CHAPTER-9
SUMMARY AND CONCLUSIONS

Besides the social desirability of improving health, the health status of the population is extremely relevant to the economic development of a country. Better health status of the population is an important index of prosperity and well-being of a country. Improving health status has become one of the paramount national objectives and the basis to sustain and stimulate optimum level of economic efficiency and development in a country. There is ample evidence to suggest that the contribution of improved health and health care services to the promotion of economic welfare and development in many developing and developed nations has been substantial. All the citizens of a nation share an interest in health care services and it is in the national interest that resources available for health care should be spent efficiently. The government must allocate scarce resources between competing uses in a manner that priority sectors are not neglected.

Mainstream economists consider that expenditure on health care and family welfare services is the most productive investment that enhance the productive capacity of workforce by promoting and maintaining human health from diseases on the one hand, and by reducing pain and sufferings from ill-health on the other. The continued escalation of health care expenditure coupled with the growth of the egalitarian bias, implying that all citizens should have an equal access to arrangements, has spurred economists and other social scientists to study health care services from different angles. It is not surprising, therefore, that the analysis of health and health care services has become a topic of widespread interest. The
significance of the present study is thus obvious.

In Punjab, studies analyzing the health sector are very much lacking. Health being one of the most important necessities of life these days, it is therefore important to have detailed information on health issues which could help the state in planning various health programmes. The study is mainly confined to Punjab state and can prove to be of great help for the policy makers.

OBJECTIVES

The objectives of the present study are to:-

(i) examine the major indicators of health like birth rate, death rate, life expectancy and infant mortality rate, etc.

(ii) analyze the trends in health care infrastructure like number of hospitals, dispensaries, primary health centres, beds etc.

(iii) examine the trends and pattern of public expenditure on health.

(iv) analyze the distribution of health expenditure (inter-sector and inter-class analysis).

(v) study the various factors that limit the ability of the health sector to improve the health of the people.

METHODOLOGY AND SAMPLING DESIGN

The study has been based on both primary as well as secondary data. The secondary data has been collected for the period 1981-2008 from various issues of Statistical Abstract of India, Statistical Abstract of Punjab, Health Information of India / National Health Profile, Report on Currency and Finance, Economic Survey and Plan Documents etc. For analysis the data has been disaggregated into three time periods i.e. 1981-1990, 1991-2000 and 2001-2008. Various mathematical and statistical tools like
percentages, growth rates and semi-logarithmic trend etc. have been used for the purpose of quantitative analysis. Graphs, pie-charts and bar diagrams have also been used for presentation of data.

Primary data has been collected for the period 2008-09. The sampling design has been generated through a comprehensive survey and a multistage stratified random sampling has been used. A sample of 200 households has been selected out of which 120 are from rural areas and 80 are from urban areas on the basis of proportion of rural-urban population of Patiala district in 2001 census. The sampling design for the rural areas consists of following three stages:

1. Selection of Development Blocks
2. Selection of Villages
3. Selection of Households

1 Selection of Development Blocks

There are eight development blocks in the Patiala district. The final ranks to Borda scores show the levels of development of these blocks in terms of ten socio-economic indicators of development. The indicators used for calculating the level of development of blocks are literacy rate, density of population, percentage of SC population to total population, percentage of workers to total population, cropping intensity, number of tractors per 1000 hectares, population served per medical institution, population served per bed, population served per bank and population served per educational institution. The blocks have been classified as developed, semi-developed and less developed blocks. On the basis of ranking, Samana, Nabha and Bhunerheri have turned out to be developed, Patiala and Ghanour as semi-developed and Sanour, Rajpura, Patran as comparatively less
developed. One development block has been randomly selected from each developed, semi-developed and less developed blocks which turn out to be Nabha, Patiala and Rajpura respectively.

2. Selection of Villages

The next step is selection of villages. In Nabha block there are 174 inhabited villages and 32824 households. Patiala block has 108 inhabited villages and 20687 households and Rajpura has 149 inhabited villages and 28234 households. Two villages have been selected from each block. The villages have been selected keeping in view their distance from the Primary Health Centre (PHC). One village is selected which is near the PHC i.e. within the radius of 5 km from the PHC and the other village is the one which lies beyond the radius of 5 km from PHC. The villages selected from Nabha are Gadaia and Durgapur; from Patiala, Kauli and Bahadurgarh; from Rajpura, Jansui and Khanpur Khurd.

3. Selection of Households

All households of the selected villages have been listed, and ultimately a proportionate random selection of households has been made to represent each stratum. In this manner, 120 households have been selected from the rural areas.

The sampling design for the urban area consists of following two stages:

1. Selection of Towns/Wards

The next concern of the study has been to select representative town from the urban areas of Patiala. From urban areas of Patiala four towns have been selected namely, Patiala, Shekhpura, Rurki Kasba, Sanour and further data has been collected from two wards of each town.
2. Selection of Households

All households of the selected municipal wards have been listed, and ultimately a proportionate random selection of households has been made to represent each stratum. In this manner, 80 households have been selected from the urban area.

The present study has been divided into nine chapters. Chapter 1 deals with the introduction, objectives, methodology and data sources used for the study. Chapter 2 provides review of literature. Chapter 3 examines the health scenario in India. Chapter 4 provides information on status of health in Punjab. Chapter 5 deals with trends in health infrastructure in Punjab. The trends and pattern of public expenditure on health in Punjab have been highlighted in Chapter 6. Chapter 7 examines the distribution of health expenditure of sampled households in Punjab (inter-sector and inter-class analysis). The problems and challenges faced by health sector in Punjab have been explained in Chapter 8. Chapter 9 summarizes the main findings of the study and provides important suggestions.

Major Findings:-

The main findings relating to health scenario in India have been presented below:-

- On comparing the selected health indicators like life expectancy, infant mortality rate, under-five mortality rate, maternal mortality rate and probability at birth of surviving to age 65 of India vis-à-vis world as well as other developing countries of the world it has been found that the average life expectancy at birth for India i.e. 63.1 years was lower than that of the world i.e. 67 years and of developing countries i.e. 64.9 years during 2000-05. The Infant Mortality Rate (IMR) in
India at 63 years (per 1000 live births) was higher than that of the world (54) as well as developing countries (60) in 2003. Mortality of children under 5 years at 87 (per 1000 live births) in India too was higher than the world average at 80. The Maternal Mortality Rate (MMR) in India at 540 (per 100000 live births) in 2000 was higher than that of other South Asian countries such as Pakistan (500), Bangladesh (380) and Sri Lanka (92). The probability at birth of surviving to age 65 in India was more for females i.e. 67.4 than that of males i.e. 59.2, but lesser than the world average of 73.1 and 64.5 respectively. Thus the performance of India’s health status vis-à-vis other countries of the world in terms of the most frequently used health indicators does not present an encouraging picture.

