AN EVALUATION OF HEALTH CARE POLICIES IN INDIA: AN INTER STATE COMPARISON

(Summary)

THESIS

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Summary

Healthcare is one of India’s largest sectors, in terms of revenue and employment, and the sector is expanding rapidly. During the 1990s, Indian healthcare grew at a compound annual rate of 16%. Today the total value of the sector is more than $34 billion. This translates to $34 per capita, or roughly 6% of GDP. By 2012, India’s healthcare sector is projected to grow to nearly $40 billion. The private sector accounts for more than 80% of total healthcare spending in India. Unless there is a decline in the combined federal and state government deficit, which currently stands at roughly 9%, the opportunity for significantly higher public health spending will be limited. One driver of growth in the healthcare sector is India’s booming population, currently 1.1 billion and increasing at a 2% annual rate. By 2030, India is expected to surpass China as the world’s most populous nation. By 2050, the population is projected to reach 1.6 billion. This population increase is due in part to a decline in infant mortality, the result of better healthcare facilities and the government’s emphasis on eradicating diseases such as hepatitis and polio among infants. In addition, life expectancy is rapidly approaching the levels of the western world. By 2025, an estimated 189 million Indians will be at least 60 years of age—triple the number in 2004, thanks to greater affluence and better hygiene. The growing elderly population will place an enormous burden on India’s healthcare infrastructure. The Indian economy, estimated at roughly $1 trillion, is growing in tandem with the population. Goldman Sachs predicts that the Indian economy will expand by at least 5% annually for the next 45 years (see chart), and that it will be the only emerging economy to maintain such a robust pace of growth. The Constitution of India envisages the establishment of a new social order based on equality, freedom, justice and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to develop in a healthy manner.

Since the inception of the planning process in the country, the successive Five Year Plans have been providing the framework within which the States may develop their
Health services infrastructure, facilities for medical education, research, etc. Similar guidance has sought to be provided through the discussions and conclusions arrived at in the Joint Conferences of the Central Councils of Health and Family Welfare and the National Development Council. Besides, Central legislation has been enacted to regulate standards of medical education, prevention of food adulteration, maintenance of standards in the manufacture and sale of certified drugs, etc.

Health and healthcare need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Health is clearly not the mere absence of disease. Good health confers on a person or groups freedom from illness and the ability to realize one’s potential. Health is therefore best understood as the indispensable basis for defining a person’s sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality costs of care and current bio-medical understanding about health and illness.

Healthcare covers not merely medical care but also all aspects of preventive care too. It cannot be limited to care rendered by or financed out of public expenditure within the government sector alone but must include incentives and disincentives for self care and care paid for by private citizens to get over ill health. In India, private out-of-pocket expenditure dominates the cost financing healthcare. Healthcare at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible hand of the market, nor can it be established on considerations of utility maximizing conduct alone.

What makes for a just health care system even as an ideal? Four criteria could be suggested- First universal access, and access to an adequate level, and access without excessive burden. Second fair distribution of financial costs for access and fair distribution of burden in rationing care and capacity and a constant search for improvement to a more just system. Third, training providers for competence, empathy, accountability, pursuit of quality care and cost effective use of the results of relevant research. Last, special attention to vulnerable groups such as children, women, disabled and the aged.
Primary Health Care is a vital strategy that remains the backbone of health service delivery. India was one of the first countries to recognize the merits of Primary Health Care Approach (PHC). PHC was conceptualized in 1946, three decades before the Alma Ata declaration, when Sir Joseph Bhore made recommendations that formed the basis for organization of basic health services in India. The Bхore Committee report laid emphasis on social orientation of medical practice and high level of public participation. The salient features of this committee are presented below.

1. Integration of preventive and curative services at all administrative levels.
2. Short Term- Primary Health Centers for 40,000 population.
3. Long Term (Three million Plan)- Primary Health Centers with 75 beds for each 10,000-20000 population.
5. Provision of Social Doctor.
6. Inter-sectoral approach to health services development.
7. Three months’ training in preventive and social medicine to prepare social physicians.

