October 2006

REPORT OF THE WORKING GROUP ON HEALTH CARE FINANCING INCLUDING HEALTH INSURANCE FOR THE 11TH FIVE YEAR PLAN

Ministry of Health & Family Welfare

Nirman Bhawan, New Delhi - 110011

Ministry of Health & Family Welfare

Subject: Report of the Working Group on Health Care Financing including Health Insurance for the 11th Five Year Plan

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The Planning Commission constituted a Working Group on the above mentioned subject with the following Terms of Reference:

(i) To review the present position of health financing at state, centre and individual levels. Keeping in view identified problems and constraints of existing system, make suggestions for improvement in quality and efficiency with reduction in the cost of health care to the poor in the Eleventh Plan;

(ii) To suggest management strategies for community based health insurance as well as process and impact assessment parameters for these initiatives during the Eleventh Plan;

(iii) To assess disease burden and cost of ill health in the country and project figures for 2012 and 2017;

(iv) To give cost estimates for health care-public, NGO and private-current and for the Eleventh Plan period;

(v) To suggest alternative sources / strategies for health financing during the 11th Plan to meet the cost of health care;

(vi) To deliberate and give recommendations on any other matter relevant to the topic.

The membership of the Committee was as follows:

1	Secretary (Health & FW) Ministry of Health & Family Welfare, GOI	Chairman
2	Joint Secretary (In-charge of Insurance), Ministry of Finance	Member
3	Joint Secretary, Ministry of Finance	Member
4	Director General, NSSO, New Delhi	Member
5	Director General, NCAER, New Delhi	Member
6	Secretary (Health), Government of Andhra Pradesh	Member
7	Secretary (Health), Government of Madhya Pradesh	Member
8	Secretary (Health), Government of Karnataka	Member
9	Secretary (Health), Government of Gujarat	Member
10	Shri A. Kumar, Director (H&FW), Planning Commission, New Delhi	Member
11	Shri K.M. Gupta, Director, Ministry of Finance, New Delhi	Member
12	Director, Centre for Development Studies, Thiruvananthapuram	Member
13	President, IMA, New Delhi	Member
14	Shri Ashok Sahni, Hon. Executive Director, Indian Society for Health Administrators, Bangalore	Member
15	Dr. Ravi Duggal, CEHAT, Mumbai	Member
16	Shri B.B.L. Sharma, Health Economist, New Delhi	Member
17	Prof. Ramtesh Bhatt, IIM, Ahmedabad	Member
18	Dr. A.S. Dua, Former Member, Sub-Commission, NCMH, New Delhi	Member
19	Dr. Moneer Alam, Health Economist, IEG, New Delhi	Member
20	Dr. K.S. Nair, Faculty, NIHFW, New Delhi	Member
21	Dr. P. Mohapatra, Ex-Director, Institute of Health Systems, Hyderabad	Member
22	Joint Secretary, Ministry of Health & Family Welfare	Member Secretary

The Secretary (H&FW) authorized Ms. K. Sujatha Rao, AS & DG (NACO) to be the Chairperson on his behalf and Shri Amarjeet Sinha, Joint Secretary, Ministry of Health and Family Welfare, to be the Member Secretary. The group met on 18th July, 2006. The minutes of the meeting are placed at Annex – I.

Introduction : The context

India is one of the few countries that has a public health spending of less than 1% of GDP resulting in nearly three quarters of the money being met from out of pocket by households. Of the Rs. 148727 crores spent on health during the year 2004 – 2005 accounting to 5.2% - of 5DP at the factor cost Government spent is about 22% (Annexure II) Almost 73% was met by households making it a very regressive system of health financing. Of this, about 50% was spent on primary care. Estimates show that Government in 2004-2005 met barely 50% of the total required to implement the six National Health Programs aimed at controlling communicable diseases such as malaria, TB, leprosy, HIV/AIDS and RCH. Besides, data also shows that over time, revenue outlays for health in proportion to total budgets have been steadily falling in almost all states. **Annexure II, III, IV.** Data also showed that besides chronic underfunding, the sector was plagued with instances of inefficiencies at several levels resulting in waste, duplication and suboptimal use of scarce resources. All these factors combined have had an adverse impact on the functioning of the public health sector's ability to provide health care services to the people, resulting in an estimated 3.3 % of the population getting impoverished on account of high health expenditures incurred in private sector hospitals. Health spending averaged 11% of non food expenditures and almost 5% of the total annual expenditures of households. Almost 40% were reported to have taken loans to incur such expenditures and nearly 10% sold assets resulting in intergenerational poverty.

It is in the above context that the Working Group on Health Financing deliberated the specific TOR's in two meetings as under :

Terms of Reference – I

To review the present position of health financing at state, centre and individual levels. Keeping in view identified problems and constraints of existing system, make suggestions for improvement in quality and efficiency with reduction in the cost of health care to the poor in the Eleventh Plan;

The Working Group on Health Financing initiated the deliberations keeping in mind the need to ensure an equitable and efficient health system through the rational use of resources. In reviewing the present position of health financing and the existing system of health financing in the country, note was taken of the recently published report of the National Commission on Macro Economics and Health (NCMH August 2005) which had undertaken a detailed exercise on financing of health care. The Report had made certain projections of investments required to be made in the health sector for reducing inequities and inefficiencies that characterize the health sector. The WG also reviewed the health spending estimates as provided under the National Health Accounts framework for the year 2001-02 and later reiterated by the Ministry of Health- **Annexure V.** It also noted three subsequent developments having implications for health financing:

a) The NSSO 60th Round Report (January – June 2004) on Morbidity Health Care and the condition of the aged (March 2006) showing two worrying developments : an increase by nearly 50% in health expenditures in urban and rural areas as compared to the last survey conducted in 1994-5;and a near stagnation in the utilization of public facilities with a sharp fall in Bihar - **Annexure VI .**

b) The Report of the Task Force on Innovative Health Financing Mechanisms under the NRHM (December 2005). The Report recommended the need to develop systems for risk pooling for obtaining access to medical services from the public and private facilities in accordance with commonly agreed standards and prices. Based on this the Ministry of Health & Family Welfare has developed a framework for Community Health Insurance advocating a policy of different approaches being adopted as far as risk pooling and community health insurance is concerned.

c) Approval of the detailed Framework for Implementation of the National Rural Health Mission (July 2006). The approval includes in principle agreement on financial resources for the NRHM 2005-2012 in line with the commitment made in the Common Minimum Programme and the recommendations of the NCMH, providing for an annual increase of 30-40% Central Government allocation and 10% by States'.

Apart from the NSSO surveys that have shown the steady decline in the utilization of public facilities except in a few states, evidence from several other reports have also conclusively brought out the increasing dependence of the private households on the private sector, often paying huge amounts often for substandard quality of care. While at the periphery, primary health care facilities lack drugs, well trained personnel, diagnostic facilities, poor access due to inconvenient location and mismanagement, the higher level facilities provide low quality of care due to patient overload and exhausted staff. It is clear that with the mere correction of these shortcomings and by bringing in better management, utilization of the existing facilities can be improved. This alone will substantially reduce out of pocket expenditures, particularly among the poor, and also get better returns on the investments made in the establishment of the public health infrastructure.

