Budget TRACK

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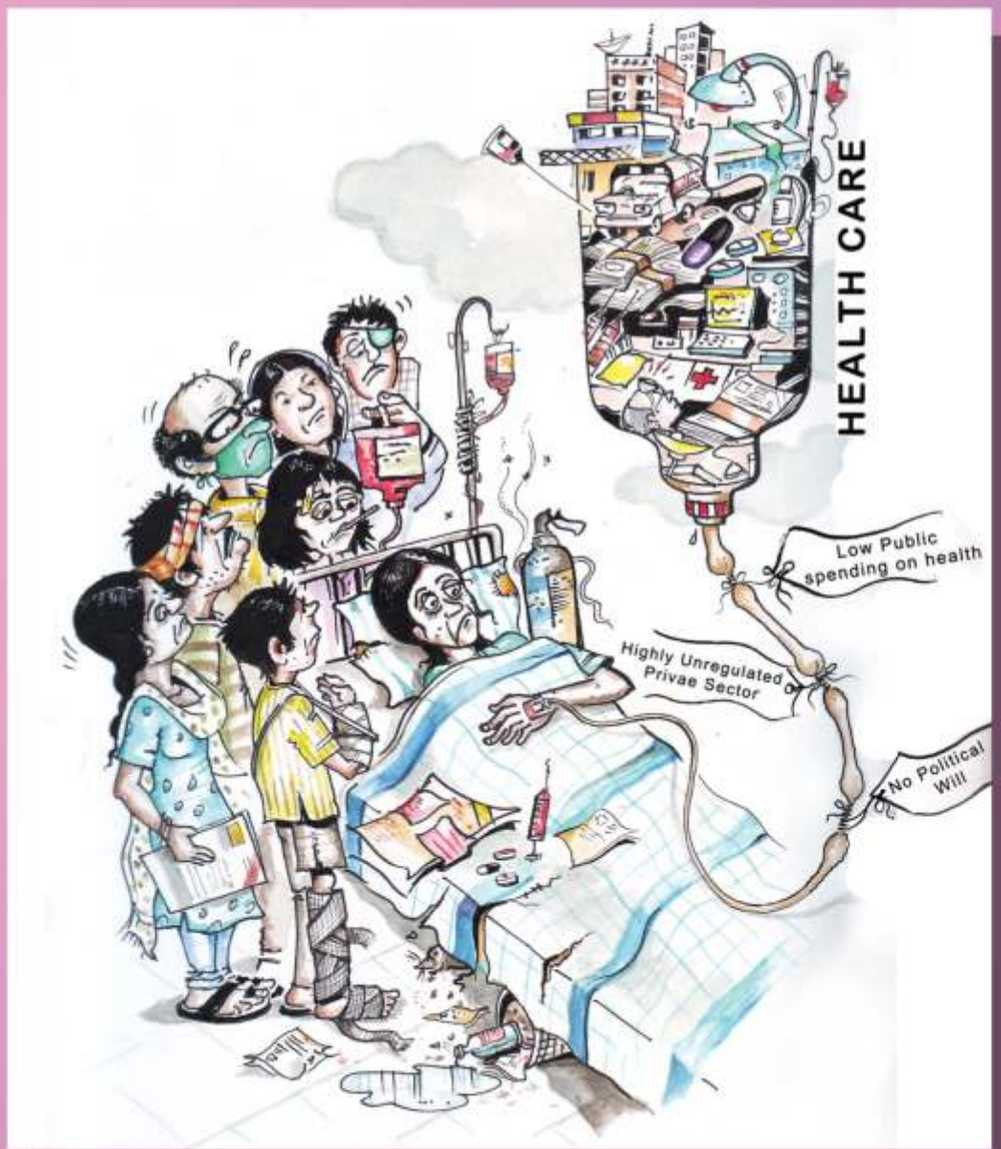

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Foreword

You would have heard the simple yet sound adage that "Health is Wealth" and also agreed wholeheartedly. It seems, however, that the Indian government continues to ignore the intrinsic merit behind this statement as is revealed by the continued indifference towards provisioning adequately for the health sector. Recently, the Prime Minister in his Independence Day speech said that the 12th Plan would be a health plan just as the 11th Plan was an education plan. If the way the Union government has side-stepped provisioning of 'universal','quality' and 'free' education to all is any indication to go by, it is with some scepticism that one would consider this proposal of the 12th Plan being a plan focused on health!There has been a proliferation of private players in the education sector and the 11th Plan has clearly veered towards a more active role for the private sector in its multiple avatars. In India, private out-of-pocket spending in healthcare is already sky-rocketing. Given this situation, a clearly-defined legislation that outlines provision of universal quality and free healthcare to all is the need of the hour.

In this regard, *Jan Swasthya Abhiyan* (JSA) - the Indian chapter of the global People's Health Movement - has been leading this demand. In 2004, in collaboration with National Human Rights Commission (NHRC), JSA had organised several public hearings across the country on right to healthcare, the findings of which culminated in a set of detailed recommendations by NHRC to the Union government. One of these recommendations was to enact a national law for recognising and operationalizing the right to healthcare in India. In January 2008, the Ministry of Health and Family Welfare initiated drafting a National Health Bill that has been in the public domain as the Draft National Health Bill 2009. However, critical gaps remain in the draft legislation. This issue of Budget Track focuses on some of the key concerns with regard to the draft legislation and other critical issues pertaining to people's right to health.

To begin with, Imrana Qadeer outlines the social context of the National Health Bill 2009 by bringing into focus the onset of privatisation and destruction of public institutions by the adoption of a 'bio-medical' approach. Ravi Duggal then takes us through the political economy of healthcare financing in the country by tracing the move from *Jajmani* system to commodification of healthcare. He also charts the five steps to re-structuring the existing system to align healthcare in a rights-based approach. Abhijit Das and Moumita Ghosh follow this with examining how far the country is from achieving universal health coverage. In this regard, they present an overview of the Thailand model of universal health coverage or the commonly-known '30 baht' scheme. Indranil picks up this thread of universal health coverage and de-constructs the focus on coverage rather than provisioning. In this regard, he reviews insurance mechanisms versus tax-financed options to public provisioning for healthcare and also examines the Thailand experiment in considerable detail.

Another key ingredient to ensuring universal healthcare is access to essential medicines. Narendra Gupta highlights how this seems a far-fetched thought when 65 percent of the Indians do not have access to essential medicines. He also provides a ballpark estimate of how much the government needs to spend to make access to essential medicines a reality. Moving on, Jashodhara Dasgupta shifts the focus on a vital aspect that needs sustained attention of policymakers, i.e. public provisioning for maternal health. She reviews the present government provisioning for maternal health and comments on *Janani Suraksha Yojana* as the sole vehicle to reduce maternal mortality and also flags some concerns relating to quality of expenditure. Biraj Swain then directs our attention to the foot soldiers delivering healthcare to all – the doctors – and the need to regulate their service conditions to ensure that the legislation (when it is enacted) is adequately bolstered with clear guidelines on the *do*s and *don't*s for private practitioners.

The usual Budget and Policy Tracking piece presents an overview of the Union Budget 2011-12 and summarises the discussion in Parliament during Budget session before highlighting some of the key policy debates.

We do hope you enjoy reading this issue as much as we did in putting it together!

The Social Context of Draft National Health Bill-2009

Imrana Qadeer*

In a democratic arrangement, it is often embarrassing for states to flout promises openly. Transitions in political perspectives thus become shrouded in complex semantics. In India, the gap between health policies and governance has consistently increased till the 1990s when the policy itself turned around to welcome privatisation and commercialisation and shed the responsibility for free basic healthcare provisioning though ensuring health of the people remained a Directive Principle. Despite the fact that in the early nineties the adjustment policies did wear the cloak of social security net to underplay the impact of cuts and rollback in welfare investments, the emphasis remained on commercialisation of the public sector, opening spaces for public private partnerships and shift of subsidies to the private sector. These shifts were neither necessary nor based on the needs of the civil society; political compulsions of a state dependent on national and international capital and its expanding free markets demanding its support both to offset the negative impact of a minimalist State that acts as a client, a steward and an investor seemed to be at work[i]. Apart from the fiscal and financial liberalisation that these shifts required, another important vehicle of change has been a series of new legislations. Legislations reflect the dominant social ethos of a country wanting to carry out a certain set of policies. The current spate of legislations indicates that the new policies – in the face of protests and reminders of promises – needed legislative protection.

It is this larger political compulsion that informs the Draft National Health Bill (NHB)[ii]. Despite its very progressive preamble promising protection and fulfilment of rights regarding health and wellbeing – equity and justice through universal access to health and all underlying determinants of health and healthcare – the Bill is in fact weakened by its lack of specificity. There is no clarity regarding definitions of terms used. This permits several interpretations for various promises and sometimes the definitions are unacceptable. For example, access is defined in economic terms alone as affordability or, "one's ability to purchase" (pp13 of Draft Bill) and not free availability. Free and universal access to healthcare through third party payment is restricted to "those who are unable to meet their basic needs" (pp8 of the Draft Bill). "The immediate duty" to provide free and universal healthcare is only for "the vulnerable and the marginalised" (part 3, section (c)). Hence, the rest of the poor are left out as no time plan is proposed to cover them. Second, the "vulnerable" too remain undefined. This brings back silently the narrowly targeted approach while a big chunk of the deserving are left to the vagaries of the medical market with no options of a public facility.

The need to strengthen the dwindling public sector at the tertiary level and the state's responsibility towards provisioning Primary Healthcare to all is ignored. The state is permitted to retract from provisioning by becoming the third party payer for its vaguely targeted population. The State is required to be the regulator of standards, norms and values, it is to acquire the role of "steward" (a term that is never defined). The fact that the relative higher costs of services are in the private sectors are overlooked, shows the bias of the steward! The matter is further confounded as essential public health services and functions (a part of the core obligation of the State) are never defined. Terms such as users, providers and stewards fail to present with clarity any distinctions between the health system, health service system and medical services system. Also ignored are the contradictions between private (profit-based and accountable to individuals) and public (non-profit, accountable to public) sectors. The two sectors are integrated to make a health service system where resolution of conflicts invariably favours the private interests, be it the shift of subsidy, control over more paying facilities or, training of doctors and nurses. Thus, the partnership is to be governed by rules that are one-sided. Another omission is in the priority given to food, water, sanitation and housing as key social determinants of health. Though important, in a society introducing rapid cutbacks on public sector including welfare, to ignore the key factor of employment/ livelihoods and minimum wages reflects an inherent bias. A bias reflected in the government's decision to write off income tax worth Rs, 3,74,937 crore for the corporate sector[iii] and undermining of the National Rural Employment Guarantee Act and the Public Distribution System. Similarly, lifestyle diseases identified are cardio-vascular, diabetes and hypertension are defined as, "diseases associated with the way of life"! The fact that occupational diseases, under-nutrition, anaemia and infectious diseases are not identified as outcomes of choices under compulsion, by

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people living in poverty reflects yet another bias. Over and above this is the fact that the judiciary and the Health Ministry are no more the main implementers of the legislation. A bureaucratic hierarchy of boards at various administrative levels is proposed to implement the legislation.

The result is that in spite of a long list of obligations of the State, universal access (as free availability) remains a far cry while the targeted agenda is to cover an undefined "vulnerable" and, help the private sector consolidate through shift of subsidies and keeping the public sector tertiary hospitals out of competition! The definition of essential health services being unclear, the issue of standards of quality healthcare also remains fudged. The promise for reviews of policy is unconvincing as the very law reflects compulsions of the economy rather than a rational review of past experiences and policies regarding people's welfare despite several international covenants to which India is a signatory. Despite emphasising decentralisation, the Centre's regulatory powers are enhanced and the states –starved of resources – are made responsible for legislations regarding social determinants of health.

To understand the logic behind the Draft National Health Bill, 2009, it is important to understand the new place of the health sector in the current global economy. The changing global balance in favour of structural adjustment has impacted the health scenario drastically. Health sector investments are considered good business by the World Bank today while in the '70s, these were considered undesirable[iv]. The major shifts over time are: healthcare has become a commodity from a service and the decades old debate on weaknesses of the medical market has been ignored. Methodologies to identify needs of the backward sections have been replaced by the notion of demands to assess supplies. Bio-medical factors have acquired priority over key social determinants of health and assessing efficiency of health systems in monetary terms rather than health outcomes.[v]

Capitalism's compulsion to open new areas of investment lies at the roots of these shifts. Having captured the human body and the health market, it has found a great potential in the discipline of international health. Over the past three decades, international health has acquired a disciplinary boundary wherein, research on the developing world's health problems and services in order to promote expansion of global medical market, constitutes the core. Mostly located in the western world, these centres attempt primarily to integrate science and technology with business to give a rational face to the solutions they offer. By using a reductionist bio-medical approach, they universalise health problems and offer technological solutions that can be introduced into the global market. In the words of these experts, "we are increasingly confronted with a global convergence of health problems".[vi]

They argue that due to control of childhood infectious diseases, childhood mortality has declined in most regions of the world. As a result, many countries are now undergoing an epidemiological transition, resulting in a marked shift in the global pattern of disease. By 2020, adult conditions such as cardio-respiratory diseases, cancers and other chronic conditions are *expected to eclipse communicable diseases as leading health burdens* (emphasis mine). The global epidemic of type 2 diabetes and the emergence of new infectious agents – severe acute respiratory syndrome (SARS) and the influenza A (H5N1) virus – exemplify this shift. Thus in their perspective, local priorities of developing countries are subsumed in the global burden of disease and cross border technology, knowledge and expertise transfers are the answer to reduce this burden.

These experts (Robert Eiss and Roger Glass) also point out that sciences are converging on a common set of approaches to address disease burden. Some of the major scientific opportunities around global health enterprises, according to them, are: genomics, molecular epidemiology and diseases of poverty, diagnostics, clinical trial and regulatory needs, integrating research into resource poor country's implementation programmes and improving capacities. The first opens up possibilities to quantify disease risks that gene variants confer and conceive new therapeutic and preventive strategies, the second using bioengineering, proteomics and digital technologies ushers a new era of chip diagnostics. These advances have profound implications for addressing global health priorities – from the classical tropical infections to the slowly rising chronic and degenerative diseases. According to them, Bill & Melinda Gates Foundation and others are working to create low-cost diagnostics suited to the medical needs and social contexts of the developing world. Similarly, the focus on drugs and vaccines to reduce the global health burden has also enhanced scientific and management skills, and ethical review capacities to support clinical trials in low and middle income countries. What they miss is that vaccines for diseases of poverty such as diarrhoea[vii] being promoted by the Bill & Melinda Gates Foundation ignore the very root of the problem and seek answers in technology while neglecting poverty as well as primary care infrastructure that has failed to provide full coverage of basic immunisation.