With the beginning of health planning in India and first five-year plan formulation (1951-55), Community Development Programme was launched in 1952 for the all-round development of rural areas, where 80% of the population lived. Community Development was defined as “a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance upon the community’s initiative”. The Community Development Programme was envisaged as a multipurpose programme covering health and sanitation (through the establishment of primary health centers and sub-centers) and other related sectors including agriculture, education, transport, social welfare and industries. Each Community Development Block (CDB) comprised approximately 100 villages with a total population of one lakh. For one CDB, one Primary Health Centre was created.

the close of second five year plan (1956-61),"Health Survey and Planning Committee", The Mudaliar Committee, was appointed by the Government of India to review the progress made in the health sector after submission of Bхore committee report. The major recommendation of this committee report was to limit the population served by primary health centers to 40,000 with the improvement in the
The quality of health care provided by these centers. Also, provision of one basic health worker per 10,000 populations was recommended. The Jungalwalla Committee in 1967 gave importance to integration of health services. Integrated health services were defined as "a service with a unified approach for all problems instead of a segmented approach for all different problems". The committee recommended integration from the highest to lowest level in the services, organization and personnel. The Kartar Singh Committee on multipurpose workers (MPW) in 1973 laid down the norms about health workers. For ensuring proper coverage the committee recommended, one primary health centre to be established for every 50,000 population. Each primary health center to be divided into 16 sub-centers each for a population of 3,000 to 3,500. Each sub-centre to be staffed by a team of one male and one female health worker. The work of 3 -4 health workers to be supervised by one health assistant.

The Shrivastav Committee on Medical Education and Support Manpower in 1975 suggested creation of bands of para-professional and semi-professional health workers from within the community (e.g. school teachers, post masters etc.). It also recommended the development of a “Referral Service Complex” by establishing linkages between the primary health centre and higher level referral and service centers, viz taluka/tehsil, district, regional and medical college hospitals.

Following the suggestions of the Shrivastav committee report, Rural Health Scheme was launched in 1977, wherein training of community health workers, reorientation training of multipurpose workers, and linking medical colleges to rural health was initiated. Also to initiate community participation, the Community Health Volunteer-Village Health Guide (VHG) Scheme was launched. The VHG was to be a person from the village, mostly women, who was imparted short term training and small incentive for the work.

The Alma Ata declaration of 1978 launched the concept of Health for all by year 2000. It was signed by 134 governments (including India) and 67 other agencies. The declaration advocated the provision of first contact services and basic medical care within the framework of an integrated health services. The declaration asserted “PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the
community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”.

Against this backdrop, the present thesis has been carried out to study the healthcare policies in India, its evaluation and inter-state comparison of the policies. The present study gives a detailed outline of the various healthcare policies right from the first Five Year Plan till date.

The entire thesis has been divided into seven chapters. Chapter I gives an introduction, rationale of study, objectives and research methodology of the present health system of India at large and gives details of how the various committees helped and formulated the recommendations for developing the Healthcare Policies in India ever since Independence. The topic itself specifies the need to evaluate the existing health care policies. The slow pace of growth has been experienced by the country from the last two decades. Despite the fact that the country has its own health policy, which aims to achieve the highest attainable goals as mentioned in INHP-2002, but still we are not able to achieve the set goals within the set time frame and whatever we have achieved is, region biased or state biased. So it becomes a crucial part of research to identify the reasons behind this and in the continuation of that such type of evaluation can help the policy makers and planners in designing the health policies.

The study would have wider scope in the area of health care research and will also be helpful for the policy planners in policy making and formulation. It would be contributing as one of the source to enhance the available knowledge base for policy making. The objectives of the study are:

- Review of Existing National and State level Policies.
- Review of existing situation of health status in selected states.
- Identification of health indices for the comparative analysis.
- Identification of Policy gaps at different levels
- At the level of Planning & Formulation.
- At the level of Implementation.
- Inter-state comparative analysis of policy level gaps.
- Formulation of alternative packages for policies.
This study was a review of secondary literature. A combination of search techniques are employed to find the relevant data. Major source of information and data are online journals. Different scientific engines are searched for related articles, using different search words and their combinations. The search engines used are:

- Ovid
- Pub Med
- Google

And the phrases used for searching are, “Health policies in India”, “health scenario in different Indian states”, “Health indicators”, “Health infrastructure”, “Health financing”, “Quality of health care services”, “challenges in health care”, “National health polices”, “Health policies in states”, “Health service coverage”, “private sectors health spending”.

