Working Paper Number 2

Structural Adjustment and the Health Care Sector in India
Some Policy Issues in Financing

Brijesh C Purohit*

The paper examines different strategies for the financing of health care in India, where the effect of structural adjustment has been to undermine the traditional resource base. The relative merits of user fees, insurance schemes, administrative decentralisation and partial privatisation are discussed. The main policy conclusion is the need for better regulation of the various modalities of health care delivery

---

***** Visiting South Asian Scholar, Queen Elizabeth House, University of Oxford, Oxford, OX1 3LA, UK Thanks are due to Barbara Harriss-White for her valuable comments. The study was supported by the South Asian Visiting Scholarship to the author at Queen Elizabeth House

1. Introduction

In the last decade, many developing countries have attempted structural adjustment programmes (Cornia et al,1988). India also chose to adopt the path of structural adjustment in the early 1990's. Besides other liberalisation measures, this implied a reduction in the budgetary deficit. Thus spending by the government on social sectors had to be curtailed (Prabhu,1996). The impact of this expenditure reduction is also being felt on the health care sector. In general, in the period between 1984-93, the central grants to states declined from 19.9 per cent to 3.3 per cent (Duggal et al, 1995a, b ; NIPFP,1993). The impact of this decline is most noticeable on specific purpose central grants for public health and disease control programmes. The central component for the former of these (namely, public health) dropped from 27.92 per cent to 17.7 percent. The latter in the same duration declined from 41.47 per cent to 18.50 percent. The impact of this falling share of central grants was more pronounced in the poorer states which are unable to raise local resources to compensate for this loss of revenue[1]. While the orthodox literature stresses targeting as the technical response to scarcity in the social sector, the questions tackled were different. In fact a variety of alternative mechanisms for rationing access to health care have emerged which ranged from statutory entitlement at one extreme, to non-provision at the other. In between are numerous methods to achieve deterrence, dilution and delay of access to care (Creese, 1991). To overcome this adverse aspect of structural adjustment, it is necessary to devise a health sector strategy that could augment its resource base. This is radically different policy issue to the options conventionally discussed with regard to public health/ institutions etc.

Four approaches could augment the resource base of the health care sector: i) to adopt the system of cost recovery at the secondary and tertiary level health institutions (World Bank, 1993,

[1]The constitution of India provides a division of responsibility between the central and state governments. There are three lists delineating the division of work between Centre and States. Accordingly, the establishment of institutions of national importance, which may include research and tertiary level institutions, falls under the "central" list and in these areas the central government has exclusive jurisdiction. The areas including public health, sanitation, hospitals and dispensaries fall under the state list. The primary responsibility for the provision and regulation of such services lies with the states. The subjects like population control and family planning, medical education, prevention of food adulteration, drugs and poisons, regulation of medical profession, vital statistics including registration of births and deaths etc. are in the concurrent list, where centre can direct the states to act in a particular manner. This division of responsibility makes the states primarily responsible for the expenditure on basic preventive, promotive and curative services.

1995); ii) to adopt other innovative financing mechanisms including specific taxes,cesses, local levies and community level endowment funds supplementing public funding and provision of public health services; iii) to initiate suitable health insurance coverage with appropriate public-private mix; iv) adopt another mode of health care delivery where the government encourages private sector participation by taking up the role of public purchaser of private services rather than remaining a provider *per se*. The suitability of each of these strategies in the Indian context is, however, an empirical question. There is only fragmentary evidence in the Indian context with which to reflect upon these health care financing issues. It is thus interesting and necessary to explore the various issues pertaining to the feasibility and efficacy of various resource mobilisation measures in the health care sector by analysing the experience of various countries which have either adopted structural adjustment policies or have otherwise reformed their health care sectors. Keeping in view the significance of learning from the innovative nature of such developments and the possibility of reflecting upon the Indian situation in the light of various interesting developments elsewhere, the present study carries out a detailed review of relevant experiences in health services financing of developing as well as developed countries. We will bear in mind the inter- relationship between finance and other supply aspects of health care services, namely, the planning, organisation, availability and delivery of health care services. Related demand-side questions, namely of access, utilisation and the quality of care are also reflected upon. These issues lead us to ethical questions: whether health should be considered something which may be provided to all by the government or whether it should be considered like any other commodity left to market forces?

The paper is therefore divided into six sections. The following section discusses the experience pertaining to user fees. The analysis of different insurance mechanisms is carried out in section III. The various health financing reforms especially pertaining to decentralisation and privatisation are discussed in section IV. This is followed by a synthesis of the relative merits and demerits of different health financing innovations. Keeping in view the relevance of different financing mechanisms from the point of view of health services availability, efficiency in production and consumption of health services and the applicability in the Indian context, policy implications are derived which comprise the final section.

2. User Charges

Among the various financing options to fund recurrent costs, user charges remain the most controversial. The possibility of their implementation in the public sector was put primarily on the policy agenda following the World Bank's policy document on *Financing Health Services In Developing Countries: An Agenda For Reform* in 1987. It got a further thrust from the Bomako Initiatives promoted by UNICEF and endorsed by WHO and African leaders in the same year.

The economic rationale behind the imposition of user fees emphasises that: i) payments for services will discourage frivolous use of health facilities; ii) by making payments consumers will become conscious of quality and will demand it and iii) the greater funds availability of funds through user fees at the point of service will increase both the availability and quality of services (Griffin, 1987). However, in practice the positive benefits envisaged through user charges did not materialise or were over-shadowed by other negative unintended outcomes. The socially regressive impact of user fees in particular has been prominently highlighted in the experience of most of the developing countries.

The exhaustive reviews by Griffin (1987) and Creese (1991) summarise the experiences of user fees in many Asian and African countries[2]. It has been found that owing to exemptions for indigent and the poor, the user fees cannot recover the entire recurrent costs. The proportions of cost recovery in terms of gross yield vary between 5-15 percent in African countries. In terms of the total budget of health ministry, for instance, the collections from user fees may be as low as 3 percent (Quick et al, 1993).

Studies in different countries for the most part indicate a dampening impact of user fees on the utilisation of health services. For example, in Zaïre it was observed that a price increase in health services overall led to a fall in utilisation rate from 37 percent to 31 percent (De Bethune et al,

[2]In earlier World Bank studies of user fees, Vogel (1988a) has covered the countries, namely, Botswana, Burkina Faso, Brunie, Cote d'Ivoire, Malawi, Mozambique, Zimbabwe, Ethiopia, Ghana, Kenya, Lesotho, and Rwanda. The recent studies in the African sub-continent have covered some new aspects of user fees in the countries of Burundi, Cameroon, Egypt, Guinea, Kenya, Nigeria, Uganda and Zambia. See, for instance, Forsberg et al, 1992; Quick et al,1993; Litvack and Bodart, 1993; McPake et al, 1993, Ellis et al, 1994; Collins et al, 1996; Mwabu and Wang'ombe, 1995.

