Fiscal Reforms Under A New Health Policy

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Background

India is knocking at global markets. Since the mid-eighties India has rapidly integrated with the world economy and now faces not only the ups but also the downs, as protection of the internal economy has become a thing of the past. The globalisation of India was speeded up under the Structural Adjustment Program (SAP) designed with World Bank assistance to reform India's economy. A large part of the middle class has certainly benefited from the SAP and related initiatives but overall poverty has not declined - if at all it has added to the misery of the already impoverished masses and exacerbated the crises in healthcare.

Health sector reforms did not stay far behind. But the question is, were they reforms in the positive or progressive sense? In the name of reforms, again under the aegis of the World Bank, and other bilateral and multilateral agencies like USAID, DIFID, WHO, UNICEF etc., public health investment became even more selective and targeted at selected populations. Thus family planning and immunisation services, and selective disease programs like HIV-AIDS, acquired an even more central position in public health care and other concerns like curative services, hospital care, malaria, tuberculosis, maternity services, etc. lost further ground. The new priorities were not priorities determined by those who needed health care but by global agents of change who were in the business of adjusting India to the world economy!

Economic reforms towards liberalisation began in the early eighties. This is important to note because most often there is a tendency to look only at the post-1991 period. Data available up to now clearly shows that the economic performance of the eighties far outweighs that in the nineties. And the underlying fact about this is that in the eighties there was no structural adjustment or World Bank diktat. The classical 'Hindu' rate of growth in the eighties had doubled from 3% to 6%, without much inflation and with declining levels of poverty. Thus we were already liberalising our economy and speeding up growth without the World Bank running the show.

In fact, the post (1991)-reform period slowed down growth, increased poverty and inflation, and reversed many trends of the eighties. No doubt, it caught up towards the mid-nineties, but it has not yet surpassed the achievements of the eighties. Thus in the eighties India was developing rapidly with a gradual globalisation process and with the advantage of its inner strength which insulated it from global shocks. In the nineties there was rapid globalisation, which exposed India to global fluctuations; if India survived the Asian shock, which destroyed Indonesia and other Southeast Asian economies, it was because of its sheer size and the strengths of its own local markets.

Another fact to contend with is the as yet dependence of over two-thirds of the population on agriculture and 70% of the population living in rural areas. Since the larger impact of macro-economic reforms is on the urban-industrial sector, which integrates globally with much ease, the rural population in a sense still has relative protection from global impacts. Further, it is the consistent good performance of agriculture that has helped ward off the severities of SAP, which many other countries have faced. In addition, India's strong investments in the past in rural development, especially employment guarantee programs and agricultural subsidies aided in reducing the adverse impact of SAP. And this is not likely to change thanks to the strong farm lobby that is in fact demanding greater investments and subsidies for the rural economy.

Thus at one level India is much more exposed to the global market with increasing vulnerability. But at another level it continues to enjoy an inner strength and autonomy because of its sheer size, its large rural-agricultural population and a large local market of its own, despite the fact that politically the situation is very fluid. This background is important for understanding the impact, changes and crises in the health sector.

The Health Sector

Poverty is the real context of India. Three-fourths of people live below or at subsistence levels. This means 60-80% of their incomes goes to food consumption. In such a context social security support for health, education, housing etc. becomes critical. Ironically India has one of the largest private health sectors in the world with over 80% of ambulatory care being supported through out-of-pocket expenses. The public health services are very inadequate. The public curative and hospital services are mostly in the cities where only 25% of the one billion population resides. Table 1 summarises the development of healthcare infrastructure and its outcomes. Rural areas have mostly preventive and promotive services like family planning and immunisation. The private sector has virtual monopoly of ambulatory curative services in both rural and urban areas and over half of hospital care. Further, a very large proportion of private providers are not qualified to provide modern health care because they are trained in other systems of medicine (traditional Indian systems like ayurveda, unani and siddha, and homoeopathy) or worse still have no training whatsoever, and because of lack of regulation they are also using modern medicine to treat patients. This adds to the risk faced by the already impoverished population.

The health care market in India, as elsewhere in the world, is based on a supply-induced demand and keeps growing geometrically, especially in the context of new technologies. Thus India has a large and dominant private health sector and a weak public health sector despite its poverty, with the former having curative monopoly and the latter carrying the burden of preventive services.

With such a structure of healthcare services and pressures of the SAP kind of reforms a very clear impact one sees is declining state investments in the health sector. With rising debt burdens of the state, the social sectors are the first to receive the axe. There has been a declining trend since 1991 in social sector expenditures, especially by the Central government and this is best reflected in compression of grants to the states for social sector expenditures. Health care expenditures too have been affected both in quantitative terms (declining real expenditures) and qualitative terms (increasing proportion of establishment costs and declining proportion on medicines, equipment, maintenance and new investments).

