HEALTH AND HEALTHCARE IN WESTERN AND CENTRAL INDIA

The Criticality of Public Finance

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Introduction
The western and central region of the Indian subcontinent includes a mix of states with widely differing political economies. It includes some of the most developed states of the country like Maharashtra and Gujarat, which also form the axis of industrial India, and also some of the less developed, like Madhya Pradesh, Chattisgarh and Rajasthan. One need not emphasise that a very close association exists between economic development and health and healthcare, which is very clearly manifest in the health outcomes of these states. Maharashtra and Gujarat besides being industrial centres have also created agrarian wealth through sugarcane, cotton, groundnut and milk. The latter has had significant impact on health outcomes of rural populations in these states. Another feature of this entire region is the large *adivasi* population in all these states. Infact the tribal belt of India begins from south Rajasthan, traverses through north and south Gujarat, through north and east Maharashtra, the entire southern length of MP and into Chattisgarh, and ofcourse beyond into Orissa, Jharkhand and right upto north-east India. This is important because when we look at the starvation pattern in India the tribal belts are often the most severely affected, including in the highly developed state of Maharashtra.

While India lost the opportunity of implementing a national health care system via the Bhore Committee[1] recommendations and made very poor investments in the public health sector over the years, the mid-seventies became a turning point for major investments, especially in rural India via the Minimum Needs Program. The 5th to 7th Plan period may be regarded as the 'golden era' of public health sector performance in India when not only public investments and expenditures in healthcare peaked but also health outcomes witnessed rapid changes. (see Table 2 and 5) Supported by their economic development Maharashtra and Gujarat made early progress in health and healthcare, and Rajasthan and MP because of inadequate economic development support were slower on the uptake. This hypothesis gains greater significance when we look at intra-state differences, especially in Maharashtra and Gujarat. In both these developed states economic development (whether industrial or agrarian) is concentrated in some pockets and the high achievements of these pockets of growth undoubtedly skew the overall health outcomes. MP and Rajasthan having fewer pockets of growth are unable to come up with health outcomes that are comparable to Maharashtra and Gujarat. And an analysis of the health scenario and data from these states (Table 1) clearly throws up evidence of the criticality of public financing of the health sector if improvements in health status of the people have to be achieved and sustained.

Health and Healthcare
The pattern of development of the health sector is closely linked to the political economy and the level of economic development. While economic development can create conditions for better access to healthcare as well as a better average standard of living and hence improved health outcomes, a political economy based on largely private health financing can create large adversities for health not only for the poorer sections of society but also the middle classes. Thus the role of public financing is critical in both developed and underdeveloped

[1] Bhore, Joseph, 1946 : Report of the Health Survey and Development Committee, Volume I to IV, Govt. of India, Delhi

economies. In most developed countries where healthcare access is near universal public financing, whether through state revenues and/or social insurance, has been the critical component in realising universal access with equity.[2, 3] In western and central Indian states one can see these associations in operation very visibly.

Maharashtra is the most developed state in the country with the highest per capita income in real terms. At today's level it has the best health outcomes amongst the central-western region of India and this position has been occupied by Maharashtra since many years. If we look at historical data we see that public financing and development of public health facilities played a very critical role in giving Maharashtra an early lead in health outcomes. What was unique to Maharashtra was decentralised health budgets through zillah parishads right from the start for the development of the rural healthcare system. Maharashtra was perhaps the first state to realize the policy entitlements of one PHC for 30,000 population and one CHC for 5 PHCs. This was possible due to comparatively adequate investments and a higher level of per capita spending compared to other states in the region. (Table 5)

Gujarat's trajectory was similar to Maharashtra's pattern. Being close behind Maharashtra in both industrial and agricultural development, Gujarat too had the necessary economic support to facilitate health development. But for Rajasthan and Madhya Pradesh neither was this opportunity there nor did their governments invest adequately in per capita terms in healthcare. (Table 5) It must be noted that in terms of percent of govt. spending and as a proportion to NSDP, Rajasthan and MP were on par or even better than the developed states but this high level is belied when we look at per capita expenditures. The higher ratios for NSDP and govt. spending in the latter states are due to low economic development and low income levels.

Further, health and development cannot be seen only in terms of state averages because all these states are huge and intra-state differences are very strong. At one level there are rural-urban hierarchies in type and quality of health services available with the urban sectors hogging most of the curative budget and often two to three times the resources in proportion to their strength in the states' population, and the rural areas getting mostly preventive and promotive services like family planning, immunisation, ante-natal care and some amount of disease surveillance. At another level there are sub-regional hierarchies in the form of pockets of growth like the sugar and cotton belts in Maharashtra, the groundnut, milk and cotton belts of Gujarat, the industrial areas of Mumbai-Thane-Pune, Surat-Ankleshwar, Indore, Raipur, Kota etc.. Health outcomes in these privileged pockets are vastly different from rest of the state's regions, and of course often public health resource commitments are also skewed in favour of these privileged areas.

Another difference between the developed and underdeveloped states of the region is the availability of private health services. Maharashtra and Gujarat have a well-developed private health sector and this is largely due to the high level of economic development, which ensures purchasing power availability. In contrast the relative lack of purchasing power in Rajasthan and MP have inhibited large-scale private health sector growth. This is clearly seen in larger levels of utilisation of public facilities in Rajasthan and MP, especially for the more expensive hospital care. Further, when we look at morbidity levels and hospitalisation rates and contextualise them within the utilisation pattern it becomes clear why the poorer states, at

[2] Roemer, Milton, 1985: National Strategies for Health Care Organisation, Health Administration Press
[3] OECD, 1990 : Health Systems in Transition, Organisation for Economic Cooperation and Development, Paris

one level, and the poorer classes at another level report lower morbidity and hospitalisation rates – the lack of purchasing power forces them to ignore and/or postpone attention for their illnesses. (Table 3) Thus healthcare development patterns and the political economy of health in the two different sets of states of this region are very different both in terms of the trajectory of growth as well as where they have reached today.