These phrases are used individually and in combinations and different number of articles were found. While searching at Google, number of web links were found which contained information related to the topic. Websites of the following agencies were found to be helpful.

- Reserve Bank of India
- Planning Commission of India
- World Health Organization
- World Bank
- Populations Council
- United Nations Fund for Population Development
- Ministry of Health and Family Welfare, Government of India
- Department of Health and Family Welfare, Gujarat, Tamilnadu, Maharashtra, Uttar Pradesh, Rajasthan and Bihar state government.

Searches through the Library Catalogue of Lucknow University were made, using phrases like “Health care review in India”, “Healthcare financing”, “Healthcare Indicators in Indian states”, “Health sector reforms”; etc, and a few relevant books were found.
The cross sectional and time series data is collected from various sources. The cross sectional data is collected from different reports of central and state governments. The world development indicators, World Development reports provided the data on global indicators of health. The National Family Health Survey (NFHS), Reproductive Child Health (RCH), Ministry of health and family welfare have provided the health outcome, infrastructure and health professional statistics. The data of state heath care expenditure from 2000-2009 is taken from RBI handbooks of state finances. Other than these sources, economic survey, central government budgets, five year plans of planning commissions are also referred.

Chapter II gives the account of the current health scenario in better performing states and low performing states which formed the basis of this thesis. The present study includes the following states of India to compare the health status of developed and developing states of India.

Developed State (Better performing states):
1. Maharashtra
2. Tamil Nadu
3. Gujarat

Developing States (Low performing states):
1. Uttar Pradesh
2. Bihar
3. Rajasthan

In India, the aim of the Government is to lower the incidence of the different diseases and encourage the human development. But health outcomes are depending on the socio-economic, geographic differences in the country. Higher incidence of various diseases is not expected in any country. They are harmful for economic, human and social development. The reductions of different diseases are mentioned in the millennium development goals. The developed countries have higher achievements in terms of health outcomes and vis-a-vis in developing countries.

Chapter III gives an account of public healthcare system in the states of India. In this chapter, state wise review of the existing policy framework and current programs including the physical and financial progress has been done. The review process
comprises of in-depth analysis of state specific policies on health care, population control etc. In this chapter efforts have been made to analyse the existing policies on health programs, progress of National Rural Health Mission (NRHM) in physical and financial terms along with the program wise issues and challenges.

**Chapter IV** deals with the Health sector spending in the states their levels and trends. Although over the last 50 years India has shown improvement in its health infrastructure and broad health indicators, on public financing front it is far from satisfactory levels.

The provision of health care in India is a responsibility shared by the state, central, and local governments. The delivery of health care is effectively a responsibility of the state governments. The centre is responsible for health care in Union Territories without legislature. It is also responsible for developing and monitoring national standards and regulations, providing the link between the state governments and international and bilateral agencies, and sponsoring numerous schemes through the provision of finance and other inputs for implementation throughout the states. Goals and strategies for the public sector in health care are established in a consultative process involving both the central and state governments. Within the overall ambit of national policies, there is scope for the state to formulate its own health policy and administer health schemes in conformity with local conditions.