Eiss and Glass highlight that product development partnerships in global health R&D have created numerous business models such as, "The Medicines for Malaria Venture" and "TB Alliance"; these ventures manage two-thirds of identified drug development projects for neglected diseases. The support to these new ventures includes patent pooling, humanitarian licensing, and access to small molecule chemical libraries in the private sector under appropriate legal arrangements; and market analyses such as estimates of demand, to engage corporate interest. These efforts might have increased the drug business but the two disease control programmes in India have barely improved. Yet another opportunity identified by them is the need to reverse brain drain and to strengthen institutions in resource poor countries through *promotion of*

skills necessary for technology transfers and the marketing of scientific products; and promoting international linkages, including the creation of expatriate communities of academics as collaborative partners and supportive networks (emphasis mine).

If we take examples of these corporate experiments, third phase trial of HPV vaccine (produced by Merck and Glaxo) was conducted by PATH (an international NGO) in Andhra Pradesh where six schoolgirls died. An enquiry[viii] revealed lack of procedural correctness and ethical practices, yet no one was held responsible. Similarly, the inclusion of pneumococcal, hepatitis B, Hib & Pentavalent vaccines in the national immunisation programme raised serious criticism of cost efficiency and validity by professionals[ix,x] raising doubts about the value of these aggressive strategies. Yet, international health experts have put their faith in global convergence of disease patterns, a common set of approaches based on advanced technologies and intervening in disease control programmes and capacities of the poor countries' professional providers.

International health research then played a key role in altering concepts and perspectives pushing the biomedical approach, even while acknowledging social complexities, and contributed to the rationale behind de-legitimisation of the public sector in health and consolidation of medical markets underlying the policy shifts in the Indian State. It also groomed a significant section of Indian professionals, who support its strategies – fully or partially – by assuming that India's robust economic growth, its civil society organisations, the growing body of new legislation[xi] and, integrating public and private sectors[xii] are the key to redressing its ills. The NHB, a product of this way of thinking[xiii], is a necessary instrument in India's health policy compromises that make the poor second rate citizens. To see it as a victory of the struggle for rights and ignore the absence of real punitive clauses for denial of this fundament right to health, can only be short sighted as control by the private sector and the ensuing destruction of public institutions will be too drastic for any later legislative corrections.

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Reforming Financing Strategies for Equity and Universal Access to Healthcare

Ravi Duggal*

Introduction

Access to healthcare is critically dependent on how healthcare provision is financed. Countries that have universal or near universal access to healthcare have health financing mechanisms which are single-payer systems in which either a single autonomous public agency or a few coordinated agencies pool resources to finance healthcare. All Organisation of Economic Cooperation and Development (OECD) countries excluding the U.S. have such a financing mechanism. In these countries, 85 percent of financing comes from public resources like taxes, social insurance or national insurance which insure healthcare to over 90 percent of the population – even in the U.S., public finance (Medicare and Medicaid) constitutes 44 percent of total health expenditure but one-third of the population in the U.S. is either uninsured or under insured. In fact, the U.S. and Canada stand out in sharp contrast even though they are neighbours and strong capitalist economies. Canada gives healthcare access to its entire population free of direct payments at 40 percent of the cost that the U.S. spends, and has better health outcomes.

Outside the OECD group, a number of developing countries in Latin America, Asia and Africa like Costa Rica, Cuba, Argentina, Brazil, South Africa, Kenya, South Korea, Iraq, Iran, Thailand and Sri Lanka too have evolved some form of single-payer mechanisms to facilitate near universal access to healthcare. It is only in countries like India and a number of developing countries, which still rely mostly on out-of-pocket payments, where universal access to healthcare is elusive. In such countries, those who have the capacity to buy healthcare from the market most often get healthcare without having to pay for it directly, and those who suffer a hand-to-mouth existence are forced to make direct payments, often with a heavy burden of debt, to access healthcare from the market.

India is the most privatised health economy in the world and this despite the fact that three-fourths of the country's population is either Below Poverty Line or at the subsistence level. Given the political economy of India, one would have expected the State to be the dominant player in both financing and providing healthcare for considerations of establishing equity in access to healthcare. But this has not happened.

Political Economy of Health Financing

Historically, the Indian State has always been an insignificant player in provision and/or financing of ambulatory healthcare. Private providers, both modern and traditional, as well as informal providers, have been dominant players in the healthcare market. While pre-colonial healthcare was still largely within the *jajmani*[i] realm of transactions, the establishment of modern medicine during the Colonial period gradually moved it in the direction of commodification. Today, the healthcare system is dominated by modern medicine and healthcare is available largely as a commodity. Even the traditional and non-formal providers, often practitioners of quackery, use modern medicine in their practice and operate within the market context. In case of hospital care, the transition has been very different. Right from pre-colonial times, through the Colonial period and the post-Independence period up to the mid-1970s, the State and its agencies were the main providers of hospital care. There were also significant non-state players who set up large charitable hospitals. By the 1970s, medical education made a major transition; post-graduation, specialisation and super-specialisation became sought after and the character of medical practice changed. Specialists on one hand began setting up private nursing homes and the corporate sector on the other hand began to show interest in entering the hospital sector. Also, major changes in medical technology, which hastened the process of commodification of healthcare, made for-profit hospitals a lucrative proposition. By the 1980s, the State was already decelerating investments in the hospital sector and this was a clarion call for the private sector to increase its presence. By the turn of the millennium, the for-profit hospital sector had not only become dominant but also within the state sector, privatisation via user-charges as well as through contracting out or leasing had become the order of the day.

It is apparent from the above discussion that the largest source of financing healthcare in India is out-of-pocket or self-financing. Out-of-pocket spending on healthcare as a mode of financing is both regressive and iniquitous. Latest estimates based on National Accounts Statistics indicate that private expenditures on healthcare in India are about Rs. 275,000 crore and 98 percent of this is out-of-pocket. Public expenditures on healthcare are about Rs. 60,000 crore additionally. Together, this adds up to 5.7 percent of GDP with out-of-pocket expenses accounting for 78 percent of the share in total health expenditures or 4.3 percent of GDP. This is a substantial burden, especially

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for the poorer households, the bottom three quintiles, which are either Below Poverty Line (BPL) or on the threshold of subsistence, and when illness strikes, such households just collapse. In fact, for the poorer quintiles, the ratio of their income financing health expenditures is 2 to 4 times more than the average mentioned above. Further, while this burden is largely self-financed by households, a very large proportion of this does not come from current incomes. A very large proportion, especially for hospitalisation comes from debt and sale of assets.

Data from the 52nd Round National Sample Survey (NSS) of 1995-96 (Table 1) reveals that over 40 percent households borrow or sell assets to finance hospitalisation expenditures, and there are very clear class gradients to this – nearly half the bottom two quintiles get into debt and/or sell assets in contrast to one-third of the top quintile; in fact, in the top quintile this difference is supported by employer reimbursements and insurance. When we combine this data with the ratio of "not seeking care when ill" in case of acute ailments by the bottom three quintiles in contrast to the top quintile – a difference of 2.5 times, and the reason for not seeking such care being mostly the cost factor – it becomes amply evident that self-financing has drastic limits and in itself is the prime cause of most ill health, especially among the large majority for whom out-of-pocket mode of financing strains their basic survival.

In sharp contrast, in countries where near universal access to healthcare is available with relative equity, the major mechanism of financing is usually a single-payer system like tax revenues, social or national insurance or some such combination administered by an autonomous health authority which is mandated by law and provided through a public-private mix organised under a regulated system. Canada, Sweden, the United Kingdom, Germany, Costa Rica, South Korea, Australia, Japan are a few examples. Experiences from these countries indicate that the key factor in establishing equity in access to healthcare and health outcomes is the proportion of public finance in total health expenditures. Most of these countries have public expenditures averaging 80 percent of total health expenditures[2]. The greater the proportion of public finances, the better the access and health outcomes. Thus India, where public finance accounts for only 20 percent of total health expenditures, has poor equity in access to healthcare and health outcomes in comparison to China, Malaysia, South Korea, and Sri Lanka where public finance accounts for between 30 percent and 60 percent of total health expenditures[3].

In India, public health expenditures had peaked around the mid 1980s and thereafter there was a declining trend, especially the post-structural adjustment period. The decade of the 80s was a critical period in the country's health development because during this period not only did the public health infrastructure, especially rural, expand substantially but also major improvements in health outcomes were recorded. After that, public investment in health dropped sharply and public expenditures showed a declining trend both as a proportion to GDP as well as in total government spending. This has also impacted health outcomes, which are showing a slower improvement if not stagnation. At the same time, private health sector expansion got accelerated and utilisation data from the two NSS Rounds 42nd (Pre-1991) and 52nd (Post-1991) Round – a decade apart – provides sufficient evidence of this change. (Table 2 and 3) The 60th Round in 2004 shows a further decline of the public health system.

Thus, if India has to improve healthcare outcomes and equity in access, then increasing public health expenditures will be critical. It will have to reverse the post-1991 declining trends in public health spending and, to begin with, move towards the UPA government's target of three percent of GDP public health expenditure. Apart from this, the healthcare system will need to be organised and regulated in the framework of universal access, similar to countries like Canada or Costa Rica, or more recently our close neighbour Thailand. Of course, India has its own peculiarities and the system that will be designed will have to keep this in mind. We cannot transplant say the Canadian or Costa Rican or Thailand system into India as it is, but we can definitely learn from their experience and adapt useful elements.

Towards a New Financing Strategy

Currently, India's health financing mechanism as mentioned earlier is largely out-of-pocket and one sees a declining trend in public finance. Table 4 indicates trends in health expenditures over the last three decades. It is quite evident from the data that public finance of healthcare is weakening and private expenditures becoming even larger.

First, within the existing public finance of healthcare, macro policy changes in the way funds are allocated can bring about substantial equity in reducing geographical inequities between rural and urban areas. At present, the Central and state governments together spend Rs. 550 per capita, but this is inequitably allocated between urban and rural areas. The rural healthcare system gets only Rs. 300 per capita and urban areas get Rs. 1,300 per capita, a difference of over 4 ½ times[4]. If allocations are made using the mechanism of global budgeting, as is done in Canada for instance, that is on a per capita basis, then rural and urban areas will both get Rs. 550 per capita. This will be a major gain, nearly two times, for rural healthcare and can help fill gaps in both human and material resources in the rural healthcare system. The urban areas in addition have municipal resources, and of course will have to generate more resources to maintain their healthcare systems which at least in terms of numbers (like hospital bed: population ratios and doctor: population ratios) are adequately provided for. Global budgeting also means autonomy in how resources are used at the local level. The highly centralised planning and programming in the public health sector will have to be done away with and greater faith will have to be placed in local capacities.

Second, the public exchequer even today contributes substantially to medical education to the extent that nearly 80 percent of medical graduates are from public medical schools. This is a major resource that is not fully utilised. Since medical education is virtually free in public medical schools, the state must demand compulsory public service for at least three years from those who graduate from public medical schools as a return for the social investment[5]. Today, only about 15 percent of such medical graduates are absorbed in the public health system. In fact, public service should be made mandatory also for those who want to do post-graduate studies (as many as 55 percent of MBBS doctors opt for post-graduate studies).

Third, the governments can raise additional resources through charging health cesses and levies on health degrading products (if they cannot ban them) like cigarettes, beedis, alcohol, paan masalas and gutka, personal vehicles etc. For instance, tobacco, which kills 670,000 people in India each year, is a Rs. 45,000 crore industry and a 2 percent health cess would generate Rs. 900 crore annually for the public health budget. Similarly alcohol, which presently also generates about Rs. 45,000 crore in revenues, can bring in substantial resources if a 2 percent health cess is levied. The same logic can be applied to personal transportation vehicles both at point of purchase as well as each year through a health cess on road tax and insurance paid by owners. Land revenues and property taxes can also attract a health cess which is earmarked for public health (municipal taxes already have an education cess component).

Fourth, social insurance can be strengthened by making contributions similar to the Employees State Insurance Scheme (ESIS) compulsory across the entire organised sector and integrating ESIS, Central Government Health Scheme (CGHS) etc. with the general public health system. Also, social insurance must be gradually extended to the other employment sectors using models from a number of experiments in collective financing like sugar-cane farmers in south Maharashtra paid Re 1 per tonne of cane as a health cess and their entire family was assured healthcare through the sugar cooperative. There are many NGO experiments in using micro-credit as a tool to factor in health financing for the members and their family. Large collectives, whether self-help groups facilitated by Non-Governmental Organisations, or self-employed groups like headload workers in Kerala, can buy insurance cover as a collective and provide health protection to its members. At least 60 percent of the workforce in India has the potential to contribute to a social insurance programme. But the bottom line is that all these resources should be pooled in a single health fund along with tax revenues so that delivery of healthcare is common to all and not discriminatory on the basis of the contribution one has made.

Fifth, other options to raise additional resources could be various forms of innovative direct taxes like a health tax similar to profession tax (which funds employment guarantee) deducted at source of income for employed and in trading transactions for self-employed. Using the Tobin tax route is a highly progressive form of taxation which in an increasingly service sector based economy can generate huge resources without being taxing on the individual as it is a very small amount of deduction at the point of transaction. What this basically means is that for every financial transaction, whether cheque, credit card, cash, stock market, forex etc., a very small proportion is deducted as tax and transferred to a fund earmarked for the social sector. For example, if 0.025 percent is the transaction tax, then for every Rs. 100,000 the transaction tax would be a mere Rs. 25 or one paisa per Rs. 40 transacted. This would not hurt anyone if it were made clear that it would be used for social sectors like health, education, public housing, social welfare and so on. In fact, where the stock market is concerned, which is anyway speculative in nature, a one percent transaction charge on the daily turnover of Rs. 150,000 crore could net in close to 8 percent of GDP annually. So, in this era of high economic growth, raising additional resources is not the issue; it is the lack of political will to prioritise healthcare which is the concern.