Threat to Public Spending

The achievements of the public health sector in improving health outcomes during the eighties received a set back with the economic crises of 1991 and the subsequent economic reforms which followed under the SAP strategy commandeered by World Bank. As mentioned earlier, during the 5th to 7th Plan period public health services and public health investment was relatively robust and this got reflected in faster improvements in health outcomes, to begin with in developed states and to be followed by the underdeveloped. (Table 2 and 5) This approach received a set back at the turn of the nineties when resource commitments in the public health sector declined, and especially so in the developed states.

This is reflected at one level in slowing down of improvements in health outcomes and the widening rural-urban gap of these outcomes. (Table 2) And at another level the public health care facilities are getting incapacitated because the necessary inputs that are needed to run these facilities are not being adequately provided for. (Table 4) The 2002 National Health Policy unashamedly acknowledges that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource allocations generally insufficient:

"It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services."[4].

This is largely caused by compression of public spending in the health sector and secondly due to allocative inefficiencies caused by unprecedented increases in salaries as a consequence of the 5th Pay Commission implementation (around 1996-1998). Non-salary components have shrunk considerably as budget increases do not factor for allocative efficiencies for effective running of the public health system. This coupled with privatisation policies, including introduction and/or increase in user charges, have taken the public health system to the brink of collapse. With greater dependence on the market for healthcare, access becomes more difficult.

The evidence for this is clearly brought out in the changes one sees across the 42nd and 52nd Round NSS surveys[5], when over this decade utilisation of private health services, especially

[4] MoHFW, 2002: National Health Policy 2002, *para 2.4.1*, GOI, New Delhi

[5] NSS-1987:Morbidity and Utilisation of Medical Services, 42nd Round, Report No. 384, National Sample Survey Organisation, New Delhi; and NSS-1996:Report No. 441, 52nd Round, NSSO, New Delhi, 2000

in the hospital sector, increases substantially, out-of pocket spending gallops, indebtedness due to health care affects half the users and the proportion of non-utilisation also increases. And it is the developed states that experience the adversities of SAP policies more because the declines in public spending has been larger in these states. Thus in the nineties Rajasthan and MP show relatively higher increases in public spending and hence health outcomes improve faster in these states in contrast to the developed states where declines in public spending lead to stagnation in health outcomes. (Table 2 and 5) This is also unflinching evidence in support of the hypothesis that public financing makes a critical difference towards improving health outcomes even in the absence of significant economic development of these states.

Infact, when we relate health outcomes with expenditures we see that in comparison to similarly developed countries India's (as well as states of this region) performance is the worse despite India having one of the highest total health expenditures amongst these countries.[6] This is largely due to the fact that in India the spending is mostly out-of-pocket because public resources committed are very low. In a scenario of poverty such a mechanism of financing will never show up good health outcomes because out-of-pocket health expenditures for the poor as well as the not so poor means foregoing other basic needs or worse still getting into indebtedness. National surveys show loans for healthcare to be the number one reason for families, especially the poor, getting into indebtedness (in the category of consumption loans)

Another dimension of the reform process is that of disinvestments by the state in economic activities. This is supposed to release resources for a larger role of the state in social sectors - the "human face" in the reforms/adjustment process. While divestment of public sector undertakings has been taking place, there is no evidence of increased support to the social sectors like health and education. This is perhaps due to the simultaneous shrinking of state revenues due to cuts in tax rates, excise duties etc. which reduces the states share in the national income, that is declining tax : GDP ratios (from a peak of over 16% in mid-eighties down to 13% presently)[7]. This trend is in itself a threat to public spending because not only the promised additional resources are not available for the social sectors but also some support which was available through public sector enterprises is now getting diminished and is already getting reflected in increased unemployment ratios which are up from around 2% in the eighties to over 7% presently[8].

The social sectors, which are of primary importance for human resource development, are critically dependent on public financing. The latter becomes even more important in the

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[6] **Health Outcomes in Relation to Health Expenditures**

	Total Health Expenditure as % of GDP	Public Health Expenditure as % of total	U-5 Mortality	Life Expectancy	
				Male	Female
India	5	17	95	59.6	61.2
China	2.7	24.9	43	68.1	71.3
Sri Lanka	3	45.4	19	65.8	73.4
Malaysia	2.4	57.6	14	67.6	69.9
South Korea	6.7	37.8	14	69.2	76.3

Source: Changing the Indian Health System – Draft Report, ICRIER, 2001

[7] DEA, 2003: Economic Survey 2002-03, GOI, New Delhi
[8] Ibid.

context of poverty because such support creates equity even with high levels of income poverty. Three-fourths of people live below or at subsistence levels. This means 70-90% of their incomes goes to food and related consumption. In such a context social security support for health, education, housing etc. becomes critical. Ironically, India has one of the largest private health sectors in the world with over 80% of ambulatory care being supported through out-of-pocket expenses.

