

RURAL HEALTH IN PUNJAB
- NEEDS REFORMS AND INVESTMENTS -

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Health services play vital role in the socio-economic development of a country/region. Mainstream growth economists and institutions, in unison, emphasize on the public provision of health services not only for low cost and quality reasons, but also for preventing occurrence of diseases/illnesses (Mushkin, 1962; World Bank, 1993 and WHO, 1996). Even, World Health Organisation (WHO) declares that access to quality health care is everybody's right and favours more public funds to develop an effective and efficient public health system in each country (WHO, 1996). In fact, there are certain sound economic reasons behind this phenomenon like the 'market failure' in purchasing and provisioning of health services; 'achieving equity' in health outcomes; 'imperfect information' on the part of people about health problems/treatment process/es; and 'numerous externalities' in the form of improving child survival rate, promoting women health, and reducing population growth (World Bank, 1993; Grosh and Glewwe, 2000).

In Punjab, rural health along with the education continues to be one of the pillars to develop human resources and economic reconstruction of the economy (Gill and Ghuman, 2000). In fact, during the 1970s and the mid-1980s, more public funds have been pumped in Punjab to develop public health services (Singh, 2005). The state, being one of the highly developed states of India, has the capacity to invest more and its people are expected to enjoy

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better health levels compared to the people living in Southern states like Kerala and Tamil Nadu where one could see much better education and health related indicators than that of Punjab (Brar, 2002). Since the mid-1980s in Punjab, the under-currents of political turmoil, severe state resource crunch and non-responsive administration in the state on one hand, and the adoption of new economic policy (NEP) of 1991 that insist upon the integration of nation's economy into world economy (through the forces of liberalization, privatization and globalization) on the other hand forced the state to allocate meager public funds to the social sectors, especially to the public health sector. This has brought out a faster deterioration in the public health infrastructure and services, particularly in rural Punjab.

The paper makes modest attempt to examine the rural health scenario in Punjab as well as builds a case for radical policy reforms. The paper has been divided into six Parts. Part I analyzes, in brief, the theoretical implications of global forces on the health sector of state. Part II presents the progress in health indicators and emerging health scenario in the state. Part III, examines the growth and pattern of public expenditure on health services in Punjab. Part IV deals with the main features health care infrastructure developed so far in the state. Non-functional and dismal performance of rural health services has been presented in Part V. The summary of main conclusions and emerging issues are set forth in Part VI.

GLOBAL FORCES AND HEALTH SECTOR

THEORETICAL UNDERSTANDING

Global forces are influencing India's health sector in many ways (Misra, et al., 2003) In its true essence, global forces mean the growing process of economic interdependence of nation-states through the increasing volume and variety of cross-border transactions of goods/services, free movement of capital, people, ideas and knowledge, and more importantly, diffusion of new technology at an astonished speed (Gill, Singh and Brar, 2010). It means that process of globalization has economic, political,

technological, and cultural dimensions that are interwoven with each other and affecting the main activities of nation-states. But defining the globalization as mere 'openness of economy' does not convey and capture the multiple, often contradictory, contours of real forces/mechanism that are at work among the nation-states.

This process of integrating a nation's economy to world economy, indeed, affects the people's health and health delivery system positively/negatively and directly/indirectly. Its positive impacts may be observed in the range of better health outcomes (more incomes, better living conditions, better access to health technology/medicine, better prevent/control over diseases, high life expectancy, etc.). And, its highly deleterious impacts on human health are high treatment costs, elite oriented policies, high incidence of man-made diseases, irrational use of drugs/technology, etc. The global forces directly influence a nation's health mainly through: (i) enhanced movement of pharmaceutical products, health personnel and patients across the national boundaries; (ii) elite oriented health consumerism and medical tourism via the internet and other means; and (iii) establishment of big corporate hospitals having Five Star facilities. On the other hand, more mobility of people increases more chances of spreading/contracting diseases across the borders. Further, globalization, if accompanied by low public funds to health sector, plays havoc with health of the poor in developing countries (Baum, 2001).

