DEVELOPING DISTRICT HEALTH ACCOUNTS FROM A BLANK SHEET

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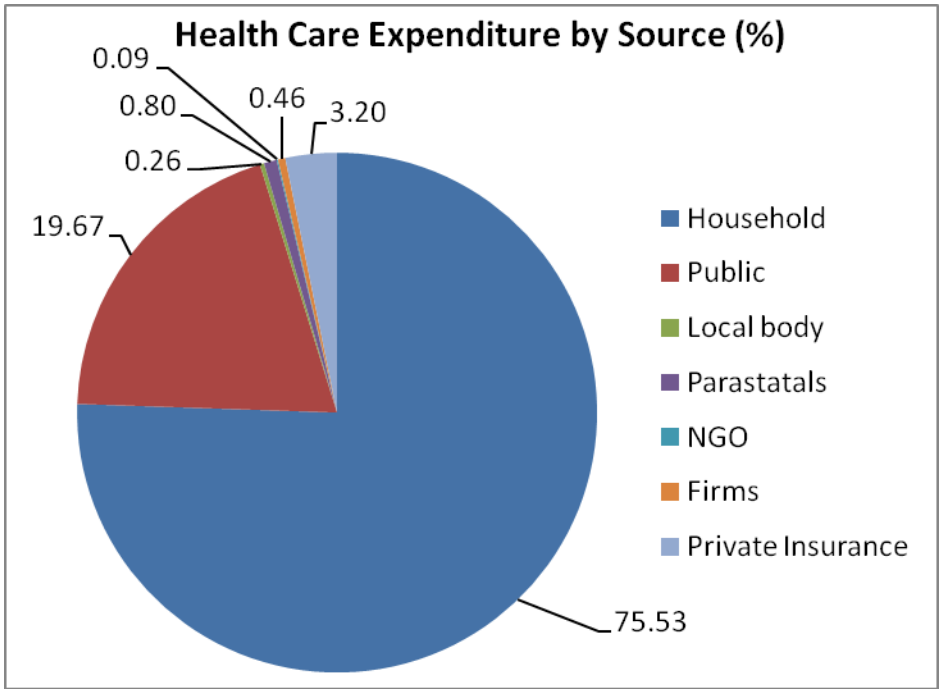
Executive Summary

The study tried to develop Health Accounts for a district in the state of Karnataka in the Indian union. The attempts of developing Health Accounts are on the learning curve in most of the developing countries. Contrary to this most of the European countries and few countries in the American continent have produced health accounts. Though India did produce its Health Accounts very recently, more distance needs to be covered at the state level. Health Accounts are considered to be more useful as a policy tool for bringing in corrective measures as regards the financing of disease specific interventions. The conceptual clarity of developing such accounts are also in infancy in most of the developing countries due to the fact that the OECD model of System of Health Accounts (SHA) as well as the Producers' Manual of Health Accounts (WHO, USAID & WORLD BANK) cannot be easily adopted and adapted in the context of developing economies. In this background the study assumes significance due to the fact that it would be an in-house and pioneering exercise to develop and understand the conceptual as well empirical issues in developing health accounts. The study would be useful for the academicians and the managers of health sector in the years to come. The lessons learnt would be useful in scaling up such experiments both at the state and national level. Health Accounts would provide broad indicators for policy makers just like the information that emanates from the National Income Accounts. Tracking down of Actors, Activities and Transactions in the health sector would help us to use the scarce resources for better governance of the health sector.

In the following discussion an attempt is made to present the broad messages of the study. **The total health expenditure of the district accounts for about 4.5 per cent of the district income.** Out of the total resources flowing into the health sector of the

district, Households contribute about 75 per cent which is also supported by other studies at the national level and at different state levels. Public expenditure which includes both state, union governments accounted for about 19 per cent. Except Private Insurance which was to the extent of 3.20 per cent, rest of the sources did not have any significant share in the total health expenditure. This only reflects the issue that majority of the burden as far as health care financing is concerned falls on the households.

Chart: 1



It can be observed from the data that was gathered to understand the district level health expenditures that the households are bearing the major responsibility as far as financing health care services are concerned. This is true from various other studies which have been carried out in different parts of the country. The NSSO data also supports our findings. This also brings out the limited role played by the public sector in supporting the health care delivery to the general public. Thus, one can certainly argue for the expansion of the public kitty towards the provision of health services.

A further look at the total health expenditure from the point of view of Providers reveals that most of the expenditure is concentrated towards curative services that too in the urban areas. The analysis also indicates dire neglect of rural based services, primary and secondary health care. The kind of expenditure also indicates lack of funds for preventive and promotive health care services. In one considers Public expenditure alone it can be observed that it tilts towards preventive services, but at the same time the need is felt to take care of other aspects like curative and other ancillary services as well.

Most of household expenditure is devoted for the purchase of medicines from the retail sector. This may probably reflect upon the lack of public supplies in this regard. The need is also felt to promote insurance in health sector for better protection of weaker sections of the society.

Finally one should speak about adapting the OECD methodology in the Indian context. There is a difficulty of bringing in the international protocols as far as health care functions and agents are concerned. The need is felt to spell out our won functional categories as well as provider categories. The study has made a modest attempt is putting the OECD and the World Bank / WHO methodology in the Indian context.

As the attempts relating to development of NHA are getting firmed up in developing countries, the present exercise assumes significance. The lessons learnt would be useful for developing similar exercises at the state and national level in the Indian Union**. The study would be a useful tool for the managers of the health sector at the district level. On the academic front the exercise would highlight the strengths and weaknesses of developing health accounts at the sub regional level.**

1. Statement Of The Problem

Every one wishes to be away from disease, disability and premature death. Substantial evidence is now available regarding the fact that good health is an important contributor to economic growth in any nation. In this background both policy makers and researchers have recognized the importance of investments in health. Public spending on health and education bring about a change in incomes among the poor. Such investments also seem to be the major determinants, which would contribute to the better health status of the community.

India had adopted the goal of Health for All by the year 2000 A.D. It is now obvious that there is still quite a long way to go before that goal is achieved. Presently new targets have been set forth as Millennium Development Goals to be achieved by the year 2020. These goals have been reiterated in the National Health Policy of 2002 that has been already adopted by the Indian Parliament. The country has been spending significant amounts of its resources for the provision of health and medical care services, but there is still a large demand – supply gap accompanied by problems of inequitable access to facilities and a virtual absence of low-cost risk-pooling mechanisms for the poor and vulnerable groups of the population. There is a growing realization among administrators and researchers that a major cause of implementation slippages of the policy proclamations relate as much to **the problem of non-availability of useful data as to the non-use of available data on the health sector**. In other words, pronouncements of desires have not been supported by suitable informational structures and databases for effective health sector governance in India. In such a context, health sector accounting is visualized as a tool for efficient governance. By facilitating greater transparency in the flow of resources from sources to uses, health sector accounts enable health sector managers to get a clear idea about the incidence and impacts of targeted policy interventions. Further, the dynamic benefits from health accounting flow in the form of critical informational inputs to policy makers for appropriate

moulding of health delivery systems taking into account budgetary innovations, structural and health sector reforms, decentralization of governance, equity and gender interventions, disease burdens, risk pooling and health sector research requirements.

As per the Constitution of India, the provision of health care by the public sector is a responsibility shared by State, Central and local governments, although it is primarily a State responsibility in terms of service delivery. A careful understanding of financial flows of the health sector seems to have emerged as an important policy tool in the recent times. The earlier attempts in developing countries were restricted to the estimation of health expenditures from the public sector only. This was obviously due to data limitations experienced in such countries. To have a comprehensive picture about health expenditure we must take into account not only public sector spending but also private sector contributions in this regard. This gives us a form of accounts for the health sector, which may be the national health accounts.

However, health accounting is still in its infancy stage in India and research in this field is still on the learning curve. A careful understanding of financial flows of the health sector seems to have emerged as an important policy tool in the recent times. The earlier attempts in developing countries were restricted to the estimation of health expenditures from the public sector only. This was obviously due to data limitations experienced in such countries. In the light of the limited availability of resources to the health sector a judicious use of resources assumes utmost significance. To have a comprehensive picture about health expenditure we must take into account not only public sector spending but also private sector contributions in this regard. This gives us a form of accounts for the health sector, which may be the national health accounts.

2. SNA And Health Accounts:

Both national income accounts and national health accounts are similar, in the sense that what national health accounts describe for the health sector is being done by national income accounts for the economy as a whole. Both these estimates agree to the fact that money payments or transfers should not be double counted and a distinction to be maintained between capital and current expenditures With regard to the health sector, the national health accounts is a recent addition and in most of the developing countries the efforts are still in infancy.

After the entry of OECD and WHO's Producers' Manual there seem to be no serious effort in the Indian context to develop health accounts. The only exception could be the national level effort by MOHFW and WHO in India which has tried to produce the NHA for India for the year 2001-02. The scenario at the state level still remains unexplored. In a vast and varied country like India, the need is always felt to develop health accounts at the state level and from the lessons learnt as part of such exercises, one may proceed further to develop health accounts at the national level.

Better understanding on the information on financing of Health Sector is a sine qua non for most of the developing countries. This is because it acts as a basis for wise policy change in the area of health sector reforms. Any attempt in analyzing health care financing should have sound estimates of national health expenditure. In other words, it should take into account total spending, the contributions to such spending from different sources and the claims on spending by different uses of funds.

The 1993 revision of United Nations system of National Accounts (SNA 1993) has extended the boundaries of national income accounting to sectoral accounts. National Health Accounts developed in the United States in the form of United States National Health Accounts (USNHA) and the OECD experiment are considered to be the two major

attempts in evolving a system of National Health Accounts (NHA). There is a subtle distinction between NHA and SNA with regard to health expenditure estimation. SNA shows links between the health sector and the macro economy, the NHA attempts to describe the flows of expenditures between different institutional elements within a health care system, with the emphasis on structuring the data in a manner most relevant to health sector system operates (Rannan Eliya and others 1997). NHA also excludes valuation of economic activities and concentrates only on expenditures, and sometimes NHA also ignores a distinction between capital and revenue expenditures.

Objectives of SNA are to provide a cross-national and stable framework for the consistent compilation and structuring of macro economic data. Thus SNA provides broad contours of economic activities across the whole economy. In so doing SNA lays less emphasis on defining in greater detail the specific activities that occur within each sector of the economy. Due to the rigidities within the SNA to understand the impact of individual sector on the macro economy the concept of satellite accounts emerged. These sector specific accounts were separate in nature but were linked to the central framework.

SNA clearly identifies production activities, which are carried out under different units using different inputs to produce certain outputs. Satellite accounts are permitted to vary both classifications of production as well as production boundary. For Example, SNA classifies on site medical facilities in any production unit as ancillary activities and considers the cost of such facilities as indirect costs in producing the product by the production unit. The satellite accounts treat this facility as the activity of health care and the costs incurred are included as direct costs incurred in providing health services. Sometimes the production boundary may itself undergo a change, the SNA does not include services rendered by household members or other voluntary work but in a satellite accounts these can be measured if one desires accordingly. The distinction

between central framework and satellite accounts may also vary with respect to income, uses of goods and services, assets and liabilities, purposes and the like.