We have seen earlier that the public health services are very inadequate. The public curative and hospital services are mostly in the cities and in this region between 20-40% of the population reside in them. Rural areas have mostly preventive and promotive services like family planning and immunisation. The private sector has virtual monopoly of ambulatory curative services in both rural and urban areas and over half of hospital care. Further, a very large proportion of private providers are not qualified to provide modern health care because they are either trained in other systems of medicine (traditional Indian systems like ayurveda, unani and siddha, and homoeopathy) or worse do not have any training, and these are the providers who the poor are most likely to seek health care from. In the underdeveloped states the proportion of unqualified or inadequately trained practitioners is much higher. This adds to the risk faced by the already impoverished population. The health care market is based on a supply-induced demand and keeps growing geometrically, especially in the context of new technologies. The cost of seeking such care is also increasing. This means that the already difficult scenario of access to health care is getting worse, and not only the poor but also the middle classes get severely affected.[9] Thus India has a large, unregulated, poor quality, expensive and dominant private health sector, and an inadequately resourced, selectively focused and declining public health sector despite its poverty, with the former having curative monopoly and the latter carrying the burden of preventive services.

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

Infact, the post (1991)-reform period slowed down growth, increased poverty[10] and inflation, and reversed many trends of the eighties. No doubt it caught up towards the mid-nineties, but it has not yet surpassed the achievements of the eighties. Thus in the eighties India was developing rapidly with a gradual globalisation process and with the advantage of its inner strength which insulated it from global shocks. In the nineties there was rapid globalisation that exposed India to global fluctuations; if India survived the Asian shock, which destroyed Indonesia and other Southeast Asian economies, it was because of its sheer size and the strengths of its own local markets. Another fact to contend with is the as yet dependence of

[9] The 52nd Round NSS data reveals that for inpatient care 46% of poorer classes and 34% of the richer classes either sold assets or took loans to pay for treatment. And those using private hospitals were 16% more likely to get into indebtedness than those using public hospitals. (NSS-1996 : Report No. 441, 52nd Round, NSSO, New Delhi, 2000)

[10] The poverty ratio is much debated and different estimates are there. The official line is that poverty ratio has declined considerably in the nineties and stands around 27% but if we move away from the numbers game and look at the character of poverty its increasing severity with starvation deaths is most striking. In the eighties one had stopped hearing of starvation deaths.

over two-thirds of the population on agriculture and 70% of the population living in rural areas. Since the larger impact of macro-economic reforms is on the urban-industrial sector, which integrates globally with much ease, the rural population in a sense still has relative protection from global impacts. Further, it is the consistent good performance of agriculture that has helped ward off the severities of SAP, which many other countries have faced. In addition, India's strong investments in the past in rural development, especially employment guarantee programs and agricultural subsidies aided in reducing the adverse impact of SAP. And this is not likely to change thanks to the strong farm lobby that is in fact demanding greater investments and subsidies for the rural economy. Thus at one level India and the states in this region are much more exposed to the global market with increasing vulnerability. But at another level they continue to enjoy an inner strength and autonomy because of sheer size, large rural-agricultural population and a large local market of its own, despite the fact that politically the situation is very fluid. This background is important for understanding the impact and changes in the health sector.

Moving Towards a New Paradigm[11]

One question often raised is 'Why Invest in Health?' and as one argument states that investment elsewhere often has positive impact on health. Yes, that is true but provided such health impacting investment is available! India's social infrastructure is inadequate and poor across the board. Whether it is education, sanitation, drinking water, rural transportation, electricity supply, water harvesting etc.., they are worse if not as bad as the public health care services. Over the years public health services have deteriorated. If one reviews health plans and policies one sees a clear direction of abdication of responsibility by the State. From comprehensive basic care we have moved towards a program based approach (much like fire-fighting) and now even getting selective about programs and recipients of these services. This approach of the State has created favourable conditions for the private health sector to grow from strength to strength, and often aided by public resources.[12]

The other argument that investing in health care is gilt-edged because it has wide ranging spin-offs in the overall economy is also very credible. Kerala in south India is a very good example. Kerala is economically less developed but has the best health profile in the country. This is because of its long history of public investment in health care services in both rural and urban areas. Conversely, with declining investment in the last decade we see adversities in Kerala's health profile. Similarly metropolitan areas like Mumbai, Delhi, Chennai, Bangalore, Ahmedabad, Indore etc. have seen vast investments in public health services and these are reflected in reasonably good health outcomes. In recent years one can see deterioration because of reduced investments and expenditures, which is forcing people to access increasingly healthcare from the private sector that is expanding rapidly. Also these prime public health services have come under the purview of privatisation and user fees have been introduced across the board with the consequence that a large number of poor who were main user of these services have moved away from them.

With such a health system in the country the health of the people cannot be any good. There is no dearth of evidence to show that India's health indicators are one of the worst in the world. Infact the latest Human Development Report shows a downward trend in India's

[11] The discussion from here onwards is contexualised for the country as a whole but is relevant for all the states in the western and central region.

[12] Duggal, Ravi, 2000: The Private Health Sector in India – Nature, Trends and a Critique, VHAI, New Delhi

global ranking[13]. Thus there is a crying need to reorganise the country's health care system. The future lies in creating an organised and regulated healthcare system, which is responsive to people's needs and accountable to them. While reorganisation will be a long-term process, beginnings will have to be made by rationalisation of the existing healthcare system. For example, strengthening primary care (especially first line curative) services, organising a referral system for secondary and tertiary care, reallocation of resources on a more equitable basis etc.

Operationalising the New Paradigm

Post Independence the Indian State had committed itself to comprehensive health care for all irrespective of the capacity to pay. We even had an elaborate national health plan in the form of the Bhore Committee Report. But as we have seen earlier over the years there has been a clear process of dilution of the basic health care package. Basic health care has to be viewed as a right. Today the world has moved beyond only political rights being fundamental, and increasingly social and economic rights are acquiring such recognition. Thus we would like to view health care in a rights perspective and frame priorities accordingly.

