HEALTH SECTOR FINANCING IN CONTEXT OF WOMENS' HEALTH

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Prologue

In the last decade or so the health of women has been receiving special attention the world over. From the Nairobi UN Conference, through the Cairo ICPD and to the recently concluded Beijing Conference, health and health care of women has been an important agenda item which has taken a growing share of attention, and especially so reproductive health. And it is here where the catch lies.

While recognising the importance of reproductive health, especially in a country like India which still has relatively high fertility, overwhelming proportion of deliveries being conducted at homes, often under unhygienic conditions, a supposed unconcern for gynaecological morbidities and an embarassingly high proportion of abortions being done illegally, it is even more important to emphasise the need for making available comprehensive health services to all, and especially to women as a group for their special needs. The danger of beginning with reproductive health is narrowing down the focus to the uterus, precisely what the womens' health movements want to avoid. And pushing for making reproductive health a special program under the State's primary health care program would end up the same way in which earlier versions of health programs of women like the MCH program or safe-motherhood have ended - targets for population control programs, and especially hazardous contraceptives like injectables and implants.

Thus the demand must begin with provision of easily accessible and free of cost comprehensive health care for all, with a clear recognition and provision for the special needs of women, as well as for other vulnerable groups like children, senior citizens, tribals etc.. Natural and social justice demands that society must provide for a basic decent human life. This becomes even more imminent in countries where poverty is rampant but it is precisely in such countries where social provisions, like health, education, housing, public transportation and other public utilities, are not available to a large majority of the population.

Health Sector in India

Before we look into gender inequalities in the context of health care it is important to review the overall availability of health care services in the country.

If one looks at statistics, India perhaps has adequate health care infrastructure available. We have about 8 lakh hospital beds and 10 lakh qualified medical practitioners, that is 85 beds per lakh population and 110 doctors per lakh

population. If distributed rationally this is a fairly adequate number. But then reality is different.

Firstly 80% of the qualified practitioners are in the private sector and they operate without any regulations or control whatsoever, and of course for profit. The private health sector market is completely supply induced and the patient is totally at the mercy of the practitioners' whims and fancies. Secondly, 60% of those in private practice are trained in systems other than modern medicine or allopathy and yet a very large majority of these other system practitioners (ayurveda, homeopathy, unani, siddha, etc.) treat patients with modern medicines (of course, some allopaths also indulge in cross practise). Thirdly, two-thirds of private practitioners are located in urban areas when 70% of the population resides in rural areas. Fourthly, the public health sector too has an urban bias. Eighty percent of public sector medical care services and consequently as much of the budget for medical care is for urban areas. The rural areas have Primary Health Centres (PHCs) which provide mostly preventive and promotive services like immunization, ante natal services and family planning services, but medical care which is the main demand and need of the people is not available in rural areas, as even 4/5th of the public hospitals and beds are located in urban areas.

Apart from the formal health sector discussed above there is the informal sector of hereditary, caste-based and/or unqualified/untrained practitioners of various kinds. Their numbers, though exactly not known, is as large or perhaps larger than the formal sector - various types of unqualified practitioners ranging from outright quacks to paramedics, dais, bhagats, vaidoos, witch doctors, herbalists, a variety of others and ofcourse the local disease/technique specialists like abortionists, white discharge experts, jaundice specialists, snakebite specialists etc...

Women and the Health Sector

Given the above dismal picture of health care in India not much can be expected in favor of women as clients of the health care system. Both the private and the public health system's core attention towards women is viewing the latter as mothers. While the private nursing home sector mostly comprises of maternity homes, the public health sector's major concern vis-a-vis women is to prevent them from becoming mothers. While the private maternity homes cater to the urban population and the middle classes (about 50 million women in the reproductive ages) the public sector's health services offer family planning services (overwhelmingly tubectomies and IUCDs) in both rural and urban areas covering over 100 million couples. The maternity services available under the public sector, especially in rural areas, is mostly through paramedics like auxiliary nurse midwives or trained dais.

