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Impact And Implications Of Economic Reforms On Health Sector: A Study With Special Reference To Assam

Dr. Nirmala Devi

Assistant Professor of Economics, Arya Vidyapeeth College,
Guwahati, Assam, India

Abstract: The need for reforms in India's health sector was emphasized since the Eight Five Year plan in 1992. Market reforms in health sector were advanced with the view that excessive burden on the government will not be able to reverse the deteriorating healthcare scenario of the country. In order to resolve the problem of inefficiencies in public healthcare system, reforms were carried out either by pushing for privatization or operating in public private partnership mode. The pro reform literatures imply that some of the collaborative initiatives between the public and private sector are of course innovative and has been able to improve the quality and access to better health care facilities.

On the other hand, the anti reform argument emphasizes on the adverse impact of economic reform. Provisioning of healthcare services, medical technology, medical and paramedical education started getting increasingly commercialized and unregulated during the 1990's and that had adverse impacts on quality and cost of healthcare. Since the initiation of economic reforms in India, central and state governments have retreated from the social sector, by reducing their share of expenditure on basic healthcare, and providing fiscal space to private players including the insurance sector. While budgetary expenditures increased on the energy, transport and irrigation sectors, social sector (like education and health) expenditure drastically declined.

Under the above background, the present paper is a modest attempt to analyze the impact and implications of economic reforms on the health sector in India with special reference to Assam. The paper examines the pattern of public and private health expenditure, utilization of public health facilities in terms of both inpatient and outpatient care and implications of recent economic reform in the form of National Rural Health Mission.

Keywords: health expenditure, utilization, privatization, inpatient, outpatient, structural adjustment.

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I. INTRODUCTION

The need for reforms in India's health sector was emphasized since the Eight Five Year plan in 1992. Market reforms in health sector were advanced with the view that excessive burden on the government will not be able to reverse the deteriorating healthcare scenario of the country. In order to resolve the problem of inefficiencies in public healthcare system, reforms were carried out either by pushing for privatization or operating in public private partnership mode. Public private partnership (PPP) has been called upon to improve equity, efficiency, accountability, quality and accessibility of the entire health system (Bhatt, 2000; Sen et al., 2002). The pro reform literatures imply that some of the collaborative initiatives between the public and private sector are of course innovative and has been able to improve the quality and access to better health care facilities. However for proper collaboration among the public and private sector in the health sector the functioning of the private sector is to be reviewed carefully so that it can meet the necessity of the rural poor (Sen et al,. 2002).

On the other hand the anti reform argument emphasizes on the adverse impact of economic reform on the health sector of the country. Provisioning of healthcare services, medical technology, medical and paramedical education started getting increasingly commercialized and unregulated during the 1990's and that had adverse impacts on quality and cost of healthcare. While an average Indian's life expectancy has

increased, infant and maternal mortality rates have declined but in comparison to other developing countries, growth is still unsatisfactory. While budgetary expenditures increased on the energy, transport and irrigation sectors, social sector (like education and health) expenditure drastically declined (Guhan, 2001). Economic reforms in the health sector introduced a range of measures such as user fees, contracting out of clinical and ancillary services, decentralization and public-private partnerships. Incentives were offered to the private health industries which led to high technology diagnostic centers in urban areas. Qualified and trained health personnel moved massively from the public health system to the private sector due to higher remuneration (Ghosh, 2010; Baru et. al., 2010).

Under the above background, the present study examines the impact and implications of economic reforms on the health sector of the country with special reference to Assam. The paper examines the pros and cons of economic reforms in the health sector specifically in the state of Assam. The outline of the remaining section of the paper is as follows. Section 2 of this paper discusses about the pattern of public health spending as a proportion of GSDP of the state. Section 3 of the paper will give an overview of public and private health expenditure across the major states of the country. Section 4 of the paper will examine the utilization pattern of public health facilities based on National Sample Survey Organization estimates. Section 5 of the chapter discusses about the recent health sector reform in the form of National Health Mission. Section 6 summarizes the study.