Basic health care, or primary health care as it is referred to today, must begin with family physician services and have adequate support of referral services for specialty and hospital care, including special services for the large disabled population. This should be under an organised system, which in today's given reality best exists as a public-private mix. Curative and preventive services have to be integrated so that existing dichotomies are removed. Pharmaceutical services also need to be regulated and organised, especially given the WTO's anticipated impact. With drug price control virtually out of the window, the rising prices are already creating a crisis in healthcare treatment both in public and private domain.

A system based on a public-private mix would be most suitable for the reality in India. The State has to play a central role in helping develop an organised system of health care as against the prevailing laissez-faire approach. The existing health care services will have to be restructured under a defined system and it's financing organised and controlled by an autonomous body. To facilitate such restructuring a well defined system of rules and regulations will have to be put in place so that minimum standards and quality care are assured under such a system.

There will be a lot of resistance to implementing such a system but it is here that the State will have to demonstrate its guts. Experience across the world shows that wherever near universal access exists the system is a public-private mix organised under a single umbrella, well regulated and with fiscal control with a monopolistic and autonomous agency or group of agencies. The best examples are Canada, Britain, Sweden, Germany, Costa Rica and South Korea, among others.

[13] India's human development index rank is down from 115 in 1999 to 124 in 2000, though still better than the 1994 rank of 138. India is on the fringe of medium and low HDI group of countries. India's improvement in the HDI in the last 25 years has been marginal from a score of 0.407 in 1975 to 0.577 in 2000 - this works out to an average increase of 1.6% per annum. The slowing down of growth is shown in the table below: (Source: UNDP Human Development Report, various years)

	1975	1980	1985	1990	1995	2000
HDI score	0.407	0.434	0.473	0.511	0.545	0.577
Annual % increase over previous period	--	1.3	1.8	1.6	1.3	1.1

Public spending on health care is barely 1% of GDP as it stands today and in some of the states in this region much lower. This infact is a decline over earlier years, especially the mid-eighties when it was 1.32% of GDP at the national level and higher in some of the states of this region. Nearly 70% of state spending goes to urban areas, mostly for hospitals. The balance 30% in rural areas is spent mostly on family planning services, immunisation and selected disease surveillance. Private out-of-pocket expenditures on health care are not available in any organised way. At best estimates can be made based on sample surveys of household expenditures and indirectly by extrapolating on the basis of the strength of the private health sector. It is today estimated to be over 4% of GDP, more than double that of estimates available for the sixties and seventies.

A restructured public-private mix would need much less resources. Estimates calculated for the basic health care package, including existing public secondary and tertiary services would cost around 3% of the GDP. This would mean a whopping saving of 40% of what is spent overall now and coupled with much better quality and more effective services. In terms of sharing costs the public share would definitely need to go up and private resources would be channelised through employers, employees and insurance funds or other collective mechanisms of pooling resources like few NGOs, unions etc. have demonstrated. The State would have to raise additional resources through earmarked taxes and cesses for the health sector. This would mean a greater burden on those with capacity to pay but there would be an overall saving of out-of-pocket expenses for all but especially for the poor.

Thus the new strategy should focus both on strengthening the state-sector and at the same time also plan for a regulated growth and involvement of the private health sector. There is a need to recognise that the private health sector is huge and has cast its nets, irrespective of quality, far wider than the state-sector health services. Through regulation and involvement of the private health sector an organised public-private mix could be set up which can be used to provide universal and comprehensive care to all. What we are trying to say is that the need of the hour is to look at the entire health care system in unison to evolve some sort of a national system. The private and public health care services need to be organised under a common umbrella to serve one and all. A framework for basic minimum level of care needs to be spelt out in clear terms and this should be accessible to all without direct cost to the patient at the time of receiving care.

Today we are at the threshold of another transition which will probably bring about some of the changes like regulation, price control, quality assurance, rationality in practice etc.. This is the coming of private health insurance that will lay rules of the game for providers to suit its own for-profit motives. While this may improve quality and accountability to some extent it will be of very little help to the poor and the underserved who will anyway not have access to this kind of a system. Worldwide experience shows that private insurance only pushes up costs and serves the interests of the haves. If equity in access to basic health care must remain the goal then the State cannot abdicate its responsibility in the social sectors. The state need not become the primary provider of health care services but this does not mean that it has no stake in the health sector. As long as there are poor the state will have to remain a significant player, and interestingly enough, as the experience of most developed countries show, the state becomes an even stronger player when the number of poor becomes very small![14]

[14] Data from OECD countries clearly shows that the State is a major player in health financing and over three-fourths of the resources for the health sector in these countries, except USA, comes from the public exchequer; even in the USA it is over

While reorganisation of the health sector will take its own time, certain positive changes are possible within the existing setup through macro policy initiatives - the medical councils should be directed at putting their house in order by being strict and vigilant about assuring that only those qualified and registered should practice medicine, continuing medical education (CME) should be compulsory and renewal of registration must be linked to it, medical graduates passing out of public medical schools must put in compulsory public service of atleast five years of which three years must be at PHCs and rural hospitals (this should be assured not through bonds or payments but by providing only a provisional license to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies only to those who have completed their three years of rural medical service), regulating the spread of private clinics and hospitals through a strict locational policy whereby the local authority should be given the right to determine how many doctors or how many hospital beds they need in their area (norms for family practice, practitioner : population and bed : population ratios, fiscal incentives for remote and underserved areas and strong disincentives and higher taxes for urban and over-served areas etc.. can be used), regulating the quality of care provided by hospitals and practitioners by setting up minimum standards to be followed, putting in place compulsory health insurance for the organised sector employees (restructuring the existing ESIS and merging it with the common national health care system where each employee has equal rights and cover but contributes as per earning capacity, for example if each employee contributes 2% of their earnings and the employer adds another 3% then nearly Rs.100 billion could be raised through this alone), special taxes and cesses for health can be charged to generate additional resources (alcohol, cigarettes, property owners, vehicle owners etc.. are well known targets and something like one percent of sales turnover for the products and a value tax on the asset could bring in substantial resources), allocation of existing resources can be rationalised better through preserving acceptable ratios of salary : non-salary spending and setting up a referral system for secondary and tertiary care. These are only some examples of setting priorities within the existing system for its improvement.

