CHAPTER IX
SUMMARY AND CONCLUSIONS

Health is a productive asset that influences economic development significantly. Health is seen as a part of the basic human capabilities and an integral part of welfare. As conceived by WHO, health is a state of physical, mental and social well-being and not merely the absence of disease or infirmity. An investment in health increases the productive capacity of the working population and hence, the level of income tends to rise and to that extent, it contributes to a decline in the incidence of poverty. It is a well known fact that India is next only to China, in terms of population in the world but the health status of a majority of people is far from satisfactory as compared to China and other developed countries. However, over the last five decades or so, India has built up health infrastructure and manpower at primary, secondary and tertiary care in government and private sectors and has made considerable progress in improving the health of its population particularly in rural areas. But the ultimate objective for health care provision is not necessarily to make available increased number of doctors, nurses, health facilities and other paramedical staff, but rather these resources are the means towards an end. The final outcome is the remission of diseases which will lead to better health outcomes and improved health status. If India has to achieve objective of growth with equity and social justice then health care needs should be strengthened in such way so as to ensure accessibility, efficiency and equity in health system. Thus, the study has been carried out to examine the public health expenditure and health status in India. The specific objectives of the study were:

OBJECTIVES OF THE STUDY

1. To measure the nature and level of inter-state disparities in health status in India.

2. To examine the growth of public health expenditure of India and to measure its trends over-time.
3. To examine the relationship between indicators of health status and public health expenditure over-time and between the states.

4. To identify the main determinants and develop a composite index of health status among the states.

5. To examine the public health system and health related policies over time in India.

6. To give conclusions and policy implications to improve health status in India.

HYPOTHESES OF THE STUDY

In the light of above mentioned objectives, the study attempted to test the following hypotheses:

1) There exist inter-state disparities in India in the health status, but these have declined overtime.

2) The states with higher per capita health expenditure have experienced relatively better health status.

3) Effect of public health policies on the health status continues over a longer period.

PLAN OF THE STUDY

To meet the objectives, the study has been organized into nine chapters. First chapter introduces about the overview of the health status, public health expenditure and public health system in India. Second chapter reviews the studies relating to health sector in India. Third chapter deals with data base and methodology. It lists the different sources of data and methodology used for carrying out the study. Fourth chapter measures the nature and level of inter-state disparities in health status in India. Fifth chapter examines the public health expenditure and measures its trends over-time. Sixth chapter examines the relationship between health status and public health expenditure and measure its trend over time and between different states. Seventh chapter identified the main determinants and have developed a composite index of
health among states. Eighth chapter examines the public health system and effect of health policies over time observed in India. Ninth chapter, the last chapter of the study, gives the summary and conclusions of the study making suggestions for the all-round development of health status of people in India.

DATA BASE AND METHODOLOGY

In this study, the states have been taken as regions in view of the consideration of the availability of data. Moreover, the states being the political and administrative units, the findings and the suggested policy implications of the study can also be used and implemented. Fifteen major states of India have been taken for analyzing the inter-state disparities in health sector. These states included Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orrisa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal.

The study is based on secondary data and covers a period from 1980-81 to 2004-05. Due to availability of population related data for census years only; the study has been carried out for 1980-81, 1990-91 and 2000-01. The requisite data for the study has been obtained from various sources/publications like Statistical Abstract of India, Ministry of Health and Family Welfare reports, Census of India, Reports of Health Information of India, Human Development reports, Planning Commission Reports, Economic Surveys, World Health reports, Central Bureau of Health Intelligence reports, National Accounts Statistics, Government of India reports etc.

Keeping in view the long time period and number of states, the data was collected at three points of time viz. 1981, 1991 and 2001. For examining the trends in public health expenditure, time series data has been taken from 1981 to 2001. The statistical techniques which were used to analyze the data included percentages, coefficient of variation, growth rates, compound growth rates, simple regression analysis, rank correlation, factor analysis, and convergence-divergence analysis. Initially the data regarding different health status variables were standardized using population/area considerations and further normalized for factor analysis. Based on factor analysis and weights derived from it Health Index has been constructed.
MAIN FINDINGS

Health is an important factor in the formation of human resource development which plays a vital role in improving the qualities of human beings. Health status is multidimensional in nature and it is difficult to measure it precisely. It is captured through a number of indicators. Life expectancy at birth, Infant mortality rate, Doctors per 000 of population, hospitals per 000 of population, beds per 000 of population, literacy rate, sex ratio, crude birth rate (CBR) and crude death rate (CRD) were the noted variables on which data has been collected and examined from 1981 to 2001. To examine the nature and level of these variables, the data has been divided into three periods: 1981 to 1991, 1991 to 2001 and 1981 to 2001. Growth rates have been computed and analyzed.

