989) and the World Bank (1995) reveal that the expenditure incurred by the people on private health services, exclusively for curative services, is three times the amount spent on the utilisation of government services. According to the World Bank (1993), the per capita health expenditure in 1990-91 was Rs 320. The total health spending in India accounts for about 6 per cent of GDP. Although this figure is higher than in other Asian countries such as China, Indonesia, Thailand, Philippines, Pakistan, Bangladesh, and Sri Lanka, most of these countries have better health outcomes. Furthermore, of the 6 per cent, public health spending is just 1.3 per cent against 4.7 per cent by the private sector. In addition, the portion of public expenditure devoted to *disease control programmes is* very low compared to many other countries at India's per capita income level (Ministry of Health & Family Welfare, 1999-00). Even the meagre expenditure in the rural primary health centres (PHCs) is chiefly devoted to achieving family planning targets. This single-minded obsession has so alienated the PHCs from the people that it has been unable even to achieve its family planning goal as revealed by the constant population growth rate of 2.1 per cent in the last three decades. Several studies in our own country like those at Jamkhed, Munnar, and Nabdwa reveal that far more healthcare can be provided to all our people at much lower costs, for it is not the amount that is expended that matters but the way it is utilised.

Kerala, in India, and Sri Lanka have demonstrated marked improvement in their health status even within a democratic set-up. This was the result of a strong political will to serve the interests of the people at large. They not only incurred higher expenditure on the social sector like health and education but also ensured proper utilisation in an egalitarian manner.

3. Network of Health Services

The network of health services in India can broadly be divided into (1) rural healthcare, and (2) urban healthcare services. The hierarchical structure of these services (starting from the highest to the lowest) is as shown in Chart 1.1).

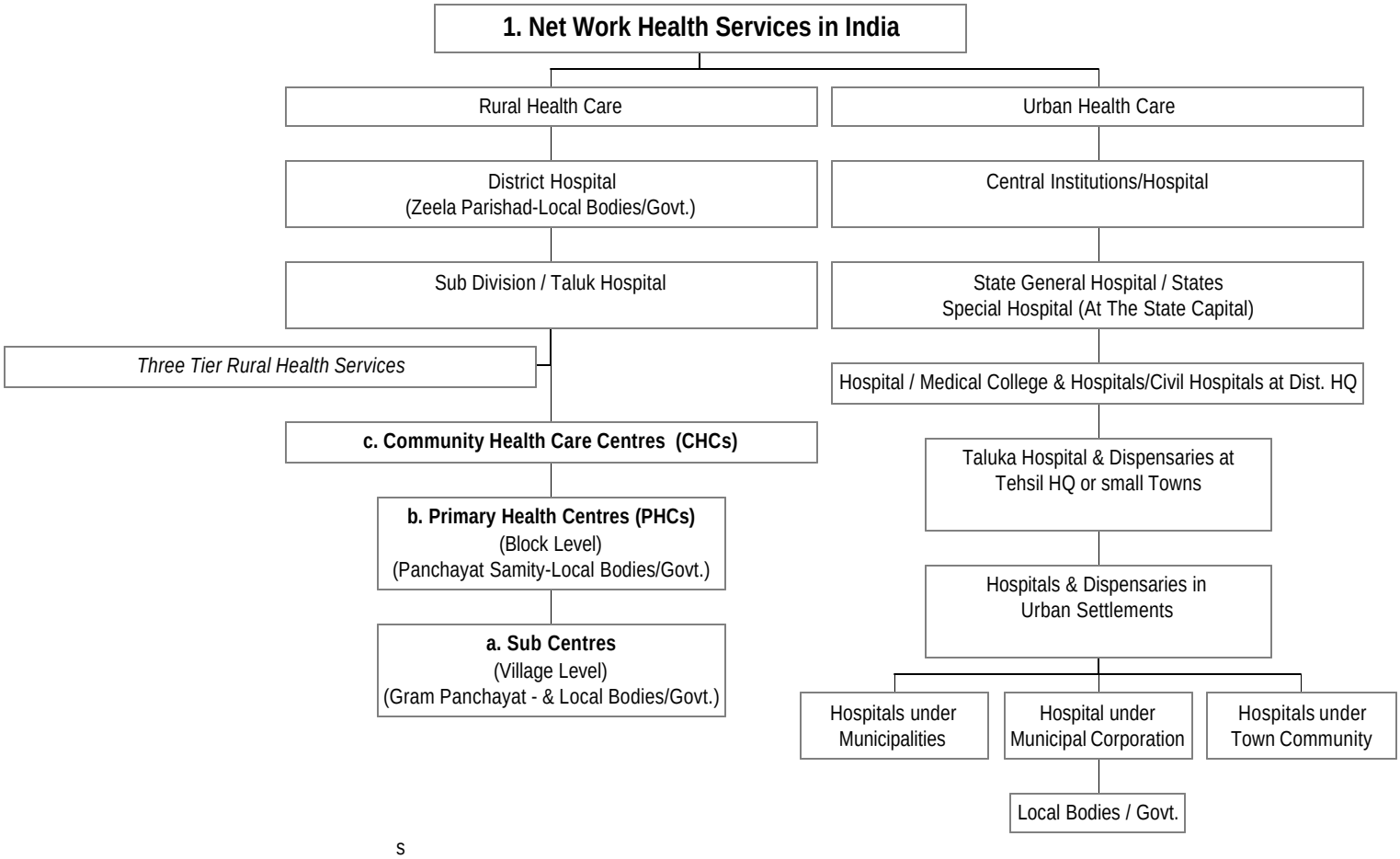
Within (1) rural healthcare services at the lowest level, the network catering to the needs of the majority of the population living in the rural areas consists of a three-tier health services, viz., (a) Sub-centres (SCs), (b) Primary Healthcare Centres (PHCs), and (c) Community Healthcare Centres (CHCs). A brief description is as follows :

(a) SCs: It is the most peripheral contact between the primary healthcare system and the community. The SCs have mainly promotive and adductive functions relating to maternal and child health, family welfare, nutrition, immunisation, diarrhoea control, and control of communicable disease programmes. They also provide basic drugs for minor ailments that are needed for taking care of essential needs of women and children. It is manned by one male and one female multipurpose worker/ANM. Of the total functioning SCs, 71 per cent is funded by the Department of Family Welfare and the rest are funded under the state minimum needs programme (MNP)/ basic minimum services (BMS) programmes.

(b) PHCs: The PHC is the first contact point between the village community and the medical officer. These are established and maintained by the state government under the minimum needs programme (MNP). A medical officer supported by 14 paramedical and other staff man a PHC. It acts as a referral unit for six SCs, and has 30 beds. The activities of PHCs involve curative, preventive, promotive, and family welfare services

(c) CHCs: These are established and maintained by the state government under the MNP/BMS programmes. Four medical specialists man it, i.e., one surgeon, one physician, one gynaecologist, and one paediatrician, supported by 21 paramedical and other staff. It has 30 beds with one X-ray machine, labour room, and laboratory facilities. It serves as a referral centre for four PHCs.

Chart 1.1



s

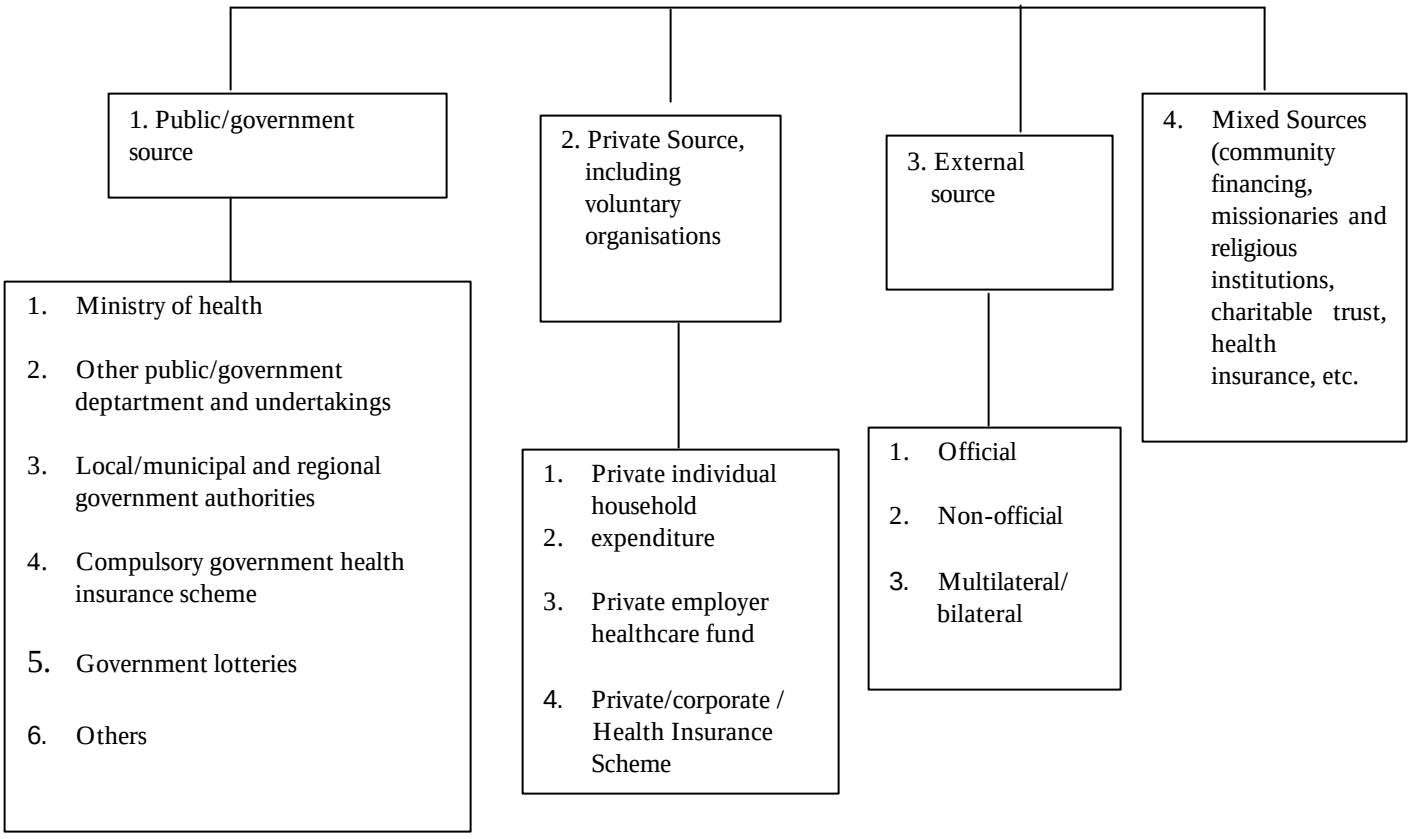
Source: Annual Report. 1999-00, Ministry of Health and Famity Welare, Government of India.

4. Sources of Financing Health Care in India

The national healthcare finance consists of both cash and kind (resources/inputs) required at all levels of healthcare, viz. primary, secondary, and tertiary. There has been serious contemplation on multiple sources of finance and management of healthcare services as in India (Chart 2.1).

Chart 2.1

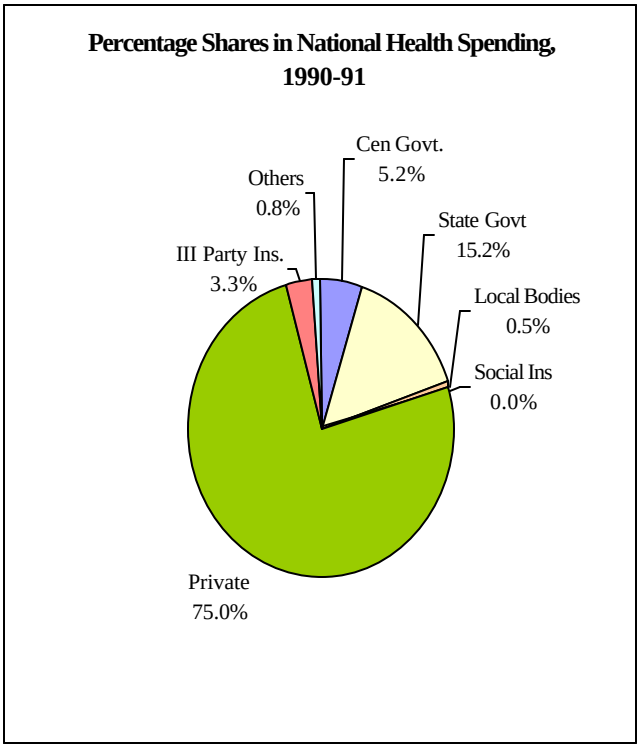
Multiple Source of Financing in Healthcare Services



Source: Kataria, M., Finances of Health Care Services (BOP-WHO Workshop-1995)

Chart 2.2

Percentage Shares in National Health Spending



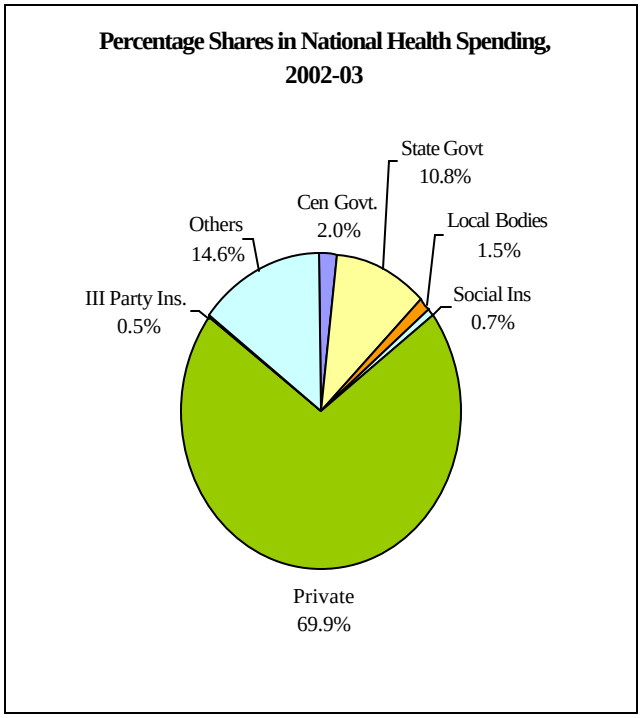


Table 2.1 : National Health Spending by Source for the year 1990-91 and 2002-03 at current and constant (1993-94) prices

Sl. No.	Source	Per capita per annum in rupees				Percentage share to total Health Spending	
		At Current prices		At 1993-94 prices			
		1990-91	2002-03	1990-91	2002-03	1990-91	2002-03
1	Central Government	16.5	33.2	22.4	19.4	5.2	2.0
2	State Government	48.6	176.5	65.92	103.2	15.2	10.8
3	Local Government	1.5	23.7	2.0	13.9	0.5	1.5
4	Social Insurance	----	11.4	----	6.7	0.0	0.7
	Total Government	**67**	**245**	**90**	**143**	**20.8**	**15.0**
5	Private Households/ Out-of Pocket	240	1138.9	325.5	666.0	75.1	69.9
6	Third-party insurance and employer payment	10.5	7.6	14.2	4.4	3.3	0.5
7	Others (External Doners/Pharma industry	2.5	237.3	3.4	138.8	0.8	14.6
	Total Private	**253**	**1384**	**343**	**809**	**79.0**	**85.0**
	Total Health Spending	**320**	**1629**	**433**	**952**	**100.0**	**100.0**

Source : Compiled from (1) World bank (1995)'India : Policy and Finance Strategies for Strengthening Primary Healthcare services; (2) Ravi Duggal: 'Operationalising Right to Healthcare in India' , Center for Enquiry into Health and Allied Themes.

Note: The figures at 1993-94 prices have been arrived at by using the GDP deflator.

The national health spending by source presented in Table 2.1 for the year 1990-91 and 2002-03 reveals the share of private expenditure to total national health spending increased from 79 per cent in 1990-91 to 85 per cent in 2002-03 where as the share of total government spending declined from 20.8 per cent in 1990-91 to 15 per cent in 2002-03. Within total government spending the share of central government declined from 5.2 to only 2 per cent and state governments from 15.2 to 10.8 per cent in the respective years. Within total private health spending the expenditure by private households (out-of-pocket) marginally declined from 75.1 per cent to 69.9 per cent. The per capita expenditure under the 'Others' i.e. external donors/ pharma industry, increased from 0.8 per cent to 14.6 per cent in the respective years. The above figures provide enough testimony to the fact that the burden of health spending on the private households has continued to reamin at an alarmingly high level even after a decade. On the other hand the decline in the share in government spending reveals that the government is shying away from fulfilling it's the constitutional commitment on 'right to health' for its citizens.

Table 2.2 : National Health Spending by Use and Source (Row %), 1990-91 (in rupees per capita per annum)

Sl. No.	USE	Source					
		Central govt.	**State/local bodies**	**Total (Centre and states)**	**Corporate / Third party** 3.3	**House holds**	**Total**
		1	2	3	4	5	6
1.	**Primary**	7.3	9.5	16.8	1.4	81.8	100.0
1.1	Curative	0.7	6.0	6.7	1.6	91.8	100.0
1.2	Preventive and public health	43.9	29.4	73.3	0.0	26.7	100.0
2	**Secondary/tertiary in-patient care**	2.3	21.6	23.9	6.4	69.6	100.0
3	**Non-service provision**	36.0	64.0	100	0.0	0.0	100.0
	Total	6.1	15.6	21.7	3.3	75.0	100.0

Source: World Bank, 1995

Table 2.2 presents the percentage distribution of National Health Spending by Use and Source. In the total percapita per annum expenditure in Primary healthcare, 81.8 percent is contributed by the out of pocket expenditure of households; central

government, 7.3 per cent; state/ local bodies, 9.5 per cent; and corporate/third party, 1.4 per cent. Within primary healthcare, the share of household expenditure on curative services is 91.8 per cent. For curative healthcare, thus, households have to bear it mainly out of their own pockets. This puts a burden mainly on the poor, who can hardly afford to pay, and people in rural areas where access to public health services in curative healthcare is inadequate. On preventive and public health services, another component of primary healthcare, the households spend 26.7 per cent, while the central and state governments/local bodies together spend 73.3 per cent. Again in respect of secondary/tertiary in-patient care**,** the households' share is about 69.6 per cent, with the state and central governments spending 21.6 per cent and 2.3 per cent, respectively, of the total expenditure.

Table 2.3 National Health Spending by Source and Use (Column %)
(Rs. per capita per annum, 1990-91)

Sl. No.	Use	Source					
		Central govt.	State/local bodies	Total (Centre & States)	Corporate/third party	Households	Total
		1	2	3	4	5	6
1.	**Primary**	70.5	35.9	45.7	24.2	64.0	58.7
1.1	Curative	5.7	19.2	15.4	24.2	60.8	49.7
1.2	Preventive and public health	64.8	17.0	30.4	0.0	3.2	9.0
2	**Secondary/Tertiary in-patient care**	14.8	53.8	42.9	75.8	36.0	38.8
3	**Non-service provision**	14.8	10.3	11.5	0.0	0.0	2.5
	Total	100.0	100.0	100	100.0	100.0	100.0

Source: World Bank, 1995

In the total expenditure by the government (Centre and states—Column 3), primary healthcare consumes 45.7 per cent (15.5 per cent on curative and 30.4 per cent on preventive and public health); secondary and tertiary, 42.9 per cent; and non-service provision, 11.5 per cent. The households on the other hand use 64 per cent of their total health expenditure on primary healthcare (60.8 per cent curative, and only 3.2 per cent on preventive and public health), and 36 per cent on secondary healthcare services. In the total expenditure incurred by the corporate/third party, secondary/tertiary services constitute 75.8 per cent and curative, 24.2 per cent (Table 2.3).

Table 2.4 Percentage Distribution by Use and Source: per capita per annum health expenditure of Rs. 320 (1990-91)							
	Corporate/third party Use	Source					
		Central govt.	State/local bodies	Total (Centre and states)	Corporate/ third party	House holds	Total
		1	2	3	4	5	6
1.	**Primary**	4.3	5.6	9.9	0.8	48.0	58.7
1.1	Curative	0.4	3.0	3.4	0.8	45.6	49.7
1.2	Preventive and public health	4.0	2.7	6.7	-	2.4	9.0
2	**Secondary/tertiary in-patient care**	0.9	8.4	9.3	2.5	27.0	38.8
3	**Non-service provision**	0.9	1.6	2.5	-	-	2.5
	Total	6.1	15.6	21.7	3.3	75.0	320.0
Source: World Bank, 1995							

The percentage distribution of the total per capita expenditure of Rs 320 across use and source clearly indicates that the households themselves bear the expenses of primary healthcare to the extent of 48 per cent of the total health spending (45.6 per cent on curative and only 2.4 per cent on preventive healthcare), and 27 per cent on secondary healthcare. On the other hand, the government expenditure on primary healthcare is just 9.9 per cent (3.4 per cent on curative and 6.7 per cent on preventive and public health), and 9.3 per cent on secondary healthcare. This reveals the extent of burden the households are to shoulder on the health front (Table 2.4).

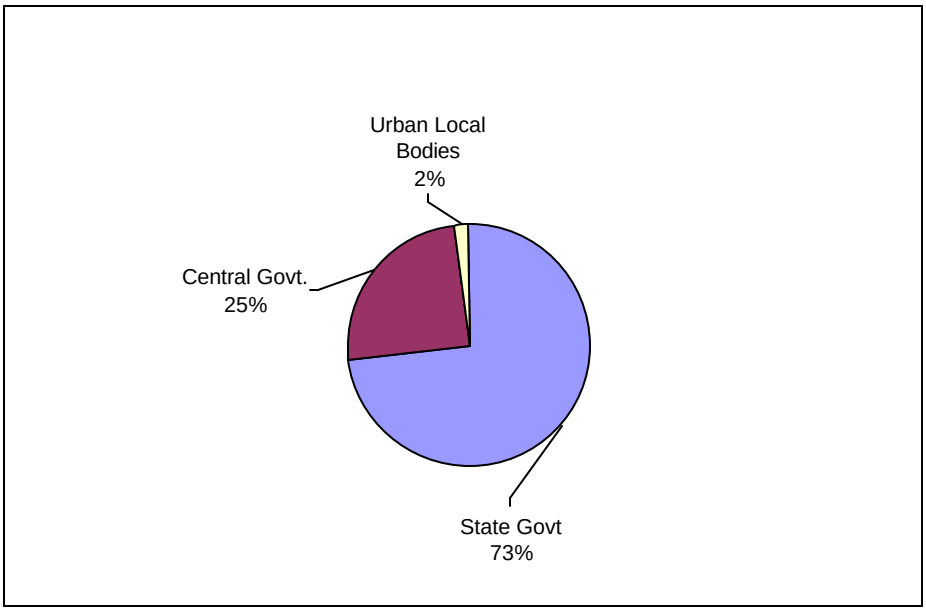
5. Role of Central, State/ Local Governments and Private Sector in Health Care Services

Health sector delivery is primarily the responsibility of the state governments. However, the central government also exercises its direct control in respect of international health, prescription and enforcement of medical standards with respect to medical education, besides managing central research and training health institutions. The legislative and executive functions concerning these activities are the responsibilities of the central government. Also, the concurrent list of the Indian Constitution (listing the responsibilities that lie simultaneously with both the Centre and the states) includes prevention of infectious and contagious diseases, mental deficiency, regulation of births and deaths, and control of adulteration of foodstuffs and other foods. But the provisions of curative medical services and preventive healthcare to the people are the direct responsibility of the state governments or

the union territories. Besides, the local bodies, non-government organisations, charitable trusts/dispensaries and hospitals, missionaries/religious institutions, and private sources play a major role in the provision of health services to the people both in urban and rural areas .

Chart 3.1

Government Health Spending by Source (%)



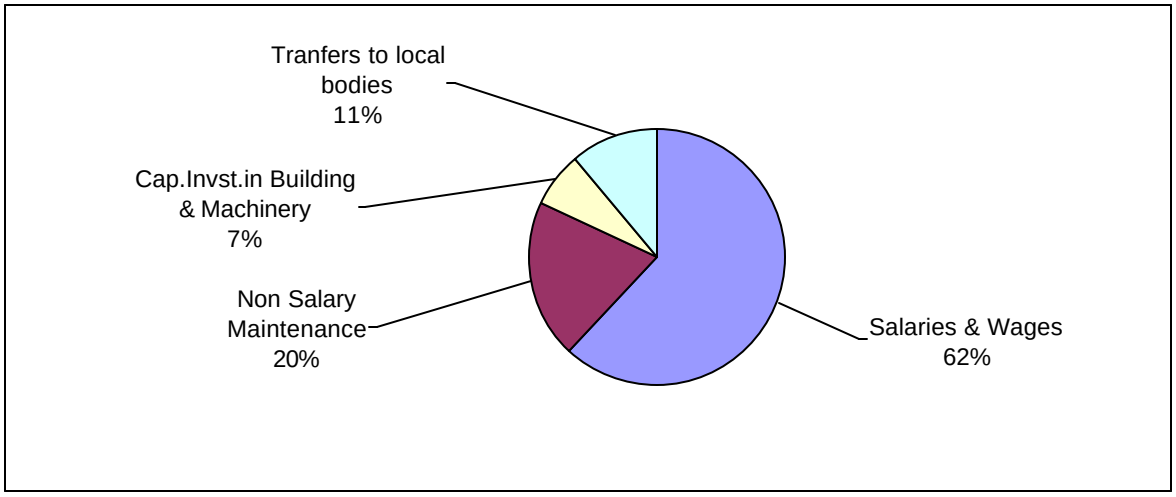
Of the total government health spending, state governments account of about 73 per cent; central government, about 25 per cent; while a small amount, say 2 per cent, is financed by urban local bodies (Chart 3.1).

Although the Centre finances only 25 per cent of total government health spending, the centrally-sponsored programmes have been the major catalyst to shaping of new directions in the pattern of health spending (Ministry of Health and Family Welfare, 1999-2000). The rapid growth of family welfare programme since the late 1970s indicate the broad shifts towards preventive and promotive health spending by the government. The growth in the rural water supply programmes in the early 1980s and the ICDS (Integrated Child Development Services) programmes more recently are additions added to this trend, apparently in line with the emphasis on rural primary healthcare contained in the National Health Policy adopted in 1983. However, expenditure on disease control programmes has grown less rapidly throughout this period, declining as a share of total spending on the broadly defined sector .

Table 3.1: Share of Centre and States in Different Components of Government Health Budget by Use (1991-92)			
	Centre's share	**State's share**	**Total**
Hospitals	3.1	96.9	100.0
Public health	0.0	100.0	100.0
Primary care (disease control)	99.7	0.3	100.0
Family welfare	22.6	77.4	100.0
Insurance (CGHS, ESIS)	18.2	81.8	100.0
Medical education and others	41.7	58.3	100.0
Administrative and other	11.0	89.0	100.0
Capital investment	49.7	50.3	100.0
Source: 'India: New Directions in Health Sector Development at the State Level: An Operational Perspective', World Bank, 11 February 1997			

In respect of sharing different components of expenditure, it can be observed (Table 3.1) that the Centre's share in primary healthcare amounts to 99.7 per cent, with states spending only 0.3 per cent. However, in respect of expenditure on public health, the state's share is 100 per cent.

Chart 3.2
Components of Consolidated Health Spending by Central and State Governments



In the components of consolidated health spending of the central and state governments, salaries and wages account for about 62 per cent; non-salary maintenance comprises about 20 per cent, capital investments in building and machinery accounts for 7

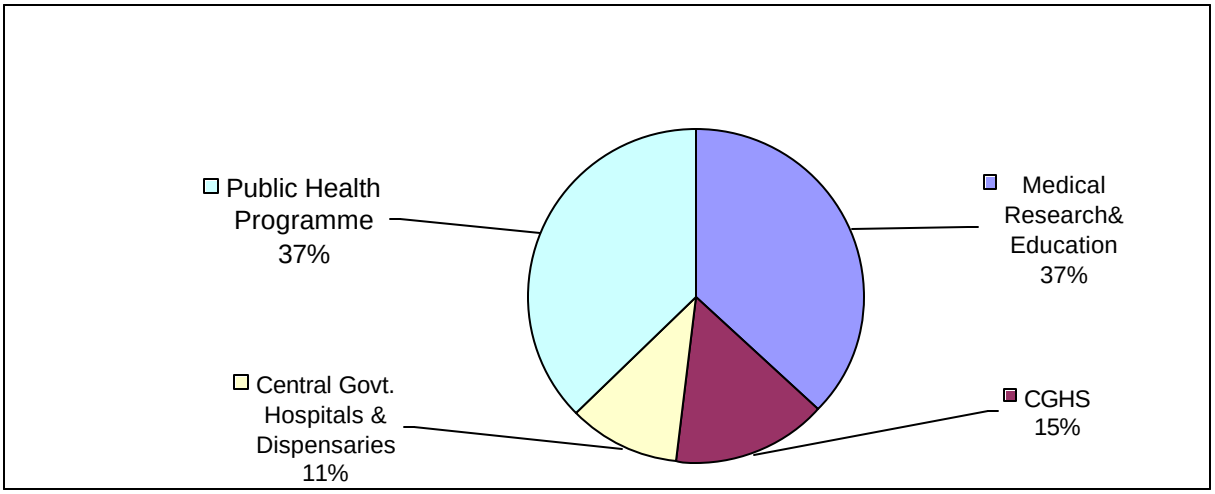
per cent, and transfers to local bodies make up the remaining 11 per cent (average of 14 major states in 1985-90, NIPFP, 1993) (Chart 3.2).

5.1 Central government:

Medical education and research consumes 37 per cent of the Centre's revenue expenditure; Central Government Health Schemes (CGHS), 15 per cent; and central government hospitals and dispensaries, 11 per cent. This leaves less resources for public health programmes (with 35 per cent share) and even lesser for primary healthcare (Raman, 1994) (Chart 3.3).

Chart 3.3

Components of Central Health Spending (1990-91)

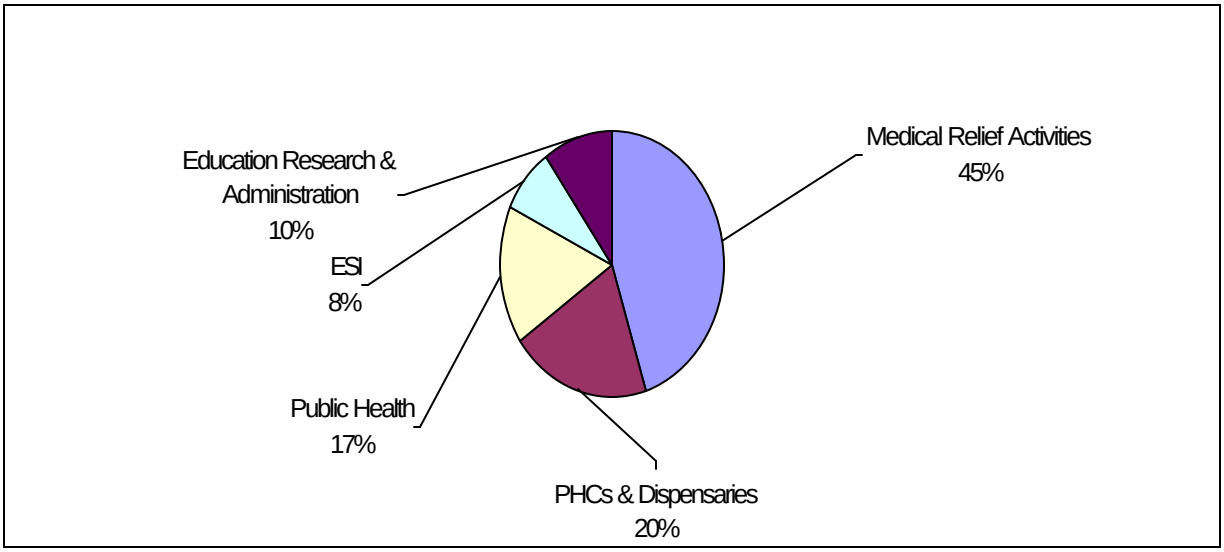


5.2 State Government:

The states devote 45 per cent of the medical and public health revenue expenditure to medical relief activities, most of which is support to government hospitals located in major cities providing free or highly subsided in- and out-patient care, irrespective of the ability to pay. The PHCs and dispensaries form 20 per cent share; public health, 17 per cent; ESIs, 8 per cent; and education and research and administration, the remaining 10 per cent. Hospitals are increasingly competing with public or community health programmes for the state resources (Chart 3.4).

Chart 3.4

Components of States' Health Spending (1990-91)



The volume of funds for the state's health sector is determined by (a) its ability to collect taxes (b) the share it receives in central taxes, statutory revenue gap, and upgrade grants it receives from the Centre, and (c) the competing demands of other sectors within the state budget.

The poorer states, with less capacity to raise internal resources but greater **requirement** for health sector, are left with fewer resources to work with. Between 1985 and 1988, the per capita expenditure on health in the richer states was 2.7 times more than in the poorer states (Tulsidas 1993).

The states are placed in the uncomfortable position of choosing between spending on immediate care for individuals like those who visit public hospitals in Delhi and other major cities versus funding programmes that may have long-term benefits for a wider, less well-defined community. Expenditures on hospitals not only have the effect of drawing scarce resources from public health efforts but also widen rural-urban differentials in access to health services.

Some central schemes depend on matching grants from the states. A few centrally-funded communicable diseases programmes are funded on a 50-50 matching basis by state and central governments. Even in 50-50 matching schemes, states are often required to contribute more than 50 per cent, besides having to bear other recurrent costs. Sometimes,

the states' share reaches even up to 90 per cent. The poorer states are not able to come up with the subsequent matching grants to make optimal use of the programmes

In recent years, the family welfare programmes and few other centrally-sponsored schemes have fallen behind in their payments to the states. Effectively, the states have been paying for the schemes that were supposed to be centrally-funded. Over the long run, these debts will be repaid but the states which cannot afford this suffer the most. The states have to bear the responsibility of the recurring costs for the centrally-initiated projects after the **subsequent plan period** when it gets converted into a non-plan expenditure.

Table 3.2 Flow of Funds (States' tax revenue +central transfers) from State Governments to Financial Intermediaries and from Financial Intermediaries to various Providers of Health Services

Source							
State departments of finance							
Intermediaries (financing agents)							
	Providers Of services	**State department Of health**	**Local/ministry & departments**	**Other ministry & departments**	**House Hold**	**Employees state insurance scheme (ESIS)**	**Non–profit Institutions NGOs**
		(1)	(2)	(3)	(4)	(5)	(6)
1	**Urban health centre**	-----	——	-----	-----	——	——
A	Hospital	+	------	+	+	-------	-----
B	Dispensaries	+		+	+		
2.	**Rural health**	**-----**	——	——	**-----**	**-----**	-----
A	Sub. Centre	+	+	**------**	-----	-----	-----
B	PHC	+	+				
C	CHC	+	+				
D	Hospitals	+	+				
3	**ESIS facilities**	+	------	-------	+	+	-----
4	**Other services**		——	——	——	-----	-----
A	Paramedical services	+	+		+	+	+
B	Pharmaceuticals	+	+		+	+	+
	Other ministry Facilities	-----	----	+	+	----	-----
6	**Charitable institution / NGO's facilities**	------	------	-----	+	-----	+

Source: Symposium on Financial Reforms, Department of Family Welfare, Govt. Of India, Imperial Hotel, New Delhi, 9-10 August 2001, Supported by : European Commission

Table 3.2 presents the Flow of Funds mechanism (states' tax revenue + central transfers) of State Governments to Financial Intermediaries and from Financial Intermediaries to various Providers of Health Services. (The table is a simplied version of a chart presented in the report on ,' Symposium on Financial Reforms' Sponsored by European Commission , Delhi, August 2002) . It may be observed that funds flow from the state department of finance to

six financial intermediaries. And from these intermediaries to the service providers. And each service provider receive funds from multiple sources. For example hospitals and dispensaries receive funds from three differenct sources. Similarly, the paramedical services and pharmaceuticals receive funds from five sources.

Note:.(+) sign refers to sources of finance. 'Financing agents' are those entities which pay for or purchase healthcare services. They may own and operate provider institutions, as the Ministry of Health does, or they may finance services provided by others, as typically does private health insurance. They receive funds from the state depaartment of finance and pay them to providers .

5.3 Local Governments

There are several types of local bodies in the country, classified according to the size of population governed. These include municipal corporations of large cities in which there could be more than one body like in Delhi, municipal administration found in many smaller cities, notified area town committees and village *panchayat*s etc.

Transfers to local bodies, as share of total state government budgets, for example, vary from over 40 per cent (Gujarat and Maharashtra) to 15 per cent or less (Haryana and Madhya Pradesh). For the 14 major states, the average share of transfers to local bodies was 30 per cent of total expenditures in the second half of the 1980s; the share of such transfers accounts for about 11 per cent of state health spending (Chauhan 1997)

While little attention has been paid to the participation of municipally and locally-founded institutions in providing health services in India, a significant level of services are provided by such institutions, particularly in urban areas—the main agents responsible for providing public healthcare services—including: water and sanitation services, preventive health services (immunisation, health education, etc.), curative health services, dispensaries, hospitals, maternity and child welfare centres, etc.), and services such as registration of vital events and pollution control measures—to the growing urban population. Some of these responsibilities are obligatory while others are optional at the discretion of the governing body. Funds for municipal health expenditure are allocated from central, state, and municipal specific sources. With respect to contribution from the states, approximately 10 per cent of the municipalities' expenditure on health can be attributed to grants from states. In general, public health accounts for at least one-third of municipalities' expenditures (Berman, 1997).

In the contrary, rural local governments[*] ,i.e., *panchayat* institutions, play a small role in provision of health services. As the lowest level of public system, the *panchayat* institutions have little financing autonomy and their role is limited to taking part in implementation of health programmes funded by the state government.

5.4 Private sector

The role of the private sector in the overall healthcare strategy is not clearly defined despite accounting for 80 per cent of the overall health expenditure of the country. The vital role played by the private sector in the provision of select areas of the health services, mainly include 'ambulatory'/'curative' services, whereas the scope in other areas for greater private sector involvement has not been fully recognised by policy-makers (Chauhan 1997).

In the National Health Policy 1983, the Government of India envisaged support to private and voluntary health sector; privatisation by handing over public institutions to private bodies; provision of private medical/ health insurance; and permission to private practice to government doctors. Unfortunately, even after passing of two decades, very little progress have been made towards these desired objectives (Ministry of Health and Family Welfare, 1999-2000).

It has, therefore, become all the more essential to encourage private sector involvement in preventive and promotive aspects of healthcare rather than solely in individual curative care. This will, to a considerable extent, reduce the burden of the public sector involvement in preventive and promotive healthcare. On the one hand, **public expenditure on preventive and promotive health services will fall** and, on the one other, **regional imbalances will be smoothened** by pursuing and encouraging the private sector to concentrate their services in the 'rural' and 'remote' areas.

In order to promote partnership between the public, private, and voluntary healthcare services, it is necessary to **enhance the quality of services of these private institutions** to generate public faith and confidence as well as improve the existing arrangement for regulation and monitoring of private healthcare in the present and future Plan periods.

---

[*] In India, the notion of local involvement was institutionalised with the establishment of a 3-tier Panchayat Raj (local-self government) system: the village panchayat as the lowest tier, the Panchayat Samiti at the Block level as the middle tier, and the Zilla Parishad/ District Development Council at the top. The extent and tempo of the involvement of the PRI's in basic planning and implementation of development Projects widely vary between states and even within a state (Chauhan).

6. Centrally Sponsored Projects (CSP) - In Crisis

Although health is a state subject, the centrally sponsored projects (CSPs) have been an important policy initiative of the Government of India to support the health sector programmes. The Centre provides direct support to the states in meeting both recurring and non-recurring expenditure on these programmes. The criteria for allocating resources lack transparency not only from Centre to states but also from states to districts, and equity issues in resource allocation are not addressed. Long-term sustainability of these programmes remains a major issue. Over the period, uncertainties in resource flows have grown considerably and have affected programme implementation.(Bhatt, 2000).

The budget allocations of the CSPs have two components. Under the first, the states receive financial allocation through budgetary support to meet salary and other establishment expenses. The second involves allocation to state implementing agencies in the form of kind resources. The states depend, to a large extent, on the Centre to implement various components of the CSPs. For example, in most states more than 95 per cent of family welfare budget support comes from the Centre. The mechanisms used in transferring funds and other resources have been questioned, like:

6.1 Payment delays to states and districts:

Although financial rules and procedures are well defined, the delay in funds flow has been the general experience for the managers implementing health sector programmes. Under the existing systems, financial resources flow through different levels in government. From the central government treasury, it is passed on to the state treasury, and is then made available to implementing agencies at the district or block levels. Non-components of the programmes are implemented through NGOs and the private sector.

There are number of instances of delay in making funds available to various implementing agencies in the health sector. For example, a review of the national TB programme identified delay in funds disbursement as the key component of its poor performance. The experiences suggest that funds for mobility, medicine, and maintenance are generally not available. Accordingly, the family welfare programmes have made number of changes to strengthen funds flow up to sub-centres. These changes pertain to strengthening the management structures of the programme through creation of societies to transfer the funds and other resources. However, these changes have not been effective in

handling this problem. For example, one of the states which set up the state and district society to channel RCH funds experienced a delay of 262 days in getting funds. There were arrears to the extent of 68 per cent of cash releases for family welfare programmes in Gujarat in 1997-98; the all-India average worked out to 30 per cent for 1997-98. At the district level, no guidance is available to programme managers on utilisation of these funds. This leads to further delays in making funds available for use (Bhatt 2000).

6.2. Under-utilisation and under-funding

There are also instances of funds allocated for different programmes components and sub-components being under-utilised. These do not get noticed because of lack of adequate 'financial management information system' that could provide information beforehand on the extent of utilisation of funds. The information on arrears also shows that it is generally the larger states which face problems suggesting complexities in managing the programmes in these states. Within a given programme the variations in utilisation of different schemes is also significant. There is no financial information system, which provides advance information about extent of utilisation of funds. In the process, the utilisation pattern of many components goes unnoticed.

6.3 Lack of Co-ordination :

At the implementation stage, there is considerable amount of confusion at different levels about the way the implementing agencies are expected to interact with agencies outside the government and how funds are supposed to be utilised. This results in delay in carrying out various activities of the programme. In the absence of clear guidelines, government officials hold conflicting views on public-private interaction and, thus, resources are not put to use and sometimes under-utilised. For example, in one district because of lack of these guidelines, RCH funds were still not used after 275 days of disbursement of funds. It has also been observed that districts lack appropriate financial management systems and skills to handle many of the new challenges and lack flexibility in using the resources to address local-level needs. For example, in one district where most of the sub-centres are housed in rented premises, the RCH funds earmarked for minor works (or construction) was problematic to utilise.

6.4 Uneven and irregular-flows:

Cash remittances to districts are highly uneven and uncertain. The mechanism of transferring funds from the Centre to states and from the state to districts does not exactly match cash remittances made by the Centre or/and cash remittances received by the district. As per one observation, the data on release of funds for three schemes of family welfare to a particular district in West Bengal reveals that till September no remittance reached the district barring a meagre 1.21 per cent in July; 57 per cent of the remittance reached in the third quarter, and the remaining 42 per cent reached in the last quarter of the financial year (Bhatt, 2000).

It seems that different criteria are used in allocating funds under different schemes to districts. The story is not different for inter-year allocations and expenditure flows, there are variations in the intra-year expenditure too. It has been observed that in some programmes, the increase in allocation has been even to the extent of 120 per cent, while in some schemes there was a decline in allocation from 100 to 0 percent in the following year. Some of these variations are because of delays and previous year allocations. It is observed that delayed allocations create considerable burden on the implementing agencies to spend funds in the shortest possible time. This also raises a number of questions about the capacity of health departments and management issues in implementing the programmes effectively.

7. The Health Scenario in India

In the year 2005, the sensex was zooming, economic growth was at 8 per cent and India is to all intents and purposes, spells a success story. But even today, one out of every nine children born dies before his first birthday. And these are the governmenr's own figures.

If there is a silver lining in this dark cloud in the health front, it's that the IMR has been falling since 2003. The latest figures are 60, down from 63 in 2002. But this figure is not good enough to hide India's shame, brighter in the light of the country's economic boom (Jain 2006). The Infant Mortality Rate (IMR)is considered the most important measure of how well the government distributes available resources for health, education, and status of women and public spending.

It is defined as the number of infant deaths per 1,000 live births in a community during a particular calendar year. According to experts, deprivation among people of a particular region, class of ethnic group within a country is likely to show in the form of an increased IMR. A country like Sri Lanka, riddled with civil war has managed to keep it at 17 per 1,000, compared to India's 60. Even Bangladesh is improving at a faster rate than India. Kerala, with am IMR of 16, is the only state with a figure similar to developed countries. Certain areas in Madhya Pradesh, Orissa and Rajasthan have an IMR figures above 90-100. No attempts have been made to target areas like Southern Orissa , Vindhyas in Madhya Pradesh or Central Uttar Pradesh. "At this rate, the IMR and child mortality projected up to 2016 shows that India may not be able to achieve the target set for an IMR of 30 by 1010 without making concerted efforts to improve the content and quality of health services," said Arving Pandey, Director, Indian Council of Medical Statistics. The community role is vital in detecting the first signs of illness in a child. With a little bit of training, they can amend some age-old practices, that increase chances of children dying. For example, some communities traditionally wash the child after it is born, the mother is not allowed to breast-feed for four days and she is not allowed to step out for 40 days. A few community projects have been launched and have shown dramatic results, to the extent of halving the IMR in some tribal communities. Dr. Abhay Bang and Rani Bang published these findings in a study in acclaimed medical journal Lancet.

7.1 India Vs. Selected Countries:

It is already mentioned, Infant Mortality Rate (IMR) is considered the most important important measure of how well the government distributes available resources for health , education, and status of women and public spending.

Table 5.1: Natality, General Mortality, Population Growth Rate, Expectation of Life ast Birth (By Sex) & Infant Mortality in selected Countries of the World (2000-05) (Medium Variant Projections)							
Sl. No.	**Country**	**Natality (per 1000 population)**		**Population Growth Rate (%)**	**Infant Mortality Rate (per 1000 live births)**	**Expectation of lifae at Birth (years)**	
		Live Birth	**Death**			**Male**	**Female**
1	India	23.8	8.5	1.5	64.0	63.2	64.6
2	Pakistan	35.9	9.6	2.4	87.0	61.2	60.9
3	Bangladesh	28.9	8.3	2.0	64.0	61.0	61.8
4	Srilanka	16.4	6.6	0.8	20.0	69.9	75.9
5	Japan	9.2	8.2	0.1	3.0	77.9	85.1
6	Malasia	22.6	4.6	1.9	10.0	70.8	75.7
7	Indonasia	20.7	7.3	1.3	42.0	64.8	68.8
5	Australia	12.3	7.4	1.0	6.0	76.4	82.0
6	Canada	10.3	7.5	0.8	5.0	76.7	81.9
7	United Kingdom	11.0	10.4	0.3	5.0	75.7	80.7
8	Russia	8.6	14.6	(-) 0.57	16.0	60.8	73.1
9	U.S.A.	14.5	8.3	1.0	7.0	74.3	79.9
	World Total	21.3	9.1	1.2	56.0	63.3	67.6
Source : Health Information of India, 2003							

The comparison of the basic health indicators with selected countries for the period 2000-05 is presented in Table 5.1. The live birth per 1000 population in India is 23.8, whereas the world average is 21.3. The highest is in Pakistan at 35.9 and the lowest in Russia at 8.6. The death rate per 1000 population is 8.5 in India and for World it is 9.1. The maximum is reported for Russia at 14.6 and minimum for Malaysia at 4.6. India's population growth is 1.5% per annum against 1.2% for the world, the minimum being in Russia at (-)0.57% and maximum in Pakistan at 2.4%. The Infant Mortality rate per 1000 live births in India is 64 against 56 for the world, the maximum is in Pakistan at 87 and minimum in Japan at 3. The expectation of life at birth in India is 63.2 for males and 64.6 years for females as against the world average of 63.3 for males and 67.6 for females. The maximum is reported for Japan with 77.9 years for males and 85.1 years for females. The minimum is in Bangladesh with 61 for males and 61.8 for females.

7.2 Achievements of National Health Targets:

As already stated, the targets set by the government of India to achieve health for all by 2000' is far from being achieved. The same can be observed from the figures published in the governments own publication i.e Economic Survey for the year 2001-02 as presented in Table 5.2. The target was to achieve 1.2% annual growth in population by the 2000 , where as the same was still at 1.96% in the year 2001. The birth rate was targetted at 21 per 1000 and death rate 9 per 1000. The birth rate in 2002 was still at 25 per 1000 but there was a slight decline in the death rate at 8.1 per 1000. The Infant Mortality rate was targetted for 60 per 1000 live births. But in year 2002 the same was 64. But this figure is for all India. If we look at the distribution across states and rural urban areas, a glaring disparity exists with much higher IMR than the all india average and targetted figures.

Table 5.2:Achievements of national Health Targets

Parameters	National Targets for 2000	Level of Achievement
Population (annual growth rate)	1.2	1.96 (2001)
Birth rate (per ,000)	21	25 (2002)
Death Rate (per '000)	9	8.1 (2002)
Infant mortality rate (per '000 live births)	60	66 (2001)
Couple Protection Rate (%)	60	------
Source: Economic Survey of Delhi, 2001-02; Health Information of India-2003.		

7.3 .Dispasrity across States:

As already mentioned that although the IMR in the Rural India is reported at 69 per 1000 live births and in Urban areas the same is 40 the variation across the states is alarmingly wide. The state-wise infant mortality rate for the year 2002 is presented in Table 5.3. Although at the all-India level the infant mortality was 64 per 000 live births, across states, wide disparity is observed. In the overall, it ranges between the minimum at 10 in Kerala to the maximum in 87 in Orissa. Again the rural/ urban disparity within the states is quite high. In urban areas of the states it varies between the minimum at 8 in Kerala to the maximum at 58 in U.P. In rural areas, the minimum is in Kerala at 11 and high as 91 in Orissa.

Table 5.3: Infant Mortality Rate (per 1000 Live Births) 2002 and Percentage of Population below Poverty line by States 1999-00							
		Infant Mortality Rate			Percentage of Population below poverty line		
Sl. No.	State	Rural	Urban	All	Rural	Urban	All
1	Andhra Pradesh	71	35	35	11.05	26.63	15.77
2	Assam	73	38	70	40.04	7.47	36.09
3	Bihar	62	50	61	44.3	32.91	42.6
4	Gujarat	68	37	60	13.17	15.59	14.07
5	Haryana	65	51	62	8.27	9.99	8.74
6	Himachal Pradesh	60	32	58	7.94	4.63	7.63
7	Karnataka	65	25	55	17.38	25.25	20.04
8	Kerala	11	8	10	9.38	20.27	12.72
9	Madhya Pradesh	90	56	85	37.06	38.44	37.43
10	Maharashtra	52	34	45	23.72	26.81	25.02
11	Orissa	91	56	87	48.01	42.83	47.15
12	Punjab	55	35	51	6.35	5.75	6.16
13	Rajasthan	81	55	78	13.74	19.85	15.28
14	Tamil Nadu	50	32	44	20.55	22.11	21.12
15	Uttar Pradesh	83	58	80	31.22	30.89	31.15
16	West Bengal	52	36	49	31.85	14.86	27.02
	All India	69	40	64	27.09	23.62	26.1
Source : 1) Health Information of India-2003; 2) Planning Commission, Government Of India							

	Table 5.3a: Ranking of Infant Mortality Rate (per 1000 Live Births) 2002 and Percentage of Population below Poverty line by States 1999-00						
		Infant Mortality Rate			Percentage of Population below poverty line (HCR)		
Sl. No.	State	Rural	Urban	All	Rural	Urban	All
1	Orissa	1	3	1	1	1	1
2	Madhya Pradesh	2	2	2	4	2	3
3	Uttar Pradesh	3	1	3	6	4	5
4	Rajasthan	4	4	4	10	10	11
5	Assam	5	7	5	3	14	4
6	Haryana	9	5	6	14	12	14
7	Bihar	10	6	7	2	3	2
8	Gujarat	7	8	8	11	10	12
9	Himachal Pradesh	11	13	9	15	16	15
10	Karnataka	8	15	10	9	7	9
11	Punjab	12	11	11	16	15	16
12	West Bengal	13	9	12	5	11	6
13	Maharashtra	14	12	13	7	5	7
14	Tamil Nadu	15	14	14	8	8	8
15	Andhra Pradesh	6	10	15	12	6	10
16	Kerala	11	16	16	13	9	13
	All India						

Source : 1) Health Information of India-2003; 2) Planning Commission, Government Of India
Note : The States are arranged in the descending order of ranking for IMR for All India.

It has already been mentioned, IMR is considered as the prime indicator to assess the health stutus of the pople. It is also observed that the economic status of the people has a direct bearing on the IMR. Table 5.3a presents the ranking of the states in the descending order of the IMR (All) and also the percentage of population below poverty line. It may be observed that three poorest states, Orissa, Bihar and Madhya Pradesh with ranks at 1,2 and 3 also have the highest IMR with similar ranking.

The coefficient of correlation between IMR and HCR is estimated at 0.53.

Table 5.4 : Expectation of Life (years) by Sex for Selected states in India (1995-99)			
Sl. No.	**State**	**Male**	**Femlae**
1	Andhra Pradesh	61.6	64.1
2	Assam	57.1	57.6
3	Bihar	60.7	58.9
4	Gujarat	61.9	63.7
5	Haryana	64.1	65.0
6	Himachal Pradesh	65.1	65.8
7	Karnataka	62.4	65.5
8	Kerala	70.6	76.1
9	Madhya Pradesh	56.5	56.2
10	Maharashtra	64.5	67.0
11	Orissa	57.6	57.8
12	Punjab	66.9	69.1
13	Rajasthan	59.8	60.9
14	Tamil Nadu	63.7	65.7
15	Uttar Pradesh	58.9	57.7
16	West Bengal	62.8	64.3
	All India	60.8	62.5

The expectation of life (years) by sex for selected states is presented in Table 5.4. For all India the same is 60.8 for males and 62.5 for females. Across states for males it is the highest in 65.1 years in Himachal Pradesh to the lowest at 56.5 in Madhya Pradesh. For females the same is found to be the highest in Maharashtra at 67 years and lowest in Assam at 57.6 .

7.4. National health spending

From Table 5.5 it is observed that the share of government expenditure on health to GDP remained more or less the same being less than 1 per cent from 1993-94 to 200-01 and showed a marginal increse to the extent of 0.90 per cent in the year 2002-03. As against this, the share of private (out-of –pocket) expenditure shows an increase from 3.14 per cent in the year 1993-94 to 5.77 per cent in the year 2002-3.

Table 5.5: National Health Spending (Rs. Billions)							
	1993-94	**1994-95**	**1995-96**	**1996-97**	**1997-98**	**2000-01**	**2002-03**
Central Government	7 (0.08)	11 (0.11)	12 (0.10)	13 (0.10)	14 (0.09)	23 (0.11)	35 (0.14)
State Government	68 (0.79)	72 (0.71)	89 (0.75)	99 (0.72)	113 (0.74)	156 (0.75)	186 (0.76)
Total (center + states)	**75 (0.82)**	**83 (0.82)**	**101 (0.85)**	**112 (0.82)**	**127 (0.83)**	**179(0.86)**	**221 (0.90)**
Private (Out-of Pocket)	**195 (2.27)**	**279 (2.75)**	**329 (2.77)**	**373 (2.73)**	**459 (3.01)**	**982 (4.70)**	**1200 (4.87)**
Total (Government + Private)	270 (3.14)	362 (3.57)	430 (3.62)	485 (3.54)	586 (3.85)	1161(5.56)	1421 (5.77)
Total GDP	8592 (100.0)	10128 (100.0)	11880 (100.0)	13682(100. 0)	15225(100. 0)	20895(100. 0)	24633(100. 0)
Figures in parenthesis are percentages to total GDP for the respective years.							
Compiled from : Source : Ravi Duggal (2003)							

Table-5.6 Health Expenditure as a Percentage to GDP in Select Countries, 1990				
Country	**High-income countries (per capita GNP $9,500 and above)**			
	Per capita 1990	**Total 1990**	**Public 1990**	**Private sector 1990**
United States	2,763	12.7	5.6	7.0
France	1,869	8.9	6.6	2.3
Japan	1,538	6.5	4.8	1.6
Australia	1,331	7.7	5.4	2.3
United Kingdom	1,039	6.1	5.2	0.9
Singapore	219	1.9	1.1	0.8
Low-income countries (per capita GNP $750 and below)				
India	**21**	**6.0**	**1.3**	**4.7**
Sri Lanka	18	3.7	1.8	1.9
Pakistan	12	3.4	1.8	1.6
China	11	3.5	2.1	1.4
Nigeria	9	2.7	1.2	1.6
Bangladesh	7	3.2	1.4	1.8
Source: World Bank. World Development Report: 1993, Inverting in Health, Oxford University Press, New York, 1993.				

The health expenditure as percentage to GDP in selected sounctires reveal that among the high-income countries, the health expenditure (both public and private) as a percentage of GDP varies between 6.1 per cent in UK and 12.7 per cent in the US. The same in respect of low-income countries varies between 2.7 per cent in Nigeria with highest

in India being 6 per cent. In respect of public sector health spending, it varies between 4.8 per cent in Japan and 6.6 per cent in France among the high-income countries, while it varies between the lowest at 1.2 per cent in Nigeria followed by 1.3 per cent in India , being the highest in China at 2.1 per cent among the low income countries (Table 5.6).

7.5 Hospitals and dispensaries:

Table 5.7 Number and Percentage Distribution of Allopathic Hospitals/Beds in Allopathic Hospitals Dispensaries (according to ownership) as on 1.1.2002

	Government (no.)	**Local bodies (no.)**	**Private & vol. orgs. (no.)**	**Total (no.)**
Hospitals	3593	455	11345	15393
Dispensaries	8478	1748	12065	22291
Total	12071	2203	23410	37684
Beds in allopathic hospitals	389141	32148	262256	683545
Beds in dispensaries	13512	1378	14772	29662
Total	402653	33526	277028	713207
	Government (%)	**Local Bodies (%)**	**Private & Vol Orgns (%)**	**Total (%)**
Hospitals	23.34	2.96	73.70	100.00
Dispensaries	38.03	7.84	54.12	100.00
Total	32.03	5.85	62.12	100.00
Beds in allopathic hospitals	56.93	4.70	38.37	100.00
Beds in Dispensaries	45.55	4.65	49.80	100.00
Total	56.46	4.70	38.84	100.00

Source: Health Information of India, 1994, p. 120, Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, Govt. of India.

From the distribution of number of allopathic dispensaries and hospitals number of beds therein, it is observed (2002) that private hospitals account for 73.7 per cent of all hospitals and 38 per cent of all beds, 54 per cent of the dispensaries and 49.8 per cent of the beds therein. As against this, public hospitals (government and local bodies) constitute 26.3 per cent and 62 per cent beds. In respect of dispensaries, the same constitutes about 45.8 per cent and 50.2 per cent, respectively (Table 5.7). It is already mentioned that the private sector

is mainly catering to the ambulatory/curative services with urban bias and regional variations. rather than providing preventive and promotive health care in the rural areas.

7.6. Rural Health Care Services:

As already mentioned, the primary healthcare infrastructure consisting of SCs, PHCs and CHCs provide the mechanism for sustained and continous outreach of all to the health and family welfare programmes. The Planning Commission has, therefore, earmarked funds each year for strengthening of this infrastructure under the MNP. The Commission provides approximately 50 per cent of Plan funds for MNP, the states are not able to spend this amount and usually divert it to non-MNP component .

Table 5.8 Targets and Achievements in the Establishment of Sub-Centers, PHC's and CHC's in 7th and 8th Plans and 9th Plan Periods

	7th Plan (1985-90)			8th Plan (1992-97)			9th Plan (1997-02)		
	Target	**Achievement**	**Achievement as percentage of Target**	**Target**	**Achievement**	**Achievement as percentage of Target**	**Target**	**Achievement till 31.3.01**	**Achievement as percentage of Target**
(a) Sub centres	54612	45960	84	17030	5060	30	7686	1053	14
(b) PHCs	12392	9556	77	4450	1769	40	1521	693	46
(c) CHCs	1523	1149	75	1269	450	35	2903	410	14
Total	68527	56665	83	22749	7279	32	12110	2156	18
Source: Health Information of India.(various issues)									

From the Table 5.8 it may be observed that achievements in the establishments of sub-cnters as percentage of target gradually declined from 84 per cent in the 7th Plan to as low as 14 per cent in the 9th Plan (till 31.3.03). The same in respect of PHC's declined from 7 7 per cent to 24 per cent during the same period. For th CHCs the achievements was 83 per cent in the 7th Plan which came down to just 18 oper cent in the 9th plan. This widening gap between the targets and achievements in the plan periods reveals the gaps in in the planning and implimentation there of..

Table 5.9 Number of Sub-Centers, PHC's and CHC's Functioning, Estimated Requirement and Shortfall in 6th ,7th , 8th and 9th Five Year Plans					
SL. No.		End of 6th Plan (1985)	End of 7th Plan (1990)	End of 8th Plan (1997)	End of 4th year of 9th Plan (31.3.01)
1	(a) **Sub centres** – Functioning(No)	84376	130165	136258	137311
	Required (No)	120424	131724	148186	158383
	Shortfall (No)	36048	1559	11928	21072
	% shortfall over requirement	30	1	8	13
2	**(b) PHCs-** Functioning (No)	9115	18671	22176	22842
	Required (No)	20069	21952	24695	26394
	Shortfall (No)	10954	3281	2519	3552
	% shortfall over requirement	55	15	10	13
3	**(c) CHCs-** Functioning (No)	761	1910	2633	3043
	Required (No)	5017	5488	6173	6598
	Shortfall (No)	4256	3578	3540	3555
	% shortfall over requirement	85	65	57	54
	Total – Functioning (No)	94252	150746	161067	163196
	Required (No)	145510	159164	179054	191375
	Shortfall (No)	51258	8418	17987	28179
	% shortfall over requirement	35	5	10	15

Source: Health Information of India.(various issues)
Note: The figures on the required number of Sub-Centers has been estimated by applying the population norm for the respective years

Table 5.9 presents the percentage of shortfall in setting up of SCs, PHCs and CHCs over the requirements from 6th to 9th plan period. In respect of setting up of SCs the percentage shortfall over requirement declined from 30 in the end of 6th plan to 13 in the end of 4th year of the 9th plan. For PHCs the same declined from 55 per cent to 13 per cent .

In case of CHCs the shortfall, which was 85 per cent in the 6th plan came down to 54 per cent in the 9th plan.

7.7 Acute shortage medical manpower:

There is an acute shortage of health manpower in the rural health care centres in various categories. The extent of shortage of manpower in terms of number vacant as percantage to number sanctioned in SCs, PHCs and CHCs from 1987 to 2001 is presented in Table 5.10a is alarming. The percentage of vacant posts in repect of specialists like paediatricians, physicians, obstetricians and surgeons vaary between 46 and 57 per cent as in the year 2001. The doctors at PHCs by 13.4 per cent. In respect of other supporting medical manpower like block extension educators, pharmachists , nurse midwiife etc. the percentage of vacant posts vary between 7 and 15 in the yer 2001. Surprisingly, since 1987 the figures for the percentage of vacant posts consistently remained more or less the same till 2001. .

It is very much evident though there is no shortage of doctors and nurses in the country, they are reluctant to work in the rural areas. However, it is true that there is an acute shortage of para-medical personnel in our rural health system. Professional staff is not up-to-date on clinical and management skills, training facilities are limited, and there is little on-the-job training (Chauhan 1997). In order to meet the shortage of para-medical manpower, which varies from state to state, the Planning Commission has identified several areas of vocational training course in the 10+2 stream. But only a few states have so far made use of this facility.

Table 5.10 Extent of Vacancies in Health Manpower in Rural Primary Healthcare Centers (PHCs) (in numbers)							
		As on 31. 3. 91			As on 31. 3. 02		
Sl. No	**Category**	**Sanctioned**	**In position**	**Vacant**	**Sanctioned**	**In position**	**Vacant**
1	Doctors at PHCs	24930	21428	3502	29689	25724	3965
2	Surgeons	903	668	235	1518	781	737
3	Obst. Gynae.	616	356	260	1498	780	718
4	Physians	524	396	130	1305	704	601
5	Padeatricians	513	275	240	1019	440	578
(Item 1 to 5)	**Medical personnel**	**27486**	**23123**	**4367**	**35029**	**28429**	**6599**
6	Block extension educators	6156	5717	439	6743	5708	1035
7	Health assistant (male)	24942	22967	1975	23569	19927	3642
8	Health workers (male)	86651	78584	8067	84750	71053	13697
9	Health asst/ LHV (female)	21666	19108	3303	23032	19855	3257
10	Health workers (female)/ ANMs	133394	122264	11130	148151	137407	10765
(item 6 to 10)	**Para-medical staff**	**272809**	**248640**	**24914**	**286245**	**253950**	**32396**
11	Pharmacist	20584	18591	1993	22972	21118	2469
12	Lab. Technician	10186	8627	1559	15544	13262	2368
13	Nurses (mid-wives)	14520	12076	2444	32723	27336	5495
(item 11-14)	**Technical staff**	**45290**	**39294**	**5996**	**71239**	**61716**	**10332**
Source: Compiled from Health Information of India, Central Bureau of Health Intelligence, Ministry of Health & Family Welfare, Government of India , New Delhi (1991 & 1993)							

Table 5.10a :Manpower Vacant as percentage to number Sanctioned in Sub-Centers, Primary Health Care Centres and Community Health Ceners in Rural India in the year 1987 to 2001

Sl.No.	Health Manpower	1987	1991	1996	1999	2001
1	Paediatricians	-----	46.78	39.11	55.93	56.72
2	Physicians	-----	24.81	44.83	53.75	46.05
3	Obstetricians	-----	42.21	48.53	46.27	47.93
4	Surgeons	-----	26.02	47.80	46.92	48.55
5	Doctors at PHCs	13.85	14.05	13.73	14.14	13.36
6	Block Extension Educators	7.99	7.13	17.18	13.65	15.35
7	Health Assistants (Male)	16.48	7.92	-----	15.75	15.45
8	Health Assistants (Females)	20.85	15.25	-----	13.94	14.14
9	Health Worker (male)	5.19	9.31	-----	16.20	9.98
10	Health Worker (female)	7.27	8.34	-----	6.91	6.72
11	Pharmachist	9.08	9.68	9.58	10.53	10.75
12	Laboratory Technicians	11.83	15.31	23.79	20.03	15.23
13	Nurse Midwife	11.16	16.83	21.43	22.34	16.79

Source: Compiled from: Health Information of India, Ministry of Health & Family Welfare. (Various issues)

7.8 Rural Urban disparity in health cares:

A comparative picture of the provision of health services as well as basic health indicators reveal a large gap between rural and urban areas (Table 5.11). The number of hospitals per thousand population in rural areas is 0.2 and in urban areas it is 0.3; doctors per thousand population is 0.6 and 3.4 respectively. The per capita per person public expenditure

on health is Rs.80/- in rural areas as against Rs.560/- in urban areas. The out of pocket expenditure (per capita per person) is Rs.750/- and Rs.1150 in rural and urban areas respectively. This is expected due to higher per capita income of the urban people. As regards the basic health indicators, the infant mortality rate (IMR) per thousand live birth is 74 in rural areas as against 44 in urban areas, the under 5 mortality rate per thousand live birth is 133 and 87 respectively in rural and urban areas and on.

Final	**Table 5.11 Rural Urban Disparity in Health Care in India (2002-03)**		
Sl.No.	Subject	Rural	Urban
1	Hospital Beds (per 1000 population)	0.2	3.0
2	Doctors (per 1000 population)	0.6	3.4
3	Public Expenditure (per capita per person in rupees))	80.0	560.0
4	Out of Pocket Expenditure (per capita per person in rupees)	750.0	1150.0
5	Infant Mortality Rate (IMR) per 1000 live birth	74	44
6	Under 5 Mortality Rate (per 1000 live birth)	133	87
7	Births Attended (%)	33.5	73.3
8	Full Immunization (%)	37	61
9	Median ANCs	2.5	4.2
Source: Ravi Duggal (2003), Operationalising Right to Health Care in India, Centre for Enquiry into Health and Allied Themes; www.cehat.org.			

7.9 Gender bias:

In India, females continue to be at greater risk than men of dying from childhood through their childbearing years. The sex ratio remains unbalanced, and in some states appears to be deteriorating. Publicly-supported reproductive and other healthcare for women has barely begun to meet the needs, particularly among the rural poor.

7.10. Low priority in preventive health care:

The healthcare system in India is largely 'curative' and 'clinical'. Within curative and clinical preoccupations, the emphasis is on the number of hospitals, institutions, health infrastructure, equipment, and personnel rather than primary healthcare; the urban rather than rural population; doctors rather than paramedical (again with urban bias); and services

that have larger private than social returns and family planning and child health to the wider aspects of female health (Berman, 2000). The private sector also shows marked preference for large hospital based curative services in urban areas. On the other hand, the preventive, promotive and surveillance and improvement of healthcare- including environment related diseases for the masses mainly in rural areas-have received very low priority.

7.11 Overlapping and duplication in health services:

The present state mechanism of delivering public health services face serious problems, including overlapping functions among the various tiers of the healthcare system. Services provided at different tiers of the system are often duplicated and there is no clear delineation at each type of facility—the lower-tier institutes such as PHCs are under-utilised due to multiple reasons, including lack of support from referral institutions. The same is applicable to the national disease control programmes. The problems related to the availability and quality of staff impedes the technical efficiency of health programmes and affects productivity. It is, therefore, necessary to provide better incentive to the workforce and address training needs. There is a need to develop a mechanism to provide increased supplementary central funding to the backward states where raising of alternative sources of revenue are limited.

7.12 Poor Information System and Records and poor infrastructure development:

There is no indication in the state's annual plan document on the progress of the completion of the buildings of the peripheral healthcare institutions, construction of staff quarters, provision of essential supplies, filling up of all vacant posts and serviced training to the workers to improve their knowledge and skills for which funds are allotted. Convergence of services at the grass-root level is essential but lacking in most of the states. The mechanism adopted by various states is normally not described in the document.

Moreover, the achievement in terms of establishment of PHCs and CHCs is highly unsatisfactory (Table 5.8). Though the provision of funds for construction of primary healthcare institutions were fixed long back, no state has asked for revision of norms

7.13 Under-funding and under-utilisation:

Though the pattern of funding to the states by the Planning Commission is uniform, there are substantial differences between states in utilisation of funds, as well as, completion of the targeted work without time and cost overruns. The communicable disease programmes and other primary healthcare services have suffered for inadequate funding or under-utilisation of funds in many states. Most require matching state funds, for which poorer states that suffer most from the associated health problems (Berman) are least able to provide. Funds from the Centre are withdrawn if states' matching grants do not come forward. The Planning Commission provides approximately 50 per cent of plan funds for MNPs. Some states are not able to spend this amount and usually divert it for non-minimum needs programme component.

Broadly, the phenomenon of under-utilisation of funds is reflected in the difference in the Centre's budget allocation, release, and utilisation in different schemes and programmes. But this provides *an overall picture. The fact that funds allocated are under-utilised goes unnoticed because of the lack of an adequate 'financial management information system (Rajaraman, 2001b; Bhatt, 2000).* Within a given programme, the variations in utilisation of different schemes are also significant. Information suggests that it is generally larger states that face problems, suggesting complexities in managing programmes in these states. The gravity of the situation can be well-imagined from some of the scattered reports available from newspapers, magazines, and journals published recently. Patients suffer as Delhi government hospitals fail to utilise funds. For example, GB Pant Hospital, Delhi's premier hospital, had utilised only 36 per cent of its annual plan outlay of Rs 25 crore for 2001-02 by December 2001; the Maulana Azad Medical College and Hospital spent only Rs 2.79 crore of its annual outlay of Rs 90 crore (Shariff, Ghosh, and Mondal, 2002).

8. Challenges Ahead: The Priorities

8.1 Epidemiological transition:

The demographic characteristics, epidemiological features, and the burden of disease determine relative stages in **health transition** ranging from a high incidence of communicable disease with relatively lower levels of non-communicable disease and injuries to a situation of high levels of non-communicable disease and injury, with relatively lower incidence of communicable disease . But India is likely to face a duel challenge in the near future. The burden of both communicable and non-communicable diseases is likely to create an adverse epidemiological transition. On the one hand, the communicable diseases will continue to haunt the country and, on the other, the burden of non-communicable diseases and injuries will rise further. Further, due to the decline in both mortality and fertility, the age structure of the population will shift. With the increase in the proportion of people over the age of 60, the burden of non-communicable diseases will rise further. At the same time the challenge of communicable diseases among the infants, young, middle-aged, and poor will persist (Chauhan 1997). WHO estimates indicate that by 2020 non-communicable diseases like heart attacks, cancer, and diabetics will account for over 70 per cent of deaths in India.

8.2 Epidemiological polarisation:

Due to uneven distribution of health services, one part of the population will successfully complete a demographic and epidemiological transition while the other will be left behind at the pre-transition stage dominated by disease and poverty. The demand of the urban middle and upper classes for sophisticated treatment will clash with free clinical services for the poor and rural population. This points to a major policy challenge.

According to the World Development Report (WDR), the states need to develop the 'essential components' of basic package of health services in view of the 'health transition' underway, and the major health problems which will face them in the coming years. For this, state-level variations in epidemiology and burden of disease (BOD) should be taken into account. The states should undertake the analysis of the 'BOD' regionally and at the community level, review the cost effectiveness of key health interventions, and carry out other important work such as manpower planning to facilitate and improve policy-making. The cost effectiveness analysis in the health sector is an instrument (like that of cost benefit analysis) to measure the relationship between various health interventions and outcomes

quantitatively). Since outcomes can be measured in deaths or disability averted, the recent practice is to calculate the BOD in terms of DALYs (disability adjusted life years). DALYs combine duration of life lost due to premature mortality with duration of unhealthy life lived with disability and express this as a single index, which can be used as a measure of effectiveness. The cost effectiveness analysis can be drawn by using cost per DALYs gained as a measure of attractiveness of interventions

8.3 . Basic Package of Health Services :

The package of services would consist of communicable disease prevention and treatment, limited clinical services, essential and emergency obstetric and paediatric care within easy access to people living in rural areas; capacity building for prevention and health promotion programmes to cope with non-communicable diseases; and risk reduction, prevention, treatment of injuries; and limited, cost-effective treatment of non-communicable diseases such as cataract operations and basic medical treatment of heart attack, stroke, and pain relief. However, this should take into account the public and the extent to which private sector is already providing these services, the role of the health sector in government's poverty alleviation programmes, the cost effectiveness of health interventions, and programmes that create large externalities. The package of services needs to be developed through a consultative and collaborative process involving leading health practitioners and policy-makers from the different levels of the health system, private, and NGO sectors for social input, and the finance departments of state governments to assess the financial ability of the state to provide the recommended package of services.

8.4 Burden of Disease by Causes of Death :

Table 6.1 :Distribution of Causes of death in India, 1998					
Sl. No.	**Causes of death (excluding 1st row, distribution of population)**	**Number in thousands**	**Per cent of deaths (excluding 1st row, population)**	**Percentage of world**	**Percentage of low and middle income countries**
		(1)	(2)	(3)	(4)
	Distribution of population	982223	-----	16.7	19.7
	Total deaths	9337	100.0	17.3	20.3
I	**Communicable and preventable diseases**	3944	42.2	24.0	24.7
I.1	**Infectious and parasitic diseasees**	2121	22.7	21.6	21.9
I.2	**Respirotory infections**	987	10.6	28.1	30.9
I.3	**Materma conditions**	125	1.3	25.3	25.4
I.4	**Perenatal conditions**	612	6.6	28.4	29.1
I.5	**Nutritional defeciencies**	100	1.1	20.4	21.4
II	**Non-communicable consitions**	4470	47.9	14.1	18.1
II.1	**Malignant neoplasms**	653	7.0	9	12.5
II.2	**Other neoplasms**	5	0.1	4.6	7.2
II.3	**Diabetes mellitus**	102	1.1	17.0	23.2
II.4	**Nutritional/ Endocrine disorders**	2	0.0	1.4	2.1
II.5	**Neuropsychiatric disdorders**	104	1.1	14.4	21.0
II.6	**Sense organ disorders**	0	0.0	0.2	0.2
II.7	**Cardiovascular disorders**	2820	30.2	16.9	21.5
II.8	**Respiratory diseases**	284	3.0	9.5	10.9
II.9	**Digestive diseases**	240	2.6	13.4	16.4
II.10	**Diseases of the genito-urinary system**	102	1.1	13.4	16.3
II.11	**Skin diseases**	2	0.0	5.4	7.7
II.12	**Musculo-skeletal diseases**	3	0.0	2.5	3.8
II.13	**Congentenial abnormalities**	153	1.6	29.8	32.1
II.14	**Oral diseases**	0.0	0.0	18.7	23.0
III.	**Injuries**	923	9.9	16.0	17.5
III.1	**Unintential**	723	7.7	20.7	22.8
III.2	**Intentional**	200	2.1	8.8	9.5
Source: Peters et al. (2002, pp.310-15) (taken from India Development Report-2004-05. Indira Gandhi Institute of Development Research.					

In India, reduction in mortality has doubled life expectancy at birth in the last 50 years and almost trebled it in the last 100 years, [1] but this comes with a greater incidence of sickness (morbidity).[2] An epidemiological transition seems to suggest a shift from communicable to non-communicable diseases.

The World Health Organization (WHO) estimates for 1998 (Table 6.1) show all sub-groups of communicable and preventable diseases have higher proportion of deaths than population proportion when compared with world or low-and middle-income countries . Diabetes mellitus, neuropsychiatric disorders (not when compared with world), cardiovascular disorders, congenital abnormalities, and oral diseases in non-communicable tdiseases, and unintentional injuries put greater burden. Infectious and parasitic diseases, respiratory infections, perinatal conditions, cardiovascular disorders, malignant neoplasn, and unintentional inhuries together account for more than four-fifths of deaths in terms of major causes (column 2 or 3) India faces the duel burden of communicable as well as non-communicable diseses (Mishra 2005)

8.5 Identifying need-based solutions:

- Taking into account the potential health needs of the population in terms of health status indicators covering (a) health policy, (b) socio-economic indicators related to health, (c) healthcare indicators, and (d) health status indicators that are necessary to prepare health profiles for village settlements, tribal settlements, *taluka*s, **districts, urban** slums, and towns and cities for planning, programming, allocation of health manpower, provision of health infrastructure to attain the goal of 'health for all' with more equitable, effective, and accessible healthcare delivery system. The organisation and management of the healthcare system based on PCHs should continue. In metros, a well-equipped, viable network on accidents and emergency care centres at suitable locations should be developed to cater to the emergency needs of trauma and non-trauma patients since it is beyond the capacity of the PHCs (Ministry of Health and Family Welfare, 1999-2000).

[1] Life expectation at birth in India is as follows : 1901-female 24.0, male 23.6; 1951-female 31.7, male 32.5; and 1993-97- female 61.8, male 60.4, Central Bireau of Health Intelligence (CBHI) 2002, p.53.

[2]Comparable estimates of NSS 28th round (1973-4), 42nd Round (1986-97) and 52nd Round (1995-6) confirm this increasing trend , National Sample Survey (NSSO) 1998b, p.18.

- Specific focus should be given on the major areas for action such as control of malaria; immunisation coverage of infants; access to safe drinking water and sanitation; improved nutrition and food safety; and innovative, action-oriented school health curriculum for the promotion of healthy lifestyles, particularly as regards to sexually-transmitted diseases like AIDS. Poverty and ill health are closely interrelated. While poverty prevents the person from satisfying the most basic human needs (adequate food, safe water and sanitation, and access to social services such as basic health and education), ill health inhibits an individual's ability to work, reduces earning capacity, and deepens poverty. Poverty should, thus, be tackled on two fronts: first, ensure that the poor have access to primary health (especially family with young children and vulnerable groups such as the elderly), and, secondly, enhance the health potential of the current workforce and future workforce (school children).

- The government's primary care services do not appear to be well-targeted at the poor. Despite public subsidies for hospital care, out-of-pocket expenses for serious illness impact the poor disproportionately. In a serious illness episode, families might pay fully for private ambulatory care, then go to a public hospital where they might receive a no-fare or highly subsidised day charge but still pay for other services as well as for items not available at a public hospital. After discharge, they may again pay fully for private follow-up treatment. The total costs of treatment are much higher due to the use of private health services (Chauhan 1997). In order to address this high level of out-of-pocket spending, the government needs to encourage prepaid risk pooling mechanisms in the long run, such as better targeted social insurance schemes, private voluntary insurance[3], and community financing. Risk pooling would provide more accessible and efficient healthcare to both the poor and non-poor as a whole. The private heath insurance schemes in India, which have

[3] Health Insurance: a variety of insurance mechanism have been deployed to finance health insurance: (a) compulsory, (b) voluntary contributions both from employees and also employers are the crucial source of addditional funds in India. It is more so when finances are directly required from achieveing the health of all. However, it is realised that it is not realistic to expect the people below poverty line in rural and urban slum areas in India to be able to pay to cover the whole cost of health service. Again, compulsory health insurance may also not be a workable proposition for financing of healthcare in all the situations. This may have a limited clientele. In developing countries like India, the population covered through compulsory insurance is small and confined mostly to organised sector with regular incomes through schemes such as Employees State Insurance Scheme (ESIS) and Central Government Health Schemes (CGHS). Besides,in government-sponsored social insurance programmes there are health insurances linked to employer-owned facilities and also private insurance schemes and health cooperatives as a mechanism of financing healthcare. Schemes like Mediclaim and Mediplan have just come in vogue which are covered under the general insurance scheme. In this mechanism of financing healthcare, there is an inbuilt general notion of the value of risk coverage. (Sharma 1995)

just begun to operate on a limited scale, can be enhanced adequately to have a larger coverage with appropriate government advocacy, as income levels and literacy increases. [4]

- The states are interested to start externally aided projects without considering the implication of increase in Plan/non-Plan expenditure when external aid is stopped. The state governments need to prioritise and ensure that sufficient funds are maintained in their non-Plan health budget to provide adequate and timely supply of essential inputs to existing facilities. For this, the following packages have been recommended (i) review staff norms and ensure necessary nursing care, (ii) allocate at least Rs 50, 000 per annum at current prices for drug purchase to each PHCs, (iii) rationalise personal policies to ensure adequate staffing of posts at the rural PHCs, (iv) ensure that doctors provide at least two years of rural service as a precondition to eligibility for admission to post-graduate courses, (v) provide staff quarters where critically needed, and (vi) provide regular training to medical/paramedical staff in health management and health economics. For adopting this, it is necessary to assess the existing position through a sample survey at the PHC level [Khurana 1995).

- The government should consider developing a national health financing scheme to provide grants to states and local governments. The NG0s and private sector organisations should be motivated to develop, test, and evaluate new and innovative approaches to financing. Another alternative for supplementing health resources could be to levy rational user charges for Government and privately provided health care. However the poorer people have to be exempted from payments. Most countries of South East Asia like Indonesia, Mayanmar and Nepal adopted the user charges system in various forms (Gupta and Sharma 1995)

- The *panchayat* administration provides an excellent basis for greater community-level participation in the planning processes for healthcare services, but the structures and systems linking the *panchyat* administration with health administration need to be defined more clearly. In order for the *panchayati raj* institutions (PRIs) to be more effective, more powers should be given to them in the areas of budget allocation, resource use, revenue raising, planning, policy-making, supervision, maintenance, and training. The notion of decentralised governance will be more meaningful only when PRIs' responsibilities are enhanced and their access to united resources become more substantial. PRIs should raise resources locally through various methods which have been attempted successfully in some

states, such as reward for tax effort, incentive outlays, and donations from private citizens and institutions, A process of consultation between the Department of Health at the state level and PRIs needs to be initiated on these aspects, and structures and systems need to be worked out to facilitate implementation (Ministry of Health and Family Welfare, 1999-2000).

- It has been established by several studies that private sector investment could surface mostly in clinical and curative and in areas of higher profitability confined mostly to the urban areas. Therefore, private investments should be restrained through government regulations and guidelines. Private sector participation can be encouraged where it has a comparative advantage such as tertiary-level healthcare, super-speciality and support services, and should also adopt appropriate therapeutic norms and regulations recommended by the national programme by the state governments. Even in preventive and promotive care services, private sector participation can be encouraged through provision of incentives and developing schemes to finance, train, and integrate private providers in case-finding, diagnostics, and treatment for priority health problems that are of public health significance (Chauhan 1997).

- The private contracting of health services, especially support services such as laundry, kitchen, landscaping, dietary services, sanitation, security, and mainstream diagnostic and clinical services, by the governments is becoming increasingly important since state governments can effect substantial cost-savings through such a mechanism. Private contractual services can be more efficient and effective than direct labour. The contracted-out services are a small proportion of overall expenditures at the state level in India, but there appears to be considerable scope for the expansion of contracting-out services, especially for non-clinical ones.

- The public subsidy on medical education should be reduced. This is an area where the private sector can be motivated to invest in opening medical institutions and reduce much of the burden of public expenditure incurred which can be diverted for providing more essential medical services in need of funds.

- In order to overcome the shortage of doctors and nurses in remote and rural areas, incentives have to be provided to medical professionals to encourage them to remain in their rural posts and discourage absenteeism. It is, therefore, necessary to conduct a study to estimate the extent of shortages of critical, medical and manpower in rural and remote areas.

- Of late, there has been a spurt in participation by NGOs (voluntary organisations, trusts, charitable institutions, and medical research institutes) in 'joint sector projects' and 'contractual services', but mainly concentrated in urban areas and in curative, clinical, and diagnostic services (Department of Family Welfare, 2001).

In order to overcome the delays in the implementation of government schemes due to the complex funds flow mechanism and administrative procedures, the involvement of societies (registered under Societies Act, 1860) was introduced in several schemes by the government. But several shortcomings were noticed in the functioning of these societies too. It is still at an experimental stage before a decision regarding the future involvement of these societies can be arrived at. It is now being widely recognised that involving people (people's participation) to look after their own problems could yield maximum benefit and success. In this respect, the concept of 'community financing' of primary healthcare is gaining ground and is being considered a crucial venture in the mobilisation of resources by the community to support, in part or in full, provision of the basic promotive, preventive, and curative services for its members. In states like Kerala, cooperatives have been established in which community pays regular contributions and run services. This is an important area that calls for adequate attention. In a recent move, the Andhra Pradesh government passed an order handing over the running of over 3,000 government-run hospitals to cooperative societies. According to the new order, the hospitals will be run by societies headed by local legislators, *zilla parishad* chairpersons, or other elected political representatives. The 11 teaching hospitals attached to medical colleges will be run by societies headed by district collectors. This means the government will pull out completely from the scene and societies will be responsible for the day-to-day upkeep of these hospitals. Though doctors and other paramedical staff will be on the government's payroll for now, their services will gradually be transferred to the societies. The order says the societies will explore all avenues to generate funds to run the hospitals, including levying of charges for services rendered. However, it is all a matter of time before any comments can be made on the success and effectiveness of this move (Ashok 2003).

- Apart from the above, as an alternative source of healthcare in remote and rural areas, the Planning Commission encourages promotion of the 'Indian system of medicine and homeopathy' in the country, and provides enhanced outlays for strengthening this system of medicine instead of opening more allopathic dispensaries in the rural areas and

tribal areas. However, the states have started proposing establishment of hospitals under these systems of medicines without indicating the supporting data. It is, therefore, required to evaluate through a sample survey the popularity and acceptability of the specific type of indigenous system of medicine like homeopathy, ayurvedic, unani, siddha, etc., among the rural and tribal people.

9. Addressing the Broad Issues Identified

In the backdrop of the entire scenario presented in the text, planners at the national and state level are concerned with a number of issues i.e. how much financial resources will be needed in the future for the provision of healthcare services to the people? Who will pay for the services and how? What will be the role of different public and private health institutions having different financial mechanisms? How does the source of financing affect efficiency and effectiveness of services? To what extent will the costs of health and family welfare services be shared by the beneficiaries across income groups to maximise the coverage?

In a 'Symposium on the Operationalisation of Financial Reforms', organised by the Department of Family Welfare, Government of India, and supported by the European Commission, a consensus was reached on the need to address four broad issues concerning India's healthcare system, in the light of the World Bank's proposal for SAP. These are: (1) decentralisation of financial and management responsibilities; (2) planning and pooling of funds (sector-wide approach—SWAP); (3) financial information system (desegregated and classified health expenditure national health accounts); and (4) flow of funds mechanism and financial management.

A detailed discussion of the four broad issues mentioned as above with viable recommendations for addressing the same is as follows. These recommendations are presented at a Glance in Table 9.2..

9.1 Decentralisation of financial system and management[5]

The need to push away the responsibility in the decision-making and delivery of public services (particularly in health and education) from the central government administration to the population being served is being globally recognised. In India, too, the first theme of the National Population Policy—2000 (NPP) acknowledged the need for delegation of (a) administrative and managerial, and (b) financial powers, including resource mobilisation to the local government institutions, i.e., PRIs.

In this respect following studies should be conducted to determine:

- The role of PRIs in managing and raising funds for health and family welfare services within the proposed decentralised system. The Kerala government launched major drive to devolve power to local government institutions. After 1996, up to 40 per cent of the annual government budget was pushed directly into the hands of municipalities and *panchayat* councils. Once they had the power to plan for themselves, the first thing the *gram sabha* decided upon was to capture rainwater from the roofs. For making PRIs empowered, they should first have the power to make their own plans and have the money to execute them:
- the extent to w hich the authority for 'activity planning' and 'budget management' can be handed down to the lower levels of the health system.
- to evaluate the scope for introducing the system of 'earned autonomy', which implies that the better-performing districts and states are given 'greater autonomy' of planning and budgeting.(and the extent to which local institutions are eager and willing to avail this 'earned autonomy'); along with this, it is, however, necessary to know the constraints and bottlenecks that hinders better performance at present.
- To prepare village-specific resource plan/resource mapping to undertake micro-level planning at the *gram sabha* levels focusing on health problems.
- To formulate 'district plans' to arrive at the resource mapping for healthcare services.

[5] A recent report, commissioned by DFID from Andhra Pradesh, highlighted that fragmented funding sources, much of which is not under state control, is the main limiting factor at present. Many agencies such as UNFPA have called for integrated budgets at the district and higher levels. The creation of district-level health and family welfare societies/bodies in few states have been motivated by decentralisation of central responsibility and convergence between different programmes.

- To establish linkages between public expenditure and health needs, for e.g., per capita allocations adjusted for epidemiological factors; improper allocation of funds results in unspent surplus funds in some programmes whilst others face deficit. For this, it is proposed to investigate and identify the specific local needs on the basis of sample survey of villages (preferably stratified). Apart from this, quadrant charts can be plotted (like maternal mortality against per capita health spending, per capita spending against number of births attended by qualified workers etc) to identify loopholes in the health system. For instance, Maharashtra had relatively low MMR despite less money being spent, and Rajasthan had relatively high MMR despite more money being spent. The charts can be used to investigate the causes underlying these anomalies
- To study the extent, time taken and stages involved in the devolution of financial powers from the Department of Health and Family Welfare to district governments, to PRIs, and to *gram sabhas*/*gram swaraj* (the village development fund is called *gram kosh*).
- In several states, hospital management committees, including strong representation of elected and government officials, are emerging as important mechanisms for financial autonomy at the hospital level. Typically, such committees have the authority to raise resources locally, and to invest in quality improvements in service and infrastructure. This is very important in the context of the move towards decentralising financial autonomy. It is proposed to identify and evaluate the organisational setup and performance of scope and viability for introducing such societies on an extensive scale in all states. For instance, the Rogi Kalyan Smity (RKS) (registered under the Societies Registration Act, 1860) has been set up in Madhya Pradesh. The main objectives of the RKS are to oversee management of hospitals, guarantee consultation and diagnostic services, ensure availability of female beds in maternity wards, utilise the revenue collected from user-charges for patient facilities, provide good quality of treatment to below-poverty-line patients, and levy user-changes in consultation with people's representatives. It has come up as an innovative move towards introducing user-charges and decentralisation. Similarly, in Rajasthan the Medical Relief Society (MRS), now expanded up to CHC level, was created in 1995 in all hospitals with 100 or more beds, and has been a successful innovation towards decentralisation. MRS has

also arranged facilities like *Sulabh* complexes, and maintains building, equipment, contracting-out services, etc.

- The community financing of primary healthcare is another area of health economics. In practice, community financing of primary healthcare is considered mobilisation of resources by a community to support, in part or in full, the basic promotive, preventive, and curative services for its members. There are many types of projects/schemes financed by the community. In Kerala, cooperatives have been established in which the community makes regular contributions. These 'contributed health funds' cover the amount, which would have been charged to users. These could also be in the form of 'community pharmacies', based on the funds which are used to maintain the most essential drugs. Other 'community resource inputs may consist of construction material for health facilities, other materials, and labour—including skills in some form of contributed services like that of health guides and trained dais, etc. A feasibility study may be conducted in each state to explore the possibilities of motivating people for community financing schemes.
- To evaluate the schemes related to substituting public funds with private funds in secondary and tertiary hospitals by instituting rational 'user-charges'. These charges are levied for government or privately-provided healthcare. However, the poor have to be exempted from these payments. Rarely, any school of economic thought today questions the validity of the user-charges as a means of alternative financing; to study the existing pattern of user-charges introduced in government hospitals and diagnostic centres; and to estimate the capacity of the people across various income groups to bear with the user-charges [the declaration by Delhi's health minister on setting up of 'pay clinics' in government hospitals in the capital paved way for unprecedented development (Ministry of Family Welfare)].
- **Joint sector projects:** The concept is to have contribution from the private sector and the government sector jointly. The infrastructure, land, and services offered by the private sector can be assessed and treated as equity with matching grant from the government, provided the private sector is willing to set aside 30-40 per cent free beds for patients. The equity share of the government could be in the form of financial support or by way of land, building, equipment, etc. Performance of these healthcare

centres should be evaluated in the light of the extent of the terms, conditions, and future scope for such centres.

- **Contractual Services**: Another way is to contract out to the private sector those services which have been persistently with the public sector, and where the public sector presence or the delivery system is weak. The other option is to make the existing public and private sector industries alive to their responsibility in providing a social service, like some health service located in the areas surrounding an industry. It is proposed to study the performance of these contractual services.
- **Health Insurance:** Social health insurance scheme is also being considered an alternative to provision of healthcare facilities, particularly to the poor. However, empirical evidence shows that social health insurance may improve equitable access to care if the scheme is implemented in such a way that it aims, the long run at least, at progressively serving the poor. Full cost recovery from private and government subsidised insurance must also be implemented. A sample survey of public and government insurance companies providing medical claim insurance must be conducted to study the extent to which the insurance companies are making their presence in the delivery of healthcare services.

9.2 Planning and pooling of funds (sector-wide approach—SWAP) Sector-wide approach (SWAP):

The health sector is fragmented between the Union versus state versus district; CSPs versus others; health and family welfare versus women and child development (WCD).

The Tenth Five-Year Plan document notes:

- The health sector is divided into programmes, programmes into schemes, and schemes into components, and each component and its sub-components are handled at different levels;
- Some of the resources are transferred to the states and in some cases the state is bypassed and resources are transferred directly to districts without coordinating and compiling information at the state and district levels;
- Different remittance mechanisms and criteria are followed for different schemes in allocation at various levels (the centre, state, and district levels);

- Programmes are managed through offices which are physically dispersed with little exchange of information and coordination between them;
- Different monitoring and evaluation requirements exist for different schemes—the financing arrangements are complex;
- Duplication of schemes in the same district or the same scheme is implemented by different agencies;
- At the state level, a lot of funds are off-budget through societies, etc., whereas on-budget funds are slow to be disbursed; and
- The accounting process is mixed and slow.

Therefore, a common health policy termed sector-wide approach (SWAP) is critical to ensure that all programmes and instruments in the sector (both external and domestic) are consistent. The aim of SWAP is to assist NPP 2000 in providing an integrated package of essential services at the village and household levels under SAP.

SWAP means all significant funding for the sector as a whole to make allocation more efficient. SWAP evolves from an agreement among the government/donors to more coordinated arrangements and may mean a single sector, common monitoring arrangements, or more coordinated procedure for funding under government leadership and procedures addressing both the public and private sectors. For this, there should be common formats for procurement, disbursement, accounting, and audit. Common reporting, too, is necessary in order to ensure a clear overview of developments in the sector that helps in further and efficient planning and implimentation. In this, funds could be pooled from several sources but a common, and agreed upon, expenditure plan is drawn up. It avoids duplication of expenditures like several programmes implementing the same activities in a district (it is necessary to identify the extent of such duplications in a district).

Substantial groundwork is needed for adopting sector-wide thinking, planning, policy-making, programming, and budgeting, etc.

- To begin with, it is required to identify the existing state of affairs, i.e., scheme-wise expenditure and release of funds at different levels, viz. the central government, the state governments, and the district and local governments; to enlist the essential medical services required at the village and household levels on a priority basis; prepare an epidemiological profile for identifying the pattern and burden of decease; *et al*.

SWAP links the plans at the national, state, and/or district levels with those of the development partners. The traditional project-based approach doesn't bring sustainable improvement in services; donors' projects absorb scarce human/financial resources and the local capacity is not developed.

- To identify duplication in spending as well as the states that do not have an expenditure plan; to evaluate the existing roles of private sources and governments in regulating these services; to identify the priorities on the basis of local needs for allocation of funds for various schemes; and to identify the wasteful expenditure.

9.3 National Health Accounts (NHA)

(Financial information for health service planning)

Like 'the flow of funds mechanism' and 'financial management', the 'audit and other accountability mechanisms' are equally vital to the performance and capability evaluation for streamlining the flaws and defeciencies.

Several issues that fall under the umbrella of 'financial information system' need to be addressed. The currently available data on investments is not complete, and does not always allow detailed analysis; there is often duplication in financial reporting on donors funds; and the current process of auditing expenditures creates serious delays in the flow of funds

To overcome this, the national health/sub-national accounts can offer practical information for better policy development, planning, and budgeting which bring about efficiency in expenditure—for instance, reducing wasteful expenditure and identifying the useful one—and is a key to health sector improvements.

The economic classification of health and welfare services expenditure statement is the key to preparing the NHAs. For this, it is necessary to study the relative role of different providers of health services through preparation of health accounts using, 'sources and uses matrix', detailing supply and consumption with minutes of fund use, productivity, etc., both for government and the private sector, including HHs. It will also provide a linkage with the national accounts and other large-scale surveys, etc. Information at the disaggregated level on current expenditure—for instance, proportion of expenditure on primary (preventive and curative care); secondary and tertiary expenditure; on in-patient and out-patient treatment; expenditure by line items like salaries, drugs, etc.; and expenditure on programme

administration and expenditure on health insurance, etc—needs to be gathered. The total expenditure on healthcare can also be arrived at by summing up the current expenditure on health and health-related services and the gross capital formation. Regular statements in this form can help to understand country's performance over a period of time and make inter-country comparisons. The information, thus, compiled can also be used for cost-benefit analysis to justify a particular health service or intervention in preference to the other.

Current expenditure on health = Expenditure on personal healthcare services + Expenditure on services for preventive and public health + Expenditure on health programme administration + Health insurance

Total expenditure on health = Current expenditure on health + Gross capital formation + Expenditure on health-related services

There are several anomalies and deficiencies which are needed to be streamlined for introducing the system of 'national health accounts', and some of which are as follows:

Delay in funds flows and low disbursement caused by complex procedures and multiple channels, especially in CSPs, results in delay in starting the project. There are several flows in the audit reports prepared by several implementing agencies, like late submission of audit reports, non-attachment of statement of expenditure (SOE), lack of clarity in observations, and understanding of the project scope, purpose, and verification of the eligibility of expenditure. Therefore, the entire audit system needs to be evaluated.

There should be uniformity across the states, and a clear understanding of the project structure, scope, concepts, and achievements is important.

The project accounts are not compiled with by the project authorities. The comptroller and auditor general has to generate accounts to suit the requirements; this causes delay. A system to prepare project financial statements within two-three months of the closing of the year has been proposed to be established. The computerisation of the treasury accounts is likely to generate such accounts. The utilisation certificates should include the major work done in terms of physical targets and achievements

It has been observed that the implementing agencies at the grassroots level are incapable of handling numerous interventions. **A study on the nature and extent of these interventions has been proposed**. It is also necesssary to study the capability of these institutions in formulating the audits as well as to study the performance-linked audits in order to judge the fairness in progress implementation.

The current budgeting system was not in consonance with the decentralised planning process. It has been observed that of the 600 districts, 300 had sent the SNNA plan and only about 100 had followed proper procedures. Unless capacity is built, functionaries are sensitised, and standards laid down, such a changeover is not feasable (Ministry of Health and Family Welfare, 1994).

To evaluate the extent of new on line accounting soft ware developed in several states, **an independent body to evaluate for 'beneficiary assessment' and 'facility survey' has been suggested. A regular survey of this can ensure a wealth of information of different aspects of programmes.The survey will cover, based on a structural design, households in every district. This has been done in the case of RCH household survey. The CAG should be a member of the technical advisory group for such survey.**

9.4 Flow of funds Mechanism and financial management:

Table 9.1 Flow of Financing in India's Health Sector (three dimensional matrix of Sources, Intermediaries and Uses)							
Providers of health services(uses)	**Main Sources**						
	Central govt	**State govts**	**Local govts**	**External agencies**	**Non-profit insts./NGOs**	**Corporate sector**	**Households**
	Financing agents (intermediaries)						
1) Govt. rural healthcare - (I)PHCs (ii)secondary (iii) tertiary	(i)S.D of health (ii) PRI	(i)S.D of health (ii)PRIs	(i) PRIs	(i)S.D of health	-----	(i) households (HHs)	(i)HHs
2) Govt. urban healthcare (I)dispensaries (ii) hospitals/ clinics (iii) other govt facilities including. ESIS, railways, defence	(i)S.D of health (ii) local govt (iii)social insurance	(i)S.D of Health (ii)Local Govt (iii)Social Insurance	(i) Urban local bodies	(i)S.D of health	----	(i)Social insurance (ii) HHs	(ii) Social insurance (ii) HHs
3) Charitable instns.	(i)Non-profit institutions/NGOs	Local govt (R & U)	-----	(i)Non-profit/ NGOs	(i)Non-profit/ NGOs	(i) HHs	(i) HHs
4) Diagnostic care centres/ drug outlets	(i)SD of health (ii)non-profit/ NGOs	(i)S.D of health (ii) local govt (R & U) (iii) non-profit/ NGOs	-----	(i)SD of Health (ii)Non-Profit/ NGO's	(i)Non Profit/ NGOs	(i)Pvt Insu. (ii) HHs	(i)Pvt. Insurance (ii)HHs

5) Pvt. Clinics	-----	-----	-----	-----	-----	(i)Pvt.Insu. (ii)Corporate sector (pvt.& public) (iii) HHs	(i)Pvt. Insurance (ii) HHs
6) Pvt. Hospitals	-----	-----	-----	-----	-----	(i)Corporate sector pvt. & pub) (ii)HHs	HHs
7) Other industries as secondary producers of health	(i) Other industries as secondary producers of health	Other ministries & divisions	-----	-----	-----	(i)HHs	
Source: Compiled and simplified from the figures presented at the 'Symposium on Financial Reforms', Department of Family Welfare, Govt. of India, Imperial Hotel, New Delhi, 9-10 August 2001, supported by the European Commisssion.							

.

The existing flow of financing in India's health sector is presented in Table 9.1. It clearly depricts multiple source of financing health are, multiple intermediaries and multiple providers of health services .

The fund flows, audit, and other accountability mechanisms are important to ascertain the genuineness of the utilisation, its sustainability and adherance to the programme objectives, and timely completion of the programmes (Ministry of Health and Family Welfare, 1994).

The organisation and management of health services are the responsibilities of states. However, the central government has several CSPs as a policy initiative to support health sector programes. The implemention of these programmes face number of financial flow problems. Over the period, the resource flow has become more uncertain, thus, affecting the programme performance. **It is in this background that the need to strengthen the funds flow mechanism has asssumed considerable importance.** For this, the government has initiated the process of strengthening the institutional mechanism by setting up autonomous societies for the purpose of transfering resources to implement these programmes. However, the effectiveness of societies in channelling funds and strengthening the ability of the implementing agencies is yet to be experienced. The delay in realising funds continues to persist even in this new mechanism. For example, funds release for the new RCH programme through societies indicates a delay of 262 days in one district (Bhatt, 2000). There is considerable amount of confusion as the personnel administering these societies are also part of the government.

Consequently there is a major consensus about linking 'performance of the programme with funds disbursement'. Three systems of funds disbursement are being followed by disbursing agencies at present. These are:

1. **Expenditure-based disbursement (EBD) systems:** Under this system, funds are released on submitting expenditure statements or utilisation certificates.
2. **Performance-based disbursement systems:** Under this, system reimbursements are linked to meeting certain pre-agreed milestones or benchmark between the financing agency and the implementing agency.
3 **Activity-based planning, budgeting, and planning systems:** Different from the PBD and benchmarking, it is the bottoms-up approach focusing on detailed planning of activities for the project and preparing plans and budgets for financial alloctions. It is important

that the activities of the project are elaborately defined and a comprehensive accounting system, which is able to record and process financial information, is in place. The National Polio Surveillance Project (NPSP) has proposed to use the activity-basesd budgeting and planning system in its surveillance programme.

It has been viewed that (Ministry of Health and Family Welfare, 1994) integrated audit by CAG will only be possible if expenditure and outputs are linked at the initial stages of the project or programme. Therefore, working out the modalities for introducing such a system at the level of implementing agency through a sample survey has been proposed.

- In this respect, the activity mix and performance indicators would be important outcomes of financial management and reporting system. **It has been suggested that uniform and simple reporting under externally-assisted projects and programmes is desirable, and, therefore, needs to be worked out.**
- Timely disbursement of funds from the centre to the states and districts is essential to ensure the delivery of quality health services. Funding for services at the district level currently comes through numerous independent channels, including central allocation routed through state governments. State allocations involve a plethora of vertical programmes for individual diseases such as malaria, leprosy, and/or tuberculosis. In addition, the past decade has seen the introduction of funding mechanisms that bypass the regular state budgets through societies/bodies. Therefore, to study this aspect at the state and district levels is important**.**
- Furthermore, a major factor in the slow fund disbursement is the lack of capacity to deliver multiple activities at the lower levels of the system. Programme design should pay attention to this factor.
- Effective financial reporting is critical for accountability in the use of funds. Delay or default in reporting of statements of expenditure reported by the states and other projects is a major bottleneck in the flow of funds. It further delays the consolidation of expenditure at the central level. Improved systems of accounting and auditing of expenditure will ultimately reduce shortages in the funding of staff and supplies.
- The merger of the multiple vertical societies is recommended. Transferring funds through the parallel system of societies is inefficient. Funds are locked into bank accounts, and are there are difficulties assessing whether/how the funds have been utilised. In addition, it is not possible for the Centre to manage multiple societies.

Improved and more frequent accountability through programme surveillance is urgent to evaluate the performance of the society mechanism in transfering fund flows and matters of accountability connected therein. As viewed from several quarters, it is necessary to find out if existence of multiple societies give rise to problems or not. As the societies were created to bypass the difficulties faced with the working with the treasury, under different communicable disease programmes, there has been an absense of control either by the Government of India or the state governments on the district-level societies. Therefore, **it has been suggested that state governments should have a single society for all the programes and answerable to the Centre.** For instance, the earthquake relief operations in Gujarat had a bad experience with the allocated funds being locked up.

- In respect of utilisation certificates, the deputy CAG observed that these certificates generally mention expenditure and should also include major work done along with it. It has been seen that the performance reports and utilisation certificates go to different agencies, rather than a single agency as it should be.
- It has been observed that poor health outcomes are directly due to low levels and quality of spending. The poor quality of spending results from high non-salary expenditure—some projects suffer from deficit in funds and some have surplus. Thus, a study of the investment pattern of the PHCs and hospitals catering to the rural areas'needs is important. There also needs to be an investigation into the alleged tendency of focusing on infrastructure expansion, especially with most of the spending being done on establishment whereas the component of expenditure on programmes is usually less than 20 per cent, even disregarding maintenance and sustainability on the part of these health services. For this, it is necessary to conduct area-specific studies to identify (a) the extent of low levels of spending, (b) the quality of spending, and (c) the real needs.
- In addition to the above, broadly, the study should include issues such as, the role of public financing in providing health services, the potential for user-charges and private insurance to finance public hospitals while extending protection to the poor, as well as the lessons learnt from government grants to the NG0s and their potential for expanded coverage of key programs to the poor, etc..

Table 9.2: AT A GLANCE
Recommendations in the move towards SAP

Field of study	Move towards				
	I) Decentralisation of financial and management responsibilities	**II) SWAP**	**III) Preparation of NHAs**	**IV) Flow of funds and financial management**	**V) Others**
	1	2	3	4	
(A) Governments		It is necessary to identify the existing state of affairs i.e. schemewise expenditure and release of funds at different levels of Central, State, district and local govts.	To evaluate the entire audit system . There should be unformity across states and understanding of the project structure , concepts and achievement is important. Exp. on Pub. Health & Health Prog. Admn.	To identify the defeciencies in financial reporting with accountability .	
(i) PRI's	To probe: PRI' present role, capacity and strategies to be adopted. What should be their role in raising funds within the proposed decentralized system? The extent of activity planning and budget management could be handed over to them, scope for introducing earned autonomy		Study the nature and extent of allaged interventions at the grass root level, capacity of these institutions in formulating the audit, the scope of performance linked audit	Stages, time taken in the devolution of financial powers and fund flows from Deptt. Of H & FW to Dist. Govt to PRIs including funds for CSPs	
(ii) Municipality					
(iii) District		To prepare epidemiological profile at national, state and dist. Level	**[For preperation of NHA the three way/ dimentional metrix presented in the enclosure be referred to as an useful accounting format]**	Funds including for CSPs come through numerous channels Causing delay in the implemention of scheme and utilizaation of funds etc. to study this aspect	
(iv) State		To identify duplication in scheme/ spending and absense of expenditure Plan	To evaluate the introduction of new on line accounting soft ware in several states	In case of several programmes SOE is not attached	
v) Central					

	Move towards				
	I) Decentralisation of financial and management responsibilities	**II) SWAP**	**III)Preparation of NHAs**	**IV) Flow of funds and financial management**	**V) Others**
	1	2	3	4	
(B) AREA					
(i) Village	Resource mapping /Plan focussing health problems, to identify tocal needs in terms of epedemologicl profile, quadrant charts etc through sample survey	Aim is to enlist and provide integrated/ essential package of health services at the village and HH level on priority basis (epidemological profile)			
(ii)Towns/ cities					
(iii) Dist.	Resource mapping /Plan focussing health problems				
(iv) Govt. hospitals and dispensaries		Existing role in regulating the services	(the agency for compiling NHA & their mutual responsibilities need to be worked out , certain standards of data Collection, analysis and data requirements are to be pre-decided.		
i)SC/PHC/CHC					To study Investment pattren i.e exp. On inrastructure, line items and programs i.e quality of spending
ii)Taluk hospitals					Study the ways of increasing resource Mobilisation at local Hosps./ clinics incldng,donations from Financial Instns.
iii) Dist. hospitals	Pattern of user charges in govt.Hosps/diagonestic centres				
iv) State hospitals					

	Move towards				
	I) Decentralisation of financial and management responsibilities	**II) SWAP**	**III)Preparation of NHAs**	**IV) Flow of funds and financial management**	**V) Others**
	1	2	3	4	
v) Central hospitals					
vi) Private hospitals		Existing role in regulating the services			To study nature, quality covaerage etc of health servicies in both rural and urban aareas as against govt. facilities
vii)Joint sector projects	To evaluate functioning and performance of such hospitals and services				
IV. Registered socieites (Act 1860)	Role of autonomous Hosp. Management committees enjoying financial autonomy in management and fund raising, service quality improvement issues			In the past decade autonomous societies were set up by passing the state treasury to overcome delay . to evaluate the performance and accountability of these societies.	
V. Cooperatives	Role of community financing / pharmacies of PHCs through cooperatives like in Kerala				
VI. Health Insurance (government and private)	To conduct sample survey of public/ pvt. Health insurance compaines to access its role and contribution				
VII. Households		Aim is to provide integrated package of essential health services at the village and HH level	To conduct 'Beneficiary assessment and facility survey,' on regular basis in every dist (as done in RCH HH survey) on diffeerent aspects of health programs (CAG should be a member of the Technical Advisory Com. of such survey.		To conduct market survey of the people across occupation and Y-groups across on Exp. On pvt treatment by type, capacity to bear user charges.

Feld of study	Move towards				
	I) Decentralisation of financial and management responsibilities	**II) SWAP**	**III)Preparation of NHAs**	**IV) Flow of funds and financial management**	**V) Others**
	1	2	3	4	
Policy in brief:	The need for delegation of (1) administrtive and managerial and (2) financial powers including resource mobilization to local govt. instn.s i.e PRI's	SWAP means all significant funding for the sector as a whole. It evolves from an agreement amont govt., doners, private parties etc, under a common format for procurement, disbursement accounting and audit.Fragment funding sources much of which is not under state control is main limiting factor.	Quantify health expenditure,estimate relative contribution of public and pvt.sector, classify health exp.in terms of pri., sec. & ter. Care , inpatient and out patient, line items salaries, drugs etc., infrastructure dev. Linking national Accounts & other laarge scale surveys and help understand country's own performance and making inter-country comparisons.	Over the period resource flow have become more uncertain affecting program performance.To evolve appropriate mechanism tor timely disbursement of funds form Center to states and to districts to ensure the delivery of quality and timely services. To study the aspect of linking programme performance with funds disbursement..	Govt.s current 'population-size' healthcare strategy Based on P.H. Care centers needs review and restructurre it based on epidemiological data aavailable at the grass root level.

Source: Compiled and simplified from the Figure entitled, Flow of Financing in India's Health Sector', presented in the document on ,"Symposium on Financial Reforms" (Session 3), Department of Family Welfare, Govt. of India, Imperial Hotel, New Delhim, 9-10 Augusst, 2001, Supported by European Commisssion.

10. Summary and Conclusions:

The Indian Constitution guarrented the 'Right to Life' as a basic human right to every citizen of India under asrticle 21. In article 47 of the Directive Principles of the Indian Constituion , the Governments responsibility concerning public health has also been laid down. Yet the Government is bascktracking from fulfilling this responsibility. This is obvious from the fact that the government's proporation of expenditure on public health services has been declining every successive years (20.8% in the FY 1990-9 to 11.5% in FY 2002-03). . This is also evident from the fact that private health spending has increased from 79 % to 85 % in the above mentioned FY's respectively.

The commitment made in the Alma Ata Declaration of 1978 towards achieveing 'Health for all by 2000' is far from being fulfilled. In fact, the primary health care services are becoming more and more difficult for people in villages, remote tribal regions and urban slums. At the village level, there is no resident health care provider to treat illnesses or implement preventive measures. All hospitals are located in cities, and here too public hospitals are increasingly starved of funds and facilities. Thus there is lack of availability of government health care services on one hand and exorbitant cost of private health services on the other. This often leaves common people in rural areas and the poor in urban areas left with no option but to resort to treatment from quacks (unqualified doctors). Thus the majority of the population is being deprived of the basic 'Right to Health Care'.

The Indian Health Report., prepared as a backgfround for the WHO, points out that the biggest problems with the India's health system are the lack of government spending in the health sector (0.9 per cent of GDP as gainst 2.2 per cent by lower-middle income countries) and the ineffeciencies and misuse of tahe meage resources that are available. The IHR points out that India accounts for a third of global tuberculosis incidence and the larger number of active TB patients. Though the number of malaria cases decreased to about two million, but owing to local out breaks, there were high mortality. The *plasmodium falciparum* , the most dangerous strain accounting for almost half of malaria cases in 2001. The resurgence of communicable diseases such as malaria and tuberculosis has also partly been due to low levels of public expendiute in India. In 1994, over 1,000 people died in Rajasthan of malaria aepidemic and during the same time in Delhi over 300 deaths were reported from haemorrhagic dengue fever. The report further reiterates that, ' extending the coverage of crucial health services, including a relatively small number of specific interventions could save millions of lives each year, reduce poverty, spur economic development and promote global security'.

The 'health transition' that India is going to undergo reveals that the country is likely to face a duel challenge in the near future. The burden of both communicable and non-communicable diseases is likely to create an adverse apidemilogical transition. Due to uneven distribution of health services, one part of the population will successfully complete a demographic and epidemiological transition while the other will be left behind at the pre-transition stage dominated by disease and poverty. The demand of the urban middle and upper classes for sophisticated treatment will clash with free clinical services for the poor and rural population. This points to a major policy challenge.

Specific focus should be given on the major areas for action such as control of malaria; immunisation coverage of infants; access to safe drinking water and sanitation; improved nutrition and food safety; and innovative, action-oriented school health curriculum for the promotion of healthy lifestyles, particularly as regards to sexually-transmitted diseases like AIDS. Poverty and ill health are closely interrelated. While poverty prevents the person from satisfying the most basic human needs (adequate food, safe water and sanitation, and access to social services such as basic health and education), ill health inhibits an individual's ability to work, reduces earning capacity, and deepens poverty. Poverty should, thus, be tackled on two fronts: first, ensure that the poor have access to primary health (especially family with young children and vulnerable groups such as the elderly), and, secondly, enhance the health potential of the current workforce and future workforce (school children).

In a 'Symposium on the Operationalisation of Financial Reforms', organised by the Department of Family Welfare, Government of India, and supported by the European Commission (2001), a consensus was reached on the need to address four broad issues concerning India's healthcare system, in the light of the World Bank's proposal for SAP. These are (1) decentralisation of financial and management responsibilities; (2) planning and pooling of funds (sector-wide approach—SWAP); (3) financial information system (desegregated and classified health expenditure national health accounts); and (4) flow of funds mechanism and financial management.

Section 7 deals in detail, the contents of the 'Symposium on the Operationalisation of Financial Reforms(2001) along with a blue print of the 'proposed filed of study' which needs to be undertaken for initiating the reforms process in a most pragmatic manner. The tangible out come of the present paper could largely be derived from undertaking research studies mentioned in Table 7.2.

References:

1. Baru Rama V. (1994), 'Structure and Utilisation of Health Services: An Inter-State Analysis', *Social Scientist*, Vol. 22, Nos. 9-12, September-December.

2. Baru Rama (2003),'A Policy Analysis of the Health Sector Reform Process in India', India Habitat Centre, New Delhi.

3. Bajpai Nirupam (2004),'India's Health needs a dose of funds, reforms', Business Line, Financial Daily from the Hindu group of publications.

4. Bhatt Ramesh (2000), 'Emerging Institutional Mechanism in Financing Health Sector Programs and its Implications', Indian Institute of Management, Ahmedabad, March.

5. Berman Peter A (1997), 'National Health Accounts in Developing Countries: Appropriate Methods and Recent Applications', *Health Economics*, Vol. 6, pp. 11-30.

6. Chauhan Devraj, N.H. Anita, and Sangita Kamdar (1997), 'Healthcare In India—A Profile', The Foundation for Research in Community Health, Mumbai/Pune.

7. Duggal Ravi (2003), Operationalising Right to health Care in India, Centre for Enquiry into Health and Allied Themes; www.cehat .org

8. Ashok (1997), 'Co-operatives to Take Control of Andhra Hospitals', *The Hindustan Times*, 10 May 2003.

9. Department of Family Welfare (2001), 'Symposium on Financial Reforms', supported by European Commission, Government of India, and Imperial Hotel, New Delhi, 9-11 August.

10. Gupta D.N. & Sharma B.B. L.: Resources for Health Sector, User Charges and Various Issues and Implications Thereof,. BOP-WHO Workshop on Economic Issues in planning and Financing of Health Services, (November 13-17, 1995, New Delhi, Bureau of Planning , Directorate General of health Services, Ministry of Health and Family Welfare, Giovernment of India, New delhi-110 001.

11. Kundu A. K. (1995): An Overview of Health Scenario and Emerging Issues, BOP-WHO Workshop on Economic Issues in planning and Financing of Health Services, (November 13-17, 1995, New Delhi, Bureau of Planning , Directorate General of health Services, Ministry of Health and Family Welfare, Giovernment of India, New delhi-110 001.

12. Khurana I. R. (1995) : Policy and Financing Strategy of Health Care in India, 'BOP-WHO Training Workshop on Economic Issues in Planning and Fianancing of Health Services', Bureau of Planning, Directorate General of Health Services, Government of India, November 13-17, New Delhi.

13. Vishwakarma and Mishra (1995) : Health Admisistraation in India , 'BOP-WHO Training Workshop on Economic Issues in Planning and Fianancing of Health

Services', Bureau of Planning, Directorate General of Health Services, Government of India, November 13-17, New Delhi.

14. Ministry of Health & family Welfaare (1994), 'Health Information of India', Central Bureau of Health Intelligence, Government of India.

15. Ministry of Health & Family Welfare (1999-2000), 'Annual Report', Government of India.

16. Mishra Srijit (1995), ' Public health Scenario in India', India Development Report (2004-05), Indira Gandhi Institute of Development Research, edited by Kirti S. parikh , R. Radhakrishna, Oxford University Press, New Delhi.

17. National Council of Applied Economic Research (1991), 'Household Survey of Medical Care' sponsored by Ministry of Health, Government of India, New Delhi.

18. Sengupta Amit (1994), 'World Development Report 1993: Implications for Infrastructure, Development in Healthcare and the Pharmaceutical Industry', *Social Scientist*, Vol. 22, Nos. 9-12, September-December.

19. Shariff Abusaleh, Prabir Ghosh, and Samir K. Mondal (2002), 'Indian Public Expenditures on Social Sector and Poverty Alleviation Programmes during 1990s', Overseas Development Institute, Working Paper 169, London.

20. Jain Sonu (2006), 'Missing Little Indians'; newindpress (http:\\www.newindpress…/sundayitems.asp?

21. World Bank (1997), 'India: New Directions in Health Sector Development at the State Level: An Operational Perspective', Population and Human Resources Division, South Asia Country Department II (Bhutan, India, Nepal), Wasington, D.C..

22. World Bank (1995), 'India: Policy and Finance Straategies for Strengthening Primary Healthcare Services', Report No. 13042-IN, Population and Human Resource Division, South Asia Country Department II, 15 May, Wasington, D.C..

23. World Bank (1993), 'Investing in Health', *World Development Report*, Washindgton D.C..

24. World Bank (1992), "India: Health Sector Financing—Coping with Adjustment Opportunities for Reform", Population and Human Resource Operations Division, South Asia Country Department II (India), 30 June, Wasington, D.C..