Priorities For Making It Work

To re-organise the healthcare system we need a policy statement to begin with. That is there has to be a political will to carry out such restructuring and reorganisation as well as the strength to fight resistance from vested interests of the existing system.

While the ideal would be to see an organised system in place with an Act of Parliament, the reality is that the political will is missing. The latter is due to health care as a right not being a priority issue in civil society as yet. However, there is adequate interest and concern to take up piecemeal reforms and here the priorities are clear. Improvements and accountability of the existing system, both in public and private domain is emerging on the agenda of reforms. People are demanding quality care and with the consumer courts on their side are increasingly confronting bad medical practice. The medical profession has also awakened to the existing mess and is organising to put its house in order - minimum standards, continuing medical education, accreditation are clearly an emerging agenda with them.

In the public domain there is pressure for privatisation via introduction of user charges. Civil society groups in a number of places are fiercely resisting this. This battle has the potential of

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40% but in India the State contributes less than one-fifth, the balance coming out of pocket of households. (OECD, 1990: Health Systems in Transition, Organisation for Economic Cooperation and Development, Paris)

taking health care into the arena of a rights perspective and expedite the process towards an organised system of health care.

To establish right to health and healthcare with the above scenario certain first essential steps will be necessary:

- equating directive principles with fundamental rights through a constitutional amendment
- incorporating a National Health Act (similar to Canada Health Act) which will organize the present healthcare system under a common umbrella organization as a public-private mix governed by an autonomous national health authority which will also be responsible for bringing together all resources under a single-payer mechanism
- generating a political commitment through consensus building on right to healthcare in civil society
- development of a strategy for pooling all financial resources deployed in the health sector
- redistribution of existing health resources, public and private, on the basis of standard norms (these would have to be specified) to assure physical (location) equity

As an immediate step, within its own domain, the State should undertake to accomplish the following:

- Allocation of health budgets as block funding, that is on a per capita basis for each population unit of entitlement as per existing norms. This will create redistribution of current expenditures and reduce substantially inequities based on residence.[15] Local governments should be given the autonomy to use these resources as per local needs but within a broadly defined policy framework of public health goals
- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools, as also make public service of a limited duration mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and will have a dramatic impact on the improvement of the credibility of public health services
- Essential drugs as per the WHO list should be brought back under price control (90% of them are off-patent) and/or volumes needed for domestic consumption must be compulsorily produced so that availability of such drugs is assured at affordable prices and within the public health system
- Local governments must adopt location policies for setting up of hospitals and clinics as per standard acceptable ratios, for instance one hospital bed per 500 population and one general practitioner per 1000 persons. To restrict unnecessary concentration of

[15]To illustrate this, taking the Community Health Centre (CHC) area of 150,000 population as a "health district" at current budgetary levels under block funding this "health district" would get Rs. 30 million (current resources of state and central govt. combined is over Rs.200 billion, that is Rs. 200 per capita). This could be distributed across this health district as follows : Rs 300,000 per bed for the 30 bedded CHC or Rs. 9 million (Rs.6 million for salaries and Rs. 3 million for consumables, maintenance, POL etc..) and Rs. 4.2 million per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs. 3.2 million as salaries and Rs. 1 million for consumables etc..). This would mean that each PHC would get Rs. 140 per capita as against less than Rs. 50 per capita currently. In contrast a district headquarter town with 300,000 population would get Rs. 60 million, and assuming Rs. 300,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs. 150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would have to contribute 5% of its budget. Ofcourse, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. (Duggal, Ravi 2002: Resource Generation Without Planned Allocation, Economic and Political Weekly, Jan 5, 2002)

such resources in areas fiscal measures to discourage such concentration should be instituted.[16]

- The medical councils must be made accountable to assure that only licensed doctors are practicing what they are trained for.[17] Such monitoring is the core responsibility of the council by law which they are not fulfilling, and as a consequence failing to protect the patients who seek care from unqualified and untrained doctors. Further continuing medical education must be implemented strictly by the various medical councils and licenses should not be renewed (as per existing law) if the required hours and certification is not accomplished
- Integrate ESIS, CGHS and other such employee based health schemes with the general public health system so that discrimination based on employment status is removed and such integration will help more efficient use of resources. For instance, ESIS is a cash rich organization sitting on funds collected from employees (which are parked in debentures and shares of companies!), and their hospitals and dispensaries are grossly under-utilised. The latter could be made open to the general public
- Strictly regulate the private health sector as per existing laws, but also an effort to make changes in these laws to make them more effective. This will contribute towards improvement of quality of care in the private sector as well as create some accountability
- Strengthen the health information system and database to facilitate better planning as well as audit and accountability.

