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PROVISION OF PUBLIC HEALTH IN LOW INCOME COUNTRIES : PROBLEMS, REFORMS AND LESSONS FOR INDIA.

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Although the relationship between health and development is reciprocal, development can also worsen the health condition of the population. Therefore, achieving better health for the population requires implementing programmes in nutrition, health care and environmental sanitation etc particularly in rural areas where the vast majority of the population in low income countries live. However, since a significant cut is effected in the health sector budget during a period of budgetary constraint, it is important to improve efficiency in the delivery of health services, allocation of expenditure and to privatise some activities as well as to pay greater attention to preventive care in rural areas as this involves significantly less expenditure than the provision of better health services in urban areas. An analysis of the health status of population in the low income group of countries, and India and China reveals that in respect of most indicators, China outperforms low income group of countries which in turn outperforms India. This is despite the fact that in terms of absolute amount, per-capita amount and as a proportion of GDP, health expenditure in India is far greater than in China. Such a result can, therefore, be said to have been achieved by China by making the health system more efficient in terms of both cost and delivery of services. All the reforms proposed in this paper have been implemented in China. Three major problems of health sector-allocation, internal inefficiency and equity also exist in India. In the matter of implementing reforms, although India's situation is different from that of other countries, in that (i) the states are primarily responsible for the health care and (ii) a vast and thriving private sector operates in India's health sector, it is doubtful that the proposed reforms could be implemented in India where there is no political commitment to any reform.

INTRODUCTION

Change is development strategy from growth oriented to equity oriented in the 1970s and the concern in the 1980s about the adverse impact of slower economic growth in the state of health of children, in Africa in particular, led the development economists and national governments to pay greater attention to the health sector in the overall development policy framework. Generally the relationship between health and development is reciprocal. While better health contributes to economic development, economic development tends to improve the state of health of the population in a country. Since Development can also worsen the health condition of the population, the proponents of health sector programmes advocate that achieving reductions in morbidity and mortality would require the implementation of programmes in nutrition, health care and environmental sanitation etc., This is particularly true in low income economies where the vast majority of population live in rural areas where programmes in nutrition, health care and sanitation have hardly been implemented on adequate scales. The maternal and child health are of special importance in the overall health sector issues because better health of the children which improves the quality of future human capital and lessens the future burden of the health sector on the nation's taxpayers depends on the health of the mother. However, since the relative priority accorded to the health sector in the governments' budget still remains very low in most of these countries, under stringent economic condition, any cut in government expenditure tends to fall heavily on health, education, etc., and as a result, the health programmes in rural areas tend to suffer more severely than those in urban areas.

But the provision of better health services in rural areas which absorb the overwhelming majority of population (as high as 94 per cent in Burundi, 92 per cent in Rivanda, 91 per cent in Burkina Faso and 90 per cent in Nepal) (World Bank 1993) would involve significantly less expenditure than the provision of better health services in urban areas. Therefore at times of funding cuts, it makes all the more sense to improve efficiency in the delivery of health services by improving the administration of health services, allocation of expenditure and by privatising some activities. This paper examines, in terms of several indicators, the current provision of health services, the quality of health, the major problems experienced in dispensing health services and the reforms needed in the health sector in low income countries. It concludes with some observations on what kind of reforms should be introduced in India's health services.

HEALTH DEVELOPMENT RELATIONSHIP AND TRENDS IN HEALTH STATUS

Poor health is a source of inadequate human resources. Less time is lost and more effective effort is expended when the labour force is in good health.

Liebenstein's x-inefficiency arises when resources are used in such a way that even if they are making the right product, they are doing so less productively than is possible. Thus an hour of a labourer debilitated and unmotivated by disease may be less productive than it could be, even in its best use. This kind of inefficiency may be more important than allocative inefficiency in accounting for both the low levels of income and the difficulties in development of low income economies.