1989). The decline in pre-natal contacts were around 11 percent. Generally it is the poor who tend to respond negatively to price increases thereby affecting equity. A study contrasting rural and urban responses in Ghana found that an increase in the price of health care in rural areas led to a decline which sustained even after two years. By contrast, in urban areas, the attendance over this period sustained. Moreover, there was a diversion of rural demand to unlicensed sellers of drugs (Waddington and Enyimayew, 1989; 1990).

However, Cameroon is an example where user charges did not lead to reduction in demand (Litvack and Bodart, 1993). In a more recent study it was found that in Kenya the experimentation to introduce the fee in a phased manner also led to a fall in OPD visits from 14,000 per month to 10,000 per month (Mwabu and Wang'ombe, 1995). The study results indicate higher sensitivity to the costs of diagnostic services relative to registration fees.

Further, the vulnerability owing to user fees has been focussed on certain age groups and types of diseases. For instance, in Lesotho, the impact of an increase in fees was greatest on the 0-5 years age group (Bennett, 1989). Even in Lesotho (Byrne and Gertler, 1990), it was observed that children in general and adults with cardiovascular and genito-urinary conditions were at greater risk of reduced access to health care due to fees increases (Byrne and Gertler, 1990). Likewise, in Swaziland, a decline in the use of government services for STD and respiratory diseases was suspected (Yoder, 1989). In Bangladesh, it seemed to deter patients with communicable diseases (Creese, 1991). Following the reforms in 1980's, in China the emphasis on user fees to obtain self sufficiency in health service finance has also been associated both with a regressive impact on utilisation and with wasteful investment on inappropriate high-tech equipment (Liu et al, 1995).

The study by Mcpake et al (1993) found that in most countries examined the incentives created by the pricing structure of these initiatives and the lack of appropriate exemption mechanism to protect vulnerable groups were the problem areas. The travel and other costs pertaining to the use of higher level facilities led to problems with patients unable to afford the services under the

Bomako initiatives[3].

As Creese (1991, p.318) opines "Fees in the health sector are thus not an instrument of health policy, but a means of fiscal policy, with the health ministry being a tax collecting agency". However, efforts have been made to overcome some of the problems associated with user fees. For instance, in another study in Kenya by Collins et al (1996), it was indicated that the implementation of user fees in phases according to the level of facility (national, provincial,district and sub-district hospitals and health centres) led to better acceptance both by the providers and patients. The phased implementation backed by the development of better management systems helped to reduce the decline in demand and revenue collections improved. The improved management system included steps like the preparation of cost sharing operation manuals, and staff training for procedures pertaining to patients' claims, cash collections, waivers, exemptions, accounting and reporting etc. Likewise, anomalies in exemptions like free services to civil servants were replaced by new medical allowance to the civil servants. The phased implementations downward from the apex referral hospital as well as the retention incentive created by appropriate management training helped to improve collections. However, the results of the management training input did not indicate a consistent improvement in quality of services (Collins et al, 1995).

Cost increases to patients by user charges can be partly mitigated by supply-side cost sharing ie cost control and containment measures. It has been pointed out by Ellis and Mcguire (1993) and Hodgkin and Mcguire (1994) that to pay providers in advance on the basis of the average cost of treating groups of diagnostically related illnesses would make providers more cost conscious and thus cost reduction or containment will take place.

Nonetheless, as against its economic rationale, the experience of user fees has been so far found to be unsatisfactory either with respect to the quality or to the accessibility of services (Creese, 1991). Further the literature remains obscure on the question of the impacts of different payment systems such as flat fees, differentiated fees, fees per episode or per item of service,

[3]In fact similar set of costs also deterred the patients to afford these facilities available through NGOs (Mcpake et al,1993).

prepayment versus payment at times of use (Creese, 1991). The limitations of user fees for financing supervision, logistical support, referral linkages and evaluation have been also recognised (Abel-Smith and Dua, 1988) and thus it is best considered as an imperfect and partial solution to the problem of increasing health service resources (Stinson, 1984).

3. Insurance

The health insurance mechanism provides a way by which risk sharing within society may take place (Akin, 1987). Those who do not fall sick but participate in the insurance schemes contribute towards the expenses of health care of other members of the community. Simultaneously, the insurance provides security that in times of illness care will be paid for by a third party.

The experience of risk sharing in developing countries has been very limited. There generally do not exist large scale health insurance schemes either in public and private sectors. According to one survey by the World Bank, the population coverage by insurance in 1985-86, except for China and Korea, varied between 0.3 percent in Papua New Guinea to 34.8 percent in the Philippines. In China and Korea, the population coverage remained 59.3 percent and 56.5 percent respectively (Griffin, 1992). In another survey by the World Bank, Vogel (1990a, b) has covered 23 Sub-Saharan African countries[4]. Among these only twelve countries had formal insurance[5]. The percentage of the total population insured ranged from 11.4 percent (in Kenya) to merely.001 percent (in Ethiopia). Besides these, the other five countries which had insurance included Burkina Faso, Burundi, Cote d'Ivoire, Mali, Nigeria, Senegal, Sudan, Zambia and Zimbabwe. The share of public insurance in the total recurrent health expenditure in these countries varied between .043 percent (in Cote d'Ivoire) to 24.1 percent (in Zambia). In the

[4] Burkina Faso, Burundi, Cameroon, Cote d'Ivoire, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, Sudan, Swaziland, Tanzania, Uganda, Zaïre, Zambia and Zimbabwe (Vogel, 1990a).

[5] In the study by Vogel (1990a), health insurance is defined as a formal pool of funds held by a third party (or by the provider, in the case of Health Maintenance Organisation (HMO), which relies on pre-payment by its insurers) that pays for the health care costs of the membership of the pool. This third party can be a governmental social security or other public insurance fund pool or any private fund pool.

same group of countries, the corresponding share of private insurance remained in the interval of .02 percent (in Ethiopia) to 16.51 percent (in Zimbabwe). The findings of this survey indicate that in the existing set up of insurance the main beneficiaries are the relatively small middle classes. Vogel concludes "development of health insurance to date in Sub- Saharan Africa has not promoted greater equity in the access to health services by the poor, nor has it permitted greater access" (Vogel, 1990). In most of these countries owing to lack of deductibles and co-insurance, there results inefficiency in consumption of health services. Similarly, on the production side, the system, being based on open-ended, cost based retrospective payments, had a perverse effect on providers. The latter have no incentive to minimise costs thus medical costs tend to escalate.

