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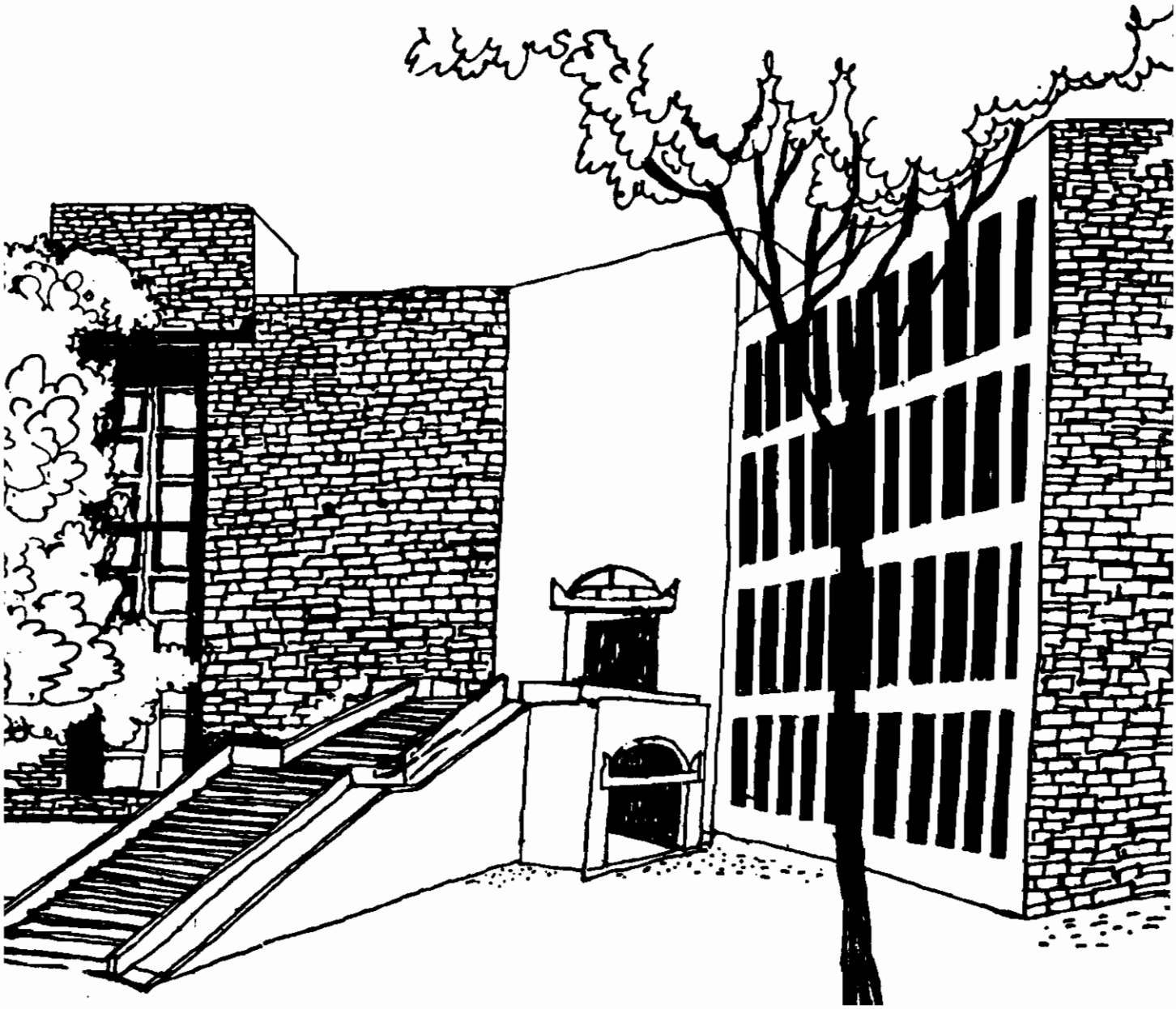

BUDGETARY SUBSIDIES IN THE HEALTH SECTOR: A CASE OF GUJARAT STATE

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Abstract

Budgetary subsidies in the health sector in Gujarat are estimated by following the methodology of the White Paper on Subsidies in India (1997). It includes both the explicit and implicit subsidies for the merit and non-merit sub-sectors in the state. These subsidies are estimated for the recent years 1995-96 to 1999-2000. The cost recovery rates in the health sector are also estimated and compared to the major states in the country. Gujarat's case is comparable to other major states in the health sector. Implicit subsidies are more dominant than the explicit subsidies in this sector. Very low cost recovery rates in the sector are associated with serious problems in the public provision of healthcare services in the state. After briefly discussing some of these problems, required reforms in this sector are suggested.

