Public Investment in Primary Health Care

Suranjan Sarma

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Suranjan Sarma

PREFACE

Investment on health care and education for the masses amounts to investments on human capital. Indeed both these types of capital are required by the developing countries like India to accelerate their pace of growth and development. However one of the failures of India's development effort in the post independence period has been in making elementary education and primary health care available widely to the masses. This becomes clear from the comparison of India with some other Asian countries such as South Korea, China, Thailand etc., where indicators like life expectancy at birth and infant mortality rate are much favourable although these countries started from similar levels of economic conditions in the post-World War II period.

Assam's position in the matter of health care stands even below the all India position. There was of course an impressive expansion of the network of public sector rural primary health centres in the state in the 1980s- thanks mainly to the upsurge of state government's capital expenditure on this sector during the decade from 1970s to mid 1980s (as per 'Finance Accounts' of the Government of Assam). But due to a squeeze in revenue expenditure of the government since the late 1980s, the service catered by this network might have become thin in substance. Complaints about non-availability of even the basic services in primary health centres are frequently reported in media. Thus the need to examine the nature and magnitude of the government efforts in the area of primary health care in Assam induced me to take up a study of government expenditure on rural primary health care there. The emphasis on rural areas is because of the fact that the government efforts are more urgently required for improving the health care service to the more disadvantaged

sections of the society, who are disproportionately concentrated in the rural areas.

In the pursuit of the study, we had to confront two main problems. The first problem was related to the definition of primary health care. In spite of the popularity of the term, the relevant literature was found to be devoid of its consistent and unanimous definition. The second problem was related to the nature of classification in which data on government expenditure on health care are available. The components of primary health care do not always correspond to specific items of that scheme of classification. Even when such correspondence exists, the rural urban division is not always available. Accordingly some exercises had to be taken up for resolving these two problems.

Similarly the need for an objective assessment of the role and effectiveness of public sector primary health care system vis-a-vis the health care service requirements of rural households induced me to take up a grass-roots level field study focused at the problem. The results from analysis of some of the findings of that field study have been reported here. Some policy measures were also worked out which would be necessary for human capital formation in the state of Assam.

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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
CHC	Community Health Centre
CSSM	Child Survival and Safe Motherhood Programme
DHS	Directorate of Health Services
FRCH	Foundation for Research in Community Health
GNP	Gross National Product
GOI	Government of India
ICCW	Indian Council for Child Welfare
ICDS	Integrated Child Development Service Scheme
IRCS	Indian Red Cross Society
MCH	Maternal and Child Health
MPW	Multi Purpose Worker
NGO	Non Government Organisation
NHP	National Health Policy
NMEP	National Malaria Eradication Programme
NSDP	Net State Domestic Product
NTP	National Tuberculosis Control Programme
ORG	Operations Research Group
PCE	Per Capita Expenditure
PCI	Per Capita Income
PHC	Primary Health Centre
PPI	Pulse Polio Immunization
SDM & HO	Sub-Divisional Medical and Health Officer
UIP	Universal Immunization Programme
UNO	United Nations Organization
VHAA	Voluntary Health Association of Assam
WHO	World Health Organisation

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INTRODUCTION

Introduction of the Subject

Economic reforms in India since 1991 have a pro-market orientation. The reforms are guided by the argument that in the first forty years of economic planning the state in India interfered too much with the market mechanism not only by taking up production of diverse range of commodities, but also by subjecting private enterprise to numerous bureaucratic controls. While delicensing and deregulation, aimed at allowing market forces a greater role to play, has been generally welcomed, there has also been concerns that the burden of structural adjustment might have fallen more heavily on the poorer section of the society. Moreover the poor, with their meagre purchasing power, live only in the fringes of the market system. Therefore, market mechanism on its own is unlikely to operate at the best interest of the people at the bottom end of the income distribution. Thus, to give the economic reforms programme a human face and to add a welfare component to the reform package, the state needs to intervene more vigorously in such areas as target oriented poverty alleviation programme, basic education and primary health care. For instance, market forces cannot be expected to provide adequate health care in economically backward sectors such as the rural areas, where poverty mainly concentrates. Thus the goal of providing health care particularly to the rural population has to be pursued actively and directly by the state.

One of the failures of India's development effort in the

post independence period has been in making elementary education and primary health care available widely to the masses. This becomes clear from the comparison of India with some other Asian countries that started from similar levels of economic conditions in the post World war II period. For instance, in 1995, the life expectancy at birth in India was 61.6 years compared to 72.5 years in Sri Lanka, 71.7 in South Korea, 69.5 in Thailand and 69.2 in China. Similarly, adult literacy rate in the same year in India was 52 percent compared to 90.2 percent in Sri Lanka, 98 in South Korea, 93.8 in Thailand and 81.5 in China. While infant mortality rate per thousand life births declined in China from 150 in 1960 to 38 in 1996, the corresponding decline in India was much slower from 165 to 73 only (UNDP, 1998: 128-130, 148-149).

Assam's position in the matter of health care stands even below the all India position. According to statistics relating to the period 1988 - 1992, life expectancy in Assam was only 54.1 years compared to all India level of 58.7 years and infant mortality rate per thousand life births was 77 in Assam compared to 73 at the all India level (Dev and Ranade, 1997).

Clearly state intervention in the area of health care has not been adequate and effective in India and more so in Assam. The present study is motivated by the necessity to examine the trends and effectiveness of government spending on the health sector especially on primary health care for the rural population. The emphasis on rural areas is because of the fact that the government efforts are more urgently required for improving the health care service to the more disadvantaged sections of the society, who are disproportionately concentrated in the rural areas.

Objectives

The objectives of the present study are as follows:

(1) To examine the trend and nature of public expenditure in health care in Assam, with special emphasis on expenditure on primary health care in rural areas.

(2) To examine the effectiveness of the existing public sector health set up in rural areas in delivering primary health care to the masses.

(3) To examine the effective coverage of specific rural

health care schemes such as 'Immunization' and various 'Disease Control Programmes' on target population groups.

(4) To examine the extent to which the burden of procuring health care service on a household is affected by the household's access to public sector health care system.

(5) To examine the relative roles of government and non-government agencies in providing rural health care services in Assam.

(6) To recommend policy measures for better implementation of programmes of rural health in Assam.

Hypothesis

The central hypothesis of the present study is that the ineffective implementation of the health care programmes is the main factor responsible for the poor health conditions of the rural population in Assam.

As a corollary, it follows that improvement in implementation of schemes can enhance the returns on investments on primary health care.

Data Source and Methodology

The present study is based on both primary and secondary data. The secondary data have been partly compiled from published reports of the State and Central Governments, such as reports published by Comptroller and Auditor General, Government of India, relevant research publications in journals and books etc. Apart from these published sources, some unpublished data have been directly collected from various government/ semi government offices, such as, The Directorate of Health and Family Welfare Services, Government of Assam; The Directorate of Economics and Statistics, Government of Assam; The Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, Government of India etc.