The dysfunctional nature of the health was also perceived to be the result of a centralized disease control approach that provided little scope for inclusive strategies where the beneficiaries of the system also had a role to play; inflexible financial systems and procedures; and poor human resource management. The financing system is equally dysfunctional as funds are released in five years cycles, divided under different and complex budget heads- revenue, capital etc providing for little flexibility to respond to any health emergency. To address such technical and allocative inefficiencies in resource utilization, Government has in the last one year initiated several interventions under the National Rural Health Mission (NRHM) in 5 key areas that when implemented will have a significant impact on reducing current inequities in health care financing and access.

- Decentralized planning under which every district is expected to prepare a perspective and an Annual District Health Action Plan 2005-2012, projecting the basic health care needs of local communities, integrating also the wider determinants of health and combining promotive, preventive and curative care in a common referral link that operates from the village to the District Hospital. This process is based on the principle of decentralization of funds and functions to Panchayat Raj institutions and locally elected bodies, hospital committees in partnership with community organizations and Village Health and Sanitation Committees and broader civil society. This measure will bring in both accountability and generate demand for services as well;
- Strengthening of management capacity at all levels, with equal emphasis on skill development and development of the required human resources for coping future health challenges;

- Improved financial management by providing flexibility and making it performance and outcome based;
- Improved delivery of services based on the recognition of the need to guarantee a minimum package of services to every citizen at all the levels of care; and
- Close monitoring based on baseline surveys and a list of critical health indicators.

The practice, constrains and action needed to overcome taken may be seen at **Annexure- VII**.

It is believed that the implementation of the above initiatives will increase utilization of the health facilities and provide the poor a measure of protection from risk and reduce out of pocket expenditures. The implementation of the policy framework indicated above will however require a quantum increase in resources. Such an increase is expected to be provided under the NRHM during the XIth Plan period as per norms described below :

NORMS AND BROAD FINANCIAL FRAMEWORK OF THE NRHM:

The NRHM derives its cost norms from three sources: (i) existing norms of schemes brought under the umbrella of NRHM; (ii) norms and (iii) standards developed by the National Commission on Macro Economics and Health; norms suggested in the EFC. A diverse set of norms are expected to provide flexibility to States in planning and to accommodate interventions/innovations as required for meeting local needs.

For achieving program efficiencies ,the National Disease Control Programmes related to control of TB, Malaria, Blindness , Iodine Deficiency, Kalazar. the Integrated Disease Surveillance Programme, and all the Family

Welfare Programmes of the Ministry of Health and Family Welfare have been integrated under the NRHM. Financial integration is proposed by creating a single Budget head for NRHM, while other disease control programs such as Cancer, non – communicable diseases, HIV/AIDS prevention etc. will converge their programs with the NRHM interventions. Such integration is expected to bring down duplication of services and make better use of existing resources. Optimizing existing resources and infrastructure will alone release an estimated 30% of existing budgetary outlays for alternative use.

13. The National Commission on Macro Economics and Health has provided the cost of a package of services to be provided at the primary and secondary levels of health care facilities. The core and basic package include childhood diseases/health conditions, maternal diseases/health conditions, blindness, leprosy, TB, Vector borne diseases, RTI/STI, preventive and promotive activities, minor injuries, other minor ailments, and snake bite. The NCMH also provides standard costs for non-recurring and recurring costs of Sub Health Centres, PHCs, CHCs. The Ministry of Health and Family Welfare has developed IPHS for SHC/PHC/CHC and is in the process of developing IPHS for Sub Divisional and District Hospitals. The NCMH assessments, read with the IPHS and the actual Facility Survey of each health facility, will determine the actual resource need. The over all resource envelope for NRHM has been projected as per assessment of NCMH, which is in line with the CMP promise of raising public expenditure on health to 2-3 % of the GDP.

Specific norms have been proposed for untied grants at al levels of health action. These include – (i) grants to Panchayats/Rogi Kalyan Samitis; (ii) capacity building in community organizations; (iii) skill needs of doctors/para medics/educated RMPs; (iv) local criteria and need based selection of resident health workers/Nurses/Doctors/Specialists as per IPHS; (v) partnerships with

the Non Governmental sector; (vi) nurturing and development of ASHAs; (vii) strengthening of Block and district level management; (viii) improving physical infrastructure for health; (ix) MIS/monitoring-evaluation of programme; (x) behaviour change and communication/IEC; (xi) support to mobile medical units in each district of the country; (xii) grants to Rogi Kalyan Samitis at PHC, CHC, Sub Divisional, District Hospital in all States and to Government Medical College Hospitals in special focus States; (xiii) grants – in-aid to NGOs at district, state and national levels; (xiv) support for school health programmes/ ICDS health component, nutrition and health education programmes for women, resources for surveys, public reports on health, etc.; (xv) Social health insurance as per local models with subsidies only for Below Poverty Line Families at par with the current limits under the Universal Health Insurance Scheme; (xvi) strengthening nursing institutions/Medical Colleges in capacity development; (xvii) Ambulances and phones at al levels; (xviii) National and State level Health System Resource Centres and District and Block level resource Groups; (xix) strengthening procurement and logistics in States; (xx) meeting diversity of northeastern States.

RESOURCE ASSESSMENT AND CENTRE – STATE SHARING

As regards costing of additional resource needs, the National Commission on Macro Economics and Health has made a detailed assessment of investment requirements, based on disease burden estimations, bare minimum standards and treatment protocols, and unit cost estimations of providing such services at government prices that are 30-50% lower than the private sector. The Commission has recommended additional non-recurring investment of Rs. 33,811 crores and a recurring investment of Rs. 41,006 crores for health promotion, regulatory systems, enforcement of regulations, human resources for

health, training, research and development, delivery of health care services, and social health insurance as under :

Table 1: Estimated Additional Resources as Estimated by NCMH

Activity	Non – recurring additional investment	Recurring additional investment
1. Health Promotion including publicity and dissemination and community involvement for preventive activities.		**Rupees 4000 crores**
2. Training – of Village Health Committees, unqualified RMPs, village level workers, in service health personnel, fellowships, rural allowance for health personnel, etc.	**Rs. 853 crores**	Rs. 765 crores
3. Delivery of health care services (Bare minimum requirements)	**Rs. 23968.92 crores**	**Rs. 20,958.86 crores**
4.Social Healt insurance including premium – subsidy for BPL families.		**Rs. 9000 crores**
5. Human resource for health – opening, upgrading and strengthening Nursing Colleges	**Rs. 3923 crores**	**Rs. 526.50 crores**
TOTAL	**Rs. 28744.92 crores**	**Rs. 35250.26 crores**

The resource projections indicated above have been found to be realistic and adopted for purpose of estimating additional allocations under NRHM for the XIth Plan period. However, there is need to bear in mind two caveats: 1. The cost of construction and other unit costs in the North Eastern States, the hilly regions, need to be estimated by 1.5 times; and 2. Given the current absorptive capacities in the States and weak management structures at various levels, it is likely that the demand for resources may be lower than anticipated. Therefore, while adopting the resource envelope suggested by NCMH in principle, the actual need year on year requirement of resources will depend on the pace at

which States push reforms in order to remove the clogs that are currently constraining their e ability to absorb and effectively utilize additional resources.