On the other side, in an indirect way, global forces affect the people's health in most of developing countries through the heightened industrial activities, depletion of natural resources, indiscriminate use of insecticides/pesticides, increasing environmental pollution (Air and water pollution), unsafe/untreated disposal of industrial waste, etc. Moreover, high consumption of tobacco/alcoholic products, rising consumption of packed/frozen foods and aerated beverages have also affecting the people's health negatively. The emergence of high risk diseases like diabetes, cancer, heart disease, and other life style diseases (TB, HIV/AIDS,

etc.) can be linked to the global economic policies. Moreover, for the resource poor people, falling prey to high risk chronic and life style diseases means less employment, subsequently more poverty and malnourishment of women/children in the family which is also attributed to global forces by some authors (Cornia, 2001 and Chatterjee, 2007).

In India, during the early 1990s, with the formal acceptance of structural adjustment programme (SAP), integration of Indian economy to global economy became a reality. In fact, the imposition of SAP has considerably reduced state investment in the social sectors including health sector in India. In public health fields, the role of the state has increasingly been marginalized. Further, health sector reforms piloted by the World Bank in India are actively promoting private sector initiatives, giving more emphasis to non government bodies, contracting out, and suggesting other forms of organization (Public-Private Partnership) in health management. In nutshell, main aspects of IMF-World Bank inspired health reforms in India are: cuts in public health sector investments, opening up of health care to the private sector, levying of users' charges, contracting out some services of public hospitals and relying upon purely techno-centric public health interventions (Qadeer, 2000).

And, due to cutbacks in public health sector funds, primary health care services suffered a major setback in India. For want of more funds, infectious diseases control programmes were disrupted, FW programme began to focus on reproductive health of married women only, children' health and their nutritional needs were ignored. By handing over the health care to private sector players, without any regulatory mechanism to ensure the quality and standards of treatment, state is withdrawing itself from the constitutional obligations and seriously affecting the equal access of health services to the marginalized section of society (Baru, 1998). All these forces are found to be working more vigorously in the state of Punjab (Gill, Singh and Brar, 2010).

II

The economic theory states that high per capita income often leads to improvements in living standards and health status of people. Rising per capita income in Punjab has a favorable impact on life expectancy at birth for males and females. For instance, life expectancy of males during 2001-06 was 69.8 years, whereas it was 68.4 years during 1996-2001. Similarly, the life expectancy of females was 72.0 years during 2001-06 compared to 71.4 years during 1996-2001 (Table 1). Although the rural areas in Punjab had performed very well in bringing down the birth rate to 18.8 per thousand people and the death rate to 7.4 per thousand people in 2006, yet both these rates can further be improved (Singh, 2005). However, infant mortality rate in rural Punjab is still high (48 per thousand live births). And, total fertility rate (TFR) and maternal mortality rate (MMR) estimated to be very high (2.98 children per woman and 178 per lakh live births). Besides these, there exists a big gap in proportion of other public facilities such as accessibility of safe drinking water (piped water) and sanitation (toilet facilities, connectivity to drainage, etc) in rural Punjab. About one-fourth of Punjab's villages (24.04 percent) did not enjoy any drinking water supply scheme. These facilities, in fact, greatly influence the health status/quality of life of people (IIPS, 2001). It clearly shows that, rural people still deprived of basic health related facilities, despite achieving high economic growth in the past.

Further, the data on incidence of morbidity in rural Punjab showed that, on the whole, 127 persons per 1000 population were suffering from one or other types of illness during the first half of 2004. Incidence of morbidity was much higher in rural areas (136 persons per 1000 population) compared to that of in urban areas (107 persons per 1000 population). Further, morbidity incidence was significantly higher among females both in rural and urban areas (Table 2). It was very much higher when compared to all India average incidence of morbidity. In fact, Punjab became second highest morbidity state after the Kerala in the country (NSSO, 2006). An analysis of estimated number of persons reporting ailment/s in Punjab over two and half decades (1973-74, 1995-96

and 2004) revealed that number of ailing persons in the state grew at the rate 3.8 per annum during 1973-74 to 1995-96. Between 1995-96 and 2004, growth in number of ailing persons rose to 7.1 per cent.