The vital statistics provide the base information on the health status of any region or community. Crude Birth Rate (CBR), Crude Death Rate (CDR), Infant Mortality Rate (IMR) and life expectancy at birth are the important indicators that reflect the health status and human development of any region. The data regarding these health indicators in India has been analyzed over the period 1981-2008. This period has been further disaggregated into three time periods i.e. 1981-1990, 1991-2000 and 2001-08. The Crude Birth Rate (CBR) in India declined continuously from 33.9 births per 1000 population in 1981 to 22.8 births per 1000 population in 2008 i.e. a decline of 32.74 per cent. The decline in CBR was observed to be the highest during the period 1991-2000. A declining trend has been observed in both rural and urban areas during the period 1981-2008, but still a large gap persists between them. During the first period, the percentage decline in crude birth rate was higher
in rural areas than that of urban areas while during the second period the rate of decline was higher in urban areas than that of the rural areas. During the third period again, the percentage decline in CBR was slightly higher in rural areas as compared to the urban areas.

- The Crude Death Rate (CDR) also showed a decline from 12.5 deaths per 1000 population in 1981 to 7.4 deaths per 1000 population in 2008 i.e. a decline of 40.8 per cent. The maximum decline in death rate was observed during the period 1981-90. On comparing the CDR in rural and urban areas, it has been found that though the CDR declined in both rural and urban areas but still a large difference exists between them. During the first period, the percentage decline in CDR was quite high for rural areas than the urban areas; during 1991-2000 though the rate of decline was higher in rural areas than that of the urban areas, but the gap between both the areas narrowed down than before, while during the third period this gap widened as the decline was higher in rural areas as compared to the urban areas.

- Similarly the Natural Growth Rate (NGR) declined from 21.4 in 1981 to 15.4 in 2008 i.e. a decline of 28.04 per cent. The maximum decline in NGR was observed during 1991-2000. On comparing the rate of decline in NGR in rural and urban areas, it has been found that the rate of decline in NGR of population during all the three periods i.e. first, second and third was lower in rural areas as compared to those of the urban areas.

- The Infant Mortality Rate (IMR) dropped significantly from 110 per 1000 live births in 1981 to 53 per 1000 live births in 2008 i.e. a decline of more than 50 per cent. The maximum decline in IMR was observed during the period 1981-90. During the first period, the
percentage decline in IMR was remarkable in rural areas as compared to that of the urban areas while during the second period, the rate of decline was greater in urban areas than that of rural areas. During the third period, the rate of decline in IMR was recorded to be higher in rural areas than that of the urban areas. The IMR in rural areas accounted to be higher than that of urban areas throughout the study period depicting marked rural-urban differences.

- The life expectancy at birth in India underwent a significant change from 55.4 years during 1981-85 to 63.4 years during 2002-06, registering an increase of 8 years. During the corresponding period the life expectancy increased by 8.5 years for females and 7.2 years for males. Besides, it has been observed that female life expectancy has remained higher than male life expectancy throughout the study period.

- Further it has been observed that the trio of crude birth rate, crude death rate and infant mortality rate have remained higher in rural areas as compared to that of the urban areas throughout the study period. This is due to inadequate health facilities, illiteracy and poverty etc. in rural areas. Despite policy commitments to provide equal access to health care provision in rural as well as urban areas, marked rural-urban differences remain unchanged due to lack of implementation of these policies.

- A large number of factors like increasing incomes, increasing literacy, awareness and use of birth control, general improvement in medical assistance, increase in number of hospitals, doctors, nurses, discovery of wonder medicines to control epidemics like cholera, tuberculosis, small pox etc. and spread of immunization programmes have helped
to bring down crude birth rate, crude death rate, infant mortality rate and rise in life expectancy in India.

- The number of hospitals increased nearly 2.5 times during 1981-2001, but then reduced in 2002 due to exclusion of CHCs and non-reporting. The figures showed a further decline in 2006 because these included only allopathic hospitals. The number of hospitals showed an increase of 1.70 times during 1981-90 and it increased by 1.57 times during 1991-2000. The number of hospitals per 1 million population increased from 10 to 17 during 1981-2001. The number of dispensaries went up 1.33 times during 1981-2002. The number of dispensaries showed a significant rise during 1981-90, while it declined during 1991-2000. The number of dispensaries per 1 million population rather declined from 25 to 22 during 1981-2002. The number of beds increased 1.61 times during 1981-2002, but later reduced in 2006. The number of beds increased by 1.42 times during 1981-90, while it rose by 1.13 times during 1991-2000. The number of beds per 1 lakh population increased from 83 to 92 during 1981-2002.

- The number of AYUSH institutions spiralled up from 15823 to 25074 during 1981-2009, indicating a growth rate of 1.60 per cent per annum. During the period 1981-2009, the maximum growth has been observed in the number of homeopathic institutions (3.35 per cent) followed by siddha (2.66 per cent), ayurvedic (1.20 per cent) and unani (0.97 per cent) institutions. It has also been revealed that during 1981-90 the maximum growth rate was recorded for homeopathic institutions (17.03 per cent) while during 1991-2000 and 2001-09
The maximum growth was recorded for siddha institutions i.e. 4.28 per cent and 4.59 per cent respectively.

- The number of sub-centres increased by 4.34 times from fourth plan to tenth plan. The number of PHCs increased by 30.85 times since the first five year plan. In accordance with the progress in the number of SCs and PHCs, the number of CHCs have also shown an upward trend and the number of CHCs increased by 18.90 times since the fifth five year plan. Although public health care facilities in terms of SCs, PHCs and CHCs have been expanding fairly rapidly across India still they are in shortage.

- The number of medical practitioners zoomed up from 268700 to 757400 during 1981-2009, showing a growth rate of 3.87 per cent per annum. The medical practitioners per 100000 population climbed up from 39.32 to 65.06 during 1981-2009, depicting a growth rate of 1.88 per cent per annum. The maximum growth rate in number of medical practitioners and medical practitioners per 100000 population has been observed during the period 1981-90.