SNA guidelines for evolving a **Satellite Accounts** (may be Health Accounts in this case)

- The goods and services considered specific to the field.
- The activities for which capital formation will be recorded.
- The transfers that are considered specific to the field.

Uses will be classified as

Consumption - final and intermediate

Capital formation

Transfers – Current and capital

Current and capital uses of residents financed by rest of the world

Actors will be classified in the same manner as institutional sectors and types of producers in the central framework as shown below:

- Market producers
- Non-market producers
- Government
- Households
- Rest of the world.

Health Accounts have a methodology of their own and the attempts in estimating them have demonstrated that they are likely to be different from the central framework of SNA. NHA have developed independently for the most part from the SNA and satellite accounts. They have been compiled in response to the needs of health sector managers. The first set of NHA estimates was compiled in the United States only 35

years ago (Rice and Reed 1964). Only in recent years many countries have begun work in this direction.

The basic function of the NHA is to show and link between the sources and uses of health care expenditures. Similar to SNA these are shown in a matrix format. Unlike NHA the previous health expenditure surveys have not considered both sources and uses of funds. The aim of NHA is to measure the total volume of financial expenditures and present them in such a way that the flows of resources between different units in a health care system are immediately visible to the managers of the health sector.

A satellite account usually tries to show the link between the sector in question and the overall macro economy.

Distinctions between NHA and SNA

NHA	SNA
Focuses on expenditures in a Specific purpose in a given year. For example health	Focuses on the valuation of economic activities
More concern for clearly defined sectoral purpose of an expenditure	Distinguishes between primary and secondary purpose
All expenditures associated with Health are considered as health Expenditure regardless of their Economic purpose	Does not consider such expenditures on health

Source: *Rannan Eliya, Ravindra, Peter Berman and Aparanaa Somanathan (1997) A Comparison of the system of National Accounts and National Health Accounts Approaches, Special Initiative, Report No. – 4, Bethesda MD, Partnership for Health Project Abt Associated Inc.*

3. Developing District Health Accounts:

Health Accounts at the sub regional levels pose typical problems of their own due to the complexities involved in developing them. Though district is considered as a basic unit of administration in the country, availability of right kind of data gets blurred at this level of desegregation. District as a unit seems to behave like open economy and clear cut demarcations would be difficult to ascertain. But nonetheless one can attempt District health accounts by making certain heroic assumptions. For example cross district transactions need to be ignored at the outset. However one easy thing that is useful and handy at the district level would be the identification of **"ACTORS**" in the health care system.

One has to rely on the System of Health Accounts (SHA) developed by the OECD as well as the Producers' Manual of National Health Accounts of WHO to develop Health accounts for a given region. The ambitious OECD model, designed to apply in a complex, multi-dimensional process environment, addresses the three main sets of questions:

- Where does the money come from? (Sources of funding)
- Where does the money go? (Providers of health care services and goods)
- What kinds of services are performed and what types of goods are purchased?

District Health Accounts (DHA) would consist of a set of tables, which would display various aspects of district's health expenditure. The basic objective of DHA is thus to address the following set of questions.

- How are resources mobilized and managed for the health system?
- Who pays and how much is paid for health care?
- Who provides goods and services, and what resources do they use?
- How are health care funds distributed across the different services, interventions and activities that the health care system produces?
- Who benefits from health care expenditure?

4. Objectives

The broad objective of the study is to develop Health Accounts for the district of Dharwad in Karnataka State in the Indian Union. The proposed study tried to address the following specific objectives.

- To sketch the overall funding mechanism of health services in the Dharwad district
- To present the health sector scenario of Dharwad district in comparison to that of the state
- To identify different Actors, Activities and Transactions in the provision of hea;th care – fixing the boundaries
- To identify all sources and uses of financial flows for health in the context of overall health system spending
- To develop Health Accounts for Dharwad district using the internationally accepted National Health Accounts (NHA) methodology which is used to determine a nation's overall health spending patterns

5. Methodology and Sample Design:

Health Accounts at the sub regional levels pose typical problems of their own due to the complexities involved in developing them. Though district is considered as a basic unit of administration in the country, availability of right kind of data gets blurred at this level of desegregation. District as a unit seems to behave like open economy and clear cut demarcations would be difficult to ascertain. But nonetheless one can attempt District Health accounts by making certain heroic assumptions. For example cross district transactions need to be ignored at the outset. However one easy thing that is useful and handy at the district level would be the identification of **"ACTORS**" in the health care system.

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5.1 Major Entities of the Health Care System:

Following are the major entities, which are part of Health accounts

- Entities, which act as ultimate sources of funds.
- Entities, which transfer the resources between the funding entities and the actual providers of services.
- Providers of services.

5.2 Sources of funds are grouped into the following major categories.

1. Public Sector – Government ministries and administrative departments.
2. Public sector – other government agencies.
3. Private Sector – firms and enterprises.
4. Private Sector – Non-governmental organizations (NGO).
5. Households -Out of Pocket Spending (OOPS)
6. Foreign sector – Government and non-government sources.

Next Step would be to classify Financing Agents taking into account the fund flow model for the district. Providers of Health Care Services – classifying as per the OECD standards

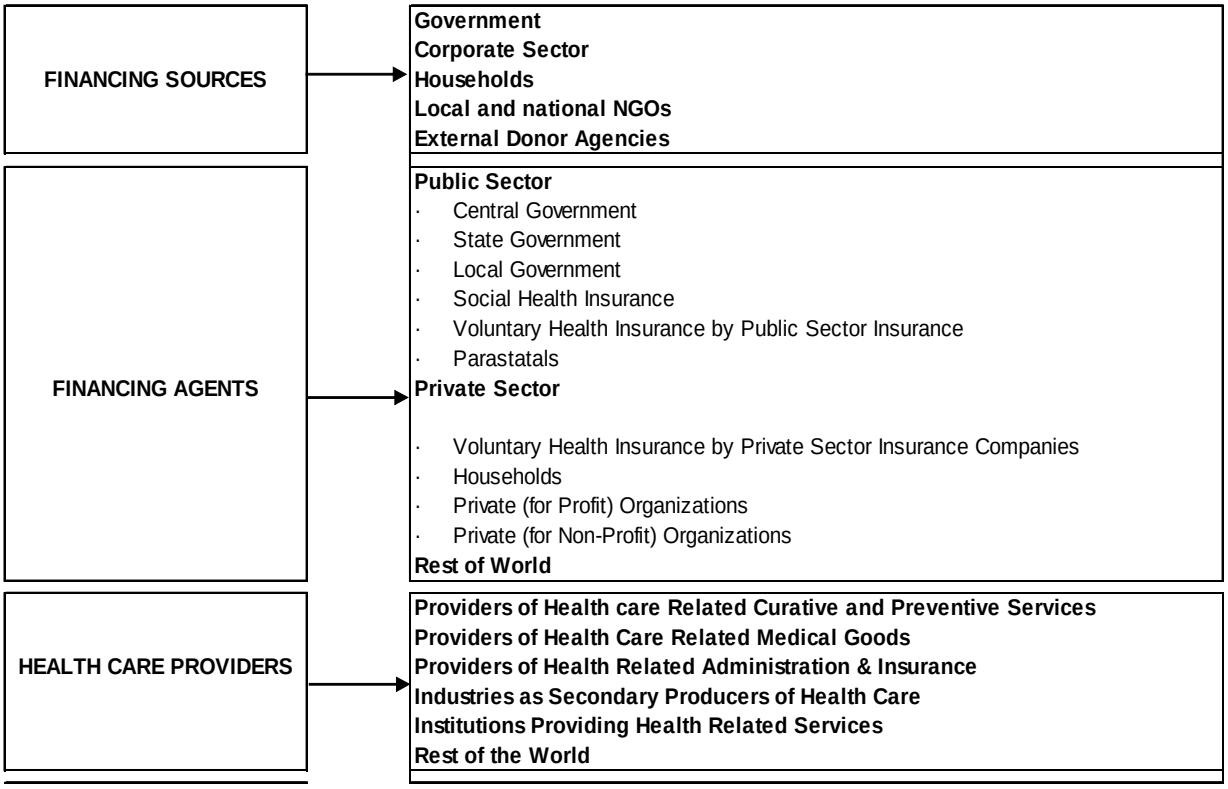
5.3 Actors

Following the WHO (2003) classification, the actors associated with the health care activities may be categorized as:

(a) Financing sources
(b) Financing agents;
(c) Health care providers and
(d) Health care beneficiaries.

The following chart gives in detail different entities that exist in the health care system of Karnataka state.

Chart-2



Apart from the usual schema of provider classification based on the OECD standards, attempt should be made to include locale specific providers like

- Registered Medical Practitioners
- Untrained DAIS
- Faith Healers

  Herbal Medicine Providers and the like

6. Boundaries and Classifications

Time Boundary: Setting the time boundary of Health Accounts requires that a choice be made about the period (fiscal/calendar year) for which the expenditure data would be presented in the accounting matrices and, secondly, the accounting practice (cash/accrual accounting) to be followed. The present study focuses on the financial year of 2007-08 and all the money transactions relating to health in this year have been considered.

Government expenditure data are usually available for fiscal years. It is expected that the legally recognized entities (NGOs, Private Practitioners, Corporate Health Care Facilities, etc) would also be maintaining records on a fiscal year basis to comply with tax and audit related regulations. For households and the informal private providers, however, the survey data collected from them about health care spending would be referring to the last calendar year. In such cases, the need is felt to convert the calendar year data to fiscal year data following the methodology outlined in the WHO *Guide* (2003) so that the final HIV AIDS Accounts matrices are presented for the chosen fiscal year. The choice of the fiscal year as the accounting period is justified because of its relevance to policy making in the Indian context.