Beyond the above and some other occassional services like ante-natal care and abortion services (both within the context of family planning), very little else is available to women to address their general and other gender-specific health care needs. Ofcourse the informal sector practitioners do cater to some specific

needs of women like abortions, white discharges, psychic problems (what patriarchal literature calls hysteria) etc.. but very little of it is documented to enable a discussion or make comments. Some efforts are definitely being made to understand the contributions and /or harms of such providers. Some NGOs and Womens' groups have put in efforts to document this and have even helped in improving skills of such practitioners.

This gross neglect begins with defining women's health care needs and their low status in society. Women in India, and especially those in rural areas, given their general living conditions and the double burden on their shoulders, have never publicly voiced their concern over their reproductive, sexual and gynaecological health needs. Even something as obvious as menstruation is grossly neglected and this has serious consequences because many diseases in our country are related to blood loss - tuberculosis, malaria, dysentry, kalaazar, hookworm - and hence makes anaemia an extremely important concern of women's health which presently receives very little attention.

The health system, as indicated earlier, views women's health only in terms of their uterus. Thus, historically all health programmes designed specifically for women have been related to that - MCH, family planning (contraception), child survival, safe motherhood, etc.. What is tragic is that even this narrow focused approach has failed to provide women with safe pregnancy, maternity, contraception, etc.. High maternal mortality and the high level of unsafe, unhygenic births, especially in the countryside, is evidence which stands out pointedly.

The table below clearly shows the poor overall coverage of both the private and public health sectors taken together for the various MCH services as found during the 42nd Round of the National Sample Survey in I986-87 and the NFHS in 1992-93. The rural - urban and the strong class differences are also worth noting. While the NFHS data is not strictly compararble with the NSS data, the improvement in coverage, especially of immunisation and ANC, over the period due to perhaps the mission approach and higher allocation of resources is also worth noting.

MCH Services Utilisation (Public & Private Sectors) Across Classes and Rural-Urban Areas : All India Percentage Coverage 1987 and 1993.

Class	Rural					Urban				
	Completed Immunization		Maternity Care		Births	Completed Immunization		Maternity Care		Births
	Polio	Triple	ANC	PNC	Domi -cilary / Hosp -ital	Polio	Triple	ANC	PNC	Domi -cilary / Hosp -ital

1987 - NSS	7.24	4.41	17.36	10.35	86.75	8.91	14.31	9.54	39.04	21.16	62.05	33.75
Bottom 10%	25.76	20.44	41.67	20.36	55.24	39.03	59.26	51.16	94.05	58.32	8.75	84.25
Top 10%	10.77	7.56	21.15	12.60	80.52	13.53	26.82	20.51	46.83	23.76	46.85	48.20
All												
Difference Between Top & Bottom (Times)	3.5	4.6	2.4	2.0	0.6	4.4	4.1	5.4	2.4	2.7	0.1	2.5
1993 - NHFS	48.4	46.6	56.7	-	83.0		70.2	68.8	81.1	-	41.5	57.6
	16.0											

Source : 1987 - NSS :Compiled from Sarvekshana Issue No. 47; April-June 1991, Tables 2R, 2U,5R, 5U, 6R, 6U, 7R, 7U, 8R, 8U. Data is from the NSS 42nd Round Survey - 1987; and 1993 - NHFS : Compiled from National Family Health Survey - India 1992-93, Tables 9.1, 9.5, 9.11, IIPS, Bombay, 1995

Note : ANC is Ante Natal Care, - PNC is Post Natal Care and MCH is Maternity and Child Health.

The health workers and infrastructure available even for these limited programs is grossly inadequate and of poor quality. In rural areas the PHC's and subcentres are so poorly equipped for even these meagre services that the doctors and nurses are unwilling to risk even a normal delivery. Ironically even tubectomy, the government's most favored 'health' program, is not available on demand to women at the PHC because it is done only in a camp where extra facilities/resources are made available. Further, the obsession of public health services with family planning has discredited the entire public health system in the rural areas.