The pace of growing morbidity was much higher in rural Punjab, especially during the latter period of 1995-96 to 2004 (8.1 per cent per annum) compared to the earlier period of 1973-74 to 1995-96 (3.0 per cent per annum). However, in urban Punjab, growth rate in the morbidity was 6.2 per cent per annum between 1973-74 and 1995-96 compared to the growth rate of 4.8 per cent per annum between 1995-96 and 2004. At all-India level, morbidity was also grown during the latter time period (1995-96 to 2004) compared to the previous time period.

The data on morbidity by type of diseases/ailments (grouped into 21 categories) state that the respiratory/ENT diseases, fevers of unknown origin, cardiovascular diseases, gastro-intestinal diseases, disorders of joints and bones, and bronchial asthmas emerged as the top six ranking diseases/ailments in descending order of their prevalence in rural Punjab. Intriguingly, nearly three-fourth of sick persons (58.66 per cent) in rural Punjab suffered from these six diseases/ailments (NSSO, 2006). Besides the prevalence, on an average, every seventh patient suffering from diseases in rural Punjab required hospitalization (indoor treatment) during 2004. In the hospitalization cases, accidents/injuries/burns, gastro-enteritis, fever of unknown origin, kidney/urinary tract infections, gynecological disorders and cardiovascular diseases (in order of importance) emerged as six top ranking diseases/ailments. It means that chronic diseases along with infectious and man-made diseases (accidents, injuries, etc.) were taxing the health of rural people in Punjab. It showed that ruralites in the state were passing through a peculiar health transition phase where the morbidity from chronic, infectious and man-made diseases was rising at an alarming rate, although the mortality data had shown a decline. Hence, low morbidity, low mortality and healthy aging seem to be a distant dream in rural Punjab.

III

For socio-economic welfare of people, developing countries are investing more public funds in the social sector programmes, namely, education, health and fertility control (Walle and Nead, 1995). Further, shifts in pattern of public expenditure in favour of social sectors will certainly improve the living conditions of the poor and, also, the re-distribution of public services towards them (Wulf, 1975). In fact, global forces may affect allocation of public funds not only to the health sector as a whole, but also within the health sector in India (Qadeer, 2000). These forces may distort the priority status of many health care programmes in India as well as in states, mainly due to the cutback in public health sector investments, donor driven priorities and emphasis on privatization of health care. Interestingly, all these forces are working more vigorously in Punjab as the state's health sector plan was found to be largely dependent upon the Union Government's finances and policy matters.

PUBLIC EXPENDITURE ON HEALTH SERVICES

An assessment of sector-wise allocation of public expenditure in Punjab is, therefore, necessary and rewarding as the state health sector has to compete with other development and non-development services under the new economic policy of liberalization, privatization and globalization (LPG). In Punjab, the analysis of public expenditure on health including family welfare (FW) services on revenue account (Table 4) reveals that, although the total expenditure on these services (in real terms at 1993-94 prices) has spiraled from Rs. 138.81 crores during the triennium ending 1980-81 to Rs. 371.73 crores during the triennium ending 2004-05, yet, in the relative terms, the share of health sector out of the total budgetary expenditure, development expenditure and state income has shown a decreasing trend. For instance, the share of health sector remained around 9 percent between the triennium ending 1980-81 and the triennium ending 1986-87. And there after, it decreased to 6.97 per cent during the triennium ending 1989-90, 5.46 per cent during the triennium ending 1992-93, and 4.35 per

cent during the triennium ending 1995-96; again slightly rose to 5.48 per cent during the triennium ending 1998-99 and fell to 4.02 per cent during the triennium ending 2004-05.

A similar picture emerged when one viewed the share of health sector as the proportion to total development expenditure and social services in the state. Further, as the percentage of NSDP, the share of health services in Punjab never reached to one percent for the most of years against the India's normative ratio of 3 per cent of the state/national income. This shows that the public expenditure on health sector has experienced a decelerated growth over the time period, especially after the initiation of NEP of 1991 (post-reforms period) in India and Punjab also.