The planning process influences the financing of the health sector in India. The overall allocation of resources by the centre’s Planning Commission and Finance Commission provides opportunities for state’s initiatives in new projects. In addition, intra-sectoral allocation of grants-in-aid and other earmarked funds from the centre to states also takes place. The budgeting and accounting of government expenditure at the central and state levels are influenced by the planning process, within the five-year plans. Once the five-year period of any particular plan is over, the recurrent expenditure associated with the continuation of that activity is generally transferred to the non-plan budget, except for the Family Welfare Program.
The local bodies have no significant financial authority in India except in large cities. In some states, local bodies have been entrusted with the responsibility of managing services and implementing national programs. The involvement, however, varies widely across the states. The financial powers of local bodies are rather limited and transfer from the state varies widely. Even when transfers are not too insignificant, they are specific purpose grants to support specific services. Two developments of the 1990s would have made a difference to the management of the health sector in the states. The first is the Health Sector Reforms (HSR) initiated by some of the states. Since 1992, the Government of India and the World Bank have been engaged in a dialogue on health sector development. The focus of that dialogue has been on helping India address the most burdensome diseases in a cost-effective manner and move towards the establishment of health systems that are efficient and effective. The Health Sector Reform and financing at the state level is consistent with the Country Assistance Strategy of the World Bank. The first part of the strategy in the health sector seeks to reduce the most significant diseases through the support of priority programs, and the second part of the strategy seeks to strengthen the health system of the states by providing more efficient and effective health care. Andhra Pradesh was the first Indian State to begin implementing HSR. Three other states - Karnataka, Punjab and West Bengal- joined soon after to be followed by Maharashtra and Orissa. Like the HSR elsewhere, the Indian HSR seeks to adopt a need-based health care strategy and prioritize state expenditure, implement cost recovery mechanisms, involve the private and NGO sectors, and improve the analytical basis of decision-making and strengthen the management of public sector health. The second development of the 1990s was the 73rd and 74th amendments of the Constitution of India and in 1992 for decentralizing governance and administration. The state governments were required to enact conformity legislation and conduct elections to put the new Panchayati Raj (PR) regime in place aimed at promoting participatory democracy. One of the greatest merits of the amendments is to empower women and marginalised and socially depressed groups through one-third reservation for women and reservation for scheduled caste (SC) and scheduled tribe (ST) based on their population in elected bodies. But the conducting of elections and delegation of powers to PR institutions to build them as institutions of self-government has varied enormously across the Indian States.
States governments have their own independent health care policies. The states can spend larger proportion of money on the health care in relation to their population. They are entitled to provide the health care to all population in their jurisdiction. The higher growth rate of population is another factor which reduces the per capita expenditure on health care. Sometimes, the higher income states are not necessarily spending more on the health care, the priorities might be different. Some states with lower percent of urban population allocate a higher percentage of health care expenditure to urban sector. Rural sector is given negligible importance (Reddy K.N and V. Selvaraju 1994). The prices of medical equipments and medical technology also change. Lifestyle, health requirements, demographic pattern of population is always changing. The medical professionals require training to upgrade their knowledge and skills. It has reflection on the overall disease' pattern. Economic resources are scarce and that has to get utilised in an efficient way. But the lower resource states do not have choice but to spend less on the health care. Such lower spending has consequences on the health infrastructure and professionals. Both are critical factors and decide the disease outcome in particular state. The number of hospitals, beds and health professionals cannot be maintained on a sustainable basis with the rising population. The lack of health care and timely access affect on the population. The rich people have the alternative arrangement of health care but the poor do not have it. The poor people are spending more time, energy and money to get the heath treatment. They often visit public hospitals by travelling at their own cost. The direct and indirect cost associated with getting health care is high for poor people. The repeated visits cannot be possible from longer distance at a particular time. Sometimes the rural and poor populations do not have choice but to depend on the public health care. An unavailability of health professionals and health care not only affect day to day life but for their future health and income. There is direct link between the illness and poverty of a family. If the link is direct then overall consequences in terms of health, education and income are very high. The poorer and populated states must invest regularly in health services. Such efforts will reduce the gaps in health care services and it will be accessible, affordable, equitable health care to all.

Chapter V, gives details of major issues and challenges for better functioning of health system. The state governments have to trigger greater change with respect to
key policy reform and institutional strengthening. The major challenges faced by the states in delivering a package of health care services and enhancing the performance of the delivery system are summarized below.

States in India are beginning to address health care delivery issues in more efficient ways. Three main issues with regard to the existing health care strategy at the state level need to be addressed.