While the expenditure on education is expected to increase the quality and quantity of human resources in the future by lengthening the expected working life of people, returns to investment in health are more difficult to estimate than the returns to investment in education. This is due to the fact that in a social cost-benefit analysis, the social marginal product of labour should be estimated to determine the value to society of extended working life. However, in most low income economies, the marginal product of labour being very low, the production benefits of extended working life are expected to be very small. Also the increase in productivity resulting from improvement in health, the qualitative effects of health expenditure are difficult to measure. Since the overall health status of a country's population is determined by the impacts of a variety of factors, including the expenditure on health, it is difficult to identify the productive benefits of health expenditure. Apart from increasing the quantity and quality of human resources, expenditures on health can also increase the availability and/or productivity of such non-human resources as larger tracts of land previously rendered non-usable by endemic diseases *(Gillies et al 1992)*.

Health improvements by reducing death increases the population growth. But the decline in death rate by encouraging a drop in fertility may also limit population growth which, in turn, by reducing the pressure of population on the declining supply of natural resources, may contribute to the preservation of environment. Also improved health may enable poor people to look for and to be in productive employment and thereby help them take a long run view of the optimal use of natural resources. Protection of the environment is essential for sustainable growth and development of the economy. Furthermore, resources saved from being spent on health can be diverted to other productive sectors of the economy. Although the drop in fertility resulting from improvement in health conditions may be outweighed by increase in population growth resulting from reduced death rate, the argument does not justify reduction in population growth by allowing persons already born to die when there are means to save them.

In other words "cost" should not be used as an argument against health improvements *(Gillies et al 1992)*.

Increase in income and improved social indicators are closely interwined. One supports the other in a variety of ways. Thus

the social indicators of high income countries in general would be better than of middle income countries and the social indicators of middle income countries would be better than those of low income countries. Again within each income group, two types of trends are noticed. Countries within higher incomes are expected to enjoy better social indicators than those within lower incomes in the same group. Secondly, for each country within the same group, as income continues to increase, its social indicators also exhibit improving trends. However, exceptions are also noticed. A low income country can have better social indicators than many middle income countries. Sri Lanka is an example. Within each group and between groups, countries that have achieved broad provisions of health care, spending on health as percentage of GNP is several times higher than in countries such as India and Pakistan where under 5 mortality remains very high and the percentage of children immunized remains low *(World Bank 1990)*.

Improvements have been recorded in the health status of population in most low income economies. Table 1 illustrates the improvements in several health indicators in all groups of countries. Low income countries recorded improvements in all indicators. The life expectancy at birth increased between 1980 and 1991 and crude death fell substantially between 1978 and 1991. The infant morality rate fell considerably between 1970 and 1990. While the fertility rate and the maternal mortality rate also declined, they still remained high in 1991 and 1988 respectively. The number of population per physician fell and the share of fish products in total protein intake also increased slightly between 1970 and 1990. But the performance of LIEs is worse than that of the middle income group of countries.

However, when one compares India's and China's performance with that of the LIE group, it would appear that in most indicators, China's performance is significantly better and India's performance is worse than the group performance. Therefore, compared with India, China's performance appears to be vastly superior to that of India. Apart from these, in respect of other indicators, such as the prenatal mortality rate (referring to the number per 1,000 births, the probability of dying by exact age 5) and prevalence of anemia in pregnant women (referring to the percentage of pregnant women below the norm for hemoglobin), the pattern is similar: India outperforms sub-Saharan Africa, other Asia and islands outperforms India and China outperforms other Asia and islands. These are illustrated in Table 2.

As the table illustrates, in 1960, the hild mortality rate in China was higher than in other Asia and islands which includes the rest of Asia. But by 1975, China was able to reduce the rate drastically. However, much of the problems relating to maternal

and child health are related to the environment in which they live. Quality of food, drinking water and of sanitation are important determinants of health status. Since the vast majority of population in these countries live in rural areas, the sanitary conditions in rural areas is bound to produce a marked impact on the overall national level. About 1.3 billion people in the developing world lack access to clean and plentiful water and nearly 2 billion people lack access to an adequate system for disposing their faeces. Faeces deposited near homes, contaminate drinking water, fish from polluted rivers and coastal waters and agricultural produce fertilised with human waste are all health hazards. It is estimated that in 1990, in India about 85 per cent of population were without sanitation and 26 per cent without water supply compared with 15 per cent and 27 per cent in China *(World Bank 1993)*.