The above are just a few examples of what can be done within the existing system with small innovations. But this does not mean that radical or structural changes should not be done. Ultimately if we have to assure universal access with equity, then we have to think in terms of restructuring and reorganising the healthcare system using the rights-based approach. This requires a multi-pronged strategy of building awareness and consensus in civil society, advocating right to healthcare at the political level, demanding legislative and constitutional changes, and regulating and reorganising the entire healthcare system, especially the private health sector.

Thus, we have to stem the growing out-of-pocket financing of the healthcare system and replace it with a combination of public finance and various collective financing options like social insurance, collectives/common interest groups organising collective funds or insurance. At another level, the healthcare system needs to be organised into a regulated system that is ethical and accountable and is governed by a statutory mandate, which pools together the various collective resources and manages autonomously the working of the system towards the goal of providing comprehensive healthcare to all with equity. This will happen only if the entire healthcare system, public and private, is organised under a common umbrella through a single-payer mechanism which operates in a decentralised way[6].

The Latest Budget

Let us review briefly Union Budget 2011-12 to see whether the government is on track and is serious about moving towards universal access to healthcare.

The 2011-12 budget overall shows that there is further compression in public spending. There is a southward trend in the budget

with the estimates indicating only a 13 percent nominal increase over the previous year and a decline in the budget estimate as a proportion of the GDP by more than 1 percent point to14 percent of GDP, this happening despite the real growth rate being over 8 percent. Similarly, tax revenues of the Central budget have remained stagnated at around 10 percent of GDP. The Centre has failed to net in increased revenues from the growing national income. And the present budget does not give any indication that the Tax: GDP ratio will move northwards. Unless the latter happens, we cannot expect public spending, especially for the development and social sectors like rural development, health, education, welfare, housing, and so on, to grow significantly. Today, public spending on health is a mere 1 percent of GDP when WHO recommends that it should be at least 5 percent. The government over the last six years has not been able to move towards its own target of 3 percent of GDP for health. The share of the Central government in public spending for health is a mere 0.25 percent of GDP when as per the UPA target, it should be 40 percent of 3 percent of GDP, that is, 1.2 percent of GDP or Rs. 86,400 crore at today's prices.

In contrast to that, the Ministry of Health allocation is only Rs. 30,456 crore, short by Rs. 55,944 crore as per commitment of the UPA government. Of the Rs 30,456 crore, Rs. 1,700 crore or 5.5 percent of the Health Ministry's budget goes to HIV/AIDS, which has been accorded a status of a separate Dept in this year's budget; Rs 771 crore goes to Health Research, mainly ICMR, and its institutions and Rs. 1,088 crore to AYUSH (Dept. of Ayurvada, Yoga and Naturopathy, Unani, Siddha and Homoeopathy) . The Health and Family Welfare department gets Rs 26,897 crore, of which Rs. 16,140 crore goes to the National Rural Health Mission (NRHM), Rs. 5,435 crore to the Central Government Hospitals and Medical Colleges, and a further Rs. 653 crore goes for healthcare of Central government employees under the Central Government Health Services (CGHS) - a whopping Rs. 3,628 per Central government employee in sharp contrast to about Rs. 500 per capita which all state and the Central governments together spend on healthcare for its citizens

Under NRHM, some of the key allocations are Rs. 1,238 crore for the various National Disease Control Programmes like TB, Vector borne diseases, blindness. leprosy etc., Rs 3378 crore for Family Welfare, Rs. 240 crore for RCH, Rs 511 crore for routine immunisation and Rs. 664 crore for polio, Mission and RCH Flexipool Rs. 8,776 crore. In addition, NRHM also gets funds of Rs. 1,784 crore under the NE special programme and Rs. 247 crore under AYUSH.

So what does this tell us? The overall spending on healthcare by the government is certainly very low when we consider global standards. As a consequence, the out-of-pocket burden for citizens, especially so of the bottom two quintiles, is huge - about Rs. 3,000 per capita. Within the Central budget, the allocation to the Health Ministry has increased by 21 percent over the previous year and gives the impression that health and other social sector programmes are an important priority for the government. This is largely due to the political push under the flagship programmes and is a good sign but when we look at actual expenditures, then this optimism is belied. Actual spending in the social sectors like health and education are invariably 10-15 percent less than the budget estimates and often in the key programmes like NRHM and Sarva Shiksha Abhiyan as also pointed out in the audits conducted by the Comptroller and Auditor General of India. This year for the first time, the Central budget has included actual expenditure for 2009-10 and we see that for the Health Ministry the overall shortfall in expenditure, as per the budget estimates, was 8 percent and 10 percent for the plan component of the budget, most of which goes as grants to state governments. However the surprise is (actual expenditures are still provisional) that NRHM shows an actual expenditure in excess of 17 percent (7 percent excess in plan expenditures), largely due to the RCH and immunisation programmes and pumping in of non-plan resources (whopping increase from the Rs. 72 crore in budget estimates to Rs. 1,397 crore in actual expenditure) which certainly shows an increased commitment on the part of the Central Ministry of Health. Perhaps 2009-10 was the year for the consolidation of the NRHM programme but this came as a cost to the medical care sector under the Ministry of Health, which means that public hospitals and teaching hospitals were neglected, their shortfall in expenditure being as much as 20 percent

To conclude, while the UPA government seems to be inclined towards strengthening the public health system by giving a larger weightage to the health sector in budgetary allocations, overall this is not enough because there is significant compression of overall public spending. The consequence is that this impacts public health spending and the neglect of the public health system continues.

[1] The jajmani system was a set of economic interrelations across caste groups in the local community which had social sanction and linked to it mandatory social obligations. While at one level it facilitated economic organisation of the local community and assured livelihoods within both productive and service sectors, at another level it also restricted occupational mobility because occupational assignment under such a system was caste based, especially for service occupational categories. Hence the jajmani system also kept intact the economic basis of the caste system. Today it is largely destroyed but may be found in pockets in most states, especially the Hindi heartland.
[2] http://www.oecd.org/document/39/0,2340,en_2649_201185_2789735_1_1_1_1,00.html accessed 2nd August 2005
[3] WHO (2004). World Health Report -2004, Geneva, WHO
[4] These estimates are calculated by the author based on an assessment that the rural healthcare system effectively gets one-third of the budgetary resources.
[5] To train one MBBS doctor the governments spend between Rs. 15 and 20 lakhs and thus has every right to expect a minimal amount of public service in return.
[6] See the Medico Friend Circle Bulletin 342-344 August2010-Jan 2011(www.mfcindia.org) for a detailed debate on this issue

Table 1: Key Data on out-of-pocket expenditures, source of finance and for not seeking care across expenditure quintiles and social groups, NSS 52nd Round, 1995-96

	I Poorest	II	III	IV	V Richest	SC/ST	Other	All
Outpatient								
Rural								
Rs. per episode	77	94	124	130	174	92	138	128
Urban								
Rs. per episode	95	141	139	164	225	122	166	160
In-patient								
Rural								
Rs. per Hosp.	1020	1197	1495	1931	4595	2789	3133	3102
Urban								
Rs. per Hosp.	835	1499	1964	2765	7470	2046	4303	3921
Debt and sale of assets (%)	47	45	42	42	32			43
Did not seek care (%)	24	21	18	18	9			17
Cost as factor in not seeking care (%)	33	23	21	22	15			24

Source: Compiled from NSS 52nd Round data files, NSSO, New Delhi, GOI, 1998

Table 2: Per 1000 Distribution of Hospitalised by Type of Facility during 1986-87 and 1995-96, India - NSSO

Hospital	Rural		Urban	
	1995-96 (52nd Rd.)	1986-87 (42nd Rd.)	1995-96 (52nd Rd.)	1986-87 (42nd Rd.)
Public Hospital	399	554	418	595
PHC / CHC	48	43	9	8
Public Dispensary	5	-	4	-
All Govt. sources	**438**	**597**	**431**	**603**
Private Hospital	419	320	410	296
Nursing Home	80	49	111	70
Charitable Institution	40	17	42	19
Others	8	17	6	12
All Non-Govt. sources	**562**	**403**	**569**	**397**
All Hospitals	1000	1000	1000	1000

Source: NSSO (1998): Report No 441 on Morbidity and Treatment of Ailments, NSS, GOI

Table 3: Percentage Distribution of Non-Hospitalised Treatment by Source of Treatment during 1986-87 and 1995-96, India - NSSO

Source of Treatment	Rural		Urban	
	1995-96 (52nd Rd.)	1986-87 (42nd Rd.)	1995-96 (52nd Rd.)	1986-87 (42nd Rd.)
Public Hospital	11	18	15	23
P.H.C. / C.H.C.	6	5	1	1
Public Dispensary.	2	3	2	2
ESI Doctor, etc.	0	0	1	2
All Govt. sources	**19**	**26**	**20**	**28**
Private Hospital	12	15	16	16
Nursing Home	3	1	2	1
Charitable Institutions.	0	0	1	1
Private Doctor	55	53	55	52
Others	10	5	7	3
All Non-Govt. sources	**81**	**74**	**80**	**72**
Total	100	100	100	100

Source: NSSO (1998): Report No 441 on Morbidity and Treatment of Ailments, NSS, GOI

Table 4: Health Expenditure Trends in India

Year	Total Public Health Expenditure (Rs. crore)	% of GDP	Private Health Expenditure (Rs. crore)	% of GDP	% Private to Total Health Expenditure
1975-76	678	0.90	2466	3.26	78.43
1980-81	1286	0.99	5284	4.06	80.43
1985-86	2966	1.19	9054	3.61	75.32
1991-92	5640	0.96	16065	2.73	74.01
1992-93	6464	0.74	17557	2.61	73.09
1993-94	7681	0.98	19543	2.50	71.78
1994-95	8565	0.93	27859	3.04	76.48
1995-96	9601	0.89	32923	3.07	77.42
1996-97	10935	0.88	37341	3.00	77.35
1997-98	12721	0.92	45899	3.30	78.30
1998-99	15113	0.94	65340	4.04	81.21
1999-00	17216	0.96	83517	4.76	82.91
2000-01	18613	0.98	98168	5.18	84.06
2001-02	19454	0.94	110000	5.32	84.90
2002-03	19732	0.88	125000	5.60	86.36
2004-05	25800	0.85	170000*	5.3	86.82
2006-07	36500	0.91	210000*	5.8	85.19
2007-08	43100	0.90	240000*	5.1	84.78
2008-09 RE	51600	0.96	260000*	4.83	83.44
2009-10BE	590	1.01	2750*	4.7	82.33
2010-11BE	650	1.04			

* Estimates by author for private expenditures; RE=revised estimates, BE=budget estimates
Source: Public: Finance Accounts of Central and State Governments and RBI's Finances of State Governments, various years;
Private: CSO – GOI – Private Final Consumption Expenditures, National Accounts Statistics, 2003

How far are we from Universal Health Coverage in India?

Abhijit Das and Moumita Ghosh*

The rapidly deteriorating public health system in India has come under some policy attention in the last five years or so. While there is some degree of consensus on the fact that the current moribund public system cannot serve the health needs of the population, there are some radical divergences in approaches to the solutions. One school of thought, and which has the support of a section of the international financial organisations, is to continue with the rapidly growing trend of privatisation including the facilitation of the privatisation processes of current public health institutions. Others argue that there is a case for strengthening existing public health infrastructure and services.

The concern for improving health systems in India is not just the result of an internal concern. In 2005, WHO member states adopted a resolution encouraging countries to develop health financing systems aimed at providing Universal Health Coverage (UHC). This was defined as securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost. Thus, universal coverage incorporates two complementary dimensions in addition to financial risk protection: the extent of population coverage (i.e., who is covered) and the extent of health service coverage (i.e., what is covered)[1]. UHC entails strengthening health systems for better outreach, apt governance and management including financial sufficiency and innovations in resource pooling and spending. Universal coverage provides an essential operational framework for actualising the right to health.

Public health spending in India – Promises, Aspirations, Reality

Many of us who are now over 40 years of age were probably born in public hospitals, but few of our children were born there. This transition is symptomatic of the changes that have taken place in our health system over the last 30 years. Health systems were affected by the first wave of economic liberalisation. Supported by the economic crisis and changing economic priorities, the private sector in health started growing by leaps and bounds. But this was only possible because the public hospitals now were starved of funds and soon the situation was that public investment in health in India (as a proportion of GDP) was among the five lowest nations in the world at less than 1 percent (WHO recommends 5 percent) It is not surprising that while India's economic prowess is celebrated, and we count ourselves as part of the exclusive G-20, our healthcare indicators continue to hover near the bottom quintile (20 percent) of the world's countries. These shortcomings were acknowledged when the National Health Policy was articulated in 2002. It was however the first UPA government that made a firm promise to increase public spending on health to at least 2-3 percent of GDP through its National Common Minimum Programme (NCMP) announced in 2004. The National Rural Health Mission was launched the next year. Since then, the government has made some increases in public investment on health but with a 7 to 8 percent growth in GDP, the overall investment in health continues to be well below 1.5 percent of the GDP.

National Health Accounts (NHA) is a mechanism to understand and analyse health related expenditures and allocations. India has started this process over the last 10 years. NHA 2004-2005 show government and private expenditure on health to be around 20 and 80 percent respectively. By source, the Central government accounted for 6.78 percent while state governments contributed 12 percent. Under private expenditure, households contributed a significant portion at 71.13 percent of total health expenditure with social insurance funds at 1.13 percent and private employers at 5.73 percent. The total external aid contribution was very low at 2.28 percent of the total health expenditure. Private providers of health in 2004–05 accounted for 76.74 percent of the health expenditure incurred[2].

The 11th Five Year Plan (2007 – 2012) recognised the low public health spending and promised to increase it to at least 2 percent of GDP by the end of the plan period. It recommends innovative health financing mechanisms drawn from some successful state experiences like:

- comprehensive risk pooling packages through the public system and through accredited private providers;
- community based health insurance (CBHI) initiatives based on some individual contribution to the premium, along with a government subsidy;
- health insurance for the unorganised sector;
- maternity health insurance;
- incentives for providers linked with performance to check attrition and so on.