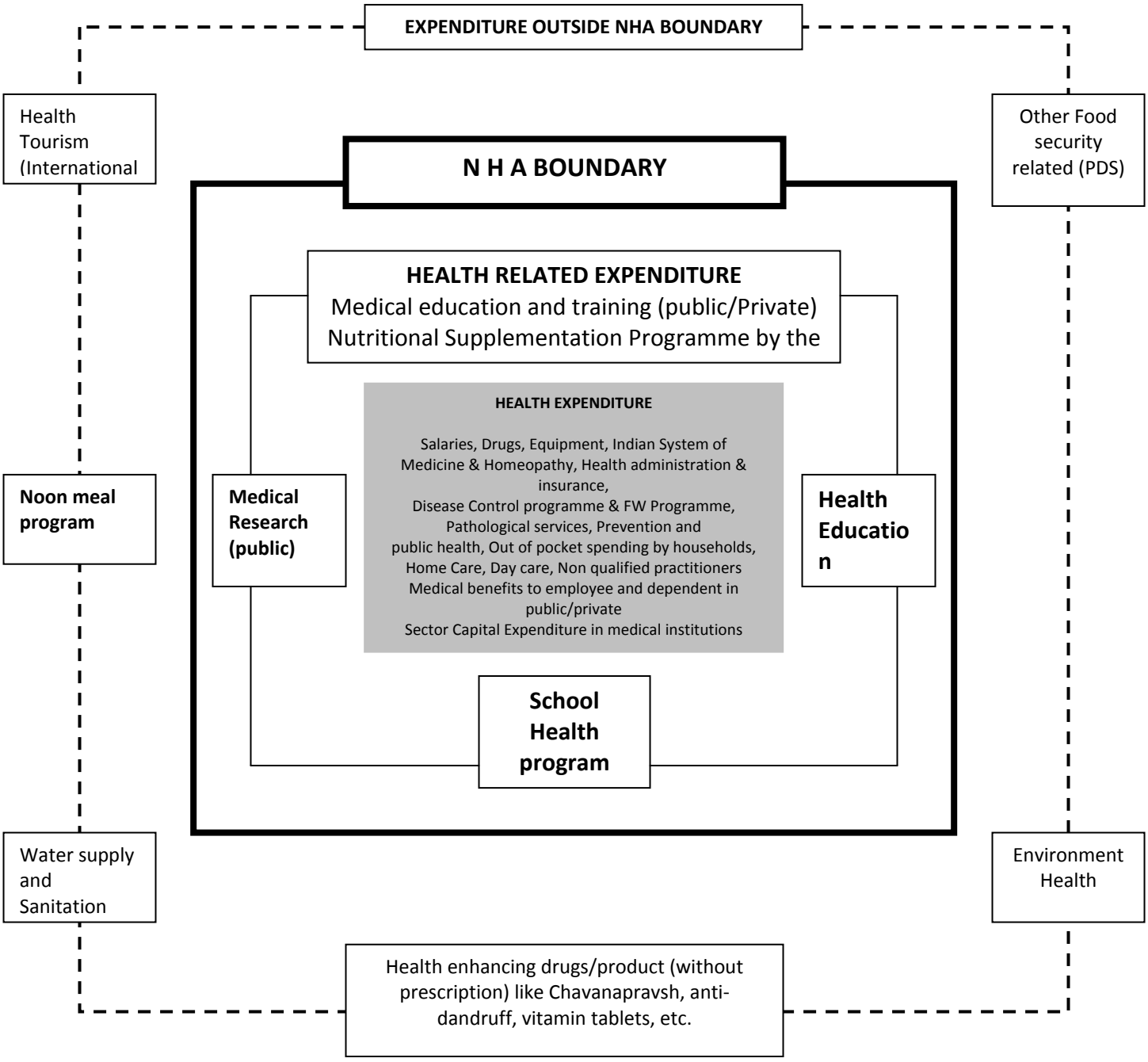
Accrual accounting is the preferred method in the construction of health accounts and accordingly the present study would generate data on expenditure actually made for health care activity that took place during the chosen accounting period.

6.1 Space Boundary: At the outset, it would be better to know the broad activities which are covered under the System of Health Accounts (SHA). If one goes by the OECD standard, the following activities would be considered while attempting health accounting exercise. One should consider the following as a broad pointer and there is a scope to redefine and fine tune it.

- Promoting health and preventing disease.
- Curing illness and reducing premature mortality.
- Caring for persons affected by chronic illness who require nursing care.
- Caring for persons with health related impairment, disability and handicaps who require nursing care.
- Providing and administering public health.
- Providing and administering health programmes, health insurance and other funding arrangements.

The above categories would broadly indicate the health per se activities that need to be considered while developing health accounts. Based on this broad list the boundaries considered for the present study are presented graphically as noted below.

Chart-3



Source : Adapted from *National Health Accounts, 2001-02*, MOH, Government of India

6.2 Functional Boundaries: Following the framework of the space boundary, the functional boundaries in the health care are considered as indicated in the chart below

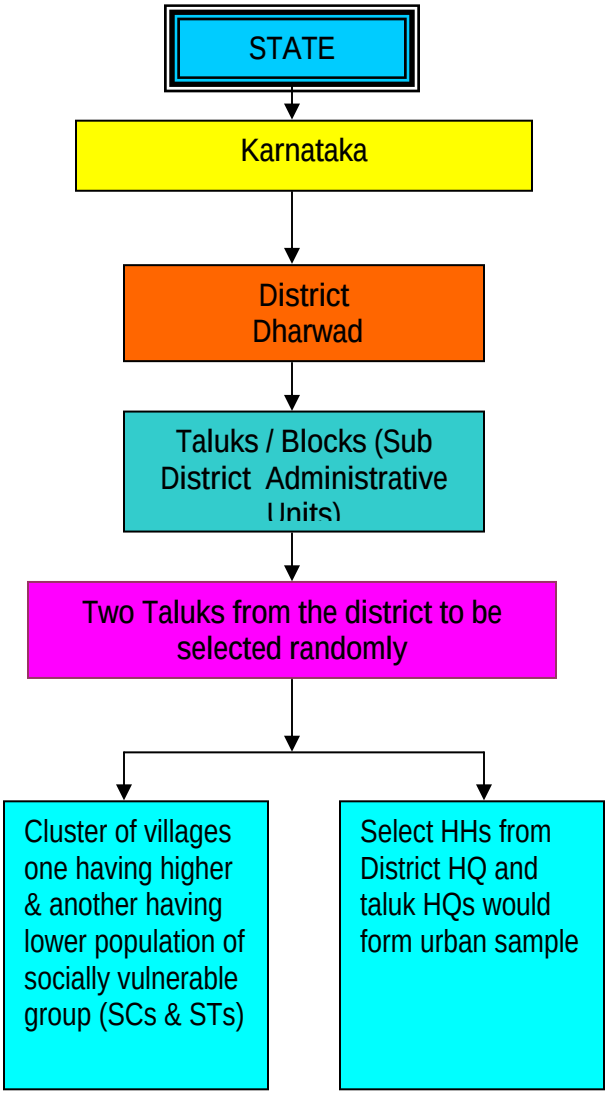
7. Health Care Functions

1. Services of curative care
2. Services of rehabilitative care
3. Services of long term nursing care
4. Ancillary services to medical care
5. Medical goods dispensed to outpatients
6. Prevention and public health services
    a. Family health and reproductive health services
    b. Maternal health
    c. Infant and child care
    d. Family planning services
    e. Other reproductive health services
    f. School health services
    g. Prevention and management of communicable diseases
    h. Immunization
    i. Sexually Transmitted Diseases (STDs)
    j. Others not elsewhere classified
    k. Prevention and management of non-communicable diseases
    l. Occupational health care
    m. All other public health services not elsewhere classified
7. Health administration and health insurance
8. Health related functions

8. Sample Frame for the Study:

The study relied upon both primary and secondary data sources. In this context the HH survey was conducted to obtain HH expenditure on health. The households were selected from the district and we surveyed 500 households with due representation to urban and rural segments. The following chart would explain the sample frame for the HH survey.

Chart 4 Showing Sample Frame for the Study



9. DATA SOURCES

Apart from the household survey, the data would be collected from different providers of health care both in public and private domain. Secondary data sources are as indicated below.

Table 1

Name of the Financing Sources/Agents	**Documents available**
Government 1. Central 2. State	I. Budget Documents II. Annual Reports III. Audit Reports
Local Bodies Panchayati Raj and Rural Development Institutions	I. Consolidated Data for the State 1. State Finance Commission Reports 2. Department of Panchayat Raj and Rural Development 3. State Audit Report by the CAG 4. Statistical Abstract II. District Level Data by Line items 1. CEO Zilla Parishad : Income & Expenditure Statement 2. Regional/District Fund Audit Report 3. Annual Administrative Report of Panchyats 4. District Panchayat Office
Municipalities	I. State Level Consolidated Data 1. Department of Municipal Administrator 2. State Finance Commission Report 3. State Audit Report II. District Level Sub-head wise Accounting 1. Regional/District Audit Fund 2. Income & Expenditure Statement of Corporations 3. Hand Book of Municipal Statistics
Employees State Insurance Scheme	1. Regional office, Employees State Insurance Corporation (ESIC) 2. Director of ESI Medical Services
Central Government Hospital Services (CGHS)	1. Central Office 2. Demand for Grants-Ministry of Health & Family Welfare
Private Insurance	1. Regional office of Insurance Companies 2. Annual Report of IRDA - for National Figures
Corporate Bodies	1. Annual Reports of respective Corporate Bodies 2. Department of Industries and Commerce, Government of Karnataka 3. Employees State Insurance Corporation, Regional office, Bangalore
NGOs	1. Government Grant-in-Aids (Central Government & State Government) – Budget documents (Demand for Grants) 2. State level/District level Societies for HIV/AIDS, RCH activities: Annual Report/Half yearly Reports 3. External Assistance Report by the Ministry of Finance & FCRA-Report on Contributions to Voluntary Organizations 4. NSS data (52nd Round) on health expenditure on charitable hospitals
Drug Expenditure	1. Central and State Govt. Expenditure on drugs 2. Budget documents - Other departments/MOHFW/Other Ministries 3. Commissioner of Commercial Taxes 4. NSS data for Household Drug Expenditure

10. Estimation Procedure:

The sample data was analyzed and presented in the health accounting format using the WHO / OECD standards. The expenditures were grouped according to the functional classifications of the internationally accepted criterion. Similarly the classification for Sources, Agents of funds and Providers of Health Care were arranged in the format of System of Health Accounts (SHA). As far as the household survey was concerned, the data was collected from different villages in the selected taluks of the chosen districts. At the first level of aggregation, the village average for the household expenditure was worked out. Taking into account the number of villages surveyed in a taluk, the taluk level household expenditure was arrived using the average expenditure in a taluk. In the second level of aggregation, the average for different taluks was used as the basis to arrive at district specific averages. Using the average household expenditure on health for different districts, the overall average household expenditure was calculated for the total surveyed households.

Total Expenditure on Health incurred by the HHs in the state are summarized as follows:

(i) Average HH_{exp} * POPn in village = total exp on health by the HHs in the villages (TEHHV)

(ii) TEHHV * POPn in the Block= Total expenditure on health by the Households in the blocks (TEHHB)

(iii) TEHHB * POPn in the Taluka = Total Expenditure on health by HHs in the talukas (TEHHT)

(iv) TEHHT * POPn in the dist = Total Expenditure on health by the HHs in the dist (TEHHD)

(v) (TEHHD) * POPn in the State = Total expenditure on health incurred by the households in the state

Taking this grand average as the basis, the household expenditure was blown up for the state as a whole.

With regard to the expenditure incurred by the NGOs, again the average for all the NGOs surveyed was worked out and using this as the basis the state level expenditure was worked out taking into account the number of NGOs operating in the state.

As far as the corporate expenditure is concerned, the survey data was used to calculate the average expenditure per industrial worker. Taking this average as the basis, the total contributions from the industrial sector was worked for the state as a whole.