Strategies and Approaches

An organised and universal healthcare system is possible only under a rights perspective. Right to health and healthcare is a fundamental social and economic right recognised by the International Covenant on Economic, Social and Cultural Rights. But such a demand is not on the political agenda in India. The Peoples' Health Assembly initiative (called Jan Swasthya Abhiyan in India)[18] has voiced such a demand but this requires a widespread awareness campaign and participation of many more civil society groups.

On the other end of the spectrum the medical profession needs to be educated not only about self-regulation and the need to organise for minimum standards for quality healthcare but also about the benefits of an organised public-private mix healthcare system.

Only such an approach can lead us closer towards a system that guarantees universal access. Healthcare will have to be viewed in the context of social security. The latter becomes even more urgent under the changing political economy. To support this new public management systems and innovations in health financing to raise additional resources will be needed. And

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[16] Such locational restrictions in setting up practice may be viewed as violation of the fundamental right to practice one's profession anywhere. It must be remembered that this right is not absolute and restrictions can be placed in concern for the public good. The suggestion here is not to have compulsion but to restrict through fiscal measures. In fact in the UK under NHS, the local health authorities have the right to prevent setting up of clinics if their area is saturated.

[17] For instance the Delhi Medical Council has taken first steps in improving the registration and information system within the council and some mechanism of public information has been created.

[18] *The People's Health Campaign* is a unique grassroots-to-global movement for *'Health for All'*, a campaign for better health. This innovative campaign has been active since July 99, to enquire into the current state of health services and to demand better health care The background to this campaign is a global wake-up call being given to governments around the world, reminding them of their promise and pledge made in 1978 to provide 'Health for All by 2000 AD'. India took the lead in this campaign and over 1200 health, science, womens' and other organisations and NGOs, including 19 national networks, in 20 states are involved in the Peoples Health Assembly (PHA) process.

that the support to such a system must come through a mechanism of public (collective) financing is very critical from the standpoint of both equity and sustainability.

We are at a stage in history where political will to do something progressive is conspicuous by its absence. We may have constitutional commitments and backing of international law but without political will nothing will happen. To reach the goals of right to health and healthcare discussed above civil society will have to be involved in a very large way and in different ways.

The initiative to bring healthcare on the political agenda will have to be a multi-pronged one and fought on different levels. The idea here is not to develop a plan of action but to indicate the various steps and involvements that will be needed to build a consensus and struggle for right to healthcare. We make the following suggestions:

- Policy level advocacy for creation of an organized system for universal healthcare
- Research to develop the detailed framework of the organized system
- Lobbying with the medical profession to build support for universal healthcare and regulation of medical practice
- Filing a public interest litigation on right to healthcare to create a basis for constitutional amendment
- Lobbying with parliamentarians to demand justiciability of directive principles
- Holding national and regional consultations on right to healthcare with involvement of a wide array of civil society groups
- Running campaigns on right to healthcare with networks of peoples organizations at the national and regional level
- Bringing right to healthcare on the agenda of political parties to incorporate it in their manifestoes
- Pressurizing international bodies like WHO, Committee of ESCR, UNCHR, as well as national bodies like NHRC, NCW to do effective monitoring of India's state obligations and demand accountability
- Preparing and circulating widely shadow reports on right to healthcare to create international pressure

The above is not an exhaustive list. The basic idea is that there should be widespread dialogue, awareness raising, research, documentation and legal/constitutional discourse.

To conclude, it is evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. There are a lot of small efforts towards this end all

over the country. Synergies have to be created for these efforts to multiply so that people of India can enjoy right to health and healthcare.[19]

Table 1: Overall Health input and outcome profile, and utilisation and expenditure patterns

	Chattisgarh	Gujarat	Madhya Pradesh	Maharashtra	Rajasthan	India
Input Indicators						
Beds per lakh population (1998)	na	155	27	98	42	72
Registered doctors per lakh population		66.2	21.7	71.2	36.9	53.6
Percent beds private (1998)		63.3	NA	47.9	NA	37.3
Percent beds in urban areas (1998)		90.1	65.9	87.0	94.6	73.3
Health exp as a % of NSDP (1998-99)		1.0	1.1	0.6	1.3	0.8
Rev. exp on health as a % of total rev exp (1999-2000)	4.3*	5.2	5.2	4.6	6.4	3.5
Health exp per capita in rupees (1998-99)		183.6	107.8	131.1	162.4	134.4
Outcome Indicators						
Crude Death Rate (2000)		7.9	10.2	7.5	8.4	8.5
Total Fertility Rate (1998-99)		2.72	3.31	2.52	3.78	2.85
Infant Mortality Rate (1998-99)		62.6	86.1	43.7	80.4	67.6
Life Expectancy rate (1992-96)		61.4	55.2	65.2	59.5	60.7
% pregnant women receiving full ANC		25.0	10.9	31.0	8.3	20.0
% children Fully Immunized		53.0	22.4	78.6	17.3	74.0
% Institutional Deliveries		46.3	20.1	52.6	21.5	33.6
% women with BMI below 18.5 kg/m2		37	38.2	20.2	36.1	35.8
% children with Weight by height below -2 SD		16.2	19.8	21.2	11.7	15.5
Utilisation and out-of-pocket Expenditure Profile						
% using public OPD (1995-96)						
Rural		25(32)	23(33)	16(26)	36(56)	19(26)
Urban		22(19)	19(32)	17(25)	41(57)	20(27)
% using public IPD (1995-96)						
Rural		32(49)	53(79)	31(44)	65(80)	45(63)
Urban		37(59)	56(77)	32(46)	73(86)	43(60)
Average total expenditure on OPD care (1995-96) *Rupees per illness*						
(a) Rural						
Public		76	104	90	198	129