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1. Introduction:

Health-care is an important determinant of the quality of life and thereby the welfare of the population in a society. In developing countries where a large segment of the population lives below the poverty-line defined in the absolute terms of per capita calorie intake, the provision of health-care becomes almost an obligatory function of the governments. The health-care in these countries is, therefore, provided by both the public and the private sectors. Provision of this critical social infrastructure by the government has to be based on numerous considerations. Some of the important concerns are the location, extent, quality and cost of the health-care facilities. The ability-to-pay of the intended beneficiaries of these publicly provided health-care facilities would be expected to govern the extent of the budgetary support needed. However, very often, some inefficiencies do creep in and other factors and considerations become important in determining the budgetary support for the health-care provision by the government. While the low ability-to-pay of the intended beneficiaries is a justified cause for the budgetary support or subsidy, the inefficiencies and other

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factors are unnecessary and avoidable costs to the government. In developing countries where the governments are assuming a much larger role of the welfare state, there are many competing uses of the scarce meagre resources available with them. It is, therefore, important to have some dimensional idea about the budgetary support or subsidy in the health sector provided by the government to be able to appreciate the extent and nature of the problems and their possible remedies.

In the federal democratic set-up in India, health-care is the state subject. The state governments have to provide the health-care facilities to the population and decide the policies in the health sector. Economically Gujarat is one of the relatively better-off states in India. In terms of public finances also, it is among the relatively better performing states in the country. However, with liberalization and economic policy reforms, the states are required to control their expenditures, raise revenues and reduce their fiscal deficits. Gujarat's fiscal deficit like most other states in India is also alarmingly high. Gujarat is the first state where the Asian Development Bank (ADB) has provided loan assistance for restructuring the economy and reforming the policies. The ADB sponsored studies to estimate the government budgetary support/subsidies in different sectors, identified problems and suggested specific remedies in terms of policy reforms for the consideration of the Gujarat state government.

In the next section. we discuss the concept and classification of subsidies. The methodology to estimate the subsidy in general from the budget documents

is described in the third section. We present the estimates of the budgetary support/subsidy in the health sector in Gujarat state for recent years in the fourth section. Some of the important problems in the public provision of health-care in Gujarat are discussed in fifth section. The sixth and the final section presents some specific suggestions for reform in this sector.

2. Concept of Subsidy and its Classifications:

Indirect tax is generally obtained as a difference between the output price and the cost of production. By the same token, we can treat the subsidy as the negative indirect tax and obtain it as the difference between the cost of production and output price. Generally, the term "subsidy" corresponds to the indirect taxation only. The counterpart of the direct taxation is generally referred to as "income/asset transfers" or "transfer payments". However, the budget-based subsidies could be of two types: (a) explicit subsidy, and (b) implicit subsidy. The subsidies that appear explicitly in the budget documents increasing the government expenditures are "explicit subsidies". The "implicit subsidies", on the contrary have to be estimated indirectly because they reduce the revenues of the government. For example, a scholarship given to a medical student or free medicines given to the patients (e.g. TB patients) are explicit subsidies. But lower fees charged to the medical students in government colleges or a low price charged for an X-ray in the public hospitals are involving implicit subsidies. Both these types of subsidies affect the fiscal deficit of the government but through different routes. Moreover, in the case of the explicit

subsidy, the direct beneficiaries are well-dined and identifiable, whereas they are not so easily identifiable in the case of implicit subsidy. The impact of implicit subsidy is generally diffused, uncertain and difficult to quantify. These differences call for their separate treatment for designing the strategies to reduce the fiscal deficit.

Another important classifications of the budgetary subsidies is in terms of the merit goods and non-merit goods. The merit goods are the goods that create large positive externalities thereby generating much larger social benefits compared to their costs to the society. These goods are considered highly desirable for the social welfare. The public health projects, preventive health interventions, etc. are the examples of the merit goods in the health sector. The non-merit goods are also desirable but do not have a very large positive externalities. The distinction between a merit and a non-merit good is thus more in terms of the degree of externalities rather than kind. It is to some extent an arbitrary dividing line. For example, most of the curative medical interventions would be non-merit goods but the cure of contagious diseases would qualify to be a merit good. If some broad estimates of the subsidy are available with the classification of the merit - non-merit goods, it can help in divising an appropriate reform strategy because reduction of the subsidies on non-merit goods may not have the same effect as the one of reducing subsidies on merit goods.

3. Methodology for Estimating Budgetary Subsidy:

We have estimated the subsidies as per the budgetary approach which includes both explicit and implicit subsidies. It also includes both the departmental and non-departmental subsidies. The method used here is the same as the one used by the *White Paper on Subsidies* brought out by the Central government (1997). Accordingly, while estimating the budgetary subsidies in the health sector, 'pure public goods' are excluded. The budgetary subsidies are estimated as excess of such adjusted costs over receipts. The total cost is estimated by adding the variable and fixed costs. Revenue expenditure on the given service is treated as the variable cost. In calculating revenue expenditure, net intra-governmental and general purpose inter-governmental transfers have been excluded. Transfer payments to individuals have also been excluded. The fixed costs are the annualised capital costs which are equal to the nominal depreciation rate plus the interest cost of capital. Following the same methodology and assumptions used in the *White Paper on Subsidies* (1997), the nominal depreciation rate is calculated as the sum of long-term inflation rate (measured over a period of 30 years preceding the year 1995-96) and a two per cent real depreciation rate (assuming an average life of fifty years for a capital asset). The annual depreciation rate of 9.4% is obtained for Gujarat on cumulative capital expenditure for the creation of physical assets in the service. The interest cost of capital is taken as the average effective rate reflecting the opportunity cost of the government fund. It is calculated as the

average effective interest rate based on the actual amount paid in respect of internal debt loans from the Central government and Provident Fund. It is rounded to 12.5% for present calculation. Use of marginal rate instead of the average rate would only raise the estimates of subsidy further. The recoveries are the current receipts from a service which are usually in the form of user charges, fees, interest receipts and dividends.

It may be noted here that expenditure on defence, general administration (e.g. secretariat expenses) and expenditures on relief from natural calamities are excluded since they are treated as pure public goods. Similarly, net intra-governmental and general purpose inter-governmental transfers and transfer payments to individuals are also excluded while estimating the excess of costs over recoveries because they can be conceptually treated as pure public goods. All other services are divided into the merit and non-merit services based on their perceived externalities. In the health sector, for the sake of empirical convenience, public health is taken as the merit service and the rest is considered as the non-merit services.

The above methodological procedure can be summarised by the following equation taken from the *Discussion Paper on Subsidies* (1997):

$$S = RX + (d + i)\, K_o + i\,(Z_o + L_o) - (RR + i + D)$$

where,

RX is the revenue expenditure on the service.

d is the nominal depreciation rate.

i is the interest rate

K_o is the sum of capital expenditure on the service excluding equity investment at the beginning of the period.

Z_o is the sum of equity and loans advanced to public enterprises, classified within the service category at the beginning of the period.

L_o is the sum of the loans advanced for the service at the beginning of the period.

RR is the revenue receipts from the service.

i + D is the interest, dividend and other revenue receipts from public enterprises falling within the service category.

4. Estimates of Budgetary Subsidy in Health Sector:

Based on the methodology described in the preceding section, the estimates of costs and recoveries in the health sub-sectors in Gujarat State were prepared for the year 1995-96. These estimates are presented below in *Table 1.* At an aggregate level, the exercise was repeated for subsequent years upto 1999-2000. These aggregative estimates of the costs, recoveries and subsidies are presented in *Table 2* below.

It can be observed from the *Table 2* that the budgetary subsidy in the health sector in Gujarat is increasing at an alarming rate of 18.8% p.a. during 1995-96 to 1999-2000. The rates of growth in subsidy to the merit and non-merit sub-sectors of HFW sector are not very different. Moreover, the Bureau of Economics and Statistics, Government of Gujarat has estimated the explicit subsidy in the HFW sector including the Grants-in-Aid (GIA) and other transfers to the local bodies for the year 1994-95. According to their estimates, the total explicit subsidy (including GIA) in the health sector is about Rs. 25 per capita

Table 1: Estimates of Costs and Recoveries in the Health Sub-sectors in Gujarat, 1995-96

(Rs. in lakhs)

Budget Codes	Item	Revenue Receipts	Rev. Exp. (Variable Cost)	Annualized Capital Exp. (Fixed Cost)	Accumulated Cap. Exp. till 31.03.1995	Depreciation on Accumulated Cap. Exp. @ 9.4%	Interest Cost @ 12.5%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2210	Medical & Public Health						
01	Urban Health Services - Allopathy						
	Direction & Admn.		(237)				
	Employees State Insurance Scheme	(1937)	4119				
	Medical Stores Depots (-) under investigation	23	75	-0.14	-0.66	-.06	-0.08
	Hospitals and Dispensaries	112	11979	409.13	1869	175.50	233 63
	Other Health Schemes		6				
	Tribal Area Sub Plan		496				
	Other Expenditure / Receipts	53		0.09	0 40	0.04	0.05
	Total-01	188	16675	409.13	1869	175.50	233.63
02	Urban Health Service - Other Systems of Medicine						
	Ayurveda		942				
	Homeopathy		4				
	Other Systems		28				
	Tribal Area Sub Plan		20				
	Total - 02	0	994				
03	Rural Health Services - Allopathy						
	Health Sub-Centres		730	0.18	0.80	0.08	0.10
	Primary Health Centres		3990	1.98	9	0 85	1 13
	Community Health Centres		2205	32 40	148	13.90	18.50
	Tribal Area Sub Plan		875	44 44	203	19 06	25.38
	Other Receipts	0 24					
	Total - 03	0.24	7800	79 01	361	33.88	45.13
04	Rural Health Services - Other Systems of Medicine						
	Ayurveda		262				
	Homeopathy		7				
	Tribal Area Sub Plan		145				
	Total - 04		415				
05	Medical Education, Training & Research						
	Ayurveda	4	711	32.84	150	14.09	18.75
	Homeopathy		121	0 22	1	0 09	0 13
	Allopathy		3437	264.43	1208	113 43	151 00
	Tribal Area Sub Plan		10				
	Other Systems of Medicine	35	0	0	0.01		
	Total - 05	39	4279	297 88	1359	128	169.88
06	Public Health						
	Direction & Admn.		(351)				
	Training		243				

	Prevention & Control of Diseases		6525	1 75	8	0.75	1 00
	Drug Control		660				
	Manufacture of Sera/Vaccine	29	127	0.44	2	0.19	0.25
	Public Health Laboratories	1	10	140.97	644	60.47	80.50
	Public Health Education		71				
	Tribal Area Sub Plan		643				
	Other Expenditure	15	72				
	Other Programmes		0	3.06	14	1.31	1.75
	Fees & Fines, etc.	8					
	Service & Fees	3					
	Total - 06	56	8351	146.23	668	62.73	83.50
08	General						
	Health Statistics & Evaluation		48				
	Other Expenditures	570	28				
	Tribal Area Sub Plan			55.60	254	23.85	31.75
	Total - 08	570	76	55.60	254	23.85	31.75
	Grand Total - 2210	2790	39178	987 88	4511	424	563 88
2211	Family Welfare						
	Direction and Administration		(370)				
	Training		713				
	Rural Family Welfare Service		4608	3.50	16	1.50	2 00
	Urban Family Welfare Service		285				
	Maternity & Child Health		245				
	Transport		159				
	Compensations		675				
	Mass Education		93				
	Other Services & Supplies		442				
	Tribal Area Sub Plan		15	0.22	1	0 09	0 13
	Other Expenditures / Receipts	51	8	79 24	362	33.99	45 25
	Total - 2211	51	7243	82 97	379	35 59	47 38
	Total Health & Family Welfare	904	45829	1070 38	4890	459.13	611.25

Note: Figures in the parentheses are not considered in the respective column totals as per the methodology described in the text

Source: Calculated from the *Finance Accounts - Government of Gujarat*, Comptroller and Auditor General of India, 1997 as per the methodology described in the text.

Table 2: Estimates of Costs, Recoveries and Subsidy by Merit/Non-Merit Health Sector in Gujarat, 1995-96 to 1999-2000

(Rs. in lakhs)

Year	Sector	Variable Cost	Fixed Cost	Total Cost	Recovery (Revenue)	Subsidy	Cost Recovery Rate
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1995-96	HFW	45829	1070	46899	904	45995	1.93%
	Merit	8351	146	8497	56	8441	0.66%
	Non-Merit	37478	924	38402	848	37554	2.21%
1996-97	HFW	50619	1012	51631	814	50817	1.58%
	Merit	9224	184	9408	50	9358	0.53%
	Non-Merit	41395	828	42223	764	41459	1.81%
1997-98	HFW	61283	1226	62509	1473	61036	2.36%
	Merit	11167	223	11390	91	11299	0.80%
	Non-Merit	50116	1002	51118	1382	49736	2.70%
1998-99 (RE)	HFW	90670	1813	92483	1419	91064	1.53%
	Merit	16522	330	16852	88	16764	0.52%
	Non-Merit	74148	1483	75631	1331	74300	1.76%
1999-2000 (BE)	HFW	91751	1835	93586	1938	91648	2.07%
	Merit	16719	334	17053	120	16933	0.70%
	Non-Merit	75032	1501	76533	1818	74715	2.38%

* HWF = Health and Family Welfare

Source: Based on Budget Documents of Govt. of Gujarat and Finance Accounts - Govt. of Gujarat.

which works out to about 27% of the total subsidy in the health sector.[1] This implies that the extent of implicit subsidy in the health sector in Gujarat is about 73%.

In this context, it is interesting to observe from *Table 2*, the trends in the cost recovery rates over the recent years when economic policy reforms are compelling the state governments to show fiscal discipline. The table shows that

[1] The CSO's estimates of the explicit subsidy for the year 1993-94 as given in the *White Paper on Subsidies* (1997) does not include GIA and other transfers to the local bodies. As a result, it reports zero explicit subsidy in the health sector in Gujarat.

there are some efforts to increase the cost recovery rates in the health sector but the efforts are not sustained. In fact, during 1996-97, the cost recovery actually declined absolutely when the total cost rose substantially. In 1997-98, however, there seems to be a major effort at raising the cost recovery. It increased by over 80%. The merit and non-merit sub-sectors also showed more or less the same extent of increase in cost recovery during 1997-98. The story of 1998-99 (Revised Estimates) is again of marginal slackening in the cost recovery. Again in the Budget of 1999-2000, it is envisaged that the cost recovery in the health sector would increase absolutely by over 36%. On account of such trends in the recent years, the extent of subsidy in the health sector in Gujarat continues to be very high at around 98%. The merit and non-merit sub-sectors in health also enjoy very similar magnitude of subsidies. It is worth comparing the subsidy in the health sector in Gujarat with other states. The *White Paper on Subsidies* (1997) provides the estimates for 1993-94. *Table 3* below presents these estimates.