In order to compare inter-state disparities, rank correlation and coefficient of variation has been calculated and interpreted accordingly.

First indicator of the study is Life Expectancy at Birth (LEB). During 1981-1991, India’s LEB in rural areas increased by 15.2 percent while in urban areas it increased by 18.36 percent. Across all states LEB in urban areas, increased at much faster pace than in rural areas. It implied that LEB as an indicator of health status had shown positive improvement in this decade in both rural and urban India while in urban India growth rate was higher than in rural one, due to the fact that people had better access to modern medical facilities and led a better quality of life. When inter-state disparities in LEB (both rural and urban) were compared using Coefficient of Variation (CV), then it was found that it decreased from 1981 to 1991 and further from 1991 to 2001 depicting that inter-state variations in terms of LEB has decreased overtime leading to convergence of LEB.

From 1981-1991, IMR at an all India level declined at the rate of 24.36 percent in rural areas and by 26.12 percent in urban areas. BIMARU states in both rural and urban India were the states where IMR had declined at the rate less than that of national average. When inter-state disparities in IMR (rural and urban) across the states were compared then its CV value showed that it led to divergence from 1981 to 1991 but after 1991 it converged.
At an all India level from 1981 to 1991, Doctors per' 000 population increased at the rate of 20.21 percent in rural areas while 24.01 percent in urban areas. During the second period, doctors per' 000 of population in rural areas increased at the rate of 23.56 percent while in urban areas the increase was at the rate of 27 percent. During 1991-2001, growth rate was observed to be higher than that in 1981-1991. In case of inter-state disparities, it was seen that in both rural and urban areas from 1981 to 1991, inequalities diverged and then from 1991 to 2001 these converged.

From 1981-1991, rural hospitals increased at the rate of 33.14 percent while urban hospitals serving per' 000 of population increased at the rate of 39.98 percent. During the second period, 1991 to 2001, growth rate in rural areas turned out to be 37.56 percent while in urban areas it was around 43.12 percent. When hospitals serving per’ 000 of population (both rural and urban) were compared then it was found that from 1981 to 1991, it led to divergence and 1991 to 2001, it led to convergence. Thus, over-time inter-state disparities decreased after 1991.

In case of beds per '000 of population from 1981-1991, at an all India level, growth rate was found to be 17.57 percent for rural India and 24.76 percent for urban areas. In the second period, growth rate of this indicator was 19.25 percent for rural areas and 27.92 percent for urban areas. When beds per’ 000 of population were taken (both rural and urban) into account then CV increased from 1981 to 1991 showing divergence that is inter-state disparities increased but after 1991 these decreased.

From 1981-1991, at an all India level, growth rate of literacy was 17.85 percent in rural areas and 23.12 percent in urban areas. During the second period, growth rate in rural areas turned out to be 19.95 percent and 24.85 percent in urban areas. In case of literacy (both rural and urban) growth rates were positive and same trend was observed during 1981 to 1991 and 1991 to 2001, that is it leads to convergence depicting that inter-state inequalities decreased overtime between different states of India.

If the trend was observed in growth rates of sex ratio in India then it was seen that during the first decade growth rate in sex ratio at an all India level was -0.74 percent. Growth rate lied in the range of -0.32 percent to 1.42 percent. During the second decade of the study period growth rate of sex ratio improved significantly.
When Coefficient of Variation for sex ratio was calculated to determine the trend of convergence or divergence it was observed that 4.7 percent variations were found between states of India in 1981 and it increased further to 4.8 percent showing minor divergence and then from 1991 to 2001, it increased to 5.19 percent implying that sex inequalities increased over time period among different states of India. It is very disturbing fact that inequalities in sex ratio among the states were widening due to the menace of female foeticide showing a paradoxical situation. In states like Punjab and Haryana where other indicators of health status have performed better as compared to other states of India, but in sex ratio, both are far below as compared to rest of the states of India.

During 1981-1991, growth rate of CBR declined by 13.2 percent in rural areas and 15.45 percent in urban areas. During second period, it declined by 17.15 percent in rural areas and 18.05 percent in urban areas. During 1981, CV for CBR in rural areas was turned out to be 12.45 percent and which further increased to 19.32 percent in 1991 and 21.41 percent in 2001 showing divergence i.e. inequalities increased in CBR (rural). CBR in urban was out to be 19.54 percent, which increased to 23.77 percent in 1991 showing divergence but later on in 2001 it decreased to 18.69 percent showing the convergence i.e. CBR (urban) disparities decreased from 1991 to 2001 depicting positive health scenario in the country.