The secondary data thus collected have been found useful for analyzing the trend and nature of public expenditure in health care in Assam and also for an assessment of the

existing state of primary health care in Assam vis-à-vis the same at the average all India level. But for a detail examination of the problems related to implementation, impact and effectiveness of specific health care schemes on target population groups and the relative importance of government and non-government agencies in implementing various schemes of rural health care, a field survey was carried out during the first quarter of 1998. The detail of the methodology of the field study is reported in Chapter Eight.

While the analysis of the secondary data was carried out using simple statistical tools like ratio, percentage and averages, in the analysis of primary data a wider range of statistical and econometric tools has been used. Besides the elementary tools of ratio and averages, coefficients of association have been worked out and multiple regression analysis been carried out according to suitability of these tools. The significance of estimated parameters have been tested using various test statistics such as Chi-Square, t and F according to their suitability.

Layout of the Dissertation

This introductory chapter is followed by a theoretical discussion of the relationship between economic development and health care in Chapter Two. The role of state in making health care available to the masses and the problems involved in measurement of returns on public investments in health care has also been discussed. Chapter Three begins with a review of the National Health Policy in light of commitment of the world community to achieve 'health for all by 2000 AD'. The evolution of the primary health care approach has been traced and the definition of primary health care adopted for the present study has also been spelt out in the same Chapter. Chapter Four is a review of studies on financing of health care in India in the post independence period. This chapter prepares the background for a detail analysis of public expenditure in Assam on health care in general and primary health care in rural areas in particular, which is presented in Chapter Five. As mentioned above a field study became necessary to go into the issues of effectiveness of the government expenditure on rural primary health care. But

before the findings of the field study could be presented it was felt necessary to describe the administrative and infrastructure set up meant for the delivery of primary health care. This description is presented in Chapters Six and Seven. The research design and methodology of the field study has been outlined in Chapter Eight, and the profiles of the field study locations and the sample of households have been described in Chapter Nine. The analysis of the data collected in the field study and the findings emerging from such analysis have been presented in detail in Chapter Ten. The concluding chapter i.e., Chapter Eleven, presents a summary of the findings, the conclusions emerging from these findings and suggestions put forward on the basis of insights gathered from this study.

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2

ECONOMIC DEVELOPMENT, HEALTH CARE AND THE ROLE OF THE STATE

The Economic Development: The Evolving Concept and Changing Approach

In the context of the underdeveloped countries there is a general concern for rapid economic development. Although development is desired by all, its meaning is not entirely unambiguous. Indeed, over the last four/ five decades - in which development economics has come up as an independent and important branch of study, the connotation of the term development seems to have changed and continuously evolved through time. Broadly however, development can be understood as a process of change in which the economy evolves towards a more advanced structure in which the population at large enjoys a better standard of living. Such a definition, though useful for conceptualization of the term economic development, is not clear enough for the practical task of measurement of development. To extract a working definition out of it, one requires further elaboration.

Many early development economists equated economic development with growth of real GNP per capita i.e., the rate at which the volume of goods and services per head had increased in the economy. In fact, early classification of the countries by the United Nations Organization into highly developed, developing and underdeveloped one was based

on the level of per capita income converted to a common currency.

However the level of per capita real GNP as the indicator of the level of development of a country or the growth rate of real GNP per capita as the measure of its economic development suffers from certain limitations. The most obvious shortcoming arises from the fact that a purely per capita GNP based measure does not give any idea about the distributional aspect of the income generated in the country. The growth of GNP per capita is no doubt important for making available larger volumes of goods and services for the country's population. However, to ensure that such growth translates itself to improvement in the level of living of the masses, it is necessary that growth is widely shared by the population. In other words, as per capita income grows, distribution of income must not become more unequal and preferably should become more equal. Hence attempting to modify the measurement of development in terms of real GNP growth rate per capita Meir (1984) defines economic development "as the process whereby the real per capita income of country increases over a long period of time - subject to the stipulations that the number below an absolute poverty line[1] does not increase, and that the distribution of income does not become more unequal".

Because of such obvious limitations of an aggregative measure like GNP growth per capita, attempts have been made to devise such measures, which would evaluate the progress made in course of time in achieving a better standard of living for the population at large. Chennery and Ahluwalia constructed a poverty weighted index of development. The index was a weighted sum of income growth rates of different sections of population in which the poorer section income growth received higher weight. Moris D. Moris devised the physical quality of life index for measuring progress of countries in achieving better quality of life for its population. Moris ignored income and rather concentrated in factors such as life expectancy at birth, infant mortality rate and literacy rate, which are some of the very important and direct indicatiors of living standard of the masses.

These attempts at devising a more satisfactory and a broad based measure of development came about in the same time in which there was also a rethinking on the strategy of development among development economists. In 1950 and 1960s development economists in general recommended acceleration of economic growth through industrialization as the main strategy for economic development. They expected the problem of poverty and unemployment to be automatically solved by the trickle - down effect of accelerated growth of GNP. The literature coming out in 1970s reflected a change in this view. Summarizing these things Meir writes, "Development economists no longer worship at the alter of GNP, but concentrate more directly on the quality of the development process. Instead of settling for any aggregate, or even per capita index of 'development', many now advocate that direct attention be given to the achievement of better nourishment, better health, better education, better living conditions and better conditions of employment for the low end poverty groups in the poor countries of the world. Instead of seeking 'development' as an end, we might better view it as a means - as an instrumental process for overcoming persistent poverty, absorbing the surplus labour and diminishing inequality".

The evolution of the concept of development has continued during the 1980s and in the 1990s too. The desirability of the growth process to be consistent with conservation of environment and natural resources led to the emergence of the concept of sustainable development[3] in the late 1980s. In the 1990s the United Nations Development Program (UNDP) has come up with the concept of 'human development'[4] emphasizing once again the fact that the development is more about human being rather than about mere increase in the average income of the population. Since the year 1990 UNDP has been computing human development indices (HDI)[5] to rank countries of the world according to their achievements in the level of human development. The human development index is based on the three factors namely - life expectancy at birth; educational attainment comprising adult literacy and a combined primary, secondary and tertiary enrolment ratio; and income.

The above trend in development literature clearly shows the growing importance assigned by development economists to an approach, which directly addresses to the problem of improving living conditions of the people at the lower end of the income distribution. In such an approach to development public investments on health care and education occupies a central place.