11. A Brief about Dharwad District:

Dharwad district in Karnataka state has been selected for the empirical analysis of the study. The district is situated in the western sector of the northern half of the Karnataka State. The district encompasses an area of 4263 sq. kms lying between the latitudinal parallels of $15^0$02' and $15^0$51' North and longitudes $73^0$43' and $75^0$35' East.

Dharwad district comprises of five taluks- Dharwad, Hubli, Kalaghatagi, Kundagol, and Navalgund. Based on the agro-climatic conditions, the district can be divided into *Malnad*, *Maidan* (dry tract) and the transitional belt. The annual rain-fall in the *Malnad* tract varies between 838 mm and 939 mm. The transitional belt receives rains less than 777 mm per annum, the lowest being 612 mm. *Malenadu* is marked by a chain of low hills and valleys with comparatively heavy rainfall. The greater part of this region remains sparsely populated. The *Maidan* or the black soil plain to the eastern belt is an extensively cultivated area. Cotton, jawar, chilly and wheat are the main crops. The area supports a sizeable population residing in large and compact villages. Households in Malenadu heavily depend on forests and other common lands for their livelihoods.

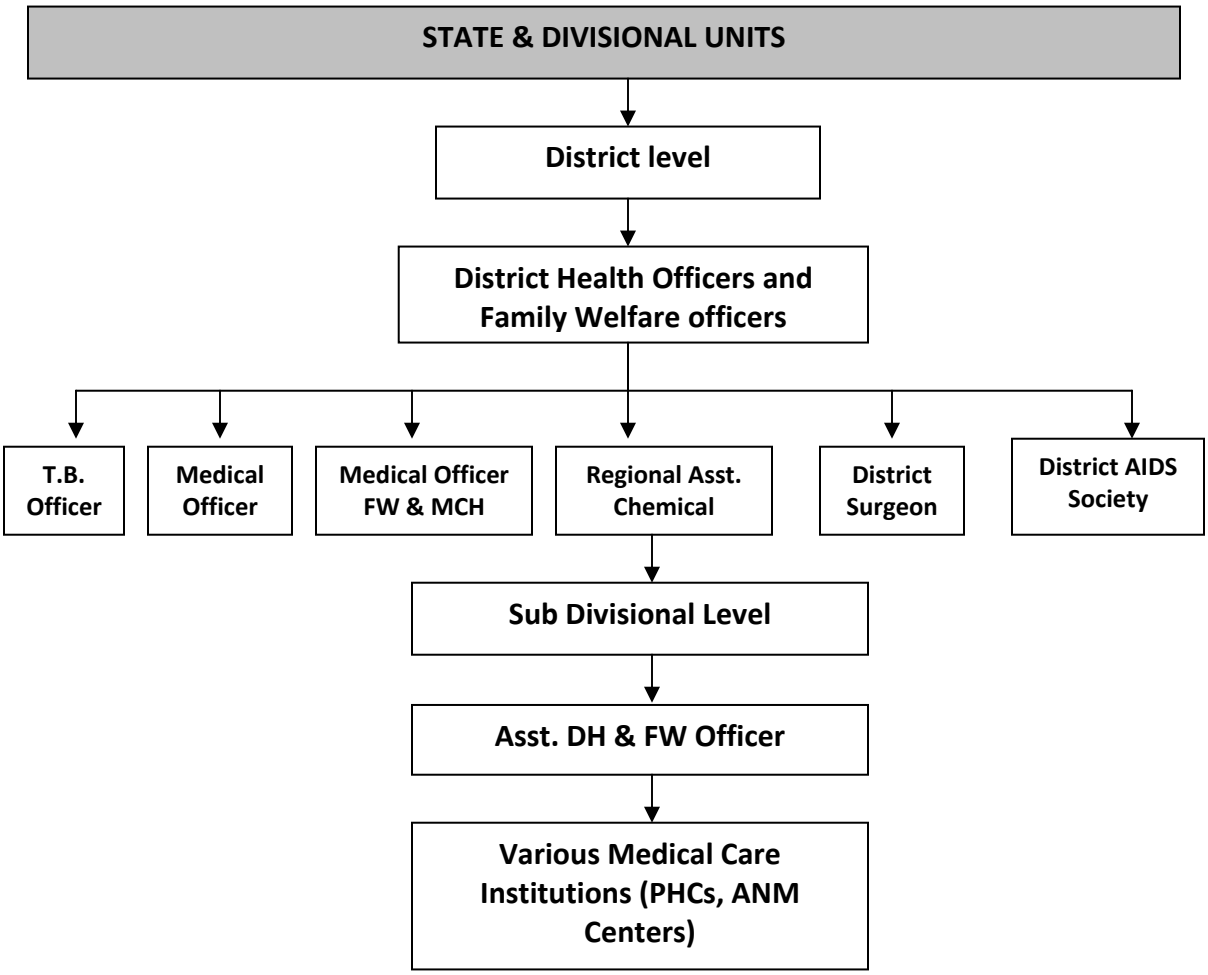
Table2 : Dharwad District Statistics at a Glance

Sl No	Particulars	Period	Unit	No	S No	Particulars	Period	Unit	No
1	Total Villages	2001 Census	No.s	390	12	Population Dencity (Per Sq Km)	2001 Census	No.s	377
2	Inhabited Villages	2001 Census	No.s	372	13	Total Banks	31/03/2007	No.s	209
3	uninhabited Villages	2001 Census	No.s	18	14	Co-operative Societies	31/03/2007	No.s	717
4	Total Gram Panchayats	2005	No.s	127	15	Members in Co-operative Society	31/03/2007	No.s	582716
5	Total Population	2001 Census	No.s	1604253	16	Total Motar Vehicles	31/03/2007	No.s	243744
6	Rural Population	2001 Census	No.s	722336	17	Post Offices	31/03/2007	No.s	217
7	Urban Population	2001 Census	No.s	881917	18	Telephone Connections	31/03/2007	No.s	93260
8	S.C. Population	2001 Census	No.s	131969	19	Net Income (current prices)	2003-04	In Lakhs	369586
9	S.T. Population	2001 Census	No.s	70442	20	Per Capita Income (current prices)	2003-04	In Rs	22281
10	Religionwise Population	2001 Census	No.s		21	Primary Schools	31/03/2007	No.s	842
	Hindu	2001 Census	No.s	1221335	22	High Schools	31/03/2007	No.s	191
	Muslim	2001 Census	No.s	315177	23	Fair Price Shops	31/03/2007	No.s	540
	Christians	2001 Census	No.s	27634	24	Geographical Area	2005-06	Hectares	427329
	Jain	2001 Census	No.s	25089	25	Forest Area	2005-06	Hectares	35235
	Others	2001 Census	No.s	15018	26	Net Sowing Area	2005-06	Hectares	325549
11	Literacy	2001 Census	Percentage	70.87	27	Irrigated Area	2005-06	Hectares	42899

11.1 Institutional Structure for the Delivery of Health Care Services:

There are various private hospitals, clinics, pathological centers and local healers providing services to the affected patients. The official machinery which is in place is reflected in the following chart.

Chart5 : Institutional Structure for the Delivery of Health Care Services



The following table would give the health infrastructure that exists in the district

Table 3: DHARWAR DISTRICT HEALTH INFRASTRUCTURE & RELATED INDICATORS

Community Health Centre(s)	6
Primary Health Centre(s)	33
Primary Health Unit(s)	12
A N M Sub centre(s)	144
Average Distance to Nearest Community Health Centre in Kms	8
Average Distance to Nearest Primary Health Centre in Kms	7
Average Distance to Nearest Primary Health Unit in Kms	2
Average Distance to Nearest A N M Sub Centre in Kms	1
Community Health Centre - Building(s)	8
Primary Health Centre - Building(s)	40
Primary Health Unit - Building(s)	11
A N M Sub Centre - Building(s)	95
Ambulance(s)	6
No of Habitations with Telephone Facility	47
Blood Banks(s)	2
Health Centre Latrine(s)	78
Health Centre Drinking Water Facility	80
Operation Theatre(s)	39
No of Beds	220
Pharmacy	59
No of Private Doctors	395
Medical Officers - Sanctioned	66
Medical Officers - Working	72
Nurses - Sanctioned	142
Nurses - Working	175
A N M - Sanctioned Posts	337
A N M - Working	327
Medical Officer Quarter(s)	24
A N M Quarter(s)	82

12. District Health Accounts: Results

A total of 250 households (HHs) were surveyed in the district. Out of which 200 were from the rural areas and rest were from urban areas. Hindu HHs accounted for about 92 per cent and about 7 per cent were Muslims and Christians has the meagre share of 0.4 per cent. If one looks at the social bifurcation, it can be observed that about 22 per cent belonged to the Scheduled Category (SC) and 1.6 were Scheduled Castes (ST). Other Backward Castes (OBC) accounted for about 27 per cent and 49 per cent belonged to the General category.

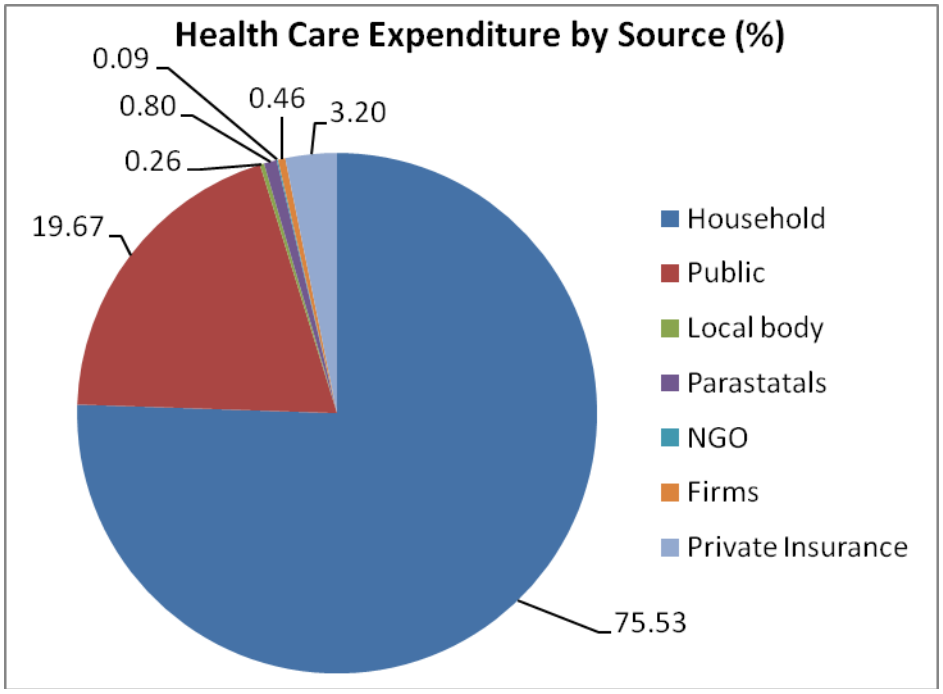
In the discussion below the Health Accounts per se are presented. It can be observed from the following table and graph that out of the total resources flowing into the health sector of the district, Households contribute about 75 per cent which is also supported by other studies at the national level and at different state levels. Public expenditure which includes both state, union governments accounted for about 19 per cent. Except Private Insurance which was to the extent of 3.20 per cent, rest of the sources did not have any significant share in the total health expenditure. This only reflects the issue that majority of the burden as far as health care financing is concerned falls on the households.

