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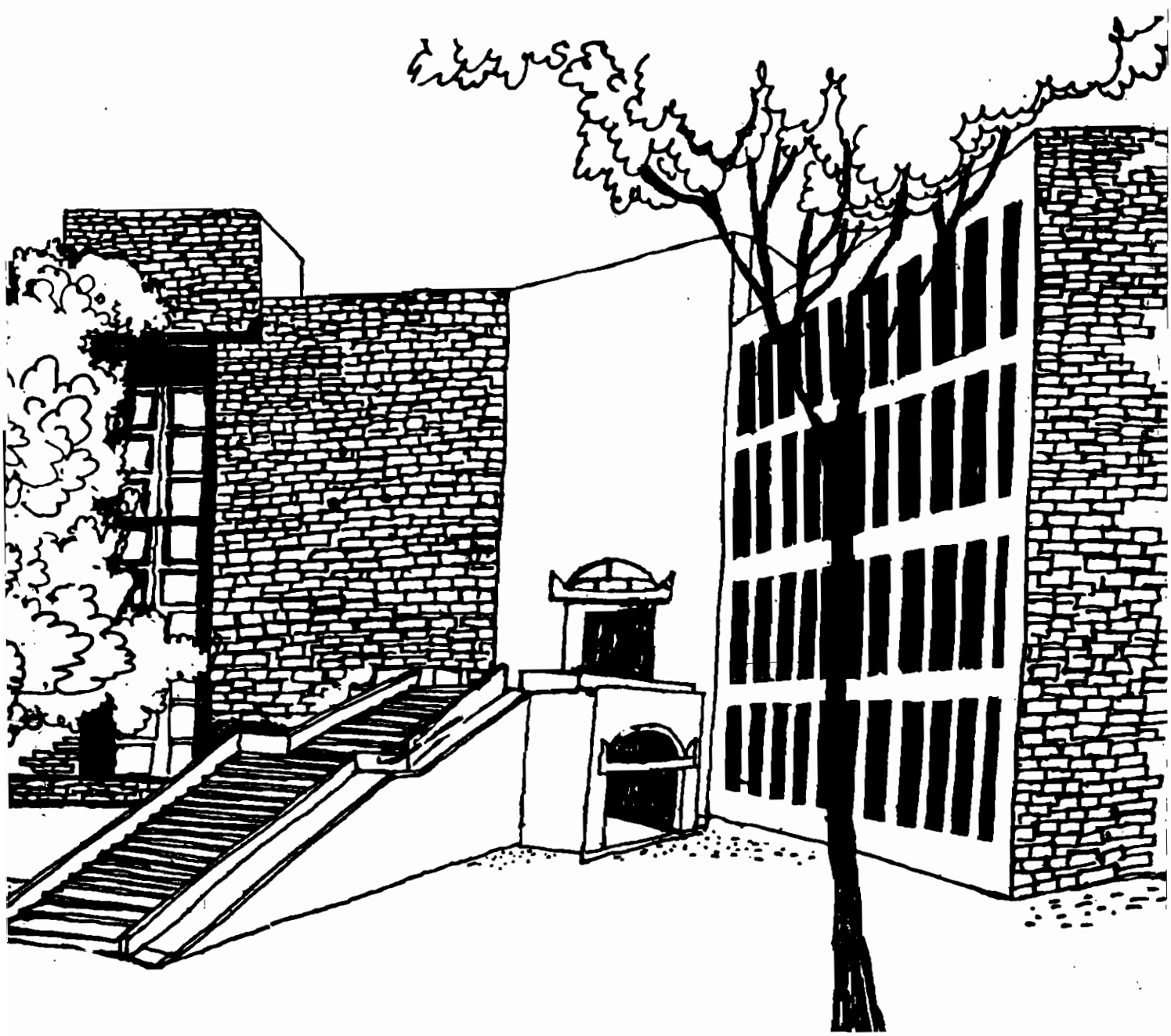

Union Budget 2004-05 and the Health Sector

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Abstract

The Union Budget 2004-05 of Government of India in some way marks a deviation from its preceding budgets in terms of its specific focus on social sector. The budget document is basic policy paper of the government and in some sense provides a mirror of government's priorities. However, one basic question remains how to translate these policies into implementable plans and how to make sure that the government is able to deliver the planned development. Many times we focus on priorities and policies without giving due consideration to ground level realities, the policy pronouncements are mere rhetoric and problems remain. In some ways the recent budget has done the same with the health sector. There is probably lack of clarity on issues the health sector is facing. We aim at addressing some of these issues in context of health sector and describe how this year's budget has missed the focus.