The annual growth rate of CDR in rural India was worked out to be -22.62 percent during 1981-91 while for urban India, growth rate was -22 percent. However during 1991-2001, growth rate of decline was much more in rural India than that in urban India. It has declined to the extent of -17.92 percent in rural areas and -18.02 percent in urban areas. Further its CV decreased from 1981 to 1991 and then increased from 1991 to 2001 showing convergence depicting that inequalities decreased in CDR in rural areas. Same trend was observed in urban areas.

The analysis of rank correlation revealed that the states which recorded above national average growth rate were Kerala, Karnataka, Gujarat, Maharashtra and Madhya Pradesh in almost all the health status variables. On the other hand, the states which had below national average growth rate were Bihar, Uttar Pradesh, West Bengal and Andhra Pradesh from the first decade of the study period. Another fact
which came to light from this analysis is that the same states recorded above national average growth rate in the decade 1991-2001 as were in the decade of 1981-91 and none of the state which in the previous decade was below average position has come up in the above national average growth rate. This means that the lagging states have not made any serious effort to improve their position and register higher growth rate than the national average growth rate.

The Coefficient of Variation among the states was calculated in order to establish the convergence or divergence of the interstate inequalities in health status indicators. The analysis revealed that in almost all the variables during the first period of the study (1981-1991), majority of the indicators showed divergence in the interstate disparities except for the indicator of life expectancy at birth, literacy and CDR whereas in the second decade of the study period (1991-2001), majority of the indicators showed convergence except for the indicator of sex ratio, this showed that over time the interstate disparities in the health status variables were narrowing down.

Under the Indian Constitution some of the health utilities like public health, hospitals and dispensaries were included in State List of functions, while some others like population, medical education, medical profession, registration of births and deaths were under the Concurrent List. Given India’s size and the fact that health is a state subject, it is important to examine inter-state differences in spending patterns.

Yearly growth rates have been calculated for per capita expenditure at constant prices on health done by different states. Per capita expenditure on health has been taken from 1981 to 2005. Inter state annual growth rates and compound growth rates have been calculated. The annual growth rate of per capita expenditure turned out to be 18.4 percent during 1981-1982. However, it declined till 1995-1996 and reached 0.05 percent in 2004-05. The growth rate was lowest (0.05 percent) during 2004-05. Maximum growth rate of 19.89 percent was observed in 1995-96.

During 1987-88, Andhra Pradesh growth rate was maximum which came out to be 30.38 percent. Assam’s (North Eastern state of India) growth rate came out to be 42.47 percent in 1984-85, it became negative in 1999-2000 that is -15.95 percent. Bihar's (one of the BIMARU state of India) annual growth rate during 1983-84 came out to be -2.43 percent. Negative growth rate was again observed in 1996-97 that is -
Growth rate of Orrisa in per capita health expenditure was maximum during 1982-83 that is 26.78 percent then it declined and became negative in 1993-94 that is -3.47 percent and in 2000-01 that is -5.31 percent. Punjab's growth rate in per capita health expenditure was 9.96 percent in 1981-82 thereafter it increased to 27.89 percent in 1983-84, further it became negative in 2000-01 that is -8.03 percent. Per capita health expenditure growth rate in Rajasthan came out to be 19.6 percent in 1981-82, thereafter to 38.2 percent in 1982-83, then negative in 1983-84 that is -2.37 percent and then positive. Further, negative growth rate was observed from 1987-88 to 1990-91 and then positive growth rate in per capita health expenditure in 2000-01. Tamil Nadu's growth rate was 43.4 percent in 1981-82 thereafter it declined in 1984-85 that is -19.54 percent and -18.41 percent in 1985-86. In case of Uttar Pradesh, annual growth rate came out to be 15.04 percent in 1981-82, it increased to 20.86 percent in 1982-83 and further to 23.53 percent in 1983-84 thereafter it declined and
became negative in 1992-93 that is -0.51 percent and -0.31 percent in 1993-94. In case of West Bengal growth rate came out to be 14.55 percent in 1981-82, declined to 11.87 percent in 1982-83, became negative in 2000-01 that is -14.43 percent.

