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 would seem 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 skyrocketing. 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 2008, in collaboration with National Human Rights Commission (NHRC), JSA had organised several public hearings across the country on the 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 economic context of healthcare financing in the country by tracing the move from Ayurvedic to pharmaceutical industry and its commoditisation of healthcare. He also charts the five steps to re-constructing the existing system to align healthcare in a rights-based approach. Abhijit Das and Manojit Ghosh follow this and examine how far the country is from achieving universal healthcare 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 deconstructs the focus 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, Jajmani Shastri 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 SurakshaYojana as the sole vehicle to address the issue of 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 duties and duties 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!

Inrana Qadeer*

In a democratic arrangement, it is often embarrassing for states to foster 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 prioritisation 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 jump in this period is undeniable 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 to support both to offset the negative impact of a miniscule foreign aid that sets as aside a wealthy and an uninsured seemed to be at public work. Apart from the fiscal and financial liberalisation that those shifts required, another important vehicle of change has been a series of new legislations. Legislation reflects the dominant social ethos of a country wanting to carry out a certain set of policies. The current state 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 promises - needed legislative protection. – in the face of protests and reminders of legislations indicates that the new policies required, minimal State that acts as a client, a state dependent on national and civil society; political compulsions of a private sector. These shifts were neither partnerships and shift of subsidies to the impact of cuts and rollback in welfare provisioning though ensuring health of welcome privatisation and commercialisation and shed the perspectives thus become shrouded in responsibility for free basic 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. Price and universal access to healthcare through third party payment is restricted to “those who are unable to meet their basic needs” (pp13 of the Draft Bill). The “immediate duty” to provide free and universal healthcare is only for “the vulnerable and the marginalised” (part 3, section I(l)). Hence, the rest of the poor are left out as no time plan is proposed to cover them. Second, the “vulnerable” (ii) 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 shuddering public sector at the tertiary level and the state’s responsibility towards provisioning Primary Healthcare to all is ignored. The state is permitted to retreat from provisioning by becoming the third party payer for its vaguely targeted population. The State is required to be the regulator of the extent. The health services and functions (a part of the health of the State) are never defined. Terms such as users, providers and caregivers fail to present with clarity any distinction 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 inevitably favours the private interests, be it the shift of subsidy, control over more paying facilities or, training of doctors and nurses. Thus, the partnerships 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 cathartic public sector including welfare, to ignore the key factor of employment/ livelihoods and minimum wages reflects an inherent bias. A bias first, if in the government’s decision to write off income tax Rs. 34,857 crore for the corporate sector and undermining of the National Rural Employment Guarantee Act and the Public Distribution System. Similarly, lifestyle diseases identified are cardiac vascular, diabetes, hypertension are defined as “diseases associated with the way of life?”. The fact that occupational diseases, undernutrition, anaemia and infectious diseases are not identified as outcomes of choice under compulsion, by people living in poverty reflects yet another bias. Over and above this is the fact that the judiciary and the Health Ministry are not 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 for a very while the targeted agenda to cover is 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 healthcare being unclear, the issue of standards of quality healthcare also remains fades. The promise for review of policies is unbecoming as the very law reflects complications of the economy rather than a rational review of past experiences and policies regarding people’s welfare despite several international conventions to which India is a signatory. Despite emphasising decentralisation, the Centre’s regulatory powers are enhanced and the states’ imposed and “vulnerable” 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 phase of the sector in the current global economy. The changing global balance in favour of structural adjustment has impacted the health scenario dramatically. Health sector investments are considered good business by the World Bank today while in the 70s, these were considered un-profitable. The major shifts over time have healthcare that 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-medicai factors have acquired priority over key social determinants of health and assessing efficiency of health systems in monetary terms rather than health outcomes.

Capitalism’s compulsion to open new areas of investment lie 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, those centres attempt primarily to integrate science and technology with business to gain a rational face to the solutions they offer. By using a reductionist biomedical 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”.