**First**, the government's health care strategy is anchored on population-size based norms rather than the specific health needs at the community level. Different needs result from variations in disease pattern, and the extent of private and non-government (NGO) sector involvement in health care provision at the community level. For example, at present, communicable diseases account for about 53% of the burden of disease, non-communicable diseases about 30%, and injuries and accidents about 17%. There is, however, some difference between the states, indicating that a health transition is underway, with an increasing incidence of non-communicable diseases, and injuries and accidents. This transition is expected to gain momentum resulting in a considerable change in the disease pattern over the next 10 to 20 years. Moreover, epidemiological indicators in all states today show that the disease pattern varies from community to community, and between rural and urban areas within states. Studies and data also show that the changing nature of the burden of disease, the role of other providers, the needs of the consumers and societal dynamics at the block, district, state and regional levels necessitate a change in health care planning strategy to address present and future needs.

**Second**, the technical efficiency of key programs is seriously limited, as service functions are duplicated, and technical paradigms have become out-of-date. The mechanism for delivering public health services faces serious problems, including overlapping functions and duplication among the various tiers of the health care system. It is expected that in the year 2020, the burden of non-communicable disease will increase to 57% of the total, and injuries to 19%, while the burden of communicable disease will decrease to 24% (based on data from Muffay and Lopez, 1996) of government's objective of funding a basic package of health services, substantially more resources for health care are required, but the overall state finances noted pose a serious problem. Second, within the health sector in most states, resource allocation in the public sector is skewed in favor of tertiary care
services relative to needs at the primary and secondary levels, particularly rural and community hospitals.

**Third**, much of the resources are absorbed by salary costs. The recurrent budget for operations and maintenance is chronically under-funded and the programs are not fully effective. The resource constraints faced in the health sector will require alternative methods of health care financing to supplement budgetary allocations. Alternative methods of financing health care, such as cost recovery, social and private insurance, and participatory schemes, are limited. Reported revenue data indicate that cost recovery in the health sector is about 3% on average in India, although there are problems in estimating the level. Some of the problems faced with cost recovery include:

(a) Lack of an appropriate mechanism within the government to review user charges  
(b) Weak administrative mechanism for collecting user fees  
(c) Difficulty in targeting the poor for exemption from user fees  
(d) Constraints to greater retention of funds generated through user charges at the point of collection.

**In Chapter VI**, deals with the evaluation of the Government Policies in the domain of managerial and institute capacity building, quality of health infrastructure, coordination, service coverage and health finance.

**Chapter VII** that is the last chapter gives the account of the observations, finding and various recommendation for the better function of the health system on the whole.

**Recommendations**

In response to the challenges faced in the health sector at the state level in India, it would be important for state governments to undertake a series of measures to increase the effectiveness of their health systems and initiate a process of reform. The following recommendations are therefore suggested:

1. **Reorient the Health Care Strategy** Integrate the Population-Size Based Approach with Need Based Approach. To enhance the effectiveness and efficiency of health care programs, states should integrate the current population-size based approach with one that would address the health care needs of the states based on
the disease pattern, and the extent of private and NGO sector involvement in health care delivery at the community level. The development of health care strategy at the state level should involve local administration in the planning process to reflect the needs at the community level. The states should provide greater input in health policy making at the national level as well.

States should develop the essential components of a health care system to provide a basic package of services to address the major health problems and the transition in disease patterns underway. The development of this package of services would take into account state level variations in the disease pattern, public expenditure considerations, the extent to which the private sector is funding some of these services, the extent to which poverty alleviation is part of the government’s strategy in the health sector, the cost-effectiveness of health interventions, and programs that have large positive externalities. The package of services would consist of communicable disease prevention and treatment; limited clinical services; essential and emergency obstetric and pediatric care within easy access of people living in rural areas; capacity building for prevention and health promotion programs to cope with non-communicable diseases and their risk reduction; prevention and treatment of injuries; and limited treatment of non-communicable diseases which is cost-effective, such as cataract operations and basic medical treatment of heart attack, stroke and pain relief.