Hence it may be argued that government expenditure and efforts are required to achieve improvement in these areas. Since the rise in per capita income and the improvement in health indicators appears to be highly correlated, one would expect the rise in per capita income to be associated also with a rise in expenditure on health. On the basis of that argument, one would expect China to spend more on health than India. Would that be so? Let us therefore examine the pattern of expenditure on health in these two countries in 1990.

EXPENDITURE ON HEALTH

Table 3 illustrates the pattern of health expenditure in sub-Saharan Africa, India, other Asia islands and China in 1990. It can be seen from the table in both absolute and per capita terms, India spent more than China on health. India's health expenditure as a percentage of GDP was significantly higher than that of China. It was also higher than that of sub-Saharan Africa and other Asia. However, the other increasing point to emerge from the table is that in India, the share of private sector health expenditure in GDP was substantially higher than that of public sector expenditure, whereas in China, the private sector played a minor role. The amount of aid flow on health was also larger for India than for China, but other Asia and sub-Saharan Africa received substantially more than these two countries.

Table - 1

Improvement in Health Indicators

	Life expectancy rate as birth (years)		Crude death rate (per 1000 population)		Infant mortality rate (per 1000 live births)		Fertility rate (number of Children)		Matermal mortality rate (per 1 million live births)		Population per physician		Fish products (% of daily protein supply)	
	1980	1991	1970	1991	1970	1990	1970	1991	1980	1988	1970	1990	1970	1990
Low income economies	57	62	14	10	109	71	6.0	3.8	564	308	14080	6760	5.8	6.3
Middle income economies	60	68	11	8	80	38	5.0	3.2	204	107	3640	2060	6.5	6.8
High income economies	71	77	10	9	20	8	2.4	1.8	11	n/a	710	420	8.2	8.6
Fuel exporters	57	66	18	11	128	70	6.8	5.7	n/a	492	10730	2030	6.4	6.1
India	52	60	18	11	137	90	5.8	3.9	500	n/a	48490	2460	1.6	1.6
China	64	69	8	7	69	38	5.8	2.4	44	115	n/a	n/a	3.1	3.9

Source : World Bank (1982,1990,1993), World Development Report, New York : Oxford University Press

Table - 2

Maternal and Child Health Status

	Prental mortaility rate	**Child mortality rate**			**Prevalence of anaemia in pregnant women**
	1990	**1960**	**1975**	**1990**	**1970s and 1980s**
sub-Saharan Africa	**68**	**251**	**212**	**175**	**41**
India	**64**	**235**	**195**	**127**	**88**
Other Asia and Islands	**49**	**182**	**135**	**97**	**58**
China	**25**	**210**	**85**	**43**	**25**

Source : World Bank (1993), World Development Report, New York : Oxford University Press

Table - 3

Pattern of Health Expenditure and External Assistance on Health, 1990

	Total Health Expenditure (dollars)		**Health Expenditure as % of GDP**			**Development Assistance for Health**		
	(millions) 1990	**(per capita) 1990**	**Total 1990**	**Public Sector 1990**	**Private Sector 1990**	**Total aid flow in dollars 1990 (millions)**	**Aid flow per capita 1990**	**Aid flow as % of total health expenditure 1990**
sub-Saharan Africa	12080	24	4.50	2.50	2.0	1251	2.5	10.4
India	17740	21	6.00	1.30	4.7	286	0.3	1.6
China	12969	11	3.50	2.10	1.4	77	0.1	0.6
Other Asia and islands	41752	61	4.50	1.80	2.7	594	0.9	1.4

Source : World Bank (1993), World Development Report, New York : Oxford University Press.

It would, therefore seem that larger expenditure may not necessarily achieve health. What are important are the efficiency and effectiveness with which the money is spent and the programmes are implemented. China's success appears to a great extent to be due to these non-monetary factors. In most of the third world, a great deal of additional health could be obtained from a relatively small number of cost-effective interventions that could be delivered at modest cost and with little need for high level facilities or medical specialities.