Health Care, Education and Economic Development

From the above discussion it is clear that for economic development improvement of health care and education for the masses is equally, if not more, important as increase in the level of productions for economic development of a country. Indeed, the link between health care and education and economic development is two way—Firstly, better health care for the masses improves their living conditions and thereby directly achieves a goal of economic development. Secondly, better health care and education improve people's ability to work and efficiency of labour. This in turn contributes to general improvements of productivity and thereby can stimulate economic growth, which is essential for economic development. Highlighting this argument Todaro (1985) writes, " The low incomes and low levels of living for the poor, which are manifested in poor health, nutrition and education, can lower their economic productivity and thereby lead directly and indirectly to a slower growing economy. Strategies to raise the incomes and levels of living of, say, the bottom 40 percent would therefore contribute not only to their material well being but also to the productivity and income of the economy as a whole". In other words, investment on health care and education for the masses amounts to investments on human capital, which like physical capital, is in scarcity in underdeveloped countries. Indeed both these types of capital are required by the developing countries to accelerate their pace of growth and development.

There seems to be a great deal of complementary and mutually reinforcing effects between investments on health care and education. Investments in health care service may pay off in terms of economic growth as well as equity by

improving the educational performance of poor people in the developing countries. Evidence in support of this can be found in some World Bank Reports. The Banks' World Development Report 1990 states - "Better nutrition improves the child's capacity to learn and increases their productivity. On the other hand, malnutrition is related to lower cognitive test scores and worse school performance" (World Bank, 1990). The same report also finds that "one year of mother's education has been associated with a 9 percent decrease in under 5 mortality.[6] The children of better educated mothers, other things being equal, tend to be healthier". Also education has a strong negative effect on fertility.

Need for State Interventation in the Health Sector

State intervention in case of health services can be justified at least on three important grounds.

(i) A large part of health care services has a public good character. For instance, one person's access to information on malaria control does not leave that information less available for others. Also some services, such as immunizations, that are not public goods but carry substantial externalities. (e.g., immunizing a child slows down transmission of measles and other diseases conferring a positive externality). In such a situation the private sector and the market mechanism are not best suited to make the welfare maximizing level of investments. Thus from an efficiency point of view, government is likely to have a potentially important role in the area of health services having the characteristics of public good and externalities.

(ii) Leaving aside this component of health care service which has character of public good and also emits a great deal of externality, personalized health service such as care of medical professionals, medicines etc., can be technically as well supplied by the private sector as the public sector. However, leaving supply of such health care service entirely to the private sector will make it inaccessible to a vast majority of the people in less developed countries (LDC) —especially the section

with low level of income and also those who live in relatively remote areas. The market forces will naturally ensure adequate supply of medical services to that section which has the purchasing power to procure the services. The poorer section obviously will not be able to afford the expensive medical services provided by the private sector. Notwithstanding the efforts by charitable and voluntary organizations to extend medical services to a wider section, a large-scale state intervention is essential to make such services available to the economically disadvantaged section of the society. The state may intervene directly by setting up an its own operating network of clinics and health centres, or indirectly by offering subsidies to the private sector to make it cater to the lower income sections also. Alternatively, the state may adopt a combination of both these approaches.

(iii) Making primary health care freely or cheaply available for the masses, which can be made possible by adequate and effective public investments in this area can act as an anti-poverty measure. Poor are largely concentrated in the informal sector as wage earners or self employed in petty services. So ill health and sickness leads not only to suffering due to disease but loss of income and consequently to fall in nutritional standard. But an effective public investment programme in primary health care targeted for poverty groups and backward areas (rural areas) can prevent and cure many sickness. This in turn, will protect income level and promote productivity. Both serve to promote development.

New Economic Policy and the Role of the State in the Health Sector

The New Economic Policy (NEP) being pursued in India since 1991 has brought a marked change in the role of the state in the affairs of the economy. The delicensing and deregulation process of the NEP are aimed at replacing a system of state controls by market initiatives. The reduced state control has also been accompanied by shrinking of public sector activities

in areas where private sector and market forces are expected to perform better. In spite of the pro-market orientation of the economic reform programme the limitations of the market mechanism are also widely acknowledged. Accordingly even the strongest supporter of market forces today does not talk of revival of old fashion 'Laissez - Faire'. Instead, there is a call for reorientation of the role of the state in the economy. For instance, while the state is expected to retreat from sectors where the market mechanism can perform more efficiently, the state activities are expected to be more intense in sectors where the market mechanism fails. Primary health care along with basic education and infrastructure development constitutes an area where the state is now expected to operate more vigorously.

According to Jean Dreze and Amartya Sen, government's duties vis-de-vis a citizen's comprised of both negative roles and positive ones. The negative roles consists in preventing what are taken to be bad developments (for example, outlawing monopolistic arrangements) whereas positive roles concern supporting constructively the efforts of the citizens to help themselves (for example, by arranging public education, by redistributing land, by protecting the legal rights of disadvantaged groups). They add that much of the debate on liberalization and deregulation in India is concerned with removing what is diagnosed to be counter productive nature of negative operations of the governments but what the debate neglects altogether is the importance of positive functions such as provision of public education, health service and arrangement of social security. The authors therefore call for a broadening of the focus of the public debate on economic reform in the country with due importance on the positive roles of the government.

Referring to the neglect of primary health care and basic education in India's planned development effort the same authors comment, "India's failure to have an adequate public policy in educational and health matters can be of profound significance in assessing the limited success of Indian development efforts over the last half a century. A policy reform that concentrates just on liberalization and deregulation cannot deal with this part of the failure of past

planning's. The removal of counter productive government controls may indeed expand social opportunities for many people. However, to change the circumstances (such as illiteracy and ill health) that severely constrain the actual social opportunities of a large part of the population, these permissive reforms have to be supplemented by a radical shift in public policy in education and health. If we see economic development in the perspective of social opportunities in general, both for their intrinsic importance and for their instrumental value, we cannot afford to miss this crucial linkage" (Dreze and Sen, 1995, p. 16).

The Returns on Public Investments on Health Care

Government spending on primary health care can be viewed both as a subsidy for consumption of health care services and as an investment on human capital formation. As a subsidy, the public funding can take several forms - subsidies to private providers and non government organizations that serve the poor, vouchers that the poor can take to a provider of their choice, and free or below cost delivery of public services to the poor. Viewed as a subsidy, it becomes desirable that such fund is utilized that its benefit goes mainly to the economically worst off section of the society. As a component of investment on human capital the question of the rate of returns of public expenditure on primary health care becomes pertinent. However, measuring the rate of returns on this form of social investments is an extremely complicated task. Public provision of primary health care benefits the society in a number of ways. The direct form of benefit of public investments in health care manifests in the form of increment in life expectancy, strength and stamina, the vigor and vitality of the people. These increments also contribute to increased productivity of the economy, which constitutes a form of indirect benefit of the public investments on health care. The value of this benefit to the society could be enormous but not always traceable and tangible. This makes quantification of the total benefits of the public investment programmes on primary health care a difficult task. Consequently, measuring the social rate of returns of such investments also becomes difficult.