Union Budget 2004-05 and the Health Sector

The Union Budget 2004-05 of Government of India in some way marks a deviation from its preceding budgets in terms of its specific focus on social sector. The focus of the new government on planned development towards the agriculture, rural development and poverty alleviation has been emphasised. The Union Budget document has the main limitation that it is essentially a policy paper and not a plan document. It is in some sense a mirror of government's priorities and the current budget of the United Progressive Alliance government. However, one basic question in the whole process is how to translate these policies into implementable plans and how to make sure that we are able to deliver the planned development. Many times we focus on priorities and policies without giving due consideration to ground level realities and the policy pronouncements remain rhetoric. In some ways the recent budget has done the same with the health sector. There is probably lack of clarity on issues the health sector is facing. We aim at addressing some of these issues in context of health sector and describe why this year's budget has missed the focus.

I. Health sector and CMP: UPA's priorities

The National Common Minimum Programme (CMP) of the United Progressive Alliance (UPA) government contains four important guidelines for the health sector: (a) increasing allocation to 2-3 per cent of GDP; (b) major expenditure on primary health care and communicable diseases with political backing for HIV/AIDS control; (c) health insurance for the poor; and (d) regulation of drug prices for 'life-saving' drugs and revival of public sector production units. The Common Minimum Programme (CMP) has focused on building a stronger and competent health system for the rural India. The first budget of the UPA government has given a broad guideline on the government's plan to address these issues.

II. Budget allocations to health sector

This year's budget has done very little towards making move towards achieving goal of spending 2 to 3 per cent of GDP on health. Out of the total central budget outlay, for the year 2004-05, of Rs. 1637.20 billion, Rs. 74.81 billion is allocated for Ministry of Health and Family Welfare, which marks 4.6 per cent of the total budget allocation (see Table 1).

Table 1: Central Plan Outlay for Ministry of Health & Family Welfare (millions of rupees)

Expenditure Head	2003-04 Budget Estimate	2003-04 Revised Estimate	2004-05 Budget Estimate
Department of Health	15500	14480	18000
Department of AYUSH*	1500	1350	1810
Department of Family Welfare	49300	47000	55000
Total for MoHFW**	66300	62830	74810
Total Central Outlay	1478930	1417660	1637200

*AYUSH: Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy
** MoHFW: Ministry of Health and Family Welfare.
Source: Budget 2004-05

Independent estimates suggest that implementing the CMP promise on education, health and employment could cost the exchequer up to Rs. 3000 billion, but the Finance Minister has provided only Rs. 100 billion extra for this in the 2004-05 Budget. Health being a state subject most of the resource come from budgetary allocations at state level. The central government finances only national health programmes and family welfare programme. Therefore, augmenting resources to health sector depends on ability of the state governments to allocate higher budgetary support to the health sector.

Health being State subject in India much depends on the ability of the State governments to allocate higher budgetary support to health sector. This *inter alia* depends on the current levels of spending, what target spending as per cent of income the State governments assume to spend on health and given fundamental relationship between income levels and public expenditures, how fast expenditures can respond to rising income levels. The data on public expenditures of 14 major states in India on health suggest that at state level, governments have target of allocating only about 0.43 per cent of State gross domestic product (SGDP) to health and medical care. This does not include the allocations received

under central sponsored programmes such as family welfare. Given this level of spending at current levels and the fiscal position of state governments the goal of spending 3 per cent of GDP on health looks very ambitious goal. The analysis of data also suggests that elasticity of health expenditure with SGDP is 0.68 which suggest that for every one percent increase in state per capita income the per capita public healthcare expenditure has increased by around 0.68 per cent. During the period 1990 to 2002 analysis of total revenue expenditure for 14 states in India shows that in case of 4 state government's expenditure on health has declined in real terms and on all-India basis increased by only 7.34 per cent in real terms (see Table 2).