Another very striking impact is the rapidly rising cost of medicines. With a large dependence on the private health sector, even by the poor, this has meant extreme hardship. With the drug price control virtually on its way out and with India having signed the WTO treaty on IPR we are moving closer to international prices of drugs. The combined effect of the above facts makes a deadly mixture that results in reduced access of the poor to health care. With the dominance of the private health sector in India in provision of ambulatory care the rising costs could spell disaster for the poor, given the fact that the State is gradually reducing its responsibilities in provision of health care.

At the global level World Bank is propagating selective care for selected (targeted) populations under the public domain. The WHO too has dropped its Health For All commitment and fallen in line with the World Bank thinking. This global pressure on the Indian State is evident through its policies of focusing on selective services. For instance RCH and AIDS receive overriding support over comprehensive primary health care or basic referral services.

Another trend that further reduces access is the increased corporate control of health care. New medical technologies have helped complete the commodification of health care and this has attracted increased interest of the corporate sector, which has jumped into the health care business in a very big way. The State has nurtured the private sector over the years and corporatisation is only a logical progression of the State's vision of health care provision.

Box 1:Some Examples of State Nurturing the Private Health Sector

- Medical education is almost wholly state financed and its major beneficiary is the doctor who sets up private practice after his/her training.
- The government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It provides incentives, tax holidays, and subsidies to private pharmaceutical and medical equipment industry. It manufactures and supplies raw materials (bulk drugs) to private formulation units at subsidised rate/low cost. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially the highly expensive new medical technologies.
- The government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes. Hence they don't contribute to the state exchequer even when they charge patients exorbitantly.
- Construction of public hospitals and health centres are generally contracted out to the private sector. The latter makes a lot of money but a large part of the infrastructure thus created, especially in rural areas is inadequately provided hence cannot meet the health care demands of the people.
- Medical and pharmaceutical research and development is largely carried out in public institutions but the major beneficiary is the private sector. Development of drugs, medical and surgical techniques etc. are pioneered in public institutions but commercialisation, marketing and profit appropriation is left with the private sector. Many private practitioners are also given honorary positions in public hospitals, which they use openly to promote their personal interests.

The Fiscal Crises and Reforms

Towards the end of World War-2 and on the eve of India's Independence, a comprehensive national health plan popularly known as the Bhore Committee Report was presented to the Govt. of India. The First Health Minister's Conference in 1948 reviewed this Report and felt that the resources to implement this plan were not available. The resources required were a mere 2.5% of the GNP! Thus the crises began right at that point of time – healthcare was not regarded as a priority. Afew elements from the Bhore Plan were picked up

and the public healthcare system was designed. Over the years it evolved in a piecemeal fashion with a program based approach, which was often dictated by international agencies, especially the population lobby. Such an orientation of public health prevented the development of a comprehensive healthcare system and made the healthcare crises go from bad to worse.

In the late seventies and the first half of the eighties in response to the growing unrest in the country, especially in the rural areas, the Central government supported a massive expansion of the rural health infrastructure through the Minimum Needs Program. This helped states mainstream modern health care in the rural areas. But at the turn of the nineties with SAP, things changed. The pressure of World Bank kind of reforms impacted severely on the social sectors and resource allocations to the latter came under strain. Since then the Central government has reduced investments in the health sector and moved away from its social responsibility. Their only interest remains supporting medical care in Delhi and some union territories and promoting aggressively family planning in the rest of the country, especially the villages. The little support it gives for public health programs like tuberculosis, AIDS, leprosy, blindness control etc. are increasingly coming from international borrowings and serving the agenda of international agencies like World Bank. Capital expenditures have disappeared and grant in aid to states, which largely supports preventive care programs like the National Disease Control Programs, is also declining as a ratio within the Central health budget. This is clearly an indication that the Central government is cutting back expenditures in the health sector and contributing to the crises in public healthcare. (Table 2)

The situation of the state governments, which have prime responsibility in the provision of healthcare services, is not very different from that of the central government. One sees the same declining trends. The state government's expenditures too are mostly on urban health care – teaching hospitals, district hospitals and health administration – and on family planning in the rural areas. One sees a drastic decline of expenditures by state governments on medical care, part of which is absorbed by family planning. Capital expenditures, which were low in the seventies and eighties when the big rural infrastructure expansion took place under the Minimum Needs Program (largely supported by the Centre), also show a declining trend. The fifth pay commission has put a further strain on resources and worsened allocative inefficiencies.

In budget year 2001-02 we are looking at public health expenditure of about Rs.220 billion by Central and State governments combined, and at current rates one may expect budget 2002-2003 to gross Rs.250 billion. The figures look big but then we are a big country. These figures become insignificant when we view it in terms of the country's GDP – they do not even touch 1% of GDP! The question here is that, is the health sector worth just that much? The answer is an emphatic NO! Private health care accounts for four-fifths of health spending in the country, and hence we are now talking of a significant figure of Rs. 1200 billion or about 5% of the GDP.