The difficulties in estimating the cost and measuring the benefits of public expenditure in health care notwithstanding, there has been some attempts at measuring the rate of returns on such investment. For instance, Panchamukhi (1980) points out that, "Loss of output due to ill health and the treatment costs can be considered as measures of the return of the preventive health measures. Following this logic, the sum of the estimate of life- time earnings of a worker and the expenses on his medical treatment during his sickness, would give the returns on health investments" (Panchamukhi, 1980). But he himself finds that such a method would suffer from number of shortcomings. Firstly, the method assumes that it would be possible to prevent death or disease by deliberate policies of health development, which in fact may have only a marginal effect. Secondly, the entire output flow is attributed to health investments while in fact the health of a worker is only one of several factors determining his productivity. Thirdly, good health may be an end in itself; hence expenditure on health has to be counted as consumption rather than investment. Fourthly, the method implicitly assumes that jobs are available to all and that jobs changes are ruled out.

In view of the reorientation of the role of the state in the 1990s the conventional approach of social cost benefit analysis for justifying public investments has also come under scrutiny. As Devarajan et al (1997) writes, "Instead of asking if the project generates a positive net social benefit, governments and agencies are asking if there is a rationale for public provision of that good or service. Whether the standard approaches to project analysis are suited to answering the latter question is not clear..... , by contrast, projects with a strong public sector rationale, such as vector control and immunization are likely to be those with large positive externalities. The resulting improvement in welfare although apparent, is difficult to quantify in net present value or rate – of – return calculations". In light of this logic our discussion in the previous section amply justifies state intervention in provision of primary health care in a developing society even though a satisfactory measure of returns on public investments on primary health care may not be readily

available. Nonetheless, resources with the governments being a scarce commodity it is desirable that their use gives the best possible returns to the society. This brings in the question of effectiveness of government spending on the health sector. For, more effective the investments are the higher will be the returns to the society. The issue therefore is not merely the quantum of government spending in this sector but the effectiveness with which the allocated government expenditure is utilized. The pertinent questions therefore in this context are whether the intended services accrue to the targeted population and if the services rendered have an impact on the income and living condition of the recipients. The present study therefore endeavours to analyse not only the trends in the quantum of public expenditure on primary health care but also to examine its effectiveness in terms of the efficiency of delivery and minimization of leakages. However, before taking an analysis of the issues related to public investments on primary health care it would be necessary to devote some space to the description of the 'Primary Health Care Approach and The Government Health Policy' in India in the post independence period. The next chapter therefore will begin with such a description.

NOTES

1. ABSOLUTE POVERTY LINE: Absolute poverty line is that level of income which is inadequate to obtain the minimum necessities for the maintenance of human efficiency or, it is a condition of acute physical wants - starvation, malnutrition, disease, want of clothing, want of shelter, and almost total lack of medical care.

   According to World Development Report, 1990 - a consumption based poverty line can be thought of as comprising by two elements -the expenditure necessary to buy a minimum standard of nutrition and other basic necessities and a further amount that varies from country to country, reflecting the cost of participating in the everyday life of society. The cost of minimum adequate calorie intakes and other necessities can be calculated by looking at the prices of the foods that makeup the diets of the poor. For, cross-country comparison the report assessed a poverty line for India at Purchasing Power Parity $275 of income per capita per year at 1985 prices (The limit which is commonly used for India for estimating a poverty line).

2 TRICKLE - DOWN THEORY OR TRICKLISM: It is undoubtedly the most famed promise of post 1945 western economic development theorizing. It states that: rapid gains in overall and per capita GNP would either 'trickle down' to the masses in the form of jobs and other

economic opportunities or create the necessary conditions for the wider distribution of the economic and social benefits of growth. (In other words) this national income growth will trickle down to improve levels of living for the very poor (Todaro, 1981). The trickle down orthodoxy was that making the wealthy richer in the take off stage was justified because in due course of time, and without any special intervention (i.e., automatically) accelerated economic growth would filter down and spread across, bringing the benefits of capitalist growth to the poorer segments of developing societies. While not all would agree that trickle down bias was a deliberate intention on the part of postwar theorists the consequences of the trickle down orthodoxy are undeniable: it relegated poverty alleviation to the bottom of the development agenda, in total disregard of the inherent factor endowments of LDCs, it also encouraged labour saving technologies, often encouraged foreign indebtedness to pay technology import (Mehmet, 1995).

3. SUSTAINABLE DEVELOPMENT: Sustainable development addresses both equity within generations and equity among generations enabling all generations, present and future, to make the best use of their capabilities. It brings the development process within the carrying capacity of nature, giving the highest priority to environmental regeneration - to protect the opportunities of future generations.

   Thus, sustainable human development is a process of change in which the exploitation of resources, the direction of investments, the orientation of technological development and institutional change are made consistent with future as well as present needs (World Commission on Environment and Development, 1987).

4. HUMAN DEVELOPMENT: Human development is a process of enlarging people's choices. In principle, these choices can be infinite and can change over time. For the purpose of computing H.D.I., human development has been defined as a process of enlarging people's choice in three essential areas - viz., (i) life expectancy, representing a long and healthy life; (ii) educational attainment, representing knowledge; and (iii) real GDP (in Purchasing Power Parity Dollars), representing a decent standard of living.

   However, the concept is supposed to be somewhat wider - "Human development does not end at three essential ones for a decent standard of living for people. Additional choices range from political, economic and social freedom to opportunities for being creative and productive and enjoying personal self respect and guaranteed human rights. Human development thus has two sides. One is the formation of human capabilities - such as improved health, knowledge and skills. The other is the use people make of their acquired capabilities - for productive purposes, for leisure or for being active in cultural, social and political affairs" (UNDP, 1995).

5. HUMAN DEVELOPMENT INDEX (HDI): The HDI contains three indicators -life expectancy representing a long and health life; educational attainment as measured by a combination of adult literacy (two thirds weight) and combined primary, secondary and tertiary

enrolment ratios (one third weight); and standard of living as measured by adjusted real GDP per capita (in purchasing power parity dollars). It is increasingly being used to monitor the progress of nations and of global society (UNDP, 1995).

6. UNDER 5 MORTALITY: The probability of dying between birth and age 5, per thousand births.

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APPENDIX 2.1

A Note on Health Economics

With the growing emphasis on human resource development for promoting the long run growth prospects of economics and the emergence of concepts like human development the subject of health has been receiving greater attention of economics. However, health economics as a distinct and well-defined discipline is yet to be widely recognized and pursue. Nonetheless, there have been arguments for treating health economics as a genuine branch of applied economic studies. To sum up such arguments we make use of the following quotations—

"Economics as applied to the health field or health economics seeks -inter alia- to quantify over time, the resources used in health services delivery, their organization, the allocation of the resources for health purposes and the effects of preventive, curative and rehabilitative health services on individuals and society. As such, health economics has become a distinctive field of study emphasizing in particular the application of economic theory to practical problems in improving the use of resources to achieve the supply of effective and efficient health care" (Lee and Mills, 1979).