Before the economic reforms in the mid 1980’s, public spending on health in India peaked at about 1.6 percent of GDP and 4 percent of the government budget. During the 1990’s government health spending failed to keep up with the expanding economy and by 2001 it constituted 0.9 percent of GDP and 2.7 percent of government budget. These numbers fell to 0.8 percent and 2.4 percent in 2004 and 2005 respectively.

Compound growth rates were computed for per capita health expenditure from period 1981 to 2001 and its sub periods. From 1981 to 1991, India’s per capita health expenditure increased by 9.8 percentage points. Growth rate fastened during 1991 to 2001 that is by 12.26 percentage points. Haryana, Kerala, Madhya Pradesh, Maharashtra, Orrisa, Rajasthan, Tamil Nadu and West Bengal were the observed states where growth rate was less than national average. Maximum growth rate was observed in Karnataka (14.73 percentage) followed by Uttar Pradesh (12.53 percent) and Punjab (13.26 percentage). From 1991-2001, states where growth rate was less than national average were those of Andhra Pradesh, Assam, Bihar, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Orrisa, Rajasthan, Tamil Nadu and Uttar Pradesh. Highest compound growth rate was observed in the state of West Bengal (14.96 percent) followed by Punjab (14.29 percent). When overall period that is 1981 to 2001 is considered then at an all India level growth rate was 9.92 percent. Maximum growth rate was observed in the state of Karnataka (11.78 percent) followed by Punjab (11.17 percent) whereas Assam, Bihar, Gujarat, Haryana, Madhya Pradesh, Maharashtra, Orrisa, Rajasthan and Uttar Pradesh were the states where per capita health expenditure grew at the rate less than national average.

India was one of the pioneers in health service planning with focus on primary health care. In 1946, Health survey and Development Committee headed by Sir Joseph Bhore recommended establishment of well structured and comprehensive service with sound primary health care infrastructure. Improvement in the health status of the population has been one of the major thrust areas. At the time of
independence, the country’s health care infrastructure was mainly urban and clinic based. Outreach of services was very limited; there were very few preventive and rehabilitative services available. From first five year plan, governments has made efforts to build up primary, secondary and tertiary care institutions and to link them through appropriate referral systems. The health sector’s allocation was Rs. 65.2 crore for the first plan (3.4 percent of total), 140.8 crore (3.1 percent of total) for second and 2.9 percent for the third plan, Rs. 336 crore for fourth plan (3.2 percent of total). Further, 682 crore for fifth plan (3.1 percent of total), Rs. 1821 crore for sixth plan (3.1 percent of total), Rs. 3393 crore for seventh plan (3.1 percent of total), Rs. 7576 crore for eighth plan (3.2 percent of total). During fifth and sixth five year plans programs to assist delivery of preventive medicine were launched which led to improvement in the health status of rural population. Supplemental nutrition programs and providing safe drinking water were given high priorities. Further these plans aimed at training more community health workers and efforts were launched to control communicable diseases. There were also efforts to improve regional imbalances in the distribution of health care resources. However, from the ninth five year plan onwards an upward trend in the allocation of funds to the health care has been witnessed. This was due to the increasing awareness at both national and international level to improve the quality of life of human beings, so that they can productively participate in the process of economic development. Moreover, an increasing importance of social sector was recognized by the policy planners both at the state and national level. During ninth plan, health sector allocation increased to Rs. 10818.4 crore that is 4.09 percent of total. Efforts were made to tackle the burden of diseases so that there is sustained improvement in the health status of population. There was introduction of Health Management Information Systems. Further Panchayati Raj Institutions were introduced in planning and monitoring of health programmes at local level so that there is greater responsiveness to health needs of people and greater accountability; to promote inter-sectoral coordination and to utilize local and community resources for health care. Further during tenth and eleventh plan respectively its allocation was Rs. 31020.3 crore (3.97 percent of total) and Rs. 46669 crore (6.5 percent of total) respectively.
Health expenditure over the planning period has increased in India. In the first plan total investment was 1960 crore. Total expenditure on health expenditure was 3.4 percent. In the eleventh plan total investment increased up to 1484131 crore in which health investment was 58920.3 crore which was 3.97 percent. In twelfth five year plan, health investment is made as much as 6.05 percent of the total investment.