The Gross Budgetary Support in the 11th Plan was Rs. 120,374.00 crore (at 2006–07 prices) and Rs. 136,147.00 crore (at current prices) which is about four times the initial outlay for the 10th Plan (Rs. 363,78.00 crore). A large proportion of this amount, i.e., Rs. 89,478.00 crore (65.72 percent) is for the National Rural Health Mission (NRHM), the flagship health initiative of the Government of India.

NRHM was conceived as an overarching framework for channelising and effective utilisation of funds in the public health sector. It was supposed to be the main vehicle to increase government health expenditure to 2-3 percent of GDP. The resource needs projected and the actual allocations and releases are given in Table 2.

Clearly the allocations and releases have not matched the promises!

Extending Coverage

While financial allocations are an important prerequisite to ensure adequate health services, it does not automatically ensure that the poorest of the poor can access them and for all their needs. Health insurance schemes are notorious for their exclusionary clauses. "Fee for service" was an important slogan promoted by the votaries of health sector reform. Across many countries in Africa, free public health systems were transformed into fee for service systems. The results were not very encouraging. In many places hospital attendance for even vital services like childbirth related services fell. Many states in India started adopting this mechanism under the guidance and support of donor "partners". It was only with the introduction of NRHM that the services were meant to be free for the poor was explicitly articulated. However, some states still continue to impose a fee for service regime. This confusion over "fee for service" or "free service" continues into the hospital management committee or Rogi Kalyan Samiti (RKS) debate. Hospital Management Committees were established in the pre-NRHM era when collection and utilisation of "user fees" and local revenue generation was considered to be an important local management function. The RKS on the other hand is expected to keep the users' interests paramount, because the funds it is expected to manage are provided as "untied" funds and grants as part of the NRHM package. Madhya Pradesh is one state which has not yet managed to transition into the NRHM paradigm.

Free services for the poor have now become an acceptable paradigm but there is still a lack of clarity about what is the range of services that will be free. NRHM incorporates a notion of "service guarantees" and the implementation framework spells out a list of concrete service guarantees for different levels of services viz. Primary Health Centre,

Table 1: India's Health Expenditure (in %)

Expenditure	NHA 01-02	Share of GDP	NHA 04-05	Share of GDP
Public funds	20.3	0.94	19.67	0.84
Private	77.4	3.58	78.05	3.32
External	2.3	0.11	2.28	0.10

Source: National Health Accounts 2004-05, Ministry of Health and Family Welfare, Govt. of India

Table 2: Financing National Rural Health Mission (amount in Rs. Crore)

Year	Central Government Resource Allocation	State Contribution	Total	Allocation	Release
2005-2006	6500	-	6500	6731.16	5862.57
2006-2007	9500	-	9500	9065.00	7361.08
2007-2008	12350	2179	14529	11010.00	10189.03
2008-2009	17290	3051	20341	12050.00	11229.47
2009-2010	24206	4272	28478	14050.00	11631.39
2010-2011	33884	5980	39864	15440.00	
2011-2012	47439	8372	55811	16140.76	

Source: www.mohfw.nic.in

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Community Health Centre. However, there is no mention or record of any mechanism through which this guarantee can be invoked. In effect, this list of services is an aspirational list for a particular level of facility. There is an accompanying set of Indian Public Health Standards which are expected to be met to provide the Concrete Service Guarantee. Even though the NRHM is over five years into its seven-year lifespan, less than half the facilities in the NRHM high focus state will be IPHS compliant or in a position to provide the concrete service guarantee.

At this point in time there is also a lack of clarity about the nature of coverage – financial and therapeutic – beyond the level of the district hospital. I would like to illustrate this with an example that I am very familiar with and which relates to maternal health services. Maternal health, especially the Janani Suraksha Yojana (JSY) has become the most visible face of NRHM. It includes a cash incentive to all women in the NRHM high focus states (and for the poor in the non high focus states). While there is provisioning for normal deliveries, and for emergency transport and emergency obstetric care up to the district hospital, there is no clarity about what happens when the district hospital is unable to manage an emergency. Enquiries that I have made through various sources indicate that once the "Lakshman rekha" of the district hospital is breached, the coverage ends. And this is for the "signature" programme of the "flagship" scheme. One wonders what it is with other health situations.

Achieving Universal Health Coverage - Thailand experience

The problem of universal coverage may appear intractable, especially for a developing country like India. However, Thailand is one country which has been able to achieve universal coverage in the very recent past. It formulated a policy on universal coverage in 2001 that contributed to designing three major public health insurance schemes subsuming the earlier schemes and ensuring 100 percent coverage. Apart from providing separate schemes for the government and private employees, the UHC or "30 Baht scheme" covered the rest of the population (around 75 percent of the population) who were not beneficiaries of the other two schemes. Under this scheme, the previously uninsured population had to give a premium of 30 baht to get universal coverage. Later, this premium/co-payment was removed. Table 3 summarises the characteristics of the Thailand system.

Table 3: Financing Health Protection in Thailand

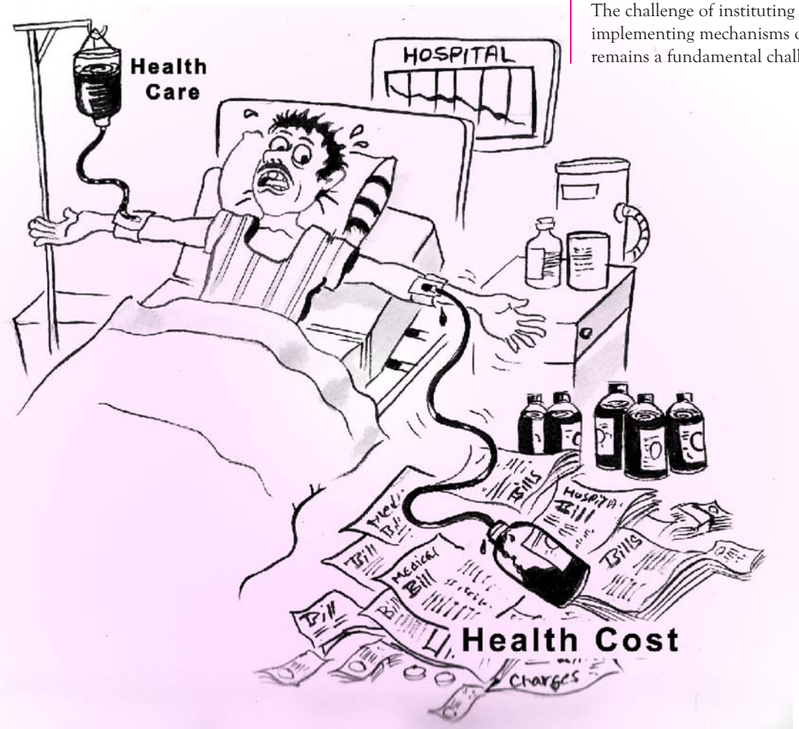
Characteristics	Social Security Scheme	Civil Servants' Medical Benefit Scheme (CSMBS)	UC/ 30 - Baht Scheme (now without copayments)
For whom	Private employees	Government employees, public sector workers and their dependents that includes parents, spouses and children	Self employed and those not covered by other two schemes
Nature	Compulsory	Fringe benefit	Compulsory
Source of finance	Contributions by employees, employers and the government	General taxes	General taxes
Provider Payment Mechansim	Capitation (Testing Diagnostic Related Group payments for inpatient care)	Fee-for-service (Testing Diagnostic Related Group payments for inpatient care)	Global budget and capitation
Benefits	Comprehensive package with: Outpatient and inpatient services in public and private facilities; Maternity benefits Immunization and health education With cash benefits	Comprehensive package with: Outpatient services in public facilities; Inpatient services in public and private facilities (emergency cases only); Maternity benefits Annual physical check up benefits	Comprehensive package with: Outpatient and inpatient services in public and private facilities; Maternity benefits; Immunization and health education
Access to a provider	Through a contracted hospital or its network; with registration requirement	Member is free to choose a provider	Through a contracted hospital or its network; with registration requirement

Source: Attaining Universal Health Coverage: A Research Initiative to support evidence-based advocacy and policy-making Egea, 2010

Contemporary efforts in India

While the Thailand scheme seems reasonably straightforward, its implementation in the Indian scenario will be fraught with challenges. As a part of the preparatory processes towards the formulation of the 12th Five Year Plan, the Planning Commission has constituted a High Level Expert Group on Universal Health Coverage. This group is currently deliberating to develop a model healthcare system encompassing a range of issues that include service provisions, management reforms and accountability, community participation, human resources, provisioning of drugs and vaccines and not just the issue of financing. The group is discussing alternative approaches for progressively reorganising health systems. Some of the challenges that the group is seized with include issues relating to the unregulated private sector, linkages between the social determinants of health and service provision, urban health, coordination between the Centre and states and so on.

While the government has committed itself to raising allocations, there are doubts whether this alone will be sufficient to alleviate out-of-pocket spending of the poor or prevent impoverishment. There are doubts whether it will check the high attrition in health workforce or even facilitate more recruitment of health professionals. There are also fears that an increasing flow of resources into the public health system could mean higher incidences of leakage and misappropriation of funds. The challenge of instituting and implementing mechanisms of accountability remains a fundamental challenge in India.



[1] http://www.who.int/bulletin/volumes/86/11/07-049387/en/
[2] National Health Accounts: India, 2004-2005

Universal Health Coverage: Maximising Corporate Profit to Minimize People's Pain?

Indranil*

Health system in India is among the most privatized in the world. Of the total spending on health, with 71 percent coming from people's pocket, the government share is less than a fifth. Almost 60 percent of hospitalisation and four out of every five short duration ailments are treated in the private sector. Increasing domination of private sector in service delivery led to high dependence of people on their own means to manage health care expenses, leading to indebtedness and poverty; prolonged marginalization of a large section of population from any access to modern health care system and uncontrolled escalation of profits of the private sector and especially the corporate hospitals. The Indian state has not only remained silent to the agonies of people, it has adopted a whole range of "Health Sector Reforms" like gradual withdrawal from providing health services, cut back public spending on health, privatization and commercialization of existing facilities and services, provision of subsidized land and other incentives to systematically help private sector grow. The growth of private sector is very much in the interest of the rich and the privileged and the bias towards private sector is clearly evident from government policies and its spending priorities.

All of a sudden, when there is the talk about universal access to health care to protect people from catastrophic health expenditure, one finds no reason to believe that it would be done without safeguarding the interests of the private super-specialty hospitals, nursing homes, the specialists and surgeons. Apprehensions turn into conviction when we follow the recent developments in health policy and planning in the country. There are concrete indications that health financing is being geared up to provide health insurance using various means including private insurers and private providers. The 'call for action', in the Lancet India series, the framework for Universal Health Coverage (UHC) developed by the High Level Expert Group on Health (HLEGH) for the 12th Plan clearly point towards such a design. This piece will attempt to deconstruct the logic behind this design, based on international experience and the Indian context, that though there cannot be any compromise on universalisation of health provisioning, the cause may be defeated if we depend heavily on private sector.

Public spending on health in India is among the lowest in the world when compared in terms of share of GDP and per capita spending. There were only seven countries in the world (Myanmar, Guiana, Lao PDR, Pakistan, Azerbaijan, Cote d'Ivore, Singapore) which spent lesser proportion of GDP on health in 2007. Some developing countries like Brazil, Chile, Costa Rica, Cuba, Colombia, Thailand, Malaysia, South Africa, which have made significant efforts in recent history towards provisioning of universal access to health, spend much higher proportions of GDP on health. Governments in neighbouring countries like Sri Lanka, China, and Nepal could mobilise more resources towards health than what was done in India. Per capita public investment on health in India is almost at the same level with the average of the low income countries (LICs) and much lower than the low middle income countries (LMICs).

This clearly points to the essentiality of public investment in ensuring universal health care and draws home the point that the current level of spending in India is clearly unacceptable. Countries like Brazil, Thailand, and South Africa which have recently attempted to universalize have stepped up public spending on health to 3-5 percent of GDP. However, it should be noted here that the increase in investment has not been sudden in many cases and was taken up gradually.

It is encouraging to see that a consensus among policy makers is gradually emerging that the present system of financing has to change and India should strive for universalisation. Let us quickly look at three important developments that took place in the last couple of years to understand the direction in which health financing is going. The National Health Bill was put up by the government in late 2009 for wider consultations. Lancet published a special volume on universal coverage of health in India in early 2011 and Planning Commission set up the HLEGH in February 2011, whose final report is due in June 2011. Both the Bill and the Lancet report are proposing that universal 'coverage' should be an immediate priority of the government. It is worth noting here that the emphasis is on coverage rather than on provisioning. Even the Terms of Reference of the HLEGH asks the Group to suggest a strategy for Universal Health coverage but not systems or provisioning. Lancet "call for action" lays bare what all is on the cards. It proposes setting up an "Integrated National Health System" including public and private health providers. According to

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Table : International comparison of government expenditure on health (2000- 2007)

	General govt. expenditure on health as % of GDP*		General govt. expenditure on health as % of total expenditure on health		Per capita govt. expenditure on health (PPP in $)	
	2000	2007	2000	2007	2000	2007
Bangladesh	1.0	1.1	38.0	33.6	8	14
Brazil	2.9	3.5	40.0	41.6	202	348
Chile	3.4	3.6	52.1	58.7	320	507
China	1.8	1.9	38.7	44.7	42	104
Colombia	5.5	5.1	80.9	84.2	314	435
Costa Rica	5.0	5.9	76.8	72.9	360	656
Cuba	6.1	9.9	90.9	95.5	341	875
India	1.1	1.1	24.5	26.2	16	29
Malaysia	1.7	2.0	52.4	44.4	159	268
Nepal	1.3	2.0	24.9	39.7	11	21
Pakistan	0.6	0.8	21.3	30.0	10	19
South Africa	3.4	3.6	40.5	41.4	223	340
Sri Lanka	1.8	2.0	47.9	47.5	49	85
Thailand	1.9	2.7	56.1	73.2	89	209
South-East Asia Region	1.2	1.3	31.2	36.9	18	36
Low income	1.8	2.2	37.6	41.9	14	28
Lower middle income	1.6	1.8	37.0	42.4	35	76

Source: World Health Statistics, 2010. * derived from WHS

them "...comprehensive health insurance that is financed through a combination of public, employer, and private sources" would be rolled out (Lancet Call for Action, pp 763). Apart from financing and regulating, the roles of government as envisioned in the volume are to ensure provisioning in rural and underserved communities and preventive and promotive work.