"Health economics as a discipline does not exist independently of economics as a discipline: there are few techniques of economic analysis that are not applicable in the topic of health; moreover, there are few theoretical ideas in health economics that are truly sui generis. Health economics as a topic does not strike a chord either: it has at present no settled bounds of convention, other than those bounding the topic health itself, though there is a striking asymmetry in the distribution of research effort to the topic of health - an asymmetry that varies from place to place. Accordingly, we

are left with the discipline of economics applied to the topic of health" (Culyer, 1981).

"The intrusion of economics into the subject of health naturally causes concern. Health is basically a humanitarian cause - literally a matter of existence. Naturally there is no question of costs, prices, effectiveness and priorities where lives are concerned. But when issues concerning health emerge as health care provisions to be administered from public funds, questions of choices, priorities and effectiveness are bound to be raised and need to be answered. Thus economics is an inevitable intruder and as time passes, it has acquired a positive role" (Umashanker, 1992). In short, the task of health economics is "to appraise the efficiency of the organization of health services and to suggest ways of improving this organization" (Mushkin, 1958).

The Encyclopedia Britannica sums up the definition of health economics "as the study of the uses of resources for health services, planning and administration of the health sector and the effects of health and ill-health on the economy."

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3

THE PRIMARY HEALTH CARE APPROACH AND THE NATIONAL HEALTH POLICY

Meaning of Health

Traditionally, health has been viewed in its narrow connotation of absence of disease. However, with growing advancement and understanding in various spheres it has now been universally acknowledged that health has much wider ramifications and ought to be perceived in its holistic perspective (Sarma and Singh, 1991). The preamble of the charter of the World Health Organization (WHO) formed in 1948, defines health as a 'state of complete physical, mental and social well-being and not merely absence of disease or infirmity'. Physical component pertains to the body, mental to the mind and social to the entire socio cultural environment. And all these factors have a direct significant role in the health of - (i) an individual, (ii) a family and (iii) the entire community.

Meaning of Health Care

Generally, combining all the personal and community health services including medical care and related education and research directed towards protection and promotion of the health of the community is called the health care service. The health care is classified into three groups - (a) Medical Care (medical relief, hospital and dispensaries and so on), (b) Public Health Services (such as, communicable disease control, water supply and sanitation etc.), and (c) Family Welfare Services (family planning maternal and child, immunization etc.).

Involvement of World Community in Health Care

With the end of the Second World War, all over the world the process of independence of the colonies started. The process was almost completed during 1960s. In the seventies, the whole world was divided economically into two distinct groups – (i) Developed nations- the former colonial powers falling into this category, and (ii) Developing nations comprised by newly independent countries. The gap between the health of people in the developed and the developing nations was vast. According to Kenneth Newell "in 1974 the situation was such that the majority of the rural populations of the developing world do not have sufficient food to enable them to have a normal growth and development; one out of four of the children of many groups died before the age of one year; epidemic and endemic communicable diseases were a day to day reality...". This attracted the attention of the world community like United Nations and World Health Organization etc., which showed a new direction to the development of health and health care services. The Alma-Ata Declaration is the result of such an approach.

Evolution of the Concept of Primary Health Care

At the World Health Assembly in 1977 the member states of WHO addressed the challenge of providing to all the people a level of health that would, by 2000 AD, enable them to lead a socially and economically productive life. This goal before the member nations was summed up by the Executive Board of WHO in 1978 as that of achieving 'an acceptable level of health for all' - an expression to be rephrased later as 'health for all by 2000' (World Health Organization, 1988). But the real question that begged an answer at that time was 'How can the exiting achievements of science and technology be applied to improve the health status of the countless millions for whom they were not affordable and not accessible through the conventional delivery systems?' In other words, 'How were the nations of the world to make 'health for all' a tangible reality for all their people?' It was in order to find an answer to this question that delegates from 134 member states of WHO and representatives of 67 member nations of the UNO, specialized agencies and non-governmental

organizations assembled in September in 1978 in Alma-Ata in the erstwhile USSR for an international conference (WHO-UNICEF, 1978). The Alma-Ata Declaration urged that 'the primary health care approach be used for reducing the widespread disparities in health and health care services that formed an appalling record of neglect and deprivation in many parts of the world'. Thus the movement for 'health for all by 2000' got formally launched in the Alma-Ata Conference with the acceptance of primary health care approach as a strategy for achieving this goal. Primary health care was then defined as 'essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford' (World Health Organization, 1988).

Described thus, the idea of primary health care is unexceptionable in principle. Unfortunately the idea was not spelt out with enough rigor for putting its into practice. Indeed the concept seemed to be too wide and all embracing to be conducive for formulation of focused action plan. Consequently, putting primary health care approach into practice required further interpretation of the definition. One cost-effective approach soon disseminated by Walsh and Warren (1979) consisted of selecting and prioritizing a limited number of diseases for control and eradication so as to decrease mortality quickly. This 'selective primary health care' and variants of this approach quickly gained acceptance amongst international donor agencies such as World Bank, USAID and UNICEF. With the process of time through this approach got extended and many elements of the initial primary health care concept got incorporated in it. UNICEF introduced the growth, oral rehydration, breast-feeding and immunization (GOBI) approach as part of its child survival development revolution. Subsequently this approach was extended to include the three Fs, viz, female literacy, family planning and food supplements. Meanwhile, the 'expanded programme on immunization' (EPI) was given considerable support by USAID and other multinational and bilateral donors. In India the National Health Policy of 1982, which was inspired by Alma Ata Declaration to achieve 'health for

all' by the year 2000, interpreted primary health care approach as 'a strategy taken by the government with active involvement of the community to fight against major infectious, endemic and communicable diseases to assure a productive life to the people' (Government of India, 1982).

National Health Policy in India

Since the inception of the planning process in our 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 and research etc. To give continuity and a long- term perspective to the programmes taken up in the health sector, there was a need for a national health policy. It was in response to this need that the National Health Policy was evolved and formally announced in 1982. The National Health Poiicy of 1982 was inspired by Alma-Ata Declaration for implementing global strategy for 'health for all'. The National Health Policy clearly admitted the failures of the government in health sector in the past. It was clearly stated in the policy that it seeks to provide universal comprehensive primary health care services relevant to the actual needs and priorities of the community at a cost to which people can afford while ensuring that the planning and implementation of the various health programmes are through the organized involvement and participation of the community which also utilizes the services rendered actively by private and voluntary organizations in the health sector. The policy embraced in its fold the health components of the revised 20 point programme such as - the promotion and substantial augmentation of primary health care services to all the people of the country, control of leprosy, tuberculosis and blindness, acceleration of welfare programmes for women and children, nutrition programmes for pregnant women, nursing mothers and children. The health policy underlined the importance of medical education as a crucial component for the health delivery system.