INTRA-SECTOR PLANNED HEALTH EXPENDITURE

Theoretically, allocation of more public funds to health sector is of paramount importance, particularly to improve its accessibility and relevance to the poor sections of society. But, in practice, the intra-sector allocations (expenditure) within health sector are also very important and useful to determine the changing health priorities of the state, if any. However, the programme-wise disaggregated data of total public health expenditure in Punjab are not available, except for the planned expenditure during different plan periods. The data revealed that a very high proportion of total health sector's planned expenditure incurred on a single programme, i.e., the FW programme. The share of FW programme that was 34.57 percent in the Sixth FY Plan (1980-85) decreased to 28.92 percent in the Seventh FY Plan (1985-90) and rose to 30.84 per cent in the Eighth FY Plan (1992-07). Then it decreased to 21.56 per cent during the Ninth FY Plan (1997-2002). However, planned allocation rose to 33.73 per cent during the Tenth FY Plan (2002-07). Establishment and strengthening of new/old hospitals, PHCs, dispensaries, etc. received second priority status programme, mainly owing to the rural health component of Minimum Needs Programme. Under this head, a little more than one-fourth (25.56 percent) of total health plan expenditure was incurred during the Sixth FY Plan (1980-85), more than one-half (56.33 per cent) during the Ninth FY Plan

(1997-2002) and a little less than two-fifths (37.46 per cent) during the Tenth FY Plan (2002-07).

Control/eradication of communicable diseases is another major component of public health plan expenditure up to the Eighth FY Plan (1992-97). Plan expenditure under this head was 13.46 per cent during the Sixth FY Plan (1980-85) and rose to 27.03 per cent during the Seventh FY Plan (1985-90), but declined to 10.95 per cent during the Eighth FY Plan (1992-97). During the Ninth FY Plan (1997-2002) and Tenth FY Plan (2002-07), this head has just 0.83 per cent and 2.48 per cent share in the allocation of funds respectively. On the other hand, medical education, research and training consistently decreased its share in relative terms from 14.62 percent during the Sixth FY Plan (1980-85) to 11.27 percent during the Seventh FY Plan (1985-90), 10.87 percent during the Eighth FY Plan (1992-97) and 5.84 per cent during the Ninth FY Plan (1997-2002). And, during the Tenth FY Plan (2002-07), there is proposal to spend 14.03 per cent of total health plan allocations. This has posed very serious repercussions on the doctors' training, developing core competencies among them and deterioration in the tertiary health care provided by the hospitals attached with government owned Medical Colleges of the state. Moreover, it is quite interesting that the indigenous systems of medicine (*Ayurvedic*) and homeopathy are being continuously neglected, at least, in terms of allocation of plan funds in Punjab. Also, the Employees State Insurance Scheme did not find any priority status (Table 5).

PLANNED HEALTH EXPENDITURE: CENTRE VS. STATE SHARE

The constitutional division of powers between the Centre and the States in India clearly shows that the state governments have exclusive jurisdictional powers to establish and monitor the provision for the 'public health and sanitation', 'hospitals and dispensaries' and 'burials and cremations' in their respective areas. The role of central government is limited largely to regulate the medical standards, formulate health policy, resolve international health issues, issue policy directions and allocate more finances

for strategic health programmes/schemes (Prakash and Raj, 1972). Thus, in theory, creating provisions for health care are largely the state-subject, but in practice the central government is playing very significant role through financing states' health sector plans. An analysis of data reveals that the central government financed a greater part of Punjab's planned health expenditure; 47.62 percent during the Sixth FY Plan (1980-85), 57.83 percent during the Seventh FY Plan (1985-90), 59.57 per cent during the Eighth FY Plan (1992-97) and 39.99 per cent during the Tenth FY Plan (2002-07). The data also illustrate that all the priority programmes of state health plan like the family welfare and control of communicable diseases got more allocation of central funds, mainly due to the policy of central government to promote these programmes. Among these priority programmes, the FW is fully central funded programme and in the case of two other programmes, liberal central grants along with matching contributions by the state are made available. The Punjab government utilized these grants to expand health care and family welfare infrastructure in the state.