- The number of Auxiliary Nurse Midwives (ANM) showed maximum compound annual growth rate of 8.69 per cent followed by the number of health visitors (6.83 per cent) and nurses and midwives (5.32 per cent) during the period 1981-2008. It has also been observed that there has been a consistent increase in the number of registered nursing personnel except during the first period for the number of nurses and midwives where a decline was registered in their number. Besides it has been observed that the growth has been slower in case of nurses and midwives and health visitors as compared to the growth of ANMs during the study period.
The total number of registered practitioners under AYUSH in India increased at a compound annual growth rate of 2.64 per cent during 1981-2009. The maximum growth rate has been witnessed during the period 1981-90. During the study period, maximum growth has been observed in the number of homeopathic practitioners (2.83 per cent) followed by ayurvedic practitioners (2.73 per cent) and unani practitioners (2.21 per cent) while the number of siddha practitioners declined showing a negative growth rate (-0.67 per cent). During the first period, maximum growth was witnessed in ayurvedic practitioners while during the second and third period maximum growth was noticed in homeopathic practitioners.

The data regarding pattern of central allocation on health, family welfare and AYUSH in India reveals that during the first plan period total investment on all heads of development was Rs. 1960 Cr which increased to Rs. 1484131.3 Cr during tenth plan. Total investment on health in absolute terms increased tremendously from 65.3 Cr to 58920.3 Cr during first plan to tenth plan but as a percentage of total plan investment outlay increased marginally from 3.4 per cent to 3.97 per cent. Investment on health during first plan was 3.3 per cent of total plan investment and it showed a consistent decline thereafter during all the subsequent plans and it settled at 2.09 per cent during the tenth plan, while the investment on family welfare as a percentage of total plan investment increased from 0.01 per cent during the first plan to 1.83 per cent during the tenth plan. It indicates that health has been given lesser importance as compared to family welfare in central allocation. An amount of Rs. 136147 (6.31 per cent) during eleventh plan indicates investment on both health and family welfare, as
department of health and family welfare merged from 2005. This amount also includes Rs. 4496.08 Cr for newly created health research department created during 2008-09. Investment on AYUSH increased from Rs. 108 Cr during eighth plan to Rs. 3988 Cr during eleventh plan and its percentage to total plan investment rose from 0.02 per cent to 0.18 per cent.

- In India, public spending on health as a percentage of Gross Domestic Product (GDP) gradually accelerated from 0.22 per cent in 1950-51 to 1.05 per cent during the mid-1980s, and stagnated at around 0.9 per cent during the later years. It has also been observed that health expenditure as a percentage of GDP on revenue account has always been greater as compared to that of capital account. In terms of per capita expenditure, it increased significantly from less than Re.1 in 1950-51 to about Rs. 215 in 2003-04 and a greater improvement has been observed mainly after mid 1990s.

- The aggregate spending on health services as a ratio of Gross State Domestic Product (GSDP) has been extremely low and has been declining over the time. The aggregate spending on health services relative to GSDP showed a marginal increase from 1.23 per cent in 1995-96 to 1.37 per cent in 2000-01 mainly due to the pay revision in the states in 1998-99 and declined thereafter to 1.18 per cent in 2004-05. Also, there are inter-state inequalities in per capita spending on health services and these have shown a steady increase over the years. During 1995-96 the per capita health expenditure was lowest in Uttar Pradesh (Rs. 87.88) and highest in Rajasthan (Rs. 250.01), showing a difference of about three times. During 2004-05, the per capita health expenditure varied from Rs. 100 in Bihar to Rs. 448 in
Tamil Nadu, thus showing a difference of four and a half times between the lowest and highest expenditure. It indicates an increase in inter-state inequalities. On observing the position of Punjab it has been revealed that during 1995-96 state incurring highest health expenditure (Rajasthan) incurred about 1.5 times more health expenditure than Punjab, while during 2004-05 state incurring highest health expenditure (Tamil Nadu) incurred 1.2 times more health expenditure than Punjab. The coefficient of variation in per capita health expenditure incurred by states increased steadily from 0.31 in 1995 to 0.38 in 2004-05, which indicates a steady increase in inter-state inequalities.

- Since 1995-96, household expenditure on health has been growing at the rate of approximately 14 per cent overall. The maximum expenditure has been found to be incurred on outpatient care, while the minimum expenditure has been incurred on contraceptives. It has been noticed that except the category of child birth, all other categories registered a growth rate in double digits indicating a fairly good growth rate. The growth in inpatient expenditure was highest i.e. in the range of 16-18 per cent during 1995-96 to 2003-04.

- The role of the households in health care spending has increased substantially. The data pertaining to the health care spending in major states for the year 2004-05 depicted that households undertook nearly three-fourths of all the health spending in the country. Public spending was only 22 per cent and all other sources accounted for less than 5 per cent. It has also been revealed that both the per capita spending and the share of households varied across states. Many of the states undertook more than 75 per cent of all health spending
indicating an exceptionally high burden upon them.

The main findings relating to health in Punjab have been presented below:-

The government of Punjab is committed to enhance the health status of its population with strong focus on improving health outcomes especially among women, children and vulnerable populations. A brief information on progress of health status in Punjab has been given below.

- The birth rate in Punjab declined from 30.3 births per 1000 population in 1981 to 17.3 in 2008 i.e. a decline of 42.90 per cent. The decline was observed to be maximum during the period 1991-2000. Further, area-wise analysis depicts a declining trend in both rural and urban areas during the period 1981-2008. The percentage decline in birth rate during the first and second period was higher in the urban areas (i.e. 10.18 per cent and 27.73 per cent respectively) as compared to those of rural areas (i.e. 7.79 per cent and 20.70 per cent respectively), but during the third period, the rural areas showed a greater decline (18.55 per cent) as compared to that of urban areas (13.90 per cent).

- The death rate of Punjab declined from 9.4 to 7.2 during 1981-2008 i.e. a decline of 23.40 per cent. Death rate showed maximum decline during 1981-90, while during the third period death rate has rather shown an increase from 2005 onwards mainly due to diseases like cancer, heart diseases and other life style diseases. On comparing the percentage decline in death rate in rural and urban areas, it has been observed that during the first period, the death rate declined sharply in urban areas (18.31 per cent) as compared to that of rural areas (15 per cent). During the second period, it reduced by 8.24 per cent in rural areas while in urban areas a lot of fluctuations have been observed.
During the third period, instead of declining, death rate went up. The figures of rural areas reveal that death rate reduced from 7.2 to 6.9 during 2001-04 but later increased from 7.2 to 8.0 during 2005-08. In the urban areas, death rate declined from 6.4 to 5.6 during 2001-04 but increased from 5.8 to 6.0 during 2005-08. This recent rise in death rate in Punjab, in spite of advanced medical facilities is really worrisome.