2. Rationalize Service Norms and Update Technical Paradigms. Service norms at different level health facilities should be rationalized on the basis of demand for services and patient load to address problems of duplication in service delivery and lack of efficiency. Analysis shows that substantial cost savings would be gained if an effective referral system was developed and services could be provided at the lower levels of the health care system before patients are pushed up to a higher tier. Incentives should be provided to increase the effectiveness of the referral mechanism between the different tiers of the health system. Once service norms have been established, new yardsticks defining the sanctioned staff at health facilities of different size, infrastructure requirement, equipment, drugs and medicine and supporting services should follow. New technical paradigms also should be adopted to strengthen the effectiveness of programs and packages of services.
3. **Workforce Issues.** Create Incentives for Staff. Incentives should be enhanced to address the issue of shortage of critical medical personnel, particularly doctors, in remote and rural areas. Such incentives could include monetary as well as non-monetary benefits such as suitable accommodation, preferential school admissions for children of doctors living in remote areas, transfer to an urban area after a stipulated length of stay, and training opportunities in clinical and management skills.

4. **Provide Training.** A large pool of staff needs retraining, and the public health functions of various personnel categories should be strengthened. States should consider alternative means of engaging key technical staff on contractual arrangements. Lessons could be learned from the experience of some state governments that are successfully utilizing staff through contractual arrangements in the implementation of some national disease control and other programs.

5. **Coordinate Public and Private Sectors Roles:** The overall strategy for the health sector should take into account the existing levels of private finance and provision of services at the state level. State governments should play an active role in creating an enabling environment for greater private sector participation in the health sector and fostering public-private partnership, while ensuring that the quality of care in both the private and the public sectors improves. There are several options for the government to ensure that the private health sector continues to play a vital role in the health sector and expand the scope of its activities.

6. **Increase Private Participation.** To make more efficient use of total resources available in the health sector, state governments need to evaluate alternatives related to direct provision of services versus public financing of some activities performed in the private sector. First, state governments should facilitate the further expansion of the private sector in areas where it has a comparative advantage such as tertiary level health care, super-specialty and support services. Second, state governments should encourage the private sector to adopt appropriate therapeutic norms and regimens recommended by the national programs. Third, state governments should promote private sector participation in preventive and promotive care services by providing 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.
7. Increase Opportunities for Contracting Out. There are no legal barriers inhibiting the use of contractual services for support functions, and the Contract Labor Regulation and Abolition Act (1970), which prohibits certain institutions from contracting out perennial services, exempts hospitals and health care facilities. Private contractual services are often more efficient and effective than directly hired labor. In view of the difficulties of employing government staff, such as slow recruitment procedures and poor attendance, contracting out certain services especially support services, is an attractive alternative. The state governments should, wherever economically attractive, contract out support services such as laundry, kitchen, landscaping, dietary services, sanitation, security and mainstream diagnostic and clinical services. In addition to economic considerations, state governments should ensure that the quality of services is maintained. This will require improved management skills. Administrative procedures and guidelines, and adequate accountability functions should be in place to facilitate the contracting out of services.

8. Strengthen Linkages between Government and Non-Governmental Organizations (NGO). Government is the major provider of preventive and promotive health care services, but its coverage is limited. There should be a concerted effort by the states to involve credible NGOs in this area and provide them with opportunities to work with PRIs. Support for NGOs should be increased in areas such as social marketing of essential drugs and contraceptives, and behavior changing health education activities. The government should actively seek the cooperation of NGOs in disseminating public health messages by involving them in information, education and communication (IEC) activities. NGO participation could be promoted in the delivery of primary health care and first referral services in remote and rural areas where outreach is limited, as well as in urban slums. Contracting out the delivery of primary health care in remote areas through the NGO sector, which has a comparative advantage in improving access to such health services for some disadvantaged groups, could also be promoted.

9. Expand Capacity to Monitor and Certify. The government's capacity to register, certify and monitor private health care provision, especially the qualifications of doctors and other medical personnel and the quality of their services, should be strengthened. State governments could enact legislation and issue guidelines to
register nursing homes, private clinics/hospitals and ensure minimum standards of care. Some of these functions could be undertaken collaboratively by the central and state governments, while others could be undertaken by a professional body such as the Indian Medical Association in accordance with all-India standards.