Even in urban areas where infrastructure and physical access to public health services is relatively far better, women get a raw deal. Let alone their special health needs, even general health needs of women don't get the necessary attention. This is evident when we see the unfavorable ratio of beds assigned to women as well as the actual utilisation by women for both outdoor services and indoor services. Further, many studies have also indicated that neglect of illness care makes women carry a high burden of chronic ailments. All this is due to, as indicated earlier, women's health needs having the least priority in the family and hence getting neglected.

As mentioned earlier, given the existing pattern of health care provision, access to general health care needs for the masses too is extremely restricted. More so current trends of increased privatisation and the concept of selective primary care for public services is going to make the situation far worse for the poor majority. And within this a place for women's health care needs gets even further diluted or even more focused in terms of control of fertility.

Health Care Spending

While the problem starts at the family level itself wherein women's health needs are least important, the actual neglect is due to inadequate allocations by the state for health care services. The world over it has been proved that with universal access and assurance of basic health care womens' access to health

care services has become equitable at least for general health services, if not as yet fully for their special health needs as women.

With the present level of allocation by the State to the health sector of less than one percent of the GDP not even one-fourth of the health needs of the people are met.

The States commitment to provide health care for its citizens is reflected not only in the inadequacy of the health infrastructure and the low levels of financing but also in the declining support to various health care demands of the people, and especially since early eighties when the process of liberalisation and opening up of the Indian economy to world markets began. This is evident from the data in the following table.

Selected Public Health Expenditure Ratios 1981 - 1995

Year	1980-81	1985-86	1991-92	1992-93	1993-94	1994-95
1.Health Expd. as per cent of total govt. expenditure	3.29	3.29	3.11	2.71	2.71	2.63
2.Expenditure on medical care as percent of total health expd.	43.30	37.82	26.78	27.66	27.46	25.75
3.Expenditure on disease programs as percent of total health expd.	12.96	11.69	10.59	10.84	10.41	9.51
4. Expenditure on family planning as percent of total health expd.	11.94	17.94	19.39	16.54	16.88	17.27
5.Capital expd.as percent of total health expd.	8.15	9.23	8.43	4.20	4.67	4.46
6.Absolute annual per capita growth rate of health expd.in percent	15	21	11	13	17	7
7.Total Health Expenditure (Rs.bn.)	11.89	27.15	52.01	62.04	71.83	78.67

Source : Duggal R, Nandraj S & Vadair A; CEHAT Database - Special Statistics : Health Expenditure Across States -Part I and II, Economic And Political Weekly, 30:15-16, April15/22, 1995

Medical care (Hospitals and Dispensaries) and control of communicable diseases are crucial areas of concern both in terms of what people demand as priority areas of health care as well as what existing socioeconomic conditions demand. As with overall public health spending both these programs also show declining trends in fiscal allocations in the eighties and nineties. In fact in the case of disease programs this decline is surprising because of the large foreign assistance for AIDS and Blindness control - this then means that other crucial diseases like tuberculosis, malaria, leprosy, diarroheal diseases, ARI etc.. are being further neglected ! This increasing disinterest of the State in allocating resources for the health sector (family planning being an exception) is also reflected in investment expenditure - there has been a very large decline in

capital expenditures during the nineties. Further, when we look at the growth rate of health expenditures we also see a declining trend and if we correct this absolute growth rate for inflation we would get a large negative growth for the most recent years.

When we look at these same ratios across states not one state government shows a significant trend different from the overall trends (see Duggal,Ravi et.al., 1995). This only goes to show how strongly the Central government influences the states' financing decisions even in a sector where the constitutional responsibility is vested with the state governments and the Centre's grants are only about 10% of state government spending. This 'united action' has been possible because health care policy-making and planning is largely done at the level of the Central government and hence the latter can use arm-twisting tactics. This structure of planning reduces any initiative that a state government may want to take for reallocating resources to favor demands of people for health care. The result is that people do not get satisfactory services from the public system and hence get discouraged to use it.