PROBLEMS IN HEALTH SECTOR IN LIEs

Governments in most developing economies play a crucial role in making provision for adequate health services for their population. With the growth in population, the demands on health sector services have also grown rapidly in these countries. Government's involvement in health sector is supported by the politically acceptable popular arguments that the poor cannot afford health expenditure and that investing in the health of the poor is an economically efficient strategy for reducing poverty and alleviating its consequences. However, to ensure that subsidised health services actually reach the poor, it may be necessary to impose restrictions on the type of health care provided by the public sector. Universal free health services may not reach the poor and may lead to the rationing of services. In other words, government intervention in health sector must be based on strong economic rationales. The three important rationales are :- (i) Public goods, (ii) external economies and (iii) market failure. In health sector, public goods are generally characterised by large externalities and include such items of public health services to the population at large as malaria control, immunization etc., Public sector financing of "essential" clinical or individual services which are highly cost effective, produce strong external economies and greatly improve the health of the poor can be included as a component of a poverty reduction programme. The final rationale rests on the market failure argument, the governments' role in clinical services should not extend beyond providing a package of essential services previously mentioned and improving the capacity of insurance and health care markets to provide discretionary care through private or social insurance *(World Bank 1993)*. However, since the most important problem facing the government is that of making the right choice of the area, type and coverage of intervention, the intervention may also fail due to (i) the government's misjudgment about how an intervention will work in practice, (ii) lack of capacity on the part of the government to administer and implement policies, (iii) corruption among and incompetence of public officials and (iv) the pressure of special interest groups within and outside of the health system.

Failure of intervention obviously would make the government expenditure cost-ineffective in terms of benefits as the following table (Table 4) illustrates.

It can be seen from the table that the desired expenditure on total public health (Row 3) for all developing countries should be 15 dollars per capita. But the actual expenditure is between 5 and 7 dollars - less than half the amount. On public health, the actual expenditure is about one-fifth of the desired amount. On the other hand, on discretionary clinical services, the actual expenditure is more than twice the desired expenditure.

Thus appropriate amount of expenditure is not being channeled into priority sectors. A study *(Akin and Birdsall 1987)* identified the following three major problems facing the health sector in developing countries: (a) an allocation problem - too little spending on basic cost - effective services compared with costly services; (b) an internal efficiency problem - public health programmes that do not work well; and (c) an equity problem - the poor benefit little from public health spending.

ALLOCATION PROBLEM

In the majority of developing countries, much of the expenditure on health is spent on more costly and less effective curative services than on less expensive and more effective basic health services. The share of tertiary and secondary care hospitals in total public expenditure on health amounts to between 70 and 75 per cent in many countries. Even the expenditure on tertiary care hospital alone accounts for 30 to 50 per cent of the public sector's health budget *(World Bank 1993)*. But less than 25 per cent of government spending is directed to cost-effective public health measures and essential clinical care. If public resources tied up in the few, mainly urban, hospitals were directed to lower levels of the health system in the country-side, many common causes of illness and hospitalisation could be treated at an earlier stage and even prevented altogether.

INTERNAL INEFFICIENCY PROBLEM

One kind of inefficiency, most common to health sectors in developing countries, is the widespread use of higher level health care facilities by patients who could be treated in less sophisticated units. The result is that the urban health care facilities become overcrowded and are stretched to their limit, whereas rural clinics remain largely unused.

The second type of inefficiency results from the lack of complimentary inputs such as fuel, drugs, and even sanitary supplies in public health system under budgetary restraint in both urban hospitals and rural clinics.

However, the irony of the situation is that a substantial drop in the supply of

such inputs to achieve a reasonable cut in total spending, considerably lowers the effectiveness of the health system, while the salaries of the staff remain untouched. Private health services, on the other hand, continue to expand.

inequities in developing countries. Since a very large proportion of the total population live in rural areas, a large proportion of public budget on health should be directed to these areas. Griffin's study (1991) shows that, in industrialised countries, slightly less

Table - 4 'Allocation of Public on Health in Devloping Countries (per capita dollars)