However, there are case studies of different types of insurance schemes having relatively low coverage. Prior to reforms of 1980's, in the Asian sub-continent, Chinese health care system in fact provided an excellent example of successful insurance schemes in rural areas. Prior to the recent reforms, even since the 1950's an exhaustive health insurance coverage existed in China for the different tiers of its health care system, namely: village, township and county. In the post-reform period, however, the coverage has fallen drastically in the rural areas. Currently, there operate three types of insurance in China. These are known as Gogfei Yiliao or Publicly Funded Medical Care, Laobao Yiliao or Labour Insurance Medical Care and Cooperative Medical Care Scheme (Ho, 1995). Among these, the Publicly Funded Medical Care is funded from government budget. It provides coverage for civil servants, workers in public agencies, universities, handicapped military officials above a certain ranking and university students. By the end of 1993 the scheme covered some 29 million people. Labour Insurance Medical Care is financed at the enterprise level from Welfare funds of the enterprises. It provides coverage for employees in state and collective enterprises and their immediate family members. By the end of 1993, it covered 144 million people. The Cooperative Medical Care Scheme is being practised in rural areas. Prior to the reforms, in 1978-79, nearly 80-90 percent of rural population was covered. In the post reform era, this coverage declined sharply and in 1993 only 20 percent of workers in agriculture sector are being covered. Before the 1980's agricultural reforms, health services in rural China were organised and financed through the cooperative medical system (CMS). By the end of 1983, the collective system of agricultural communes was almost replaced by individual household farming systems whereby each household leased its own land and retained all the

earnings. It is noteworthy that China's remarkable achievement in terms of its IMR falling from 200 per 1000 live births (in 1949) to 47 per 1000 live births (1973-75) and increased life expectancy from 35 to about 65 years (or in other words its "first health care revolution") had its roots in the successful cooperative medical system (CMS). The latter was characterised by collective financing, prepayment and three tier organisation of health services (Hsiao, 1984; Halstead et.al, 1985). Under the CMS, village health stations, township health centres and county hospitals provided a closely inter-related referral system. After the collapse of CMS, each of these became independent institutions.

In India, a good example is provided by ESIS scheme in urban areas meant for industrial workers. This scheme has been in existence since 1952. It covers nearly 28 million people, which is larger than many national systems in Latin America. Yet research shows that ESIS has been incurring losses. These are due to its coverage which extends beyond health care alone. Being a social security scheme ESIS has provision for wage compensation against sickness and also allows cash payments for partial debility and occasions like marriage and funeral. In fact, the amount of money sanctioned under the cash benefit component of the ESIS has brought about substantial operational inefficiency in the scheme (IIMA, 1987).

Likewise case studies of small scale insurance schemes operated by NGOs in different parts of India have been documented (Dave, 1991). Case studies of insurance card schemes in some Asian as well as in African countries also exist. Typically, these card schemes have problems of low coverage, poor quality of services, administrative and financial problems.

In Thailand, for instance, a voluntary health card scheme has been operative since 1983. It has only 5 percent coverage of the population. People are reluctant to buy insurance cards unless there is some unavoidable expenditure like expected delivery etc. The scheme depends heavily on Government subsidies and card holders complain of getting less attention than non-card holders (Piyaratn, 1994). In another card scheme in Vietnam running since 1993, the coverage is less than 5 percent of population. Problems in its implementation include high dependence on government subsidies, poor quality of services, doctors asking for bribes and discrimination against card holders (Abel-Smith, 1993).

In a card scheme implemented in Burundi since 1984, coverage is 23 percent of households. Yet revenue from card sales covers only one third of the drug costs. Many households did not participate due to poverty. Problems like a 50 percent higher utilisation of health services by card holders than by the general population, card holders receiving less attention, low quality of services, drugs being frequently out of stock are reported. In Burundi, responses from women respondents also indicated their impressions that: i) card was good for poor families or families with seasonal income and ii) good for women with husbands who drink (Arhin, 1994).

In most of the developed countries, except Britain, Scandinavia and Japan which started full coverage through their national health services respectively in 1948 and 1960 (Scandinavia and Japan), full coverage began as recently as the 1970's or 1980's[6]. The experience of these developed countries indicate that initially there have been problems in formulating health insurance to cover the self employed (eg farmers, fisherman and others, people with low earnings and other self employed). The various approaches to overcome this difficulty in covering the self employed in a health insurance coverage included: i) cross subsidising the low income self employed by means of other funds, ii) subsidising such insurance (for self employed) by public funds (Powell and Anesaki, 1990) and iii) efforts to collect some contribution from farmers by land tax, according to potential profit (eg in Italy), by a health tax on agricultural produce (eg in Brazil), and by a contribution as part of the income tax (eg in Netherlands, France and Belgium). A variety of means were adopted to cover the unemployed, the elderly and the disabled. These included, for instance, considering the elderly as dependent on insured persons and the payments of the contributions for those dependent on social assistance by the central or local government agency.

Likewise, as Hurst (1991) observes, the organisational pattern of insurance funds in the developed countries also had a number of variants which included, for instance i) one insurance fund in which powers are delegated to local areas. It simplifies administration when people change employers or places of residence ii) a series of local funds iii) a mandatory set of certain defined benefits to be provided by all funds, whether these funds are centralised or de-centralised; the

[6]for instance, the full coverage was started in 1970's in Canada. It began in 1980's in Italy, Spain, South Korea and Portugal.

pattern existing currently in Germany, Japan and South Korea and iv) competition between funds for members with a central body collecting the contributions and distributing them among the chosen insurers according to the risks of their members; the model existing in the Netherlands.

Similarly, health insurance systems could be distinguished in terms of direct and indirect systems. In the former, eg in East European countries, the salaried professionals would have their own hospitals and health centres. In the latter, for instance prevailing in Belgium, Canada, France, Japan, Luxembourg and Germany, health insurance funds would contract all services paying private doctors on the basis of fees for services. However, in the countries with national health insurance systems, the services of private profit-making insurers are not used. The central government in most of these countries plays a crucial role in regulating non-profit insurers (Abel-Smith, 1992).

Further, as it prevails in Europe, basically the third party payment takes place in either of three forms distinguished as: i) the reimbursement model ii) the contract model and iii) the integrated model (Hurst, 1991). In the reimbursement model, there is no direct connection between the insurers and the providers. Consumers pay the premium to the insurers and providers are also paid by the consumers and who in turn get it reimbursed. In the contract model, there is a direct payment to the providers by the insurers which is based on a contract. In the integrated model, providers are paid directly by the insurers in a vertically integrated organisation of providers and financiers. This is done, for instance, by global budgets and salaries. In countries like UK, New Zealand and Sweden, a trend towards the separation between the purchasers and providers is replacing the earlier vertically integrated system. By contrast, the trend is towards integrated health care organisations like Health Maintenance Organisations (HMO's) in the USA. However, in the situation exemplified by the USA, where there are multiple third party payers, the notion of price competition among providers and third party payers becomes important. This leads to four basic models involving the providers and insurers in different situations of price competition or its absence (Fig 1). In all, through a combination of these four basic models, there could be ten different models of health insurance (Fig 2).