The data sources that we have relied on are Finance and Accounts (FA) compiled by the Comptroller and Auditor General of India (CAG), detailed demand for grants (DDG) of Ministry of Health and Family Welfare (MOHFW) and statistical handbook of Assam for various years. The DDGs are unaudited data which is discussed and voted in the parliament. On the other hand Finance and Accounts are audited by the CAG. The data on NHM has been collected from the Office of the NHM, Government of Assam. The paper considers the budgetary expenditure of the state in the form of finance accounts documents and non-budgetary expenditure in the form of NHM flexible pool expenditure. To estimate the public and public health expenditure across the states the data on public and private health expenditure has been compiled from the reports of National Health Accounts, 2001-02 and 2004-05. In order to examine the utilization pattern of healthcare facilities the study relied upon the 42nd, 52nd and 60th round NSSO survey reports.

II. PUBLIC SPENDING ON HEALTH

This section discusses about the pattern of public health expenditure as a proportion of Gross Domestic Product or Gross State Domestic Product. Study of public health expenditure with respect to GDP is important because it is a major determinant of health expenditure. As the ratio of health expenditure to GDP increases, economic and industrial development of the country is also enhanced. In most of the developed countries of the world public spending account for around 5 percent of GDP. In India public expenditure on health is less than 1 percent of GDP (Hitris and Posnett, 1992; Hansen and King, 1996; Gerdtham and Lothgren, 2000; Karataz, 2000). Some of the policy documents have also focused on this issue. Policy documents like the Approach Paper to 11th five year plan (2007-12), approach paper to 12th five year plan (2012-2017), the High Level Expert Group Report, National Rural Health Mission and the Report of the National Commission on Health have emphasized the need to raise the level of public spending on health to 2 to 3 per cent of GDP from the recent one per cent (Choudhuri and Nath, 2012).

The pattern of public health expenditure with respect to GDP indicates that, health expenditure was as high as 1.05 per cent during the early parts of 80s, but during the last part of 1080s a decline in the share of health expenditure has been noticed because of the fiscal stress and the condition further deteriorated after the initiation of the economic reform measures of 1990s. It has been observed that the resource allocated to the health sector has declined for the period from 1992-93 (1.01 per cent) to 1998-99 (.99 per cent). However, a small increase has been noticed from 1.04 per cent in 1999-2000 to 1.09 per cent in 2009-10. The share of public health expenditure was lower than 1 per cent for three consecutive years i.e. from 2003-04 which is probably because of implementation of Fiscal Responsibility and Budget Management Act (FRBM) in 2003-04 (Hooda, 2013) (Table1).

In Assam on an average 1.08 percent is spent on health. Moreover, there has been a decline in health expenditure of the state since 1990-91 to 1999-2000 (Table-2). The proportion of health expenditure to GSDP declined from 1.21 in 1990-91 to 1.06 in 1999-2000. One of the probable reasons of declining public health expenditure as a proportion of GSDP is the initiation of the structural adjustment programme at the centre in 1991. There was a reduction in the central transfer of funds to almost all states so as to contain the fiscal deficit. This resulted in reduction in the resource pool of the state governments because of which the state governments were forced to cut down their budgetary allocation on different sectors specifically the health sector (Selvaraju and Annigeri, 2001, Tulasidhar, 1993, Ghuman et al. 2009, Choudhuri and Nath, 2012). Sarma (2004) in a study related to health expenditure in Assam has noted that in times of fiscal hardship public expenditure has been squeezed more in the health sector than in any other sector.

The entire period covering 2000-2001 to 2007-08, the health expenditure as a proportion of GSDP was less than one for the state of Assam. Choudhury et al., (2011) noted that although there has been a decline in the expenditure in the central fund to the states due to initiation of economic reforms, the centre still is spending a major amount on family planning

Year	*Public expenditure on health as a percentage of GSDP of the state*
1992-93	1.01
1993-94	1.05
1994-95	1.01
1995-96	1.00
1996-97	0.93
1997-98	0.95
1998-99	0.99

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1999-2000	1.04
2000-2001	1.05
2001-02	1.03
2002-03	1.03
2003-04	0.99
2005-06	0.96
2006-07	0.96
2007-08	1.02
2008-09	1.06
2009-10	1.09
Average expenditure	*1.01*

Source: Mid-term Appraisal Report of the 10th and 11th five year plan, Planning Commission, 2002-07, 2007-12, Government of India

Table 1: Public Expenditure on health as a percentage of the GSDP of the state

and disease control programme. However during the mid-nineties various donor agencies and autonomous bodies emerged through whom the central government directly invested in the state. This resulted in a decline in the central expenditure to the state through the budgetary channel which might explain the continuous decline in the public health expenditure since 2000-2001. It was only after 2007-08, that a slight increase has been noticed in the share of health expenditure to GSDP of the state. One reason for the increase in the share of health expenditure to GSDP might be the implementation of the National Rural Health Mission in the state, which included the state share of central expenditure. Health expenditure as a proportion of total social service expenditure also shows a declining pattern since 1990-91 to 2005-06. It declined from 16 percent in 1990-91 to 10 percent in 2005-06. However, a slight increase in health expenditure was noticed since 2006-07.

Year	*Share of health expenditure in GSDP*	*Share of total health expenditure in total social sector expenditure*
1990-91	1.21	16
1991-92	1.32	16
1992-93	1.15	15
1993-94	1.23	15
1994-95	1.17	12
1995-96	1.17	15
1996-97	1.10	15
1997-98	1.12	14
1998-99	0.92	12
1999-2000	1.06	13
2000-01	0.97	12
2001-02	0.94	13
2002-03	0.76	12
2003-04	0.78	11
2004-05	0.80	10
2005-06	0.71	10
2006-07	0.89	12
2007-08	0.92	13
2008-09	1.15	14
2009-10	1.71	17
2010-11	1.42	14
2011-12	1.40	14
Average expenditure	*1.08*	*13*

Source: Finance Accounts, annual reports, Government of Assam

Table 2: Health expenditure as a proportion of Gross State Domestic Product (GSDP) of Assam, in percent, 1990-91to 2011-12

III. PUBLIC AND PRIVATE HEALTH CARE EXPENDITURE IN INDIA AND ASSAM: AN OVERVIEW

This section will make a comparative analysis on public and private health expenditure across the major states of the country for the period 2001-02 and 2004-05 which constitute the post-reform period. The data has been taken from the National Health Accounts Reports of 2001-02 and 2004-05. A comparison of the two reports of the National Health Accounts shows that there has been an increase in the share of private expenditure in total per capita health expenditure in most of the states during the period from 2001-02 to 2004-05 (Table-3).

The share of private expenditure on health increased in states like Assam, Kerala, Maharashtra, Orissa, Rajasthan, Tamil Nadu and West Bengal. The highest increase in the share of private expenditure was noticed in the state of Assam from 69 per cent in 2001-02 to 79 per cent in 2004-05 followed by West Bengal and Kerala. The share of private expenditure to total per capita health expenditure was highest in the state of Kerala (90 per cent). A decline in the share of private expenditure to the per capita total health expenditure was noticed in the states of Bihar, Gujarat, Haryana, Himachal Pradesh and Madhya Pradesh. However, among the major states 10 states showed private spending in the range of 81 per cent to 90 per cent. Himachal Pradesh was the only state where the private sector expenditure declined to 58 per cent in 2004-05 from 62 per cent in 2001-02.

Major state	*Public expenditure in healthcare*		*Private expenditure in healthcare*	
	2001-02	*2004-05*	*2001-02*	*2004-05*
Andhra Pradesh	18	18	83	82
Assam	31	21	69	79
Bihar	12	18	88	82
Gujarat	18	21	82	79
Haryana	10	19	90	81
Himachal Pradesh	38	42	62	58
Karnataka	29	28	71	72
Kerala	13	10	87	90
Madhya Pradesh	15	18	85	82
Maharashtra	19	17	81	83
Orissa	23	20	77	80
Punjab	17	18	83	82
Rajasthan	30	24	70	76
Tamil Nadu	24	18	76	82
Uttar Pradesh	8	13	93	87
West Bengal	23	14	77	86

Source: National health accounts 2001-02 and 2004-05

Table 3: Public and private expenditure in healthcare

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IV. UTILIZATION OF PUBLIC AND PRIVATE HEALTH FACILITIES: EVIDENCES FROM NSSO

This section will discuss some of the evidences from the NSSO reports with respect to the pattern of utilization of health care facilities in the state of Assam since 1986-87 to 2004.

PUBLIC PRIVATE SECTOR USE FOR INPATIENT CARE

The dependence on government health facilities has been very high during 1986-87 (Figure 1). 83 per cent of the population depended on government health facilities for treatment in the rural areas for inpatient care. The share declined from 83 per cent to 74 per cent during the period of 2004. Although the share has declined, a majority of the population in the rural areas are dependent on public hospitals for treatment. However, the dependence on government health facilities drastically declined which is specifically visible for the urban areas of the state. Dependence on government health facilities declined from 80 per cent in 1986-87 to 65 per cent in 1995-96 and further to 55 per cent in 2004. The decline in the utilization of government health facilities can be mainly attributed to the growing impetus for privatization during the post reform period. The state support for private sector in the form of public private partnership resulted in establishment of health centres specifically in the urban areas of the states. There has been increase in cost of care in both rural and urban areas of the state, the rise being higher in the urban areas.

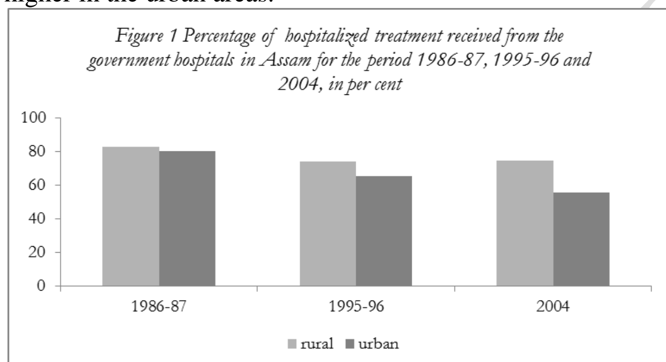

Figure 1

PUBLIC PRIVATE SECTOR USE FOR OUTPATIENT CARE IN ASSAM

A similar picture has been observed for outpatient care in the state (Figure 2). The dependence on government health facilities for outpatient care declined from 40 per cent in 1986-87 to 29 per cent in 1995-96 and further to 27 per cent in 2004 in the rural areas of the state. Similarly for the urban areas the dependence on private hospital has been more or less same for the entire period. It ranges from 22 per cent to 27 per cent for the whole period under consideration. However, the dependence on government health facilities has been lower for outpatient care in comparison to inpatient care in both rural and urban areas of the state. During 2004, 27 per cent of the population depended on government health facilities in rural areas while 24 per cent depended on government health facilities in the urban areas. Although the dependence on government health facilities is high there has been a decline in utilization of public hospitals because of low quality of care and other reasons like lack of skilled health personnel, long waiting hours, lack of equipments and lack of medicines.

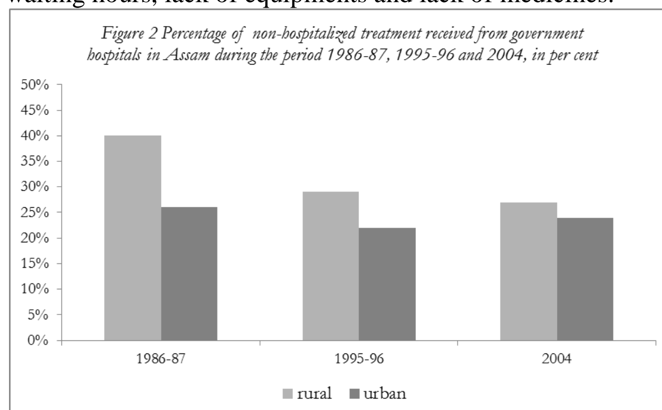

Figure 2

V. RECENT REFORM IN THE HEALTH SECTOR: NATIONAL HEALTH MISSION (NHM) IN ASSAM

The introduction of economic reforms in the state has resulted in initiation of programmes like the National Health Mission. The National Health Mission is an initiative launched by Government of India in 2005 to meet the health needs of the rural poor and underprivileged section of the country. This is one of the major programme initiated under the recent health sector reform measures. The programme initially aimed at meeting the health needs of 18 states with weak health outcome indicators. The main objective of the programme is to reduce infant and maternal mortality rate, to provide universal access to public health services including women's health, child health, water, sanitation, and hygiene. It also emphasizes on universal access to immunization and nutrition for the general masses, prevention and control of communicable and non-communicable diseases, proper access to comprehensive primary health care, to stabilize population and gender and to maintain demographic balance, to revitalize local health tradition and mainstreaming AYUSH and to promote healthy lifestyle among the rural poor. Table 4 shows the various components of National Health Mission (previously National Rural Health Mission).

The discussion on pattern of public health expenditure as a proportion of GSDP shows that there has been an increase in the total health spending after 2005 which is mainly because of the implementation of the programme of NHM in the state. Before the introduction of the NHM, health expenditure by the centre at the state level was mainly through state treasuries. However, after introduction of NHM many donor funded health programmes has come into being which are outside the state treasuries. During the recent time period health expenditure by the centre at the state level is incurred through non-treasury routes. These are in the form of expenditure on institutions located in the states, direct transfer to the implementing agencies under centrally sponsored schemes and expenditure under Central Government Health Schemes (CGHS). The increase in expenditure through these agencies

in the state has resulted in an increase in health expenditure through the non-treasury routes while the flow of expenditure through treasury routes has been declining over the years. The flow of expenditure through treasury routes is mainly through grants in aids to the state government and Union Territories.

Health systems strengthening	*Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)*	*National Disease Control Programmes (NDCPs)*
✓ Mobile Medical Units	✓ Maternal health • Janani Sishu Suraksha Karyakram • Janani Suraksha Yojana	✓ National Iodine Deficiency Disorder
✓ Patient transport Service	✓ Child health and immunization • Pulse Polio Programme • Rashtriya Bal Swasthya Karyakram • National Deworming Day	✓ National Vector Borne Disease Control Programme
✓ Infrastructure	✓ Adolescent health • Adolescent friendly health clinics • Weekly iron and folic acid supplementation • Menstrual hygiene scheme	✓ Revised National TB Control
✓ Human resources	✓ Family planning	✓ National Leprosy Eradication Programme
✓ Drugs and logistics		✓ Integrated Disease Surveillance Project
✓ Telemedicine		✓ National Mental Health Programme ✓ National Communicable Disease Control Programme ✓ Programme for Prevention and Management of Burn Injuries

Source: Government of Assam, National Health Mission, 2008.

Table 4: Components of National Health Mission

HEALTH EXPENDITURE PATTERN UNDER NHM

The NHM funds are generally routed through state health societies. Only a part of the funds are routed directly through state treasuries and get reflected in the state budget documents. Therefore, adding state share of NHM and central share will lead to overestimation of the total health expenditure of the state. The state share of health expenditure has to be deducted before calculating central spending of NHM for the state. NHM has been acting as an independent implementing agency in the state. It is a separate entity and funds are allocated separately for the programme. Only the state share of NHM is reflected in the finance accounts or the detailed demand for grants. The per capita expenditure on NHM has been calculated in Rs. per capita at 2004-05 prices to show the expenditure pattern under NHM. Figure 3 indicates the per capita government health expenditure and per capita NHM expenditure in from 2005-06 to 2011-12. To recall, the government/budgetary expenditure here include the expenditure statements available in Finance Accounts documents.

It can be observed that the per capita budgetary expenditure increased from Rs. 153 in 2005-06 to Rs. 355 in 2010-11. Similarly, the per capita NHM expenditure has also been increasing from Rs. 3 to Rs. 246 in 2011-12. The proportion of increase in NHM expenditure is however higher. There is a slight decline in both per capita budgetary expenditure and per capita NHM expenditure during 2011-12. The per capita budgetary expenditure declined to Rs. 311 during the period of 2011-12 and per capita NHM expenditure declined to Rs. 202 during the same period.

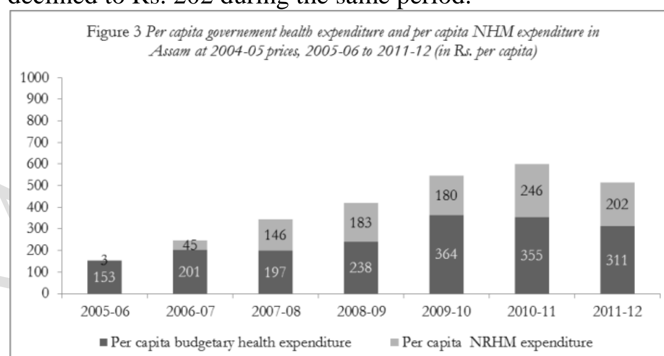

Figure 3 *Per capita governement health expenditure and per capita NHM expenditure in Assam at 2004-05 prices, 2005-06 to 2011-12 (in Rs. per capita)*

Figure 3

During the recent period the expenditure through independent implementing agencies like NHM has been increasing. The highest share through implementing agencies constitute of expenditure through the NHM flexible pool. The transfer of funds through non-treasury routes especially through the NHM flexible pool is higher for the north-eastern states. Uttar Pradesh, Assam, Maharashtra, Andhra Pradesh and West Bengal are the states receiving highest share of NHM flexible pool. These states account for 47 percent of expenditure incurred through NHM flexible pool. One of the reasons of high expenditure in these states is that they have a higher population share with respect to the other states of the country (Choudhury et al., 2011).

COMPONENTS OF NATIONAL HEALTH MISSION (UNDER NATIONAL HEALTH MISSION)

Expenditure on universal immunization programme (UIP) was highest during the period of 2005-06 (26 percent) (Figure 4). In 2006-07, the share of expenditure on reproductive and child health scheme (RCH) (44 percent) is the highest. The share of UIP has been declining since the period of 2007-08 (4 percent). Since 2009-10, the share of UIP is constant at 2 percent till 2011-12. During the recent period a major amount is spent on RCH (44 percent) in 2011-12. Expenditure on prevention and control of diseases (PCOD) constituted of 37

percent in total NHM expenditure. The percentage share spent on NHM flexipool is 17 percent for 2011-12. The pattern of expenditure by NHM indicates that the main focus of the programme is on preventive care. This has an impact on the rural households because for curative care they have given preference to private health facilities or district or civil hospital. This is mainly because of the fact that the basic health facilities for curative care are not available in the government health facilities. Moreover, the quality of care is low in case of curative care in the nearby public health institutions.

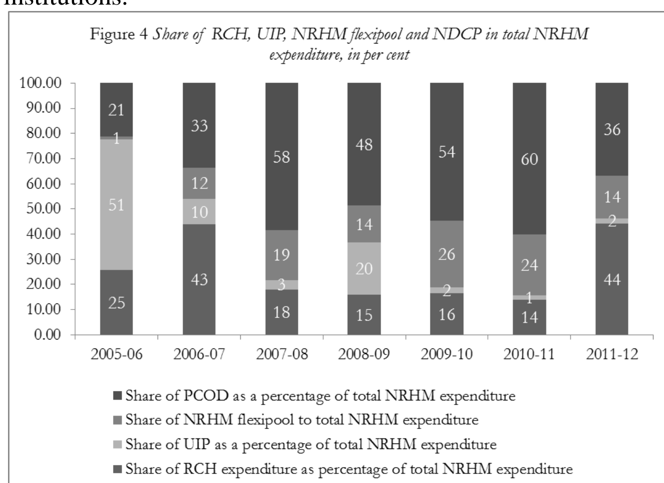

Figure 4 *Share of RCH, UIP, NRHM flexipool and NDCP in total NRHM expenditure, in per cent*

Figure 4

The mission is also spending a major amount on various child, maternal health and disease control programme. The increasing trend of expenditure through individual implementing agencies in the form of NHM has some positive implications but how far these agencies will be able to utilize the fund transfer in the long run is a matter of concern.

VI. CONCLUSION

The study shows that the overall health expenditure of the state indicates a declining trend as a proportion of GSDP of the state. Moreover, an increase in the private health expenditure has been observed in most of the states of the country, the increase being the highest in the state of Assam. Although the dependence on government health facilities is high in the state, the utilization of public health facilities has been declining over the years. This decline in the utilization of public health facilities is mainly due to decline in the quality of care in the government health facilities and growing impetus to private health sector in the state.

However, the scenario of present health programmes specifically in the form of National Health Mission shows a positive impact on the present health scenario of the state. Expenditure through non-treasury routes in the form of NHM flexipool has been increasing. While the expenditure through non-treasury routes has been increasing in the form of autonomous bodies and implementing agencies, expenditure through treasury routes has been declining specifically after implementation of the programme of National Health Mission in 2005.

The implementation of NHM has resulted in decline in the fund flow through centrally sponsored scheme (CSS) and central plan scheme (CPS) of the state. Fund transfer through CSS and CPS has been an important policy to support the various health programmes run by the state government. With these funds the government could meet some of the emergencies with respect to various health programmes related to communicable and non-communicable diseases like trachoma, blindness control programme and family welfare programmes. However, the decline in the central transfer of fund has resulted in discontinuation of some of these programmes in the recent period. Thus a cut in the fund allocation through treasury routes raises the question of sustainability of these centrally sponsored programmes. This pattern of health expenditure indicates that the state government has to bear a major share of expenditure on these programmes though their own resources.

Thus to conclude, reforms measures seems to have both positive and negative impact on the health sector, negative impacts outweighing the positive impacts as observed from the given literatures. Thus the study imply for the need of increasing public health expenditure not only for India but also for the state of Assam. Moreover, there should be proper allocation and utilization of central funds government should also focus on restricting the unnecessary crowding out of the private health sector in the state.

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