Items in the Package	Expenditure				
	Proposed		All Developing	Actual expenditure	Coverage
	LIEs	MIEs	Countries	in all developing countries	
1. Public health	4	7	5	1	Essential public infrastructure school health programmes; tobacco and alcoho l control; health, nutrition STD prevemtion; monitoring and 'surveillance
2. Essential clinical services (minimum package)	8	15	10	4-6	Tuberculosis treatment; management of the sick child, prenatal and delivery car; family planning; STD treatment; treatment of infection,and minior trauma; assessment,advice and pain alleviation
3. (1)+(2) Total public health and minimum clinical service	12	22	15	5-7	All other health services, including low-cost effective treatment of cancer, cardiovascular disease; other chronic conditions; major trauma;neurological and psychiatric disorders
4. Discretionary clinical service	-6	40	6	13-15	
5. Total (3)+(4)	6	62	21	21	

EQUITY PROBLEM

In respect of health status, physical access to health services, consumption of health care, the distribution of the financial burden of health care spending and public expenditures for health, there exist severe

than 50 per cent of the total health budget is spent on hospital services which are mainly in the urban areas. But developing countries, particularly the least developed countries, spend 60 to 80 per cent of public health budget on urban hospitals, even

though only a small fraction of population will ever need hospital services. Even within the same region, the poor have less access to health care facilities than the well off. In Bangladesh, for example, the infant mortality rate in the rural areas is nearly twice the urban average and about 50 per cent higher than the average rate for the entire country. In Indonesia in 1991, for example, rural households in the top income docile were three times more likely to live in a village with a health centre than those in the bottom docile *(World Bank 1993)*. Despite significant improvements in lower level health facilities in Indonesia in the 1980s, slightly over 10 per cent of public spending on health in 1990 went for services received by the bottom 20 per cent of households, whereas the top 20 per cent received 29 per cent of the government subsidies. It has also been found that the few countries in which public expenditure on health has been biased towards the poor, the public policy has been able to reduce inequities in access and health status. One such example is Malaysia *(World Bank 1993)*.

HEALTH SECTOR REFORMS

In a comprehensive package of reforms, reform of the financing of health services is only one item, albeit a very important item. But this reform must be accompanied by reforms in other areas such as management, training and supervision in the public delivery of health services. The major problem with the reforms appear to be their political non-acceptability. Reforms designed only for the poor will not receive political support. On the other hand, maintaining a proper balance between more care for fewer people and the same amount of care for more would require limiting public finance to cost-effective services for which there is a sound rationale. To this end, the following four reforms are worthy of consideration by developing countries:

(1) Government health facilities should be supplied on user-change basis.

(2) Health insurance programmes should be introduced.

(3) Private sector should be encouraged to provide services for which the households are willing to pay.

(4) Government health services should be decentralised on a selective basis.

Since in most developing countries government health care facilities are supplied free of charge no revenues can be collected from those who are willing and able to pay.

A modest fee, not exceeding 1 per cent of annual income, to cover at least four visits to a hospital per year, especially for drugs and curative care, could finance 15 to 20 per cent of most countries' operating budgetary expenditure for health care *(Akin and Birdsall 1987)*. It is about this share of the budget that is required to pay for drugs, fuel and building maintenance. If the poor are exempted from paying charges for

expensive curative services, charges for such services for the non-poor could be raised to reflect the actual cost of such services. However, as Akin and Birdsall note, an effective policy of user charges cannot be implemented unless access to and quality of services improve; revenues saved are channeled into underfunded programmes; and the poor are protected.

The user charge system may not be appropriate for all types of health problems. To make such a system effective, an appropriate health insurance scheme needs to be put in place.

LESSONS FROM CHINA

In China since 1981, health institutions had to earn much of their operating costs from sales of drugs and services and currently about 60 per cent of the population is covered by some form of health insurance. Apart from salaries which are financed from public budget, other expenditures on health sector personnel are financed from revenues from used charges. But the expensive treatment of such diseases as tuberculosis was also placed under user charge system with the result that the doctors, in anticip ation of being reimbursed by health insurance, provided excessive expensive diagnostic tests and after-test treatment to patients. This forced many poor people to opt out of the treatment resulting in very little drop in the incidence of the disease. Recognizing the problem, the government now has begun a major tuberculosis control effort that provides subsidies for treatment and appropriate incentives for providers of care *(World Bank 1993)*.