Low levels of public spending for health and low levels of utilisation of public health services are closely linked. The 1987 NSSO survey on utilisation of health care facilities revealed that for outpatient care public services were utilised for only 26% of the cases. But it also reveals that states with a higher percapita public health expenditure had better rates of public facility use. Further, states having a weak penetration of the private health sector had very high public health facility utilisation (NSSO, 1987). Similar trends have also been found in studies done by NCAER, NIHFW, FRCH and others.(see Berman, Peter et.al.eds, 1992; World Bank, 1994) However, for hospital care the use of public hospitals is as yet higher but that is because 70% of hospital beds are in the public domain. But with 80% of hospitals being in urban areas the rural residents, who constitute 3/4ths of the population, have tremendous difficulties in obtaining such care.

During the 1980's the State did put in genuine efforts at expansion of the rural health infrastructure (even though for strengthening the outreach of family planning), but it is precisely during this period, as we have seen above, that there was a declining trend in public spending on health care. This same period also witnessed a massive growth rate of expansion of the private health sector (Jesani, A et.al., 1993). The database of the NIPFP shows that real growth rates of public health spending have declined rapidly during the 1980's, and more so for Central government spending (see table below).

Real Growth Rate (percent) In Health Care Expenditure

	1974-1982	1982-1989
1. 15 Major States	9.99	8.42
2. Central Government	12.13	3.44
3. Centre + States	10.03	8.22

Source : NIPFP, 1992 - State's Financing of Health Care in India : Some Recent Trends - V B Tulasidhar, mimeo.

Since the 1980's India's debt burden and interest payments have galloped at a rapid rate. It is this state of the economy which has had its bearing on State spending and social sector are the first to get the axe. Under structural adjustment since 1991 there has been further compression in government spending in an effort to bring down the fiscal deficit to the desired level. The GOI budget expenditures have declined from 19.8% of the GDP in 1990-91 to 16.58% in 1993-94. This compression again has been more severe for the Central health sector. The NIPFP database gives evidence for this compression that has taken place over the last decade. It shows that the state's share in health expenditures has increased and that of the Centre declined drastically. Further, the breakdown of Central assistance to states reveal that central programs or centrally sponsored schemes are the most severely affected. And since most of the centrally funded programs are of a preventive and promotive nature a decline of spending on these programs means serious consequences for the health of the nation, especially given the fact that the private sector has no interest in preventive and promotive care (see tables below).

Share of Centre and States in Health Expenditures (percent)

	1974-1982	1982-1989	1992-1993
1. State's own funds	71.6	79.9	85.7
2. Grants from Centre	19.9	5.8	3.3
3. Centre's expenditures	8.5	14.3	11.0

Source : NIPFP, 1993 - Structural Adjustment Program : Its impact on the Health Sector, V B Tulasidhar, mimeo.

Share of Central Grants in State Health Spending (percent)

	Medical and Public Health	Public Health	Disease Programs	Family Welfare
1984-1985	6.73	27.92	41.47	99.00
1989-1990	3.91	16.66	29.12*	74.51
1992-1993	3.70	17.17	18.50	88.59

* figure for 1988-89; Source : same as above Table

Another serious problem in public health spending is the large and increasing proportion of the expenditure on salaries. This in part explains the poor utilisation of public health services because non-salary components like medicines, fuel, equipments, etc.. are inadequately funded. The NIPFP database

shows that commodity purchases declined steadily from 29% of total expenditure in 1978 to 22% in 1988 as did capital expenditures from 9% to 7%. It also revealed that real growth rates in salary expenditures during that period was 9.8% and that of commodities was 5.3% (Tulasidhar,1992). NCAER also found in a district and municipal level study in four states that non-salary inputs ranged between 5% and 21% (World Bank, 1994). This declining share of non-salary spending will only further aggravate the inefficiencies within the system causing further damage to the already poor reputation of public health services.

The analysis and evidence presented above clearly indicates the urgency of stemming declining public spending on health care and taking appropriate fiscal actions to improve the efficiency and effectiveness of the public health care system.