Table 4: Health Care Expenditure by Source

Source	Expenditure	%
Household	9030.68	75.53
Public*	2351.74	19.67
Local body	31.03	0.26
Parastatals	95.57	0.80
NGO	10.25	0.09
Firms	54.46	0.46
Private Insurance	382.27	3.20
Total	11956.00	100.00

**Public included Central Government Share and Other state Govt. Departments*

Chart6



A further look at the total health expenditure from the point of view of Providers reveals that most of the expenditure is concentrated towards curative services that too in the urban areas. For example the highest share is taken away by Dispensing chemists (Allopathy) – 42 per cent, followed by Specialty Hospitals (Allopathy) – 22 per cent, Nursing care facilities – 14 per cent, Other residential care facilities – 9 per cent. All these together accounted for about 87per cent of the expenditure. This only indicates dire neglect of rural based services, primary and secondary health care. The kind of expenditure also indicates lack of funds for preventive and promotive health care services. This information is shown in the table below.

Table 5: Household Expenditure by Health Care Provider

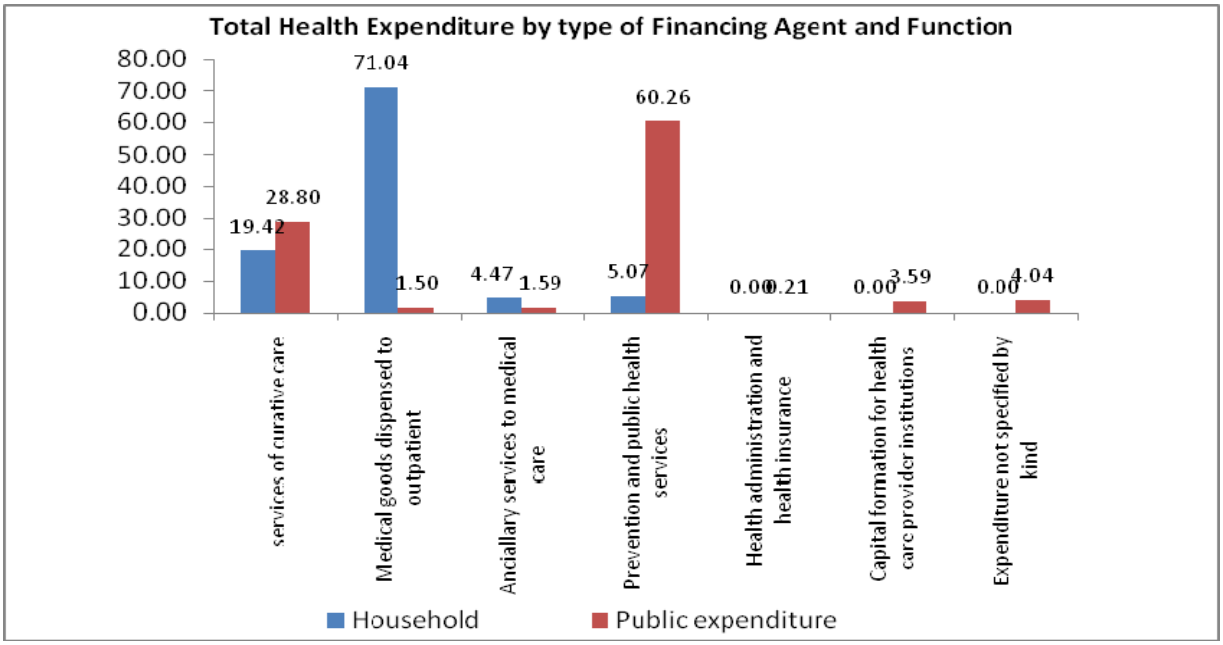
Providers	ICHA Code	Amount Rs. In lakhs	%
State Government's Department Hospitals (e.g. Department of education / police / mines / others)	HP.1.1.1.2	2.18	0.02
Primary Hospitals in Rural Areas (e.g. .PHC/PHU)	HP.1.1.1.2.1.1	111.13	1.23
Primary Hospitals Urban Areas (e.g. UHC/UHP/UFWC)	HP.1.1.1.2.1.2	0.48	0.01
Secondary and Tertiary Hospitals (e.g. CHC/Taluka/Sub-divisional hospitals)	HP.1.1.1.2.2	23.04	0.26
General Hospitals (e.g. Municipal Hospitals)	HP.1.1.1.3	5.82	0.06
General hospitals (Allopathy)	HP.1.1.2	25.33	0.28
General hospitals (Allopathy	HP.1.1.3	1.53	0.02
Specialty Hospitals Allopathy)	HP.1.3.1.2	0.38	0.00
Specialty Hospitals (Allopathy)	HP.1.3.1.4	1990.96	22.05
Specialty Hospitals (ISM and H)	HP.1.4.1.4	15.14	0.17
Ayurvedic services	HP.1.4.4	432.67	4.79
Herbal medicines	HP.1.4.4.1	8.76	0.10
Herbal Medical shop	HP.1.4.4.2	59.68	0.66
Nursing Care Facilities (e.g. Maternity Homes)	HP.2.1.1.2	8.70	0.10
other treatment or surgery	HP.2.1.1.3	50.36	0.56
Nursing care facilities	HP.2.1.1.4	1287.62	14.26
Other residential care facilities	HP.2.9.1.4	825.86	9.15
Dispensaries and Clinics (Allopathy)	HP.3.1.1.1.2	26.80	0.30
Dispensaries and clinics (Allopathy.)	HP.3.1.1.1.4	21.83	0.24
Dispensaries and Clinics (ISM &H)	HP.3.1.2.1.2	11.95	0.13
Dispensaries and clinics(ISM&H)	HP.3.1.2.1.4	73.58	0.81
Offices of other health practitioners (Paramedics)	HP.3.3	62.88	0.70
maternity at home	HP.3.4.1.1	0.36	0.00
other diagnostic scanning centre	HP.3.5.1	1.09	0.01
Medical and diagnostic laboratory	HP.3.5.2	39.62	0.44
blood banks	HP.3.9.2.1.1	69.86	0.77
Dispensing chemists (Allopathy)	HP.4.1.2.1	3862.15	42.77
optical shops	HP.4.2	5.82	0.06
Private (for profit) hospitals	HP.1.1.5	5.09	0.06
Total		**9030.68**	100.00

If we look at the total health related expenditure provided by different Financing Agents towards different functions of health care, the following picture emerges. The public expenditure is tilting towards Prevention and Public health services which is to the extent of about 60 per cent and 28 per cent is towards curative care. The Households spent about 71 per cent towards purchase of medicines and medical goods from the retail sector and about 19 per cent for services of curative care. The following table graph would illustrate this.

Table 6: Total Health Expenditure by type of Financing Agent and Function (Rs. In Lakhs)

Health Care Functions Descriptions	ICHA Code	Total Health Expenditure		Percentage to Total	
		Household	Public Expenditure	Household	Public Expenditure
Services Of Curative Care	HC.1	1753.45	677.41	19.42	28.80
Medical Goods Dispensed To Outpatient	HC.5	6415.55	35.25	71.04	1.50
Ancillary Services To Medical Care	HC.4	403.40	37.30	4.47	1.59
Prevention And Public Health Services	HC.6	458.28	1417.11	5.07	60.26
Health Administration And Health Insurance	HC.7		5.02	0.00	0.21
Capital Formation For Health Care Provider Institutions	HC.R.1		84.54	0.00	3.59
Expenditure Not Specified By Kind	HC.nsk		95.09	0.00	4.04
Total		9030.68	2351.74	100.00	100.00

Chart 7

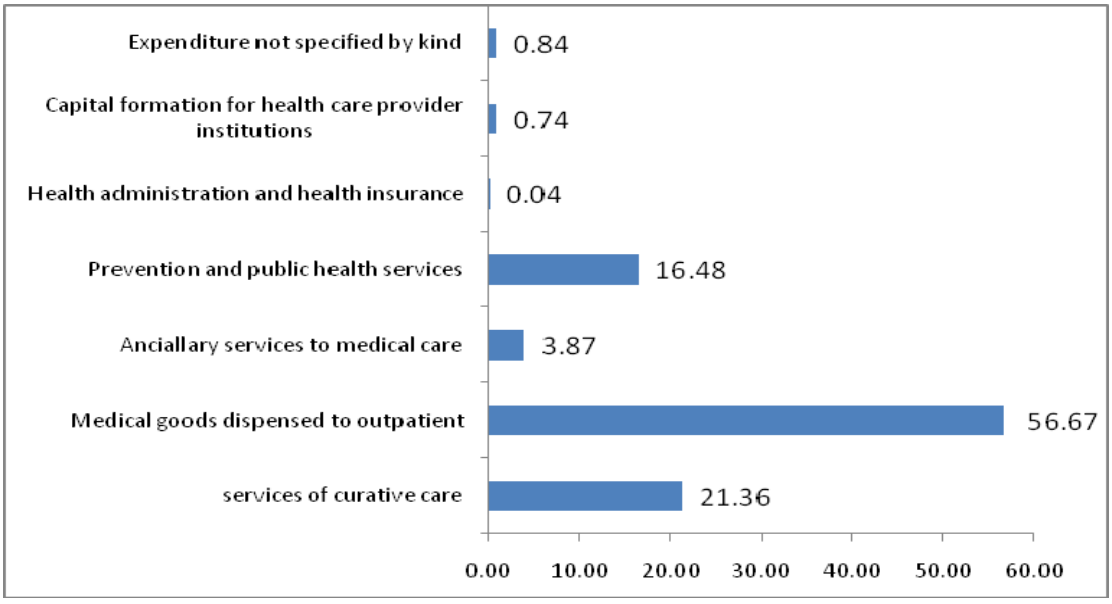


The expenditures on health were grouped into the international health related functional categories using the OECD methodology. The picture from such grouping reveals that the major share is consumed by medicines and medical goods supplied by the retail sector which to the extent of 56 per cent. This was followed by the services of curative care (21 per cent), prevention and public health services (16 per cent). Ancillary services to medical care and health insurance received very negligible amounts. This indicates the need to promote risk pooling mechanism in relation to the health expenditures. The following table and graphs would depict this scenario.