A substantial share of the additionality indicated above will have to come from Central funds. It is proposed that NRHM provide 100% grants to States on a 75-25 sharing basis between the Center and States during the XIth Plan. The long term additional funding by the Central Government will significantly improve the central share in overall public expenditure on health. While doing so, the Central Government will constantly monitor the state expenditures on health to ensure that they increase in proportion to central spending in real terms.

Given the absorptive capacity in the States and the time it may take to improve the implementation capacity, it should be fair to assume an annual 30% increase in health sector allocations up to 2007-08 and an annual increase of 40% from 2009-201o to 2011-12. Following this broad assessment, the Central Government resource needs are likely to be as follows:

Table 2 : Projected Resource need for NRHM 2005-2012

Rupees in crores

Year	Central Government NRHM allocation	Recurring	Non-Recurring	State Contribution	Total
2005-06	6500			-	6500
2006-07	9500	9000	500	-	9500
2007-08	12350	11000	1350	2179	14529
2008-09	17290	13000	4290	3051	20341
2009-10	24206	16206	8000	4272	28478
2010-11	33884	23884	10000	5980	39864

2011-12	47439	42439	5000	8372	55811

The resources indicated above relate to communicable disease control programmes, RCH, Family Planning, IDSP, etc. programs that come under the NRHM. There is need to, however, also provide an estimate of resources required for the non-communicable disease control programmes (mental health, vascular diseases, cancer, etc.), HIV/AIDS, medical education, etc. Since the non-communicable diseases do not entail any externalities, normally public funding is not provided in a significant manner. However, with evidence suggesting increasing prevalence of hypertension, mental health, accidents & injuries affecting a large number of poor and the treatment under all these conditions being exorbitant, public health financing has to take into account provisioning of free treatment in all public health facilities for these diseases/conditions. It is accordingly recommended that 20 per cent of the total amount projected in the table 2 above may be provided additionally for tertiary care which may also include medical education and research.

Regarding HIV/AIDS, the importance of containing this disease needs to be under-scored since treatment of AIDS is extremely expensive besides the fact that this infectious disease has the capacity to devastate the socio-economic fabric as witnessed in South Africa. Adequate resources have to be provided to stabilize and reverse the epidemic. For the Phase-III of the National AIDS Control Programme to be implemented during the 11th Five Year Plan, an estimated amount of Rs. 11,285 crores has been projected. Of this an amount of Rs. 8,000 crores is required to be provided in the budget. 25 per cent of this is under domestic budget (NRHM) and 75 per cent under the EAP component. Therefore, the additional budgetary provision over and above Rs. 55,811 crores projected in Table-2 above is Rs. 5,814 crores for the HIV/AIDS programme.

Thus the additional total resource requirement for health during the 11th Plan is estimated to be Rs. 72,788 crores.

Terms of Reference - II

To suggest management strategies for community based health insurance as well as process and impact assessment parameters for these initiatives during the Eleventh Plan;

Need for new avenues of health financing

The Group expressed its desire to explore new health financing mechanisms in order to reduce the burden of health expenditures among the poor households. The National Commission on Macroeconomics & Health has pointed out that 3.3% of India's population is impoverished every year on account of health distress. There is also evidence to suggest that the poorest 10% of the population rely on sale of assets to meet their health care needs. A study in some of the poorest districts by Jha & Jhingran 2002 had revealed that illness of a family member is the most common reason among poor households leading to a financial crisis and causing a sense of insecurity. Nearly 40% of the Below Poverty Line families reported having faced a financial crisis during the last two years and about 69% of these was on account of illness and 11% on account of a death of a family member. Clearly poor people in rural areas are spending significant amounts on health care leading to their impoverishment.

Vulnerability and risk among informal sector workers

Work and social security are the central concerns of the poor in our country. Most of our nation's poor or almost 400 million workers are engaged in

the informal economy, also called the informal or unorganized sector. There are a large number of agricultural labour who fall in the below poverty line category. Among these workers, women are the poorest and most vulnerable of all facing varied risks. Risk pooling could be one way of reducing such risk.

The poor have devised their own systems to cope with the many risks in their lives. The most well-known of these is savings for a variety of purposes, including coping with risk – paying for medical expenses, funeral costs, or a leaking roof. The system of "Vishi", or contributing to a central pool of money which is then drawn upon by a few of the contributors in times of need, is thus a kind of risk management. The several examples of micro credit organizations and the Self- Help Group movement are based upon and built on these practices.

Current Status of Health Insurance in India:

The ESIS and CGHS are the oldest schemes for social health insurance in India. ESI Hospitals provide services to an estimated 35 million beneficiary across the country, while the CGHS serves an estimated 4 million cardholdres. CGHS uses a subscription but the actual expenditure incurred is many times more than the premium collected. The experience with health insurance so far has been mixed. Some policies like Mediclaim covers more than 75 lakh persons with a range of premium varying from Rs. 175 to Rs. 5770 per annum, the claims ratio being 84%. The Yeshasvini Cooperative Farmers Health Care System, the work of Karuna Trust, the Vimo SEWA, etc. are some recent examples of community health insurance providing protection against catastrophic health expenditure. Similarly, State Governments and some central ministeries have also been exploring the possibilities of risk pooling for Health Care. Government of Assam started a Health Insurance Scheme which covers major surgeries but

excludes essential maternity care etc. Government of Jharkhand is trying to design a Health Financing Product without exclusions in one block of each District with the partnership of industrial houses and Insurance Management Organization. Government of Kerala has recently initiated a programme of health insurance for 25 lakh below poverty line families called Kudumbshree Scheme which tries to rectify some of the exclusions in the earlier UHIS Scheme. The National Commission on Enterprises in the unorganized sector has also been examining the feasibility of Health Insurance for informal sector workers. The Ministry of Textiles has started a Health Insurance Scheme for co-operatives of weavers.

One of the impressive models of CBHI aimed at the poor is SEWA in Gujarat. SEWA's experience over 14 years based on insuring over 140,000 workers and their families suggests that for health insurance to be viable, it has to be controlled and run by the users themselves - negotiating fees, treatment regimens etc. with providers, both public and private. Those providers that adopt poor quality of care or fraudulent practices are black-listed. This has already had the effect of providers improving the quality of their care and revising some of their prices. It has also resulted in the public health system gearing itself up to provide the care required, with the public charitable trust hospitals serving as a back-up or alternative to the public and private-for-profit health providers. Finally, the experience of SEWA with health insurance has encouraged the development of a "cashless" system with providers, both public and private, enabling women and their families to seek quality care of their choice without having to pay upfront immediately. This new system is being tested out in eight talukas in Gujarat, as well as two working class neighbourhoods of Ahmedabad city.