- The natural growth rate of population in Punjab declined from 20.9 in 1981 to 10.1 in 2008 i.e. a decline of 51.67 per cent. The maximum decline in NGR was observed during 1991-2000. During first and second period, the percentage decline in natural growth rate of population was lower in rural areas of Punjab (i.e. 4.33 per cent and 26 per cent respectively) as compared to those of the urban areas (i.e. 7.48 per cent and 36.18 per cent respectively), while during the third period, the percentage decline in natural growth rate of population was lower in the urban areas (17.88 per cent) as compared to that of the rural areas (32.89 per cent).

- During 1981-2008, Infant Mortality Rate (IMR) dropped from 81 per 1000 live births to 41 per 1000 live births (40.38 per cent), thus showing a significant decline. The maximum decline has been observed during the period 1981-90. The infant mortality rate reduced in both rural and urban areas during the study period but there is a clear difference between urban and rural infant mortality rate. The percentage decline in infant mortality rate during the first period was quite high in rural areas (25 per cent) as compared to that of urban areas (11.76 per cent), while during the second period, the percentage decline in urban areas was higher (5 per cent) as compared to that of
the rural areas (3.45 per cent). During the third period, the percentage decline in infant mortality rate was higher in rural areas (18.18 per cent) as compared to that of the urban areas (10.81 per cent). It has also been observed that the infant mortality rate has remained higher throughout the study period in rural areas than that of the urban areas. Infact, lack of rural bias is one of the reasons why Punjab has had a much slower decline in infant mortality.

- The total life expectancy at birth in Punjab increased from 63.1 years in 1981-85 to 70.2 years in 2006-10, registering an increase of more than 7 years. During the corresponding period, expectation of life in Punjab increased by 8 years for females and 6.1 years for males. The life expectancy of females has always remained higher as compared to males during the study period.

- As a result of socio-economic development and family planning intervention Punjab has undergone substantial transformation in its fertility profile. During 1981-2008, the fertility rate declined from 4.0 to 1.9 i.e. a decline of 52.50 per cent. The decline was observed to be highest during the period 1991-2000. Rural-urban variations have been observed in fertility rates too. Rural areas have shown higher fertility rates as compared to that of urban areas for all the years. During the first period, the rate of decline in fertility was found to be higher in rural areas (17.07 per cent) as compared to that of urban areas (14.71 per cent), while during the second period, the percentage decline in fertility was higher in urban areas (25 per cent) as compared to that of rural areas (18.75 per cent). During the third period, the percentage decline in fertility was higher in rural areas (20 per cent) as compared to that of the urban areas (14.29 per cent).
The achievements in immunization in case of expectant mothers increased tremendously witnessing a growth rate of 33.35 per cent during 1981-2009. The growth rate was observed to be highest (9.93 per cent) during the period 1981-90. In case of infants, the achievements in immunization increased with overall growth rate of 1.25 per cent during 1981-2009. The growth rate was observed to be maximum (4.06 per cent) during the period 1981-90. The achievements in immunization in case of children showed a growth rate of 2.33 per cent during 1981-2009. The growth rate in this case too was found to be maximum (6.66 per cent) during the period 1981-90.

The achievement in prophylaxes against nutritional anaemia in case of children showed a tremendous increase during the initial years but dropped consistently after 2004-05 during the study period. However, the maximum progress (4.45 per cent) was observed during the period 1981-90. The achievements in prophylaxes for expectant mothers also declined during 1981-82 to 2008-09. The growth rate was observed to be maximum (4.81 per cent) during the period 1981-90. Thus it can be concluded that during the recent years i.e. during 2006-09, the achievement rates of prophylaxes have been very low for both children and expectant mothers.

Major findings regarding health infrastructure in Punjab are as follows:-

The public medical institutions are owned by state or local governments or by voluntary organizations. During 1981-2008, the total number of medical institutions increased from 1868 to 2228 showing a growth rate of 0.21 per cent per annum. During this period the number of medical institutions owned by state government
increased from 1772 to 2154 showing a growth rate of 0.33 per cent per annum. Contrary to above, the medical institutions owned by local government showed a decline depicting a negative growth rate i.e. -2.93 per cent per annum and the medical institutions owned by voluntary organizations showed only a meagre increase from 47 to 50 (0.11 per cent per annum) over this period of time. It has also been observed that during all these years the proportion of state owned medical institutions have remained to be maximum as compared to those owned by local government and voluntary organizations. On observing the medical institutions area-wise it has been revealed that the number of medical institutions increased in both rural and urban areas. During 1981-08, their number increased from 1509 to 1764 (0.10 per cent per annum) in rural areas and in urban areas their number rose from 359 to 464 (0.99 per cent per annum). This shows that the growth rate has been higher in urban areas as compared to rural areas.

On observing the medical institutions by type of institutions it has been found that during 1981-2008, the rural areas witnessed a decline in the number of hospitals and dispensaries showing a negative growth rate of -2.10 per cent per annum and -0.92 per cent per annum respectively. The urban areas also depicted a negative growth rate in number of hospitals (-0.46 per cent per annum) while the number of dispensaries increased showing a growth rate of 0.81 per cent per annum. The number of PHCs increased in both rural and urban areas. The number of PHCs in rural areas showed a higher growth rate (5.58 per cent per annum) as compared to urban areas (1.08 per cent per annum). It has also been observed that in rural areas, there have
been maximum number of dispensaries followed by PHCs, hospitals and other medical institutions, while in urban areas there have been maximum number of dispensaries followed by hospitals, PHCs and other medical institutions.

- During 1981-2008, the total number of ayurvedic, homeopathic and unani institutions increased from 521 to 636 showing a growth rate of 0.60 per cent per annum. The maximum growth rate has been observed for homeopathic institutions (3.80 per cent per annum) followed by ayurvedic institutions (0.22 per cent per annum), while unani institutions showed a negative growth rate i.e. -0.16 per cent. The maximum growth rate for homeopathic and ayurvedic institutions has been observed during the period 1981-90.