Table 7: Total Health Expenditure by type Function (Rs. In lakhs)

Health care functions descriptions	ICHA code	Total expenditure	%
Services of curative care	HC.1	2430.86	21.36
Medical goods dispensed to outpatient	HC.5	6450.80	56.67
Ancillary services to medical care	HC.4	440.70	3.87
Prevention and public health services	HC.6	1875.40	16.48
Health administration and health insurance	HC.7	5.02	0.04
Capital formation for health care provider institutions	HC.R.1	84.54	0.74
Expenditure not specified by kind	HC.nsk	95.09	0.84
Total		11382.42	100.00

Chart 8

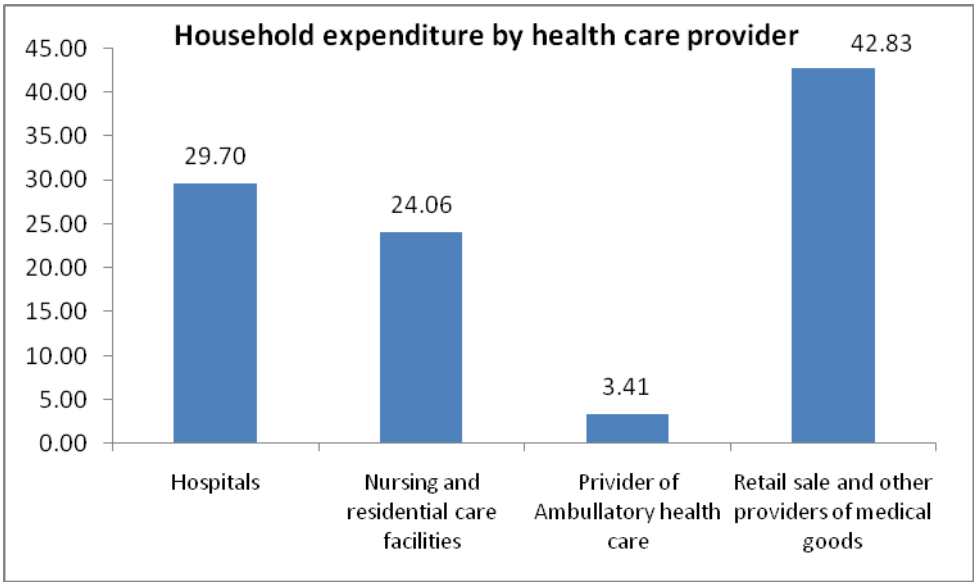


In one looks at the household expenditure alone in the total pool, it can observed that the expenditure is skewed towards purchase of medicines from the retail sector which is to the extent of 42 per cent. This is followed by expenditure on Hospitals (29 per cent) and Nursing and residential care facilities which was to the extent of 24 per cent. Following table and graph depict this picture.

Table 8: Household expenditure by health care provider

Providers	ICHA Code	Amount Rs. In lakhs	%
Hospitals	HP.1	2682.19	29.70
Nursing and residential care facilities	HP.2	2172.55	24.06
Provider of Ambulatory health care	HP.3	307.97	3.41
Retail sale and other providers of medical goods	HP.4	3867.97	42.83
Total		9030.68	100.00

Chart 9



13. Few Observations:

It can be observed from the data that was gathered to understand the district level health expenditures that the households are bearing the major responsibility as far as financing health care services are concerned. This is true from various other studies which have been carried out in different parts of the country. The NSSO data also supports our findings. This also brings out the limited role played by the public sector in supporting the health care delivery to the general public. Thus, one can certainly argue for the expansion of the public kitty towards the provision of health services. **The total health expenditure of the district accounts for about 4.5 per cent of the district income.**

A further look at the total health expenditure from the point of view of Providers reveals that most of the expenditure is concentrated towards curative services that too in the urban areas. The analysis also indicates dire neglect of rural based services, primary and secondary health care. The kind of expenditure also indicates lack of funds for preventive and promotive health care services. In one considers Public expenditure alone it can be observed that it tilts towards preventive services, but at the same time the need is felt to take care of other aspects like curative and other ancillary services as well.

Most of household expenditure is devoted for the purchase of medicines from the retail sector. This may probably reflect upon the lack of public supplies in this regard. The need is also felt to promote insurance in health sector for better protection of weaker sections of the society.

Finally one should speak about adapting the OECD methodology in the Indian context. There is a difficulty of bringing in the international protocols as far as health care functions and agents are concerned. The need is felt to spell out our won functional

categories as well as provider categories. The study has made a modest attempt is putting the OECD and the World Bank / WHO methodology in the Indian context.

As the attempts relating to development of NHA are getting firmed up in developing countries, the present exercise assumes significance. The lessons learnt would be useful for developing similar exercises at the state and national level in the Indian Union**. The study would be a useful tool for the managers of the health sector at the district level. On the academic front the exercise would highlight the strengths and weaknesses of developing health accounts at the sub regional level.**

Annexure:

APPENDIX

Health Care Expenditure by Health Care Providers (Household) (Rs. In Lakhs)

Rs. In lakhs

	Providers	ICHA Code	Consultancy	General medical services	dental services	Surgical treatment	Ambullatory surgery	Chemo therapy	ENT services	Eye care services	deliveries at home	received from the doctor	purchased	appliances and other durables	glasses and vision products	wheel chairs	Pathological services	diagnostic imaging services	other ancially services	MCH services	Child health services	Family planning services
			HC.1	HC.1.2	HC.1.3.2	HC.1.3.3	HC.1.3.3.1	HC.1.3.3.2	HC.1.3.4	HC.1.3.4.1	HC.1.4	HC.5.1.1	HC.5.1.2	HC.5.2	HC.5.2.1	HC.5.2.4	HC.4.1	HC.4.2	HC.4.4	HC.6.1.1	HC.6.1.2	HC.6.1.3
201	State Government's Department Hospitals (e.g. Department of education / police / mines / others)	HP.1.1.1.2	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
203	Primary Hospitals in Rural Areas (e.g.PHC/PHU)	HP.1.1.1.2.1.1	1.02	38.89	0.00	0.00	1.15	0.00	0.00	0.00	0.00	69.50	0.00	0.00	0.00	0.00	0.38	0.00	0.00	0.19	0.00	0.00
204	Primary Hospitals Urban Areas (e.g.UHC/UHP/UFWC)	HP.1.1.1.2.1.2	0.00	0.48	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
205	Secondary and TertiaryHospitals (e.g.CHC/Taluka/Sub-divisional hospitals)	HP.1.1.1.2.2	12.31	1.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.24	0.00	0.00	0.00	0.00	0.89	0.00	0.00	7.53	0.00	0.00
206	Speciality Hospitals(Allo.)	HP.1.3.1.2	0.38	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
208	Nursing Care Facilities (e.g.Maternity Homes)	HP.2.1.1.2	2.40	0.54	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.29	2.18	0.00	0.29	0.00	0.00
210	Dispensaries and Clinics (Allo.)	HP.3.1.1.1.2	6.11	2.56	0.29	0.77	0.00	0.00	0.00	0.15	0.00	1.09	0.00	0.00	0.00	0.00	10.06	5.76	0.00	0.00	0.00	0.00
211	Dispensaries and Clinics (ISM &H)	HP.3.1.2.1.2	3.64	0.31	0.00	4.37	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.64	0.00	0.00	0.00	0.00	0.00
220	blood banks	HP.3.9.2.1.1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	69.86	0.00	0.00	0.00
301	Genaral Hospitals (e.g.Muncipal Hospitals)	HP.1.1.1.3	4.08	0.15	0.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.46	0.00	0.00
402	Speciality Hospitals (Allo.)	HP.1.3.1.4	4.44	794.03	2.18	7.28	5.09	1.75	0.36	0.73	0.00	1039.60	37.23	0.73	0.00	0.00	1.64	6.58	0.00	60.20	0.00	29.11
403	Speciality Hospitals (ISM and H)	HP.1.4.1.4	0.00	6.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.88	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
404	Nursing care facilities	HP.2.1.1.4	112.15	43.68	0.00	496.33	4.95	0.00	0.00	8.44	0.00	525.14	6.55	0.00	0.00	2.91	9.46	31.44	0.00	0.00	46.58	0.00
405	Other residential care facilities	HP.2.9.1.4	16.74	8.88	0.00	43.67	0.00	0.00	1.02	0.00	0.00	158.07	177.57	0.00	0.00	0.00	31.29	61.13	14.56	298.38	0.00	14.56
406	Dispensaries and clinics (Allo.)	HP.3.1.1.1.4	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.28	14.56	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
407	Dispensaries and clinics(ISM&H)	HP.3.1.2.1.4	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	14.56	0.00	4.37	45.56	9.10	0.00	0.00	0.00	0.00
408	Offices of other health practitioners (Paramedics)	HP.3.3	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.28	55.60	0.00	0.00	0.00	0.00
412	other treatment or surgery	HP.2.1.1.3	0.00	0.00	0.00	50.36	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
413	optical shops	HP.4.2	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.82	0.00	0.00	0.00	0.00	0.00	0.00	0.00
414	maternity at home	HP.3.4.1.1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.36	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
426	Medical and diagnostic laboratory	HP.3.5.2	0.00	13.39	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.94	0.00	0.00	0.00	0.00	10.19	13.10	0.00	0.00	0.00	0.00
427	other diagnostic scanning centre	HP.3.5.1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.09	0.00	0.00	0.00	0.00
501	General hospitals (Allo.)	HP.1.1.2	3.49	0.73	0.00	17.47	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.64	0.00	0.00	0.00	0.00	0.00
519	Dispensing chemists (Allo.)	HP.4.1.2.1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.57	3764.99	71.68	14.41	0.00	3.49	0.00	0.00	0.00	0.00	0.00
601	General hospitals (Allo.)	HP.1.1.3	0.00	1.53	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
802	Private (for profit) hospitals	HP.1.1.5	0.00	1.46	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.46	0.00	0.00	0.00	0.00	1.46	0.73	0.00	0.00	0.00	0.00
	Ayurvedic services	HP.1.4.4	22.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	258.35	152.10	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Herbal medicines	HP.1.4.4.1	1.48	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Herbal Medical shop	HP.1.4.4.2	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	59.68	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total		**190.45**	**913.95**	**2.62**	**620.24**	**11.19**	**1.75**	**1.38**	**9.32**	**2.55**	**2088.39**	**4212.68**	**86.97**	**20.23**	**7.28**	**132.26**	**186.71**	**84.42**	**368.04**	**46.58**	**43.67**

Classification System for Financing Sources of Health Care Activities in Karnataka

Code	Description			
FS.1	**Public funds**			
FS.1.1	Territorial government funds			
	FS.1.1.1	Central government revenue		
	FS.1.1.2	Regional and municipal government revenue		
		FS.1.1.2.1	State government revenue	
			FS.1.1.2.1.1	Health sector revenue
			FS.1.1.2.1.2	Other sources
		FS.1.1.2.2	Local government revenue	
			FS.1.1.2.2.1	Health sector revenue
			FS.1.1.2.2.2	Other sources
FS.1.2	Other public funds			
	FS.1.2.1	Return on assets held by a public entity		
	FS.1.2.2	Other		
		FS.1.2.2.1	Employer funds of Parastatals	
		FS.1.2.2.2	Other sources	
FS.2	**Private funds**			
FS.2.1	Employer funds			
FS.2.2	Household funds			
FS.2.3	Non-profit institutions serving individuals			
FS.2.4	Other private funds			
	FS.2.4.1	Return on assets held by a private entity		
	FS.2.4.2	Other		
FS.3	**Rest of the world funds**			
	FS.3.1	Private external funds		
	FS.3.2	Public external funds		
		FS.3.2.1	Bilateral and multilateral donors	
		FS.3.2.2	Development banks	