The major problem of health setor development in India, especially in the last two decades, has been that new programs are begun and new facilities started with plan funds (and an increasing amount with foreign borrowings) but their future sustenance is not completely assured by additional non-plan allocations. Health being a state subject, its sustainability is dependant on allocations made by the state. The Centre has major control of plan resources and the states want to grab as large a share as they can. Therefore, states in the initial years of the plan scheme are willing to provide matching grants but when time comes to take charge of the programs they throw up their hands and hence the program continues to remain a part of the plan resources and the effect of the latter is that new investments get affected because of these old plan commitments not being transfered to non-plan budgets. Further, states have a tendency to divert program funds away from components they are earmarked for and this is largely due to the restricted role that states play in policy-making and planning.

This mis-match of centre-state priorities has proved very expensive as funds are wasted on inadequately provided tasks causing allocative inefficiencies and failure of the program to fulfill fully its objectives. For example, a recent GOI-WHO-SIDA evaluation of the tuberculosis program revealed the following :

_inadequate coverage of TB services in peripheral health institutions

_underfunding of drugs to the extent that the effective supply was for only one-third of the cases dectected

_over-reliance on X-ray diagnosis with the result that cases tended to concentrate in district TB centre

_ineffective laboratory services due to insufficient human-hours of the microscopist at the PHC

_inefficient drug distribution mechanism which results in a very high drop-out rate after initial symptomatic relief to the patient

As regards spending specifically for womens' health care there is only the MCH program which gets merely 2% of the national health budget (see table below).

Apart from this there is the family planning program which is targeted almost solely at women (tubectomies and iucd's) but it doesn't contribute much to womens' health care needs, if at all it has caused more harm than good. As we have seen earlier family planning budgets have grown at a steady pace but the corresponding decline in fertility rates has not been commensurate with such high investments for this high profile program of the State. In 1993-94 for instance Rs.10,725/- million (excluding MCH) were spent on family planning which was 14.93% of the national health budget. In the remaining expenditure, which is the core health budget, the stake of women is extremely limited because of the problems discussed in an earlier section.

Expenditure on MCH Services - All India.

	1975-76	1980-81	1985-86	1991-92	1992-93	1993-94(RE)	1994-95 (BE)
Rs.Million	23.66	60.38	136.14	1056.21	1117.25	1397.52	599.35*
% to total health expenditure	0.39	0.51	0.50	2.03	1.80	1.95	0.76*

* excludes central govt. which is more than half the total MCH budget.
Source: CEHAT Database, see Economic and Political Weekly 30: 15/16, April 1995

What Can Be Done ?

The above picture looks rather dismal and it must be recognised that it is a consequence of the overall underdevelopment. The New Economic Policy and structural adjustment have not been helpful, and especially so for the social sectors. What does this mean for the health sector and the people of this country?

Health care access and availability in India has a peculiar public - private mix which generates a political economy that makes the health sector purchasing-power dependant. This is a contradiction given the fact that the large majority do not have purchasing capacities even to sustain adequate nutritional requirements. In a country where nearly half the population struggles under severe poverty conditions and another one-half of the remaining manages at the subsistence level it is a sad state of affairs that social needs like health and education have to be more often than not bought in the market place. Thus, when we discuss issues in health financing we must not restrict ourselves to money-matters but bring to centrestage in our discussions macro issues like poverty, poor availability of public services and the strong market penetration of the private sector in provision of health care, etc.., that is issues of distributive justice.

Therefore when we look at issues in health care and its financing we must begin with this reality of general impoverishment on the one hand and the market led for-profit private health sector on the other. While the public health sector accounting for less than one-fifth of the overall health expenditures is financed

almost wholly through tax revenues, the dominant private health sector is financed by people directly through fee-for-services. Insurance and employer supported financing, as yet, accounts for a very small proportion of the total funding of the health sector.