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 cardiovascular, respiratory diseases, cancers and other chronic conditions are expected to exceed 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 (H1N1) 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 Eis and Roger Glass) also point out that sciences are emerging partnerships in global health R&D have created numerous business models such as “The Medicines for Malari Ventures” and “TB Alliance”; those ventures manage two-thirds of identified drug development partnerships in global health. The same collaboration, the drug business but the two disease development projects for neglected diseases. The support to these new ventures includes patent pooling, humanization, licensing and access to small molecular chemical libraries in the private sector under appropriate legal arrangements, and market准入s such as estimates of demand, to engage corporate interest. These efforts might have increased the drug business but the two disease control partnerships 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...
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 Co-operation and Development (OECD) countries except the U.S. have single-payer systems which are single-autonomous public agency or a few coordinated agencies pool resources to finance healthcare. One of 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, which still rely mostly on out-of-pocket payments, which universal access to healthcare is elusive. In such countries, those who have the capacity to buy healthcare from the market must often get healthcare without having to pay for it directly, and those who suffer a hand-to-mouth existence are forced to make do with payments, often with a heavy burden of debt, to access healthcare from the market. India is the most prioritised 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 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 medicine in their practice and operate within the market context. In case of hospital care, the transition has been very difficult. 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, the medical education made a major transition; post-graduation, specialization and superspecialization became sought after and the charlatan of medical practice changed. Specialists on one hand began setting up private running homes and the corporate sector on the other hand began to show interest in entering the hospital sector. Ako, major changes in medical technology, which hastened the process of commodification of healthcare, made for-profit hospitals a lucrative proposition. By the 1990s, the State was already decentralizing investments in the hospital sector and this was a clear 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 in 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 inefficient. Expenditure estimate based on National Accounts Statistics indicate that private expenditures on healthcare in India are about Rs. 72,000 crore and 98 percent of this is out-of-pocket. Public expenditures on healthcare are about Rs. 60,000 crore. Additionally, this adds up to 52 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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* Ravi Duggal is a Senior Analyst and Trainer associated with the Washington-based International Budget Partnership (IBP). His research work has covered 11 countries across Asia, for issues of interest include health policy and financing, women’s health issues, private health sector regulation, health insurance and micro credit.
for the poorest households, the bottom quintile is $150 versus $400 for the Below Poverty Line (BPL) or on the threshold of subsistence, and when illness strikes, such households just collapse. In fact, for the poorest quintiles, the ratio of their income financing health expenditures is 2 to 4 times more than the average mentioned above. Furthermore, 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 1998-99 (Table 1) reveals that over 40 percent households borrow to 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 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 reasons for not seeking such care being mostly the lack of funds, the income groups that are incompletely self-financing has drastic limits and in itself is the prime cause of most ill health, especially in the long run for whom out-of-pocket mode of financing strains their basic survival.

In sharp contrast, in countries where universal access has been achieved, health outcomes, the major performance of the health system is more or less uniform across social strata. In 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. For most of these countries have public expenditures averaging 80 percent of total health expenditures. The greater the proportion of public finance, the better the access and health outcomes. Thus India, where public finance accounts for only 30 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 nearly 60 percent of total health expenditures.

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 90s was a critical period in the country’s health development because due to the lack of public health infrastructure, especially rural, expanding 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 3 percent of GDP public health expenditures. Apart from this, the health system will need to be organised and regulated in the framework of universal access, similar to countries like Canada or Costa Rica, or more countries could be towards universal health insurance.

Consequently, the Indian 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. As present, the Central and state governments together spend Rs. 150 per capita, but this is inequitably allocated between urban and rural areas. The rural healthcare system gets Rs. 30 per capita and urban areas get Rs. 1,300 per capita. If there is a difference of over 40 times, if allocations are made using the mechanism of global budgeting, as is done in Canada for instance, that is Rs. 50 per capita basis, then rural and urban areas will both get Rs. 150 per capita. This will be a major gain, nearly two times, for rural healthcare and can help fill gaps in both urban and maternal 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 and 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 capacity.