[19] Duggal, Ravi: Health and Development in India – Moving Towards Right to Healthcare, Draft paper for Harvard School of Public Health initiative on Right to Development, 2002

Private		175	177	179	156	186
Total		157	155	165	192	176
(a) Urban						
Public		139	513	125	169	166
Private		230	279	195	223	200
Total		218	376	185	198	194
Average total expenditure on IPD care (1995-96) *Rupees per hospitalisation*						
(a) Rural						
Public		1465	2207	1529	2634	2080
Private		3245	3482	3836	3971	4300
Total		2663	2191	3089	3038	3202
(a) Urban						
Public		1897	1678	1439	2544	2195
Private		4185	3889	5345	4949	5344
Total		3327	2774	3997	3149	3921

Figures in parentheses are 42nd Round NSS data; *figures based on revised estimates 2000-2001;

Table 2: Health Outcomes 1976-1996 across Rural and Urban areas

	Total					Rural					Urban				
	1976	1981	1986	1991	1996	1976	1981	1986	1991	1996	1976	1981	1986	1991	1996
IMR *per 1000 live births*															
Gujarat	146	111	107	69	61	159	120	124	73	68	100	89	66	57	46
Madhya Pradesh	138	142	118	117	97	145	152	124	125	102	88	80	82	74	61
Maharashtra	83	79	63	60	48	91	90	73	69	58	61	49	44	38	31
Rajasthan	142	108	107	79	85	152	118	113	84	90	73	53	71	50	60
India	129	110	96	80	72	139	119	105	87	77	80	62	62	53	46
Mortality rate (0 - 4 ages)*															
Gujarat	58	41	37	23	20	66	44	44	26	23	37	31	23	18	16
Madhya Pradesh	53	61	50	45	34	56	66	56	49	36	36	28	26	24	18
Maharashtra	33	26	21	16	16	36	30	24	18	15	24	16	15	12	9
Rajasthan	56	50	41	31	31	57	57	45	33	34	25	19	25	21	20
India	51	41	37	27	24	55	46	41	29	26	30	20	21	16	14

** Mortality rate is per 1000 population*

Table 3: Morbidity Profile 1995-1996 NSS 52nd round

	Chattisgarh	Gujarat	Madhya Pradesh	Maharashtra	Rajasthan	India
15 day prevalence of morbidity per 1000 (rural)		46 (45)	41(43)	52(52)	28(24)	55(57)
15 day prevalence of morbidity per 1000 (urban)		36(37)	38(37)	48(51)	33(33)	54(58)
15 day incidence for acute per 1000 (rural)		25(26)	25(26)	27(27)	14(14)	30(30)
15 day incidence for acute per 1000		20(21)	20(19)	25(27)	18(16)	29(30)

(urban)						
Daily morbidity (point prevalence previous day) per 1000 rural		25(24)	18(19)	30(30)	13(10)	29(30)
Daily morbidity (point prevalence previous day) per 1000 urban		20(21)	19(19)	25(24)	19(18)	29(30)
Hospitalisations per 1000 in last 365 days rural		14(13)	7(6)	19(18)	8(6)	13(13)
Hospitalisations per 1000 in last 365 days urban		21(20)	15(16)	26(25)	14(14)	20(20)
Hospitalisations bottom 10% rural		4(3)	2(3)	10(10)	1(0)	4(4)
Hospitalisations bottom 10% urban		17(21)	9(8)	17(18)	6(12)	12(13)
Hospitalisations top 10% rural		25(23)	25(22)	40(41)	18(14)	13(13)
Hospitalisations top 10% urban		39(29)	51(49)	39(34)	36(25)	20(20)

(Figures in parentheses for females)

Table 4: Adequacy (having at least 60% critical inputs) of Public Health Facilities *(figures in percentages)* – **RCH Facility Survey 2000 (Phase 1)**

	Chattisgarh	Gujarat	Madhya Pradesh	Maharashtra	Rajasthan	India
Primary Health Centre						
Infrastructure		73	6	88	26	36
Staff		71	31	60	32	38
Supply		11	15	87	47	31
Equipments		88	28	96	59	56
Community Health Centre						
Infrastructure		82	26	97	75	66
Staff		12	2	28	16	25
Supply		2	4	8	9	10
Equipments		62	57	10	78	49
First Referral Unit						
Infrastructure		96	49	100	84	84
Staff		25	16	34	26	46
Supply		8	7	50	32	26
Equipments		85	67	34	97	69
District Hospital						
Infrastructure		100	92	90	100	94
Staff		93	75	80	66	84
Supply		21	17	20	33	28
Equipments		100	92	100	100	89

Table 5: Public Health Financing Trends 1975-2002 in *Rupees Crores* and Selected Ratios