SEWA experience points to the need for a comprehensive insurance package covering both life and non-life risks. This is advisable both because a holistic approach to risks and shocks faced by the poor is required, and also because this will lead to overall viability of insurance for the poor.

The Government of India's Universal Health Insurance Scheme (UHIS) was launched in the Budget of 2003-04 and is the first broad-based health security scheme having an element of financial contribution from the State. In 2004-05 budget the UHIS was revised to restrict it to Below Poverty Line families; increase the subsidy element to Rs.200 against the Rs.365 annual premium paid for individual coverage; Rs.300 for the Rs.547.50 premium for a family of five and Rs.400 for those paying a premium of Rs.730 for covering a family of seven persons. The coverage under UHIS is unsatisfactory (barely 1.3 lakh persons till 31 July 2005). Maternity benefit is not covered under UHIS. Exclusion of essential health care needs are likely to make any policy unattractive. Perhaps a range of health insurance products developed as per local needs, improved social marketing of such products, simpler procedures for claims, and accredited facilities for hospitalization in rural areas could have helped a larger coverage under UHIS.

The perception of Insurance Companies about UHIS

The General Insurers' (Public Sector) Association of India (GIPSA) have identified the following constraints in the UHIS programme: inability of BPL families to pay even the subsidized premium; low premium structure being cost prohibitive for effective canvassing and service; perception of government sponsored scheme as a free scheme; health insurance for poor as state responsibility and not commercially viable; and inadequate public health facilities, standards and system of Third Party Administrators.

The perspective for improving coverage for Risk Pooling

The experiences from across the world show that health insurance is neither a substitute for a well – functioning, effective and efficient public health care system, nor, an argument for undermining higher public investments as the success of risk pooling is dependent on the provision of health care services in the public and private sectors. Health insurance is an effective mechanism for reducing risk against lumpy and unpredictable expenditures that characterize health spending. Given the inability of households, more particularly the poor to raise such resources in a short time, cashless and simple procedures for claim settlement seem to be the ideal ways of ensuring access to health services to the poor and creating confidence among them regarding the system of health insurance as a way of health financing.

NRHM – An opportunity

The National Rural Health Mission (NRHM) aims to bring about fundamental reforms in the system of health care delivery as well as exploring new health care financing mechanisms and developing credible community based health insurance schemes. The NRHM envisages an empowered District Health Mission with adequate technical, managerial and accounting support in managing risk pooling and health security. With schemes to have Accredited Social Health Activists (ASHAs) for every 1000 population; strengthened 3222 Community Health Centres and a 24 hour round the clock hospital facilities in every Block; subsidizing indirect costs under the Janani Suraksha Yojana for promoting institutional deliveries among Below Poverty Line pregnant woman.

All these initiatives will contribute to providing opportunities to improve risk pooling through community based health insurance.

Need for diversity of approaches – letting a hundred flowers bloom

A critical issue in the context of India's health insurance is the rapid growth of an unregulated private health sector following no standards and with no control on the prices to be charged or use of technology. The 60th Round of NSSO shows a doubling of the costs of inpatient hospitalization in urban areas since the past decade. Combined with long waits and poor quality of care in the public health facilities, this escalation is leading to the greater indebtedness of people.

In the above context and in order to provide choice and expand access, international experience shows that insurance coverage for the poor is indeed possible, if certain critical issues are taken into account. The most important of these issues is developing a mechanism of implementation that is specially tailored to the reality of the poor, and organized according to their convenience.

Need for participation of government funded public health institutions

The Group deliberated on the participation of Government Health Care facilities in any innovative risk pooling arrangement. The Group felt that the participation of Government Hospitals and Health Centres was very critical for any risk pooling arrangement as otherwise it becomes a system of subsidizing private health care. It was also felt that the challenge of risk pooling for remote rural households can only be met when public health systems are also a part of such innovative health financing mechanisms. The example of Karuna Trust's work in Karnataka showed how by compensating poor households for loss of

wages and other indirect expenses and reimbursing hospitals a certain amount for drugs and medicines in every case of hospitalization, result in increasing access to medical care, optimal utilization of the public facilities and reduction in households expenditures. One possibility therefore is to have a number of pilots undertaken on risk pooling for poor households through NGOs, Self Help Groups, other community organizations covering the indirect expenditures that are incurred in seeking health care.

Any kind of Health Insurance Scheme, which does not involve the public medical facilities, would not succeed because, in majority of states, these are the only facilities available in rural areas. The involvement of the States could be worked out by designing a Plan Scheme by the Ministry of Health and Family Welfare with subsidy being passed on to the hospitals through the State Governments. In such a situation, the State Governments can invite bids on 'premium to the charged' at their level from all the insurance companies, both public and private. For availing of the subsidy from the Central Government, the minimum features of the Scheme could be decided a priori and informed to the State Governments. The State Government may add some more features to the scheme and may also provide financial assistance to the policyholders by contributing whole or part of the premium. In this scenario, the modalities of administering the scheme at different levels may be described in detail by the Central Government or may be left to the State Governments.

Innovative financing for efficiency

Innovative mechanisms of health financing can be used to improve accountability of the health system, be it in the public or private sector. For example if a CHC were to receive resources directly on the basis of their case load, it would contribute to a more effective service delivery. Similar would be

the case of the private sector. For involving the private sector as a provider of care paid for by a public financing system, there is need to establish effective standards, capacity to monitor their enforcement, and a regulatory framework for ensuring that providers did not exploit the market imperfections so inherent in the health sector. The work of the National Commission on Macroeconomics and Health on unit costs for core, basic and secondary health care package alongside the facility survey of the public and private sectors in 8 districts could be a useful starting point for developing standard costs and treatment protocols and a basis for public private partnerships in health service delivery.

Difficulty with formal insurance organizations

There was an apprehension feeling that the formal organization of Health Insurance Companies do not have the capacity to address the needs of the poor on account of the complex procedures involved in reimbursing the amounts and setting claims. Even the current arrangement of a few Third Party Administrators [TPA] to facilitate health care reimbursements does not seem to be effective in enabling the poor participate in health insurance. The Group felt that there was a need for a district level body to play the role of TPA. The Group felt that the District Level Board for Innovative Health Financing could mobilize finances from a varied set of sources such as user fees from those with ability to pay, household contributions, government subsidy etc. In such a system the role of the NGOs, Community Based Organizations is vital for articulating peoples needs, ensuring access without hassles and motivating communities to contribute and save for health care. For discharging these functions, the District Health Financing Boards as well as the NGO's need capacity building in management and financing. In this context it was noted with satisfaction the IRDA notification issued on 10th November, 2005 on micro-insurance,

formalizing the involvement of NGOs, cooperatives and other community based organizations in health insurance.

Role of Panchayati Raj Institutions

Panchayati Raj Institutions have the mandate to manage the Primary Health system. The various tiers of Panchayati Raj Institutions ought to exercise control and supervision over health facilities, functionaries and functions. Communitization through ownership by Panchyati Raj Institutions adequately prepared to undertake the management role is necessary for an efficient and effective health system. The experience with Hospital Development Committees in Kerala and Rogi Kalyan Samitis in Madhya Pradesh has prompted the Central Government to mandatorily seek the establishment of such community organizations in health institutions. Innovative health financing would require active ownership of the public health system by Panchayati Raj Institutions.