Establishment of hospitals, PHCs, dispensaries, etc. is another priority programmes in Punjab's health sector plan. Again, under this head, sufficient central funds were allocated in the past to finance these programmes. Actually, due to this single reason, these programmes have emerged as priority programmes in the state's health plans. In the case of controlling/eradicating communicable diseases, the central government spent more funds both absolutely and relatively compared to the funds made available by the state government. Further, 'other programmes' under the state category, which consists of minimum needs programme, hospitals and dispensaries, medical education, etc., deal with the creation and strengthening of infrastructure facilities in the state. These programmes are crucial health Programmes for the maintenance of health of the people. These are financed partly by the central government and partly by the state from own resources, and state's share under this head remained around 44 per cent in the Sixth FY Plan (1980-85) and decreased to 30.03 per cent in the Seventh FY Plan (1985-90), but rose to 35.46 percent in the Eighth FY Plan

(1992-97) and 76.19 per cent in the Ninth FY Plan (1997-2002), and declined to 58.67 per cent in the Tenth FY Plan (2002-07). Thus, state is highly dependent on central government for finances as well as health policy matters. It means that, whenever there is policy shift at the all-India level, it is automatically reflected at the states' level. Indeed, it is true in the case of health sector of Punjab.

IV

HEALTH DELIVERY SYSTEM IN PUNJAB

Public and private providers dominate the health delivery system of the state. In large urban towns of Punjab, hospitals attached with the Medical Colleges provide tertiary health care facilities. In medium/smaller towns and some larger villages, the state government runs an extensive infrastructure of districts hospitals, tehsil hospitals, community health centres (CHCs) and rural hospitals (RHs). And, a network of CHCs/RHs, PHCs and dispensaries has been serving the rural People. Theoretically, the state health delivery system is operating at three levels: (i) at the primary level, (CHC, PHCs and dispensaries); (ii) at the secondary level, (district and tehsil hospitals); and (iii) at the tertiary level (medical college hospitals and central government hospitals). On the other hand, an overwhelming majority of private health providers dominantly provide clinic/office-based practice of general practitioners, and mostly concentrate on low risk cases. An overwhelming majority of them are based in urban areas.

In Punjab, public health facilities have increased up to the mid-1980s mainly due to increased allocation of funds to state health sector and pro-rural policy of state government (Singh, 2005). Thereafter, whatever may be the reasons and factors behind this, public funds to expand state health services declined drastically in the state. The data in Table 1 showed that there was no appreciable increase in health infrastructure in Punjab since the mid-1980s. Between the triennium ending 1980-81 and 2004-05, total number of hospitals decreased from 244 to 219, the number of PHCs increased from 129 to 441, the number of dispensaries rose from 1255 to 1479, and of indigenous systems of medicine & homeopathy related

dispensaries from 454 to 636. Further, the proportion of rural hospitals just increased from 40.98 percent during the triennium ending 1980-81 to 43.77 percent during the triennium ending 1986-87. And, thereafter the share of rural hospitals decreased consistently to 35.10 percent during the triennium ending 1995-96, and 33.33 per cent during the triennium ending 2004-05.

The proportion of rurally located dispensaries also showed a marginal decrease (85.31 per cent during the triennium ending 1980-81 to 82.56 per cent during the triennium ending 2004-05), despite the allocation of more central funds to rural health under the Minimum Needs Programme that has been implemented in India since the Fifth FY Plan (1974-79). This decrease in proportion of rurally located dispensaries is, perhaps, due to the up-gradation of many rural dispensaries into CHCs/PHCs in the same area during the period of 1984-2000 (Singh, 2005). Further, population served per institution also confirmed that there has been very slow or no increase in the number of medical institutions owned by state compared to increase in population of state. For instance, population served per hospital, which was 0.67 lakh during the triennium ending 1980-81, rose to 1.17 lakh during the triennium ending 2004-05. In the case of PHCs that are exclusively for the rural areas, a different picture has been emerged. Actually, due to the additional of many PHCs over the years, population served per PHC fell from 1.13 lakh persons during the triennium ending 1980-81 to 0.34 lakh during the triennium ending 1989-90, but rose to 0.40 lakh during the triennium ending 2004-05 (Table 1). Consequently, at present, Punjab state again stayed away from the norms set by the Union Government in terms of population served per PHC (i.e. 30,000 populations per PHC). Thus, there was a no increase in the number of PHCs/CHCs in rural Punjab during the 1990s.