Health care provision is a State subject but yet the Central government is a major player. Why is this so? Why does the Central government's Ministry of Health and Family Welfare need to employ over 30,000 persons? This is largely because the Central ministry is running hospitals and medical schools, both of which are actually the domain of the State and Local governments, and with a program based approach there is a

huge bureaucracy for each program at the centre even though the programs are implemented by state and local governments. Why should the state and city of Delhi have the privilege of its hospitals being run by the Central government? Why should various health programs have an army of people located in Nirman Bhawan, the headquarters of the central Ministry of Health? This itself contributes to the crises in the health sector! It is time the Central government moved out of this domain and gets concerned with more critical issues in the health sector. Issues like helping States evolve a universally accessible quality health care system, helping State's evolve a mechanism to regulate the private health sector, and assistance in developing mechanisms for raising additional resources for the health sector and other such macro issues should instead concern the central government.

Given the bad shape in which the public health sector is, "health sector reforms" is the new keyword. At one level the World Bank is pushing processes based on the idea referred to earlier (selective care for selected groups) and at another level the existing health care situation in the country is crying for reforms of various kinds.

The various reforms underway presently, largely under the tutoring of World Bank and its allies, are not reforming the system in the sense of bringing about structural changes but only tampering with it and pushing through ideas like user charges, privatisation, new public management etc..

At another level a number of macro changes, like opening up of the insurance sector to private capital and allowing MNCs to set up health care facilities, will bring about its own impact by integrating India's health care services with the world market, and this would spell further disaster for the poor, what with the State too reducing its role in the provision of health care.

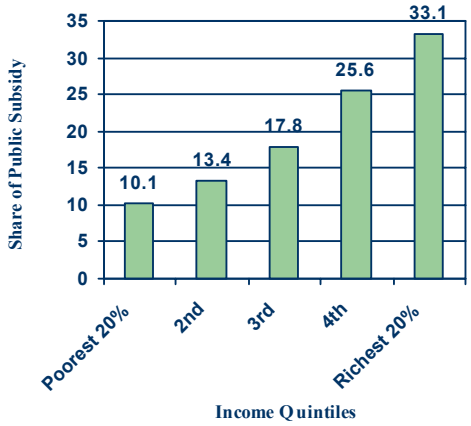
One is already seeing the impact of reduced investments and expenditures by the state in declining utilization rates of public health services. In recent years national surveys, like the National Sample Survey Organisation (NSSO) utilisation surveys in 1987 and 1996, National Family Health Surveys (NFHS) in 1993 and 1999, and the Reproductive and Child Health (RCH) rapid household survey in 1999, apart from the smaller studies, have provided reasonably good estimates of utilisation of public facilities and programs (Table 3 and 4).

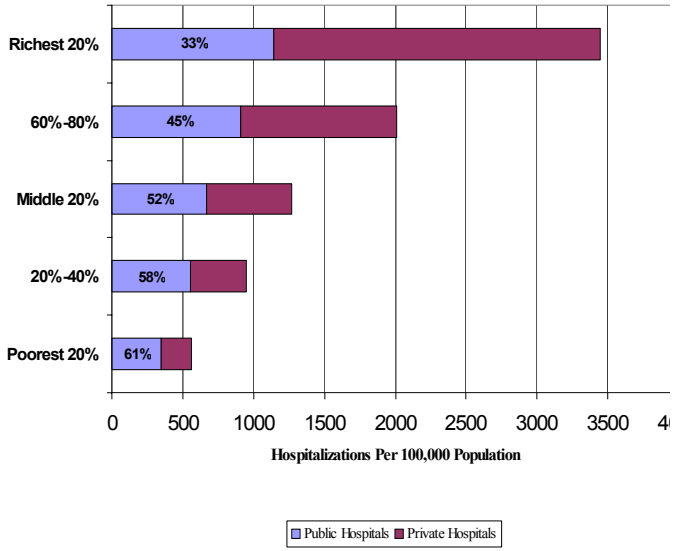
The share of the public sector in provision of outpatient care is not only small but also declining. The NSSO data reveals that the share of outpatient services provided by public institutions has declined from 26% to 23% in rural areas over the decade (1986-1996) and from 27% to 22% in urban areas (Table 4). The decline in share of OPD of public sector has been across the board in all states with Kerala, Assam, Orissa, Rajasthan and Tamil Nadu having higher utilisation rates for OPD care from the public sector. In case of inpatient care the public sector is still a major provider but here too a declining trend is seen. The NSSO data indicates that in 1986-87 the public institutions accounted for 60% of all hospitalisations and this came down to 44% in 1995-96, the decline being 40% in urban areas and 36% in rural areas (Table 4). Across states it is states like Punjab, Haryana, Bihar, Maharashtra in addition to Andhra Pradesh and Gujarat, which have both lower rates of use for hospitalisation in the public sector and also have

seen a decline over the two periods.