	Chattisgarh	Gujarat	Madhya Pradesh	Maharashtra	Rajasthan	India#
Revenue Health Expenditures						
1975-76		**34**	**31**	**64**	**30**	**611**
% of NSDP		0.92	0.86	0.83	1.20	0.98
% of govt. Expenditure		8.96	7.24	6.95	8.52	3.49
per capita (Rs.		11.24	6.61	11.26	9.87	9.91
capital as ratio to revenue expend		0.02	0.05	0.03	0.03	0.10
1980-81		**64**	**69**	**125**	**57**	**1189**
% of NSDP		0.97	1.13	0.90	1.38	1.07
% of govt. Expenditure		7.11	6.77	6.53	8.28	3.29
per capita (Rs.		18.83	13.18	19.94	16.61	17.35
capital as ratio to revenue expend		0.01	0.02	0.04	0.04	0.08
1985-86		**148**	**150**	**269**	**123**	**2715**
% of NSDP		1.20	1.25	1.02	1.60	1.32
% of govt. Expenditure		7.51	6.69	5.97	8.11	3.29
per capita (Rs.		39.35	25.37	38.09	31.36	35.52
capital as ratio to revenue expend		0.02	0.07	0.03	0.03	0.09
1991-92		**284**	**275**	**527**	**280**	**5201**
% of NSDP		1.00	0.83	0.78	1.19	0.88
% of govt. Expenditure		5.42	5.78	5.25	6.85	3.11
per capita (Rs.		67.25	40.40	65.13	61.76	60.13
capital as ratio to revenue expend		0.01	0.03	0.04	0.07	0.08
1992-93		**314**	**337**	**616**	**332**	**6204**
% of NSDP		0.83	0.91	0.73	1.19	0.92
% of govt. Expenditure		4.79	5.48	5.33	6.64	2.71
per capita (Rs.		69.09	48.33	74.15	71.30	70.15
capital as ratio to revenue expend		0.01	0.03	0.03	0.04	0.04
1993-94		**356**	**404**	**698**	**385**	**7518***
% of NSDP		0.84	0.88	0.69	1.33	0.96
% of govt. Expenditure						3.33*
per capita (Rs.		80.90	56.90	83.09	80.71	83.17
capital as ratio to revenue expend		0.01	0.03	0.03	0.03	
1994-95		**413**	**447**	**758**	**461**	**8217***
% of NSDP		0.74	0.89	0.65	1.25	0.90
% of govt. Expenditure		5.47	5.72	5.11	6.83	3.17*
per capita (Rs.		91.98	61.23	88.65	94.27	89.13
capital as ratio to revenue expend		0.00	0.04	0.02	0.04	
1995-96		**468**	**463**	**890**	**515**	**10165***
% of NSDP		0.76	0.82	0.63	1.23	0.95
% of govt. Expenditure		5.33	5.07	5.18	6.18	3.47*
per capita (Rs.		102.40	62.06	102.30	103.00	108.20
capital as ratio to revenue expend		0.01	0.04	0.02	0.12	
1996-97		**517**	**553**	**1004**	**591**	**11313***
% of NSDP		0.70	0.85	0.64	1.15	0.91
% of govt. Expenditure		5.03	4.82	4.81	7.01	3.47*
per capita (Rs.		111.42	72.76	113.74	115.88	118.44
capital as ratio to revenue expend		0.01	0.05	0.02	0.11	
1997-98		**626**	**585**	**1097**	**625**	**12627***
% of NSDP		0.81	0.83	0.64	0.91	0.91
% of govt. Expenditure		5.16	4.99	4.79	6.96	3.39*
per capita (Rs.		133.19	75.58	122.71	120.19	130.05
capital as ratio to revenue expend		0.02	0.05	0.02	0.15	
1998-99		**841**	**820**	**1160**	**820**	**16303***
% of NSDP		0.95	1.04	0.63	1.26	1.01

% of govt. Expenditure		5.39	5.77	4.52	7.08	3.6*
per capita (Rs.		176.31	104.06	128.25	157.69	165.24
capital as ratio to revenue expend		0.04	0.04	0.02	0.05	
1999-00		**913**	**836**	**1354**	**858**	**17854***
% of NSDP		1.02	0.97	0.64	1.29	0.99
% of govt. Expenditure		5.21	5.18	4.58	6.39	3.45*
per capita (Rs.		188.64	104.24	148.14	159.48	178.17
capital as ratio to revenue expend		0.04	0.05	0.05	0.04	
2000-01RE	**95**	**899**	**844**	**1605**	**920**	**20090***
% of NSDP		0.96	--	--	1.32	0.97
% of govt. Expenditure	4.26	3.87	5.28	4.40	6.09	3.40*
per capita (Rs.	45.89	182.72	139.97	172.03	167.88	197.44
capital as ratio to revenue expend	0.15	0.04	0.08	0.03	0.11	
2001-02BE	**230**	**919**	**754**	**1666**	**990**	**22950***
% of NSDP						0.90
% of govt. Expenditure	4.55	3.18	5.13	4.55	6.10	3.52*
per capita (Rs.	104.55	183.80	121.61	171.75	176.79	223.90
capital as ratio to revenue expend	0.07	0.02	0.07	0.04	0.03	

Figures with* include capital expenditures; # for India income ratio is GDP at factor cost
NSDP=net state domestic product; RE=revised estimate and BE=budget estimate

Table 6: Out of Pocket Burden to seek Healthcare 52nd Round NSS 1995-96

	Chattis garh	Gujarat	Madhya Pradesh	Maharashtra	Rajasthan	India#
Hospitalisation (Rs. crores)		205.22	186.25	698.36	122.28	4824
% of NSDP		0.33	0.33	0.50	0.29	0.45
per capita burden (Rs.)		44.91	25.17	80.27	24.46	51.35
Out patient care (Rs. crores)		778.50	1482.52	1813.66	582.31	22085
% of NSDP		1.26	2.62	1.29	1.39	2.05
per capita burden (Rs.)		170.35	200.34	208.47	116.46	235.07
Total Out of pocket burden (Rs. crores		983.72	1668.77	2512.02	704.59	26909
% of NSDP		1.59	2.95	1.79	1.68	2.50
per capita burden (Rs.)		215.26	225.51	288.74	140.92	286.42
ratio to public expenditure		2.10	3.60	2.82	1.37	2.72

for India income ratio is GDP at factor cost; NSDP=net state domestic product

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