Table 2: Growth of Per Capita Public Healthcare Expenditure (in real terms)

	Change*			Percentage Change		
	1990-1996	1996-2002	1990-2002	1990-1996	1996-2002	1990-2002
Andhra Pradesh	-211.1	263.4	52.3	-28.16%	48.92%	06.98%
Assam	3.4	-15.5	-12.1	00.56%	-02.56%	-02.01%
Bihar	-111.7	160	48.2	-26.25%	50.96%	11.33%
Gujarat	-156.6	-110.3	-46.3	-17.48%	-14.91%	-05.17%
Karnataka	-103.6	270.3	166.7	-13.23%	39.79%	21.30%
Kerala	-73.2	172.2	99.1	-07.99%	20.43%	10.81%
Madhya Pradesh	-103.6	161.1	57.5	-18.54%	35.41%	10.30%
Maharashtra	-144.2	278.3	134.1	-16.80%	38.97%	15.62%
Orissa	186.9	154.5	341.4	31.52%	35.92%	57.59%
Punjab	-414.9	583.8	168.9	-33.29%	70.20%	13.55%
Rajasthan	-86.7	152.1	65.5	-10.95%	21.60%	08.28%
Tamilnadu	-44.6	134.5	89.9	-05.07%	16.09%	10.20%
Uttar Pradesh	-160	-53	-165.2	-26.40%	-01.18%	-27.27%
West Bengal	-35.5	251.8	216.3	-05.69%	42.76%	34.64%
All India (States)	-107.8	160.8	53.1	-14.90%	26.14%	07.34%

* Figures are in Rs. millions

During this period the central government allocations to health sector has increased from 7 per cent to 13 per cent to meet some challenge but this has not been sufficient. The state initiatives towards augmenting the resources to health sector are missing. During the years 1990-2002 the public expenditure on health as per cent of state GDPs has gone down in all 14 major states (see Table 3). The results of this trend are obvious. The supply of healthcare in rural and remote areas of the country is far from satisfactory - a fact recognised by even the Economic Survey 2004. With the government health centres and hospitals suffering from chronic understaffing, lack of medicine and over-crowding, people, including

the poor move towards individual private medical practitioners, comprising of both qualified and non-qualified.

Table 3:	Per cent change in PHCE/GSDP ratio		
	1990-1996	1996-2002	1990-2002
Andhra Pradesh	-40.51%	16.46%	-30.72%
Assam	-05.79%	-06.55%	-11.96%
Bihar	-19.21%	-05.14%	-23.36%
Gujarat	-38.11%	-07.95%	-43.03%
Karnataka	-31.08%	-00.33%	-31.31%
Kerala	-31.20%	-05.61%	-35.07%
Madhya Pradesh	-31.14%	18.24%	-18.58%
Maharashtra	-37.15%	21.36%	-23.72%
Orissa	-31.53%	16.30%	-20.37%
Punjab	-40.24%	44.05%	-13.91%
Rajasthan	-26.81%	-00.74%	-27.35%
Tamilnadu	-30.40%	-11.56%	-38.45%
Uttar Pradesh	-28.96%	-12.90%	-38.12%
West Bengal	-25.90%	03.49%	-23.31%
Source: Bhat and Jain (2004a)			

The current levels of spending and its relationship with level of income do not promise that health sector will be able to mobilise higher levels of public funding. Something needs to be done to change these relationships drastically. There are no promises in this direction.

III. Health insurance

The Budget has contemplated two developments for the insurance sector. These focus on redesigning the Universal Health Insurance Scheme and liberalising private foreign ownership of insurance companies by increasing FDI limits.

Redesigning the Universal Health Insurance Scheme

The Budget 2004-05 proposes to redesign the Universal Health Insurance Scheme (UHIS). This scheme was launched in 2003-04 by focusing it exclusively on persons and families below the poverty line. The revised premium would be Rs. 165 for individuals, Rs. 248 for a family of five and Rs. 330 for a family of seven, without any reduction in benefit. The

government proposes to subsidise the premium at the rate of Rs. 200 for an individual, Rs. 300 for a family of five and Rs. 400 for a family of seven. The reason given by the Finance Minister is that BPL families do not have an ability to pay the premium.

Up to 31st March 2004 that is around a year after the launch of the scheme, 1.16 million persons have been covered under the scheme (Economic Survey 2004) of which 11,408 persons were BPL (Finance Minister' Speech 2004). This is about 1 per cent of the total persons covered. The total population living in India below poverty line is 26.1 per cent in 1999-00 which in absolute term is 260.3 million (Economic Survey 2004). The scheme was expected to cover 10 million that are below poverty line in the first year. As against this the government has been able to achieve only 0.001 per cent only.