Classification System for Financial Agents of Health Care Activities in Karnataka								
Code	**Description**						**Remarks/Examples**	**HF Code use by CMDR/ NEW cat.**
HF.A	***Public sector***							same
	HF.1.1	Territorial government						same
		HF.1.1.1	Central government					same
			HF.1.1.1.1	Central health department				same
			HF.1.1.1.2	Other than health ministry/departm			Railways, Defense, Space, Post & Telegraphs, etc	same
		HF.1.1.2	State government					same
			HF.1.1.2.1	State health department				same
			HF.1.1.2.2	Other than health ministry/departm			Education, Police, Mines, etc	same
			HF.1.1.2.3	Societies set-up by the State gover				same
				HF.1.1.2.3.1	State level			same
				HF.1.1.2.3.2	District level			same
		HF.1.1.3	Local government					same
			HF.1.1.3.1	Rural local bodies			Village/Taluka/Zilla (District) Panchayat	same
			HF.1.1.3.2	Urban local bodies				same
	HF.1.2	Social security funds						same
		HF.1.2.1	Central government				Welfare funds	same
		HF.1.2.2	State government				Welfare funds, Illness Assistance Funds	same
	HF.1.3	Social Insurance programmes						NEW
		HF.1.3.1	Employee insurance programmes (public)					2.1.1.
			HF.1.3.1.1	Central government			Central Government Health Scheme, Employee State Insurance	2.1.1.1
			HF.1.3.1.2	State governement				2.1.1.2
			HF.1.3.1.3	Other			e.g. Group Health Insurance scheme	2.1.1.3
		HF.1.3.2	Other social insurance programmes (public)					2.1.3
			HF.1.3.2.1	Central government			e.g. Universal Health Insurance scheme	2.1.3.1
			HF.1.3.2.2	State governement			e.g. Yeshaswani health insurance scheme of the state government	2.1.3.2
			HF.1.3.2.3	Other				NEW
	HF.1.4	Public sector insurance enterprises (other than social insurance)					Life Insurance Corporation of India, General Insurance Corporation of India	2.2.1
	HF.1.5	Parastatal companies					Central and State PSUs	2.5.1

Classification System for Financial Agents of Health Care Activities in Karnataka (Contd..)

Code	Description			Remarks/Examples	HF Code use by CMDR/ NEW cat.
HF.B	***Non Public Sector***				same
	HF.2.1	Social Insurance programmes (for profit enterprises)			NEW
		HF.2.1.1	Employee insurance programmes	e.g. Group Health Insurance scheme	2.1.2
		HF.2.1.2	Other social insurance programmes		2.1.2.2
	HF.2.2	Insurance enterprises (for profit enterprises)		Life Insurance Corporation of India, General Insurance Corporation of India	2.2.2.
	HF.2.3	Households' out-of-pocket payment (non profit)			same
		HF.2.3.1	social insurance contributions		
		HF.2.3.2	voluntary insurance contributions		
		HF.2.3.3	cost sharing payments		
		HF.2.3.4	others		
	HF.2.4	Institutions serving households (non profit)			same
		HF.2.4.1	Non-profit institutions serving households (social insurance)	Community-based health insurance services	same
		HF.2.4.2	Non-profit institutions serving households (other than social insurance)	e.g. Mother NGOs channelizing funds to local NGOs in the RCH Programme	same
	HF.2.5	Nonparastatal firms and corporations (other than health in			same
		HF.2.5.1	Non-profit firms and corporations		same
		HF.2.5.2	For profit firms and corporations		same
HF.3	**Rest of the world**				same
	HF.3.1	Multi-lateral organisations and agencies		e.g. UNFPA, Unicef, WHO, UNAIDS	NEW
	HF.3.2	International Non Governmental Organisations		e.g. IPPF, Mary Stopes International, Pathfinder International	NEW
	HF.3.3.	Development banks		e.g. WB, IDA, IDRB	NEW

Classification System for Health Care Providers in Karnataka							
Code	**Description**						**Remarks / Examples**
HP.1	**Hospitals**						
HP.1.1	General hospitals (allopathic)						
	HP.1.1.1	General hospitals (allopathic) in the public sector					
		HP.1.1.1.1	General hospitals owned by the Central government				General hospitals of Central government ministry/department (Defence, Railways, Post & Telegraphs, Space)
		HP.1.1.1.2	General hospitals owned by the State government				State Health Department and other-than-Health Departments of State government (Department of Education, Police, Mines, etc)
			HP.1.1.1.2.1	Primary			
				HP.1.1.1.2.1.1	Rural		Primary Health Centres (PHCs)
				HP.1.1.1.2.1.2	Urban		Urban Health Centres (UHCs), Urban Health Posts (UHPs), Urban Family Welfare Centres (UFWCs)
			HP.1.1.1.2.2	Referral (Secondary & Tertiary)			Community Health Centres (CHCs), Taluka/Sub-divisional/District Hospitals, major general hospitals and hospitals attached to autonomous institutions, KHSDP and KfW-assisted secondary care hospitals, Hospitals attached to Medical colleges and autonomous in
		HP.1.1.1.3	General hospitals owned by the Local government				Municipal hospitals
		HP.1.1.1.4	General hospitals owned by Social Insurance agencies				ESI hospitals and CGHS hospitals
		HP.1.1.1.5	General hospitals owned by Parastatals				PSU hospitals (Hindustan Aeronautics Limited, Bharat Electronics Limited, Indian Telephone Industries, etc)
	HP.1.1.2	General hospitals (allopathic) in the private (for profit) sector					
	HP.1.1.3	General hospitals (allopathic) in the private (not for profit) or NGO sector					
HP.1.3	Specialty hospitals (allopathic)						
	HP.1.3.1	Specialty (allopathic) hospitals in the public sector					
		HP.1.3.1.1	Central government				
		HP.1.3.1.2	State government				
		HP.1.3.1.3	Local government				
		HP.1.3.1.4	Social insurance agencies				
		HP.1.3.1.5	Parastatals				
	HP.1.3.2	Specialty hospitals (allopathic) in the private (for profit) sector					
	HP.1.3.3	Specialty hospitals (allopathic) in the private (not for profit) or NGO sector					
HP.1.4	Hospitals of non-allopathic systems of medicine (ISM & H)						
	HP.1.4.1	ISM & H hospitals in the public sector					
		HP.1.4.1.1	Central government				
		HP.1.4.1.2	State government				
		HP.1.4.1.3	Local government				
		HP.1.4.1.4	Social insurance agencies				
		HP.1.4.1.5	Parastatals				
	HP.1.4.2	ISM & H hospitals in the private (for profit) sector					
	HP.1.4.3	ISM & H hospitals in the private (not for profit) or NGO sector					
HP.2	**Nursing and residental care facilities**						
HP.2.1	Nursing care facilities						e.g Maternity Homes
	HP.2.1.1	Nursing care facilities in the public sector					
		HP.2.1.1.1	Central government				
		HP.2.1.1.2	State government				
		HP.2.1.1.3	Local government				
		HP.2.1.1.4	Social insurance agencies				
		HP.2.1.1.5	Parastatals				
	HP.2.1.2	Nursing care facilities in the private (for profit) sector					
	HP.2.1.3	Nursing care facilities in the private (not for profit) sector or NGOs					

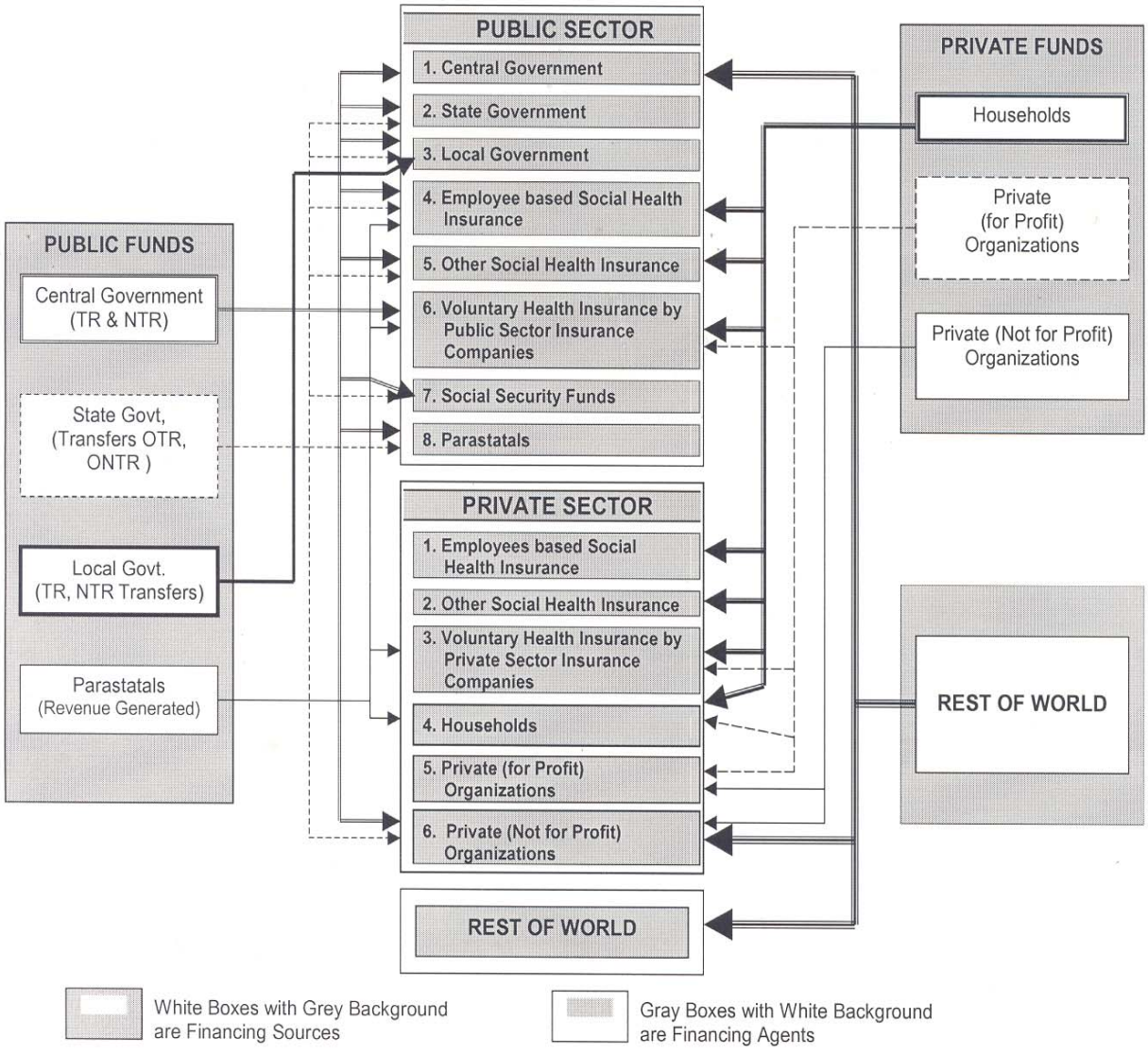
Classification System for Health Care Providers in Karnataka (Contd..)							
Code	**Description**						**Remarks / Examples**
HP2.9	All other residential care facilities						
	HP.2.9.1	Other residential care facilities in the public sector					
		HP.2.9.1.1	Central government				
		HP.2.9.1.2	State government				
		HP.2.9.1.3	Local government				
		HP.2.9.1.4	Social insurance agencies				
		HP.2.9.1.5	Parastatals				
	HP.2.9.2	Other residential care facilities in the private (for profit) sector					
	HP.2.9.3	Other residential care facilities in the private (not for profit) sector or NGOs					
HP.3	**Providers of ambulatory health care**						
HP.3.1	Offices of physicians						
	HP.3.1.1	Offices of physicians (allopathic)					Dispensaries and clinics
		HP.3.1.1.1	Health care facilities in the public sector				
			HP.3.1.1.1.1	Central government			
			HP.3.1.1.1.2	State government			
			HP.3.1.1.1.3	Local government			
			HP.3.1.1.1.4	Social insurance agencies			
			HP.3.1.1.1.5	Parastatals			
		HP.3.1.1.2	Offices of physicians in the private (for profit) sector				
		HP.3.1.1.3	Offices of physicians in the private (not for profit) sector				
	HP.3.1.2	Offices of physicians (ISM & H)					
		HP.3.1.2.1	ISM & H Dispensaries in the Public sector				
			HP.3.1.2.1.1	Central government			
			HP.3.1.2.1.2	State government			
			HP.3.1.2.1.3	Local government			
			HP.3.1.2.1.4	Social insurance agencies			
			HP.3.1.2.1.5	Parastatals			
		HP.3.1.2.2	Offices of ISM&H physicians in the private (for profit) sector				
		HP.3.1.2.3	Offices of ISM&H physicians in the private (not for profit) sector				
HP.3.3	Offices of other health practitioners						Paramedics, Quacks
HP.3.4	Outpatient care centres						
	HP.3.4.3	Free-standing ambulatory surgery centres					
		HP.3.4.3.1	Sterilization camps of the government				
		HP.3.4.3.2	Other centres				
	HP.3.4.5	All other outpatient multi-specialty and cooperative service centres					
		HP.3.4.5.1	All other outpatient care centres in the secondary and tertiary level (allopathic) hospitals				
			HP.3.4.5.1.1	Public sector			
				HP.3.4.5.1.1.1	Central government		
				HP.3.4.5.1.1.2	State government		
				HP.3.4.5.1.1.3	Local government		
				HP.3.4.5.1.1.4	Social insurance agencies		
				HP.3.4.5.1.1.5	Parastatals		
			HP.3.4.5.1.2	Private (for profit) sector			
			HP.3.4.5.1.3	Private (not for profit) sector or NGOs			
		HP.3.4.5.2	Outpatient care centres in the ISM & H hospitals				
			HP.3.4.5.2.1	ISM & H hospitals in the public sector			
				HP.3.4.5.2.1.1	Central government		