The early results suggest that the number of cases cured has risen dramatically. Thus the result of this Chinese experiment would suggest that all kinds of treatments should not be placed under user charges.

Involvement of the private sector in health services which is another component of the reform package has also been encouraged in China. In the mid-1970s, China spent about 60 per cent of its health sector budget in rural areas and aimed to send half its medical school graduates to country health centers. Although this scheme encountered difficulties, due to inadequate living conditions in rural areas, China has been able to overcome this problem by making effective use of its well known system of health auxiliaries, i.e, the legendary "barefoot doctors" who perform preventive work, treat patients at home and in the fields, assist with the government's mass health and sanitation campaigns, and disseminate information on family planning and maternal and child health care. In addition, there are more than 3 million part-time health auxiliaries assisting in the same activities *(Gillies et al 1992)*. These measures have enabled China to record vast improvements in health and life expectancy which are quite unusual for a low income country.

By keeping revenues as close as possible to the collection point, decentralisation improves incentives for collection and increases accountability of local staff. Apart from helping the growth of local managerial talent and ensuring that local expenditures reflect local needs, it also takes considerable pressure of government services. However, without adequate trained personnel to manage revenues and expenditures, a scheme of decentralisation may be difficult to implement. China implemented reasonably successfully this reform as well since the mid-1970s by allowing the local collected fees to be used by local health facilities. These reforms, if implemented, can address the three major problems in the health sector illustrated earlier.

PROGRESS IN IMPLEMENTING REFORMS

Recent studies *(Griffin 1991)* indicate that governments in developing countries in general tried to reduce the relative burden of hospitals by raising total spending on health and allocating the major proportion of it on primary health programmes in rural areas. However, in the 1980s, the need to reduce the budget deficit forced many governments to reduce the share of health in total government expenditure with the result that the cuts in health spending were effected in those areas which were more important to the community at large.

Privatisation of hospitals as an option has been considered by some countries. In China, although the curative care is provided by public hospitals, the cost is financed through private payments. Although China's hospital spending is high and rising, this approach makes individuals and social insurance bear the largest share of the burden, leaving the government to pursue the other more important goals, such as preventative care, etc., In Kenya, the national hospital was turned into parastatal in the late 1980s and in Sri Lanka in the mid-1980s, a large hospital was opened in Colombo as an independent institution operating as a self-financing joint practice by its staff and attending physicians with fees for all services and patients. Even hospital services can be contracted from the private sector, particularly from missions while the government can contribute to the capital cost of mission facilities. The performance of the mission run health facilities has in most cases found to be superior to that of government run hospitals. Government contracts can build up private sector institutions that will eventually be able to absorb large scale operations. In many countries currently, housekeeping, janitorial, catering, laundry services and even lenses for vision correction are supplied by the private sector.

As practiced in Papua New Guinea, an arrangement through which private pharmacies use the public sector as a wholesaler can reduce drug costs, regardless whether the patients use the public or private sector.

Implementing all these reforms is a difficult task and even if a country is successful in implementing these reforms, they will not solve all the problems of the health sector. For example, user charges will not solve the problem of acquiring foreign exchange to buy imported drugs and equipment nor can they guarantee that resources saved would be spent wisely. Similarly, non-government health sector may not provide all the services that the government health sector provides *(Akin and Birdsall 1987)*. However, genuine reforms could never be implemented unless there is a political commitment by government to make the health sector more effective.

Apart from the reforms discussed above, many experts believe that a reform package should also include such elements as active and continuous promotion of community health, instead of intermittent treatment of specific conditions in individuals; management of health system by non-physicians; training health care auxiliaries recruited from the community to diagnose and treat simple ailments; and limited referral of difficult tasks *(Gillies et. al 1992)*.

LESSONS FOR INDIA

All the problems of the health sector outlined above exist in India, probably in a considerably greater degree than in many other developing countries. A very large part of the health sector budget goes towards the curative care in urban hospitals than towards preventative care in rural health centers. *(Sen & Roy, 1988)*.