The UHIS has been designed to keep the transaction cost low. Given the level of competition in market place and the way such schemes are delivered to its beneficiaries, it looks very unlikely that public insurance companies will show interest in the scheme, leave aside private insurers. Ultimately it is agents who sell the insurance and not insurance companies per se. Outpatient care has been kept outside the ambit of this scheme. Many micro level experiments on community based health insurance suggest that having options for outpatient care through some scheme increases the acceptability of the scheme (Ahuja, 2004). All pre-existing diseases including maternity benefit, HIV/AIDS are kept as exclusion clause for the policy. The scheme only takes care of hospitalisation. The conditions laid down for this purpose are that hospital should be minimum of 15 beds (10 in case of class 'C' cities having a population less than 5 lakhs) with fully equipped OT, fully qualified nursing staff round the clock and fully qualified doctor should be in charge round the clock. We do not think some of these conditions are being met by majority of health facilities in India.

Maternity benefit and outpatient care is significant among the poor as total fertility rate is around 2.91, that is every woman in her reproductive age is expected to undergo pregnancy around 3 times. The new "Health Plus Medical Expenses Policy" introduced by The New India Assurance Company Ltd. from the beginning of 2004 has included benefit for

maternity as an option with an additional rider (Kar 2004). The rationale for making the scheme exclusively for people living below poverty line is not well understood as it is vulnerable to make the composition of the subscriber pool steeply skewed towards those with very high health risk. The insurance scheme will be marred by adverse selection with little scope to cross-subsidise.

Also, it needs to be understood that health insurance per se is just a financing mechanism and do not in any way ensure that health services are delivered efficiently and effectively. In fact there is case that given the complexities of insurance markets, unregulated private medical sector and private voluntary insurance are sure ways of leading the health systems to be cost ineffective, inaccessible and highly inefficient. Expanding the insurance services without considering whether medical services are available or not is sure way of making the scheme dysfunctional from the beginning. Cost and quality of these services are other important factors. Who will regulate the practices of providers? It seems that the government is trying to divert the attention from inefficient healthcare delivery system and has coined the health insurance mantra as if it is going to solve all problems. Health insurance markets are fundamentally complex in nature. In health sector we have neither invested to build capacities to manage these mechanisms nor have we developed adequate regulatory and administrative infrastructure to ensure that such systems work efficiently.

Public health expenditures are necessary to strengthen the service delivery system which is accessible to poor. The public expenditure on health increased from Rs. 28 billion in 1987 to Rs. 169 billion in 2003 at current prices. In comparison to this the private expenditure on health rose from Rs. 95 billion in 1987 to Rs. 1282 billion in 2003 at current prices (Bhat and Jain 2004). About 57 per cent of hospitals and 32 per cent of hospital beds are in the private sector (Bhat 1999) and 80 per cent of 390,000 qualified allopathic doctors registered with Medical Council of India are working in the private sector (Jesani 1989; Bhat 1996). Utilisation studies show that one-third of in-patients and three-quarters of out-patients utilise private healthcare facilities (Duggal and Amin 1989, Yesudian 1990, Visaria and Gumber 1994). With little regulatory structures in place it is not clear how the insurance schemes will function. The absence of third party administrators or similar mechanisms of

ensuring cashless facilities in different geographic locations particularly in rural areas means greater problem in claiming reimbursement from the insurance companies, resulting in lower demand for the health insurance.

The experience of community based health insurance initiative by various NGOs suggests unless insurance mechanisms focus on affordability and accessibility, acceptability, effectiveness, using holistic approach, are credible and trustworthy they have little chance to succeed (Jajoo and Bhan 2004). In most places the insurance schemes are part of their existing activities, either income generating activities or health services. However, there are also examples how social insurance can prevent misutilisation of services through co-payment, providing preventive and promotive services (Jajoo and Bhan 2004, Ranson 2003). Unless, a comprehensive approach is taken for provision and access of health security to the poor, merely increasing the subsidy level in insurance schemes is unlikely to help in generating a demand among the community towards the scheme.

Insurance sector liberalisation

The budget decision to raise foreign equity cap in the insurance sector to 49 per cent would give the global players in insurance added impetus in bringing further technical know-how as well as other expertise in the form of advanced actuarial as well as underwriting practices. These are necessary to make Indian insurance competitive. Given the fact that a vast potential of the market still remains untapped, this step would provide the foreign players the necessary boost to invest further in the insurance sector. Distribution channel statistics for life insurance companies as of 31st March, 2003 shows that 46 per cent of life insurance agents were based in rural areas and 26 per cent in case of general insurance agents (IRDA 2002-03). Our rough estimate shows that increasing the Foreign Direct Investment cap in insurance sector will pump in an additional Rs. 6.69 billion in life insurance sector and about Rs. 1.55 billion in general insurance sector of which health insurance is one of the components. One important question to ask is why there is not much activity in health insurance segment. Why is capital not coming for this segment? The development in health insurance segment is affected by whole lot of complexities on demand and supply side factors in health markets, insurance markets and poor data base. The lack of actuarial data

for setting premium, lack of proper supply side for delivery of healthcare and lack of standard procedure for costing in hospitals are some examples. The policies can explain intentions but we can not see much implementation if some fundamental conditions for health insurance to work are not addressed.