Box 2: Class Differentials in public healthcare access

Utilisation across classes and social groups using the NSSO data of 1995-96 shows sharp differentials in use of public health facilities. In terms of consumption expenditure classes (used as a proxy for income in India) in rural areas public facility use, especially public hospitals, for ambulatory care increased with mean consumption expenditure, but interestingly for PHCs it was the reverse with the lower fractiles showing larger utilisation – the gap between lowest and highest fractile was in the magnitude of 5.6 times. This unexpected finding is attributable to access being difficult for public hospitals in rural areas. In urban areas the situation is reversed with the poorer groups being the larger users of public facilities (access in urban areas is relatively better), especially the hospitals and the gap here is of the magnitude 2.2 times between lowest and highest fractile. For inpatient care the pattern was the same with the richer classes using public hospitals in numbers much larger than their proportion in the population. Here too the gap was much larger in the rural areas than in urban areas. With regard to social groups while there is some variation in use of public facilities for ambulatory care, with the tribals using public facilities, especially hospitals, in a much larger proportion compared to others, In case of inpatient care the tribals, Scheduled Castes and Others showed no significant variation from their numbers in the population. All this indicates that the access of the poor is grossly inadequate and th richer classes are proportionately larger users of the public health system, indicating inequities within the system.





When we look at this utilisation data of public facilities in the context of public investment and expenditures on health care in the last decade or so, the declining pattern of utilisation begins to make sense. Late seventies and eighties was a major growth phase for public health infrastructure, especially in rural areas (Table 1). Even in the nineties rural hospital growth has been substantial. But overall investment and growth in health care by the state has been declining (Table 2). This is reflected in lower growth in real expenditures and declining capital expenditures. This has been especially true for medical care, which is purely a state government activity. The fifth pay commission impact has been devastating; with proportion of medical care and public health program expenditures on salaries shifting from around 50% prior to the fifth pay commission to about 70% after. Thus the shift in favour of the private health sector for availing medical care in the last decade or so is not surprising because private health facilities have grown much

more rapidly in contrast to public facilities, which at best have stagnated. In the context of overall poverty this is a disturbing trend because the poor, who constitute a very large majority of the country's population, have to increasingly rely on the private health care market whose cost is growing much faster than the means at the disposal of such people. The out of pocket expenses for seeking healthcare has grown 4-5 times for hospitalisation between 1987 and 1996 (Table 3). This also gets reflected in indebtedness of households. National data shows that after loans for agricultural production, it is debt for medical care, which is the highest cause for indebtedness, especially of the poorer classes. Hence health security of the large majority of Indians is threatened.

As mentioned earlier a large part of public resources are committed to preventive and promotive health programs, especially in rural India, like communicable disease control programs, antenatal care, immunisation of children, and contraceptive services. Providing such services over the years, with the private sector playing a negligible role in this, the public health services have become synonymous with preventive and promotive care. This has been true right from the beginning and national data from the NSSO, NFHS and RCH surveys clearly demonstrate that even now the public health sector accounts for over three-fourths of all such services (Table 5). This holds true across most of the states. But despite this the coverage of these services is very inadequate (Table 6). Complete immunisation coverage, for instance, for the relevant age group is just above 40%, and the rural-urban gap is nearly two times. Also there is a lot of variation both across states as well as between rural and urban areas in coverage of these services. The urban areas do much better as do the southern states. The BIMARU[1] states have the worst performance.

In this scenario the Central government has announced a new draft health policy. This policy diverges substantially from the aims of the 1982 National health policy whose goal was "Universal, comprehensive, primary health care services". Though the NHP 2001 does not even refer to this goal, it clearly acknowledges that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource allocations generally insufficient - *"It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services."*[2]. This is open acknowledgement that public health services are facing an unprecedented crisis.

[1] Acronym for Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh which in Hindi means sick
[2] *NHP 2001 para 2.4.1*

But despite such acknowledgement the new health policy does not endeavour to offer any strategies to change this state of dismal conditions. On the contrary the policy pronouncements are encouraging private sector initiatives as well as privatisation, including user fees in public healthcare facilities. This is indicative of abdication of responsibility by the state in the health sector. In the same breath the NHP 2001 recommends larger allocation of resources both by the Centre and the state governments but does not indicate how these resources will be raised. Reading between the lines lurks the danger of using the path of user charges to enhance resources, which would defeat the purpose of equity in healthcare. In para 4.4.2 the NHP 2001 expresses the practical need to levy reasonable user charges for certain secondary and tertiary health care services. User-charges is a regressive means of recovering costs and given the overall conditions of poverty it is also not an appropriate means of collecting revenues. Those who have the capacity to pay must be made to pay through other means. All persons having regular wages/salaries or business incomes must contribute through payroll taxes for health, perhaps something similar to the profession tax charged in some states. Other ways of generating revenues need to be considered, such as proportion of turnover of health degrading products like cigarettes, alcohol, guthka (tobacco), pan masalas etc.. as a health levy earmarked for the Ministry of Health. A health cess could be charged on items such as personal vehicles, air-conditioners, mobile phones and other luxury products, owned houses of a certain type/dimensions, on land revenues, on polluting industries etc..