Simple Regression analysis was carried out to find out the effect of per capita public health expenditure on various indicators of health status of India and for its different states for three census years of 1981, 1991 and 2001. Sex ratio, Life expectancy at birth, Hospitals served per’000 of population, Beds per’000 of population, Doctors per’000 of population showed positive and significant relation with per capita health expenditure, indicating thereby that as per capita health expenditure increases these health indicators showed improvement. Crude birth rate, crude death rate and Infant mortality rate showed significant but positive relation with PCHE. Literacy rate (both rural and urban) showed an insignificant relation with PCHE. Values for $R^2$ came out to be relatively low because health is multidimensional and is affected by other factors like gender empowerment, poverty reduction, education, adequate housing, clean drinking water, sanitation etc.

Further, Health index was developed on the basis of above mentioned given variables by using the weights of each variable got from factor analysis. During 1981 in rural areas the results of Factor Analysis indicated that Crude Birth Rate, Infant Mortality Rate were the significant variables in determining health status of states, hence were the major sources of inter-state variations in health status. Hospitals served per 000’ of population and Beds served per 000’ of population were significant contributors in index of health status in case of urban areas. After a decade when scenario was observed that is in 1991 in rural areas Crude Death Rate and Crude Birth Rate were included in Factor 1 while in urban areas same variables were observed to be included in Factor 1. During 2001, good point to be noted is that both health development and infrastructural indicators play an important role in rural areas while in urban areas still infrastructural (Hospitals served per 000’ of population and Beds served per 000’ of population) indicators played important role.
It was observed that over the time health status of Kerala remained at top followed by Karnataka and Maharashtra. Further, there was improvement in ranks of Madhya Pradesh from tenth to seventh, Punjab from eighth to sixth, and Rajasthan from eleventh to tenth and Haryana from sixth to fourth. As far as the value of Health Index is concerned its value increased overtime from 1981 to 2001. If inter-state disparities were considered then it was observed that in all the states over-time the value of index increased depicting that health status have shown an improvement indicating an improvement in all the indicators.

An attempt has also been made to examine the policies and programmes relating to public health in India and how public health sector of India moved on the development path after reforms.

Public health sector reforms have been defined as a sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government. It is designed to improve the functioning and performance of the health sector and ultimately the health status of the people. In India the evolution of health system can be categorized into 3 distinct phases:

**Phase I (1947-1983):** During this period, health policy was based on 2 principals-

a) none should be denied care for want of ability to pay

b) that it was the state’s responsibility to provide health care to the people.

**Phase II (1983-2000):** When the First National Health Policy of 1983 articulated the need to encourage private initiative in health care service delivery, while at the same time expanding access to primary health care.

**Phase III (Post-2000):** Which is witnessing a further shift that has the potential to profoundly affect the health sector in three important ways:

a) The desire to utilize private sector resources for addressing public health goals;

b) Redefining the role of the state from being only a provider to a financier of health services as well;
c) Liberalization of the insurance sector to provide new avenues for health financing

Reforms have been implemented in following ways:

1) Changes in Financing methods
   a) User charges
   b) Community Financing Schemes
   c) Insurance
   d) Stimulating private sector growth
   e) Increased resources to health sector

2) Changes in health system, organization and management
   a) Decentralization
   b) Contracting out of services
   c) Reviewing the public-private mix

3) Public sector reforms
   a) Downsizing of public sector
   b) Productivity improvement
   c) Introduction of competition
   d) Improving geographical coverage
   e) Increasing role of local government
   f) Targeting role of public sector through packages of essential services

India’s health sector reforms have taken place under the broad umbrella of Structural Adjustment Program (SAP) which is termed as the New Economic Policy (NEP). The two major aspects are privatization and globalization. Aim of privatization and globalization is to improve access and to enhance the quality of social services by supporting India’s health sector reform initiatives. Thus, India’s dream of becoming “World Class” in health care system can be achieved by it, if it fulfills its two objectives: control of communicable and non communicable diseases and to increase the budget allocation on health sector by government. Hence, India faces the daunting challenge of meeting health care needs of its vast population and ensuring efficiency, accessibility, equity and quality of health care and therefore achieving the objective of growth with equality and social justice.
POLICY IMPLICATIONS

On the basis of the examination of theoretical issues and experience regarding health sector development in India and other countries as brought out in the review of literature, following general suggestions are made:

First, full and clear support by the government for the PPP programme and specific PPP projects should come from the highest political level of government. PPP projects should have clear policy framework regarding objectives, strategies and operationalization of projects. A concession agreement should be structured in such a way to cover all possible causes of later adjustments, leaving minimum room for renegotiations. It is also important that the public and private sectors work together, keeping the project and the outcomes in focus and collaborate for mutually enduring value. In India, already PPP models are working successfully in this sector. Like Bridge Trust, established in 1996 working in Mumbai focusing to remove inequalities in terms of education and health care. Another is Pratham in Mumbai with central focus on alleviating the health problems of children. Sangam Vihar in New Delhi which have transformed the stereotype of urban slums by operating its own health care system. Moreover, Working Women Forum in Karnataka which is working on health of women at grassroot level etc.