In economic theory of public health services, it is the number of beds and their utilization that are considered to be the best indicators of the strength of health care facilities prevalent in the state. Since the utilization pattern of public health services has been attempted in the next section, the population served per bed has been attempted

Table 1: Growth of Health Care Infrastructure in Punjab

| Triennium Average | All Types of Institutions | | | | | | | | | | Population Served Per Institution | | | | | |
|--------------------|---------------------------|----------------|-----------------|----------------|-----------------|----------------|----------------|------|------|------------|-----------------------------------|-------|-------|-------|-------|--|
| | Allopathic | | | | | Non-Allopathic | | | | | Allopathic | | | Non-A | | |
| | H | PHC | D | CHCs | Total | H & D | H & D | H | D | Rural PHC* | H & D | H & D | Total | Rural | Urban | |
| 1978-79 to 1980-81 | 244 (40.98) | 129 (81.65) | 1255 (85.31) | - | 1630 (78.25) | 454 (91.57) | 454 (91.57) | 0.67 | 0.13 | 1.13 | 0.36 | 0.36 | 854 | 1558 | 387 | |
| 1981-82 to 1983-84 | 256 (43.43) | 130 (85.38) | 1742 (87.92) | - | 2137 (82.05) | 533 (84.77) | 533 (84.77) | 0.68 | 0.10 | 1.13 | 0.33 | 0.33 | 802 | 1276 | 410 | |
| 1984-85 to 1986-87 | 264 (43.43) | 143 (86.51) | 1779 (87.49) | - | 2187 (82.10) | 563 (83.47) | 563 (83.47) | 0.70 | 0.10 | 1.06 | 0.33 | 0.33 | 811 | 1283 | 422 | |
| 1987-88 to 1989-90 | 250 (42.72) | 362 (93.38) | 1564 (85.57) | 23 (61.43) | 2199 (81.74) | 608 (83.20) | 608 (83.20) | 0.78 | 0.12 | 0.40 | 0.32 | 0.32 | 814 | 1291 | 436 | |
| 1990-91 to 1992-93 | 210 (38.16) | 441 (95.23) | 1470 (84.06) | 93 (60.79) | 2213 (80.96) | 628 (83.02) | 628 (83.02) | 0.98 | 0.14 | 0.34 | 0.33 | 0.33 | 841 | 1339 | 449 | |
| 1993-94 to 1995-96 | 208 (35.10) | 446 (94.62) | 1465 (83.30) | 104 (57.69) | 2223 (79.86) | 636 (79.87) | 636 (79.87) | 1.05 | 0.15 | 0.35 | 0.34 | 0.34 | 873 | 1408 | 477 | |
| 1996-97 to 1998-99 | 208 (34.99) | 444 (94.74) | 1468 (83.04) | 110 (58.36) | 2229 (79.68) | 635 (79.87) | 635 (79.87) | 1.16 | 0.16 | 0.37 | 0.38 | 0.38 | 954 | 1446 | 589 | |
| 1999-00 to 2001-03 | 216 (33.69) | 441 (94.55) | 1476 (82.70) | 108 (60.99) | 2240 (79.27) | 635 (79.87) | 635 (79.87) | 1.13 | 0.16 | 0.39 | 0.38 | 0.38 | 957 | 1483 | 566 | |
| 2002-03 to 2004-05 | 219 (33.33) | 441 (94.33) | 1479 (82.56) | 103 (62.14) | 2242 (79.13) | 636 (79.83) | 636 (79.83) | 1.17 | 0.17 | 0.40 | 0.40 | 0.40 | 1018 | 1555 | 624 | |

*Rural Population, Non-A means non-allopathic which includes Ayurvedic, Unani and Homeopathic.