While much more resources need to be allocated for the public health sector, it is also clear that allocative efficiencies have to be looked into. Since the mid-eighties the proportion of consumables and maintenance costs and capital costs in the health budget have been declining and this decline got further hastened after the 5th Pay Commission of the government of India. The two NSSO surveys of 1986-87 and 1995-96 referred to above clearly show declines in share of public sector utilization in both OPD and hospital services between the two periods and this correlates with reductions seen in expenditures on the non-salary components of the health budgets. Instead of only talking about proportionate allocations to the primary, secondary and tertiary sectors in the new policy can we also talk about global budgeting with assured allocative ratios, that is budgets being distributed on a per capita basis (of course with appropriate weighting for sparse and hilly areas) and with clearly worked out ratios and allocations for various line items. Moreover there should be autonomy to local governments to make their own health programs subject to a review based on local epidemiological information and facts.

To illustrate this, taking the Community Health Centre (CHC) area of 150,000 population as a “health district” at current budgetary levels under global budgeting this “health district” would get Rs.30 million (current resources of state and central govt. combined is over Rs.200 billion, that is Rs.200 per capita). This could be distributed across this health district as follows : Rs.300,000 per bed for the 30 bedded CHC or Rs.9 million (Rs.6 million for salaries and Rs.3 million for consumables, maintenance, POL etc..) and Rs.4.2 million per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs.3.2 million as salaries and Rs.1 million for consumables etc..). This would mean that each PHC would get Rs.140 per capita as against less than Rs.50 per capita currently. In contrast a district headquarter town with 300,000 population would get Rs.60 million, and assuming Rs.300,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs.150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would have to

contribute 5% of its budget. Of course, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. Given larger resource allocations as per the NHP 2001 recommendations, the per capita funds available would be much higher. Such reorganization of fund allocations will be a step in the direction of removing the inadequacies of the public health system as highlighted in the policy (NHP 2001, para 2.4.1 and 4.4.1).

In para 4.3.1, the NHP 2001 talks about program implementation through autonomous bodies. The "health district" mentioned above could become the basic unit with a health committee constituting elected (Panchayat), professional (doctors, nurses etc.) and consumer representatives into the governing body. This would also mean substantial pruning of the existing health bureaucracy as the control will now vest with the local authority and the role of the state health dept. would be overall monitoring and audit as indicated in the NHP 2001.

Another serious concern related to the fiscal crises of the health sector is drug availability and pricing. While the NHP 2001 does mention the need to make more provisions for medicines and other consumables, there is no mention of the Health Dept. playing a proactive role in the drug policy. This is a serious anomaly in the NHP 2001 and the Health dept must exert its right to determine the drug policy, especially with regard to price control over the WHO list of 300 essential drugs. This is extremely critical in the context of India switching over to the product patent regime under the new arrangement of WTO / TRIPS from 2005. The advantage India has of lowest prices of drugs in the world will be lost if a drug policy favouring public health concerns is not put into place before the above deadline. This is especially critical in India's case because of the combine of poverty and overwhelming dependence on out-of-pocket expenses due to use of private health services for ambulatory care.

The overall level of public health spending is very low and there is a strong case to increase allocations substantially. Apart from this improving allocative, technical and cost efficiencies within the existing system and reducing geographical disparities itself can contribute significantly to improving quality of care, demand for public services and client satisfaction. This can only be possible if at the same time the large private health sector is regulated in the interests of rational care and good quality services for the consumers. This is where the health sector reforms must begin and pave the road to health care as a right.

Hence, it is time to bring health care as a right on to the political agenda. Given this context the Peoples' Health Assembly (PHA) initiative is timely and it is trying to garner all forces towards this direction. While at one level major structural changes are needed in the context of health care as a right, at another level limited reforms within the existing system is a good point to make a realistic beginning.

To summarise the following issues of concern in the health sector emerge:

- Public Health Expenditures have been historically very low and in the last decade of the millenium we see a declining trend

- On the whole about three-fourths of these expenditures are spent on salaries (over 80% in primary care) leaving very little for other critical expenditures like drugs, capital investment, maintenance, equipment etc.. This lack of allocative efficiency is responsible for the waste, inefficiency and ineffectiveness of the public health system
- Investment expenditures (capital) have declined drastically in the nineties and this means the public health services have stopped growing
- The commitment to the health sector by the Centre is reducing but there is no evidence to show that the state governments are gearing up to take the additional burden
- The declining support by the State to the health sector, which impacts adversely on its quality of care, is pushing more and more people, including the poor, to use services of the rapidly growing private health sector
- The private health sector operates unregulated and the quality of care offered is questionable because not only non-allopaths but also unqualified persons in large numbers operate as private practitioners
- The health infrastructure, with the exception of production of doctors and medicines, is quite underdeveloped, especially in the rural areas
- The rural infrastructure apart from being grossly inadequate is also wasted because of the pressures to promote family planning, instead of providing comprehensive health care
- The overall health outcomes in the country are not very good – if we look at specific states the situation is quite alarming in the BIMARU region
- The large investment by the State in medical education is infact a subsidy for the growth of the private sector as over 80% of those who graduate from public medical schools work in the private sector, or worse still migrate abroad
- Overall there is a gross lack of accountability in both the public and private health sectors

Box 3: Suggested Minimum Primary Healthcare Package

The primary health care package under right to health care needs to be clearly defined. A suggestion of what this should comprise of to begin with is given below :

- General practitioner/family physician services for personal health care, including support of paramedics and health volunteers for preventive and promotive care.
- First level referral hospital care and basic specialty (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic) services, including dental and ophthalmic services.
- Immunisation services against vaccine preventable diseases.
- Maternity services for safe pregnancy, safe abortion, safe delivery and postnatal care.
- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.

- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Contraceptive services.
- Health education.

To conclude it is important to emphasise that a health policy, like any other policy, must make a political statement and give evidence of the backing of a political will. There must of necessity be a preamble, which makes this expression of a political commitment and in this case it must be in the context of health and health care as a right. In the absence of expression of such a political will there cannot be a policy but only a statement of intent.

Further, unlike the 1983 health policy, the new policy atleast talks about raising financial allocations. This is a positive sign and needs elaboration. As mentioned above merely raising the overall proportion of expenditure is not adequate. Equal importance has to be given to the way resources are allocated. Adding more resources without reorganizing the way they are allocated will not serve the purpose. Hence the new health policy must undertake a detailed exercise in how existing and additional resources will be used. Without doing this, the policy prescriptions will have very little meaning. It would be similar to the Panchayat Raj initiative – the structure and responsibilities were appropriately amended, elections were held but no financial resources were assigned for carrying out the changes. A suggestion for realloaction of resources has been given above and one can build on this to come up with a definitive plan provided the political will is expressed and enacted.

Reorganizing resource allocations in a meaningful way is only the first step. The restructuring of the healthcare system through a regulatory mechanism, which also organizes the entire healthcare system should follow. There is an urgent need to have a comprehensive legislation on clinical establishments and medical institutions which specifies minimum standards, good medical practice standards, a mechanism for accreditation, a system of licensing where the local govt. should have the authority to decide how many practitioners, hospitals/hospital beds, diagnostic facilities etc.. it needs under its jurisdiction. Further, renewal of doctors/ hospitals/ diagnostic centres etc.. registration and license should be subject to periodic reviews, including continuing medical education and upgradation of knowledge and facilities. Further, to rationalize health resources the state should endeavour to organize the entire health care system, public and private, under a common organized structure through which a regulated public-private mix system can be evolved, similar to most countries, which have near universal access health care systems. Such restructuring of the health care system will lead to genuine reforms and establish greater equity in access to health care. The private sector cannot be left to its own means and ways. It needs to be integrated under a common umbrella along with the public health system. Worldwide the experience shows that if near universal access has to be achieved then an organized public-private mix healthcare system has to evolve. Apart from regulation, standards, accreditation for the functioning of the healthcare system one will also need to create a monopoly

buyer of healthcare services and this need not necessarily be the state but some other public arrangement – there is a lot of global experience to learn from. Such a direction of transition is the only way out of the present public health crises faced by India.

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Table 1: HEALTH INFRASTRUCTURE DEVELOPMENT IN INDIA 1951-2000

			1951	1961	1971	1981	1991	1995	1996	1997	1998	2000
1	Hospitals	Total	2694	3054	3862	6805	11174	15097	15170	15188		17000
		% Rural	39	34	32	27		31	34	34		
		%Private				43	57	68	68	68		
2	Hospital & dispensary beds	Total	117000	229634	348655	504538	806409	849431	892738	896767		950000
		% Rural	23	22	21	17		20	23	23		
		%Private				28	32	36	37	37		
3	Dispensaries		6600	9406	12180	16745	27431	28225	25653	25670		
		% Rural	79	80	78	69		43	41	40		
		% Private				13	60	61	57	56		
4	PHCs		725	2695	5131	5568	22243	21693	21917	22446	23179	24000
5	Sub-centres				27929	51192	131098	131900	134931	136379	137006	140000
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	492634	503947	530000
		All Systems	156000	184606	450000	665340	920000			1080173	113347	1211124
7	Nurses		16550	35584	80620	150399	311235	562966	565700	607376		
8	Medical colleges	Allopathy	30	60	98	111	128		165	165	165	
9	Out turn	Grads	1600	3400	10400	12170	13934	*	*	*	*	
		P. Grads		397	1396	3833	3139			3656		
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	79.4	91.3	104.9	120.7	165.0
11	Health outcomes	IMR/000	134	146	138	110	80	74/69	72	71	72	70
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	27	27	27	26
		CDR/000	22.8	19	15	12.5	9.8	10	9	8.9	9	8.7
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62	62.4	63.5	64	65
	Births attended by trained practitioners	Percent				18.5	21.9		28.5		42.3	
12	Health Expenditure Rs. Billion	Public CSO estimate pvt.	0.22	1.08 2.05	3.35 6.18	12.86 29.70	50.78 82.61	82.17 279.00	101.65 329.00	113.13 373.00	126.27 459.00	178.00 833.00

*Data available is grossly under-reported, hence not included. The average expected outturn is between 18000 – 20000.