Amendments needed in the regulations on health insurance

The single most important determinant for the success of any health insurance scheme is the confidence and trust that it generates among the contributory households, as in this case, they are sanctioning current use for a future benefit, year after year. While the regulations for insurance are enforced by the Insurance Regulatory and Development Authority (IRDA), a structure and rules framed for their operations, licenses for Third Party Administrators systematized etc.for addressing the concerns of the model of financing proposed, two major changes would be required: (i) allowing NGOs and local district health financing boards to manage health insurance; and (ii) widen the network of the Third Party Administrators in order to provide such scope and possibility

at the district level, so as to allow entry to NGOs and district health financing boards. Monopolies of the few insurance companies and a handful of Third Party Administrators will have to give way to several players at the local level district based organizations working through an equally large network of Third Party Administrators. For effectively regulating such diverse systems of health financing models and to cope with the complexities of the health sector it would be adviseable to establish a Health Insurance Regulatory Authority as an independent authority or under the aegis of the existing IRDA.

In conclusion, it is recommended that to initiate establishing risk pools for the poor based on the concepts of community based health insurance the following steps may be considered:

- Appoint a body that will take the responsibility of organising the health insurance programme – could be an independent Health Insurance Corporation, or a cell in the Dept. of H & FW, a separate trust, or a NGO.

- Examine the feasibility of organizing large risk pools by combining the organized sector with the organized elements in the informal sector such as cooperatives, self help groups etc. This is essential as size of risk pools determine the extent to which the cross subsidization between the rich and poor, the old and the young and the sick and healthy can take place. Such cross subsidization is essential for long term sustainability of the insurance scheme.

- Arrive at a basic package that would address the medical, surgical and other health needs of the poor to be provided as inpatient or outpatient. For the BPL families, transport and wage loss compensation need to also be factored.

- The premium for a reasonable package of basic services is estimated to cost about Rs 250 for a family of five. The proportionate share between the three key stake holders will need to be finalized : the Central Governemnt, the State Governemtn and the individual households. It is necessary to note that the poor cannot sustain contributing to a scheme which is not subsidized.

- An independent body should be appointed to administer the scheme having the requisite technical and managerial capacity.

- A cell should be established to closely monitor specific indicators to ensure that the programme is on track.

Terms of Reference - III

To assess disease burden and cost of ill health in the country and project figures for 2012 and 2017;

The NCMH recently carried out disease burden estimations based on an exhaustive review of available research and data and extrapolated to 2015. These estimations were also peer reviewed by experts. For each disease/ health condition, experts also provided a minimum standard and treatment protocol. Costs of treating a condition as per the given protocol was then computed using market prices for drugs, medicines and other goods. For services and the capital infrastructure required, government rates were adopted and unit costs derived by arriving at average utilization rates currently observed. It is for this reason stated that the cost of delivering a similar service in a private facility would be 30-50 % more. As there is no new research or evidence emerging, the WG felt

that there was no purpose served in undertaking a review of these estimations. Accordingly, the disease burden for 2015 and the cost of treatment as arrived at by the NCMH is adopted.

Terms of Reference – IV

To give cost estimates for health care-public, NGO and private-current and for the Eleventh Plan period;

The only source of data available for providing an estimate of the proportional share of health expenditures by NGO's, the public and the private sector and for the XIth. Plan period is the 60th. Round NSSO which is a large household survey recently conducted. As per this survey, the average medical expenditures incurred at different health facilities for inpatient care is given below. As can be seen from the table, there has been an overall increase in the expenditures incurred in all facilities, in rural as well as urban areas. Most worrying is the near doubling of expenses incurred in the private hospitals located in urban areas. It is recommended that to get better insights into how adverse has been the impact of these increases, an analysis fractile goup wise needs to be undertaken.

Table -3 :Average Medical Expenditure (Rs.) per Hospitalization Case

Type of Hospital	Rural		Urban	
	2004	1995-96	2004	1995-96
Government Hospitals	3,238	2,080	3,877	2,195
Private Hospitals	7,408	4,300	11,553	5,344
Any Hospital	5,695	3,202	8,851	3,921

Source : 60th Round NSSO 2004

Terms of Reference - V

To suggest alternative sources / strategies for health financing during the 11th Plan to meet the cost of health care;

Currently India's health financing mechanism as mentioned earlier is largely out-of-pocket and a declining trend in public finance. Some recommendations for resource mobilization to meet the enhanced investment levels for health care are given below:

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. Presently, the central and state governments together spend Rs.250 per capita at the national level, but this is inequitably allocated between urban and rural areas. The rural healthcare system gets only Rs.120 per capita and urban areas get Rs.560 per capita, a difference of over 4 ½ times. If allocations are made using the mechanism of global budgeting, as is done in Canada for instance, that is on a per capita basis then rural and urban areas will both get Rs.250 per capita. This will be a major gain, over two times, for rural healthcare and this can help fill gaps in both human and material resources in the rural healthcare system. The urban areas in addition have municipal resources, and of course will have to generate more resources to maintain their health care systems which at least in terms of numbers (like hospital bed : population ratios and doctor : population ratios) are adequately provided for. Global budgeting also means autonomy in how resources are used at the local level. The highly centralized planning and programming in the public health sector will have to be done away with and greater faith will have to be placed in local capacities.

Second, shortage of human resources and skills is a major constraint for the public health system to realize its goal of universal access to health services. In this context it is pertinent to consider the fact that since the public exchequer contributes substantially to medical education, to the extent that nearly 80% of medical graduates are from public medical schools, there is need to utilize this resource for public good. Since medical education is virtually free in public medical schools the state must demand compulsory public service for at least three years from those who graduate from public medical schools as a return for the social investment. Today only about 15% of such medical graduates are absorbed in the public health system. In fact, public service should be made mandatory also for those who want to do post-graduate studies (as many as 55% of MBBS doctors opt for post-graduate studies). Such a measure will be the least costly way of assuring availability of the required medical skills a the point of delivery in the public health system. Such assured availability of quality care is necessary for enforcing the concept of guaranteed care, a cornerstone of the NRHM policy.

Third, the governments can raise additional resources through levying "sin taxes" - compulsory cesses and levies on products such as cigarettes, beedis, alcohol, pann masalas and guthka, personal vehicles etc. that directly contribute to enhancing health risks, that are also extremely expensive to treat. For instance tobacco, which kills 670,000 people in India each year, is a Rs.350 billion industry and a 2% health cess would generate Rs.7 billion annually for the public health budget. Similarly alcohol, which presently generates Rs.250 billion in revenues, can also bring in substantial resources if a 2% health cess is levied. With 10% of morbidity and mortality, particularly among the young is on account of accidents and injuries, 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 owners. Land revenues and property taxes can also attract a health cess which is earmarked for public health.

Fourth, social insurance can be strengthened by making contributions similar to ESIS compulsory across the entire organized sector and integrating ESIS, CGHS etc. with the general public health system. Also social insurance must be gradually extended to the other employment sectors using models from a number of experiments in collective financing like sugar-cane farmers in south Maharashtra paid Re 1 per tonne of cane as a health cess and their entire family was assured healthcare through the sugar cooperative. There are many NGO experiments in using micro-credit as a tool to factor in health financing for the members and their family. Large collectives, whether self-help groups facilitated by NGOs, or self-employed groups like headload workers in Kerala, can buy insurance cover as a collective and provide health protection to its members. At least 60% of the workforce in India has the potential to contribute to a social insurance programme.

Fifth, other options to raise additional resources could be various forms of innovative direct taxes like a health tax similar to profession tax (which funds employment guarantee) deducted at source of income for employed and in trading transactions for self-employed. Using the Tobin tax route is a highly progressive form of taxation which in an increasingly service sector based economy can generate huge resources without being taxing on the individual as it is a very small amount of deduction at the point of transaction. What this basically means is that for every financial transaction, whether cheque, credit card, cash, stock market, forex etc. a very small proportion is deducted as tax and transferred to a fund earmarked for social sector. For example if 0.025% is the transaction tax then for every Rs.100,000 the transaction tax would be a mere Rs.25 or one paise per Rs.40 transacted. This would not hurt anyone if it were

made clear that it would be used for social sectors like health, education, public housing, social welfare etc.

The Group felt that over time, attention should shift from incremental change to a structural overhaul of the health system in order to assure universal access based on a 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 reorganizing the entire healthcare system, especially the private health sector, alongside making the required level of problem investment in health care.

Likewise to reduce out - of-pocket financing of the healthcare system, policies need to be quickly put in place for a system of health financing that will be a combination of public finance and private contribution by establishing various collective financing options such as social insurance, collectives/common interest groups etc. At another level the healthcare system needs to be organized into a regulated system that is ethical and accountable and is governed by a statutory mandate, which pools together the various sources of financing and manages it for ensuring all the members access to comprehensive healthcare. This will happen only if the entire healthcare system, public and private, is organized under a common umbrella, ideally through a single-payer mechanism that operates in a decentralized way.

Terms of Reference – VI

To deliberate and give recommendations on any other matter relevant to the topic.

Strategies for health financing during the 11th plan

Hospital Development Committees/Rogi Kalyan Samitis

Hospital Committees should be established in every public health facilities with elected representatives, health care providers, representatives of consumer groups etc. For instance, in Rajasthan Medical Relief Societies, RKS in Madhya Pradesh and SKS in Haryana have been set up in all the government hospitals at district sub– division and below levels for the purpose of better maintenance and improvement of hospital services.

Availability of Drugs through PPPs

In order to provide cheaper medicines to the common man, MRS in Rajasthan has established outlets known as life-line fluid stores opened within the hospital premises, providing medicines free of cost to BPL families. PPP initiatives can be started in collaboration with pharmaceutical companies, private pharmacies and govt. hospitals

Through these initiatives several critical medicines, injections, antibiotics, IV Fluids etc. can be purchased in bulk through open tender from the manufacturing companies and sold through the outlets in the hospital premises. This will result in to reduction of prices considerably

All states may be advised to replicate similar models which would help make available critical drugs at affordable prices to the common man and to provide medicines free of cost to BPL families.

Levying of User charges

A nominal user charges may be levied for all outpatient services provided in public health facilities. Available studies show that there is a willingness to pay for services provided in government hospitals. The poorest of the poor may be exempted from paying for services. For in-patient care, a modest user charges may be levied (based on cost of recurrent items). The funds collected should be kept at the disposal of hospital committee and should be utilized for the improvement of service delivery. Government may provide matching grants linked to user charges collected to those facilities located in rural remote areas. More over the exemption mechanism needs to be properly implemented. Graded user charges can be levied. Awareness should be generated among the segment of the population who are exempted from paying user charges (as the poor in some cases do not know that they have been exempted from paying charges).

Facilities should hold periodic and timely Audit and regular utilization reviews to identify whether user fee policy has had an adverse impact. Community may be given responsibility to identify the families, which have no means to pay (eg. Tanzania). Issuing card should be made less bureaucratic.

Encourage maternal health insurance scheme

Encourage maternity health insurance scheme under the NRHM (pooling JSY incentives), to increase institutional deliveries, achieve reductions in maternal and infant mortality, stimulate the development of accreditation

systems across rural and urban India, institutionalize multiple partnerships and contribute to the development of sound, inclusive referral systems.

Encourage Small risk pools

The cost of hospitalization (both direct & indirect costs) is huge among the poor in rural areas. Currently, there is no financial protection available to this vast majority of the population. Initially, small risk pools led by a consortium of self-help groups, may be encouraged to administer financial help to needy households at village levels, in the event of hospitalization and death. Government can encourage consortium of such self –help groups by proving an initial grant for its operation.

Encourage Co-operative health insurance

Promote health insurance schemes by Involving network of co-operatives as in Karnataka. Constitute risk pools around professional or occupational groups like self help groups or micro credit groups, weavers, fishermen, farmers, agricultural laborers and other informal groups (as in Kozhikod, Kerala)

Creation of separate budget head for all donor grants

In India, foreign grant is received for combating specific diseases like HIV/AIDS, TB, leprosy, malaria etc. Such grants are disease specific which often do not take into account the disease burden or the priority of the Government. The funds from donor agencies should therefore be pooled under a single budget head so that government may prioritize the spending according to the disease burden of the population. This may well make all the difference.

Other Recommendations

- Govt should enable need based bottom up programme planning and budget should be in consonance with the extent of the disease burden

- A separate provision should be made in the budget for meeting all emergencies. Certain discretion should be allowed to reallocate available funds in meeting emergencies at least up to the District level

- Institute an internal audit system at state and district level (as done in srilanka)

Annex- I

MINUTES OF THE MEETING OF WORKING GROUP ON HEALTH CARE FINANCING INCLUDING HEALTH INSURANCE FOR THE ELEVENTH PLAN HELD ON 18th JULY, 2006 AT NIRMAN BHAVAN, NEW DELHI.

Following were present:

1. Ms. Sujata Rao, Additional Secretary (NACO), MOH&FW, GOI. – Chairperson
2. Shri I. V. Subba Rao, Pr. Secretary (Health), Govt. of AP
3. Ms. Usha Ganesh, Pr. Secretary (Health) Govt. of Karnataka
4. Shri M.M. Upadhyay, Pr. Secretary (Health) Govt. of MP
5. Dr. Amarjit Singh, Commissioner (Health) Govt. of Gujarat
6. Sh. GC Chaturvedi, Joint Secretary, Insurance Division, Ministry of Finance, GOI
7. Dr. D. Narayana, Fellow, CDS, Trivendrum
8. Dr. Ravi Duggal, CEHAT, MUMBAI
9. Dr. Moneer Alam, Health Economist, Professor, IEG, New Delhi
10. Dr. N. Devadasan, Institute of Public Health, Bangalore
11. Dr. Ravendra Singh, Director(Policy),MOHFW, GOI
12. Dr. S.P. Goswamy, National Consultant (Health Insurance), MOHFW, GOI
13. Ms. Radha Ashrit, SRO(Health), Planning Commission, New Delhi
14. Sh. Amarjeet Sinha, Joint Secretary, MOHFW, GOI- Member Secretary

The Planning Commission, New Delhi, vide their letter No. 2(15) /06-H&FW Dated 25-05-06 constituted a Working Group on Health Care Financing including Health Insurance for the Eleventh Plan, defining the Terms of Reference for deliberations. The first meeting of the Group was held on 18/07/06 under the Chairpersonship of Ms Sujata Rao, Additional Secretary (NACO), MOH&FW, GOI, New Delhi. In her welcome address, Ms. Rao requested the members to provide suggestions for low cost health care to the poor people.

Shri Amarjeet Sinha, Joint Secretary, MOHFW explained the various aspects of NRHM 2007-2012 to the participants. He also highlighted various points relating to Health Financing and Health Insurance which are under active consideration of MOHFW, GOI. He further deliberated on the factors increasing high out of pocket health expenditure and ways of reducing health expenditure. He also highlighted the various health insurance schemes being run by NGOs in various States. He gave a broad framework of Terms of References which were as follows:

i. To review the present position of health financing at state, centre and individual levels. Keeping in view, identified problems and constraints of existing system, make suggestions for improvement in quality and efficiency with reduction in the cost of health care to the poor in the Eleventh plan.
ii. To suggest management strategies for community based health insurance as well as process and impact assessment parameters for these initiatives during the 11th plan.
iii. To assess disease burden and cost of ill health in the country and project figures for 2012 and 2017.
iv. To give cost estimates for health care public, NGO and private – current and for the 11th Plan period.
v. To suggest alternative sources/strategies for health financing during the 11th Plan to meet the cost of health care.
vi. To deliberate and give recommendations on any other matter relevant to the topic.

Dr. Amarjeet Singh, Commissioner (Health), Gujarat, explained the success story of Chiranjeevee Scheme launched by the Gujarat in 5 selected districts with the help of Public-Private Partnership, providing Maternity benefit to the women. Out of 215 Gynecologists in the State, 163 got themselves empanelled under the scheme and earning substantial amount. Based on the success of the scheme, State Government would be considering introducing this scheme in whole of the State.

Shri Upadhaya, Pr. Secretary (Health), MP, explained the insurance scheme launched by the State to provide the Maternity benefit to 45 lacs BPL women. He informed that due to this scheme, the number of institutional deliveries has doubled in just 5 months. District Committee are processing the claim and releasing the money to the beneficiaries and taking the re-imbursement from the Insurance Company.

Dr. Narayana, CDS, Trivendrum mentioned that the utilisation of public services had been going down while the use of private sector health care facilities had increased. Dr. Ravi Duggal, CHEHAT, Mumbai highlighted the need for improving the utilisation of existing Government health facilities. He advocated that the funds should be provided to PHCs, CHCs etc. on the basis of utilisation of these facilities like beds, OPD, Indoor patients, deliveries etc.

Shri Chaturvedi, Joint Secretary (Insurance) suggested that private sector should be provided more funds for making available health services in the rural areas. He also advocated more public-private partnership in this regard.

Ms. Usha Ganesh, Pr. Secretary (Health) mentioned that there should be incentive for Government hospital staff also. They should be allowed to get 30% of the funds generated through the health insurance.

Some of the participants have mentioned the issues about the availability of specialist doctors for posting at rural areas, management of hospitals and the payment system to the doctors. The need for more utilisation of private health facilities was also mentioned as and where the government health facilities could not able to function properly. There was also a suggestion for taxing health hazardous items, which could be utilized for provision of health care to poor patients.

As the representative from NSSO was not present in the meeting, Ms. Rao asked Shri Amarjeet Sinha, Joint Secretary, MOHFW to request NSSO to send a representative during the next meeting apart from making a presentation on the findings from various NSSO surveys about the cost of treatment at rural areas as well as on utilisation of Government health facilities in availing various health services.

Summing up the discussions, Ms. Rao requested all the participants to send their suggestions/material on various items of Terms of Reference to Shri Amarjeet Sinha (email: **amarjeet_sinha@hotmail.com**) latest by 31/07/06, which shall be exchanged amongst the members for their final views. The next meeting would be held in the 2nd week of August 06 after the receipt of the suggestion from the members.

The meeting was ended with vote of thanks.

ANNEXURE II

HOUSEHOLD, PUBLIC AND TOTAL HEALTH EXPENDITURE IN INDIA (2004-2005)

States	Household Exp. (Rs.Crores)	Govt. Exp. (Rs. Crores)	Other Exp. (Rs.Crores)	Aggregate Exp. (Rs.Crores)	PC HH Exp. (Rs.)	PC G Exp. (Rs.)	PC Other Exp. (Rs.)	PC Exp (Rs.)	HH as % of THE (%)	PE as % of THE (%)	OE as % of THE (%)
Central Govt.	0	14819	730	15549	0	137	7	144	0	95.3	4.7
A.P.	6441	1696	640	8777	820	216	82	1118	73.38	19.39	7.29
Arun. Pradesh	430	67	0	497	3776	589	0	4365	86.51	13.49	0
Assam	3054	672	52	3778	1089	239	19	1347	80.84	17.78	1.38
Bihar	11854	1091	202	13147	1021	124	23	1497	90.17	8.3	1.53
Delhi	1004	721	55	1780	664	476	37	1177	56.41	40.48	3.11
Goa	524	116	22	662	3613	798	153	4564	79.17	17.48	3.53
Gujarat	4893	996	424	6313	920	187	80	1187	77.51	15.78	6.71
Haryana	3385	421	175	3981	1518	189	79	1786	85.03	10.56	4.4
H.P.	2126	306	40	2472	3377	486	64	3927	85.99	12.38	1.63
J & K	1759	471	47	2277	1609	431	43	2082	77.26	20.69	2.05
Karnataka	3847	1267	353	5467	702	231	64	997	70.36	23.18	6.46
Kerala	8373	1048	281	9702	2548	319	86	2952	86.3	10.8	2.9
M.P.	6432	1051	228	7711	746	164	35	1200	83.41	13.63	2.96
Maharashtra	11703	3527	726	15957	1156	348	72	1576	73.34	22.1	4.55
Manipur	420	89	8	517	1680	356	32	2068	81.24	17.2	1.56
Meghalaya	58	94	8	160	242	388	34	664	36.45	58.37	5.18
Mizoram	38	58	0	96	405	623	0	1027	39.39	60.61	0
Nagaland	1024	84	7	1116	4897	404	37	5338	91.74	7.57	0.7
Orissa	2999	684	111	3795	786	179	29	995	79.04	18.02	2.93
Punjab	3493	827	273	4593	1379	326	108	1813	76.05	18	5.95
Rajasthan	3399	1190	267	4855	565	198	44	808	70	24.5	5.5
Sikkim	72	55	0	127	1274	965	0	2240	56.89	43.11	0
Tamil Nadu	3624	1590	760	5974	566	248	119	933	60.67	26.61	12.72
Tripura	253	100	13	366	760	301	40	1101	68.99	27.35	3.66
Uttar Pradesh	17158	2650	550	20359	924	150	31	1152	84.28	13.02	2.7
West Bengal	7782	1715	433	9929	931	205	52	1188	78.38	17.27	4.36
U.Ts.	3160	325	227	3712	11168	52	37	598	85.13	8.74	6.12
State Totals	**109308**	**17965**	**5906**	**133178**	**1012**	**167**	**54**	**1233**			
GT[GOI+State]	109308	32784	6636	148727	1012	304	61	1377	73.5	22	4.46