Issues of Concern

1. Defining Primary Care : Primary health care needs to be defined in terms of peoples' needs and a minimum decent level of provision. Primary care services should include atleast the following :

(a) General practitioner / family physician services for personal health care,

(b) First level referral hospital care and basic specialist services, including dental and opthalmic services,

(c) Immunisation services against vaccine preventable diseases,

(d) Maternity services for safe pregnancy, delivery and postnatal care,

(e) Pharmaceutical services - supply of only rational and essential drugs as per accepted standards,

(f) Epidemiological services, including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures

(g) Ambulance services,

(h) Contraceptive services, and

(i) Health education

It must be emphasised that the above minimum care must be seen as a comprehensive program and not compartmentalised into separate programs as is done presently. These comprehensive primary care services must be common to the rural and urban areas and should be sensitive to special needs of groups like women, elderly, children, tribals etc..

2. The urgent need to strengthen, restructure and reorient public health services : The urban bias in medical care provision by the State needs to be removed. The Primary Health Centres (PHCs) and Subcentres (SCs) need to be thoroughly reoriented to meet peoples needs of medical care and not be obssessed with family planning alone. Facilities for medical care need to be substantially enhanced at the

PHCs both in terms of personnel and supplies in terms of the above defined minimum provisions. While supplies can be increased through larger budgetary allocations the difficulty would be in getting personnel to work in the public system. Since private individual practice is the norm it becomes necessary to involve such practitioners to join a public sponsored health care program on a pre-defined payment system like a fixed capitation fee per family registered with the practititoner. Such a system needs to be evolved both in the rural and urban areas. This would mean a five-fold increase in primary care costs which would be partly financed from within the existing resources and the remaining from the organised sectors of the economy, including insurance, and special health related taxes. Ofcourse, this would mean a lot of restructuring, including stronger regulations and control and a mechanism for regular audit of the system's functioning. This is the only way of guaranteeing universal access to

health care and achieving 'health for all'. The bottom line would be no direct payments by patients at the time of receiving care. All payments would be made through a statutory authority which would be the monopoly buyer. People having the capacity to pay should be charged indirectly through taxes, insurance premia, levies etc.. Such restructuring would not disturb the autonomy of the individual practitioner or the private hospitals except that it would strive to eliminate irrational and unnecessary practices, demand some amount of relocation of practitioners, standardise and rationalise costs and incomes, eliminate quackery and demand accountability from the providers.

3. Making the public health sector efficient, cost-effective and socially accountable : The response to the malaise of the public health services should not be 'privatisation'. We already have a large, exploitative and unsustainable private health sector. What makes the private health sector 'popular' in usage is its better access - irrespective of quality, a personalised interface, availability at convenience, and non-bureaucratic nature. The public health services by contrast are bureaucratic, having poor access - especially in rural areas, have often inconvenient timings, are generally impersonal, often don't have requisite supplies like drugs etc.. and are plagued by nepotism and corruption. There is a lot of scope for improvement of public health services with better planning, reallocation of existing resources as well as pumping in additional resources - especially for non-salary expenditures, reducing wastage and improving efficiency by better management practices and separation of primary, secondary and tertiary care through setting up of referral systems, improving working conditions of employees etc.. One good example of enhancing the value, efficiency and effectiveness of the existing system using the available resources is to assure that all medical graduates who pass out of public medical schools (80% of all graduates every year) serve in the public system for say atleast five years without which they should be denied the licence to practice as well as admission for postgraduate studies. After all the State is spending Rs.800,000 per medical graduate ! This measure if enacted by law will itself make available 14,000 doctors every year for the public health care system. There can be many such macro decisions which can help in making the existing resources more effective and useful. Further, public health services must be made accountable to local communities they serve and the latter must perform both the role of social audit as well as take responsibility of seeing that the system works properly for the benefit of patients. As regards the private health sector, as mentioned above, there is an urgent need to regulate it, standardise charges, have policies for location and distribution etc..