IV. Accelerated HIV/AIDS Control Programme

The NCMP of UPA Government, as stated above, has placed a major focus on addressing the pandemic of HIV/AIDS with political backing for such programmes. In cognizance, the budget speech of Finance Minister has called for the need for bold and determined efforts to achieve zero-level growth of HIV/AIDS (the target is to achieve zero-level growth of HIV/AIDS by 2007). The Finance Minister has also called for bringing primary health centres to monitor HIV/AIDS and has allocated Rs. 2590 million for control of HIV/AIDS. Although this type of political commitment at the highest level for control of HIV/AIDS is a welcoming step to build up effective prevention and control against the virus, the problematic areas lie in delivery mechanism, a point we have discussed earlier. HIV/AIDS has taken a dreaded figure in India now. One in seven HIV infected people are from India (UNAIDS 2004) and NACO surveillance data on AIDS cases in India shows that India has now 5.1 million HIV positive cases up from 4.5 million in 2002. In such case an allocation of Rs. 2590 million is welcome step. The commitment from the government side may also help us to attract more funds to handle the problem. However only allocation of funding in this sector is not enough, the need of the time is to have a more efficient mode of utilisation of the fund and device programme which can have maximum impact in the community. The point of reference is made here for the following two reasons:

First, there is necessity of developing a greater accountability of sources and utilisation of the fund. There is nothing of the sort in place to track resource flows and its utilisation for HIV/AIDS control programme in India. The influx of funding raises concern about the potential administrative burden placed upon countries and organisations that receives the financing: Will they be able to allocate the new resources towards the most effective HIV/AIDS interventions (PHR Plus 2004). Foreign funds are often regarded as "safe

investments" as they come with their own set of norms regarding purchase of drugs, equipment etc. A very vivid example of how funds were misutilised was given by Abusaleh Shariff, chief economist at the National Council for Applied Economic Research (TOI July 10, 2004) "Of the Rs 5000 crore set aside for centrally sponsored employment generation programmes, the states utilise no more than 50 per cent of the budgetary allocation, as a result of which they are in no position to claim higher funds the next time round. But what is less known is that of the 50 per cent supposedly utilised, only 40 per cent is actually deployed towards the project in question. This is revealed in the 'accounts' put together by the Reserve Bank of India two years after the budgetary allocations are made. Therefore, only 20 per cent of the sum set aside by the Centre actually reaches the ground, and even in that there are leakages." Similar utilisation levels in public expenditure may also be found in funds allocated for the public health sector.

Second, the Finance Minister has called for bringing Primary Health Centre in the centre stage for monitoring of HIV/AIDS programme. A review of the health centre in rural areas leaves the following disappointing fact that employees at health centres are not available on holidays and vacations, which are nearly 40 per cent of days in a year in India in government services (Mavalankar 1999a). In the absence of staff, there is none at primary health centres and community health centres to provide care. It is estimated that only 52 per cent of staff of PHCs, located in villages, stay at the place of their postings (Mavalankar 1999). Rest of them prefers to stay in nearby towns from where they commute daily. There are evidences to show that staff members are irregular to health facilities on working days. The doctors and staff are found reluctant to work in rural areas owing to not only physical hardships but also owing to lack of professional growth opportunities. Further, often doctors are available at the health facility only for 3-4 hours on a working day (Mavalankar 1999). According to a research study (Gupta and Sankar 2003) unless the doctors seeing the patients explain or mention about ARV, there is no easy way for patients to even consider antiretroviral therapy. In order to address the challenge in service delivery model, the roles and responsibilities of health professionals needs to be redefined. HIV/AIDS sector requires extremely high sensitivity of the care providers owing to associated stigma issues (Bhat, Maheshwari and Saha 2004). An analysis of the NCMP on Health (Priya et.al. 2004) points that vertical

programmes are becoming almost synonymous with primary health care while the general health services are allowed to deteriorate. The paper calls for clarity on the proportion of attention to be given to the family planning programme, the general health services and the disease control programmes. The Economic Survey 2004 released by Government of India just before the budget 2004-05, on referring to public health service delivery has pointed that the healthcare delivery system has created a paradoxical situation with a plethora of hospitals, but few located in areas of high morbidity (Economic Survey 2004).