At a cursory glance, the goal of eradicating out-of-pocket spending through universal provisioning might look promising, given the spiraling household spending on health. However, there are certain important contradictions between the goal and the design that need to be highlighted. To start with, eradication of out-of-pocket spending is a narrow goal; it should rather be one of the key strategies to achieve 'health for all'. This distinction becomes important because the goal drives the strategy. Universal health systems and coverage mean two entirely different things. While universal health system proposes a progressive socialization of health care and gradual undoing of commoditization of health care, universal coverage merely means that a financing system is developed to cover majority of people against expenses but provisioning is done essentially through market. In the following section, I highlight some key challenges with designing insurance-based models and highlight the caveats of private provisioning-based systems through international experience.

Of late, there is a renewed interest on universal coverage among international agencies that prefer insurance mechanisms than tax financed options. It is argued that insurance can increase the availability of resources for health care freeing up limited public funds to be directed towards poor people. It offers a more predictable source of funding compared with the unpredictability of tax finances. Moreover, insurance allows risk pooling; protects people from financial burden and uncertainty; it allows purchaser provider split which improves quality. One may not like to disagree with all these arguments but one would like to point out that the success of health insurance depends on the kind of insurance models adopted and the country context, especially the way health service is shaped.

There are three broad models of health financing observed globally - public assistance systems that serve the majority of a nation's population via government facilities supported by general tax revenues; health insurance systems that rely on public and private third-party mechanisms to cover the population for fee-for-service medicine; and national health service systems that cover the entire population by means of salaried health care providers working in public facilities. However, in each of these systems we can identify the variations in nature of State intervention. In the first case, the government sets up and runs its

own health system; in the second, the services are provided by private sector or the government or by both, while in the third, the government purchases the services and provides insurance to the population. In some countries, government provides insurance partially while the rest is purchased by the employers through private insurance providers. Among the different insurance models, tax financed insurance, mandatory social insurance are the most dominant forms, whereas private health insurance (PHI) and community based insurance (CBHI) are also there in some countries. In spite of the lack of evidence of success, PHI and CBHI are being aggressively promoted by international agencies.

Globally, around 100 countries have health financing systems which are predominantly general government tax financed; 60 odd countries have system of mandatory health insurance financed by pay roll-tax. Only a few countries have financing system which is predominantly private insurance financed. Practically most countries have a combination of all these. Developed countries depend heavily on either general taxation or mandated social health insurance contribution. In contrast, low income countries depend far more on out-of-pocket spending.

The problems of PHI are well documented. The most common feature of PHI models is that it leads to huge escalation of costs, siphons off resources from public sector thus, leading to deterioration of quality of services and widening of inequalities. Where it is voluntary, it remains limited to upper income groups thus making little contribution to inclusion or solidarity. A lot of emphasis is required in regulating private health insurance, when at times the cost of regulation goes up to 30 percent of the premium.

Global experience suggests that most of the developing countries do not have the capacity to regulate private health insurance and private hospitals. Despite significant efforts by the US government to regulate private sector, the experiments have largely failed to contain costs and make the system inclusive. Presently, 15 percent of US GDP goes to health financing and still a considerable proportion of people remain uncovered. The experience of Chile with private insurance shows that it covers only affluent, young, and urban men, with substantial drain of public resource and higher per person costs; whereas the compulsory national insurance scheme took care of four-fifth of population at much less cost. The success of Chile also can be attributed to sharp increase in public health expenditure to improve infrastructure, hire more personnel, and provide better equipment and salaries.

There are some developed countries where social insurance has worked well. But the nature of insurance is such that it depends on formal employment and compulsory contribution. Countries like Germany, the Netherlands, and Canada where vast majority of people are employed in formal sector; social insurance has helped provide solidarity. Social insurance has been more successful in contexts where provisioning is largely done by public sector and there is single purchaser. This is well-demonstrated in the case of Costa Rica where there is single authority which purchases health services and at the same time provisioning is dominated by public sector. The cost of regulation is much less in Costa Rica compared to countries like Chile or Columbia. But in the context of a developing country where majority of the population works in the unorganised sector, the effectiveness of social insurance to ensure coverage has remained limited.

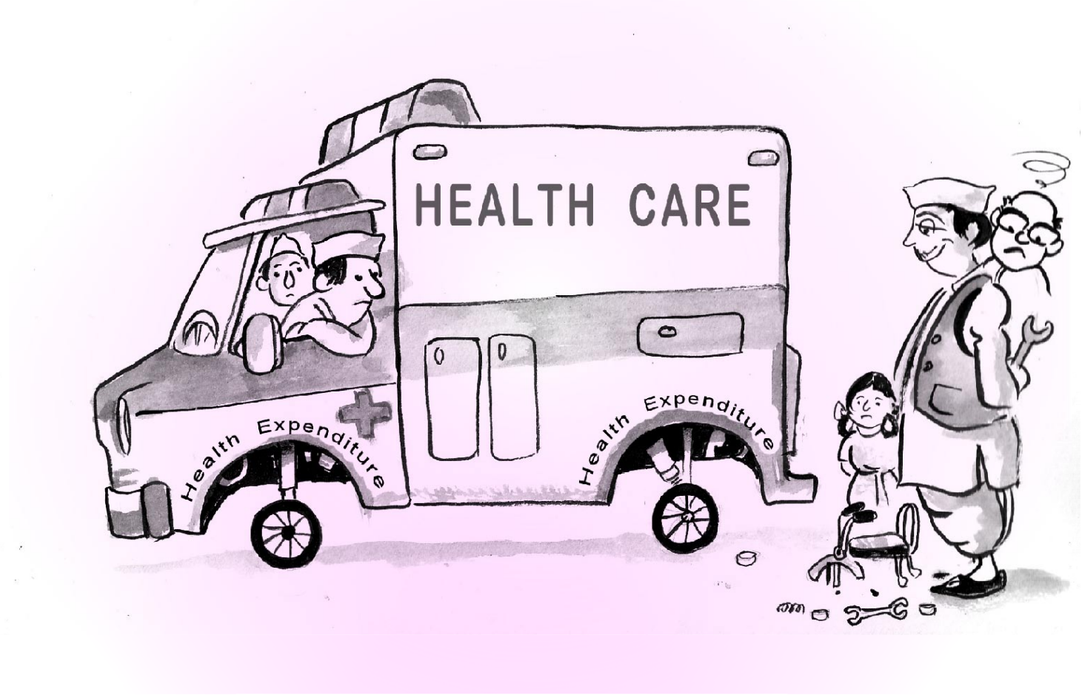
Thailand is one of the few developing countries to achieve universal coverage of health care policy through tax financed health insurance model. Attempts to achieve universal coverage have been ongoing for two decades, but progress sped up in the last decade. For a lower-middle-income country like Thailand, its 2001 policy of Universal Coverage of Health Insurance (UCS) was a bold political decision. After five years of implementation, defying apprehension by international agencies about its failure, the UCS has a record of success and sustainability and has evolved into a system with strong social involvement and ownership, and political commitment. Thailand started serious investments in their health care infrastructure in the public sector five decades ago. They realized well in advance that health personnel are the people who must deliver quality health services and who therefore need to be involved, supported, and nurtured, so as to build enough technical capacity, morale, and spirit to deliver "humane" health services to all.

There are several important lessons that we can draw, which may help us identify the best suited model for our country. Firstly, public sector-led provisioning is a must, in order to curtail cost and ensure equity. This has been demonstrated in all kind of contexts from the most developed countries like UK, Sweden, middle income countries like Costa Rica and Chile or developing countries like Cuba, Sri Lanka, Thailand, and Brazil. This is irrespective of the nature of insurance that the countries have opted for. The choice for insurance model in India is also limited to a compulsory tax financed model with single purchaser; this would reduce cost of care through greater bargains.

As discussed earlier, there is hardly any evidence that a country has been successful in ensuring universal health coverage at a manageable cost in private dominated health system. In India, where health provisioning is largely dominated by private sector and with limited capacity and political and bureaucratic will to regulate private sector, a private provisioning-led insurance scheme may have disastrous consequences. It would definitely act as a guarantee towards profit of the private sector; consequently it would cause a huge dent in the public fund, which would necessarily squeeze resources devoted to public hospitals that are anyway severely resource starved. These are not mere conjectures but observations based on concrete evidences from other countries.

Not that our national planners and advisors placed in esteem institutions are unaware of the dangers of private sector-led model. The proposed design actually fits the agenda for greater private investment in health sector. From the perspective of private sector, India is a huge market with a population of more than 100 crore. The 'problem' is that most people do not have adequate purchasing power to afford expenses of private hospitals. Despite efforts from the government to incentivize setting up private hospitals, the uncertainty about the demand has limited the growth of big private hospitals in smaller towns and villages. In such places, private sector only means the quacks, individual practitioners, and small nursing homes. The proposed design would be ideal to ensure a big market for the larger players and foster their growth.

The question about which kind of health insurance mechanism we adopt is deeply political. The experiences of developing and developed countries alike show that it is only through political mobilization that progressive health reforms have taken place. The experience of developed countries during post second world war period, the recent example of Thailand, Brazil, Venezuela are testimony to the fact that peoples interest are being safeguarded only when their voice is strong enough to overturn the vested interests of private health lobby. The failure of the US government to bring about progressive measures despite some popular protest also shows the might of private lobby. In India, where corporate lobby seems to be very strong and there is hardly any political mobilization around health rights, the possibility to ensure universal health rights seems bleak.



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Access to Essential Medicines: A Dream for Most Indians

Narendra Gupta*

India is called the world's pharmacy because it exports quality medicines to about 200 countries. It is the third largest drug producing country in the world. Whenever there is any instance of natural or other forms of humanitarian crisis, global organisations procure medicines from here in huge quantities. Countries which import medicines from India include the U.S., Japan, Australia and countries in Europe that have very stringent quality regulations. Half of the total pharmaceutical production of India is exported at rock-bottom prices, the industry is pegged at Rs. 1 lakh crore but it is at the number ten position in terms of value.

While India is able to arrange for highly affordable treatment for patients of HIV/AIDS and other diseases from countries of Africa and elsewhere, ironically, about 65 percent of Indian citizens do not have access to essential medicines, according to the World Medicines Situation Report 2004 of WHO[1]. How this is possible and why it is happening are questions that need answering.

The Indian market is glut with medicines sold in over 100,000 different names by countless pharmaceutical companies. No country in the world sells drugs with these many different names, while the fact is that there are only about 350 essential medicines and about 550 active pharmaceutical ingredients. Most medicines are essentially single ingredient and/or combination or permutations – some rational but a lot irrational or not essential. These different names, which can confuse and mislead, are there because different companies sell medicines with similar ingredients in similar proportion under different names. Some companies sell the same medicine under several names with different packaging and with different price tags to cater to various social and economic segments of citizens. For instance, Cipla, a company known for production of low cost quality generic medicines produces the anti-allergic tablet cetrizine dihydrochloride 10 mg under three different names – Okacet (MRP printed Rs. 27.50 for 10 tablets), Cetcip (MRP printed 33.65) and Alerid (MRP Rs. 37.50). It is however astonishing that Cipla supplied 10 tablets of Alerid to Chittorgarh Sahkari Bhandar, Rajasthan, for just Rs. 1.88 and the Okacet for Rs. 1.84.

Another example is that of a medicine called Imatinib used for treating chronic myeloid leukemia - a type of blood cancer. It is produced by three companies – Novartis, Natco and Cipla – in India. Packs of 120 capsules of this medicine are sold for Rs. 114,400 by Novartis, Rs. 10,800 by Natco and Rs. 10,200 by Cipla. However, Cipla supplies these 120 capsules to Indian Railways at just Rs. 6,500. It should be noted that none of these companies sell the medicines with any subsidy. All of them are making good profits, which is borne by the fact that the shares of most established pharmaceutical companies has been increasing phenomenally in the stock market.

There is more to it than meets the eye when one reads the "maximum retail price" (MRP) printed on wrappers of medicines and compares it with the actual price for which these medicines are sold by the companies in bulk. The price differences and its nuances are mind-boggling, and the common citizen has to pay what is printed as MRP[2]. These unaffordable prices of medicines are one of the major barriers for the common people from obtaining correct and full treatment.

Another plausible question would be: When the actual price of a medicine is several times less than what is printed, why is the Government of India not banning it? Well, earlier all 315 essential medicines were under price control but gradually, owing to pressure of the pharmaceutical industry and India adopting the open economy policy owing to pressure of the neo-liberal forces, a new Drug Price Control Order was passed in 1995. Since then, only 76 and after 1997, only 74 medicines have remained under price control. Unfortunately, a large number of drugs under price control are either not produced or are produced in far less quantity then companies are licensed for. Pharmaceuticals companies have also found ways to circumvent the Drug Price Control Order by combining medicines with drugs not under price control. Its consequences are highly damaging as essential medicines required for treating major health problems remain in short supply while the market is flooded with unnecessary and sometimes irrational medicines which can be sold with any mark-up.

An important reason for people's inability to access essential medicines is the inadequate public spending on health in India. The total health spending in the country is to the tune of 4.8 percent of the GDP but about 72 percent of this is private expenditure, while government spending is less than 1 percent of the GDP - one of the lowest in the world.

Almost the entire private expenditure is out-of-pocket and more than 80 percent of this is on purchase of medicines and investigations. Because of the huge out-of-pocket expenditure during 1999-2000, about 32.5 million patients fell below the poverty line after just a single hospitalisation[3]. Forty percent of those hospitalised were forced to borrow money or sell assets to meet costs[4], and 18.4 percent of the morbidities remained untreated.

Although, there is no clear and firm estimate on how much public spending is essential to ensure a reasonable level of healthcare, the WHO assumes that it should be around five percent of the country's GDP. The UPA-led government at the Centre had committed in its political manifesto before the general elections in 2004 and in 2009 to increase the public health expenditure to 2-3 percent of the GDP but this has not increased at all even with the introduction of the National Rural Health Mission since 2005.

What it Takes to Provide Universal Free Treatment in India

Since patients pay out of their pockets for medicines and there is no price control, most healthcare providers in the public system prescribe irrational/unnecessary expensive drugs because pharma companies pay bribes in various forms to them based on sale of their drugs. In the process, citizens end up paying several times more than the actual price of the medicine and are over-medicated. The only way out to save patients from this huge drain is that the government ensure free treatment to all patients who come to seek services in public health institutions. This would curb the practice of prescribing irrational/unnecessary medicines. Its other more important effect would be treatment through standard procedures and enormous savings from rising microbial resistance – the current theme of the WHO on World Health Day 2011.

Currently, the per capita public expenditure on medicine in different states of India ranges from Rs. 2 to Rs. 22 per annum. While Tamil Nadu spends the maximum, that of Rajasthan is the lowest followed by states which have poor health indicators, such as Uttar Pradesh, Bihar, Madhya Pradesh, Odisha, Chhattisgarh and Jharkhand. Some estimates of the fund requirements have been worked out by the Commission on Macro Economics and Health based on national burden of diseases, treatment cost per episode based on standard treatment procedures with use of quality generic medicines available at the lowest cost. The other estimate is based on market calculations. Both these calculations suggest that about Rs. 75 per capita or Rs. 9000 crore would be required to provide free medicines to all out patients. This is one seventh of the annual allocation for government interventions like the National Rural Employment Guarantee Scheme. This additional allocation will not jack up the public spending even up to 2 percent of the GDP. Therefore, it is doable and needs to be done urgently.

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[1] http://apps.who.int/medicinedocs/en/d/Js6160e

[2] Visit the website of the Low Cost (Generic) Medicines Initiative, Chittorgarh, http://chittorgarh.nic.in/Generic_new/generic.htm to understand the nuances of MRP

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Maternal Health: Suggested Budget Priorities

Jashodhara Dasgupta*

The global burden of maternal mortality is borne disproportionately by the women of sub-Saharan Africa and South Asia; with one in every 70 women in India facing the risk of maternal death (WHO 2010 quoting 2005 data). India has had special programmes to promote maternal well-being since the early nineties such as the Child Survival and Safe Motherhood (CSSM) programme, followed by the Reproductive and Child Health (RCH) programme that attempted an integrated approach. Despite substantial reduction in the number of maternal deaths, concurrent with lowered fertility and fewer births, progress on this continues to be uneven. Some states continue to have a persistently high burden of maternal mortality in India with an inequitable distribution across regions; some states have actually shown increase in their rates of maternal mortality in the recent past.

Maternal Mortality Ratio in India: A Ten Year Perspective

MMR or Deaths per 100,000 live births

Major States	MMR (1997-98)	MMR (1999-01)	MMR (2001-03)	MMR (2004-06)
Assam	568	398	490	480
Bihar/ Jharkhand	531	400	371	312
M. P. /Chhattisgarh	441	407	379	335
Orissa	346	424	358	303
Rajasthan	508	501	445	388
Uttar Pradesh/Uttarakhand	606	539	517	440
Andhra Pradesh	197	220	195	154
Karnataka	245	266	228	213
Kerala	150	149	110	95
Tamil Nadu	131	167	134	111
Gujarat	46	202	172	160
Haryana	136	176	162	186
Maharashtra	166	169	149	130
Punjab	280	177	178	192
West Bengal	303	218	194	141
India Total	398	327	301	254

Source: Registrar General India, (Sample Registration System), 1997-98, 1999-2001, 2001-03, 2004-06

The recent global commitments to the Millennium Development Goals (MDGs) have spurred the Indian government to show immediate reduction in unsafe childbirth practices. This has led to a scheme which offers a cash transfer to women conditional to their giving birth in hospitals. The Mothers' Protection Scheme (Janani Suraksha Yojana) also involves the ASHA (Accredited Social Health Activist) identifying pregnant women, promoting their early registration for ante-natal care and accompanying them for hospital births. Considerable resources have been spent on this scheme already and expenses will escalate further in the coming year.

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Can JSY alone reduce Maternal Mortality?

We need to examine more deeply whether such a vertical programme approach is adequate for solving a complex problem like maternal mortality and morbidity. Around 85 percent of all childbirth occurs normally and can be conducted within communities or at hospitals with minimum medical intervention. Nonetheless, a largely unpredictable 15 percent are likely to face complications that are potentially life-threatening and require skilled care as well as supplies like blood and oxygen. Given the uncertainties of transportation and decision-making, the government planned to have the maximum number of pregnant women actually in hospital before such emergencies arose. But the critical element that is missing here is the capacity of hospitals to provide skilled care in case of complications.

The facility surveys of the District Level Household Survey (DLHS 3[1]) show a dismal picture in 2005 and in 2008. In states that have the highest rates of maternal death, the health centres are chronically understaffed, staff skills are inadequate to handle emergencies and there is shortage of the required medicines, supplies and equipment. In such a scenario, there is an urgent need to strengthen these facilities even as pregnant women are urged to give birth in hospitals. The performance audit report of Comptroller and Auditor General of India on the National Rural Health Mission (NRHM)[2] has also traced that women who were registered during pregnancy did not choose to attend institutions during delivery, indicating that certain barriers are responsible and need to be identified

There is an additional issue of the sheer numbers involved. Since roughly 25 million women give birth in India each year, the overcrowding of hospitals is likely to prevent providers from giving due attention to high-risk cases and those requiring emergency treatment. Skilled care is also unavailable for abortions or treatment of post-abortion complications and miscarriages. Cases documented from several states[3] show that providers may turn away women in labour or demand money before helping them in childbirth.

The analysis of the major causes of maternal deaths (SRS 2006[4]) shows that heavy bleeding was responsible for most deaths. Anaemia makes the situation very dangerous, and a very high number of women in India are and continue to remain anaemic since 1999. The NFHS 3 report[5] said 55 percent of women in India are anaemic, mainly those with no education, or from Scheduled Tribes or in the lowest wealth quintiles. It is a matter of great concern that anaemia in women who are breastfeeding or pregnant has risen five percentage points since the last NFHS 2 survey in 1998-99. Anaemia is affected by the nutritional intake of women and their vulnerability to infectious diseases. Within the health programme, it is currently tackled only through iron tablets during pregnancy that may or may not be absorbed by the body. A significant reduction in anaemia will require many more interventions, such as food security for all families, a balanced and adequate diet for women during their life-cycle, addressing gender inequities in intra-household distribution of food, as well as safe water and sanitation to avoid infectious diseases, and primary care to treat such infections. The social determinants of health thus have a strong bearing on the prevention of maternal mortality.

How should Budgets be spent for Maternal Mortality Reduction?

The question then arises, how would the government's budget be spent in the best interests of the women and effectively prevent maternal mortality and morbidity? The possible solutions are, to strengthen the management of the health system in order to provide the best care to women, to radically increase the numbers of skilled providers, to stop paying money as a conditional cash transfer and instead support all women with unconditional maternity benefits and ensure resources to support swift transportation of complicated cases to well-equipped hospitals.

Currently India has very inadequate data on the extent, causes and trends of maternal mortality. Apart from a detailed report by the Registrar General of India in 2006 describing the situation from 1997-2003, there have been no further comprehensive studies published within the country. Given that maternal health conditions affect a few million women, and several tens of thousands lose their lives each year, the need for investing in updated and continuous surveillance and reliable data is imperative. Moreover, the social inequity trends in maternal care indicated by the NFHS 3[6] report need to be carefully examined by disaggregating all findings by class, caste, religion and rural-urban location.

In many states of India with poor health indicators, the government health system suffers from a chronic shortage of skilled personnel. There are major gaps in the human resource management, such as proper recruitment and retention policies, human resource development policies, and methods to increase staff morale and motivation to provide respectful and ethical care to the poor. Acute shortage of allopathic doctors and their diversion to private practice requires some far-sighted thinking on the medical training and its orientation. Improved training and deployment of nurses could provide them as an alternative where there are no doctors. The retention of health providers in rural areas requires creative approaches, where non-cash incentives could include clear career paths, opportunities for higher education, support for children's education and better housing facilities; measured patient satisfaction could increase chances of promotion.

Beyond human resources, the management of the health system is also plagued by poor logistics where drugs and supplies are concerned, and inadequate planning and projection of requirement. The ad hoc use of the private sector to supplement the services is often through poorly managed contracting that finally deprives the poorer

patients of affordable care. Health budgets need to invest in building a cadre of public health managers who can support the medically trained officials. Increase in health financing is urgently needed to provide primary and secondary care completely free of cost.

Beyond health systems, the budget also needs to ensure maternity benefits for all women, not just those few who are employed in the formal sector. The loss in wages for three months of maternity leave needs to be compensated so that women do not face exacerbated poverty due to missing work in pregnancy and after childbirth, and are not compelled to return to work too soon. The maternity benefits have in the past been both conditional and extremely meagre, thus making no impact on maternal well-being; and there needs to be a clear policy revision in this regard. Budget allocations also need to see food security, safe water and total sanitation as important contributors to maternal well-being.

However, increased budget allocations will achieve very little without institutionalised transparency and accountability. Within the government system there are several institutions for accountability such as the CAG, the parliamentary oversight bodies, the checks and balances among the three arms of government. But at the interface between provider and pregnant women who are the users of maternal health services, these are not helpful. Information asymmetry and unequal power relations prevent poor women users from holding providers or health managers to account for denial or poor quality of health services, or lives put at risk. Budgets and policies therefore need to institutionalise popular participation in setting health priorities, as well as to invest in building capacity for community monitoring of health services and health outcomes.

[1] District Level Household and Facility Survey 2007-2008, MoHFW and IIPS: Mumbai; seen on 4 April 2010 at http://nrhm-mis.nic.in/ui/reports/dlhsiii/INDIAREPORTDLHS3.pdf

[2] Union Audit Reports- Union Government (Civil) Performance Audit Report No. 8 of 2009-2010, (Audit of the NRHM conducted from April to December 2008) obtained from CAG website http://www.cag.gov.in/html/reports/civil/2009_8_PA/contents.htm seen on 15 July 2010

[3] See presentations at Global Maternal Health Conference 2010 (New Delhi, India) of an unpublished block-level study from six states on poor women's experiences of attempting maternal care in institutions - http://www.sahayogindia.org/pages/programmes/maternal-health-and-rights/events.php

[4] Sample Registration System – Maternal Mortality in India:1997-2003, Trends, Causes and Risk Factors, Registrar General of India 2006

[5] NFHS 3- International Institute for Population Studies and Macro International, 2008, National Family Health Survey India 2005-06, Mumbai: IIPS

[6] The NFHS 3 data on ante-natal services and delivery care received also points to stark differences based on poverty, literacy and caste

Regulating government doctors' private practice when "Codes of Ethics" fall short

Biraj Swain*

With the thrust on coverage and access to healthcare, the load on public institutions has increased. Governments (state and national) are responding with infrastructural up-gradation. Healthcare practitioners working in developing countries face constraints that are shaped by inadequate resources, health-workers' shortage, weak health-care systems. To add to this is the globally observed phenomenon of physicians working under conditions that increasingly prevent them from living up to their highest ideals, which might be creating "ethical violence[1]".

However, service provider perversion leading to bleeding of public health systems is not just a function of ethical violence. Growing patient load has been attributed for the dip in the quality of interaction between doctors and the patient, but there is more to it than what meets the eye. The dipping quality of patient-care has been attempted to be tackled through techno-infrastructural responses which could be insufficient and inadequate.

There is a need to investigate these challenges when the nature of load becomes the determinant in terms of quality of care (or lack of the same) and when fiduciary relationships dictate the terms of interaction and behavior of the healthcare professional. This becomes more complex in the context of under-performing BIMAROU (Bihar, Madhya Pradesh, Rajasthan, Odisha and Uttar Pradesh) states.

Inadequate Human Resources, Complexity of Service Provision and Negotiation:

- Every health worker covers a radial distance of about 3 kilometres[2] to provide healthcare services and conduct other allied functions.
- A sub-health centre caters to an average area of 24-36 square kilometers and four to six villages[3].
- Less than 25 percent Primary Health Centres are functional 24X7 (round-the-clock).
- Road penetration is abysmal resulting in crucial delay.
- Qualified Human Resources: There is shortage across all categories i.e.
  - Auxilliary Nurse Midwife,
  - Nursing staff, and
  - Doctors.
- Infrastructure (especially bed strength) is a critical concern.
- Acute shortage of medical colleges: There is an overall shortage of government medical colleges across the country as per population adequacy norms. The private colleges, more often than not, with their fee structures, quality of faculty and laboratory conditions leave a lot to be desired.

In the context of all the above realities, qualified human resources become very powerful in their negotiating position vis-à-vis the state and the public at large because of their sheer shortage. Considering that there is already a fiduciary relationship between the public and the healthcare professionals, i.e. the doctor in particular, this power asymmetry becomes even more skewed.

The proposed 5 percent misery tax on seeking private health-care in corporate hospitals and its consequent withdrawal has been variously trumped as public health activists' victory but in truth, it is a sad recognition of the public health infrastructure and the forcible bleeding of the patients by the private practitioners.

Disguised Private Provisioning:

On the surface, many sites present the encouraging scenario of limited private provisioning. But it would be naïve to assume that the absence of private practice signage on bill-boards and buildings actually means absence of private provisioning of healthcare. In fact it is the clandestine nature of private provisioning by public sector doctors in the name of quality care that makes planning for public health a challenge and regulation of the health sector an onerous task!

Home-based practise by public sector doctors is a common phenomenon and allowed during non-working hours. But whether the practise is actually limited to non-working hours is a moot point. Besides, since the regulators at district and sub-district levels display a reluctance to regulate, the challenge becomes more complex.

Some of the usual arguments that are encountered in defense of this behavior are as follows:

- Patient load at public institutions make quality interaction an impossibility
- Risk aversion means need for diagnostic report a priori to prescription and treatment
- The linkages means many institutions are constantly catering to patients' referrals from adjoining institutions and districts
- If certain patients/care-seekers are willing to pay for a better quality care

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then what is the harm

In a country where public health systems do not allow any interaction between patient and doctor beyond 1-2 minutes, practicing empathy, conversation, decoding symptoms via conversation and observation is a real challenge. Under the circumstances, when doctors offer these in their homes/clinics/nursing homes during their consultancies, it becomes a desirable interaction for any patient and this interaction is construed as quality care.

The same doctors, who are willing to provide quality care at home/private clinics, would:

- Refuse to deal with patients appropriately in the public institution
- Re-route them to their private practice destination
- Charge for the consultation and advisory in the public institution
- In case of accident victims, attend to medico-legal paraphernalia first before attending to the victims

The State's Response:

The governments, at federal and sub-national level, have been bringing about a series of progressive changes. With National Rural Health Mission, the government has been raising the discourse for better healthcare provisioning and better compensation for healthcare practitioners in public sector, such as:

1. Introducing two tranches daily for out-patient consultation
2. Mandating public health institutions to prominently display
   i. Provision of free treatment
   ii. Provision of free medicines
   iii. Encouraging patients or their attendants not to pay any charges to the hospital staff for treatment received
3. Scaling up Rogi Kalyan Samitis for hospital management and bringing in a modicum of patients rights into the healthcare domain
4. Encouraging doctors to attend to critical care/trauma patients/accident victims on a priority basis, both in public and private institutions and encouraging progressive medicine by providing guarantee and protection against medico legal procedural complications
5. Making rural posting mandatory before post graduate admission
6. Introducing Difficult Areas Allowance to compensate the healthcare providers working in the peripheries for the hardships incurred

While all this has led to increasing the remuneration and benefits of the doctors in particular and healthcare providers in general; in the absence of effective regulation, the perversion continues mostly unabated. The district and sub-district administrators are mostly reluctant regulators who are yet to be convinced with the need for such steps and hence consequently their implementation.

Way Forward: A Thought Experiment

Along with the body of initiatives already underway at the federal and state level, some incremental changes that will go a long way in the reforms' implementation and ethics adherence are as follows:

- Setting the appropriate metrics for monitoring and appraisals of the doctors, trainings and the systems' changes
- The tenurial security and transparency in decision making needs to be integral to the system
- While the MBBS curriculum is nationally determined, the emphasis on certain contents like Ethics can still be addressed by the Department of Medical Education at the state level
- Nursing curriculum, which could be influenced at the sub-national level, i.e. state level needs to look at building leaders rather than mere doctors' assistants in the nursing cadre
- The reforms initiated to make the department more accessible needs to be done with all sincerity
- Recognition of the sincerity and initiative of the district level regulators (health administrators) to regulate private practice amongst public sector doctors especially in the backward districts
- Introducing a dedicated Human Resources cell with specialists rather than clubbing it with establishment and infrastructure responsibilities
- Introducing zero-hour at every district management meeting for the doctors to share their angst, their experiences of ethical violence and addressing the recurrent and dominant concerns through system responses

What about Medical Council of India and its State avatars?

With the complexities of regulation in the context of acute shortage of healthcare professionals and the paradigm of pecuniary benefits threatening to become the dominant discourse, there is an increased need for the Medical Council of India and its state chapters to live up to the challenge. The litmus test of effective regulation in essential services has certain criteria i.e.:

1. All parties concerned need to be involved in rule-making
2. The parties need to be equal in terms of power
3. Common interest needs to prevail over individual interest
4. The rank and file of the parties involved need to be bound by all the clauses
5. Need to function in open and be controllable (else there will be the undesirable consequence of "Who will regulate the regulators")
6. Appropriate means of enforcement must be established

However, MCI regulations falls far short on many counts listed above. The next best thing in such a scenario is legislated self-regulation. While governments try to legislate, the partnership necessary to equate MCI's regulations to legislative instruments are still lacking.

MCI codes treat the professional/doctor as a unitary entity with omnibus codes and do not take cognizance of the location of the professional. Surely doctors located in the public sector committed to the public health goals need better guidelines. In terms of pecuniary benefits being subservient to beneficience[4] and making a case for charity, Homeopaths' Code is the only code spelling that explicitly.

Substantive clauses in the MCI codes are dedicated to regulation and intra-profession codes and camaraderie. However, public sector doctors' adherence to the substantive principles of public health commitment remains largely missing. This calls for a partnership and open dialogue with the public health departments willing to change the professional cadre in a collaborative rather than confrontational mode.

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Budget and Policy Tracking

Sakti Golder

Despite the remarkable economic prosperity achieved by India for a fairly long period, the country is still plagued by hunger with among the highest rates of malnutrition in the world. Various forms of deprivation such as lack of access to basic healthcare facilities, school education, clean drinking water, and sanitation afflict a majority of the population, which is unable to reap the benefits of sustained economic growth, leaving them poor and on the fringes of society. Perhaps with this realisation, an attempt at inclusive growth was rightly initiated in the 11th Five Year Plan period (2007-12) to ameliorate the plight and suffering of the masses. Since then, inclusive growth is a buzzword among commentators, policy makers and politicians. However, a systematic and comprehensive appraisal of the 11th Plan clearly reflects that the slogan of "inclusive growth" is not adequately backed by a paradigm shift towards "people-centred planning and development". Further, instead of adopting a holistic strategy, the approach of the 11th Plan has been piecemeal in nature. While some programmes/schemes were initiated during the 11th Plan period, they have not been implemented seriously. For proper implementation of any programme/scheme, adequate financial resources are a prerequisite. While significant outlays were recommended for many major schemes in the 11th Plan, only a fraction of the proposed outlays were made in the Union Budgets in the entire Plan period. Union Budget 2011-12 was the last budget of the 11th Five Year Plan period. Naturally, it was expected that the Union government would step up allocations significantly, especially in the social sector, to fulfill the expenditure targets set in the 11th Plan. However, it offered little in terms of firming up its intent to ensure inclusive growth, especially to address critical concerns pertaining to the social sector. The present piece would provide a brief overview of the provisions made in the Union Budget 2011-12 and some of the recent policy developments.

Box 1: Priority for Social Sectors in Union Budget 2011-12: An Overview

The Union Budget 2011-12 while paying some attention to a few important concerns pertaining to agriculture, infrastructure and climate change, seems to have completely neglected the social sectors as allocations for the social sectors do not give any cause for cheer. The total Union Budget outlay for social sectors (excluding Non-Plan Capital Expenditure on such sectors that is usually very small and sporadic), has gone down from 1.9 percent of the Gross Domestic Product (GDP) in 2009-10 to 1.8 percent of GDP in 2011-12 (BE). Moreover, with the Union Budget contributing funds worth only 2 percent of GDP for social sectors (such as education, health, water and sanitation), the country's total budgetary spending on these sectors continues to be less than 7 percent of GDP in 2009-10, whereas the comparable figure for social sector spending by the Organisation for Economic Co-operation and Development (OECD) countries is as high as 14 percent of GDP.

Pertaining to resource mobilisation by the government, the tax-GDP ratio (which is the gross tax revenue for the Centre as a proportion of the GDP) shows a small increase from 10 percent in 2010-11 (RE) to 10.4 percent in 2011-12 (BE), which is significantly lower than that for several other countries. Moreover, it has been indicated that the tax-GDP ratio for the Centre would increase only up to 11.3 percent by 2013-14, which implies that the tax base of the economy is expected to be stagnant over the next three years. This raises serious concerns, especially for financing of the social sector.

Education

The United Progressive Alliance (UPA) promise to fulfill the Kothari Commission recommendations of 1966 is still due as India's total public spending on Education at 3.39 percent of GDP (2008-09) is nowhere near the promised level of 6 percent of GDP. Looking at specific schemes, while the outlays for Sarva Shiksha Abhiyan have been increased from Rs. 15000 crore in 2010-11 (BE) to Rs. 21000 crore in 2011-12 (BE), the scheme can hardly succeed in operationalising the Right to Education Act with this magnitude of funds. As per the Centre's own estimation - a modest one from the point of view of quality - additional budget outlays for elementary education required for operationalising the Right to Education Act would be Rs. 1.82 lakh crore over a period of five years. Hence, if just one-fifth of this had to be allocated in 2011-12 with the Union Budget contributing only half of it, the outlay for SSA should have been increased at least to the level of Rs. 33000 crore. However, there are only some sops for education sector in Budget 2011-12 such as a new scheme for the Scheduled Castes (SCs) with an outlay of Rs. 196 crore, increase in the outlays for Rashtriya Madhyamik Shiksha Abhiyan (RMSA) by Rs. 923 crore and some minor increases in the budgetary provisions for some other schemes.

Health

The outlays for Health & Family Welfare have hardly been increased since the last few years. When seen as a proportion of the country's GDP, public spending on health has increased from 0.32 percent (2.1 percent of total Union Budget) in 2010-11 (RE) to 0.34 percent (2.4 percent of total Union Budget) in 2011-12 (BE). As a proportion of GDP, the combined expenditure of the Centre and States on Health works to around

1 percent in 2009-10 (it was around 1.02 percent in 2008-09), which is far short of the National Common Minimum Programme (NCMP) target of raising total public spending on Health in the country to 2 to 3 percent of the GDP. Allocations for National Rural Health Mission (NRHM) have shown a slight increase from Rs. 15,037 crore in 2010-11 (RE) to Rs. 17,924 crore in 2011-12 (BE) – hardly sufficient to augment the rural health infrastructure, fill in vacancies of doctors, auxiliary nurse midwives (ANMs), and paramedics. The Finance Minister had proposed extension of Rashtriya Swasthya Bima Yojana (RSBY) to cover unorganised sector workers in hazardous mining and associated industries like slate and slate pencil, dolomite, mica and asbestos. Undoubtedly a welcome development, it seems only rhetorical as the allocations have been reduced substantially to Rs. 279.94 crore in 2011-12 (BE) whereas it was Rs. 445.89 crore in 2010-11 (RE).

Rural Development

The priority for Department of Rural Development has been reduced as the 2010-11 (RE) outlays at Rs. 76378 crore have been brought down to Rs. 74144 crore in 2011-12 (BE). The Union government's total expenditure on rural economy (which includes expenditure on Agriculture and Allied Activities, Rural Development, Special Area Programmes, Irrigation and Flood Control and Village and Small Industries) has declined from 3.3 percent of GDP in 2008-09 to 2.3 percent of GDP in 2011-12 (BE). Outlays for key schemes have remained the same or declined: Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) [Rs. 40000 crore in 2011-12 (BE) from Rs. 40100 crore in 2010-11 (RE)], Swarnjayanti Gram Swarozgar Yojana (SGSY) (renamed the National Rural Livelihood Mission) [Rs. 2621 crore in 2011-12 (BE) from Rs. 2683 crore in 2010-11 (RE)] and Indira Awas Yojana (IAY) [Rs. 10267 crore in 2010-11 (RE) to Rs. 9896 crore in 2011-12 (BE)].

Agriculture

Allocations for extending the Green Revolution to the eastern region of the country comprising six states and the eastern part of Uttar Pradesh, providing high yielding variety seeds, technology and irrigation to the farmers, and for pulses and oilseeds in 60,000 rain-fed villages have been made.No significant policy pronouncements have been made in the budget, barring the lowering of interest to 3 percent for 2011-12 and fixing the higher target of rural credit at Rs. 4,75,000 crore - endeavours that would really benefit the farming community.

Food Security

Despite a growing recognition of the need for significantly expanding the coverage of the Public Distribution System (PDS) for foodgrains and the persistence of price rise in food articles, Union Budget outlay for Food Subsidy has been curtailed from Rs. 60,600 crore in 2010-11 (RE) to Rs. 60,573 crore in 2011-12 (BE). Further, outlays for Petroleum Subsidy have been slashed from Rs. 38,386 crore in 2010-11 (RE) to Rs. 23,640 crore in 2011-12 (BE). Given the predictions that international crude oil prices are going to rise further in the coming months, reduced subsidy in 2011-12 could result in further rise in prices of petroleum products and hence a persistence of the problem of price rise. Given the situation of mass deprivation and hunger in the country, the provision of food subsidy in the budgets appears inadequate.

Women & Children

The overall allocation for the Ministry of Women and Child Development has registered an increase of only 13 percent. Related to Women, sporadic measures are seen. The total magnitude of the Gender Budget has increased marginally from 6.1 percent in 2010-11 (BE) to 6.2 percent in 2011-12 (BE). A welcome step has been increasing the remuneration of Anganwadi Workers and Anganwadi Helpers within Integrated Child Development Services (ICDS) to Rs. 3,000 and Rs. 1,500 respectively. However, the number of ministries/departments reporting in the Gender Budgeting Statement has remained 33 with no significant revision in the format of the Statement. Allocations for several women-specific schemes such as Swadhar, Priyadarshini, and Support for Training and Employment Programme have declined as compared to the previous year's outlays.

The Union government's total allocation earmarked for Children has registered a small increase from 4.1 percent of the total Union Budget in 2010-11 (RE) to 4.5 percent in 2011-12 (BE). Within the "Child Budget" (i.e., the total allocation for all child-specific schemes) in 2011-12 (BE) amounting to Rs. 56748.6 crore, the share of Child Education is 76.4 percent, Child Development is 18.6 percent, interventions in Child Health account for 3.6 percent and those pertaining to Child Protection account for 1.33 percent. The increasing share of Child Protection in the total "Child Budget" from 0.60 percent in 2010-11 (RE) to 1.33 percent in 2011-12 (BE) is a welcome development.

Scheduled Castes (SCs) and Scheduled Tribes (STs)

As per Statement 21 and 21 A, allocations under the Scheduled Caste Sub Plan (SCSP) have increased to Rs. 30,551 crore in 2011-12 (BE) from Rs. 23,795 crore in 2010-11 while under the Tribal Sub Plan (TSP), the allocation has increased to Rs. 17,371 crore in 2011-12 (BE) from Rs. 5,445 crore in 2010-11. There is also a hike in outlays for primitive tribal groups from Rs. 185 crore in 2010-11 (BE) to

Rs. 244 crore in 2011-12 (BE). An appreciable step has been the introduction of a new Pre-Matric Scholarship, which would benefit about 40 lakh SC and ST students. In Union Budget 2011-12, separate allocations have been earmarked towards SCSP as per the recommendations of the Task Force on SCSP. These allocations will be shown in the Budget of the relevant ministries and departments under separate minor heads. From the analysis of allocations under TSP, a huge gap in the budgetary allocation for STs is clearly evident. In 2011-12, two positive developments have been introduction of a separate Budget Statement called 21 A specifically catering to STs and earmarking the TSP allocations under a separate Minor Head 796.

Minorities

Minorities have not been given much attention in this year's Union Budget except with regard to achieving the 15 percent target under Priority Sector Lending and increase in allocation of the Maulana Azad Education Foundation. The Ministry of Minority Affairs has allocated Rs. 2,850 crore in 2011-12 (BE) as compared to Rs. 2,600 crore in 2010-11 (BE). The Budget does not pay attention to issues relating to operationalisation of the Prime Minister's new 15-Point Programme even though there is a growing demand among civil society organisations to increase the ambit of the programme and to bring out a Special Budget Statement on the funds earmarked for minorities in different schemes under this programme.

Water Supply & Sanitation

The Union Budget allocations for rural water supply have increased by a small margin from Rs. 8,100 crore in 2010-11 (RE) to Rs. 8,415 crore in 2011-12 (BE). For rural sanitation, the budget allocations have shown only a negligible increase from Rs. 1,422 crore in 2010-11 (RE) to Rs. 1,485 crore in 2011-12 (BE). A less than 5 percent increase in the budget for rural water and sanitation is perhaps a reflection of the waning commitment of the government for this sector. In urban water supply and sanitation, the allocation for the Integrated Low-Cost Sanitation Programme has been reduced from Rs. 80 crore in 2010-11 (RE) to Rs. 71 crore in 2011-12 (BE). Despite water and sanitation affecting women's lives so significantly, the Department of Drinking Water Supply does not yet report in the Gender Budget (GB) Statement of the Union Budget.

Note: For further details, please refer to CBGA's analysis: UPA's Promises & Priorities: Is there a Mismatch? Response to Union Budget 2011-12, March, 2011

Issues debated in the Budget Session:

The most debated issues in the Budget Session were the auction of 2G spectrum, presence of black money in India, growing food inflation and concomitant price rise, farmers' distress owing to crop failure and price rise, poor implementation of public distribution system (PDS), and implementation of schemes like MGNREGS. Almost all of the opposition MPs as well as some of the MPs from the ruling coalition raised the issue of 2G scam. Many of them welcomed the formation of Joint Probe Committee (JPC). The issue of black money was intensely debated and many MPs unanimously raised their voice to bring back the huge amount (approximately 640 billion dollars as estimated by the Global Financial Integrity) of money, which is stashed away in foreign banks as black money.

Another issue that was raised was of the farmers' plight in the country. Agriculture is providing employment to 65 per cent of the unemployed but priority is still not being accorded to agriculture and the farmers. Although the Minimum Support Prices of wheat and rice have been increased in the recent years, the Government has not taken into account input cost of our farmers. Shri Rajnath Singh pointed out that "as per NSSO report, income of an agrarian family was Rs. 2115 in 2003-04 and it increased to only Rs. 2440 in 2011. It means that most of the farmers in India are forced to live below poverty line. Therefore, special attention should be paid towards agricultural sector. Food grains are rotting in the open in warehouses of the Food Corporation of India. When the Supreme Court has directed that this wheat should be distributed among the poor people free of cost, this Government said that it could not distribute this wheat free of cost to the poor." Legislators were in consensus to strengthen the PDS with some of them also demanding bringing some of the essential commodities under PDS. The Government has claimed that it would provide employment to 40 percent people of the country under MNREGA to remove poverty and starvation. However, the Union Government has not increased allocation for MNREGA in this Budget which was raised by many MPs. They also demanded that the workers be provided the statutory minimum wages.

Table 1: Inflation Rate in India

	2006-07	2007-08	2008-09	2009-10
All Commodities	6.51	4.82	8.03	3.57
Food	**7.99**	**5.97**	**9.07**	**14.52**

Source: Office of the Economic Adviser, Ministry of Commerce and Industry, GoI.

Price Rise/ Inflation:

The UPA-II regime is marked by its complete failure to contain this relentless rise in prices that is pushing crores of people to survive Below Poverty Line. It is evident from Table 1 that the inflation rate in India (measured by the Wholesale Price Index, WPI) has been rising continuously over the years. Inflation in food products is more prominent than overall rate of inflation. As per the latest data, overall WPI inflation stood at 8.4 percent in December 2010. In the week ending January 15, 2011, food inflation stood at 15.5 percent.

Several policies of the government could be attributed to this persistent price rise. One of the major causes of the price rise is deregulated prices of petrol, which led to price hike and a cascading impact on the prices of other commodities. One the other hand, future trading of several food items also directly pushes the prices of food articles upwards. Export-import policies of some food items are also to be blamed. To arrest this inflation, some policy measures should be immediately put in place such as a ban on speculative trading, release of excess foodgrain stocks rotting in Central government godowns to the states for sale through the PDS, and increasing the budgetary subsidy of petroleum.

Having outlined some of the key issues surrounding this year's Union Budget, it would be worthwhile to scan a few much-debated Bills that could impact a vast majority of the population. In this context, among numerous Bills tabled of late, the Pension Fund Regulatory and Development Authority (PFRDA) Bill, Labour Laws (Exemptions from Furnishing Returns and Maintaining Registers for Certain Establishments) Amendment Bill 2011, and Banking Laws Amendment Bill could have immense ramifications.

Bills in Parliament:

The Banking Laws Amendment Bill was introduced in the Lok Sabha on 22nd March 2011. The Bill, on the one hand, aims to empower the foreign bankers to dominate over private sector banks on Indian soil and on the other, to empower private sector shareholders in public sector banks to interfere in the functioning of these banks through enhanced voting rights.

The foundation of this bill was laid in the discussion paper circulated by the Reserve Bank of India, where RBI virtually called upon big industrial houses to own banks and take over the rural banks. The idea was later endorsed by the Finance Minister in his Budget Speech. The bill, according to Shri Tapan Sen, Member of the Parliament, is just another step towards surrendering to the pressure of global financial capital. They are of the opinion that the adoption of this policy is just to create a much bigger space for private sector banks and speculators, both domestic and particularly foreign, in the financial sector. It may further "squeeze the space of the nationalised banks through various policy interventions like merger of banks, reduction in number of branches in the name of duplication and other restrictive directions, thus putting them in a disadvantaged position vis-à-vis the private sector and foreign banks". Ultimately, it would end up with the diversion of the savings of the common people to speculative markets instead of development and employment generating projects. From the recent global financial meltdown, which was caused mainly due to the reckless speculation by the banking sector, the Indian government should learn a lesson and not expose the comparatively insulated public sector banks and insurance sector to the extremely volatile global financial market.

The Labour Laws (Exemptions from Furnishing Returns and Maintaining Registers for Certain Establishments) Amendment Bill, 2011, which would amount to relieving employers of establishments (employing up to 40 persons) from the obligations of almost all basic labour laws governing minimum wages, timely payment of wages, working hours, contract work, payment of bonus, and so on, was introduced in the Rajya Sabha on March 23. As a direct consequence, this would throw at least 78 percent of the workforce in the manufacturing sector alone out of the purview of labour laws and render them completely at the mercy of the employers. It is apparent that the main idea behind this bill is the persistent demands of the advocates of neo-liberalism in India for introduction of "labour market flexibility", that will give the employers unlimited authority to hire and fire without any hindrance. In this regard, they often lay the blame on Chapter VB of the Industrial Dispute Act, 1947 as being the main obstacle for employment growth in the manufacturing sector. The Bill is an attempt to dilute the Chapter VB as well as to weaken the other legal provisions for protecting the labour class. But many experts, including some of the neo-liberals, admit that the labour laws scenario in the country is "most rigid on paper" but "most flexible in practice". Violations of the labour laws are common place, particularly in the private sector in India. Furthermore, only a fraction of the entire labour force (8 percent) who are employed in the organised sector get some protection through labour laws. The remaining 92 percent are employed in the unorganised sector and are literally out of the ambit of the labour laws. In this situation, if the new bill is passed, countless workers would be denied any kind of legal protection. Even the organised sector would be severely impacted and the rights of employees visibly curtailed.

On March 24, 2011 the Pension Fund Regulatory & Development Authority Bill 2011 (PFRDA Bill), which is almost the same bill as was introduced in Parliament in 2005 with minor changes, was re-introduced in the Lok Sabha. Normally, government employees get pension at 50 percent of the last pay drawn and the pension amount gets revised periodically with the changes in price indices. This system of assured pensionary benefit i.e., the "benefit defined" pension system is going to be replaced by the "defined contribution" (i.e., the pension amount will be governed by what the employee's Pension Fund Account can earn from investment in the market). It is mentioned in the PFRDA Bill (both 2005 & 2011) that: "There shall be no implicit or explicit assurance of benefits, market-based guaranteed mechanism to be purchased by the subscriber" (Sec 20(2) (g) of the PFRDA Bill).

First, the market cannot guarantee any

assured return on investments, and this is more relevant in the present day situation with extreme volatility in both the money market and the share market. Second, the sole motive of the fund managers appointed by the PFRDA is earning their own profit. Obviously, they are expected to neutralise their risk first and then take care of the risk of the pensioners who actually supply capital to the fund managers through their life-time savings in the pension fund. Therefore, the PFRDA bill, according to different commentators, has paved the way for the new regime to replace assured pension by a pension system governed by the market forces, thus playing with the employees' life-time savings. They have also criticised it as being an onslaught on the social security right of the government employees. The fund-managers and brokers will have the last say on how the employees' savings will be invested.

Further, not only government employees, but the unorganised sector workers might also be affected through the PFRDA Bill as the government now plans to attract the savings of these workers for investment in the stock market on the same scheme of market-based uncertain returns. Recently, the government has introduced a new pension scheme, called "National Pension System" for unorganised sector workers (it is now known as Swavalamban). "Under this scheme the workers will have to contribute to pension fund a minimum of Rs 1,000 per year and maximum of Rs 12,000. After making a contribution for 30 years or so, at the age of 60 years, the worker will be eligible to get 60 percent of his contribution as lump sum and rest a pension of not less than Rs 1,000 per month, provided rest of his fund can ensure such return from the market. If his fund earns less, then the portion of lump sum receipt after retirement will go down and if his/her entire fund (100 percent of his contribution) fails to earn the minimum stipulated amount of pension (Rs 1,000) he/she has to make more contribution to be eligible for getting the minimum pension. To allure people towards this scheme, the government has announced that it will contribute Rs 1,000 every year for five years till 2015-16. Already, the government has started making aggressive efforts to enroll workers in the so-called Swavalamban scheme" (Sen, 2011). But one thing is amply clear from the above discussion that the new pension system will not ensure any secure pension amount for the unorganised workers despite his/her continuous contribution to the pension fund. The pension amount will be governed by the return earned through investment in the market.

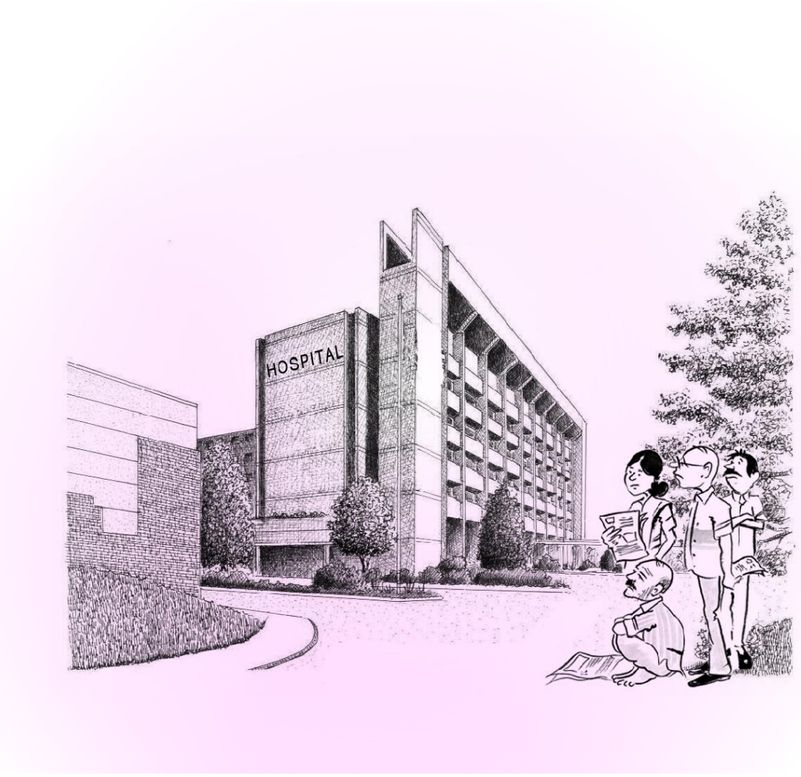
Lokpal Bill

In the past few months, numerous corruption charges have been levelled against politicians and bureaucrats, especially during the UPA II regime, cutting deep into the roots of Indian political scenario. Further, huge amounts of resources are alleged to be involved in these scandals. In these circumstances, it is imperative to take immediate action, which calls for putting in place a stringent legislation against corruption. In this context, a draft of the Lokpal Bill (2011), which seeks to appoint a Jan Lokpal or ombudsman to act as an independent body to investigate corruption, was formulated. But different commentators and civil society activists feel that the draft proposed by the Government of India is inadequate and will not serve the purpose. Therefore, it is very important that the government expedite the setting up of a mechanism in consultation with all political parties, civil society activists and concerned citizens' groups to finalise a new draft legislation.

Concluding Remarks:

India has been emerged as the second fastest growing economy in the world. But this economic prosperity coexists with the largest number of hungry people. In the latest Global Hunger Index 2010, India ranks 67th position, trailing behind Sri Lanka, Pakistan and Nepal. Further, the country alone is home to 42 percent of the world's underweight children, exposing the precarious food insecurity of the mass of the people. The widening inequalities become glaring from the fact that while 100 individuals in a country of 120 crore population own wealth equal to one fourth of the GDP, 84 crore are forced to survive on less than Rs 20 per day. This mammoth section of the population lacks even the basic amenities of life.

But the economic policies of the current regime have apparently failed to address the concerns of the common people. In addition, the failure to push for critical legislation in social sectors (barring education) has raised serious doubts about the government's stated commitment to enlarge the notion of entitlements for those at the bottom of the pile as well as to broaden the space for governmental responsibility. If the UPA is committed to its promises, it would have to go in for some serious course correction without further delay.



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