4. Modes of Financing, Payments etc.. : While the public sector is funded through tax revenues the private sector relies mostly on fee-for-services. There is a growing trend of thought favoring atleast partial user-charges or fee-for-services for public health services. This trend must be countered since in the given socioeconomic conditions such a policy would hit the majority very hard. WHO has been firm about States spending 5% of GDP on health care. In India the State doesn't even spend one percent. So the first effort must be at getting the State to commit a much larger share for the health sector from existing resources. Additional revenues specifically for health budgets may be collected

on the lines of profession tax in some states which funds employment programs, levies and cesses for health could be collected by local bodies, employers in the organised sector must be made to contribute for health care services, those with capacity to pay like organised sector employees, the middle and rich peasantry (so far completely untaxed), and other self-employed, must do so through insurance and other pre-payment programs. In a vast and varied country like India no single system can work. What we would need is a combination of social insurance for the poor (premia paid by the state), employment related insurance for the organised sector employees, voluntary insurance for other categories who can afford to pay and ofcourse tax and related revenues. Further, payments of any kind at the point of provision of care must not exist as they usually are unfavorable to patients. Payments must be made to providers by a monopoly buyer of health services who can also command certain standard practices and maintain a minimum quality of care - payments could be made in a variety of ways such as capitation or fixed charges for a standard regimen of services, fee-for-service as per standardised rates, etc.. The move towards monopoly purchase of health services through insurance or other means and payment to providers through this single channel is a logical and growing global trend. To achieve universal access to health care and relative equity this is perhaps the only alternative available at present, but this of necessity implies the setting up of an organised system and for this the State has to play the lead role and involve the large private sector within this universal health care paradigm if it must be successful.

Apart from the above macro measures which require radical changes, a lot of improvements are also possible within the existing framework of the health system. Thus, apart from substantially enhancing resources for the public health sector, there is also an urgent need to reorient spending and remove the allocative inefficiencies. This is possible in many ways :

i) If the states play a more significant role in health care planning and measure
the cost-effectiveness of intra-sectoral allocations within the program so that they can assure long term sustenance and make the program meaningful

ii)By assuring that the non-salary inputs are maintained at an adequate level, especially stocks of essential drugs, maintenance of facilities and equipments,
fuel etc.., which is efficient enough to attract patients.

iii)By rationalising the use of hospitals through a referral system. This can be achieved if primary care facilities are well equiped and better funded to meet demands of basic health care.

iv)By improving the mix of health care staff in the various facilities and programs.
For instance, improving the nurse : doctor ratio in hospitals can bring down
considerably the unit cost of hospital services.

v)By improving drug management - assuring that only rational and essential generic drugs are purchased. International experience shows that this results in reducing drug costs by half.

vi)And by assuring that allocations are based on actual requirements or needs and that once committed, funds are not diverted for other expenditures.

With regard to womens' special health care needs we must reemphasise that they need special attention but it must necessarily be within the framework of comprehensive health care services and not as a special / selective program because history tells us that special programs become ends in themselves and develop their own vested interests, and this has been especially true of programs that were designed for women which ended targetting their uteruses to stop them from reproducing.

In conclusion we must reassert the importance of much larger resources being allocated for public health care. Every effort must be made to approximate the WHO suggested guideline for spending 5% of the GDP on health care. But this will not be possible if the private health sector is left unregulated and has no links with the public system. The consequence of leaving the private health sector out of the ambit of state planning has been that with the rapid growth of the private sector, which is fueled by supply-induced demand, the wealthier and the articulate increasingly seek care in the private sector and any support socially and politically for a national health system which may be there will get buried in demands for privatization etc.. further running down the public sector and hence the poor. The global trend is to evolve an effective public-private mix which functions under a single umbrella of a monopoly buyer of health services, which can either be a statutory body constituted by an Act of Parliament, or an insurance group, or the State or some combination. This creation of a single system which assures universal coverage with equity should be the not too distant goal in the reorganisation of the country's health care services. Such reorganisation will bring a tremendous saving to the economy both in terms of cutting down wastage of expenditure, especially in the private sector (over-prescriptions, unnecessary tests, procedures and specialist referrals etc..), and in improving the productivity of the population by assuring equitable access to health care for all.

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