H= Hospital, D= Dispensary, PHC= Primary Health Centres, CHC= Community Health Centres.

Figures in parentheses are percent share of rural areas.

Source: Cullied from the **Health Information of Punjab**, (Various Issues), Directorate of Health and Family Welfare, Government of Punjab, Chandigarh.

here. An assessment of the data on population served per bed reveals (Table 1) that population served per bed in rural areas did not show any improvement, as there was one bed for every 1276 rural persons during the triennium ending 1983-84 and that ratio rose consistently to 1555 persons per bed during the triennium ending 2004-05. Also, population served per bed in urban areas also rose from 422 persons during the triennium ending 1983-84 to 624 persons per bed during the triennium ending 2004-05. This means that no appreciable effort was made by the government to improve the availability of more beds for indoor treatment in public owned medical institutions of the state. In fact, indoor treatment in these institutions has deteriorated during the post reforms period of the study.

PARTIAL INITIATIVES TO IMPROVE QUALITY OF HEALTH INFRASTRUCTURE

The state government, despite fully aware of these realities, did not make any planned effort/initiative to expand and bring reforms in the public health infrastructure both in urban and rural areas since 1991. The only two initiatives, limited in scope, have been taken to re-organize state health department in Punjab. First initiative is related to the corporatization of public health services in the state by establishing the Punjab Health Systems Corporation (PHSC) during the late 1990s by taking over only 154 public hospitals - ranging from district hospitals (17), sub-divisional hospitals (45) to CHCs /PHCs (92). The main motives of the PHSC are to (i) upgrade the secondary health care system (on selective basis) and (ii) introduce the health reforms in the state health sector. This was done with the help of World Bank Loan of Rs. 422 crores. This has generated a debate and created many suspicions in the minds of intellectuals, policy makers, and health employees, and also among the general public of the state. Many of them fear that it is the implementation of the IMF and World Bank's prescriptions of commercialization and corporatization of health services in the state. Their doubts/fears came true with the introduction of high users' charges for every service provided by these institutions.

A part of services provided by the PHSC owned institutions, by allowing the establishment of private diagnostic facilities at these institutions' premises, has been privatized, and the users' charges (high as well as comparable to private sector in many cases) are being levied for every service provided by these hospitals. However, the government defence in setting up the PHSC rests on three counts: One, it will upgrade the secondary health care system in the state with the World Bank assistance, which is in bad shape and dire need of funds; Two, corporation will have inherent flexibility of taking decisions and it would be possible for the state to govern the employees better and to give various incentives/rewards to them on the basis of their performance; and Third, it will improve the utilization of public health services by attracting the patients on one hand, and generate internal funds at the institution level through users' charges for further improvement or expansion of health services on the other.

Second initiative related to improve health care in rural areas has been taken very recently, i.e., year 2006. Under this initiative, decentralization in the administrative control of health delivery system has been introduced, particularly in the rural Punjab by hand over the control of 1310 rural dispensaries to the district level PRIs (Zila Prishad). In this new dispensation, the service-providers (Qualified Doctor) are appointed on contract assignments. The concerned Zila Prishad appoints a service-provider @ rate of Rs. 3.50 lakh per year per dispensary. And, out Rs. 3.50 lakh contract money, the service-provider is responsible for hiring the services of one pharmacist, one peon and maintaining the basic sanitation and other facilities in the dispensary. At present, on an average, there is one government health dispensary for 10 villages and each is headed by a service-provider who works under the control of Zila Parishad. If experience is successful, then the Punjab Health Department has promised to increase the rural dispensaries from 1310 to 2,600 in the next year. As per initial reports, this contract system is working well in the rural areas, the service-providers are available in the dispensaries to the rural patients during the specified hours, employees' attendance is monitored by the village Panchayat and a ten-fold

increase in patients has been recorded in the OPDs of dispensaries. However, the critics point out that the administrative decentralization is no panacea for the ills of health delivery system in the state, which requires appropriate public health interventions, state support and efficient personnel. For success of decentralization in context of Punjab, it needs a process of devolution of powers, not just the delegation of responsibility by the state to the periphery. Actually, the former involves sharing of decision-making powers and control over the resources, not just the administrative decentralization or shifting the responsibility of resource mobilization, which often has a negative impact, especially on the poor living in the periphery (rural areas).