Notes: The data on hospitals, dispensaries and beds are underestimates, especially for the private sector because of under-reporting. Rounded figures for year 2000 are rough estimates.

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years
2. Census of India Economic Tables, 1961, 1971, 1981, GOI
3. OPPI Bulletins and Annual reports of Min. of Chemicals and Fertilisers for data on Pharmaceutical Production
4. Finance Accounts of Central and State Governments, various years
5. National Accounts Statistics, CSO, GOI, various years
6. Statistical Abstract of India, GOI, various years
7. Sample Registration System - Statistical Reports, various years
8. NFHS - 2, India Report, IIPS, 2000

TABLE 2 : MINISTRY OF HEALTH AND FAMILY WELFARE EXPENDITURES 1991-2000

CATEGORY		**1980-81**	**1985-86**	**1990-91**	**1991-92**	**1992-93**	**1993-94**	**1994-95**	**1995-96**	**1996-97**	**1997-98**	**1998-99**	**1999-00**	**2000-01 RE**	**2001-02 BE**
All India Health expd. at current Rs. Billion	**Total**	12.86	29.66	50.78	56.39	64.64	75.18	82.17	101.65	113.13	126.27	150.04	172.60	196.49	217.50
	Centre	1.63	3.41	4.93	5.58	7.05	7.44	10.68	12.10	13.46	13.54	17.47	22.02 RE	27.10 BE	33.00
	State	11.23	26.25	45.85	50.81	57.59	67.74	71.49	89.55	99.67	112.73	132.57	150.58	169.39	184.50
Health expd. at 1993-94 prices Rs. Billions		39.60	65.54	68.55	67.10	70.46	75.18	74.77	85.38	88.24	92.17	100.52	112.19	123.79	132.67
Real annual growth rate of health Expenditure %		--	13.1	4.6	-2.11	5.0	6.7	-0.5	14.2	3.3	4.4	9.06	11.60	10.34	7.17
Share of state govt. in total Health expd. %		87.3	88.50	90.3	90.1	89.1	90.1	87.0	88.1	88.1	89.3	88.3	87.2	86.2	84.8
Grant in Aid component from Centre in state Health expd. %				17.0	16.2	18.9	20.7	18.8	14.8	14.1	15.6	16.1	18.2	15.6	14.2
Health expd. to total govt expd. in percent		3.29	3.54	2.88	3.11	2.88	2.91	2.13	2.98	2.94	2.65	2.75	2.70	2.74	2.75
Health expd. as % of GNP		0.98	1.34	1.01	0.97	0.98	0.98	0.91	0.96	0.92	0.92	0.95	0.99	1.04	1.02
Percapita health expd. in Rs./yr.		18.83	39.28	60.24	65.80	74.04	84.28	90.49	109.54	119.71	130.98	152.63	172.43	191.32	207.14

Source: Finance Accounts of state and central govts, various years; The RBI Bulletin, various years ; Economic Survey 2002

Table 3: Summary of information on studies on utilization of health care services and medical expenditure in India.

	Source of treatment (in percentage) *						Average medical expenditure per ailment/episode					
	Rural			Urban			Rural			Urban		
	Public	Private	Total	Public	Private	Total	Public	Private	Total	Public	Private	Total
NSSO –1995-96 (1998)												
Inpatient care	45	55	100	43	57	100	2080	4300	3202	2195	5344	3921
Outpatient care	19	64	83	20	72	92	110	168	157	146	185	178
NSSO 1986-87 (1992)												
Inpatient care	60	40	100	60	40	100	320	733	597	385	1206	933
Outpatient care	26	74	100	27	73	100	73	78	76	74	81	79
NCAER (1993)												
Inpatient care	62	38	100	60	40	100	535	1877	1044	453	2319	1197
Outpatient care	42	52	94	34	59	93	49	131	90	63	152	114
NCAER (1990)	38	58	96	39	56	95	169	147	152	126	164	143
Small Scale Studies												
1. Madhiwala (*et al.)* 2000	22.60	63.50	86.10	10.30	71.70	82.00						
Male												
Female												
Inpatient care							16.00	118.00	97.00	12.00	128.00	98.00
Outpatient care							332.00	2188.00		1938.00	2188.00	--
2. Nandraj (*et al.* 1998)	--	--	--	10.00	84.00		--	--	--	179.89	134.46	134.00
3. Kunhikannan *et al.* 1997	30	63	93	--	--	--	--	--	165.20			
4. George *et al.* (1994)	16.74	70.52	87.26	13.67	71.6	85.27			137.67			128.86
5. Kannan *et al.* (1991)	23	66	89	-	-	-	NA	NA	16.56	-	-	-
6. Duggal and Amin (1989)	10.43	79.82	90.35	15.99	73.95	89.94			103.56			100.44
7. FRCH 1984 (Jesani *et al.* 1996)	33.1	58.4	91.5	--	--	--	28.0	87.08	56.99	--	--	--

* Percentage may not add up to hundred in some cases since some have not sought treatment or might have gone for self treatment