10. Review Fiscal Structures and Develop Budgeting and Fiscal Tools. In order to simplify the complex budgeting and accounting arrangements, the state governments should, through their Ministries of Health and Family Welfare and Finance:

(a) review the fiscal structures and procedures in the health and family welfare sectors including the roles of the central, state and local government in financing the provision of basic inputs;

(b) develop program budgeting tools at the state and central levels to monitor and evaluate expenditure for important schemes; and

(c) develop fiscal tools to enable greater experimentation with resource allocation and alternative financing mechanisms, and consideration of alternatives with regard to direct provision versus financing of health care services. Provide Supplementary Finance.

The actual transfers of central resources to the states are not addressing interstate equity issues, especially for those states which are most in need. To alleviate the health care finance’ needs of poorer states, where socioeconomic and health indicators remain depressed, supplementary financing could be provided through, for example, a health resources assurance fund. Priority could be given to those states which are most in need and are taking credible steps to improve their overall finances.

11. Enhance and Prioritize State Expenditures on Health. Improve Overall State Finances. To address the overall deterioration in state finances, state governments should take credible steps such as: increase tax revenue as a share of state domestic product; increase the buoyancy of tax and non-tax revenue; and reduce overall public expenditures on subsidies, salaries, and poorly targeted welfare programs. By improving their overall financial situation, the states would be better equipped to address resource needs in the health sector. At a minimum, state
governments should maintain the share of health sector allocation in the overall budget to redress the downward trend in the share of resources evident in most states.

12. Re-evaluate Priorities within the Health Budget. The state governments should re-evaluate the priorities within the health sector budget, especially with regard to the allocation of resources between primary, secondary and tertiary levels. The primary and secondary levels of health care need additional emphasis. This could be effected through reductions in the allocation to medical education, including tertiary hospitals, and social insurance schemes such as the Employees State Insurance Scheme (ESIS) that are not appropriately targeted to the poor. The share of primary and secondary levels, which provide the basic package of public health and clinical services, should be increased within the overall envelope of state government resources for the health sector. Increase Allocations for Non-Salary Recurrent Costs. The state governments should also re-evaluate their priorities with regard to non-salary recurrent costs such as drugs, essential supplies and maintenance budgets. With some minor variation between the states, it appears that about 75% of the health budget is absorbed by staff salaries and wages. Within these overall constraints, the state governments in the next 2-3 years should allocate adequate resources for drugs, essential supplies and maintenance budgets in accordance with established norms. In addition, the health budgets of the PRIs should be enhanced in order to allow them to carry out their maintenance functions and newly provided responsibilities.

13. Implement Cost-Recovery Mechanisms. Develop an Institutional Framework for Periodic Review of User Charges. The states should set up an institutional framework to review the structure of user fees and pricing policy periodically, and recommend revisions as necessary.

14. Strengthen Collection Mechanisms and Target Vulnerable Groups for Exemptions. Analysis shows that substantial increases in revenue can be gained by concurrently strengthening the mechanism for collecting user charges and periodically revising them. State governments should increase cost recovery in the health sector from an average of about 3% to about 15-20% in the next 3-5 years. In addition, adequate targeting mechanisms to identify the poor should be implemented both in rural and urban areas. Due to the administrative costs involved, it is
preferable to strengthen the existing system for targeting the poor rather than create a new mechanism.

Retain revenues at the Point of Collection, Hospitals and health facilities should be allowed to retain all of the revenues collected. Alternatively, district health committees or health systems corporations (e.g. as in Andhra Pradesh and Punjab) could be empowered on their behalf to retain such revenues and redistribute them among hospitals within the district according to both need and level of collection.

15. Improve the Analytical Basis for Decision-Making. Cost-effectiveness analysis is an important analytical tool to aid and inform policy and decision-making in the health sector. The results have relevance for decisions regarding resource allocation for priority diseases, development of a basic package of services, rationalization of services by levels of health care institutions, and for establishing a basis for the charging of user fees. Cost-effectiveness analysis should not, however, be viewed as the only tool for decision-making. As stated in the World Development Report (1993), the most justified public measures combine a rationale for public action with a cost-effective intervention. There are several factors which need to be considered jointly in developing government resource allocation policies, including: the presence of other interventions that might affect costs; the possibility of eliminating a disease as a public health problem, such as leprosy; those diseases that have large initial costs but permanent benefits; those interventions that have positive externalities beyond health such as daily planning; those interventions that have high poverty reduction benefits; and the pattern of private health expenditures.