V

STAGNATION AND DETERIORATION OF PUBLIC HEALTH SERVICES

As already reported, there was no major increase in government owned health institutions in Punjab and beds in them since the 1990s. On the other hand, due to the collapse of administration and weak monitoring mechanism during the militancy period, the rent seeking behaviour of most of health sector employees has become the hallmark of health delivery system in the state. And, now-a-days, due to the lack of state support and funds and reoriented priorities under the SAP of World Bank, the potentials of public health infrastructure, particularly in rural Punjab, have not been optimally utilized. In fact, the available health infrastructure is allowed to deteriorate during the time period of 1990s and onwards. Many studies looking into health services in Punjab have observed that there are glaring deficiencies in machinery, equipments, appliances, buildings and residential accommodation, etc. in public health institutions (Singh, 2005). Really, decentralization has not taken place and there is no community participation. The entire burden of critically ill-patients falls on the private or corporate sector owned hospitals. The district hospitals or hospitals attached with medical colleges in the state, which were the natural priority of such patients in the past, were neither adequately funded, nor properly equipped with the latest technology/appliances and, therefore, were not preferred by the rich and the middle class

people as evidenced from the health care seeking behavior of patients (Singh, 1991). In fact, recent health policy changes introduced under the influence of global forces have, further, led to the withdrawal of government funds to public health sector and promoted private capital by allowing the creation of private health services in the state.

In health care theory, bed occupancy ratio is considered to be a better indicator of utilization as well as strength of public health services, especially in the case of indoor treatment. The bed occupancy ratio in the state has, however, shown a dismal picture. For example, district hospitals, which seem to be overcrowded with patients (bed occupancy ratio was around 100 per cent) between 1970 and 1985, have shown a downward trend in the bed occupancy ratio. A sharper downward trend in bed occupancy ratio has been observed in the tehsil hospitals, hospitals exclusively for women and tuberculosis patients. The 30-bedded, 25-bedded and PHCs that are mostly located in rural areas had shown abysmally low level of bed occupancy. Interestingly, 17 district hospitals taken over by the PHSC did not show any impressive improvement in the bed occupancy ratio, as it was 58.1 percent in the first half of 2001. Even hospitals attached with state medical colleges providing tertiary care in Punjab had witnessed a fall of about 50 percent in bed occupancy, mainly due to the deterioration in quality care and introduction of user charges since May, 1999. Consequently, patients who can afford medicare prefer to get them treated in private hospitals/nursing homes, which are grown in leaps and bounds in the state.

Actually, existence of private sector owned health services in Punjab is not a new phenomenon. The public-private mix has been existing for a long period, where the latter makes full use of the former, particularly related to supplying trained health persons (Doctors, nurses, etc.) promoting health related R & D, and determining quality treatment standards. And, under the global forces, the new thing is opening up of public domain health services to private investment and levy of high users' charges. Both these measures would be, however, failed to augment health services for the poor or to bring greater efficiency in the delivery of health services in the state. In fact, these measures have increased the cost of public health care so

high that the poor patients are deprived of accessing the low or subsidized but quality care supposed to be provided by the publicly owned health services.

In Punjab, private sector health institutions have grown at a greater speed. Among the private hospitals/nursing homes, many have better equipments and machinery than that of government hospitals. They have engaged the specialists on contract basis and employed mostly untrained paramedical staff to deliver health care to the people. Moreover, with the advent of telemedicine, nuclear medicine, non-invasive and laparoscopic surgery techniques, the patients' first priority is the hospitals where these facilities are available on demand. That is why the corporate entrepreneurs (Ranbaxy, