CHAPTER 8
HEALTH FINANCING

8 HEALTH FINANCING

8.1 PUBLIC HEALTH FINANCING

8.1.1 Budget System in India

In India the existing fiscal structure for delivering health care services including RCH is too complex to implement effective health programmes. Complex plan/non-plan budget categories, centre-state financial transfers and many vertical health programmes from centre to districts obstruct the delivery of essential inputs for health programmes. Extensive efforts have to be made to collect and compile the details of public expenditure for both states and local governments. There is no separate detailed reporting of salaries, transportation, drugs, and so on, or any specific programme components such as immunisation and contraceptives due partly to the lack of programme budgeting.

In India the government budget in one fiscal year (from April through March) is classified into three funds:

- Consolidated Fund: most important working fund earmarking tax revenue, subsidy, salaries, etc.
- Contingency Fund: fund for unexpected expenditures
- Public Account: account for management of public funds such as small savings and pensions

The Consolidated Fund has a Revenue Account and a Capital Account. Both accounts have receipts and expenditures. The structure of Revenue receipts is described as follows:

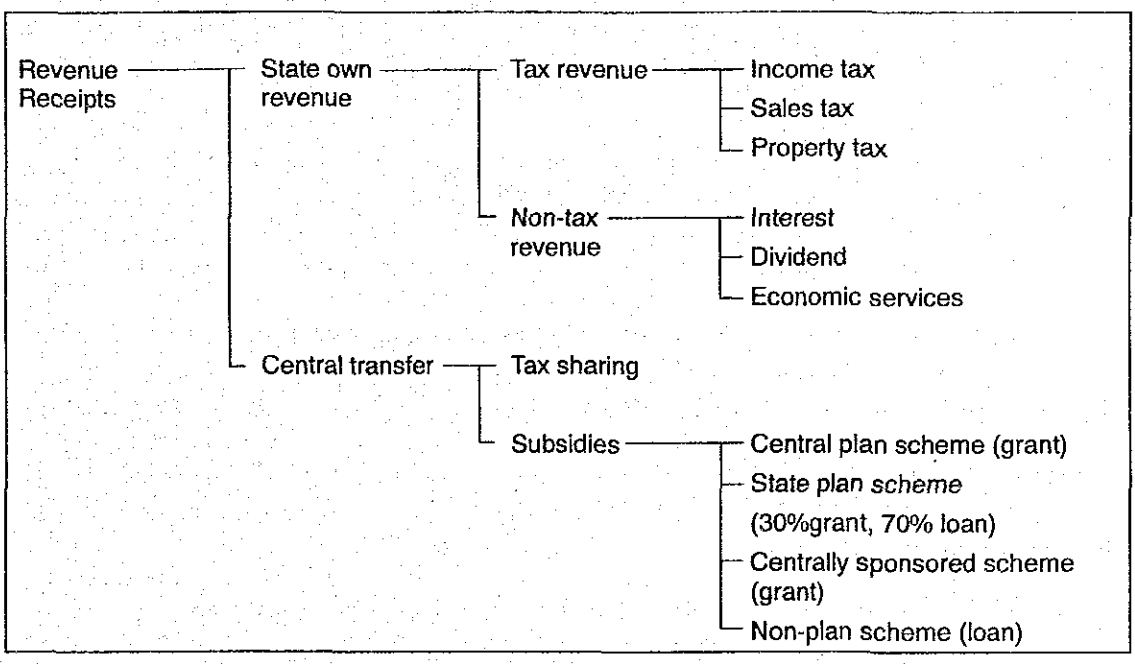

Figure 8-1 Structure of State Revenue Receipts in India

Detailed explanations of central transfer, which allocates 29% of central tax revenues to all states based on six indices such as population, area, per capita income and so on, are as follows;

Table 8-1 Detailed Classification of Central Transfer to States in India

Transfer through Finance Commission: non-plan expenditure
Tax sharing: transfer of central tax revenue to states
Gap filling grants: transfer for filling residual gap on budget of each state
Transfer through Planning Commission: plan expenditure
Central plan scheme: programme implemented by state based on central five-year plan
State plan scheme: programme implemented by state based on state five-year plan, 70% of fund is 20-years loan with fixed interest rate (11%)
Transfer through central ministries: plan expenditure
Centrally sponsored scheme: including RCH Program *
Central sector scheme
Foreign aid (grant / loan)

Note: Projects under Centrally Sponsored Scheme in MP are;

(i) RCH programme (World Bank)
(ii) Basic health services (DANIDA)
(iii) Malaria project (World Bank)
(iv) Leprosy project (WHO)
(v) HIV project (World Bank)
(vi) Border cluster districts project (UNICEF)
(vii) RCH through state sector reform bureau (WC)
(viii) Integrated population development programme (UNFPA)
(ix) TB project (World Bank)
(x) Blindness project (World Bank)
(xi) Health sector reform (EC)

The centrally sponsored scheme, one of plan expenditures, is a special grant programme only for health, education, caste, and poverty control. The decision to implement these programmes is often made at the discretion of central ministries that intend to control state ministries. Health programmes implemented under centrally sponsored schemes in MP at present are listed below. All of these programmes are grants to the MP state government, so only the central government has to pay back the loan to each donor in cases where the original fund came from a loan.

Both Capital and Revenue expenditures have two types of classifications: development, non-development and plan, non-plan. The development expenditure involves social and economic investment for infrastructure such as education, health, power, or rural development. The non-development expenditure includes mainly interests payments and pensions.

The budgeting of government expenditure is influenced by the planning process of central and state five-year plans. The ***plan budget,*** determined by the Planning Commission, refers to all expenditures incurred for new programmes and schemes that have been initiated in the current five-year plan. The ***non-plan budget,*** determined by the Finance Commission, finances the recurrent cost such as salaries, drugs and vehicles. After the completion of the five-year plan, the recurrent expenditure associated with the continuation of the programmes is generally transferred to the non-plan budget.

The responsibility for public health financing is shared mainly between the central and state governments. The central government is responsible for developing and monitoring national standards and regulations, channelling international and bilateral funding to the states, and sponsoring several centrally-funded schemes to be implemented by the states.

The **Figure 8-2** indicates this complex budget system.

State level budget system: At the state level, the State Planning Board imposes a budget ceiling for every department including DPHFW on the total permissible plan outlay during the five-year period. DPHFW is supposed to develop an action plan for how plan allocations will be used in the coming five years. In contrast, the annual government budget of DPHFW, which is first prepared by the Finance Department (FD) then approved by the state legislature, includes both the plan and the non-plan expenditure, as well as expenditures related to income from other sources such as externally-aided projects. In reality, co-ordination between the five-year plans and the annual budget is limited due to resource constraints and the absence of a medium-term fiscal framework.

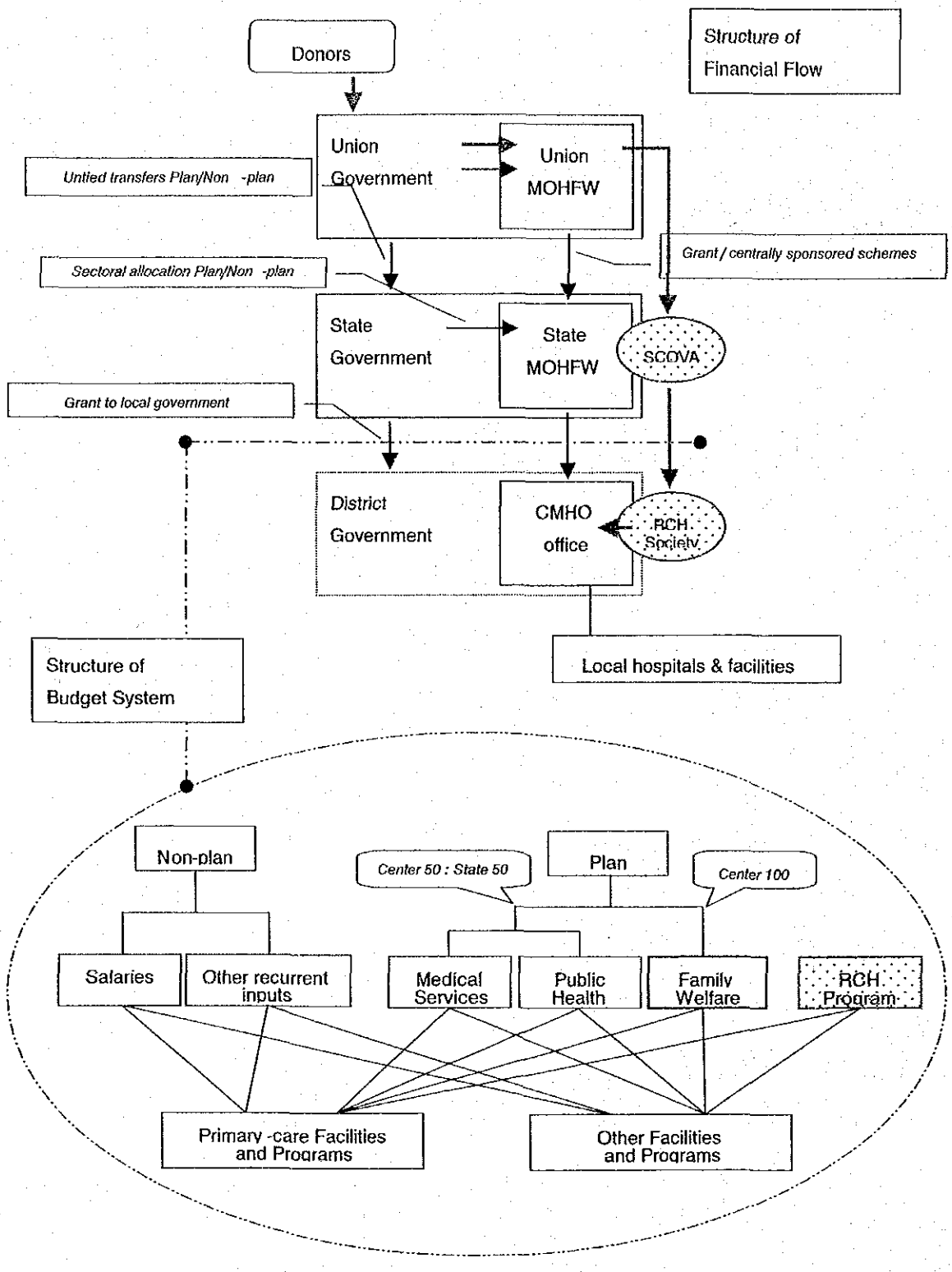

Figure 8-2 Structure of Government Health Budget

8.1.2 Financial Situation of MP State Government

The main industry in MP is agriculture whose share of the State Domestic Product (SDP) was more than 30% in 1998. This means that economic growth rate is lagging behind other states. Though MP is one of the poorest among 32 states in India in terms of per capita income (per capita income of MP was 75% of the national average in 1998) and the growth rate, the MP state government has a moderate financial standing.

The table below explains receipts and expenditure of the MP state government.

(1) Receipts and Expenditure

MP is much more dependent on the central government than other states regarding tax revenue because the state's own revenues and central transfers are higher than the national average.

- revenue was 16% (national average is 12%) of SDP in 1998
- state's own revenue was 41% (national average is 48%) of total revenue
- tax revenue is highly dependent on sales tax (90% of total) because the agriculture and service sectors are almost tax-exempt
- central transfer was 42% (national average is 24%) of total revenue (30% is transfer, 12% is grant)

Table 8-2 Receipts and Expenditures of MP Government

(Unit: billion Rs.)

	1998/9		1999/0		2000/1	
Receipts	113.45	(100%)	138.04	(100%)	141.88	(100%)
Direct & indirect tax	80.40	(70%)	90.95	(65%)	101.07	(71%)
Income from property	17.81	(15%)	26.04	(18%)	21.40	(15%)
Grant from central gov.	15.23	(13%)	21.04	(15%)	19.40	(13%)
Expenditure	142.17	(100%)	164.20	(100%)	170.57	(100%)
Expenditure for non-planning	117.42	(82%)	132.71	(80%)	141.75	(83%)
Expenditure for planning	24.75	(17%)	31.48	(19%)	28.81	(16%)
Balance	-28.71		-26.15		-28.69	

Source: Economic and purpose classification of state government budget, Dir. of economics & statistics, MP

As regards expenditure, MP has a very small share of capital expenditure while its share of development expenditure is above the national average. Among development expenditures, the education sector received the largest share (26%).

- expenditure was 20% (national average is 17%) of SDP in 1998
- development expenditure was 55% (national average is 50%), interest payment 11%(14%), public investment 8% (9%), pension 6%
- capital expenditure was 13% (national average is 36%)
- current expenditure is mainly allocated to social services, and capital expenditure is mainly allocated to economic services, i.e., agriculture and energy
- 74% of subsidy was allocated to energy sector

- debt-service burden reached 19% of total revenue (principal 4%, interest payment 15%)

Table 8-3 Breakdown of Receipts and Expenditure of MP Government in 1997

(Unit: million Rs.)

Expenditure		(%)	Receipts		(%)
Compensation of employees	58.0882	57.1	Income from property	12.1742	11.9
Net interest paid	16.5857	16.3	Indirect tax	59.9482	58.9
Subsidies	7.1780	7.0	Miscellaneous receipts	1.0972	1.0
Savings	3.2461	3.1	Grants from central gov.	10.0272	9.8
Total	101.7251	100	Total	101.7251	100

Source: Economic and purpose classification of state government budget, Dir. of Economics &Statistics, MP

(2) Fiscal Deficit

In India the overall fiscal situation in many states has deteriorated sharply since the early 1990s, with a rise in the fiscal deficit, an increase in interest payments, and an increase in debt outstanding. This serious fiscal deficit has brought the decline of the share of health and family welfare expenditure in the total state budget.

MP also has run a fiscal deficit of 3% to 5% of SDP over the period since 1980/1. During the 1980's this deficit did not seriously affect public finances because the state was able to borrow at negative rates of real interest. In 1998 the fiscal deficit increased to 5.1% of SDP; still this was less than the national average (5.5%). Itemisation of the deficit shows that loans from the central government reached 57% of the total, and others are state bonds (28%) and savings/pension (25%). These data again indicate that the MP government is highly dependent on the central government. Interest payments to the central government are expected to increase to 14% of total expenditure in 2000/1 due to financial sector reforms in India and the tightening of central bank control. However, compared to other states in India, MP's debt-to-SDP ratio and interest payments as a share of total expenditures are much better.

8.1.3 Public Health and RCH Finances in MP

(1) Five-year Plan Outlays

The public health spending can be broadly divided into three groups: health, family welfare, and water supply & sanitation. The following table explains the pattern of plan outlays on public health in India. From the first to the third plan period, health received the largest among three groups, but after that, water supply & sanitation has accounted for the largest percentage. Investment in family welfare has been increasing little by little.

Table 8-4 Pattern of Investment on Public Health in Five-year Plans in India

(Unit: million Rs.)

Five-year plan	Total plan investment (for all sectors)	Health & medical services	Family welfare	Water supply & sanitation
I	19,600	652 (3.3%)	1 (-)	10 (0.6%)
II	46,720	1,408 (3.0%)	0 (0.1%)	70 (1.6%)
III	85,765	2,259 (2.6%)	29 (0.3%)	107 (1.2%)
IV	157,788	3,355 (2.1%)	270 (1.8%)	459 (2.9%)
V	394,262	7,608 (1.9%)	498 (1.2%)	1,096 (2.8%)
VI	1,092,917	20,252 (1.8%)	1,380 (1.3%)	3,999 (3.6%)
VII	2,187,296	36,886 (1.7%)	3,128 (1.4%)	7,091 (3.2%)
VIII	4,341,000	75,822 (1.7%)	6,500 (1.5%)	16,710 (3.8%)

Source: Health Information of India 1995/96, MOHFW

The outlays for the whole health sector including FW in MP's five-year plans indicate a very significant decline over the last four decades as the following table shows. In the first five-year plan (1951-56), slightly more than 7% of the total plan outlay was allocated to the health sector. However, by the eighth five-year plan (1992-97), the outlay for health decreased to 2.6%. The data reflect the declining relative importance of the health sector compared with other sectors in development planning in MP over the last four decades.

Table 8-5 Outlay for the Whole Health Sector in Five-year Plans in MP

(Unit: million Rs)

Five-year plan	Total plan outlay	Outlay for health	% of outlay for health
I	588.6	41.4	7.0%
II	1,489.3	114.6	7.6%
III	2,866.3	140.0	4.8%
IV	4,859.3	116.0	2.3%
V	13,883.6	230.0	1.6%
VI	36,070.0	938.2	2.6%
VII	70,140.3	1,570.4	2.2%
VIII(1992-97)	154,590.0	4,038.6	2.6%

Source: Final Report of Public Finance Reform and Institutional Strengthening, ADB

(2) Health and Family Welfare budget in MP

State expenditures for broad sectors in MP are represented in the following table. While the education and agriculture sectors enjoy the largest share of expenditure, the share for medical and public health has fallen since 1994/5 from 11.5 % to 5.9 % in 1999/0, and the share of social security including family welfare activities decreased from 10.1 % to 3.1 % in the same period. Two-thirds of the total health budget comes from the central government (64.5%) and donors (2.9%).

Table 8-6 State Expenditure by Service Groupings as a Percent of Total

(Unit: %)

	1993/4	1994/5	1995/6	1996/7	1997/8	1998/9	1999/00
Current Expenditure	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General services	18.6	20.7	21.1	19.5	21.8	23.6	24.5
Social &Community services	40.2	44.9	42.7	40.0	44.5	45.0	41.7
Education	18.6	20.3	20.7	18.8	19.7	20.7	17.8
Medical & Public health	10.2	11.5	9.8	9.2	9.8	6.6	5.9
Social security (including FW)	8.9	10.1	7.8	9.4	10.7	2.9	3.1
Urban development & housing	1.1	1.2	1.1	1.0	1.1	5.1	5.0
Other	1.4	1.8	3.3	1.6	3.2	9.7	9.9
Economic services	38.7	31.7	32.8	37.1	30.3	27.9	29.1
Agriculture	22.6	22.4	22.7	20.1	20.9	20.0	17.7
Energy	10.3	3.3	4.0	12.1	3.9	3.5	8.2
Other	5.8	6.0	6.1	4.9	5.5	4.4	3.2
Grants in aid to local bodies	2.4	2.5	3.3	3.2	3.3	3.3	4.5
Capital disbursement	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Capital expenditure	78.3	69.2	72.0	76.2	78.2	77.0	77.5
General services	0.9	0.9	0.9	1.5	1.0	1.5	1.4
Social services	10.9	12.0	11.7	15.8	7.9	16.6	16.3
Education	4.8	4.8	3.4	4.0	1.8	3.1	2.1
Medical & public health	1.5	1.5	1.8	2.1	1.2	2.2	3.4
Social security (including FW)	3.3	4.3	4.1	6.6	1.2	2.1	2.3
Other	1.3	1.4	2.4	3.1	3.7	9.2	8.5
Economic services	66.3	56.3	59.4	58.7	69.2	58.7	59.7
Agriculture	46.6	39.2	40.3	40.6	26.7	42.9	42.2
Energy	11.4	8.9	12.5	11.2	38.9	7.6	8.7
Other	8.3	8.2	6.6	6.9	3.6	8.2	8.8
Loans and advances	21.6	30.7	27.9	23.7	21.7	23.0	22.4

Source: MP Partnership for development, Background paper for MP donor forum, Jan 2001

The MP health budget for RCH activities has two components: **the budget for the RCH programme wholly funded by World Bank**, and **the budget for the family welfare programme** in the government health budget.

The National Family Welfare (FW) programme is mainly a demographic programme, which was started in 1951 in India, emphasising sterilisation, IUD, oral pill, and vaccinations. This programme had evolved from a purely demographic programme to Maternal and Child Health (MCH) and Child Survival and Safe Motherhood (CSSM) by the beginning of 90s. In India over the past two decades expenditures on the FW programme have been increasing faster than total health expenditures. Expenditures on the FW programme increased by 40% in real terms between 1990/91 and 1995/96. As a result, their share increased from 14% in the mid 1970s to 18% in the mid 1990s. This trend can be seen in MP as well where nearly 90% of the budget under centrally sponsored schemes has been allocated to FW programme, as the following table shows. It should be noted, however, that the FW programme includes many essential health services related to MCH such as immunisation.

Table 8-7 Program-wise budget provisions in MP

(Unit: million Rs.)

	1995/6	1996/7	1997/8	1998/9	1999/00
National Family Welfare Program	900.9	1017.3	978.9	1053.3	1893.6
(% of total)	(89%)	(89%)	(89%)	(87%)	(92%)
Blindness control	37.0	36.5	4.60	5.30	13.6
Leprosy control	52.7	58.3	78.4	105.4	103.8
Goiter control	0.3	0.3	0.4	0.4	0.4
ICDS	17.7	20.9	30.2	36.4	36.5
Guinea worm eradication programme	0.1	0.1	0.2	0.2	0.2
Total	1,008.9	1,133.5	1,092.8	1,201.1	2,048.1

Source: Annual Report of DPHFW 2000-01, MP

The national FW programme, fully funded by the Central Government with substantial donor support, has concentrated largely on the delivery of a very narrow range of contraceptive methods. The process of integration of related programmes initiated with the CSSM programme was taken a step further in 1994 when the Cairo conference was held. GOI decided to integrate all the related programmes in the 8th Plan as the RCH Program. Supplementary donor assistance was necessary because the orientation towards a more comprehensive approach required substantial additional inputs for implementing the nation-wide RCH Program. Therefore the RCH Program launched during 1997/98 is jointly funded by World Bank, EU, UNICEF, UNFPA, etc.

Table 8-8 Family Welfare Budget for 1997/98 in MP

(Unit: million Rs.)

	Budget provision	GOI Allocation	Expenditure up to Nov.
Central Sector Scheme			
District level establishment	72.33	-	32.26
Rural FW services	335.16	168.70	194.93
Sub health centre	142.23	208.70	71.68
Construction	106.61	-	41.44
Urban FW services	52.68	44.58	16.95
CSSM	35.62	17.70	12.37
Sterilisation	77.48	77.77	15.53
Postpartum programme	74.98	49.29	37.42
IEC	15.73	10.45	-
Training of ANM/Dai/LHV	29.40	15.00	12.31
MPW scheme	29.83	9.18	6.66
Regional FW training centre	8.12	5.20	4.49
Social safety net scheme	101.90	-	-
Others	60.70	25.02	21.04
State Plan Scheme			
Sterilisation	20.50	-	3.93
Total	1,163.24	631.59	470.01

Source: DPHFW, MP

Note: This budget is administrated under the code No. 2211 which includes national FW programme and other related FW activities as well as donor supported projects.

In terms of budgeting, these FW and RCH programmes have not been fully integrated and this makes the financing situation more complicated in MP. Expenditures for the past FW programme, such as free distribution of contraceptives, compensation for sterilisation and health guides, are being already reduced, and further reductions are planned during implementation of the RCH programme. However, most of FW budget, more than 99% of the amount in 1997/98, is still allocated to past FW programme activities. In addition, funds for the RCH programme will be routed directly from donors through a registered society called SCOVA (state committee on voluntary action), and will be managed separately from the government health budget.

The budget for construction, once included in the FW budget every year, is transferred to PWD (public works department). Although DPHFW has its own plan for new infrastructure based on a five-year plan (such as establishment of new health centres and upgrading of existing buildings), construction works are carried out at the discretion of the PWD.

The PWD also takes care of maintenance of facilities and is supposed to receive a certain amount of budget for the works from any other department in charge. However, allocated money is not always enough as PWD never gets an adequate amount calculated based on the total floor space, according to the interview survey. In addition to this chronic shortage of financial resources, a lack of co-ordination between PWD and the department concerned might have lead to inappropriate maintenance of some facilities since there is no staff with knowledge of each expertise in PWD, such as public health and medical treatment. PWD manages all the construction works with geographically divided zone-wise units.

Table 8-9 Trends in government public health budget in MP

(Unit: million Rs.)

	Total government budget	Whole Public Health (inc. FW) budget	RCH budget (WB programme)	% of public health budget in total budget
1992-93	87,629.6	3,809.6		4.34
1993-94	91,874.4	4,216.4		4.58
1994-95	102,189.8	4,768.4		4.66
1995-96	104,554.2	5,211.8		4.98
1996-97	114,029.9	6,044.1		5.30
1997-98	171,436.3	6,487.9	244.2	3.78
1998-99	197,223.7	6,450.2	(total amount from	3.76
1999-2000	213,726.3	61,948.8	1997 to 2000)	2.89
2000-2001	2,293,596.6	74,676.0		3.25

Source: Annual report of DPHFW 2000-01, MP RCH consultant in MP

(3) RCH Budget

The RCH programme launched during the 1997/98 fiscal year is jointly funded by World Bank, EU, UNICEF, UNFPA, etc. This programme does not finance some of the existing FW activities at all, finances only the expansion of others (e.g., IEC, safe motherhood in the current MCH activity), and finances all costs of specific new activities (e.g., treatment for RTIs).

Although the RCH programme is funded by several donors, the whole budget for this programme is financed by World Bank in MP (channelled through societies), without any

government budget. Funda from World Bank are first transferred to the central MOHFW then transferred to the society at the state level, and finally it is allocated to societies in each district. This fund does not have complicated classifications such as *plan, non-plan,* and funds can be disbursed at any time without being involved in the government budgeting process.

Since the World Bank has implemented a **"performance based funding"** system in this programme, each society has to submit a **statement of expenditures (SOE)** each month. The World Bank decides the amount of funds to be allocated for next fiscal year based on these SOEs and the *annual performance report* and *annual work plan* that each project state has to submit to World Bank every year.

Before implementing this programme, the World Bank pointed out one of the problems of past FW programmes as follows: *since the FW programme is 100% centrally funded, the tendency of planning is to be centralized, guided by norms and centrally determined targets, and inadequately responsive to local needs.* Therefore this programme now emphasizes local capacity building that enhances decentralized planning and management, including financial management.

Table 8-10 Nation-wide Budget for RCH Program: Agency-wise Costing

(Unit: million Rs)

	IDA(WB)	GOI (incl EC)	UNICEF	UNFPA	DANIDA	DFID	Total
Vaccines		4,580	750		200	440	5,970
Local capacity enhancement	4,380	1,095					5,475
Drug kits & bulk		3,650					3,650
Training	1,326	349	1,000	425			3,100
Civil works		2,750					2,750
NGO	663.4	786.5	900	400			2,750
IEC	584.8	215.2	600	550		200	2,150
Operation cost	1,149.7	720.2				130	2,000
Missing Ess Package		1,900					1,900
Addl. ANMs	1,454.9	411.2					1,866.2
IUD insertion kits		1,680					1,680
Institutional Dev.	620.5	729.5	300				1,650
Others	7,710	5,969.3	1,925	450	130		16,184.1
Total	17,889.3	24,835.9	5,475	1,825	330	770	51,125.3
(%)	(34%)	(48%)	(10%)	(3%)	(0.6%)	(1%)	(100%)

Source: Reproductive and Child Health Program, Department of FW, MHFW, Oct. 1997

The estimated cost of the national RCH programme will be 5,112 crore Rs. (248 million US $) for 5 years during 9th plan, which started in the 1997/98 fiscal year. MP will receive 354 crore Rs for 5 years and kits essential for RCH activities as in kind support equivalent to 40-60 crore Rs. annually. Based on this plan, each district in MP will receive about 20 million Rs. for every year including kits distributed in kind.

The figures in Table 8-11 (Statement of Expenditure under RCH Program funded by the WB in MP) show the planned budget at the beginning of the programme. Actual disbursement by the WB for MP up to 2000/01 is indicated below.

Table 8-11 Comparison of Budget and Disbursement from WB for the RCH Program

(Unit: Rs.)

	Amount of budget	Amount of disbursement	%
1997/98	0	0	
1998/99	124,904,774	105,401,775	84.4%
1999/00	27,275,200	37,478,140	137.4%
2000/01	115,405,727	65,392,327	56.7%
Total	267,585,701	208,272,242	77.8%

Source: RCH consultant in MP

As more than two years have passed since implementation of this programme began, bottlenecks have been already pointed out as follows:

- There are activities where progress has been less than expected, i.e., **training of ANMs, referral transport by Panchayat, and 24hours delivery services.** The amount of budget for these activities will be decreased, while the budget for **immunisation, Dai training**, and **RCH camps** will be increased.
- One of the areas where improvements are required is **financial reporting**. Delays in financial reporting and in submission of statements of expenditure (SOEs) have been a serious problem especially at state and district levels. DPHFW cannot have accurate information about the total amount of expenditures because SOEs have not been collected. ***Due to inadequate local capacity for management***, reports submitted by district societies were very poor both in terms of timeliness and completeness.
- The RCH programme does not provide flexibility within the individual budget headings.

Due to these bottlenecks disbursements remain below projections as the above table shows, and substantial funds remain in this programme.

Table 8-12 Statement of Expenditure under RCH Program funded by World Bank in MP

(for the quarter ending December 2000)

(Unit: Rs.)

Scheme	Total amount received from GOI	Expenditure		Balance
		during the quarter	up to the quarter	
Minor civil work	44,000,000	5,084,755	15,529,766	28,470,234
Cotton & cotton bandages	4,768,836	471,307	4,767,907	929
Procurement of drugs	2,200,000	185,576	1,532,345	667,655
Contractual staff				
ANM	14,500,000	2,030,214	6,241,140	8,258,860
Staff nurse	1,500,000	615,606	2,432,341	-932,341
Lab technician	300,000	346,553	725,992	-425,992
Safe motherhood consultant	200,000			200,000
Referral transport	7,500,000	795,000	1,345,550	6,154,450
Engagement of staff under contractual staff	5,000,000	196,445	1,321,922	3,678,078
24hrs. Delivery service	16,120,160	245,850	1,872,572	14,247,588
Anaesthetist	315,000		8,000	307,000
Office equipment	700,000	50,000	485,232	214,768
Cold chain maintenance	7,415,000	542,200	971,008	6,443,992
Zila Sakshrata Samiti	9,307,500	747,070	747,070	8,560,430
Awareness Gen.Training	19,104,278	51,166	10,292,508	8,811,770
Immunisation strengthening	200,000		188,591	11,409
Pethidine injection	152,000			152,000
RTI/STI consumable	3,360,000			3,360,000
Immunisation cards	1,653,000		1,622,600	30,400
EC registers	787,000		744,720	42,280
MTP Training	977,200			977,200
Integrated Skill Training	19,989,778			19,989,778
Skill Training Specialised	643,110			643,110
ZSS Workshop	150,800	62,788	62,788	88,012
Strengthening RCH programme	5,808,000			5,808,000
Dai Training under RCH programme	6,609,600			6,609,600
Major Civil Works	73,062,439			73,062,439
CNAA Workshop	352,000			352,000
Printing of MCH & Service Delivery Register	608,000			608,000
Total	**244,259,701**	**11,424,530**	**50,892,052**	**193,367,649**
(% of total)	**(100%)**		**(20.8%)**	

Source: DPHFW, MP

(4) Societies

1) Functions of Society

In India some donors prefer to establish special societies in each state for managing the flow of funds. Many projects have suffered from bottlenecks in the flow of funds from the central level

to states or states to districts with consequent difficulties for expenditure and implementation because of the complexity of the budget system (see Figure 8-2).

The primary function of societies, originally established as organisations for literary, scientific and charitable activities, is to ensure a smooth flow of funds to the local level for implementation of programmes, often hampered by complex government procedures.

For implementing the RCH Program, societies called State Committees on Voluntary Action (SCOVA) have been established to channel funds from MOHFW to the implementing agencies at both the state and district levels. The SCOVA, called "RCH society" in MP, has the overall responsibility for financial management of this programme, and each state has to maintain bank accounts separate from the state treasury only for this programme. This helps in segregation of funds from the general state budget and increases the flexibility of the society due to a reduction in bureaucratic control.

The following figure explains the societies' process of disbursement and reporting.

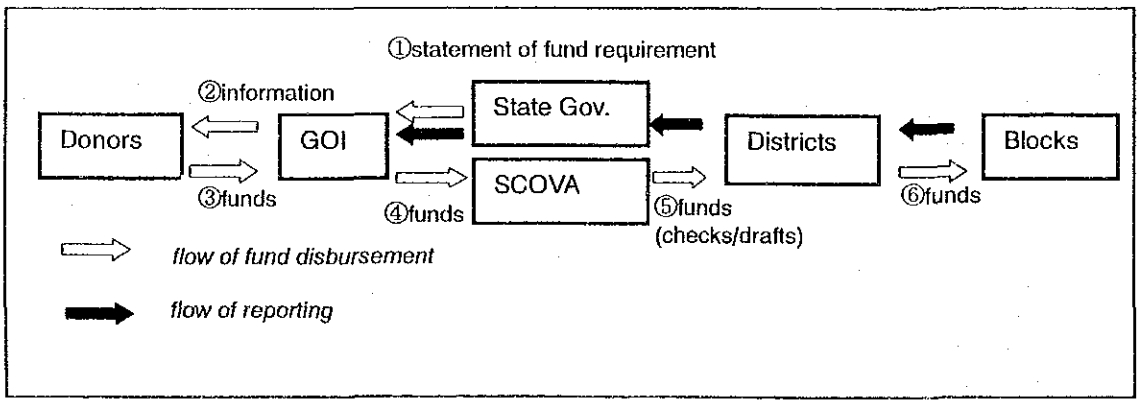

Figure 8-3 Process of Fund Disbursement and Reporting on Society

2) Membership

Twenty-two states including MP, out of thirty states that have implemented the RCH programme, have already established a SCOVA which usually has an Empowered Committee and an Executive Committee.

Members of Empowered Committee are as follows;

1.	Chief secretary, GoMP	Chairman
2.	Principal Secretary, Health	Vice Chairman
3.	Principal Secretary, Women & Child Development	Member
4.	Principal Secretary, Panchayat & Rural development	Member
5.	Principal Secretary, School Education	Member
6.	Principal Secretary, Finance	Member
7.	Principal Secretary, Medical Education	Member
8.	Principal Secretary, Tribal Welfare Department	Member
9.	Commissioner, Public Relations	Member
10.	Chairman, Family Planning Association of India, Bhopal	Member
11.	Chairman, Indian Medical Association, Bhopal	Member
12.	Health Commissioner	Member Secretary
13.	Director, Public Health & Family Welfare	Member

14.	Joint Director, RCH	Member
15.	Representative of UNFPA	Member
16.	Representative of ECTA (European Commission)	Member
17.	Representative of GoI	Member
18.	Member Secretary, Sector Reform Bureau	Member
19.	Joint Director, IPD	Member

Responsibilities and powers of the Empowered Committee are to:

- Approve the progress report of the Society for the preceding year.
- Provide for good management of funds and assets.
- Appoint account auditors for the coming year.
- Consider such issues as are brought before it by the Executive Committee.
- Notify income and expenditure statements of the agencies supported by the Society.
- Approve the budget.

The Executive Committee, working for the routine management of the programme, has meetings once a week / month. Following is the membership of the Committee:

1.	Principal Secretary, Health	Chairman
2.	Health Commissioner	Member
3.	Director, Public Health & Family Welfare	Member Secretary
4.	Nodal Officer, RCH, Joint Director, Family Welfare	Member
5.	Deputy Commissioner, Ministry of Health, GOI, New Delhi	Member

The the government fo MP issued an order in September 1998 constituting the branches of the state RCH society in the districts. The Order provides for the constitution of the District RCH Society comprising the following:

1.	Collector	Chairman
2.	Chief Medical & Health Officer	Member Secretary
3.	District Family Welfare Officer	Member
4.	District Immunisation Officer	Member
5.	Civil Surgeon	Member
6.	District Women & Child Dev. Officer	Member
7.	C.E.O. Zila Panchayat	Member
8.	Executive Engineer (PWD)	Member
9.	District Education Officer	Member

The District Society is essentially bureaucratic bringing together only the officials from different sectors. Generally, the CMHO is the member secretary in all the district level societies in health sector.

The structure of the District RCH society at Tikamgarh is entirely bureaucratic with officials from different departments being represented on it, while the Society at Damoh has two non-governmental members also.

Examples of existing societies in the health sector in MP are:

- RCH societies
- District blindness control societies

- District leprosy societies
- District TB control societies
- District AIDS control societies
- Pulse polio media committee
- Zila Swasthya Samiti

3) Weakness of existing societies

- Some societies do not have a dedicated person for financial monitoring and accounting
- Project management and control systems are weak so that societies have just become convenient channels for routing donor funds

Due to these problems and duplication of membership in many health societies, the the government fo MP has agreed to integrate societies into a single society in each district under the Sector Investment Program (SIP) supported by the EC. The new integrated society is expected to be responsible for managing all health and FW programmes in the district rather than being a mere funds-flow mechanism.

8.1.4 Health and the RCH Budget in the Study Area

(1) Health and the Family Welfare budget in the study area

District governments have no significant financial authority in India except in large cities although they have responsibility for managing and implementing national or state health programmes. Their health spending is totally dependent on and determined by the state; they have few or no financial resources of their own at present. Local bodies have very limited taxing powers or statutory rights. Transfers to local bodies, as a share of total state government budgets, vary from over 40% (Gujarat and Maharashtra) to 15% or less (Haryana and MP) according to the degree and pattern of decentralization.

As for the health budget, the amount of the transfers from state to districts is decided based on indices such as population, number of beds, and expenditure in the previous fiscal year, without considering local needs. The existing health fiscal set-up is very complex for the following reasons :

- The allocated district health budget is divided among mainly three persons, i.e., CMHO, Civil Surgeon(CS), and District Malaria Officer (DMO) and each part has duplication
- The health budget consists of a great number of vertical programmes in confused order without the concept of programme budgeting

As a whole this complex budgeting and accounting arrangement makes implementation of the health programmes inflexible and ineffective.

The following table displays the public health and FW budget in the study area.

Table 8-13 Public Health and FW Budget in the Study Area (2000/01)

(Unit: thousand Rs.)

	Tikamgarh	Damoh	Chhatarpur	Panna	Sagar
Budget for CMHO	47,946	45,738	65,456	33,388	70,609
Budget for Civil Surgeon	12,540	10,067	17,528	11,327	36,983
Budget for DMO	300	2,387	5,891	4,420	2,457
Amount of FW budget*	**17,723**	**14,519**	**10,109**	**8,770**	**17,889**
% of Plan budget	48.7%	52.2%	38.8%	48.5%	42.9%
% of Non-plan budget	51.2%	47.2%	61.2%	51.4%	57.0%
% of salaries of total budget	**80%**	**73%**	**74%**	**76%**	**76%**
Per capita health budget (Rs.) **	52.9	54.8	61.9	57.8	56.8
Total	61,006	58,416	89,018	49,287	110,468

Source: Calculated by JICA study team based on budget books of each district

Note: * Amount of FW budget is estimated by JICA study team which includes national FW programme and other related FW activities

** Each district population also estimated by JICA study team

The above figures represent the predominance of salaries, nearly 80% of total budget, in the health budget. Even in the plan budget most funds are allocated for salaries in India as well as in the study area. Since the large share of resources goes for salaries, there are hardly any resources left for other health inputs such as medicines, maintenance and medical supplies. This is one reason for low utilisation rates at public health facilities.

More detailed composition of the health and FW budget is presented in the next table.

Table 8-14 Composition of the Allocated Health Budget in the Study Area (2000/01)

(Unit: thousand Rs.)

	Tikamgarh	Damoh	Chhatarpur	Panna	Sagar
(1) Health facilities	37,086	45,626	47,136	35,428	68,285
District Hospital	10,296	8,204	14,327	9,674	24,371
TB Hospital	665	1,024	3,716	679	2,294
Other hospitals	-	4,513	7	7	2,951
Dispensary	2,486	568	6,202	1,790	7,563
Dispensary for OBC	18	18	424	18	18
CHC	4,692	4,506	3,068	70	7,300
CHC (upgrading from PHC)	327	-	-	657	-
establishment of new CHC	-	-	1,321	438	1,321
Sub-total CHC	5,019	4,506	4,389	1,165	8,621
PHC	12,172	10,025	15,388	10,877	14,913
PHC in tribal area	9	9	9	9	9
Rural FW Centre	606	853	1,565	540	1,836
Sub-total PHC	12,787	16,962	11,426	16,758	10,887
SC	1,617	2,415	2,705	2,141	3,557
additional SC	4,163	3,224	1,751	1,545	6,361
SC in tribal area	35	766	764	766	35
establishment of new SC	-	710	-	-	-
Sub-total SC	5,815	7,115	5,220	4,452	9,953
Postpartum centre (rural)	-	-	1,425	-	776
ICDS	-	2,716	-	-	851
(2) Health Programs	15,451	18,653	23,834	15,073	22,544
Malaria	4,065	7,535	7,997	5,696	8,853
Filariasis	-	437	3,118	2,264	123
Blindness	541	383	1,005	485	1,315
Leprosy	1,629	2,044	5,680	915	3,248
Goiter	-	35	-	35	35
National Family Welfare	8,374	7,391	4,872	5,116	7,462
Sterilization	840	826	720	560	1,128
BCG vaccination	-	-	440	-	378
Cholera	2	2	2	2	2
(3) Training	2,943	549	2,199	1,969	3,872
MPW	1,193	40	40	40	1,691
ANM and LHV	1,044	-	1,531	1,527	1,531
Village Health Guide	644	447	566	340	588
TBA (Dai)	62	62	62	62	62
Training centre	-	-	181	-	-
(4) Others	1,617	1,412	1,777	1,164	3,348
IEC	71	80	63	60	127
Total	**61,006**	**58,416**	**89,018**	**49,287**	**110,468**

Source: JICA study team calculation based on budget books of each district

(2) RCH Budget in the Study Area

As the following table shows, the amount of disbursement of RCH budget from World Bank to each district is decreasing year by year. Districts in MP are categorised into 3 groups, and Tikamgarh and Damoh, who are in the first group and initiated this programme earlier than

other districts, have received greater amount of funds. Due to performance-based funding, funds for low-performance activities in districts in the first group, such as referral transport, 24-hour delivery, and training were not disbursed to districts in the second and third groups. Moreover, delays in financial reporting have caused decreases in total disbursements for each district. The figures in the following table do not match the information from each CMHO office, probably because of differences of components and timing of bookkeeping. This fact exemplifies the difficulties in financial management without a proper information system.

Table 8-15 Actual disbursement from WB for RCH Program in the Study Area

(Unit: Rs.)

	Tikamgarh	Damoh	Chhatarpur	Panna	Sagar
1998/99	2,909,725	3,483,112	1,989,125	1,583,713	1,804,837
1999/00	494,715	1,355,665	42,480	24,925	401,535
2000/01	488,176	560,621	14,000	10,000	530,446
Total	3,892,616	5,399,398	2,045,605	1,618,638	2,736,818

Source: RCH consultant in MP

Even taking into consideration the multiple management problems, the amount of the disbursements for the RCH programme is very low, except in- kinds supplies, for the year 2000-2001 as compared with the FW budget, as the following table shows. Interestingly enough, Chhatarpur and Panna where the IPD project has been implemented show much higher percentage disbursement rates to the FW programme.

Table 8-16 Comparison of amount of disbursement for RCH and FWP (2000/01)

(Unit: thousand Rs.)

	Tikamgarh	Damoh	Chhatarpur (1)	Panna (1)	Sagar
FW budget (2)	17,732	14,519	10,109	8,770	17,889
RCH budget	488	560	4,963	1,955	530
(% of RCH budget)	(2.7%)	(3.8%)	(32.9%)	(18.2%)	(2.9%)
Total	18,220	15,079	15,072	10,725	18,419

Source: JICA study team

Note: (1) RCH budget for these 2 district is the total amount of the RCH and IPD projects
(2) The FW budget is estimated by the JICA study team

Several problems were pointed out at a meeting to review the RCH programme held in September 2000 in MP:

- 9 districts (out of 45 districts in MP) including Tikamgarh have not reported SOE, and 6 districts have not sent their SOE in the proper form
- The unspent budget of Contractual Appointment (training) especially for ANMs has not been returned by CMHO though very few ANMs have been appointed
- Good performance districts face shortages of funds and activities were blocked
- District level managers and programme officers lack management skills
- Inter-dependence of activities on the other department or agencies has been a major concern for poor utilisation of funds, such as poor co-operation of the PWD in expending funds for civil works

1) Damoh

In the first implementation group, Damoh district has been disbursed and has expended the largest amount among all districts in the study area. Moreover in Damoh the percentage of allotted funds expended reached 76.6%, the highest in the study area as well. Nevertheless, the greater part of the budget for Contractual ANMs, 24hours delivery services, and training for ANMs are unspent.

Table 8-17 Monthly Budget Report of RCH Program in Damoh District (as of Jan.2001)

(Unit: Rs.)

Scheme	Amount allotted	Date of receiving	Expenditure		Total	Balance
			Jan.	Cumulative		
Minor civil work	1,000,000	Jan.23,99		72,265	639,595	360,405
Procurement of drugs	108,870	May 21,99			107,807	1,063
Contractual staff						
ANM	720,000	Dec.31,98	30,982	292,438	409,850	310,150
Staff nurse	30,000	Mar.23,99	5,680	56,800	75,424	-45,424
Lab technician	31,700		5,680	56,800	63,672	-31,972
Moped Loan	784,000	May 29,98			784,000	0
Referral transport	485,000	Dec.8,98			485,000	0
24hrs.delivery system	1,204,000	May 21,99	42,900	96,950	154,480	1,049,520
Anaesthetist	4,795	May 21,99				0
Cold chain maintenance	28,000		1,027	3,427	17,427	10,573
Training						
Awareness	241,612	Apr.5,99		241,612	241,612	0
ANM/LHV/MO	495,921	Sep.11.00	59,767	165,850	165,850	330,071
UNICEF training fund	630,000	Oct.98			622,504	0
IPPI activities	2,442,300	Oct.99-Mar.00			2,290,216	0
	552,421	Oct.16,00		469,596	469,596	0
	533,475	Dec.1,00		407,908	407,908	125,567
	282,340	Jan.12,01	407,907	407,907	407,907	-125,567
MTP services	3,000	Aug.24,00			0	3,000
Outreach planning	6,500	Jan.2,01			0	6,500
Total	9,583,934 (100%)		553,852	2,271,553	7,342,848 (76.6%)	1,993.886

Source: Damoh District Health Office

2) Sagar district

The total amount allotted to Sagar district is much less than Damoh, i.e., 28% of Damoh's allotment although the population of Sagar is almost double that of Damoh. Since Sagar is categorised in the third implementation group, the number of budgeted schemes is fewer than in Damoh. Funds for civil works, Contractual ANMs, cold chain maintenance, and ANM & LHV training remain mostly unspent.

Table 8-18 Monthly Budget Report of RCH Program in Sagar District (as of Jan.2001)

(Unit: Rs.)

Scheme	Amount allotted	Date of receiving	Expenditure		Total	Balance
			Jan.	Cumulative		
Minor civil works	1,000,000	Jan.7,99		443,900	443,900	556,100
Contractual staff						
ANM	50,000	Mar.25,99				50,000
Staff nurse	30,000	Mar.18,99	11,840	26,162	26,162	3,838
Anaesthetist	7,535					7,535
Cold chain maintenance	16,000					16,000
Training						
Awareness	724,837	Mar.31,99		646,101	646,010	78,736
ANM	356,442	Sep.4,00	43,402	89,634	89,634	266,808
LHV	122,334	Sep.4,00				122,334
Mini Laproscopy	34,290	Sep.4,00				34,290
MTP services	4,000	Aug.9,00				4,000
IEC	349,000		349,000	349,000	349,000	
Total	2,694,438 (100%)		404,242	1,554,797	1,554,797 (57.7%)	1,139,641

Source: Sagar District Health Office

3) Chhatarpur and Panna district

Information on the RCH budget for these two districts is very limited. Since Chhatarpur is in the second group and Panna in the third, the disbursement for these two districts is less than Damoh. Another reason for the low level of disbursements is the presence of the Integrated Population and Development (IPD) project in these two districts whose objective is similar to RCH programme.

The IPD Project assisted by UNFPA has been implemented since June 1999 in 33 districts in 6 states including 5 districts in MP, including, Panna and Chhatarpur. Since IPD objectives overlap that of the RCH programme, the IPD project is implemented in place of the RCH programme in these two districts. Therefore the budget of the RCH programme has little allocated to these two districts after 2000/01.

The total budget is Rs.31.40 crore which will be received by the state RCH society from the GOI. Rs.1.5 crore have already been made available to five districts. Since UNFPA has not established a new society for this project in MP, funds are channelled through existing RCH societies both at state and district levels, which makes financial coordination between the IPD and RCH programmes easier. The budget of the IPD project in Panna and Chhatarpur is Rs. 1,945 and 4,949 thousand for the fiscal year 2000/01 and 10,028 and 11,671 thousand for 2001/02. The amount of budget for 2000/01 is low.

4) Tikamgarh district

Tikamgarh belongs to the first implementation and had the second largest RCH budget among the five districts.

Table 8-19 Monthly Budget Report of RCH Program in Tikamgarh District (as of Mar. 2001)

(Unit: Rs.)

Scheme	Amount allotted	Date of receiving	Expenditure		Total	Balance
			Mar.	Cumulative		
Minor civil works	1,000,000	Jan.29,99			1,000,000	0
Procurement of drugs	136,105	May28,99			136,034	71
Contractual staff						
ANM	920,000	Jan.18,99	12,363	265,528	265,528	654,472
Staff nurse/PHN	30,000	Jun.4,99			0	30,000
Lab technician	6,500	May28,99			0	6,500
Moped Loan	736,000	Jun.25,99			736,000	0
Referral Transport	470,000	Jan.18,99			470,000	0
Anaesthetist	4,110	May28,99				4,100
Cold chain maintenance	15,000	May28,99			15,000	0
Training						
Awareness	483,225	Jun.4,99			102,396	380,829
ANM	356,442	Oct.30,00			175,000	181,442
LHV	122,334	Oct.30,00				122,334
UNICEF training fund	630,000	Feb.16,99			627,428	2,572
I.P.P.I activities	300,200	Jan.16,01			300,200	0
Outreach Fair	7,400	Jan.3,01			541	6,859
Total	5,217,316 (100%)		12,363	401,562	3,828,127 (73.4%)	1,389,189

Source: Tikamgarh District Health Office

Tikamgarh is the one of the districts included in the Border Cluster District Health (BDCH) Program assisted by UNICEF. The project was planned long ago but has not started activities yet in the Cluster that includes Tikamgarh. The BCDH Program has been designed for the clusters of districts, 48 districts in India including five in MP, where health indices are poorest.

8.1.5 Financial Resources at Panchayat Level

This section reviews the financial management system of the Panchayat Raj Institution (PRI), which should be one of the most important players for improving RCH under the Government's decentralisation policy. It gives an overview of the available resources and potential for financing at the Panchayat level given the severely limited financial capacity as a whole.

The Panchayati Raj Institution (PRI) in MP consists of the Gram Panchayat (GP) at the lowest level, the Janpad Panchayat (JP) at the middle (block) level and the Zilla Panchayat (ZP) at the highest (district) level based on the present Madhya Pradesh Panchyati Raj Adhiniyam (Act). As the basis of this PRI, each village has a Gram Sabha (GS) consisting of all the registered voters, according to the 73rd amendment to the Constitution of India enacted in 1992.

The MP state government has incorporated some measures for financial strengthening of its present Panchayat Raj Act of 1993 in conformity with the 1992 amendment cited above. Based on the recommendations of the State Finance Commission (SFC), which was

established to review the financial position of the PRI in the state, revenues from a number of taxes and charges were assigned to the GP, in addition to a variety of grants from Central and state governments. GP is assumed to function as the basic unit of decentralisation, while JP and ZP are designed to work as agents of different departments to co-ordinate, monitor and evaluate GP's projects.

In principle, the GS synthesises local problems/needs and prepares a village plan with the co-operation of GP, and then GP mobilises resources to implement these plans. JP supervises and consolidates GPs' plans and sends them to ZP to support their implementation. The function to devolve funds to GP lies mostly with ZP, which merged with the District Rural Development Authority (DRDA).

The sources of income for PRI are classified as tax revenue, non-tax revenue, grants and loans. Tax revenue includes Panchayat's own taxes, assigned taxes and shared taxes. Own taxes are assigned to Panchayats and levied by them. Assigned taxes are assigned to Panchayats but collected by state government. Shared taxes are assigned to and collected by state government, but a certain share of them goes to Panchayats. Non-tax revenue is income from properties, fees, receipts etc. Grants are the funds provided by the Central and state governments as specific schemes. Besides these sources of funding, the Panchayat is also able to obtain loans from government or financial institutions, though actual examples of loans have been very rare.

Table 8-20 Taxes and Charges for PRI System

PRI	Tax and Charges
Gram Panchayat (Obligatory taxes)	Property tax on lands or building, and capital value of which including the value of the land is more than six thousand rupees. The exceptions in this case are the buildings and lands owned by Central or State government or Zilla Panchayat and buildings and lands used exclusively for religious or educational purposes including boarding houses.
	Tax on private latrines payable by the occupant.
	A lighting tax, if the arrangement has been made by the Gram Panchayat.
	A tax on person practising any profession or carrying on any trade.
	Market fees
	A fee on the registration of cattle sold in any market under the control of the Gram Panchayat.
Janpad Panchayat	A tax on theatre or theatrical performances and other performances of public entertainment. Fees for any license or permission granted by the Janpad Panchayat under the Act or for use and occupation of lands or other properties vested in or maintained by the Janpad Panchayat.
Zilla Panchayat	No tax or charge be assigned, but able to utilise its own fund

Note: Some of the interviewed Zilla were gaining income from renting shops and stamp duties and so on according to the field survey.

Although GP has been given the power and authority to levy taxes and charges, most GPs are financially dependent upon funds from Central and state governments, as all the taxes that can be levied in principle may not be in practice, and sources for non-tax revenue are also not fully exploited. Additionally, there is criticism that assigned taxes are not buoyant taxes compared to the national and state taxes. Consequently, the need and demand for fiscal assistance from Central and state government increases, and GP may be little motivated to generate its own revenues. Although the PRI has 29 tasks to cover under the 11th schedule (see Table 9-21), there has been no enabling structural reform of its financing mechanism.

Table 8-21 Eleventh Schedule of the Constitution (73rd amendment in 1992)

1. Agriculture, including agricultural extension	16. Poverty alleviation programme
2. Land improvement, implementation of land reforms, land consolidation and soil conservation	17. Education, including primary and secondary schools
3. Minor irrigation, water management and watershed development	18. Technical training and vocational education
4. Animal husbandry, dairy and poultry	19. Adult and non-formal education
5. Fisheries	20. Libraries
6. Social forestry and farm forestry	21. Cultural activities
7. Minor forest produce	22. Markets and fairs
8. Small scale industries, including food processing industries	23. Health and sanitation, including hospitals, primary health centres and dispensaries
9. Khadi, village and cottage industries	24. Family welfare
10. Rural housing	25. Women and child development
11. Drinking water	26. Social welfare, including welfare of the handicapped and mentally retarded
12. Fuel and fodder	27. Welfare of the weaker sections, and in particular, of the Scheduled Castes and the Scheduled Tribes
13. Roads, culverts, bridges, ferries, waterways and other means of communication	28. Public distribution system
14. Rural electrification, including distribution of electricity	29. Maintenance of community assets
15. Non-conventional energy sources	

Note: These are the fields which PRI is designated to look after, not the taxable domains.

As the largest funding source for PRI, a number of central and state funds (schemes) are available, and major schemes are listed below in Table 8-22. In many of those cases, funds flow from ZP to GP directly, and the elected leader of GP, Sarpanch, and Secretary as co-signatory receive funds from the GP account in three or four instalments. Appropriate timing of instalments is necessary for smooth operation of a project of the GP, and proper

management (accounting and auditing, certification of performance, reporting and sending bills, etc.) at every level should be very important.

Table 8-22 Major Schemes Available for Gram Panchayat in MP

	Name	Department	Contents
Central 75 : State 25	Swarn Jayanti Gram Swarojgar Yojna (SGSY)	Rural Development Department	Implementation of small scale enterprises for families below the poverty line
Central 75 : State 25	Jawahar Gram Saridhi Yojna (JGSY)* (ex-JRY)	Rural Development Department	Development of community infrastructure (water related, mainly) and employment opportunity
Central 75 : State 25	Employment Assurance Scheme (EAS)	Rural Development Department	Creation of employment through development of community infrastructure
Central 75 : State 25	Indira Awasi Yojna (IAY)	Rural Development Department	Provision of housing facilities to homeless people living below the poverty line
Central (100)	Rajiv Gandhi Mission for Watershed Management	Rural Development Department	Implementation of watershed management programmes through community participation
Central (100)	National Family Benefit Scheme (NFBS)	Panchayat & Social Welfare Department	
Central (100)	National Maternity (Motherhood) Benefit Scheme (NMBS)	Women & Child Development Department	Assistance (Rs.500) for pregnant women living below the poverty line
Central (100)	National Old Age Pension (NOAP)	Panchayat & Social Welfare Department	
Central (100)	Tenth Finance Commission (TFC)	Panchayat & Social Welfare Department	
Central (100)	Operation Black Board (OBB)	Education Department	
Central (100)	Social Security Scheme	Panchayat & Social Welfare Department	
Central (100)	Mid-day Meal Program	Tribal Development Department	Central gov't provision of free food grains and state gov't distribution and cooking of a food for primary schools
Central (100)	Girl Child Development Scheme	Women & Child Development Department	
State (100)	Moolbhoot		Utilised mainly for security and management of water*

Note: The budget for JGSY and Moolbhoot is calculated based upon the size of population, and allocated to almost all GPs as a minimum fund.

Although many schemes are available for GP from state to state, there are few for the social sector, particularly for health related development in MP. In addition, sarpanch or GP members are apparently more interested in infrastructure development than improvements in the social sector, according to the random interview survey, and GPs are more likely to include "big projects" in their plans. In fact, GP's annual plans are not usually realistic and are not linked to the actual distribution of funds from Central and state governments. As a consequence, the allocation and utilisation of funds for PRI have characteristically focused on infrastructure development and been supply- rather than need-driven. Enhancement of the planning capability and introduction of flexible funds are necessary to meet the local needs.

Table 8-23 Income From All Schemes for PRI with Breakdown for Target Districts (2000-2001)

(Unit: Rs.)

	Damoh	Sagar	Tikamgarh	Chhatarpur	Panna
Total Schemes	233,926,000	230,540,000	153,056,000	315,073,000	173,692,100
Basic infra.	46,040,000	68,297,000	23,637,000	98,797,000	73,242,600
Social sector	53,622,000	13,776,000	29,857,000	56,886,000	10,375,400
- Health related	900,000	1,008,000	510,000	3,928,000	851,000
Per capita (total)	219.44	118.53	132.86	219.41	203.86
Per capita (health)	0.84	0.52	0.44	2.74	1.00
(estd. Pop.)	*1,066,000*	*1,945,000*	*1,152,000*	*1,436,000*	*852,000*

Source: Zilla/DRDA office of Damoh, Sagar, Tikamgarh, Chhatarpur, Panna
Note: Schemes of JGSY and Moolbhoot are counted as "Basic Infrastructure", IAY, NMBS, Social Security Scheme, Mid-day Meal Program and Girl Child Dev't Scheme are counted as "Social Sector". "Health related Dev't" consists of Mid-day Meal Program and Girl Child Dev't Scheme. Population of each district for 2000 is based on the estimation from this study.

The Gram Swaraj system was introduced on 26th January 2001with the goal of enhancing community autonomy. Each Gram Sabha is supposed to establish a fund, called the village treasury. Funds raised from taxes from the community members, donations, surcharges on land revenue and school building, and cattle grazing fee should go to the village treasury. To make this mechanism work, systematic support is needed for all the levels, including capacity-building of GP members and Sarpanches, enhancement of JP supervision, strengthening of ZP authority, and so on.

8.2 FINANCING OF HEALTH EXPENDITURE

8.2.1 Out-of-pocket Health Spending

Total health spending in India accounted for about 6% of GDP in 1991, which is about Rs.320, or about US$13 per capita in 1991 prices. On the other hand, average per capita public health expenditure was only Rs. 83 in India in 1990 as the following table indicates.

Table 8-24 Per Capita Public Health Expenditure in Major States in India (1990)

(Unit: Rs.)

State	Health	FW
All India	**69.85**	**13.18**
Goa	490.22	7.80
Pondicherry	246.47	8.27
Rajastan	96.17	9.49
Punjab	98.59	8.82
MP	**58.10**	**7.50**
UP	43.11	8.57
Bihar	35.66	5.92

Source: Health Information in India 1995/96, MOHFW

Despite the historical emphasis on the Government's role in the health sector in India, expenditure data clearly show the predominance of non-government, i.e., household spending. Private sector expenditure in India is estimated to be about 78% of total health spending according to a World Bank report.

In MP as well, more than three-quarters of all health expenditures are financed by households, i.e. out-of-pocket payment. The MP state and central government finance about 15% and 7.5% respectively according to an ADB report. Surprisingly, most private spending on health takes place ***at public facilities***, even though services at these facilities are available free of charge in principle.

Moreover the burden of out-of pocket spending falls disproportionately on the poor even for primary illness. On average, 5% of total household consumer expenditures in rural areas went for health care, while the comparable figure for urban areas was 2.3%. Another study by DANIDA shows that those below poverty line spend between 12% and 23% of their total household income on health care. In general, the burden of out-of-pocket spending is regressive. Some studies in India have observed that people borrow about 16% of total health spending per capita peach year to finance their health costs. In some case, borrowing was as high as their annual incomes.

8.2.2 Cost Recovery / Cost Sharing

(1) Health Insurance

In order to reduce the burden of this high level of out-of-pocket spending, the government needs to encourage risk- sharing mechanisms such as social insurance, private voluntary insurance and community financing. Insurance coverage for health care is very limited in India at present, and private health insurance is generally limited to hospitalisation coverage. Although the government initiated comprehensive health insurance for employees in the government and formal private sector, only 4% of workers are covered. This coverage is very low compared to other Asian countries even considering the low income level of India.

In MP social insurance such as the Employee's State Insurance Scheme (ESIS) covers less than 1% because the system is not compulsory and many private health facilities provide better at a reasonable cost. In MP more than 60% of health facilities are private. the government fo MP set up a State Illness Fund in 1997 to provide financial assistance for households below poverty line. However, the total budget of this fund has been spent by 2000 (5 crore Rs.).

(2) User Fee : Rogi Kalyan Samiti (Patient Welfare Committee)

1) Functions of RKS

There is an increasing gap between resources that are needed and those that are available. Cost recovery or cost sharing is seen as a means to generate more revenue for public health facilities so that more resources are mobilised to keep health activities sustainable in the long run. By charging people, who can afford to pay, more resources will be available for the poor.

In India the level of cost recovery in medical and public health services is generally regarded as low. The cost recovery rate in MP is only 4%, almost the same as the national average. The only cost-sharing scheme currently working in MP is the user fee. In 1995 Rogi Kalyan Samitis (RKS) were established in MP as autonomous voluntary bodies to encourage community participation in the delivery of health services and to ensure equity and equal access. The objectives of the RKS are to provide:

- Free health services to women and girls belonging to the landless rural families
- Lodging facilities in hospitals for the relatives of patients
- Expenses for free boarding facilities for family member of patients
- Funds for improvement of hospital facilities and services such as ambulance, X-ray, hospital beds and training of staff

The RKS established in each health facility nominal user fees for patients. The income of RKS is retained at each facility and does not have to be paid into the government budget. RKS can obtain loans from banks to purchase equipment. Other than user fees, RKS generates resources through voluntary donations, running cycle stands, medical shops, and developing the vacant land around its facility.

2) Membership

RKS at district level has two organisations: a General Committee and a Working Committee.

The main members of the General Committee are as follows:

- Minister in charge of the district (president)
- Zila Panchayat
- Collector
- CMHO, CS(secretary), Senior doctor of district hospital
- Members of legislative assembly
- Executive engineer of PWD
- Secretary of Red Cross
- President of Indian Medical Association
- Members of NGOs

The main members of the Working Committee, i.e., the implementing body, are as follows:

- Collector (president)
- CEO, Zila Panchayat
- CMHO, CS(secretary), Senior doctor of district hospital
- Executive engineer of PW

3) Fee structure

The fee structure is not uniform and varies from district to district. User fees in two district hospitals in the study area and three public hospitals in Bhopal, Mandsaur and Indore are indicated below.

Table 8-25 User Fees at Major Hospitals in MP and the Study Area (2001)

(Unit: Rs.)

	Registration	X-ray test	Admission/day	Delivery	Major operation
Damoh district hospital	2	30	10	50	100
Tikamgarh district hospital	2	15~40	5	10	free
Public hospitals in Bhopal	5	30	10	N.A.	250-500
Mandsaur district hospital	2	20~50	5~150	125	350
M.Y. hospital in Indore	5	10~50	5~150	100	200~600

Source: district hospitals

Tikamgarh district hospital charges only for registration, X-ray tests, delivery and admission, but other services, including surgeries, are all free of charge. Damoh district hospital, on the other hand, charges for most services and has a private ward where the fee level is double that of the general ward. Because Tikamgarh district has a low income level and low quality hospital, the General committee of RKS asked the hospital not to charge higher fees especially among the poor.

On the contrary, Mandsaur district, which has collected the greatest amount of income through RKS in MP, charges higher fees, and it has much improved hospital services with lots of advanced medical equipment which were purchased using RKS income. Also M.Y. (Maharaja Yashwantrao) Hospital in Indore, which originally established RKS by itself in 1995, now charges more than 270 user fees after making great improvements in hospital services.

4) Income and Expenditure

a) Financial performance of RKS in MP

The total amount of funds generated by district level RKS was 233,083,985Rs. during the last five years in all of MP. According to the data analysed by DPHFW, socio-economically better developed districts such as Indore, Ujjain and Bhopal have shown tremendous growth of RKS activities as compared with poorly developed divisions including Sagar division. The pattern of resource mobilisation was related to the income level of districts and to health facilities available in each district. The best and worst ten districts in income generation are as follows:

Best 10 performing districts in income generation

1. Mandsaur	2. Ujjain	3. Seoni	4.Khargone	5. Morena
6. Satana	7. Bhopal	8. Indore	9. Dewas	10. Shajapur

Worst 10 performing districts in income generation

1.Badwani	2. Daita	3. Rewa	4. Sheopur	5. Dindori
6. Betul	**7. Damoh**	8. Harda	9. Narsinghpur	10. Umaria

Mandsaur district mobilised the most funds, more than 32 million Rs., while Damoh district mobilised only 1 million Rs. in the same period. The average amount of income from RKS for five years in MP is 5 million Rs. Income of four districts other than Sagar district in the study area were below the MP average.

The current pattern of income and expenditure in MP is shown in the following table. The most income was generated from commercial use of land and rental services, up to 26% of total income. Major funds were generated from non-medical services such as donations and commercial use of land, while resource mobilisation from medical services, i.e. user fees, is only 50% at present.

Table 8-26 Pattern of Income and Expenditure of RKS in MP (1996-2000)

Source of income			Expenditure pattern		
1	Commercial use & rental of land	26.9 %	1	Civil construction & repair of building	26.3%
2	OPD ticket (registration)	12.5 %	2	Equipments	14.3%
3	Admission	11.0 %	3	Inpatient facility improvement	5.3%
4	Lab tests	9.2 %	4	Medicines	5.2%
5	Operation	8.4 %	5	X-ray & pathology	4.0%
6	Miscellaneous	7.0 %	6	Ambulance services	2.1%
7	Donation	6.5 %	7	Wages	1.0%

Source: RKS Status Paper, DPHFW, Oct. 2001

In general, districts who have performed better at income generation have succeeded in improving the quality of hospital services. These districts spent the funds for purchase of equipment such as X-ray machines, endoscopes, ENT microscopes, computerised ECG, or Eliza reader. Some hospitals are planning to purchase CT scan from RKS funds. In hospitals where the quality of services has improved through RKS, the number of patients is increasing and there are positive signs of client satisfaction.

b) Financial performance of RKS in the Study Area

Figures in the following table display the financial performance of RKS in the study area. Incomes from RKS fluctuate year by year, and RKS revenue as a proportion of total hospital revenue is very small, usually less than 5%, except Sagar district hospital, where RKS income reached 21% of total revenues in 2000. Incomes mobilised through RKS in the study area is limited due to lack of management capacity, low quality of services, and inadequate financial planning.

Table 8-27 Income and Expenditure of RKS in District Hospitals in the Study Area

(Unit: thousand Rs.)

	Damoh		Tikamgarh		Sagar		Chhatarpur	
	income	expen.	income	expen.	income	expen.	income	expen.
1996	545	545	42	0	696 (7%)	187	-	-
1997	352 (2%)	293	165 (1%)	77	1,060 (8%)	920	271 (1%)	212
1998	190 (2%)	303	198 (1%)	32	1,393 (10%)	1,334	622 (3%)	500
1999	222 (2%)	413	507 (4%)	162	1,462 (12%)	741	1,140 (7%)	1,156
2000	384 (3%)	305	339 (1%)	53	2,918 (21%)	1,216	-	-

Note: figures in ( ) indicate RKS share of total hospital revenues

Source: Source: JICA study team based on interviews with district hospitals

In Damoh and Tikamgarh, RKS has been introduced not only at the district hospitals but also in CHCs and PHCs. In Damoh district, the CHC in Hatta and the PHCs in Patharia, Batiagarh, Patera and Jabara have introduced RKS. In Tikamgarh, the CHCs in Niwari, Prithvipur, Palera, Jatara, Baldeogargh and the PHC in Badagaon have introduced RKS. The table below shows the trend in income from RKS in both districts.

Table 8-28 Total Income from RKS Including CHCs & PHCs in Damoh and Tikamgarh

(Rs.)

	1997-98	1998-99	1999-00	2000-01	2001-02	Total
Damoh district hospital	352,418	190,887	222,473	384,626	120,122	1,270,526
CHC and PHCs	11,683	79,498	61,346	109,901	49,213	313,314
Total in Damoh	**364,101**	**270,385**	**283,819**	**494,527**	**169,335**	**1,583,840**
Tikamgarh district hospital	165,535	198,771	507,244	339,018	724,600	1,977,334
CHCs and PHC	78,666	137,566	168,201	176,611	77,735	639,279
Total in Tikamgarh	**244,201**	**336,337**	**675,445**	**515,629**	**802,235**	**2,574,447**
M.Y.Hospital, Indore	3,619,922	4,897,728	5,921,201	6,980,245	3,399,909	24,819,013

Source: District hospitals and CMHO Offices

Both Damoh and Tikamgarh are among the poor performing districts whose income from RKS is far below the state average. Compared with M.Y.Hospital in Indore, which is the largest public hospital in MP with 970 beds, a large gap in income generation can be observed in the above table. Total income from RKS for the last five years in Tikamgarh is 10% that of the M.Y. Hospital, and in Damoh it is only 6%.

Income from RKS in Tikamgarh, though the amount is not large, has been increasing steadily in the district hospital, CHC,and PHCs, while in Damoh the situation is less favourable.

5) RKS activities in Tikamgarh district

Due to the poor inability to pay among local people and low quality of hospital services, Tikamgarh district hospital can charge user fees only for four hospital services at present. Therefore, the district hospital makes an effort to increase RKS income from non-medical sources such as rents from shops and bicycle stand fee. Also the district hospital solicits donations from community organisations, and organisations like the district Red Cross support hospital services by providing medical equipment and supplies. As a result, income from non-medical sources has reaches more than 50% of total revenues, as the following table shows. Since patients are aware of improvements of hospital services, the number of patients is increasing in this hospital.

Five CHCs and one PHC have already introduced RKS, and the amount of income has been increasing in most facilities. Some CHCs charges not only for OPD services but also for X-ray, pathology, ECG and admission.

Table 8-29 Breakdown of Income from RKS in Tikamgarh District Hospital(Rs.)

	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	Total
Income from hospital services							**971,185 (49.1%)**
OPD Ticket	42,160	160,802	170,654	184,004	154,098	66,792	778,516
Admission	-	-	-	32,900	49,000	17,700	99,600
Ambulance services	-	-	-	-	14,094	-	14,094
Service for blindness	-	-	-	-	14,575	4,400	18,975
Other services	-	-	9,500	7,540	42,960	-	60,000
Income from non-medical sources							**1,006,149 (50.8%)**
Donation	-	-	-	28,000	50,000	-	78,000
Bank interest	-	1,333	6,017	12,100	14,291	15,008	48,749
Rents from shops	-	-	-	227,600	-	620,700	848,300
Bicycle stand fee	-	3,400	12,600	15,100	-	-	31,100
Total	**42,166**	**165,535**	**198,771**	**507,244**	**339,018**	**724,600**	**1,977,334**

Source: Tikamgarh district hospital

Table 8-30 Income and Expenditure from RKS at CHCs in Tikamgarh (Rs.)

		1997-98	1998-99	1999-00	2000-01	2001-02	Total
CHC Niwari	Income	30,335	51,327	56,970	69,829	30,561	**239,022**
	Expen.	4,632	23,105	12,367	30,248	19,680	**90,032**
CHC Prithvipur	Income	30,465	46,829	61,712	57,351	28,234	**225,091**
	Expen.	4,725	6,764	12,131	25,281	9,605	**58,506**
CHC Palera	Income	3,218	12,050	16,066	11,850	7,640	**50,824**
	Expen.	1,527	2,073	2,791	9,515	3,478	**19,384**
CHC Jatara	Income	10,738	15,456	13,623	15,171	7,572	**62,560**
	Expen.	250	1,000	4,160	Nil	Nil	**5,410**
CHC Baldevgargh	Income	3,910	4,624	9,604	11,530	3,728	**33,396**
	Expen.	Nil	780	640	Nil	780	**2,200**
PHC Badagaon	Income	-	7,280	10,226	10,880	Nil	**28,386**
	Expen.	-	200	800	Nil	Nil	**1,000**

Source: Tikamgarh CMHO Office

6) RKS activities in Damoh district

As table 5-28 indicates, total income from RKS in Damoh is less than Tikamgarh, although more income was generated than in Tikamgarh during the first year of implementation. At the beginning, communities expected RKS to improve health services greatly, but people have lost its interest in RKS today because the quality of services has not changed. Donations have been decreasing, as seen in the table below, and little effort has been made to increase non-medical income in the Damoh district hospital. Though the ICU unit was constructed and 50 beds were added using RKS funds, these facilities have not been fully utilised due to lack of

staff and management capacity. The number of patients is decreasing for both inpatient and outpatient departments at the Damoh district hospital year by year partly due to this reason.

On the other hand, some health facilities have succeeded in improving services by introducing RKS. For example, the CHC in Hatta installed a water tank and increased the availability of staff after introduction of RKS. The community now understands that the more they pay for RKS, the more funds will be available to benefit patients.

Table 8-31 Breakdown of Income from RKS in Damoh District Hospital (Rs.)

	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	Total
Income from hospital services							**971,185 (49.1%)**
OPD Ticket	42,160	160,802	170,654	184,004	154,098	66,792	778,516
Admission	-	-	-	32,900	49,000	17,700	99,600
Ambulance services	-	-	-	-	14,094	-	14,094
Service for blindness	-	-	-	-	14,575	4,400	18,975
Other services	-	-	9,500	7,540	42,960	-	60,000
Income from non-medical sources							**1,006,149 (50.8%)**
Donation	-	-	-	28,000	50,000	-	78,000
Bank interest	-	1,333	6,017	12,100	14,291	15,008	48,749
Rents from shops	-	-	-	227,600	-	620,700	848,300
Bicycle stand fee	-	3,400	12,600	15,100	-	-	31,100
Total	**42,166**	**165,535**	**198,771**	**507,244**	**339,018**	**724,600**	**1,977,334**

Source: Damoh district hospital

Table 8-32 Income & Expenditure from RKS at CHC/PHCs in Damoh (Rs.)

		1997-98	98-99	99-00	00-01	01-02	Total	Balance
District Hospital	Income	352,418	190,887	222,473	384,626	120,122	**1,270,526**	325,156
	Expend.	10,100	52,515	348,003	311,998	131,854	**945,370**	
CHC Hatta	Income	11,683	74,190	61,346	56,889	10,648	**214,756**	45,056
	Expend.	9,602	51,210	6,307	10,963	5,200	**169,700**	
PHC Patharia	Income	1,373	-	-	36,230	16,955	**54,558**	44,598
	Expend.	-	-	-	-	9,960	**9,960**	
PHC Batiagarh	Income	-	-	-	1,005	15,686	**16,691**	15,590
	Expend.	-	-	-	226	875	**1,101**	
PHC Patera	Income		5,308	-	15,777	5,924	**27,009**	16,865
	Expend.		21		5,411	4,712	**10,144**	
PHC Jabera	Income	-	-	-	-	-	**300**	300
	Expend.	-	-	-	-	-	**-**	

Source: Damoh CMHO Office

7) Weaknesses of existing RKS in the study area

Great improvements in hospital services through RKS have already been reported in several districts in MP, but there seems to be little impact on service improvement in Damoh and Tikamgarh. There are common factors that affect effect RKS in both districts:

- Low ability to pay
- Low expectation of health services from communities related to low education level
- Low quality of public health services due to lack of essential equipment, manpower, and management capacity

Since the income level in the target districts is lower than the state average, introducing user fees without improving hospital services could deter people from using public health facilities, as is seen at Damoh district hospital. On the other hand, once the quality of hospital services improves, willingness to pay for services increases even though the population is poor. For example, as the director (CS) of Tikamgarh district hospital has made several efforts to improve hospital management, donations from community organisations and rents from shops are increasing, and quality of services has been obviously improved. These successful cases demonstrate the importance of generating income through RKS even though health resources are limited in the study area.

DPHFW has already announced a reform plan for RKS, which includes computer and internet procurement in all hospitals in MP. Since the target districts have a number of constraints, the situation is much different from other developed districts in MP like Indore and Bhopal. We should consider an appropriate plan for districts with limited resources. Before increasing the user fees, the quality of services should be improved in the target districts. Comprehensive strengthening of the management capacity, which includes human resource development, financial management, training, and upgrading facilities, would be essential.

Also, RKS has been introduced as a mechanism for community involvement, not only as a cost recovery mechanism, in line with policy changes such as a shift from a top-down to bottom-up approach. Therefore, capacity building of the committees and training would be important in order to increase community involvement.

a) Real health spending at Public hospitals

The level of user fees at district hospitals seems reasonable in theory. However, actual personal spending at public hospitals is found to be very high, according to both the household survey and interviews with local people conducted by the JICA Study Team.

Table 8-33 Opinion of Husbands about the Cost of Delivery in Hospitals

Question: How much does it cost for your wife to deliver a baby in hospitals?

(Unit: %)

	Total	Tikamgarh		Damoh	
		Urban	Rural	Urban	Rural
1,000Rs	22.0	18.1	24.6	21.5	20.5
2,000Rs	9.9	13.3	8.8	12.3	10.0
500Rs	8.8	7.2	11.0	7.7	7.2
1,500Rs	7.1	7.2	6.8	3.1	7.9
1,200Rs	4.7	7.2	3.5	4.6	5.4
800Rs	3.8	1.2	4.3	4.6	3.7
3,000Rs	3.3	6.0	2.3	7.7	3.0

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under the JICA Development Study on Reproductive Health in MP, 2001

Results of the household survey show the perceived or actual recent cost for delivery in hospitals in Tikamgarh and Damoh districts. User fees for delivery have been fixed 50Rs in Damoh and 10Rs in Tikamgarh as explained previously. The survey result indicates, however, that most people paid much more than the fixed fee. According to this survey, 55% of local people paid more than 1,000 Rs for delivery and 82% of people reported this amount is expensive. Overcharging at public health facilities seems common and this may be one reason for under-utilisation of public services.

b) User fees at Private providers

The private sector plays an important role in India's health care delivery system. Despite the widespread public facilities, a higher proportion of health services are provided by the private sector than by government facilities. In MP approximately 60% of health facilities are said to be private though no accurate data or reports are available in this regard. GoMP has issued rules for registration of nursing homes (small private hospitals) and private hospitals from 1997. However, monitoring seems very difficult because there is little incentive to do so. In spite of importance of the private sector, the government has not clearly defined its role in the overall health strategy.

The following table shows user fees at some private hospitals and nursing homes in Damoh district.

Table 8-34 Example of Fees for Services at Private Hospital/Nursing Home in Damoh (2000)

Registration	*Outpatient care*	*Inpatient/day*	*Delivery*	*Operation*
50Rs.	30-50Rs.	100-150Rs.	1,500-2,000Rs.	3,000-7,000Rs.

Indeed, user fees for inpatient care including delivery and operation are expensive compared with fees at district hospitals indicated before. However, fees for outpatient care are relatively low. According to a review of private hospitals in the nearby state of Andra Pradesh, the cost per illness in private hospitals is nearly three times that in public hospitals for inpatient care, while for outpatient care the cost per illness in private hospitals is about double than that in public hospitals. Considering the fact that fees are often charged at public health facilities

where services are available free of charge in principle, a difference in the cost between private and public should be smaller so that most people could use public facilities.

(3) Willingness and affordability to pay

1) Willingness to Pay for RCH Services

Women respondents in the household survey expressed 2:1 a willingness to pay for RCH services, and this was equally true for both urban and rural women. Women users of the services expressed an even greater willingness to pay (3.5:1) at all levels of the system, although the amounts they were willing to pay were lower (perhaps more realistic) for every service than the amounts the general population would pay. The men responded even more positively with 93% expressing a willingness to pay for services. However, when asked how much they were willing to pay for specific services or health products, in many cases men and women were unable to give a likely amount, although this was more true for family planning than care related to pregnancy and gynaecology. (One reason people were less likely to be willing to pay for pills and condoms may be the perception of the poor quality of Nirodh and Mala D, which was mentioned in focus groups.) Men expressed a willingness to pay more than women, and few men said they would not pay anything for a specific service.

The Table below displays the mean amount men and women who participated in the household survey, which was representative of the general population, said they were willing and able to pay, the proportion who were unwilling or unable to pay anything for that service although willing to pay in theory for services, and the proportion who did not know what they could or would pay for specific RCH services.

Table 8-35 Willingness to Pay by Sex

	% pay nothing		Mean women	Mean men	% did not know	
	Women	Men	would pay (Rs.)	would pay (Rs.)	Women	Men
Gyn visit	1.7	0.2	124.03	232.20	2.9	13.4
Antenatal care	2.4	1.5	131.39	213.40	4.3	6.1
Packet of OCs	21.1	3.1	18.51	29.31	15.5	22.7
Packet 3 condoms	26.2	3.0	21.62	29.00	18.6	22.0
IUD insertion	35.9	2.7	54.67	147.44	22.6	36.6
Tubectomy	20.6	2.2	184.49	235.67	17.1	27.4
Vasectomy	32.5	3.1	144.98	152.44	19.9	38.1
Post-partum visit	8.9	1.4	212.40	263.05	7.4	6.5

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under the JICA Development Study on Reproductive Health in MP, 2001

One reason villagers may be unwilling or unable to pay for contraceptives is that when the nearest health facility is far away, they may spend all their disposable funds on transportation. This difficulty was reported in focus groups in which the participants expressed a desire for the MPWs to distribute temporary family planning methods in the village.

The same patterns of willingness and ability to pay were found in the beneficiary study among the women users of services. The table below displays the mean they would pay and the proportion who would pay for services in theory but none for that service.

2) Service Users` Willingness to Pay

The amounts people stated they could and would pay are in line with what the head of the household, usually the husband, reported they spent the previous month on medicines and other health care. Because a few reported very high amounts that skewed the means, the highest 10% of responses for medicine (those over Rs 1,000) and the top 11% for other health care costs (those over Rs 400) were eliminated from the analysis. Household heads reported spending an average of Rs 179.07 on medicines (US $3.89) with 46% having spent nothing. The spent an average of Rs 51.91 on other health care costs (US $1.13) with 56% spending nothing.

Table 8-36 Service Users` Willingness to Pay

Service	% Pay nothing	Mean amount in Rs
Gynaecology	3.3	42.53
Antenatal care	6.4	52.95
Packet of orals	11.8	10.52
Packet of 3 condoms	32.1	4.60
IUD	29.0	43.08
Tubectomy	10.1	133.30
Vasectomy	39.7	108.56
Postnatal care	10.1	172.49

Source: Beneficiary Interview Survey conducted by ORG-MARG, under the JICA Development Study on Reproductive Health in MP, 2001