Table 4: Per 1000 distribution of hospitalised treatments by type of facility during 1986-87 and 1995-96, India – NSSO				
Type of	Rural		Urban	
Facility	1995-96 (*52nd Rd*.)	1986-87 (*42nd Rd*.)	1995-96 (*52nd Rd*.)	1986-87 (*42nd Rd*.)
Public hospital	399	554	418	595
PHC / CHC	48	43	9	8
Public Dispensary	5	-	4	-
All govt. sources	**438**	**597**	**431**	**603**
Private hospital	419	320	410	296
Nursing home	80	49	111	70
Charitable institution	40	17	42	19
Others	8	17	6	12
All non-govt. sources	**562**	**403**	**569**	**397**
all facilities	1000	1000	1000	1000

Source: NSSO (1998); Report No 441 on Morbidity and Treatment of Ailments

Table 4a: Percentage distribution of non-hospitalised treatments by source of treatment during 1986-87 and 1995-96, India – NSSO				
Source of	Rural		Urban	
Treatment	1995-96 *52nd Rd.*	1986-87 *42nd. Rd.*	1995-96 *52nd Rd.*	1986-87 *42nd. Rd.*
Public hospital	11	18	15	23
P.H.C. / C.H.C.	6	5	1	1
Public dispen.	2	3	2	2
ESI doctor, etc.	0	0	1	2
All govt. sources	**19**	**26**	**20**	**28**
Private hospital	12	15	16	16
Nursing home	3	1	2	1
Charitable inst.	0	0	1	1
Private doctor	55	53	55	52
Others	10	5	7	3
All non-govt. sources	**81**	**74**	**80**	**72**
Total	100	100	100	100

Source: NSSO (1998): Report No 441 on Morbidity and Treatment of Ailments

Table 5: Utilization of public facilities for various health care services in major states in India

	Inpatient care[1]		Outpatient care[1]		Reproduction related[2]		Family planning [2]					Immunisation dozes [2]
	Rural	Urban	Rural	Urban	Any ANC [3]	Delivery[2#]	Any Method	Female Sterilisation	Male Sterilisation	IUD	Condom	
Andhra Pradesh	22.5	36.2	22	19	34.8	12.5 (37.3)	78.5	79.8	83.8	*	(15.3)	74.4
Assam	73.8	65.2	29	22	71.7		63.7	78.6	(92.3)	83.5	14.7	
Bihar	24.7	34.6	13	33	26	3.8 (10.8)	76.9	83.1	78.3	(48.3)	(11.1)	87
Gujarat	32.1	36.9	25	22	29.1		72	79.9	86.8	37.8	37.8	
Haryana	30.5	37.3	13	11	53.7		79.5	95.4	96.8	54.9	12.6	
Karnataka	45.8	29.8	26	17	43.5		85.3	89.1	(80.7)	53.7	-12.4	
Kerala	40.1	38.4	28	28	38.8		66.4	69.2	83.8	(76.3)	10.8	
Madya Pradesh	53.3	56	23	19	46.3	(13.1 (7.0)	86.6	93.9	94.8	(66.5)	14.7	91.6
Maharashtra	31.2	31.8	16	17	48.9	24.3 (25.8)	75.2	82.3	93.1	29.8	19.9	
Orissa	90.6	81	38	34	57.2	19.3 (3.4)	89.5	97.2	96.1	(73.3)	(21.7)	96.5
Punjab	39.4	27.6	7	6	51.9		64.3	96.1	(100)	45.3	10	
Rajasthan	64.9	73.1	36	41	54.4	(15.9 (5.6)	86.3	95.1	89.3	69.4	25.8	87.5
Tamil Nadu	41.1	35.7	25	28	40.3		73.5	77.3	(95.5)	40.3	14.7	
Uttar Pradesh	47.1	39.8	8	9	49.4	7.5 (7.9)	71.1	91.2	94.5	69.3	11	81.6
West Bengal	82	72.1	15	19	58.7		69.5	89.8	78.7	82.7	11.1	
India	45.3	43.1	19	20	47.3	16.7 (17.4)	76	85.3	88.6	54.1	13.9	82

Source [1] National Sample Survey, 52nd Round 1995-96

[2] National Family Health Survey 1998-99

[3] Reproductive and Child Health Survey Phase I (1998)

Figures in brackets indicates deliveries in private sector and the remaining proportion were non institutional deliveries.

Table 6: Coverage of Selected Preventive/Promotive Health Programs

Activity	Urban	Rural	All
1. Completed Vaccinations	60.5	36.6	42.0
2. BCG	86.8	67.1	71.6
3. DPT-3	73.4	49.8	55.1
4. Polio – 3	78.2	58.3	62.8
5. Measles	69.2	45.3	50.7
6. No vaccinations dozes	6.4	16.7	14.4
7.ANC	86.4	60.2	66.0
8. TT 2+ (ANC)	81.9	62.5	66.8
9. Iron Folic Acid	75.7	52.5	57.6

Note: Vaccinations for children aged 12-23 months

Source: NFHS 2: 1998-99