Second, the public exchequer today even today contributes substantially to medical education and social insurance programmes. Currently, India’s health financing is predominantly through the hospitalisation expenditure. In fact, 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. Today, only about 15 percent of such medical graduates are absorbed in the public healthcare system. In fact, public service should be made mandatory also for those who want to do postgraduate studies (as many as 55 percent of MBBS doctors opt for postgraduate studies). Third, the governments can raise additional resources though taxation, as is done in Canada, and use instruments of health degrading products (if they cannot ban them like cigarettes, beers, alcohol, Pawn masals and gutka, personal vehicles etc. For instance, tobacco, which kills 670,000 people in India each year, is 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 tax can also attract a health cess which is earmarked for public health (municipal taxes already have an education component).

Fourth, social insurance can be strengthened by making contributions similar to the Employee 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. Additionally, social insurance must be gradually extended to other employment sectors. This can be done through some models from a number of experiments in collective financing like argenticuma, hama, in which the state pays Rs 1 per tonne of cane as a health cess and their entire farm is assured healthcare through the sugar cooperative. There are many NGOs experiments in using microcredit 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 hawala 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) dedicated at some source of income and use rights-based approach. For instance, tobacco, which kills 670,000 people in India each year for 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 tax can also attract a health cess which is earmarked for public health (municipal taxes already have an education component).

Thus, if India’s health financing can be strengthened and expanded, it can bring about substantial financial resources, which are showing a slower trend in health development. 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 health care system, especially the private health sector.

Thus, we have to think about coping out-of-pocket financing of the healthcare system and replace it with a combination of public financing and various collective financing options such as social insurance, collectively/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 mandamus, which would channelise the various collective resources and manage it autonomously the working of the system towards the goal of providing comprehensive healthcare to all with equity. This will happen only if the entire health sector, public and private, is organised under a common umbrella through a single-prayer mechanism which operates in a decentralised way.

The Latest Budget

Let us review briefly Union Budget 2011-12 to understand whether the track is on or 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 to 6.8 percent of GDP; this happening despite the real growth rate being over 8 percent. Similarly, tax revenues of the Central budget have remained stagnant at around 10 percent of GDP. The Centre has failed to not 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 5 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 crores today and its budget.

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 Health and Family Welfare department and Rs 1,088 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 Hospital Rs. 6,776 crore. In addition, NRHM also gets funds of Rs. 1,178 crore under the NE special programme and Rs. 247 crore under AYUSH. So what does this tell us? The overall spending on health care by the government is certainly very low when we consider global standards. As a consequence, the out-of-pocket burden for citizens, especially as 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 flagships programmes and is a good sign but when we look at actual expenditures, this opinion 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 (actual expenditure is still provisional) that NRHM shows an actual expenditure in excess of 17 percent (17 percent excess in plan expenditure), largely due to the RCH and immunisation programmes and pumping in of nonplan resource (bumping 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 emergency 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.
### Table 2: Per 1000 Distribution of Hospitalised by Type of Facility during 1986-87 and 1995-96, India - NSSO

<table>
<thead>
<tr>
<th>Source of Treatment</th>
<th>Rural</th>
<th>Urban</th>
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<tbody>
<tr>
<td></td>
<td>1986-87 (42nd Rd.)</td>
<td>1995-96 (52nd Rd.)</td>
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<tr>
<td>Public Hospital</td>
<td>399</td>
<td>418</td>
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<td>PHC / CHC</td>
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<td>9</td>
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<tr>
<td>Public Dispensary</td>
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<td>4</td>
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<tr>
<td>All Govt. sources</td>
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<td>431</td>
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<tr>
<td>Private Hospital</td>
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<tr>
<td>Nursing Home</td>
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<tr>
<td>Charitable Institution</td>
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<td>Others</td>
<td>8</td>
<td>12</td>
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<tr>
<td>All Non-Govt. sources</td>
<td>562</td>
<td>569</td>
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### Table 3: Percentage Distribution of Non-Hospitalised Treatment by Source of Treatment during 1986-87 and 1995-96, India - NSSO

<table>
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<th>Source of Treatment</th>
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</tr>
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<tbody>
<tr>
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<td>1986-87 (42nd Rd.)</td>
<td>1995-96 (52nd Rd.)</td>
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<td>Public Hospital</td>
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<td>P.H.C. / C.H.C.</td>
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<td>1</td>
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<tr>
<td>Public Dispensary,</td>
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<td>2</td>
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<tr>
<td>ESI Doctor, etc.</td>
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<td>1</td>
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<tr>
<td>All Govt. sources</td>
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<tr>
<td>Private Hospital</td>
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<tr>
<td>Nursing Home</td>
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<td>2</td>
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<td>Charitable Institutions</td>
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<td>0</td>
</tr>
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<td>Private Doctor</td>
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<td>Others</td>
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<td>7</td>
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<tr>
<td>All Non-Govt. sources</td>
<td>81</td>
<td>80</td>
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### Table 4: Health Expenditure Trends in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Public Health Expenditure (Rs. crore)</th>
<th>% of GDP</th>
<th>Private Health Expenditure (Rs. crore)</th>
<th>% of GDP</th>
<th>% Private to Total Health Expenditure</th>
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</thead>
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<td>0.90</td>
<td>2466</td>
<td>3.26</td>
<td>78.43</td>
</tr>
<tr>
<td>1980-81</td>
<td>1286</td>
<td>0.99</td>
<td>5284</td>
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<td>16605</td>
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<td>1992-93</td>
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<td>1993-94</td>
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<tr>
<td>1994-95</td>
<td>8565</td>
<td>0.93</td>
<td>27859</td>
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<td>76.48</td>
</tr>
<tr>
<td>1995-96</td>
<td>9601</td>
<td>0.89</td>
<td>32923</td>
<td>3.07</td>
<td>77.42</td>
</tr>
<tr>
<td>1996-97</td>
<td>10935</td>
<td>0.88</td>
<td>37341</td>
<td>3.00</td>
<td>77.35</td>
</tr>
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<td>1997-98</td>
<td>12721</td>
<td>0.92</td>
<td>45899</td>
<td>3.30</td>
<td>78.30</td>
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<tr>
<td>1998-99</td>
<td>15113</td>
<td>0.94</td>
<td>65340</td>
<td>4.04</td>
<td>81.21</td>
</tr>
<tr>
<td>1999-00</td>
<td>17216</td>
<td>0.96</td>
<td>83517</td>
<td>4.76</td>
<td>82.91</td>
</tr>
<tr>
<td>2000-01</td>
<td>18613</td>
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<td>98168</td>
<td>5.18</td>
<td>84.06</td>
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<tr>
<td>2001-02</td>
<td>19454</td>
<td>0.94</td>
<td>110000</td>
<td>5.32</td>
<td>84.90</td>
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<tr>
<td>2002-03</td>
<td>19732</td>
<td>0.88</td>
<td>125000</td>
<td>5.60</td>
<td>86.36</td>
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<tr>
<td>2004-05</td>
<td>25800</td>
<td>0.83</td>
<td>170000*</td>
<td>5.3</td>
<td>86.82</td>
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<tr>
<td>2006-07</td>
<td>36500</td>
<td>0.91</td>
<td>210000*</td>
<td>5.8</td>
<td>85.19</td>
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<tr>
<td>2007-08</td>
<td>43100</td>
<td>0.90</td>
<td>240000*</td>
<td>5.1</td>
<td>84.78</td>
</tr>
<tr>
<td>2008-09 RE</td>
<td>51600</td>
<td>0.96</td>
<td>260000*</td>
<td>4.83</td>
<td>83.44</td>
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<tr>
<td>2009-10BE</td>
<td>590</td>
<td>1.01</td>
<td>2750*</td>
<td>4.7</td>
<td>82.33</td>
</tr>
<tr>
<td>2010-11BE</td>
<td>650</td>
<td>1.04</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Estimates by author for private expenditures; RE=revised estimates, RI=budget estimates
Source: Public Finance Accounts of Central and State Governments and RBI’s Financial Statements of State Governments, various years; Private: CSO = GOI – Private Final Consumption Expenditures, National Accounts Statistics, 2005
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 few 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). UHC entails strengthening health systems for better outreach, improved governance and management including financial sufficiency and innovations in revenue 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 staffed 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 process is celebrated, and we count ourselves as part of the exclusive G20, 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 increase 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 (NHAs) 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 21 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 11.3 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.

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 important local management function. The RKS on the other hand is expected to manage the utilisation of “user fees” and local revenue generation was considered to be an important local management function.

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 services 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 RKP (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 user’s interests paramount, because the funds it is expected to manage are provided as “untied” funds and grants as part of the NRHM package.

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 poorness 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 services meant to be free for the poor was explicitly articulated. However, some states still continue to impose a fee for service.

* All data is from the Director of the Centre for Health and Social Justice (CHSJ), New Delhi, and a former member of the alliance of Students’ Action for Stoppage Violence Against Women (BANAW), and the reproductive health and rights network Health Forums. Moumita Ghosh is a Programme Officer associated with the CHSJ research and documentation team. She holds an MPhil degree in Sociology.
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 provision 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 Thai system.

Table 3: Financing Health Protection in Thailand

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

Source: Attaining Universal Health Coverage: A Research Initiative to support evidence-based advocacy and policymaking Figo, 2010

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 on 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 allocate 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.

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 on 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 allocate 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.

How far are we from Universal Health Coverage in India?

http://www.who.int/bulletin/volumes/86/11/07-049387/en/  
National Health Accounts, 2004-2005
Health system in India is among the most prioritized in the world. Of the total spending on health, with 21 percent coming from people’s pockets, the government share is less than a fifth. Almost 65 percent of hospitalization 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, prioritization and commercialization of existing facilities and services, provision of subsidised 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 cataclysmic health expenditure, one finds no reason to protect people from catastrophic health expenditure. All of a sudden, when there is the talk from government policies and its spending towards private sector is clearly evident from the recent history towards provisioning of health care, commercialization of existing facilities and public spending on health, privatization and especially the corporate hospitals. The escalation of profits of the private sector in recent history towards provisioning of health care, universalisation. Let us quickly look at some 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 them “...comprehensive health insurance that is financed through a combination of public, private employer and private sources” would be rolled out (Lancet Call for Action, pp. 763). Apart from financing and regulating, the roles of government as envisaged in the volume are to ensure provisioning in rural and underserved communities and prevent and promotive work. At a cursory glance, the goal of eradicating catastrophic 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 more problematic 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 public health care and gradual undoing of commoditization of health care, universal health 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 the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of the insurance-based models and highlight the caveats of

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

<table>
<thead>
<tr>
<th>Country</th>
<th>General govt. expenditure on health as % of GDP</th>
<th>General govt. expenditure on health as % of total public expenditure on health</th>
<th>Per capita govt. expenditure on health (PPP in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>1.0</td>
<td>1.1</td>
<td>33.6</td>
</tr>
<tr>
<td>Brazil</td>
<td>2.9</td>
<td>3.5</td>
<td>40.0</td>
</tr>
<tr>
<td>Chile</td>
<td>3.4</td>
<td>3.6</td>
<td>52.1</td>
</tr>
<tr>
<td>China</td>
<td>1.8</td>
<td>1.9</td>
<td>38.7</td>
</tr>
<tr>
<td>Colombia</td>
<td>5.6</td>
<td>5.1</td>
<td>80.9</td>
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<tr>
<td>Costa Rica</td>
<td>5.0</td>
<td>5.9</td>
<td>76.8</td>
</tr>
<tr>
<td>Cuba</td>
<td>6.1</td>
<td>9.9</td>
<td>90.9</td>
</tr>
<tr>
<td>India</td>
<td>1.1</td>
<td>1.1</td>
<td>24.5</td>
</tr>
<tr>
<td>Malaysia</td>
<td>1.7</td>
<td>2.0</td>
<td>52.4</td>
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<tr>
<td>Nepal</td>
<td>1.3</td>
<td>2.0</td>
<td>24.9</td>
</tr>
<tr>
<td>Pakistan</td>
<td>0.6</td>
<td>0.8</td>
<td>21.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>3.4</td>
<td>3.6</td>
<td>40.5</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1.8</td>
<td>2.0</td>
<td>47.9</td>
</tr>
<tr>
<td>Thailand</td>
<td>1.9</td>
<td>2.7</td>
<td>56.1</td>
</tr>
<tr>
<td>South-East Asia Region</td>
<td>1.2</td>
<td>1.3</td>
<td>31.2</td>
</tr>
<tr>
<td>Low income</td>
<td>1.8</td>
<td>2.2</td>
<td>37.6</td>
</tr>
<tr>
<td>Lower middle income</td>
<td>1.8</td>
<td>1.8</td>
<td>37.5</td>
</tr>
</tbody>
</table>

Discussion

Global health financing systems which are predominantly general government tax financing and small country health insurance financed by payroll taxes. Only a few countries have financing system which is predominantly private insurance financed. Practically most countries have a combination of all these. Developing countries depend heinously on general taxation and mandatory social health insurance contribution. Lack of voluntary contributions, 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, staphs 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.

Discussion

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

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 cr. 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 of 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 a 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 substantially 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.
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 supply 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 Health Organization Situation Report 2004 of WHO. How this is possible and why it happens 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 so 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 antihistamine tablet cetirizine dihydrochloride 10 mg under three different names - Okacet (MRP Rs. 27.50 for 10 tablets), Cetcip (MRP 33.65) and Alerid (MRP Rs. 37.50). It is however astonishing that Cipla supplied 10 tablets of Alerid to Chittorgarh Sahakari 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 this 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. 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 lower than what is printed, why is the Government of India not banning it? Well, apart from 115 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 pharmaceutical industry and India adopting the open economy policy, a new Drug Price Control Order was passed in 1995. Since then, only 76 and after 1997, only 38 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 than 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 remains in short supply while the market is flooded with unnecessary and sometimes irrational medicines which can be sold with any markup.

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 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 in outpatient is out-of-pocket and more than 80 percent of this is on purchase of medicines and medicines and there is no price control, most healthcare providers in the public system prescribe irrational/excessive 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 overmedicated. 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. One 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.

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, estimates 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 2.5 percent of the GDP but this has not increased at all even with the introduction of the National Rural Health Mission since 2005.

In 2005, the government had launched the National Rural Health Mission to get the country’s health care services to those who are poor in rural India. The mission has been in operation for about 7 years now, but the budget allocation for it has not increased even though the target was to increase rural health expenditure to 2.5 percent of the GDP by 2012. As on 2009, the mission was receiving only 1.84 percent of the GDP, which is far less than the international standard of 4-5 percent.

India is the third largest economy in the world and the country’s GDP is now about 2 percent of the GDP of the U.S. (about $13 trillion), Japan (about $5 trillion) and China (about $10 trillion). In 2009, the country’s GDP was about Rs. 100 lakh crore. While the country has a GDP of Rs. 100 lakh crore, why is it not able to increase its GDP to 4-5 percent of the GDP? Why is it not able to increase its health expenditure to about 2.5 percent of the GDP? 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, and 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.

* Narendra Gupta is not only Pope in 1979. Pope is a voluntary organisation, based in Chittorgarh in Rajasthan, and licenced on human rights, rights to health, sexual & reproductive health and rights, excluding anti-childhood and anti-communism, associated with rights to education and protection and care for HIV/AIDS patients, among other issues. Dr. Gupta is also associated with several health rights campaign like Joy kusdeep Bhikchand and Global Polio Eradication Initiative.
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 lower births, progress on this continues to be uneven. Some states continue to have a persistently high burden of maternal mortality in India with an inexcusable 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

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<td>West Bengal</td>
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<td>India Total</td>
<td>398</td>
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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 a hospital. The performance audit report of the government planned to have the minimum 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.

Further to the scenario, there is an urgent need to strengthen those facilities even a pregnant woman are urged to give birth in hospitals. The performance audit report of the government indicated that anaemia will require many more interventions, such as food security for all families, a balanced and adequate diet for women during their lifecycle, 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. 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 a hospital.

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 minimum 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 1) show a dismal picture in 2003 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 those facilities even a pregnant woman are urged to give birth in hospitals. The performance audit report of the government indicated that anaemia will require many more interventions, such as food security for all families, a balanced and adequate diet for women during their lifecycle, 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.

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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 wellbeing; and there needs to be a clear policy revision in this regard. Budget allocations also need to fund food security, safe water and total sanitation as important contributors to maternal wellbeing. 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 present poor women users from holding providers or health managers to account for denial or poor quality of health services, or loss 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.

> There is a need to investigate these challenges when the nature of local 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 BHARUCH (Bihar, Madhya Pradesh, Rajasthan, Odisha and Uttar Pradesh) states. Inadequate Human Resources, Complexity of Service Provision and Negotiation:

- Every health worker covers a radially distant of about 3 kilometers 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.
- Less than 25 percent Primary Health Centres are functional 24x7 (round-theclock).
- Read penetration is abysmal resulting in crucial delay.
- Qualified Human Resources: There is shortage across all categories i.e. • Auxiliary 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-a-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 healthcare 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 signpost on billboards 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 (cash-seekers) are willing to pay for a better quality care

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CBGA Vol. 8, Track 2, August 2011

Budget TRACK

3. Scaling up Rogi Kalyan Samitis for The State’s Response:

1. Introducing two tranches daily for out-practitioners in public sector, such as:
   - better compensation for healthcare National Rural Health Mission, the series of progressive changes. With national level, have been bringing about a provide quality care at home/private this interaction is construed as quality care.
   - the same doctors, who are willing to practicing empathy, conversation, during their consultancies, it becomes a desirable interaction for any patient and their homes/clinics/nursing homes 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
   - Provision of free treatment
   - Provision of free medicines
   - 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 medicolegal platform for patients rights into the healthcare domain.

4. Encouraging doctors to attend to critical care/transect 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 summarization and benefits of the doctors in particular and healthcare providers in general; in the absence of effective regulation, the perversion continues mostly unattained. 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 ethos adherence are as follows:

- Setting the appropriate metrics for monitoring and appraisals of the doctors, training and the system changes
- The territorial 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 influenced at the Department of Medical Education at the state level
- Naming 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 accountable 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 limbo 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 doctors involved need to be bound by all the clauses
5. Need to function in open and be controllable (also 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.

MCIs 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 subsequent to beneficience and making a case for charity. Homoeopathy is the only code spelling that explicitly.

Substantive clauses in the MCI codes are dedicated to regulation and intra-profession codes and constraints. 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 clean 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 small fraction of the total outlay was actually spent and were made in the Union Budgets in the entire Plan period. Union Budget 2011-12 was the first Budget of the 11th Five Year Plan period. Naturally, it was expected that the social sector outlays would be stepped up significantly, especially in the social sector to fill 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 putting 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 specialist), has gone down from 1.9 percent of the Gross Domestic Product (GDP) in 2009-10 to 1.8 percent of GDP in 2010-12 (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 decline from 1.9 percent of the Gross Domestic Product (GDP) in 2009-10 (RE) to 1.8 percent of GDP in 2010-12 (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 1.3 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 sectors.

Education

The United Progressive Alliance (UPA) promise to fulfil the Kothari Commission recommendations of 1966 is still due as India’s total public spending on Education at 3.99 percent of GDP (2009-09) is nowhere near the promised level of 6 percent of GDP. Looking at specific schemes, while the outlays for SURA Shiksha Abhiyan have been increased from Rs. 1,500 crores in 2010-11 (BE) to Rs. 2,000 crores in 2011-12 (BE), the scheme can hardly be expected to impact the education sector with this magnitude of funds. As per the Centre’s own estimation - a modest one from a financial perspective - the Centre has estimated an annual expenditure of Rs. 2,000 crores (as a LUMP sum) on the Right to Education Act. As per the Centre, over every five years, the Centre would spend Rs. 1,825 lakhs crores over a period of five years. Hence, if just one-fifth of this had to be allocated in 2011-12, which is significantly lower than the promised amount by 2013-14, it 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 sectors.

Health

The outlays for Health & Family Welfare have hardly 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 of GDP in 2009-10 (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 to around 0.6 percent in 2009-08, which is far from 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 (BE) to Rs. 17,924 crore in 2011-12 (BE) - hardly sufficient to address the health needs of the population, fill in the vacancies of doctors 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, dockers, miners and asbestos. Unfortunately a welcome development, it seems only as 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. 70,578 crores have been brought down to Rs. 74,414 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. 40,000 crore in 2011-12 (RE) from Rs. 40,210 crore in 2010-11 (RE)], Swarnajayanti Gram Swarozgar Yojana (SGSY) (renamed the National Rural Livelihood Mission) [Rs. 26,212 crore in 2011-12 (RE) from Rs. 26,853 crore in 2010-11 (RE)] and Indira Awaas Yojana (IAY) [Rs. 1,0267 crore in 2010-11 (RE) to Rs. 9,896 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 in the country were 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 - endowments 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 increasing its persistence in food deficit years, Union Budget 2011-12 has allocated Rs. 50,660 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 deprivations 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. 1,500 and Rs. 1,500 respectively. However, the number of ministries/departments reporting in the Gender Budgeting Statement has remained static with no significant revision in the format of the Statement. Allocations for several womenspecific schemes such as Swadhar, Pradhanmantri, and Support for Training and Employment Programmes 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 4.3 percent in 2011-12 (BE). Within the “Child Budget” (i.e., the total allocation for all child-specific schemes) in 2011-12 (RE) amounting to Rs. 50,986 crore, the share of Child Education is 76.4 percent, Child Development is 18.6 percent and Child Protection is 5.0 percent, interventions in Child Protection account for 1.33 percent. The increasing share of Child Protection in the total “Child Budget” from 0.66 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. 15,445 crore in 2010-11. There is also a hike in outlays for primary tribal groups from Rs. 185 crore in 2010-11 (BE) to...
Issues debated in the Budget Session:
The most debated issues in the Budget Session revolved around the presence of black money in India, rising food inflation and concomitant price rise, farmers demanding to stop theft and price rise, poor implementation of public distribution system (PDS), and implementation of schemes like MNREGA. Almost all of the opposition MPs as well as some of the MPs from the ruling coalition raised the issue of black money. 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 460 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 the formation of the country. Agriculture is providing employment to 65 percent 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 increased in the recent years, the Government has not taken into account the input cost of our farmers. Shri Rajesh 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 rating in the open 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 charge, this Government said that it could not distribute this wheat 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 Government has not increased the allocation for MNREGA in this Budget which was raised by many MPs. They also demanded that the workers be provided the statutory minimum wages.

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) for the Reserve Bank of India, where RBI virtually called upon big industrial houses to own banks and take over the mega 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) Act, 2011, which was introduced in the Lok Sabha on March 23. As a direct consequence, this bill would throw at least 78 percent of the workforce in the manufacturing sector and a good part of the purse 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 liberalisation in India for introduction of “labour market flexibility”, that will give the employers unlimited authority to fire and fire without any hindrance. In this regard, they often lay the blame on Chapter VII of the Industrial Disputes Act, 1947 as being the main obstacle for employment growth in the manufacturing sector. The Bill is an attempt to dilute the Chapter VII as well as to weaken the other legal provisions for protecting the labour class. But many experts, including some of the neoliberal, 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 practice, 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 adversely 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 2009 with minor changes, was reintroduced 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 insured pension benefit i.e., the “defined benefit” 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 maintained in the PFRDA Bill (both 2005 & 2010) that “There shall be no implicit or explicit assurance of benefits, guaranteed payment (other than the subscription) by the subscriber” (Sec 202(2) 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 stock 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 lifetime 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’ lifetime 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 the 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 pension amount for the unorganised workers despite his/her continuous contribution to the pension fund 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 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 Lankas, 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 (earning 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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A newsletter brought out thrice every year that discusses the budget and policy priorities of the government.

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Advocacy
Bhuvnesh Jha, Gyana Ranjan Panda, Khwaja Mohsin Ul-Rehman and Prayadashini Mohan.

Research

Circulation & Administration

Illustration
Vikram Nayak

Layout and Design
Cognizant Reach & Mayank Bhattachar.

Printing
Bhawna Offset

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