In order to rectify several defects in rural health services and to restructure it, the policy suggested actions to-

(a) Provide within a phased and time bound programme a well dispersed network of comprehensive primary

health care service, integrally linked with the extension and health education approach.

(b) Involve the large number of private voluntary organization active in the health field all over the country to be utilized and enmeshed with governmental efforts.

(c) Mobilize the front line workers selected by the community and give them short periods of training to make the primary health care system more effective.

From the above set of aims and objectives of the health policy it is clear that the government envisages a large measure of decentralization in primary health care system. The policy called for implementation of the various programmes through community participation and public contribution in order to achieve meaningful results within the specified timeframe.

The emphasis of the National Health Policy thus, was on restructuring of the existing public health organizations into a comprehensive primary health care service system with an integrated referral system. The policy stressed on the encouragement of private investment on health so that the government health centres can provide free medical and health care to the poorer section of the population while the rich can go to the paying clinics.

Definition of Primary Health Care for the Present Study

As per the policy statement of Government of India, primary health care approach is a 'strategy taken by the government with active involvement of the community, to fight against major infectious, endemic and communicable diseases to assure a productive life to the people'. Hill, Farley and Rohde (1993) listed the ingredients of primary health care as (1) medical care for common endemic diseases, (2) expanded programme of immunization against infectious and communicable diseases, (3) safe motherhood programme, (4) control of malaria and tuberculosis, (5) family planning activities, (6) care of acute respiratory infections, (7) control of diarrhea and (8) nutrition. Out of the eight ingredients, expanded programme of immunization was identified as the most important part of primary health care. Northrup (1993)

stressed inclusion of oral re-hydration therapy for diarrhea control as component of primary health care. Gupta (1988) however insisted that 'the education of the people concerning prevailing health problems and preventing and controlling them is the first requisite of primary health care.'

If primary health care is defined to include all such activities, which can improve the health of the people, this will encompass a very mixed assortment of activities. For instance, besides the factors mentioned above one has to include steps to improve sanitation, provide safe water supply etc., also. In other words, the scope of the concept will become extremely wide. Notwithstanding the importance of all such activities, the concept of primary health care in the present study is limited to include the following three specific components.

1. Basic medical care including access to primary advice from qualified medical/paramedical personnel, common medicines etc.
2. Immunizations against common infectious and communicable diseases like measles, polio, tetanus, tuberculosis etc.
3. Preventive measures against common endemic and infectious diseases like malaria, diarrhea etc.

The restriction of this working definition to these three components is guided by the two considerations that (a) these items unlike water supply and sanitation fall under the traditional jurisdiction of the Ministry of Health and (b) the items unlike birth control have a direct impact on people's health.

* * *

Having traced the evolution of primary health care approach and defined primary health care in the context of the present study, the stage is now set for the analysis of trends in public expenditure on health care in general and primary health care in particular in Assam. But before taking up that a review of studies examining various aspects of health care financing in India will perhaps be in order. Chapter Four therefore will present a review of such studies. That will be followed by the presentation of the trends and

composition of public expenditure in general and primary health care in particular in Assam in Chapter Five.

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APPENDIX 3.1

Goals for Health and Family Welfare Programme (Under Global Objectives of "Health for All by 2000 AD")		
Sl.No.	*Indicator*	*2000 A.D.*
1.	Infant Mortality rate Parental Mortaligy	below 60 30-35
2.	Crude Death rate	9
3.	Pre-School Child (1-5 year) Mortality rate	10
4.	Maternal Mortality rate	below 2
5.	Life Expectancy at Birth Male Female	 64 64
6.	Babies with Birth Weight below 250 gms. (Percentage)	10
7.	Crude Birth rate	21
8.	Effective Couple Protection (%)	60
9.	Net Reproduction rate	1
10.	Growth rate (annual)	1.2
11.	Family size	2.3
12.	Pregnant Mother receiving ante natal care (%)	100
13.	Deliveries attended by trained	100
14.	Immunization Status (% covered) TT (Pregnant Women & School Child) Polio & BCG	 100 85
15.	Leprosy (% of Disease arrested out of Cases detected)	80
16.	TB (% of Disease arrested out of Cases detected)	90
17.	Blindness (% of incidence)	0.3

FINDINGS OF SOME RELEVANT STUDIES ON HEALTH CARE FINANCING

Under the Indian constitution items such as public health and sanitation, hospital and dispensaries etc., are included in the 'state list' of functions, while some others like population control, medical education, adulteration of food, medical profession, registration of births and deaths etc., fall under the 'concurrent list'. Thus although health is primarily a state subject the central government also can and actually does play an important role in the health sector. In particular the Union Ministry of Health and Family Welfare had been taking the initiative in formulation of nationwide programmes like family welfare, immunization and prevention and control of communicable and endemic diseases and financially supporting the implementation of such programmes by the state governments. Over and above the state and central governments, international organizations like WHO, UNICEF etc., have been working and spending a substantial sum of money for the general improvement of health of the masses.

Discussing the role of the state government vis-à-vis the central government in the health sector Rao (1993) observes that 'theoretically speaking each state can formulate its own health policy but financial constraints and several other factors do not permit such a course of action. In the first place, the state governments have to function within the parameters of the National Health Policy laid down by the union

government. Secondly, it is the Government of India, which provides the link and regulates the relations between the state government and international bodies like WHO or UNICEF etc. Thirdly, it is the responsibility of the union government to provide coordination between the activities of various state governments as well as with its own activities. Lastly, in regard to some vital fields the union government sponsors a number of schemes by providing finance and in many other ways to be implemented through the state agencies. Even though the freedom of the state agencies is somewhat restricted due to factors such as those mentioned above, Rao is of the opinion that within the orbit of the national policy there is enough scope for the states to administer schemes to suit the local variations' (Rao, 1993).

Over and above the state and central governments a large number of national and international voluntary organizations are also actively involved in providing various health related services. Last but not least, the private sector starting from individual practitioner to the big corporate hospitals, has been playing an increasingly important role and making substantial investment in the health sector. Thus the agencies investing and operating for up-liftment of health of the people can broadly be classified into three sections - (1) Public Sector; (2) Private Sector, and (3) Voluntary Organizations. The expenditure in health care made by the three sectors during the post independence period of India have been analyzed in several studies by agencies like Operations Research Group (ORG), Foundation for Research in Community Health (FRCH), Indian Institute of Management (IIM) etc. The studies generally try to cover the following issues - (1) to see the trends, objectives and effectiveness of the investments made by public and private sectors; (2) to analyze the cost effectiveness of the health care programmes; (3) the rural - urban distribution of the health care expenditure; (4) to examine the role and viability of the non government and voluntary organizations (NGOs) in case of delivery of health care service and (5) to compare the efficiency and wastage of the total expenditure on health by different sources of the system. The remaining parts of the chapter present a summary of the findings of the studies.