V. Tax holiday for setting up Rural Hospital

The Finance Minister in his budget speech has extended tax holidays on profits earned from setting up new hospitals with 100 beds or more in rural areas for five year under Section 80 IB. The purpose of introducing this incentive is to augment the supply of good healthcare facilities in rural areas. The geographic distribution of hospital facilities in India is skewed towards the urban areas. There is, therefore, certainly need to increase the access to hospital care facilities in rural areas. Will this incentive have any impact? We have analysed the financial results, particularly profit before tax (PBT) of 139 private (listed and not-listed) hospitals during the period 2002. The result of the analysis is presented in the Table 4. Almost 50 per cent of existing hospitals are not paying any tax. About 40 per cent of hospitals during 2002 reported negative PBT and about 16 per cent had tax liability of less than Rs. 1 lakh, 22 per cent paid between Rs. 1 lakh and Rs. 10 lakh and only 12 per cent paid tax more than Rs. 10 lakhs during the year. In terms of incentives for setting up hospitals in rural areas this is not significant and tax incentive on profits earned has no meaning here as large numbers of hospitals in private sector are not paying taxes in any way.

Table 4: Analysis of Revenue and Profit Before Tax of 139 Hospitals (Rs. in millions)

Statistics	Revenue	Profit-Before-Tax	Tax
Sum	12333	815	456
Average	89	6	3
Median	129	0.22	0

Source: Compiled from First Source Database, CMIE

Hence, the vital question here is for whose benefits is this tax holiday? The health sector is vulnerable to profit motive, information asymmetries are huge and markets can not decide, the tax incentives further promotes profit motive of healthcare providers. Through this policy we promote the idea of hospitals being profit centres. There are chances that such measures promote malpractices and extracting private benefits of control. These types of measures are susceptive to make the health delivery system vulnerable to inefficiency and malpractices. It is well known fact that most of transaction on services in hospitals are on cash basis and will not be influenced by this incentive. A large number of hospitals running on non-profit basis and through government aid are anyway not paying taxes. The budget could have looked at focusing extensively on public-private partnership and strengthening the development of not-for-profit institutions in remote areas of the country. For-profits are not the solution.

VI. Duty cut on medical equipment and ambulance

The budget has given several tax exemption and duty cut on medical equipments and ambulances. Some of them are fully exempt from custom and excise duty to several equipments used for the hearing impaired like talking books, braille computer terminals, braille writers and typewriters, assistive listening devices etc. Similarly crutches, wheel chairs, walking frames, artificial limbs, etc. for the disabled will also be fully exempted from custom duty. All ambulances will now attract a concessional excise duty of 16 per cent. Diagnostic kits for detection of all types of hepatitis are exempted from excise duty. These are welcome steps and in broad agreement with UPA government's priorities. However there is larger picture about the import of medical equipments. Data on medical equipment imports during last 13 years suggests that it has increased by about 25 per cent per annum. The total imports of medical equipments during 2003 have been in the range of about Rs. 150 billion. This is about 12 per cent of total private health expenditures (Bhat and Jain 2004b). The implications of these investments are not clear and will need further analysis in terms of its geographical distribution and utilisation. New economic policy, rapid influx of medical technology and a rising middle income class has led to huge increase in the private

medical care expenditures. However, a sector which is supposed to be not so happy with the budget 2004-05 is the pharmaceutical sector. This sector is concerned not having adequate research funds and the patent regimen due to implementation of intellectual property rights is around the corner. For example, WHO in its World Health Report 2004 raised concern that some of the generic antiretroviral drugs made in India will fall under patent protection from 2005, when the World Trade Organisation agreements on TRIPS takes effect in India.

VII. Steps ahead

Meeting the healthcare needs of population perhaps goes beyond the budget allocations. Given the growing complexities and challenges the health sector faces, reforms in this sector are inevitable. Reforms in health sector generally focus on making the health systems responsive through higher allocations and strengthening financial systems, ensuring local participation and public-private partnerships, and autonomy of health facilities. *Inter alia* it is through these reforms deficiencies in the health sector can be addressed. The reform process is also likely to help in developing strategies that ensure effectiveness and efficiency of resource use. However, the reform process makes some fundamental assumptions about the intrinsic organisational and professional commitment and availability of skilled and competent health care professional. Since development oriented human resource practices are powerful tools that commit health professionals to enhance the quality of care, we believe that health sector reforms should concentrate on human resource issues and practices more than ever before in the future.

One of the areas that need immediate attention in implementing the vision envisaged in the National Health Policy (NHP) is reforming existing institutional structure of the health care delivery system. The experience and number of studies suggest that the present structure has become dysfunctional as it has grown in size without giving due consideration to developing appropriate management structures to handle a large number of employees,

fragmented the health care delivery system by creating operating islands without any mechanism of coordination and information sharing across departments and various offices involved in implementing the programmes, the structure is with broken hierarchy without any one assuming responsibility of performance or management of key resources, the system has remained less developed in terms of management systems (financial, personnel, logistics etc.) to implement programmes effectively and with greater degree of transparency. Without addressing some of these key institutional aspects in the health sector, the effective delivery remains rhetoric. The areas that particularly need attention are: reforming the structures through which we manage our health sector programmes, addressing issues in Centre-state-district relationship in health sector, strengthening of professional bodies and making them accountable, strengthening stewardship role of the government.

What needs to be done? Institutions lay down the rules and define the mechanisms to implement the health sector strategies. One of the areas the health sector reform strategies should focus on is developing and strengthening the institutional mechanisms and processes which would go long way in implementing the health sector programmes effectively. With the growing complexities of the health sector programmes and their management, the present institutional structure is considered not adequate to handle new tasks and many challenges that programme managers face. Also, the growth of private sector throws number of challenges before the government to steer the process of the development of these institutions in right direction through right kind of regulation and various other policy interventions. The health sector reform strategies should take into considerations that appropriate institutional structures are inevitable for the growth and development of the health sector. Some broad suggestions in this direction are as follows:

Public Health Commission: In order to address the Centre-State relationships in health effectively, the Government of India should set-up a Public Health Commission. The implementation of all central sponsored programmes (including family welfare programme) should be brought under the control of this commission. The MoHFW should play an active role of financing the programmes of this Commission and its programmes and let the provision be the responsibility of Public Health Commission. At present the functions of

financing and provision, both, is responsibility of MoHFW. The Directorate of Health Services should become part of new Public Health Commission.

Redefine and reforming the role of Medical Council of India (MCI): The role of MCI over the years has got restricted to medical education. There has been no review of the functioning of the MCI. There has been dilution in its role to control the growing undesirables practices in the private health care sector. Some options are: divide the MCI into two parts: Medical Education Council of India and Medical Standards Council of India, or Create new **Medical Standards Board**, which should be responsible for setting standards for acceptable medical practice in the country. This Board should also be responsible for developing the process of accreditation and other processes ensuring healthy development medical practice. The Board should be responsible for continuing medical education programme and renewal of medical practice license of persons practicing medicine.

Health Sector Regulation Monitoring Committee: With the increasing private sector and liberalisation of insurance sector, regulations need to be strengthened. It is very important that in respect of Health Care Sector the Government may be urged to frame some sort of regulation for Hospitals, Practitioners, Nursing Homes, Labs, Drug Stores etc. There is need to set-up Health Sector Regulation Monitoring Committee which should have responsibility of ensuring that regulation get implemented and keep on examining various issues pertaining development of appropriate regulations on continuous basis. It must be taken note that regulations in health sector need continuous updating as the technology, practices and various characteristics change continuously. We need mechanism in place which can handle these challenges. Such initiative should also go into the institutional mechanisms to strengthen these regulations.

Health Financing Policy: The way the programmes in health sector are financed will have important implications for the programmes and health sector performance. There are very few initiatives around to understand the complexities of health financing and policy in the health sector in India. Many initiatives in this area are primarily driven by external agencies

policies and influences. The government should set-up Health Financing Unit within a national reputed Institute having capacities to undertake research, policy development, and dissemination work. One of the mandates of this unit should be to undertake studies to develop appropriate framework to discuss and debate social health insurance mechanisms, community based financing schemes and insurance mechanisms developed by self-help groups and community based organisation.

Hospital Management Board: The government should bring out a hospital strategy paper to define the role of public hospitals in India. There is need to make these institutions more autonomous so that they can play their role effectively. Many states in India are developing institutional mechanism of societies to address some of the autonomy issues. In order to channel their activities and steer the process of their development, each state should constitute the Hospital Management Board. These Boards will have responsibility of managing these institutions and ensure they meet the public health goals. Among other things these Boards will also look into the question of augmenting the resources and will be responsible to the government in the states. The government should at the national level also constitute a similar board which will develop appropriate strategies for the hospital sector in India. Over the period these Boards in States should also become responsible for making budgetary allocations to the hospitals.

Strategies to protect poor from high medical costs: The government has now privatized the insurance sector and we may have soon number of insurance companies which would provide the health insurance products. We know that people belonging to lower income groups would be left out in the process and will suffer because of high medical costs. In view of these the Government should take proactive steps to reform the public healthcare delivery system so that it caters to the poor better. The Government should develop the strategies to encourage the community based financing mechanisms. Developing capacities and possible models (including management structures) in this area to manage such programme should be a priority. The private health insurance companies should be required to allocate some resources towards this. Similarly NGOs should also be encouraged to develop in collaboration with the State Governments suitable benefit schemes for rural

masses and poor. There are number of experiences of NGOs which have successfully implemented such schemes in different places. The Centre/State Governments should devise new schemes on the basis of experience gained from the implementing agencies, NGOs etc. There is need to look into current subsidies and incentives in health sector and should ensure that they are fairly distributed to the poor and vulnerable groups of population. For example, present tax incentives for buying voluntary health insurance benefits only people belonging to upper income groups. This subsidy should be redistributed to the poor.

References

1. Ahuja (2004). Health Insurance for the Poor; Economic and Political Weekly, Vol 39, No28, July 10, 2004
2. Bhat R, Maheshwari SK, Saha S (2004). Treating HIV/AIDS Patients in India with Antiretroviral Therapy: A Management Challenge; Working paper No. 2004-06-03 Indian Institute of Management Ahmedabad
3. Bhat R, Jain N (2004a). Analysis of Public Expenditure on Health using State Level Data; Working Paper No. 2004-06-08 Indian Institute of Management, Ahmedabad
4. Bhat R, Jain N (2004b). Time Series Analysis of Private Healthcare Expenditures and GDP: Cointegration Results with Structural Breaks; Working paper No. 2004-05-10 Indian Institute of Management, Ahmedabad
5. Bhat R (1999). Characteristics of private medical practice in India: a provider perspective; Health Policy and Planning; 14(1): 26-37
6. Bhat R (1996). Regulation of the Private Health Sector in India. International Journal of Health Planning and Management 11: 253-74
7. Duggal R, Amin S (1989). Cost of Health Care: A Household Survey in an Indian District. Bombay: The Foundation for Research in Community Health
8. Economic Survey (2004). Ministry of Finance; Government of India
9. Gupta I, Sankar D (2003). Treatment-seeking Behaviour and the Willingness to Pay for Antiretroviral Therapy of HIV positive patients in India; World Bank publication.
10. IRDA (2002-03). Annual Report
11. Jajoo U, Bhan A (2004). Jowar Rural Health Insurance Scheme: In the Spirit of Sarvodaya; Economic and Political Weekly; Vol 39 No. 28 July 10, 2004
12. Jessani A, Anantharam S (1989). Private Sector and Privatisation in the Health Care Services. Bombay: The Foundation for Research in Community Health
13. Kar (2004). Refining Care; Asia Insurance Post; April 2004
14. Mavalankar D (1999). 'Human Resources Management: Issues and Challenges'. In: Implementing a Reproductive Health Agenda in India: The Beginning. New Delhi: Population Council. Pp 179-200
15. Nandraj S, Khot A (2003). Accreditation System for Health Facilities: Challenges and Opportunities; Economic and Political Weekly; Vol 38 No. 50, December 13, 2003
16. PHR plus (2004). Using the National Health Account Sub analysis to Track Resource Flows for HIV/AIDS; Abt Associates Inc. June 2004
17. Priya R et.al. (2004). CMP on Health; Making India World Class; Economic and Political Weekly, Vol 39, No27, July 3, 2004
18. Ranson, MK (2003). Community-based Health Insurance Schemes in India: A Review; National Medical Journal of India, 16(2): 79-89
19. UNAIDS (2004). Report on Global AIDS Epidemic
20. Visaria P, Gumber A (1994). Utilisation and Expenditure on Health Care in India: 1986-87. Gujarat Institute of Development Research, Gota, Gujarat
21. Yesudian CAK (1990). Utilization Pattern of Health Services and its Implications for Urban Health Policy. Takemi Program in International Health, Harvard School of Public Health.