Figure 1: Four Basic Models of Health Care Markets with Third Party Payers (Insurers) and Providers of Care

Third party payers	Providers of care	
	Price competition	No price competition
Price competition	1	3
No price competition	2	4

Figure 2: Different Models of the Relation Between the Third Party Payers (Insurers) and the Providers of Health Care

Third party payers	Providers of care	
	Price competition	No price competition
Price competition		
	IA competitive reimbursement model	IIIA monopolistic provider reimbursement model
	IB competitive contract model	IIIB monopolistic contract model
	IC competitive integrated model	
No price competition		
	IIA competitive reimbursement model	IVA non-competitive provider model
	IIB monopsonistic contract model	IVB bilateral monopolistic contract model
		IVC monopolistic integrated model

However, in any model involving competition among insurers, the tendency towards cream skimming has to be avoided. Cream skimming is non-existent in monopsonistic compulsory health insurance market. The latter also has the advantage of lower transaction cost than a competitive market since providers need to conclude a contract with a single payer only. However, there are certain disadvantages in monopsonistic compulsory health insurance: i) if it is a private monopsony, it may exercise monopsony power in the medical service market and it may augment the monopoly rent of a private insurer with market power in the insurance market and ii) it may lack incentives for the third party purchaser to act as an agent on behalf of the 'consumers'. To overcome this problem a system of regulatory incentives and monitoring need to be developed to ensure that the single third party purchaser acts in the public interest.

Currently the UK health care system is moving away from a monopolistic integrated model (4c) towards a monopsonistic contract model (2b) ie replacing a vertically integrated finance and delivery system by a system of contracts between a third party purchaser and competing providers. The Dutch health care system is poised to adopt a competitive contract model (1b) with compulsory health insurance. At present it is a combination of a bi-lateral monopolistic contract model (4b) (nearly 60 percent of its population is buying health insurance from a regionally based sickness fund) and a monopolistic provider reimbursement model with competing private health insurers (model 3a).

The recent amendments in New Zealand have replaced a monopolistic integrated model (4c) by monopsonistic contract model (2b). In Belgium, there is a move to introduce competitive contract model (1b) (Nonneman and Van Doorslaer, 1994). Price competition among sickness funds is also on the agenda in Germany (Schulenburg, 1994).

Thus, keeping in view the basic objectives of enhancing equity and efficiency, many OECD countries have adopted different forms of reforms. It has been observed that some forms of insurance reforms have tended to be better in certain respects than others. For example, it has been pointed out that i) the countries which relied mainly on the contract model as well as global budgeting did not have an increase in their health expenditure in relation to their GDP. For instance, in Germany and Netherlands which adopted this kind of reform, the health expenditure (as proportion of GDP) remained almost the same, although their real per capita GDP rose almost by 14 percent. Yet the countries who relied mainly on the integrated model had similar outcomes; ii) countries like Belgium and France which adopted a combination of reimbursement and partial global budgets had a rise in the share of their health expenditure but one which was lower than the rise in their real per capita income (OECD, 1992) ; iii) the introduction of market components in the health care systems in these countries might have had adverse consequences for equity in terms of allocation of internal resources geographically and across patient groups (Scottten, 1994); iv) in the countries with public integrated systems, there has been concern about under-service, inflexible and ineffective management systems (OECD, 1993); iv) in the reimbursement or contract model, where it is presumed that money follows patients, an anxiety about unnecessary care partly led to supplier-induced demand. In such systems, a concern is also voiced about excessive regulation.

Thus, each of these systems have their own merits and demerits. However, the numerous possible forms and combinations of insurance coverage indicate an evolving state of knowledge and policy in this area. It cannot be said that right options have been implemented everywhere. Choices about one system or the other is a matter both of political ideology and people's need. The perceptions about the latter tend to be more dynamic in nature than the static one. However, as Abel-Smith (1992) puts it "there is a very strong case for trying out new models in one local area before applying them nationally. The transition may well take several years and cannot be hurried".

4. Other Reforms:Privatisation and Decentralisation

Besides direct financing mechanisms, the importance of other resource mobilisation measures, in particular, decentralisation and privatisation of the health care sector has also been revealed by experience. The distinction between privatisation and decentralisation has to be borne in mind in a discussion of these experiences. The former aims at passing on the provision of certain services from government to private sector. The latter implies the transfer of responsibility for planning, management and resource generation and allocation from the central government and its agencies to other levels of government or public authorities (Rondinelli, 1981).

Many of the recent reforms in developed countries, for instance in UK, are geared towards privatisation. Policy changes in favour of privatisation cater to regulated markets in which greater reliance is placed on market mechanisms with government regulation imposed only to prevent market failure. Here the health care market may be opened to private providers and the price mechanism is a critical tool for balancing supply and demand.

Generally it is presumed that managed markets especially in the hospital sector will increase supply-side efficiency by increasing competition among providers and there will be increased transparency in trading or hospital business (Broomberg, 1994). Thus, efficient managed markets in welfare services like health presuppose i) competition between suppliers; ii) definable outputs for which consumer valuation could be made and iii) lower transaction costs compared to an existing set of costs (Sappington and Stiglitz, 1988). In some types of reforms, some of these

conditions are not satisfied. For instance, reforms in the UK have been associated with substantial transaction costs which include the costs of writing contracts, additional managerial staff deployment at various levels, monitoring their implementation and thus overall higher administrative costs in the post-reform phase (Legrand, 1994). It is estimated that following the reforms, administrative and management overhead costs in the National Health Services (NHS) in the UK have doubled from their earlier 5-6 percent of total health service expenditure (Health Policy Network, 1995)

There may be other costs associated with managed markets. These include i) loss of monopsony purchasing power by the state in health care especially skilled staff such as medical doctors ii) sacrifice of equity and probable concentration of profitable services and selection of low risk patients (Legrand, 1991). iii) the impact of private providers especially private hospitals on public hospitals providing incentives for the latter to behave like a for-profit provider which concentrates on profitable services and avoids essential but non-profitable services (von Otter and Saltman, 1992).

In case of developing countries, doubts have been expressed about the applicability and generalisation of managed markets in health care. In these countries the nature of health sector institutions, market conditions and other crucial parameters are very different from their developed country counterparts. Simultaneously, most of the conditions necessary for successful implementation for such market oriented reforms (namely, high competition among providers, information availability and transparency, and management capacity) often do not exist in developing countries (Broomberg, 1994). Nonetheless, as articulated in the World Development Reports of 1987 and 1993, the World Bank has been emphasising that the private sector can be a more efficient producer of secondary and tertiary level of health care and, therefore, that the government budget can be diverted to primary health or to a minimum package of care (WDR, 1993). But as a matter of fact in some developing countries the private sector is already playing a major role in providing health care. In India, for instance, nearly 80 percent of expenditure is being incurred in the private sector.

Despite virtual absence of the basic conditions for success, privatisation has been attempted even in developing countries. These efforts fall into one of three types, namely i) divestiture (ie change

in the ownership of an enterprise from the public to private sector) ii) liberalisation or de-regulation and iii) franchising or contracting out. Generally, the latter two forms of privatisation have been more popular in developing countries (Cook and Kirkpatrick, 1988).