Second, it is clear from the studies that India has made noticeable improvements in health sector since the 1980’s. But even then the conditions with respect to public health sector are appalling as compared to the countries like Sri Lanka, China and some countries of South-East Asia. The health status of majority of the population continues to remain poor even after a decade of reforms. Moreover, the rising cases of HIV/AIDS cases in India during the reform period pose a serious challenge which demands an immediate and sustained response from the government.

Thirdly, education plays an important role in determining the health status of population. One might also expect the health-related child care to improve with the level of the mother's education. Studies found out that infant mortality falls both in rural and urban areas as the literacy and formal education level of the mother increases. Thus, emphasis should be made on increasing the literacy rate among the masses.
Fourthly, health education should become an integral part of all general education and should receive adequate emphasis. Health education should also be an essential component of all healthcare and the health care services should assume special responsibility for the health education of the poor who need it most.

Fifthly, restructuring of the rural health programmes should be done by adopting an approach of systems analysis to get increasingly more favorable returns from the resources that are already assigned to the rural health services.

Based on the findings of the present study, following specific policy recommendations are made:

1. Public health sector spending by the central and state governments are low. Further health sector spending as percentage to GDP is also low so there is need to prioritize this sector. Both higher allocations and prioritization constitute necessary condition for this social sector for the development of India. The sufficient condition demands that the funds allocated must flow into desired channels through good governance and effective implementation.

2. From the study it came out that public health services are relatively more accessible in urban areas as compared to their counterparts in rural areas, so there is need to concentrate on health policies in rural areas. Lack of awareness, economic poverty, social disparities lead to underutilization of these services both in rural areas and urban slums. The provision of health care services now has to incorporate pro-poor approaches within its scope.

3. Although the analysis shows convergence in most of the health status indicators depicting reduction in interstate disparities but still a lot needs to be done in order to further reduce these inequalities and bring the lagging states at par with the developed states of the country.

4. Health indicators are significantly related to per capita public health expenditure. Hence, in order to improve the health status it is very important that government should raise its expenditure on health sector. To achieve the goal of “Health For All”, WHO has set the target of atleast 5 percent of GNP
on health sector. If health care patterns are to be changed steps must be taken in this direction immediately.

5. Literacy rate is found to be one of the factor influencing health indicators. Kerala has much better health indicators as compared to all India and the major factor for this is its high female literacy rate. So, government through persuasion and propaganda should raise the level of literacy, so that people should become aware about the prevailing health problems and methods of preventing and controlling them. Gender empowerment is key to health improvement and hence public policy should concentrate on gender empowerment more seriously in the states.

6. Economic growth effects health directly as well as indirectly. Thus, economic policies should concentrate on overall economic development of poor performing states so as to improve the health status of their inhabitants. Higher incomes potentially permit individuals and societies to afford better care as well as education, clean drinking water and sanitation.

7. Although the country has set up Community Health Centres (CHC's), Primary Health Centres (PHC's) and Sub-Centres (SC's) but various studies has described the pitiable condition of their buildings, lack of basic equipment and non-availability of health care providers in optimum numbers in majority of the states. Few states in India such as Punjab, Karnataka and Tamil Nadu have successfully set up health system projects with the help of World Bank to rebuild secondary health care. This initiative needs to be duplicated by other states as well as to primary health care.

8. Regarding economic reforms in public health sector, no attempt was ever made to understand the human development concerns that permeated India. No changes were initiated to mitigate them. Future reforms must emerge from continuing analysis, public discourse and experimentation. The reforms with human face must be carried out in India’s health sector. The way ahead should be based on consultations, debates and by forging a consensus amongst policy makers both at centre and states which should aim towards increasing equity,
efficiency, effectiveness, thereby meeting the health needs of the population, especially among the poor and vulnerable segments.

It may be concluded that differences in the availability of health care facilities have largely led to regional disparities. Provision of adequate health facilities is must for human development which is essential for poverty alleviation as well as for realizing the goal of economic development. Special policy packages must be provided to states which are lagging in health infrastructure. Therefore, governments must give serious thought to the administrative, regulatory, financial and institutional framework and frame appropriate policies for optimizing development gains from health sector. Good governance, both at central and state levels is critical in this context.