Classification System for Health Care Providers in Karnataka (Contd..)						
Code	**Description**					**Remarks / Examples**
				HP.3.4.5.2.1.3	Local government	
				HP.3.4.5.2.1.4	Social insurance agencies	
				HP.3.4.5.2.1.5	Parastatals	
			HP.3.4.5.2.2	ISM & H hospitals in the private (for profit) sector		
			HP.3.4.5.2.3	ISM & H hospitals in the (not for profit) sector		
	HP.3.4.9	All other outpatient community and other integrated care centres				
		HP.3.4.9.1	Public sector			Sub-centres, Anganwadis, OP and outreach activities of PHCs
		HP.3.4.9.3	Private (not for profit) sector			Women Self Help Group Centers
HP.3.5	Medical and diagnostic laboratories					
	HP.3.5.1	Clinical laboratories				
			HP.3.5.1.1	Public sector		Lab facilities in public sector health facilities, Dedicated STD laboratories of the government, VCTCs
			HP.3.5.1.2	Private (for profit) sector		
			HP.3.5.1.3	Private (not for profit) sector		
	HP.3.5.2	Diagnostic imaging				
			HP.3.5.2.1	Public sector		Diagnostic imaging facilities in public sector health facilities
			HP.3.5.2.2	Private (for profit) sector		
			HP.3.5.2.3	Private (not for profit) sector		
HP.3.6	Providers of home health care services					
	HP.3.6.1	Public sector				Mobile health clinics of the State Health Department, ANMs and other government paramedics
	HP.3.6.2	Private (for profit) sector				Traditional birth attendants (TBAs) or Dais, Private physicians and other private paramedics
	HP.3.6.3	Private (not for profit) sector				NGO Field Workers, motivators, etc.
HP.3.9	Other providers of ambulatory health care					
	HP.3.9.1	Ambulance services				
		HP.3.9.1.1	Public sector			
		HP.3.9.1.2	Private (for profit) sector			
		HP.3.9.1.3	Private (not for profit) sector			
	HP.3.9.2	Blood and Organ banks				
		HP.3.9.2.1	Blood banks			
			HP.3.9.2.1.1	Public sector		State government, Central government, Autonomous body, PSUs
			HP.3.9.2.1.2	Private (for profit) sector		Private blood banks, Private hospital blood banks
			HP.3.9.2.1.3	Private (not for profit) sector		Voluntary organization blood banks
	HP.3.9.3	Alternative or traditional practitioners				
	HP.3.9.4	All other RH-related ambulatory health care services				
HP.4	**Retail sale and other providers of medical goods**					
HP.4.1	Dispensing chemists					
	HP.4.1.1	Public sector health system				
		HP.4.1.1.1	Allopathic			
		HP.4.1.1.2	ISM & H			
	HP.4.1.2	Retail sellers in the private (for profit) sector				
		HP.4.1.2.1	Allopathic			
		HP.4.1.2.2	ISM & H			

Classification System for Health Care Providers in Karnataka (Contd..)				
Code	**Description**			**Remarks / Examples**
HP.4.9	All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods			
	HP.4.9.1	Pharmaceuticals		
		HP.4.9.1.1	Public sector	Free distribution outlets
		HP.4.9.1.2	Private (for profit) sector	Private sellers
		HP.4.9.1.3	Private (not for profit) sector	Free distribution outlets
	HP.4.9.2	Contraceptives		
		HP.4.9.2.1	Public sector	Social marketing and free distribution outlets
		HP.4.9.2.2	Private (for profit) sector	Private sellers
		HP.4.9.2.3	Private (not for profit) sector	Social marketing and free distribution outlets
	HP.4.9.3	All other RH-related medical non-durables		
		HP.4.9.3.1	Public sector	Social marketing and free distribution outlets
		HP.4.9.3.2	Private (for profit) sector	Private sellers
		HP.4.9.3.3	Private (not for profit) sector	Social marketing and free distribution outlets
HP.5	**Provision and administration of public health programmes**			
	HP.5.1	Public sector		Central H&FW Ministry, other Ministries/Departments, Central PSUs, State Health Dept., State Other-than-Health Depts., State PSUs, Panchayats, Municipalities & Corporations, Autonomous organiztions/Societies/Commissions/etc
	HP.5.3	Private (not for profit) sector		Mother NGOs involved in the National RCH Programme, NGO Partners of Karnataka State AIDS Prevention Society (KSAPS)
HP.6	**General health administration and insurance**			
HP.6.1	Government administration of health			
HP.6.2	Social security funds administration			
HP.6.3	Other social insurance administration			
HP.6.9	All other providers of health administration			
	HP.6.9.1	Public sector insurance (voluntary)		Public Sector Insurance Companies (LIC, GIC)
	HP.6.9.2	Private (for profit) sector		
		HP.6.9.2.1	General health administation	e.g., Private Corporate Hospitals
		HP.6.9.2.2	Insurance (voluntary)	Private insurance companies
	HP.6.9.3	Private (not for profit) sector		
		HP.6.9.3.1	General health administation	e.g. Charitable Hospitals
		HP.6.9.3.2	Insurance (community-based)	Community-based health insurance schemes
HP.7	**All other industries (rest of the economy)**			
HP. 7.2	Private households as providers of home care			Mostly non-monetized transactions; not considered in the present exercise
HP. 7.3	All other industries as secondary producers of health care			
	HP. 7.3.1	Producers of RH-related medical non-durables (Drug and pharmaceuticals, Contraceptives, delivery and personal hygene kits, etc)		
		HP. 7.3.1.1	Public sector	e.g. Hindustan Latex Limited
		HP. 7.3.1.2	Private (for profit) sector	
	HP. 7.3.2	Producers of RH-related medical durables (lab and other equipment, capital assets)		
		HP. 7.3.2.1	Public sector	
		HP. 7.3.2.2	Private (for profit) sector	
HP. 7.4	Providers of RH-related IEC services, Policy advocacy, etc			
	HP. 7.3.3.1	Public sector		
	HP. 7.3.3.2	Private (for profit) sector		
	HP. 7.3.3.3	Private (not for profit) sector		

Classification System for Health Care Providers in Karnataka (Concld..)						
Code	**Description**					**Remarks / Examples**
HP.8	**Institutions providing health-related services**					
HP.8.1	Research institutions					
	HP.8.1.1	Public sector				
		HP.8.1.1.1	Allopathic			
		HP.8.1.1.2	ISM & H			
	HP.8.1.2	Private sector				Both for-profit and not-for-profit institutions
		HP.8.1.2.1	Allopathic			
		HP.8.1.2.2	ISM & H			
HP.8.2	Education and training institutions					
	HP.8.2.1	Education				
		HP.8.2.1.1	Public sector			
			HP.8.2.1.1.1	Allopathic		
			HP.8.2.1.1.2	ISM & H		
		HP.8.2.1.2	Private sector			Both for-profit and not-for-profit institutions
			HP.8.2.1.2.1	Allopathic		
			HP.8.2.1.2.2	ISM & H		
	HP.8.2.2	Training				
		HP.8.2.2.1	Public sector			
			HP.8.2.2.1.1	Allopathic		
			HP.8.2.2.1.2	ISM & H		
		HP.8.2.2.2	Private sector			Both for-profit and not-for-profit institutions
			HP.8.2.2.2.1	Allopathic		
			HP.8.2.2.2.2	ISM & H		
HP.8.3	Other institutions providing health-related services					
	HP.8.3.1	Public sector				
		HP.8.3.1.1	Drug testing laboratories			
		HP.8.3.1.2	Blood safety related centres			Blood testing centres, Blood component separation units, Blood storage centres
		HP.8.3.1.3	Others			
	HP.8.3.2	Private sector				Both for-profit and not-for-profit institutions
HP.9	**Rest of the world**					Imports of medical durables and non-durables, Technical services, Consultancy, etc
HP.nsk	**Provider not specified by kind**					

Flow of Funds to the Health System from Financing Sources to Financing Agents



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