Findings on the Trends in Overall Health Care Expenditure by the Public Sector in the Plan Period

A review of the outlays and expenditure over various plan periods give some encouraging as well as some disturbing signals. The World Bank review (1993) of financing in health in Asian countries shows that around the mid 1980s, India ranked amongst the poorer countries in the world in terms of national income, but private and public spending in health care relatively was high in India, both in absolute and proportional terms in comparison with its Asian neighbours.

The total outlay on the health and family welfare sector has increased substantially over the successive plans. The total investment increased from Rs. 65.2 crores in the first plan to Rs. 6649.2 crores in the seventh plan (Gill, 1987). Even though in absolute terms the total amount of funds allocated to health and family welfare services have increased manifold, the overall percentage share of health sector of the total plan investment remained very low. According to the Operations Research Group study (by Rao, Khan and Prasad 1986 & 1993) the share of health sector stabilized at around 4 percent of government spending or around 1 to 1.5 percent of the Gross Domestic Product (GDP). The percentage of plan funds allocated to health and family planning taken together (but excluding water supply and sanitation) fluctuated around 3 percent during the period from third plan to sixth plan reaching a maximum of 3.9 percent in the fourth plan period. The corresponding figure for the seventh plan was 3.7 percent. The statistics indicate that 'health' has remained a low priority in India's plans. The overall backwardness of the state health sector and the gross inequalities in its distributions has been observed by Foundation for Research in Community Health (FRCH) study. The first FRCH study (Duggal, Nandraj and Shetty 1992) reports that public health investment and expenditures in India has increased substantially since independence, but this has not been enough to secure a minimum decent standard of health care services in the country. As a consequence, the private health sector has seized the opportunity and established its market in the profitable sub sectors of health, namely, curative care, drug manufacture and distribution. The study analyzed

investments in the state health sector since the beginning of the first five-year plan. During the first five-year plan, the state's (i.e., including all governments) total revenue expenditure was Rs. 49.37 billion for the five years, which amounted to about 10 percent of the country's GNP of that period. Out of this, the expenditure on health was Rs. 1.96 billion comprising about 4 percent of the state's total revenue expenditure. Thus as a percentage of GNP, the public expenditure on health was only 0.39. The share of expenditure on health in the total state expenditure sleeped somewhat to 3.4 percent by the 6th plan. The total state expenditure as a percentage of GNP has gone up to 34 percent. As a result, the state expenditure on health as a percentage of GNP improved to 1.15 percent. But the fact remain that in the massive expansion of state sector investment the health sector was not considered as a special growth area. Gill (1987) observed that the growth rate of government expenditure on health was comparatively higher on the third, the fifth and the sixth five-year plan periods. Further looking onto the composition of the government expenditure on health during the same plans, the author found that a large part of the expenditure went to infrastructure development, i.e., water supply schemes and construction of health centres. In fact, over one half of the medical and public health expenditure since the third plan period was being spent on water supply and sanitation. In spite of this, the author commented that the health infrastructure remained poor and the public health sector had not reached the level of infrastructure and facilities recommended by the Bhore Committee way back in 1946.

The Trends in the Composition of the Total Public Sectior Expenditure on Health

During the plan period the strategic importance of the public sector in the area of health gradually shifted from curative care to prevention and control of communicable and endemic diseases and then to family welfare programme. This shift is evident in the findings of the studies analyzing the trends in the composition of total government expenditure on the health sector. In terms of demand, curative or medical care is the most important health care activity. But the government's allocation to this activity has declined in relative

terms though private investments have been forthcoming significantly to compensate this decline.

Duggal, Nandraj and Shetty (1992) found that state expenditure on curative services as a proportion of total health expenditure declined between 1951 and 1985 from 44 percent to 37 percent. (The actual decline was even higher as till 1974 the total expenditure on health was inflated by inclusion of revenue expenditure on water supply in it. But since 1974 the latter has been recorded separately).

Till the early eighties expenditure on communicable disease control programmes was second to curative services but during sixth five year plan period family planning took second position relegating disease control programmes to the third place. The studies by both FRCH (Duggal, Nandraj and Shetty, 1992) and ORG (Rao, Khan and Prasad, 1986) revealed the fact that among communicable diseases the major share of the expenditure was incurred for the national malaria eradication programme, while the other diseases like leprosy, tuberculosis, blindness, Goitre, diarrhea disease etc., were relatively neglected. ORG study calculated that in 1982-83 about 62 percent of total disease control programme expenditure was spent only for eradication of malaria. According to the FRCH study expenditure on family planning grew rapidly since third five-year plan and gradually it became the single largest plan health programme swallowing more than half the plan resources for the health sector. Gill (1987) found that the percentage share ot expenditure in family planning to total expenditure on health has risen from a negligible amount in the first plan to 49 percent in the seventh plan. Similarly, Panchamukhi (1993) found that public expenditure in family planning increased more than eight fold during a period of nineteen years from 1966-67 to 1985-86.

The rapidly increasing allocation to family welfare programme in the latter part of planning era reflects the growing public concern about the rapid population growth in the country. Since there is no second opinion about the need of population control, the emphasis given on family welfare cannot be considered unwarranted. However, the concomitant neglect of curative care sector by the government agencies has been criticized by researchers. All the studies

mentioned above observed that the rise in allocation to the family planning sector in the five-year plans had been at the expense of the public health sector. The FRCH (1992) study remarked that besides the resources allocated to family welfare programme, the programme used the entire rural health infrastructure and its human power to meet the target of its' programmes. The consequence of this was not only the neglect of other health programmes but also the discrediting of the rural health service as a family planning service. This loss of faith in the public health sector amongst the rural population gave the private health sector an opportunity to make its presence felt as nearly the sole provider of curative care in the peripheral areas.

Differences in Rural–Urban Health Care Expenditure

It is difficult to find out the exact allocation of health sector outlays between rural and urban areas using the budget publications, as many schemes are implemented in both rural and urban areas. But an attempt by the ORG (1986) study indicates that, at the national level, as much as 44 percent of total health sector expenditure was incurred purely in urban areas, as against 15 percent in rural areas. The schemes, which are common for both rural and urban areas accounted for 41 percent of the total expenditure. If one distributes this common expenditure to the rural and urban areas in proportion to their population size (77 percent in rural and 23 percent in urban areas), the rural / urban breakup of the total expenditure works out to be 46 percent and 54 percent respectively. Thus the scenario demonstrates an urban bias in the allocation as well as actual expenditure on the health sector.

According to Duggal and Amin's (1989) estimates 70 percent of total government expenditure on health is spent in urban areas and remaining 30 percent is spent in rural areas where, 75 percent of the total population lives. They found that the average per capita expenditure on health was Rs. 40 in the country as a whole. However, it was only Rs. 16 for rural areas, and Rs. 111 for urban areas. In addition to this, in the cities municipal bodies were found to be spending about Rs. 50 per city person per annum. Taking this into

account total government expenditure worked out to be Rs. 161 per city person per year on contrast to only Rs. 16 per village person per year.