16. Develop Institutional Capacity for Health Sector Planning. States should strengthen their planning capacity in the health sector to:

(a) undertake analyses of their burden of disease regionally and at the community level;
(b) review the cost-effectiveness of key health interventions; and
(c) carry out other important analytical work, such as manpower planning.
(d) Developing local institutional capacity to undertake such analyses should remain an important priority.

17. Strengthen Public Sector Management of Health Care. Strengthen Overall Management Authority. Management arrangements at and below should be
strengthened to ensure that health programs are implemented effectively. States should strengthen the implementation and supervision capacity of the implementing agency. Andhra Pradesh and Punjab have established autonomous implementing agencies at the secondary level to improve management and administration, and provide financial and workforce related autonomy. Although this is not the only approach to improving the implementation and supervision capacity of the states, enhanced management authority with regard to finance, personnel matters and effective implementation should be ensured. It is possible for the state’s Department of Health and Family Welfare to perform these functions, but they should be given greater authority and flexibility with regard to finance, supervision and workforce related issues.

18. **Enhance the Capacity of PRIs.** Decentralized governance and local level participation can contribute to improving the health care system, through better monitoring and supervision of the functioning of the health system at the local level, and by assisting in developing plans which take care of local perceptions and needs. Panchayati Raj Institutions (PRIS) are one way of addressing the issue of decentralized governance. Analysis shows that, for the PRIs to be more effective, more power 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 decentralized governance would be more meaningful only when the PRIs' capacity is enhanced and their access to resources becomes more substantial. A process of consultation and coordination between the DOEFW and PRIs in each state needs to be initiated on these aspects, and clear structures and systems need to be worked out to facilitate implementation.

19. **Increase Coordination between Agencies.**
   - linkages between the three tiers of the PRI need to be strengthened to improve implementation of health programs
   - coordination between PRIs and the technical departments needs to be strengthened to improve implementation of health programs at the grassroots level
   - coordination between PRIs and state level agencies needs to be strengthened by developing a viable mechanism to facilitate the effectiveness and efficiency of program implementation.

20. **Corporate sector involvement.** The corporate sector should continue to play an
active role in building health systems to improve the delivery of health services. The corporate sector has a responsibility to serve the economically weaker sections of our society, without compromising on quality of service. Other areas of CSR include social health insurance, telemedicine, and health check up camps in remote areas, through public private partnership. CSR should form part of a long term strategy of the corporate sector. Corporate sector should provide high quality evidence based medical services at reasonable costs. If possible it should develop mechanisms of cross subsidizing the poor through earnings from well-off sections of the society; the case of Aravind Eye Hospital in providing free and subsidized services to almost 60% of its patients is worth taking note of. Using the-bottom of pyramid approach, the corporate sector can make reasonable profit by serving the needs of the poor.

21. Public Private Partnership (Multi-stakeholder partnership): Given the complex nature of health systems and the diversity of needs and expectations from a large heterogeneous population belonging to various socio-economic and cultural groups, no single agency can satisfactorily address the health needs. Hence governments, corporate sectors, NGOs and other sectors of societies have to enter into mutually beneficial partnership to serve the health needs of the poor and the lower income groups. These partnerships have to be well thought out, structured and open to independent assessment to ensure transparency and results. Such partnerships should also be explored in the areas of preventive and promotive healthcare as well as support services such as blood transfusion, ambulance, communication services, medical-social work etc.

22. Role of Academic and Research Institutions: Medical and Nursing Colleges: Medical education should include new areas of clinical practices, and respond to the rapidly changing health scenario in the country. These institutions should facilitate updating the technical knowledge of the existing medical professionals through continuing medical/ health education.
Bio-medical research organizations: These organizations would be keen to improving the medical technology in the country. They can help indigenize e global technologies and make them available at a very low cost. The initiatives taken by the pharmaceutical sector in this direction need to be followed by the manufacturers of medical equipment and devises.