From the table, it can be seen that in the health sector, budgetary subsidy in Gujarat is only marginally higher than the average of all states on per capita basis. It is more on account of the higher per capita subsidy in the public health (merit sub-sector). The per capita subsidy in HFW sector in states such as Goa, Haryana, Karnataka, Kerala, Punjab, Rajasthan, Tamil Nadu and West Bengal is higher than in Gujarat. Thus, compared to other states in India, subsidy in the

Table 3: Per Capita Budgetary Subsidies and Cost Recovery Rates

States	Per Capita Subsidy (in Rs.) in HFW			Cost Recovery Rates (in %) in HFW		
	Merit	Non-Merit	Total	Merit	Non-Merit	Total
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Andhra Pradesh	13.83	57.16	70.99	0.65	0.66	0.66
Bihar	4.06	37.06	41.12	1.47	2.74	2.61
Goa	22.38	305.09	327.47	0.86	0.97	0.96
Gujarat	15.10	59.63	74.73	0.62	2.41	2.05
Haryana	11.74	62.33	74.07	0.67	1.44	1.32
Karnataka	6.57	74.45	81.02	0.47	2.00	1.88
Kerala	7.64	90.56	98.20	1.05	0.77	0.79
Madhya Pradesh	10.04	46.95	56.99	0.42	1.15	1.02
Maharashtra	32.24	47.05	79.29	1.33	2.90	2.27
Orissa	8.63	48.40	57.03	1.14	0.54	0.63
Punjab	10.03	89.86	99.89	0.84	1.32	1.27
Rajasthan	8.59	73.37	81.96	0.24	1.10	1.01
Tamil Nadu	13.70	81.21	94.91	1.74	0.81	0.94
Uttar Pradesh	9.91	56.04	65.95	7.09	0.33	1.41
West Bengal	8.88	62.02	70.90	0.08	3.25	2.86
All States	11.98	59.35	71.33	1.90	1.48	1.55

Source: Calculated from Government Subsidies in India - Discussion Paper, Ministry of Finance, Govt. of India, May 1997.

health sector -- particularly the non-merit sub-sector -- is not unduly high. The cost recovery rate in Gujarat is also higher than in most other states. In the merit sub-sector of HFW, the cost recovery rate in Gujarat is much below several other states in 1993-94. In short, the table clearly reveals that the problem of high subsidy and low cost recovery rates in the health sector in Gujarat is dimensionally similar and broadly comparable to most other states in the country.

5. Problems in Public Provision of Health-Care in Gujarat:

5.1 Present Status: The Gujarat government spends 11% of its total expenditure on health and family welfare. During 1998-99 (Revised Estimate) it is to go up to Rs. 957 crores, implying a quantum jump of 50 percent over the

last year. There were about 25 general hospitals run by the state government having 5128 beds in the year 1994-95. However, 2 general hospitals have been closed down and currently 23 general hospitals and 4149 beds are available for the public. There are some municipalities and panchayats who also provide the health services to general population. The state has about 29 thousand registered doctors, 20 thousand Ayurvedic doctors and 4 thousand other doctors. That is, the population served per doctor is 845 and registered doctor is 1600. The population served per nurse is more than 3000. Considering the international standards the figures show a wide gap between desirable supply and actual supply of health services.

5.2 Problems and Perception of the People: The general hospitals run by the state governments are over-utilized at certain places and highly underutilized at several other places. The NSS survey data also revealed that primary health centres in rural and urban areas are not used by the poor and the lower income strata as much as the private health services.[2] Poor revenues of the hospitals and inferior administration are responsible for poor quality of services. It was observed by an action researcher that all the three groups in a hospital are on the run: patients run for their lives, relatives run from pillar to post to get things done and the doctors run in search of life saving drugs and other equipments! Most of the rural government hospitals in Gujarat suffer from serious underutilization of the permanent facilities like hospital beds. One government

[2] See, Pravin Visaria and Anil Gumber (1994): *Utilization of and Expenditure on Healthcare in India - 1986-87*, (mimeo.), Gujarat Institute of Development Research, Ahmedabad.

hospital in Gujarat was having only seven patients on a particular day, i.e. only one-tenth of its total capacity. On an investigation it was found that there was no chief medical officer and surgeon for past seven months. Because of this, admission for operations were also suspended. The hospital did not have gynaecologist for last seven to eight years! This is certainly not a unique case. In fact, similar stories would be found in almost all government hospitals in the rural area. Qualified doctors and nurses generally do not prefer to stay in smaller towns and villages because they lack quality socio-economic infrastructure to attract professionals to settle down.

On the contrary, in the metropolitan cities where the professionals find satisfactory level of socio-economic infrastructure facilities, there is a serious problem of overcrowding. The government hospitals are by and large in a pathetic condition. They are generally characterized by big garbage dumps, soiled bed sheets and unhygienic conditions. Several patients would be lying on the floor. All the special wards including the ward for the patients having severe burns would be functioning without Air Conditioners since they would be perennially under repairs! The hospitals, moreover, are lacking in terms of regular full-time specialists like cardiologists or orthopedic surgeon or pediatrician, etc. The government hospitals suffer from insufficient quantity and poor quality of medicines when they are most needed. There are long and almost unending queues in the Outdoor Patients Departments. This is largely because of inadequate facilities and insufficient manpower. As a result, the

patients end up wasting a lot of their time and energy finally to get frustrated with the nature and quality of the service. The physical inconvenience and mental torture that they have to suffer is extra! The consumer dissatisfaction with the government healthcare services in both the rural and urban areas is the central problem in Gujarat like many other states in India.

5.3 Officials' perception: As per the constitution, the state governments as well as the local governments are supposed to be providing health and medical facilities to the general public at subsidized rates. Thus profit maximization is ruled out by definition. With this the approach of the bureaucrats is to completely ignore the financial performance of the hospitals. In their perception any public utility by definition has to be loss making! The awareness about the principles of hospital management, which can be used for loss minimization when profit maximization is not possible, is not there at all. Even the top officials in the government seem to share the same attitude and conviction. As is popular with the bureaucracy, instead of addressing the root-cause, their approach is to set and try to achieve on paper some quantitative targets based on physical norms.

The officials did show concern about the operation and maintenance of existing equipments for which adequate grants were not available. The vehicles purchased under different schemes needed immediate attention. It was also reported that many a times the politicians would insist on buying sophisticated and modern equipments for various reasons. Genuine concern for the poor and the general public would hardly be the guiding force for such decisions.

Due to rigid and obsolete labour laws, pressures of the labour unions and apathy of the people at the top, it is very difficult to take disciplinary actions against the doctors, nurses and other supporting staff in the case of malpractices or failure to perform their duties. This has given rise to the total financial as well as non-financial mismanagement of the hospital resources at the cost of the government exchequer. More importantly, the quality of the healthcare services in the government hospitals also suffers considerably on this count.

5.4 Present User Charges: The major cause for poor cost recovery is unrealistically low charges of health services in Gujarat. They have not been revised for more than 10 years now. The registration for outdoor and indoor patients is totally free. The rates for various services were proposed to be revised in 1992, but could not be revised. Again during 1998-99, the department proposed the changes in the rates but the approval of the government has not been received so far. Currently, fees for different services range from zero to Rs. 50/- for certain services. The operations are performed free of cost. The rates for air-conditioned rooms are also kept quite low. Maharashtra is also facing a similar situation with respect to users charges. Even the proposed rates are far less than the average (private) rates prevailing in the market. The major problem, which arises in this context is, therefore, the availability of the services. For instance the price of the denture in the government hospital would be Rs. 5 or Rs. 10 but the waiting period ranges from 2 months to 1 year! It is often

argued that when the government cannot charge more in terms of money, it charges in terms of time and poor quality of services.

Personal visits to several hospitals in Maharashtra and West Bengal had also revealed that people are prepared to pay more if the quality of the services improve. Thus the latter naturally becomes the precondition for the former. Some patients avail the special room facilities of the government hospitals during the treatment of a heart attack or an injury, though they may be belonging to higher income groups. On inquiry with some of them, it was found that the rates charged by the hospitals were quite nominal and that they were prepared to pay substantially higher rates for some specific marginal improvements in the facilities. They would still be better off as the revised rates are still likely to be less than the private hospitals for similar facilities and services.[3]

5.5 Difficulties for fixing up the rates: The rate schedule for different services has to be put before the Legislative Assembly for the approval. The government hospitals or the health department of the state have no authority to revise the user fees. The revision of rates, therefore, cannot take place frequently. The proposed rate schedule passes through various layers of bureaucracy (about eight to nine) before it reaches the top officials. This is both time consuming and discouraging to those involved in the administration. Moreover, as it becomes a

[3] In Ahmedabad an experiment is being conducted to start the hospital with equity fund which would operate on a co-operative basis. The Bulk buying of medicines and bulk patient turn over would allow it to run with lower cost. The cost calculations suggest that such hospitals can achieve the break – even level in just 3 years or so. This can be quite like a public hospital but with better services at reasonable rates. In this particular case the management of the hospital is proposed to be in the hands of doctors.

government decision to change the rates, the journalists and activists also play their role to publicize these matters, by and large in a distorted manner. Thus, it becomes politically very sensitive issue requiring harsh decisions on the part of the politicians and the government. The lack of management accounting practices, the "equity" considerations and over-estimation of social benefits consequent to this, do not allow the rates to be increased or even rationalized. The changes in the user charges are proposed in the last few budgets in Gujarat without any serious follow-up action. The end result is that the budgetary subsidies on these services keep increasing and the cost recovery rates remaining at low levels. Another problem in rationalizing the rates and improving the quality of the service is the undue concern about "equity issues". More or less uniform low charges/fees for the services are very often confused with "equitable" rates to deliver the social justice. As already discussed above, low rates lead to poor maintenance and hence poor quality and inadequate quantity of service. As a result, the service is often not available when required or is available with long queues and inordinate waiting time. Thus, the government ends up charging very high time cost from the patients. The opportunity cost of time in this context is disproportionately high for those working in unorganized sectors as they are not protected by the benefits of leave like casual leave or sick leave. How far it is restoring or establishing the social justice is questionable. It should also be understood that when the government provides a service by charging uniform rates from all, it tries to

provide equitable treatment to both, the '*Haves*' and the '*Havenots*'. However, when it does not discriminate on the basis of *Purchasing Power of Money*, it does so on the basis of *Purchasing Power of Time*. Those who *Have* time are better off than those who *Havenot*. In this sense equal monetary rates do not mean equitable rates. As we have discussed, charges in terms of time is also not necessarily "equitable" in the ultimate sense.

6. Suggested Reforms:

- Develop a need based infrastructural support for health.
- Promote partnership between public, private and voluntary sector. Identify credible NGOs to work with the government hospitals.
- Restructure the user fees in government institutions by introducing higher rates for non-emergent medical services.
- Increase the user charges as proposed during this year by the department, with immediate effect.
- Introduce an automatic rise in fees by indexing it with average inflation rate of 7-8%.
- Develop an institutional mechanism for periodic review of user charges.
- Recycle the income from fees and other sources to the point of collection and develop norms for operation and maintenance.
- Introduce peakload pricing or time based price schedules for certain non-emergent services. i. e. those who value their time more and cannot wait should be asked to pay more for the service. For this the government will have to prepare the separate list for preventive and curative services. For the former the government need not charge as they may be largely in the nature of merit good or pure public good. Out of curative services it can then prepare the list of emergent services for which again there would not be any charge. This may be implemented as early as possible.

- Introduce the schemes with different quality variant and establish one to one correspondences between quality and price of a service. The groups demanding best quality can be charged properly, which can help the cross subsidization for the services to be given free of cost to poor. This will also help to break the vicious circle of low income and poor quality. Implementation of this might require some time to build up the necessary Infrastructure hence we recommend that at least by the year 2004 this can be effective.

- Some services may be declared as profit making services which can be provided for cross subsidizing other services.

- Increase the strength of closest local body and allow it to participate in management and revenue collection. The government can consider to put the control of health centers in the hands of local Panchayats.

- Identify the services, which can be contracted out, e.g. laundry, kitchen etc.

- Strengthen revenue collecting mechanism.

- Identify and appropriately target the beneficiary who requires free services.

- Improve the monitoring of personnel, supply of drugs and essential medical equipments.

- Provide better incentives to retain the doctors and nurses in the rural health centers.

- Introduce an accredition system for all private and public hospitals by developing a quality index in terms of availability of space, equipment, qualification of doctors and nurses etc. to increase competition.