- During 1981-2008, the total number of beds in medical institutions increased from 20569 to 25489 showing a growth rate of 0.67 per cent. The beds in urban areas grew at a higher rate i.e. 0.88 per cent per annum as compared to that of the rural areas (0.39 per cent per annum) during the corresponding period. The maximum growth in the number of beds has been recorded during the first period in case of both rural and urban areas. During 1981-1990, the increase in number of beds in medical institutions was found to be higher in rural areas (1.74 per cent per annum) as compared to that of the urban areas (1.69 per cent per annum). But during 1991-2000, the increase was higher in urban areas (0.81 per cent per annum) as compared to rural areas (0.03 per cent per annum). During 2001-2008, it has been observed that the number of beds in rural areas declined (-0.14 per cent per annum) while their number slightly increased in urban areas (0.22 per cent per annum). The maximum growth rate has
been observed for beds in PHCs (4.28 per cent).

During 1981-2008, the population served per medical institution increased from 8997 to 12335 and the population served per bed increased from 817 to 1078. In spite of investment in health care infrastructure in Punjab, the people of Punjab have not been able to derive fruitful benefit from it. The information regarding the average radius served per institution reveals somehow improvement over this period of time, as it has been observed that the average radius served per institution reduced from 2.929 in 1981 to 2.683 in 2008.

On observing the growth in registered health manpower in Punjab it has been found that during 1981-2008, highest growth has been witnessed in the number of nurses (7.45 times) followed by that of midwives (6.58 times), dais (2.71 times) and doctors (2.41 times). This fast increase in the number of medical and para-medical personnel had a favourable impact on the ratio of population served per person in Punjab. It is observed that during this period, population served per doctor declined from 1806 to 1225; per midwife it dropped from 3635 to 903; per nurse it reduced from 3567 to 780 and per dai it moved down from 959 to 578, thereby indicating that the rate of increase in population has been less than the rate of increase in medical and para-medical personnel.

During 1981-2008, the number of indoor patients increased from 416009 to 510472, showing an increase of 22.71 per cent, while the number of outdoor patients decreased from 14908369 to 13757716, showing a decline of 7.72 per cent. Throughout the period, the number of outdoor patients has been greater than the number of indoor patients. It is also interesting to observe that in case of indoor patients,
over all these years there has always been a greater proportion of females availing indoor health services (except for the years 1997, 1998 and 2001), thereby showing that females have been more prone to such illnesses that they had to avail indoor health services. While on comparing the number of males and females getting outpatient treatment it has been found that from the period 1981 to 1992 (except for the year 1987) there was a higher proportion of males getting outpatient treatment while the trend has reversed since 1993 and there has been a higher proportion of females than males getting outpatient treatment (except for the year 2001), which thereby shows that the health conditions of males as compared to that of females has improved since 1993. Thus, it can be concluded that the morbidity incidence has been higher in the case of females as compared to that of males as there has been a greater proportion of females than males getting indoor and outdoor health services.

An analysis of inter-district variations highlights that there were large disparities in availability of medical institutions, beds, population served per bed, population served per medical and para-medical personnel, average radius served per institution in Punjab in 1981, and in 2008 also these disparities continue to persist. Regarding the availability of medical institutions and beds in those institutions, Ludhiana, Jalandhar, Patiala, Gurdaspur, Amritsar have always been given high priority, whereas Kapurthala, Rupnagar and newly created districts lagged far behind the other districts. The population served per institution was much higher in Firozpur, Amritsar, Gurdaspur, Sangrur and quite less in Kapurthala and Rupnagar in 1981, while in 2008, the population served per institution was found to be higher in
Ludhiana, Faridkot, Amritsar, Firozpur and minimum in SBS Nagar followed by Barnala, Hoshiarpur and Kapurthala. In 1981, the population served per bed was found to be quite high in Sangrur, Gurdaspur, Faridkot and Bathinda and minimum in Amritsar, Patiala and Ludhiana, while in 2008, the districts of SAS Nagar, Sangrur and Muktsar had a comparatively higher population served per bed and Amritsar, Faridkot and Patiala had relatively lesser population served per bed. Inter-district variations have also been found in average radius served per institution, number of medical and para-medical personnel in Punjab. The newly created districts namely Barnala, Fatehgarh Sahib, Mansa, Moga, Muktsar, SAS Nagar, SBS Nagar, TarnTaran lag far behind the other districts in health infrastructure.

Major findings relating to public expenditure on health in Punjab are as follows:-

- Total receipts on revenue account increased from Rs. 682.61 Cr in 1981-82 to Rs. 26072.34 Cr in 2009-10, with overall growth rate of 14 per cent per annum. The total receipts on revenue account showed maximum growth during the third period and minimum growth during the second period. On the other hand, total expenditure on revenue account in Punjab increased from Rs. 619.95 Cr in 1981-82 to Rs. 30306.26 Cr in 2009-10, with overall growth rate of 15.10 per cent per annum. The growth rate of expenditure has declined over the study period. It was maximum during the first period and minimum during the third period. The state witnessed surplus on revenue account up to the period 1986-87 (except during the year 1984-85) and then showed a continuous deficit after 1987-88.

- The various heads of expenditure under revenue account are general
services, social services, economic services and grants-in-aid. Health is a very important component of social services. It has been observed that during 1981-82, maximum expenditure was incurred on social services followed by economic services, general services and grants-in-aid, while during 1991-92, maximum expenditure was incurred on economic services followed by general services, social services and grants-in-aid and during the period 2001-02 and during 2009-10, maximum expenditure was incurred on general services followed by social services, economic services and grants-in-aid. Thus, there has been a shift in trend from maximum public expenditure on social services in 1981-82 to economic services in 1991-92 and to general services in 2001-02 and 2009-10. The relative share of expenditure on general services and grants-in-aid have increased over the study period while the share of social and economic services have declined.

On observing the compound annual growth rates of various components of revenue account it has been revealed that during 1981-82 to 2009-2010, maximum growth has been witnessed by grants-in-aid (21.61 per cent per annum) followed by general services (18.50 per cent per annum), economic services (12.90 per cent per annum) and social services (11.90 per cent per annum). During the period 1981-82 to 1990-91, maximum growth rate was observed for grants-in-aid (33.75 per cent per annum), followed by social services (17.74 per cent per annum), economic services (16.33 per cent per annum) and general services (16.10 per cent per annum). During 1991-92 to 2000-01, maximum growth rate was observed for general services (20.35 per cent per annum) followed by social services (14.82 per cent per annum), grants-in-aid (9.35 per cent per annum)
and economic services (5.64 per cent per annum). During 2001-02 to 2009-10, maximum growth rate was observed for grants-in-aid (31.52 per cent per annum) followed by economic services (14.80 per cent per annum), social services (10.60 per cent per annum) and general services (6.40 per cent per annum).

- The total receipts on capital account climbed up from Rs. 103.02 Cr to Rs. 7872.07 Cr during 1981-82 to 2009-10. The total expenditure on capital account increased from Rs. 114.84 Cr to Rs. 3593.27 Cr during 1981-82 to 2009-10. Surplus on capital account increased from Rs. 0.31 Cr in 1983-84 to Rs. 4340.27 Cr in 2001-02, but it decreased to Rs. 1030.91 Cr in 2005-06 and later increased to Rs. 4278.80 Cr in 2009-10.

- During 1981-82 to 2009-10, capital account expenditure on general services went up from Rs. 2.41 Cr to Rs. 244.24 Cr and capital account expenditure on social services increased from Rs. 15.51 Cr to Rs. 1670.50 Cr. During the corresponding period, expenditure on economic services increased from Rs. 27.77 Cr to Rs. 1635.41 Cr and expenditure on loans and advances went up from Rs. 69.15 Cr in 1981-82 to Rs. 444.16 Cr in 2006-07, but later declined to Rs. 43.12 Cr in 2009-10.

- The share of development expenditure in total expenditure was 69.78 per cent in 1981-82 which was more than share of non-development expenditure i.e. 30.22 per cent. Further up to 1993-94, the share of development expenditure in total expenditure was more as compared to the share of non-development expenditure. After 1993-94, the share of non-development expenditure increased as compared to development expenditure (except two years 1996-97 and 1997-98).
Moreover, the rate of growth in non-development expenditure (18.60 per cent per annum) was found to be higher than that of development expenditure (12.40 per cent per annum) during the study period.

- It has been found that the expenditure on social services has always been given a high priority as compared to that of economic services (except during the years 1991-92, 1996-97, 2004-05, 2005-06 and 2007-08). Amongst the social services, the highest priority has been given to education, arts and sports. The next priority has been given to health and family welfare. Apart from it, in the case of economic services, expenditure on transport & communication and agriculture & allied activities assumed the top priority from the period 1981-82 to 1995-96. But later energy sector assumed the highest priority leaving transport & communication and agriculture & allied activities far behind.

- Among the constituents of social services, expenditure on education assumed topmost priority followed by health and family welfare during all three decades, while minimum share of expenditure was spent on other social services.

- The per capita expenditure on social services in Punjab increased nearly 17 times during 1981-2010. Throughout the study period, the per capita expenditure on education was maximum followed by health and family welfare, with an exception of only two years (2008-09 and 2009-10) during which per capita expenditure on social welfare & nutrition was more than that of health and family welfare.

- The expenditure on medical and family welfare increased in absolute terms from 56.46 Cr in 1981-82 to 985.25 Cr in 2009-10 (11.10 per cent per annum). The percentage share of health and family
welfare as a percentage of Net State Domestic Product (NSDP) has remained very low (less than 1 per cent) for most of the years. It showed a decelerated growth of expenditure on health and family welfare over the time period.

- On observing the planned expenditure on health care and family welfare in Punjab during different plan periods, it has been found that a very high proportion of total health sector’s planned expenditure has been incurred on a single programme i.e., the family welfare programme. Besides, another priority programme has been control/eradication of communicable diseases but during ninth and tenth five year plans its share declined considerably because of significance given to establishment of hospitals, dispensaries etc., owing to the rural health component of Minimum Needs Programme (MNP).

- The central government spent more funds both absolutely and relatively compared to the funds made available by the state government till the Eighth Plan period (except during the Sixth Plan) while the state’s share as compared to the centre’s share increased only during Ninth and Tenth Plan. The share of the union government in Punjab’s health sector plan has been quite high. Both the family welfare and control of communicable diseases received more allocation of central funds because of the policy of the central government to promote these programmes while the share of the state government for “other programmes” has been quite large.
Major findings relating to distribution of health expenditure of sampled households in Punjab i.e. inter-sector and inter-class analysis have been given below:

- The average size of the family in rural areas (5.08) turned out to be more than that of urban areas (4.38). Further on an average, the number of males (2.53) was more than the number of females (2.27) among the sampled households. It was observed that on an average the number of males in both rural (2.71) and urban (2.25) areas was more as compared to that of females in rural (2.37) and urban areas (2.13). Further it was found that on an average the number of dependents was more than the number of earners and hence the dependency ratio turned out to be 64.24. The number of dependents was found to be more in the rural areas as compared to that of the urban areas. Therefore, the dependency ratio was observed to be higher in the rural areas (67.72) than in the urban areas (58.45).

- Out of the total sampled households, 101 households (50.50 per cent) had family size up to only 4 persons, followed by 92 households (46 per cent) which had family size of 5 to 8 persons and a very small number of households (i.e. 7 households) had family size of more than 8 persons. On comparing the family size in rural and urban areas it was observed that 45 per cent of households in rural areas and 58.75 per cent of households in urban areas had family size up to 4 persons, 49.17 per cent households in rural and 41.25 per cent households in urban areas had family size between 5 to 8 persons, and a very small proportion of households in rural areas i.e. 5.83 per cent had family size of more than 8 persons, while there was no household with family size of more than 8 persons in urban areas.
Out of the total sampled households there were 77 households (38.50 per cent) whose heads studied below matric, followed by 52 households (26 per cent) whose heads studied up to matric and 39 households (19.50 per cent) whose heads had education up to graduation. There was an equal number of households i.e. 16 each (8 per cent each) whose heads were undergraduates and postgraduates. On comparing the level of education of heads of sampled households in rural and urban areas considerable variations were found. In rural areas, the household heads who had education level below matric (44.17 per cent), up to matric (32.50 per cent) and under graduation (10 per cent) were quite high than those of the urban areas i.e. 30 per cent, 16.25 per cent and 5 per cent respectively, while in the urban areas, a higher proportion of heads had education level up to graduation (36.25 per cent) and post graduation (12.50 per cent) as compared to rural areas where only 8.33 per cent of graduates and 5 per cent of postgraduates were found. This revealed that sampled households of the urban areas had a better position than the rural areas with respect to the educational level.

The distribution of sampled households according to average annual income earned clearly revealed that the main source of income was the income from non-agricultural activities i.e. 70.30 per cent of total income has been generated from non-agricultural activities and rest of income i.e. 29.70 per cent of total income has been generated from agricultural and allied activities. It has been observed that the average annual income in urban areas was more than that of the rural areas. It was further revealed that in rural areas, 55.08 per cent of income was earned from agricultural and allied activities and 44.92 per cent of
income was earned from non-agricultural activities. In the urban areas, a substantial percentage (92.30 per cent) of income was generated from non-agricultural activities while only a meagre proportion i.e. 7.70 per cent of income was earned from the agricultural and allied activities.

The distribution of sampled households according to their level of income showed that maximum number of sampled households belonged to low income category i.e. 86 (43 per cent) followed by middle income category i.e.72 (36 per cent) and 42 (21 per cent) in high income category. The proportion of households belonging to low and middle income category have been found to be higher in rural areas (47.50 per cent and 39.17 per cent respectively) than that of the urban areas (36.25 per cent and 31.25 per cent respectively), while the proportion of high income category was found to be greater in the urban areas (32.50 per cent) as compared to the rural areas (13.33 per cent).

The distribution of the consumption pattern of the sampled households revealed that in rural and urban areas, non-durable consumption expenditure accounted for the major proportion of the total consumption expenditure (64.07 per cent), followed by the expenditure on services (20.16 per cent), durable commodities (10.84 per cent) and marriages & other social ceremonies (4.93 per cent). It has been observed that urban areas (21.52 per cent) spent more on services as compared to the rural areas (18.53 per cent). Further on observing the consumption expenditure on services it has been revealed that health care (7.50 per cent) accounted for the largest proportion of consumption expenditure followed by education
(4.71 per cent), conveyance (3.32 per cent), rent (2.50 per cent) and entertainment (0.50 per cent) in rural areas, while in urban areas education (6.92 per cent) accounted for the largest share followed by health care (5.60 per cent), conveyance (4.90 per cent), rent (2.80 per cent) and entertainment (1.30 per cent).

➢ On comparing the type of health facility availed for the treatment of minor illness in rural and urban areas, it has been found that a higher proportion of households in the urban areas got treatment from private clinic (41.25 per cent), dispensary (22.50 per cent), private clinic and vaid/hakim/homeopath (17.50 per cent) and from private clinic and vaid/hakim/homeopath and drugstore (11.25 per cent) as compared to the rural areas i.e. 25 per cent, 18.33 per cent, 7.50 per cent and 3.33 per cent respectively. The proportion of households opting for private clinic and drugstore has been found to be higher in rural areas (16.67 per cent) than that of the urban areas (7.50 per cent).

➢ The distribution of sampled households according to the reason for choice of a particular health facility for treatment of minor illness revealed that ‘geographic accessibility’ and ‘good quality of services /tried treatment’ dominated in determining the choice of a health facility in both rural and urban areas. In rural areas, a higher proportion of households were motivated by moderate cost (20.83 per cent), no need to wait for long (9.17 per cent), and personal attention (5 per cent) as compared to the urban areas i.e. 8 per cent, 5 per cent, 3 per cent respectively. The 16 per cent of households in urban areas and 10 per cent of households in rural areas told in the survey that acquaintance with doctor was the main reason of their choice.
The households availing only allopathic system of medicine for treatment of minor illness have been found to be more in rural areas (83.33 per cent) as compared to the urban areas (71.25 per cent) while the households availing both homeopathic and allopathic, and both ayurvedic and allopathic system of medicine have been found to be more in the urban areas (22.50 per cent and 6.25 per cent respectively) as compared to the rural areas (11.67 per cent and 5 per cent respectively).

The distribution of average annual health expenditure incurred by the sampled households on treatment of minor illness revealed that households of urban areas spent 1.37 times more than that of households of rural areas on treatment of minor illness. The households of urban areas spent a higher proportion of health expenditure on medicines and injections (62.28 per cent), consultation/doctor’s fee (18.70 per cent), laboratory tests (8.14 per cent) and miscellaneous expenditure (8.01 per cent) as compared to the households of rural areas i.e. 56.95 per cent, 14.53 per cent, 6.69 per cent, 4.63 per cent respectively. The households of rural areas spent a substantial proportion (17.20 per cent) on transportation as the households of rural areas had to visit the health centres in urban areas, owing to inadequate health services in rural areas, while the households of urban areas spent only a meagre proportion (2.87 per cent) on transportation as they had an easy accessibility to health centres.

The most important source of finance used by the sampled households in both rural and urban areas for treatment of minor illness was the current income. The proportion of households that were eligible for
medical reimbursement for treatment of minor illness was found to be higher in urban areas (11.25 per cent) as compared to the rural areas (5 per cent).

There were some households which encountered either physical disability or chronic disease or any other major illness. Also there were some households which encountered more than just one type of major illness. On comparing the rural and urban areas it has been found that the rural areas had a greater proportion of households encountering physical disability (3.33 per cent), any other major illness (20 per cent), both physical disability and any other major illness (1.67 per cent), and all physical disability, chronic disease and any other major illness (2.50 per cent) as compared to the urban areas i.e. 2.50 per cent, 11.25 per cent, 1.25 per cent, 1.25 per cent respectively. It was further observed that rural areas had a relatively lower proportion of households encountering illness like chronic disease (36.67 per cent), physical disability and chronic disease (3.33 per cent) and chronic disease and any other major illness (12.50 per cent) as compared to the urban areas i.e. 40 per cent, 3.75 per cent and 20 per cent respectively. The proportion of households not suffering from any kind of physical disability, chronic disease or any other major illness was found to be same in both rural and urban areas (20 per cent each).

On comparing the type of health facility availed for the treatment of major illness in rural and urban areas it has been found that in the rural areas the proportion of households opting for public hospital (15 per cent), private clinic (10 per cent), private hospital and private clinic (15 per cent), private clinic and drugstore (7.50 per cent) was
higher as compared to the urban areas i.e. 11.25 per cent, 5 per cent, 12.50 per cent and 6.25 per cent respectively, while there was a higher proportion of households in the urban areas who got treatment from private hospital (30 per cent) and from private hospital and private clinic and drugstore (15 per cent) as compared to the rural areas (27.50 per cent and 5 per cent respectively).

- On observing the reason for choice of a particular health facility for treatment of major illness it has been found that ‘geographic accessibility’ and ‘good quality of service /tried treatment’ dominated in determining the choice of a health facility in both rural and urban areas.

- The distribution of sampled households according to system of medicine availed for treatment of major illness revealed that the households availing only an allopathic treatment and availing both the homeopathic and an allopathic treatment were found to be more in urban areas (75 per cent and 2.50 per cent respectively) as compared to rural areas (73.33 per cent and 1.67 per cent respectively), while the households opting for both ayurvedic and allopathic treatment were found to be higher in the rural areas (5 per cent) as compared to the urban areas (2.50 per cent).