Expenditure on maintaining staff is much larger than on requiring provision such as drugs, fuels, equipment, etc., A very small proportion of the total population is to some extent covered by health insurance and the share of the health sector in the total government expenditure has been falling since 1983. Therefore, there is an urgent need to implement the reforms discussed earlier. However, India's situation is also different from those of other countries in two important respects :

1. Under India's federal system, the provision of health care is the primary responsibility of the states. Therefore, states not run by the political party in power at the centre may adopt "go slow" tactics in implementing reforms. Moreover, corruption, significant erosion of human values among health sector personnel, absence of accountability of health personnel to state governments and absence of accountability of state governments to the centre may stall the progress in implementing reforms.

   Furthermore, a weak and corrupt government at the centre, more interested in retaining power, will have no political commitment to implement reforms. Unfortunately, all these problems are present in India. As

Table 5 illustrates, the share of health sector expenditure (centre and states) in total government expenditure (centre and states) has been falling since 1984. However, the state governments' expenditure on health, as a percentage of total national expenditure on health, has remained very high. The share of the states' in total health expenditure recorded a declining trend for a few years after 1981 when it stood at 72.5 per cent but resumed its upward trend from 1986 to reach 71.6 per cent in 1988. (Table-5)

that village health centers, which are designed to cater for preventative care, are almost completely bereft of drugs, equipment and other provisions and have been turned into prescription health centers.

Thus, while the money is allocated, the provisions do not seem to reach their destinations. Due to the same problems, as outlined above, it would be difficult to implement reforms.

2. The second aspect, in which India's health sector differs from that of other countries, is that a very large and

Table - 5

Central and State Governments' Expenditure on Health in India

(billions of IRs)

	1981	1982	1983	1984	1985
1. Total government expenditure	396.2	465	544.4	653.80	779.6
2. Central government expenditure on health	4.1	5.6	6.9	8.00	9.1
3. State governments' expenditure on health	10.8	12.7	15.3	18.40	20.7
4. Total government expenditure on health (2)+(3)	14.9	18.3	22.2	26.40	29.8
5. (4) as % of (1)	3.8	2.2	4.1	4.00	3.8
6. (3) as % of (4)	72.5	39.6	68.8	69.70	69.5

Source : IMF (1991), Government finance Statistics Yearbook, Washington D. C. :

Thus although the table shows that the state governments' expenditure has not fallen very much, one would find that health care facilities and improvement in health related indicators in South and Western India are vastly superior to those in Eastern India. The reasons for this anomaly ought to be found in the problems outlined above. It was observed during fieldwork in rural areas of Eastern India in 1991 and 1992, thriving private sector operates in the provision of health care. This private sector comprises a variety of institutions such as private hospitals run by business, industries and missions, private nursing homes, pharmacists, many of which also provide free doctors for consultation and prescription, village non-registered quacks and medical representatives, etc., Such

a phenomenal growth of the private sector in health care indicated by the relative share in 1990 in GNP of public and private sector health expenditure (1.3; 4.7) may be due, on the one hand, to India's long tradition and faith in private health care and to more importantly, the failure of the public health system to provide health care to both the poor and the well off. Since the poor do not seem to derive any benefit from the public health care system, the gradual privatisation of health sector activities at least in urban centers in those states in which the performance of the health sector has not been good would be a logical step to take and the money thus saved could be spent on more productive areas. However, as mentioned before, implementing reforms requires political commitments by the centre and states which are a rare commodity in India's political system.

REFERENCES

Akin, N and Birdsall, N (1987), "Financing of Health Services in LDCs", *Finance and Development*, 24(2)

Gillies, M, Perkins, D.H, Roemer, R and Snodgrass, D R (1992), *Economics of Development*, New York : Norton.

Griffin, C (1991), "The Need to Change Health Care Priorities in LDCs", *Finance and Development*, 28(1).

IMF (1991), *Government Finance Statistics Yearbook*, Washington D.C; IMF.

World Bank (1990, 1993), *World Development Report*, New York: Oxford University Press.

Raj Kumar Sen and K.C.Roy (1988), Decentralised Planning and Primary Health care in LDCs with reference to India. *Indian Economic Association Conference Volume.* Calcutta.