The experience of some of the developing countries have been quite adverse. In certain social insurance schemes in Latin America and Asia contracting out of clinical care has taken place (Mcgreevey, 1990; Griffin, 1990; Bennett and Mills, 1993). For example, in Chile the privatisation drive in 1973 accompanied by efforts to encourage new private health insurance schemes did not result in encouraging results. Due probably to lack of demand, caused by severe recession till the mid-eighties, only about 3 percent of the population had private insurance coverage (Viveros-Long, 1986). By contrast, the newly industrialised Korea owes its rapid privatisation in health care sector to high growth in GNP (Yang, 1990). In some countries, like in Mexico, international agencies like USAID have successfully encouraged privatisation of non-clinical elements of health services including drug sales, family planning, water supply and sanitation (Lewis and Kenney, 1988; Lewis and Miller, 1987). In many Latin American countries, like Brazil, Columbia,and Peru, social security schemes have started buying from both public and private providers (Gwynne and Zschock, 1989).

In general, an exploitation of the consumer (ie the patient) will take place with the sole reliance on the private- for- profit sector since a patient may commonly not be having anywhere approaching perfect information (Arrow, 1963). The private sector then generally serves the urban elite, thus exacerbating the problem of equity.

In order to encourage private providers to serve in rural areas, countries like Mexico, Malaysia, Zimbabwe and India have tried to subsidise such providers by tax reliefs (WHO, 1991). Experiments in increasing the income levels of public sector doctors (eg in Iran) and pay-clinics (eg in India and Mozambique) have also been effected. The successful contracting out of services like laundry (in Zimbabwe and India), radio therapy, CT scans and X-rays (in Malaysia) has also been done.

However, problems with contracting out are also not uncommon. For example, after contracting out hospital laundering, laundry costs in Zimbabwe increased by four times. Similarly the cost of

medical equipment maintenance after contracting out doubled without quality improvements. In Malaysia, owing to large capital requirements, the private firms did not show much willingness to contract for rubbish disposal. Moreover, it was observed by one study in South Africa that these contracts often favour the same contractor (Broomberg, 1994). This may be owing to lack of capacity and required information for design, negotiations, implementation and monitoring of efficient contracts (McPake and Ngalanda, 1994).

Besides the lack of necessary conditions for successful privatisation in developing countries, a sharp distinction between the reforms in Western Europe and developing countries has been pointed out by Bennett (1992). It is, namely, the fact that the Western European countries have maintained and moved towards universalising the public finance of health care and have created competition among a great diversity of providers (OECD, 1990). By contrast, the current emphasis in developing countries on privatisation is primarily short term move for extra funds which ignores the long term wasteful and pluralistic nature of such moves. It makes government financing less comprehensive. It does not take care of the long term implications of such moves (Bennett, 1992).

Decentralisation, like privatisation, cannot overcome all the resource constraints in the health care sector. At times, it may even have contrary effect of increasing levels of inequity. An interesting example is provided by the Chinese reform, in which, in the early 1980's, an overall decentralisation of the public financing system took place (World Bank, 1990). As a result, tax revenue for all levels of governments have decreased from 34 percent of GDP in 1978 to 20 percent in 1988. With the new system, the central government has gradually increased the retention rates in most provinces. This step was aimed at creating an incentive for the provinces to collect taxes, thus increasing tax compliance, and at the same time providing the provinces with a greater share. Another step was to introduce a provincial contracting system in 1988. This allowed the provinces to contract with the centre for a fixed revenue sharing quota. A certain base quota must be transferred to the central government and all the revenues above this quota may be kept by the province. So far, seven relatively prosperous provinces have been allowed to contract in the above manner. This has led to a serious reduction in the central government's revenue raising ability and its ability to distribute to poor provinces. This has led to further regional, provincial and urban/rural disparities in income and wealth; an unintended effect of

decentralisation.

This decentralisation of financial power in China has been coupled with fees for access to service system, a plurality of ownership in rural areas and competition among health care units working in the countryside and transfer of control and management of township hospitals from Country Health Bureaus to Township governments. Further, self sufficiency and cost recovery at each level is emphasised (Bogg et al 1994; SCRC, 1985). Consequently, many traditional Chinese Medicine (TAM) hospitals have problems of viability since the nature of their treatment does not allow for variation in their source of income. They mainly rely on sales of medicines. Thus, decentralisation policy in China, making local officials responsible for local health expenditure is likely to lead to an undue concentration of investment on medical technology, especially equipment, without consideration of efficiency, effectiveness or appropriate use (Zheng and Sheila, 1995). Further, it is not certain that medical insurance, decentralisation of decision making and financial autonomy will improve efficiency. In fact, "much depends on the Institutional set up...decision makers are conditioned by the constraints they face (both market and institutional constraints) and their interests need not coincide with the broader interest of the society" (Ho, 1995).

In this regard, reflecting upon the transformations in Chinese rural health care system, Liu et al (1995) make some very pertinent observations. They point out that "More than ten years have elapsed since China changed its economic system and China is still struggling to find an equitable, efficient and sustainable way for financing and organising health services for its rural population". They note that " the Chinese experience demonstrated the need to understand the limits of market forces and refine the role of government in rural health care under a market economy"..."However, under a market economy, the government still has a responsibility to provide sanitation, clean water, prevention, health education and primary care. In China, the government reduced its financial support for basic public health in rural areas and the controllable communicable diseases increased".

Similarly, the failure of decentralisation in overcoming health financing constraints have been noted in Papua New Guinea, where political immaturity and lack of financial management know how at lower levels of government could not enhance resources for health services despite

potential finance raising powers endowed by the constitution (Thomason et al,1991).

5. Policy Implications: Lessons for India:

The foregoing analysis indicates that there exists a range of financing mechanisms in the health care sector. The feasibility of any type of financing mechanism, however, is intimately linked to questions of equity and efficiency in regard to supply and demand in the sector. On one hand, these questions thus impinge upon supply aspects like planning, organisation and delivery. On the other, the demand side aspects regarding utilisation and quality of care also become pertinent. Simultaneously, the feasibility of any financing alternative cannot be divested from social, economic, demographic and institutional realities embedded in a country specific context. In a country such as India, there exist significant disparities across the States and, therefore, the feasibility of any policy measure is constrained by state specific factors. Indian health finance strategies might be desegregated for three groups of rich, middle income and poor states.

As indicated in section II, so far the global experience of user charges has been associated with its dampening impact on demand for health services. Though user charges are currently being deployed in most of the teaching and district hospitals in India, their revenue potential and their impact on demand has not been analysed. Case studies in some of the states indicate that efforts to capture equity considerations by means of exemption for the poor as well as bureaucratic delays in rate revisions have hampered the revenue potential of user charges even for the diagnostic facilities (Purohit and Siddiqui, 1995). Besides developing adequate information bases pertaining to cost structures of various facilities for individual states, the administrative efficiency of this mechanism is far from satisfactory.

Likewise, incentives at the hospital level are eroded due to the fact that funds collected by means of user charges cannot be retained at the site of the facilities. Since these health institutions do not have financial autonomy, currently the collections from user charges are sent to the state exchequer and refunded to the local health institutions through usual budgetary procedures. In effect, thus, these hospitals work like tax collectors for the finance ministry and do not have individual incentives to collect fees. Generally the availability and quality of health services are

not enhanced. Legislative measures are necessary to overcome impediments to user fees collections (Purohit and Mohan, 1996). Further, keeping in view the relevant experience of some of the African countries, appropriate management training especially in collection and financial techniques is necessary.

Likewise, supply side efficiency needs enhancing through measures aimed at cost containment and controls. Evidence in this regard, limited to case studies of teaching hospitals in Rajasthan, indicates that there is scope for resource mobilisation through enhancing operating efficiency (Purohit and Rai, 1992). Further studies should provide data bases for the cost and financing structures of different health procedures. Moreover, a focus on the particular aspect of the impact on demand of the implementation of user fees in public sector health facilities would be useful so that the equity implications of this mechanism in the country can be judged. At present, the studies in this regard are marked by their absence.

Similarly, more information is necessary to look into the feasibility of health insurance mechanism. Presumably the social safety nets associated with structural adjustment could be used to experiment with a localised monopolistic integrative model especially in poorer states. In richer states, however, scope for initial experimentation with other models of insurance could be studied in greater detail. Bearing in mind that the insurance schemes in the public sector have been unpopular so far owing to their low coverage and numerous administrative complexities, attempts could be made to overcome these factors. At the same time, the health insurance comprises merely one percent of the total business of insurance companies, it lacks aggressive campaigning by them. It would be possible, therefore, to stimulate insurance in health by initiating reforms such as : i) to allow multinationals in the insurance business ii) keeping in view the experience of the countries like Italy, Brazil, Netherlands, France and Belgium (which in their earlier phases moved towards universal coverage by means of taxes like land tax, tax on agricultural produce and contributions as part of the income tax), to explore the possibility of covering unorganised sector[7] iii) to initiate a series of studies in different state income categories to gather adequate information about the willingness and ability to contribute towards different kinds of insurance coverage of different social groups. Any such set of information will make

[7]See, supra p.14.

valuable contribution especially prior to embarking upon any new small or large scale insurance schemes.

It should be noted, however, that the form of insurance sought to be encouraged may have its own long term effects on the production and consumption of health care services. If open ended insurance is encouraged without specifying deductibles and coinsurance, as the experience in some African countries indicates (Vogel, 1988a), it may have adverse consequences both in terms of choosing only private providers and in terms of frivolous use of care. Similarly, the issue of revenue mobilisation by means of insurance or cost recovery should not ignore the important aspect of equity. Besides questions of inter- and intra-state equity and inter-sectoral equity, equity issues in health care have to be tackled more carefully. More specifically, the type of equity most desirable in the long run has to be clear. From a theoretical perspective at least seven different notions of equity in health care could be distinguished. These include, for instance, concepts like i) equal expenditure per capita; ii) equal inputs per capita; iii) equal inputs for equal needs; iv) equal financial access for equal need v) equal utilisation for equal need; vi) equal marginal net need and vii) equal health status (Menzel, 1983). Each one of these notions if adopted would have different implications with regard to resource requirements specified over a time horizon[8].

One of the important conclusions related to finance and delivery of health care is privatisation. In India, there exists a need not so much to privatise but to regulate the private health care sector. There currently exists a vast private sector in health care. For instance, at present about 70 percent of hospitals and 50 percent of hospital beds are in the private for profit and non-profit sector. This sector also employs about 70 percent of qualified doctors (Jesani and Ananthram,

[8]For example, equal utilisation for equal need has greater resource implications than equal financial access for equal need. Equal inputs for equal need implies that the additional year that a fifty five years old may live as a result of having medical care, has the same value as the fifty four years that a one year old might live, after having received care. Equal health status implies a different time frame than equal expenditure per capita. Moreover, equity in the provision of health care must also be considered with respect to equity in the finance of the health care. For example, if a country did provide equal health expenditure per capita, and thus achieved equity in provision but financed the health care by means of a regressive tax system, then equity still would not have been achieved. One beginning operational definition of equity for cost recovery in the health sector in developing countries might be "equal financial and physical access for equal need" where the tax system is proportional to income. This definition would correspond to the public finance concept of vertical equity on the expenditure side of the equation, but not on the tax side. (Vogel, 1988a, b)

1989). Presumably the state should play an important role in regulating this sector. However in India, the state regulation has been very lax. Even regulatory bodies like medical associations and medical councils have been lethargic. Generally the responsibility to govern medical practices through formulating proper codes and through their effective implementation lies with the medical councils and associations. However, currently these institutions seem to lack necessary infrastructure and do not have a set of standard norms for general and approved practices in the country. The state and local governments from time to time have enacted various regulations and guidelines[9]. However, a recent study conducted in Ahmedabad indicates a low awareness among private doctors about the various regulative Acts (Bhat, 1996).

It has been also observed that private sector institutions in India lack: strong peer pressure, standards for appropriate and general practices and strong mechanism to implement the existing guidelines (Bhat, 1996). More steps are necessary, therefore, to create an appropriate regulatory environment for the private health care sector in India[10].

Besides regulating the for-profit private sector, a more supportive role from the non-profit private sector, namely NGOs could be envisioned. In many remote rural areas, these organisations have been successful in mobilising resources and public support for health care (Purohit, 1995). It is important that appropriate attention is focused on the role and long term sustainability of this sector (Purohit, 1996 a, b,c).

Currently there is a move towards more decentralisation by reviving the Panchayatiraj institutions, the third tier of government. In order to overcome the resource crunch at lower level health

[9]These include the acts like Indian Medical Council Act, Code of Ethics, International Code of Ethics, Declaration of Geneva, Consumer Protection Act, Drugs and Cosmetics Act, Dangerous Drug Act, Drug Control Act, Drug Price Control Act, Pharmacy Act, Nursing Home Act, Bureau of Indian Standards and Public Nuisances Act.

[10]In this context, it has been suggested that the medical council should play an important role in regulating the medical education which in the private sector requires large sums for admission, this in turn is creating commercial minded doctors. Further, there is also a need to create a system in which doctors entering into private practice are guided to avoid wasteful practices like over-prescription of drugs and lab tests and no adherence to standards. As Bhat (1996) suggests that there is an urgent need to initiate a separate registration system which could provide structural information on the types of equipments, location, number of medical and para-medical staff etc. in a practice. Such information base is crucial in private practice.

institutions (namely Primary Health Centres and sub-centres) an interesting step could be to empower these local level institutions with the capacity to levy specific tax or cesses to be used for health care services. This, however, may require a constitutional amendment so that specific taxes could be retained at the local level institutions.

References

Abel-Smith B (1992) "Health Insurance in Developing Countries: Lessons from Experience", HP&P (3),215-226.

Abel-Smith B (1993), *The Health Insurance System in Vietnam*, Assignment report for SIDA, Stockholm.

Abel-Smith B and Dua A (1988)," Community Financing in Developing Countries: the Potential for the Health Sector", *HP&P*, 3, 95-108.

Akin J (1987),"Health Insurance in Developing countries: Prospects for Risk Sharing", in *Health Care Financing*, Proceeding of Regional Seminar on Health Care Financing, July 27- August 3, 1987, Asian Development Bank, Philippines, pp 191-236.

Arhin D (1994),"The Health Card Insurance Scheme in Burundi: A Social Asset or a Non-viable Venture", *Soc. Sci. Med*.,39 (8),861-70.

Arrow KJ (1963), "Uncertainty and Welfare Economics of Medical Care", *American Economic Review*, 53, 941-73.

Bennett S (1989),"The Impact of The Increase in User Fees: A Preliminary Investigation.", *Lesotho Epidemiological Bulletin*, 4, 29-37.

Bennett Sara (1992),"Promoting The Private Sector: A Review of Developing Country Trends", *HP&P*, 7 (2), 97-110.

Bennett S and Mills AJ (1993),"Health Insurance and the Private Sector" in *Report of The Workshop on the Public/Private Mix for Health Care in Developing Countries*, Department of Public Health and Policy, LSH&TM, London.

Bhat R (1996),"Regulating the Private Health care Sector: The Case of The Indian Consumer Protection Act", *HP&P*, 11 (3), 265-279.

Bogg L et al (1996), "The Cost of Coverage : Rural Health Insurance In China", *HP&P*, 11 (3), 238-352.

Broomberg J (1994),"Managing the Health Care Market in Developing Countries: Prospects and Problems", *HP&P*, 9 (3),237-251.

Byrne DJ and Gertlar PJ (1990), *An Analysis of the Impact of User Fees on Outpatient Utilisation In Lesotho*, The Rand Corporation, California, Draft Report.

Collins D et al (1996), "The Fall and Rise of Cost Sharing in Kenya: The impact of Phased Implementation", *HP&P*, 11 (1), 52-63.

Cook P and Kirkpatrick C (1988),"Privatisation in Less Developed Countries: An Overview" in Cook P and Kirkpatrick C (eds.), *Privatisation in Less developed Countries*, Harvester Wheatsheaf, London.

Cornia GA, Jolly R and Stewart F (1988), *Adjustment With A Human Face*, Vol I and Vol II, Oxford Univ. Press, Oxford.

Creese, A (1991),"User Charges for Health Care: A Review of recent Experience", *HP&P*, 6 (4), 303-319.

Dave P (1991),"Community and Self-Financing in Voluntary Health Programmes in India", *Health Policy and Planning*, 6 (1), 20-31.

De Bethune X et al (1989),"The Influence of An Abrupt Price Increase on Health Service Utilisation:Evidence from Zaïre", *HP&P*, 4; 76-81.

Duggal R et al (1995a),"Health Expenditure Across States-Part I", *Economic and Political Weekly*, Vol. XXX, No.15.April 15, p 834-844.

Duggal R et al (1995b),"Health Expenditure Across States-Part II", *Economic and Political Weekly*, Vol. XXX, No 16, April 22, p901-908.

Ellis RP and McGuire TG (1993), "Supply Side and Demand side Cost Sharing In Health Care", *Journal of Economic Perspectives*, 7 (4), 135-51.

Ellis RP et al (1994), "Inpatient and Outpatient Health Care Demand in Cairo, Egypt", *Health Economics*, 3 (3), 183-200.

Forsberg CB et al (1992), *Health Expenditures and Attitudes in Sub-Saharan Setting*, Stockholm, Sweden, Karolinska Institute.

Griffin GC (1987), "User Charges for Health Care in Principle and Practice" in *Health Care Financing*, Proceeding of Regional Seminar on Health Care Financing, July 27- August 3, Asian Development Bank, Philippines.

Griffin GC (1990), "Health Sector Financing in Asia", *World Bank Report No IDP*-68, The World Bank, Washington D.C.

Griffin GC (1992),"Health Care in Asia", The World Bank, Washington DC

Gwynne G and Zschock D (1989), *Health Care Financing in Latin America and the Caribbean, 1985-1989, Findings and Recommendations*, Department of Economics, State University of New York, Strong Brook.

Halstead SB et al (1985), *Good Health at Low Cost*, Rockefeller Foundation, New York.
Health Policy Network (HPN) (1995), *In Practice: The NHS Market*, National Health Service Support Federation, UK

Ho Lok Sang (1995),"Market Reforms and China's Health Care System",*Social Science Medicine*, 41 (8),1065-1072.

Hodgkin D and Mcguire TG (1994), Payment Levels and Hospital Response to Prospective Payment", *Journal of Health Economics*, 13 (1), 1-29.

Hsiao WC (1984), "Transformation of Health Care in China", *New England Journal of Medicine*, 310; 932.

Hurst JW (1991),"Reforming Health Care in Seven European Nations ", *Health Affairs*, Fall 7-21.

IIMA (1987), *Study of Health Care Financing in India*, Indian Institute of Management, Ahmedabad.

Jesani A and Anantharam S (1989), "What It Is and How to Fight It:A Report of a Workshop by Medico Friend Circle (Bombay group)", *Medico Friends Circle Bulletin*, May.

Legrand J (1994),"Evaluating the NHS Reforms" in Robinson R and Legrand J (eds) *Evaluating the NHS Reforms*, King's Fund Institute, London.

Le Grand (1991), "Quasi Markets and Social Policy", *Economic Journal*, 101, 1256-67.

Lewis MA and Kenney G (1988), *The Private Sector and Family Planning in Developing Countries: Its Role, Achievements and Potential*, The Urban Institute, Washington DC

Lewis MA and Miller TR (1987), "Public -Private Partnership in Water Supply and Sanitation in Sub-Saharan Africa", *HP&P*, 2 (1), 70-79.

Litwack, JI and Bodart C (1993), "User Fees and Improved Quality of Health Care Equals Improved Access: Results of a Field Experiment In Cameroon ", *Social Science Medicine.*, 37 (3), 369-83.

Liu et al (1995), "Transformation of China's Rural Health Care Financing ", *Social Science Medicine*, 41 (8), 1085-1093.

McPake B and Ngalanda Banda EE (1994), "Contracting Out Of Health Services in Developing Countries", *HP&P*, 9 (1), 25-30.

Mcpacke B et al (1993),"Community Financing of Health Care in Africa: An Evaluation of the Bomako Initiative", *Social Science Medicine*, 36 (1), 1383-95.

Mcgreevey WP (1990), "Social Security in Latin America:Issues and Options for the World Bank", *World Bank Report No 8456-LAC*, the World Bank, Washington DC

Menzel PT (1983), *Medical Costs, Moral Choices*, New Haven, Yale Univ. Press.

Mwabu G and Wang'ombe J (1995), "Health Service Pricing reforms in Kenya: 1989-93",

International Health Policy Program Working Paper (February), New York.

National Institute of Public Finance and Policy (NIPFP) (1993), *Structural Adjustment Programme-Its Impact on The Health Sector*, N. Delhi.

Nonneman W and Van Doorslaer EKA (1994), "The Role of Sickness Funds in Belgium Health Care Market", *Social Science Medicine*, 39; 1483.

OECD (1990), *Health Care Systems in Transition: the Search for Efficiency*, OECD Social Policy Study, OECD, Paris.

OECD (1992), The Reform of Health Care: A Comparative Analysis of Seven OECD Countries, Health Policy Studies No 2, OECD, Paris.

OECD (1993), *Health Systems: Facts and Trends*, Health Policy Studies No3, OECD, Paris.

Piyaratn PJWS (1994),"Health Insurance In Thailand", Paper presented at the *National Seminar On Health Sector Development*, Oct 4-7, Hanoi, Vietnam.

Powell M and Anesaki M (1990), *Health Care in Japan*, London, Routledge.

Prabhu KS (1996), "The Impact of Structural Adjustment on Social Sector Expenditure: Evidence From Indian States" in Rao, CHH and Linnemann H (eds), *Economic Reforms and Poverty Alleviation in India*, Sage Publication, New Delhi.

Purohit Brijesh C (1995),"The Cost Benefit Analysis of A Loan Scheme: A Case Study of Rangabelia Project", *Community Development Journal*, Vol 30, No 1, January, p 66-72, Oxford University Press, UK

Purohit Brijesh . (1996a), "Private Voluntary Health Sector in India", *Asian Economic Review*, Vol. XXXVII, No 2, August, p 297-311.

Purohit Brijesh C (1996b), "Private Voluntary Health Sector in India: Some Issues in Sustainability", *IDSJ Working Paper No68*, June, Institute of Development Studies, Jaipur.

Purohit Brijesh C (1996c), "Sustainability of Voluntary Sector in India", *Health For The Millions*, Vol 22, May-June, p 19.

Purohit Brijesh C and Mohan R (1996), "New Directions for Public Health, Financing", *Economic and Political Weekly*, Vol XXXI, No 8, February 24, p 450-453.

Purohit Brijesh C and Rai, V (1992), "Operating Efficiency in Inpatient Care: An Exploratory Analysis of Teaching Hospitals in Rajasthan, India", *International Journal of Health Planning and Management*, Vol 7, 149-162, UK.

Purohit Brijesh C and Siddiqui TA (1995), "Cost Recovery in Diagnostic Facilities", *Economic and Political Weekly*, Vol XXX, July 8, p 1700-1705.

Quick JD et al (1993), "Monitoring Methods For User Fees in Kenya: Assessing Impact on Patients, Access, Quality and revenue", Paper presented at *American Association Annual Conference*, San Francisco, California, Oct 24-28.

Rondinelli D (1981),"Government Decentralisation in Comparative Perspective: Theory and Practice in Developing Countries", *International Review of Administrative Science*, 47 (2), 133-45.

Sappington D and Stiglitz JE (1988), "Information and Regulation" in Bailey E (ed) *Public Regulation: New Perspectives on Institutions and Policies*, MIT Press, Cambridge MA.

Schulenburg JMG Vonder (1994),"Forming and Reforming the Market for Third Party Purchasing of Health Care: A German Perspective", *Soc. Sci. Med*., 39 (10),1473-1481.

Scotton RB (1994), "Let us Think Seriously About Managed Competition", *Social Science Medicine*, 38; 2.

State Council of the Republic of China (SCRC) (1985),"A Report with respect to Some Policies of Health Work Reform", *State Council Document*, 62, State Council, Beijing.

Stinson W (1984),"Potential and Limitations of Community Financing", *World Health Forum*.

Thomason JA et al (1991),*Decentralization In A Developing Country: The Experience of Papua New Guinea and Its Health Service*, Australian National University, Canberra.

Van De Ven WPMM et al (1994), "Forming and Reforming The Market for Third Party Purchasing of Health Care", *Social Science Medicine*,39 (100), 1405-1412.

Viveros-Long A (1986), "Changes in health Financing: The Chilean Experience", *Social Science Medicine*, 22 (3), 379-385.

von Otter C and Saltman RB (1992), *Planned Markets and Public Competition Strategic Reform in Northern European Health Systems*, Open University Press, Buckingham, UK

Vogel RJ (1988a), "Cost Recovery in The Health Care Sector: Selected Country Studies in West Africa", *World Bank Technical Paper N .82*, World Bank, Washington DC

Vogel RJ (1988b), "An Analysis of The Welfare Component and Intergenerational Transfers Under The Medicare Program" in Pauly, MV and Kissick WB. (eds), *Lessons From The First Twenty Years of Medicare*, Philadelphia, University of Pennsylvania Press.

Vogel RJ (1990a), "Health Insurance in Sub-Saharan Africa: A Survey and Analysis", *Working Paper WPS 476*, Africa Technical Department, World Bank, Washington DC

Vogel RJ (1990b), "Trends in Health in Health Expenditures and Revenue Sources in Sub-Saharan Africa", Background paper for African Health Policy, World Bank, Washington DC

Waddington C and Enyimayew K (1989), "A Price to pay, Part I: The Impact of user charges in Ashanti-Akin District, Ghana", *International National Journal of Health Planning and Management*, 4, 17-47.

Waddington C and Enyimayew K (1990), "A Price to pay, PartII: The Impact of User fees in the Volta Region of Ghana", *International Journal of Health Planning and Management*, 5, 287-312.

World Bank (1987), *Financing health services in Developing Countries: An Agenda For Reform*, World Bank, Washington DC

World Bank (1990), *China: Revenue Mobilisation and Tax Policy*, Washington DC

World Bank (1993), *World Development Report, Investing in Health*, Oxford University Press, Washington DC

World Bank (1995), *India: Policy and Finance Strategies for Strengthening Primary Health Care Services*, Report No 13042-IN, May 15, Population and Human Resource Division, South Asia Country Department II.

World Health Organisation (WHO) (1991),"The Public/Private Mix in National Health Systems and The Role of Ministries of Health", Report of a Meeting held at the Hacienda Cocoya, State of Morelos, Mexico, 22-26 July, Director of Strengthening of Health Services, WHO, Geneva.

Yang, B (1990),"Issues in Health Care Delivery: The Case Of Korea", Paper presented at *World Bank Seminar on Health Financing and the Role of Health Insurance*, Bali, Indonesia.

Yoder RA (1989), "Are People Willing and Able to Pay For health Services", *Social Science Medicine*, 29, 35-42.

Zheng, Xiang and Hillier, Sheila (1995),"The Reforms of The Chinese Health Care System: County Level Changes: The Jiangxi Study", *Social Science Medicine*, 41 (8), 1057-1064.