Notes:

i) Household Expenditure Based on NHA for the year 2001-02 and extrapolated for 2004-05

ii) Central Govt. expenditure includes transfer to states, other central ministries and central PSUs; and data obtained from Demand for Grants (Provisional), Govt. of India

iii) Govt. Expenditure includes Central, States, Local Govt. and PSUs: data obtained from States Finances (Provisional), RBI, Various issues

iv) Other include foreign agencies, private firms and NGOs; data relates to 2001-02, which is subsequently extrapolated for 2004-05

v) PC HH Exp. – Per Capita Household Expenditure; PC G Exp. – Per Capita Govt. Expenditure; PC Other Exp. – Per Capita Other Expenditure; HH as % of THE – Household as % of Total Health Expenditure; PE as % THE – Public Expenditure as % of Total Health Expenditure; OE as % of THE – Other Expenditure as % of Total Health Expenditure; C. Govt. – Central Govt; U.Ts – Union Territories.

Source: Report of the National Commission on Macro Economics & Health. 2005

Annexure III

TRENDS IN HEALTH EXPENDITURE IN INDIA

Year	Health Expenditure as % of the GDP			Per-Capita Public Expenditure on Health (Rs.).
	Revenue	Capital	Aggregate	
1950-51	0.22	NA	0.22	0.61
1955-56	0.49	NA	0.49	1.36
1960-61	0.63	NA	0.63	2.48
1965-66	0.61	NA	0.61	3.47
1970-71	0.74	NA	0.74	6.22
1975-76	0.73	0.08	0.81	11.15
1980-81	0.83	0.09	0.91	19.37
1985-86	0.96	0.09	1.05	38.63
1990-91	0.89	0.06	0.96	64.83
1995-96	0.82	0.06	0.88	112.21
2000-01	0.86	0.04	0.90	184.56
2001-02	0.79	0.04	0.83	183.56
2002-03	0.82	0.04	0.86	202.22
2003-04	0.86	0.06	0.91	214.62

Note:

i) GDP is at market price, with 1993-94 as the base year
ii) Includes only Central and State government expenditure

Source: Report of the National Commission on Macro Economics & Health, 2005

Annexure IV

SHARE OF HEALTH IN REVENUE BUDGET OF MAJOR STATES (IN %)

States	1985-86	1991-92	1995-96	1999-00	2003-04(R.E.)	2004-05 (B.E.)
Andhra Pradesh	6.41	5.77	5.7	6.09	5.21	4.8
Assam	6.75	6.61	6.08	5.25	4.39	4.36
Bihar	5.68	5.65	7.8	6.3	4.84	6.47
Gujarat	7.45	5.42	5.34	5.21	3.68	3.76
Haryana	6.24	4.19	2.99	4.08	3.63	3.35
Karnataka	6.55	5.94	5.85	5.7	4.85	4.18
Kerala	7.69	6.92	6.81	5.95	5.42	5.2
Maharashtra	6.05	5.25	5.18	4.59	4.39	3.89
Madhya Pradesh	6.63	5.66	5.07	5.18	4.89	5.08
Orissa	7.38	5.94	5.42	5.03	4.47	4.58
Punjab	7.19	4.32	4.56	5.34	4.27	4.05
Rajasthan	8.1	6.85	6.18	6.39	5.75	5.73
Tamil Nadu	7.47	4.82	6.4	5.51	5.26	4.91
Uttar Pradesh	7.67	6	5.73	4.42	5.13	5.75
West Bengal	8.9	7.31	7.16	6.3	5.23	5.04
All States	7.02	5.72	5.7	5.48	4.97	4.71

Source : Report of the National Commission on Macro Economics & Health, 2005.

Annexure V

STATEMENT ON FUNDS FOR HEALTH CARE IN INDIA, 2001-02

Source of funds	Exp. In Rs.000S	% Distribution
(a) Public funds		
1. Central Government	67,185,399	6.4
2. State Government	132,709,065	12.6
3. Urban Local Bodies and Panchayat Raj Institutions #	14,496,554	1.3
Total (a)	214,391,018	20.3
(b) Private funds		
1. Households	760,939,107	72.0
2. Firms $	55,365,142	5.3
3. Non Governments Institutions Serving Households (NGOs) *	799,783	0.1
Total (b)	818,104,032	77.4
(c) External Support		
1. Grants to Central Government	16,483,158	1.5
2. Material Aid to Central Government	825,937	0.1
3. Grants to State Government	2,389,555	0.2
4. To NGOs	5,147,996	0.5
Total (c)	24.846,646	2.3
Total funds	1,057,341,696	100.0

Source : National Health Accounts, India 2001-02, Ministry of Health & Family Welfare

Annexure VI

% OF TREATED AILMENTS RECEIVING NON-HOSPITALIZED TREATMENT FROM GOVERNMENT SOURCES

Major State	Rural			Urban		
	2004 *60th Rd*	1995-96 *52nd Rd*	1986-87 *42nd Rd*	2004 *60th Rd*	1995-96 *52nd Rd*	1986-87 *42nd Rd*
Andhra Pradesh	21	22	12	20	19	16
Assam	27	29	40	24	22	26
Bihar	5	13	14	11	33	17
Chhattisgarh	15	*	*	20	*	*
Delhi	@	*	*	23	*	*
Gujarat	21	25	28	18	22	18
Haryana	12	13	15	20	11	19
Himachal Pradesh	68	*	*	86	*	*
Jammu & Kashmir	52	*	*	51	*	*
Jharkhand	13	*	*	24	*	*
Karnataka	34	26	32	16	17	30
Kerala	37	28	32	22	28	33
Madhya Pradesh	23	23	24	23	19	28
Maharashtra	16	16	21	11	17	15
Orissa	51	38	37	54	34	43
Punjab	16	7	12	18	6	11
Rajasthan	44	36	46	53	41	52
Tamil Nadu	29	25	28	22	28	31
Uttaranchal	18	*	*	35	*	*
Uttar Pradesh	10	8	*	13	9	14
West Bengal	19	15	16	20	19	20
India	**22**	**19**	**21**	**19**	**20**	**24**

Note: 1. The estimates of the 52nd round are based only on the treatments with reported source of treatment

2. * denotes estimate not available and @ denotes estimate not presented

Source : Morbidity, Health Care and the condition of the aged NSS 60th Round, Ministry of Statistics & Programme Implementation, 2006.