- The distribution of average annual health expenditure incurred by the sampled households on treatment of major illness in rural as well as urban areas, revealed that the households of rural areas spent a higher proportion of health expenditure on consultation/ doctor’s fee (8.80 per cent), medicines and injections (36.70 per cent), transportation (10.79 per cent) and miscellaneous expenditure (5.48 per cent) as compared to the households of urban areas.
i.e. 6.69 per cent, 33.13 per cent, 6.21 per cent and 3.78 per cent respectively. Further it has been observed that the urban areas spent a higher proportion of health expenditure on surgery (14.92 per cent), hospitalization (21.82 per cent), laboratory tests/ X-ray etc. (13.45 per cent) as compared to the rural areas (11.22 per cent, 16.97 per cent and 10.04 per cent respectively).

The source of finance used by the sampled households for treatment of major illness in rural and urban areas depicted that a greater proportion of households in rural areas used current income alone (23.33 per cent), current income and borrowings (5 per cent) and those who used their savings, sold ornaments and made borrowings (10 per cent) as compared to the urban areas i.e. 15 per cent, 3.75 per cent and 2.50 per cent respectively. The table also revealed that in urban areas 23.75 per cent of households met their health expenditure through both current income and savings, 18.75 per cent used current income, savings and borrowings, 11.25 per cent used current income and employer and other agencies and 5 per cent used savings and borrowings, while the corresponding figures were lower for rural areas i.e. 17.50 per cent, 11.67 per cent, 8.33 per cent and 4.17 per cent.

The distribution of sampled households according to their eligibility for any type of medical benefit, for the treatment of major illness revealed that the proportion of households eligible for medical reimbursement was higher in the urban areas (12.50 per cent) as compared to the rural areas (5 per cent). Further it revealed that medical insurance was very uncommon in both rural and urban areas as there were only 5 per cent households in the urban areas having
medical insurance while there was no household in the rural areas having medical insurance.

The distribution of average annual health expenditure incurred by the sampled households on treatment of minor as well as major illness revealed that households of urban areas spent 1.33 times more than that of the households in rural areas. On comparing the pattern of expenditure in rural and urban areas it has been found that in rural areas the proportion of expenditure on medicines and injections (39.40 per cent), transportation (11.65 per cent), consultation/doctor’s fee (9.56 per cent) and miscellaneous expenditure (5.37 per cent) was higher as compared to that of the urban areas i.e. 37.11 per cent, 5.76 per cent, 8.33 per cent and 4.36 per cent respectively. It also revealed that in urban areas the proportion of expenditure was greater in case of hospitalization (18.83 per cent), surgery (12.88 per cent), laboratory tests/x-ray etc. (12.73 per cent) as compared to that of the rural areas i.e. 14.71 per cent, 9.72 per cent, 9.59 per cent respectively.

The average annual health expenditure incurred by the sampled households according to different income categories revealed that that the average health expenditure moved up as we moved from lowest income category to the highest income category. The maximum health expenditure was incurred by the high income category followed by middle income category and low income category. This pattern has been observed to be same for both rural as well as urban areas. Further the analysis revealed that health expenditure incurred was greater in the urban areas as compared to rural areas for all income categories. The low, middle and high income categories in urban areas incurred
more health expenditure i.e. Rs 5220, Rs.13021 and Rs.16088 respectively than the health expenditure incurred by respective income categories in rural areas i.e. Rs.4891, Rs.11122, Rs.13069.

It can hardly be denied that a sound health along with adequate food, clothing and shelter is vital for human beings to enjoy their lives. Being an element of intrinsic and instrumental value to human life, the level of health in society should increase, if not proportionately, with economic growth. By virtue of the robust economic growth attained by Punjab, one might have expected it to do better in other dimensions of utmost significance for human life as well. But unfortunately, it has not been so. There has been no major increase in the number of government owned health institutions in Punjab since 1990s. The grim picture of public health institutions can be estimated from the large number of sanctioned posts of doctors, paramedical staff and district-level health officers which are lying vacant. The sanctioned posts in health department of Punjab are deliberately kept vacant by imposing a ban on new recruitments not because of non-availability of qualified health personnel but largely due to pressures of globally determined economic policy and resource crunch faced by the state.

From empirical analysis it has been found that the major factors inhibiting the growth of health sector in Punjab are existence of a smaller number of public health institutions than their actual requirement, lack of some basic facilities in government health institutions, manpower shortages in the health institutions, absentee doctors, inconvenient opening hours of the health institutions, informal payments incurred and low public sector spending on health sector etc.

From the 1990s onwards, when globalization gained importance and became indispensable in India, the health sector reforms were introduced to
bring about strategic but favourable changes in the health care delivery system. The government of Punjab had introduced two reforms in health policy. First, the opening of health care services to the private corporate sector and the second was setting up of the Punjab Health Systems Corporation (PHSC) in 1996-97 by the state government, under the World Bank sponsored State Health Systems Development Project II, in which more than 150 healthcare institutions run by the government were transferred to PHSC. But both of these measures failed miserably. A state-specific health policy is the basic pre-requisite for health planning in the state. A health policy should capture a holistic view of the state’s health, identify requirements and priorities, set-up objectives and ensure optimal utilization of the allocated resources, given the capacity and constraints of the health system. The government of Punjab should focus on promoting more effective utilization of public health infrastructure. Health policy should give due care to the curative aspects along with the preventive aspects. Some of the suggestions for improving curative services pertain to easy, queue-less accessibility, service-availability for longer duration, clean premises, provision of medicines, diagnostic services under one roof on no-profit-no-loss basis with appropriate subsidies for economically weaker sections. The policy must ensure regulation of both public and private sector. While mandatory registration, service monitoring, fees regulation and rating are must for private health sector, rationalization of postings, strict guidelines for deputations, and priority settings in rural postings are must for public sector. Further, rising costs of treatment, in both the public and private sector, warrant a viable health insurance policy. There is a dire need to enhance public investments in health sector and health investment planning must be biased towards under-privileged areas and groups.
The health policy of Punjab government must ensure optimal utilization of health manpower and resources, enhance availability of primary health care and paramedical staff, set out strategies to cope with rising pressure on tertiary health care institutions and bring about awareness for a better quality of health care comprising environment and occupational health, adequate availability of drinking water, hygienic living conditions, nutritious food, removal of drug addiction and other health hazards.