Thus, the government expenditure per person in rural areas was only one tenth of the same per person in urban areas. In short both the studies revealed startling imbalance with a strong urban bias in the government expenditure on health in the country.

Financing of Health Care by Local Bodies

The National Council for Applied Economic Research (NCAER, 1981) carried out one study of resources of municipal bodies in 1976-77. This study had compiled financial data for all municipal corporations and municipalities in India. Using this database the FRCH has made estimates of municipal financing of health for the year 1981-82. The study found that an estimated Rs. 8480 million (or, Rs. 53 per capita of the 160 million urban population) was spent on health care in urban areas by municipal bodies. Similar estimates for the zila parishods (of Maharashtra) had been made by FRCH for rural populations for the same year at Rs. 0.20 per capita of rural population (Duggal, 1986 a). A study of IIM (1987) estimated municipal health expenditure for 1984-85 on the basis of a study of 9 municipal corporations in Maharashtra. This study estimated such expenditure to be Rs. 62 per capita per annum.

Financing of Health Care by Private Sector

The largest source of health finance is private expenditure on health care. Private expenditure is of two types - (a) by households in procuring services, and (b) by agencies providing services. In the late fifties and sixties Seal carried out numerous small studies in various states to record private household's expenditure on health. The study showed that in the various states private medical expenditure by the service recipients ranged between Rs. 0.40 to Rs. 7.20 per capita (Seal 1961,1962,1963). Similar studies by Duggal (1991) and Duggal & Amin (1989) showed that households in India spent on medical care 3 to 4 times over and above the government's curative care expenditure. The 28^{h} round survey by National Sample Survey (NSS, 1973-74) estimated

that the expenditure on health by household recipients was Rs. 14.05 per capita.

Analyzing the expenditure made by agencies providing health services FRCH (1989) study found that 70 percent of the total expenditure is owned by private agencies. Other survey findings on utilization patterns also indicate the high dependence of health care seekers on the private sector (Bhat, 1992, Duggal & Amin, 1989). Despite the widespread public infrastructure, a higher proportion of health services are provided by private sector than by the government facilities (Chatterjee, 1988). Bhat (1993) found that about 56 percent of the hospitals and 49 percent of dispensaries were in the private sector in India. (According to authors the significant use of resources by private health care sector is investment in new technologies). Hospitals in the private sector provide a significant proportion of hospital bed capacity and have a major influence on the utilization of such facilities. Most of the survey findings show that people perceive that the quality of private care is high, resulting in strong preferences for using these facilities. Besides hospitals and dispensaries in the organized private sector there are many other private practices of traditional and unregistered health sector. This sector had a strong presence in rural as well as urban areas.

Studies Dealing with the Role and Viability of NGOs in Health Care

During 1980s the Government of India sought to involve non-government organizations (NGOs) in various aspects of health care. For instance, to increase community participation in system managed programmes such as Universal Immunization Programme (UIP)[1] and Integrated Child Development Scheme (ICDS)[2] etc and to engage private individuals as community health workers, government wanted the involvement of NGOs. Chatterjee (1993) in her study about India's health care system found that in some instances government health facilities and medical staff has been turned over to NGOs to be run and managed. NGOs have also been involved widely in training workers for the government health system, ranging from community health workers (CHW) and anganwadi workers to doctors and health administrators.

The FORD Foundation initiatives (called ANUBHAV PROJECT[3]) to analyze NGO approach in health care services reported that NGOs performed different roles as service providers, social activists, educators and resource groups. The studies recognized that important role of the voluntary sectors are as 'innovators of health improvement'.

The attempts to turn government health facilities over to NGOs to run, for example, in the states of Maharashtra, Gujrat and Tamilnadu have been somewhat more successful. While there have been tensions between the opposite approaches of the two systems, in several instances these have been overcome. For example, although NGOs consider 'flexibility' to be among their main strengths, they have had to run the public facilities using government norms and procedures. While NGOs can hire and fire staffs freely, in the government system the 'easy way out' -dismissal- is not easily achieved. This has led NGOs to try harder to retrain workers or to deploy them in different ways, providing that this can be done. Where NGO leaders have been able to steer the system, they have been able to bring about considerable improvements in preference and effectiveness. On the whole, however, very few NGOs have come forward to undertake such challenges although several states and health programmes (e.g., ICDS) have actively sought them out (Chatterjee, 1993, p. 363).

The ANUBHAV (1986) studies commented that NGOs played a link role either by conscientizing the people to make demands on the system or by assisting them in making use of government health care services. According to Berman and Dave (1994), the non-government organizations (NGOs) have shown a high degree of creativity and innovation in developing varied sources of financing to reduce dependency on public fund and enable them to sustain their programmes. However, government funds play a major role in supporting these voluntary health activities, with less significant roles played by foreign donations, user charges, pre-paid membership and public fund raising. Thus serving the health needs of approximately 5 percent of India's population in rural and urban areas (in 1989), the NGOs were a central as

well as state government recognized sector for the delivery of health service to the masses.

Conclusion

The above review of the studies on different aspects of expenditure on health care bring to the fore some important points.

(1) In the post independence period government expenditure in health care in India has increased as a percentage of GNP. However, the share of expenditure on health care in total expenditure of the government has not improved (or even might have declined to some extent).

(2) In the composition of total government expenditure on health sector the share of curative care had steadily declined. First it was 'Disease Control Programme' and since around the 1980s it has been 'Family Welfare' whose shares in total government expenditure have been rising.

(3) The spatial distribution of government expenditure on health shows a strong urban bias. Per capita public expenditure on health in urban areas has been found to be about ten times higher than in rural areas.

(4) Both in rural and urban areas private sector has emerged as the major provider of health care specially the curative care.

(5) The several instances show that NGOs can potentially play a significant role not only in providing health care but also in better utilization of the resources made available by the public sector. However, their overall presence in the health sector is yet to assume a significant proportion. Contrary to popular belief it is the fund made available by the government rather than by international agencies and donor groups which play a more significant role in supporting the NGO activities.

NOTES

(1) **Universal Immunization Programme (UIP):** The Universal Immunization Programme was launched in 1985 with the objective of immunizing 85 percent of infants and 100 percent of pregnant women.

It is a centrally sponsored scheme, with start - up funds provided by UNICEF and other international donors.

(2) Integrated Child Development Service Scheme (ICDS): Combining child health and maternal care, the integrated child development service scheme, is a community-based programme. ICDS consists of a 'package' of supplementary nutrition, immunization, health check ups, referral, health education and pre school education.

(3) ANUBHAV Project: The FORD FOUNDATION initiated a project in 1986 to systematically analyze, document and disseminate the experiences of non-government organizations (NGOs) implementing health and family planning programmes in India. The project is known as ANUBHAV (the Hindi word for experience) project.

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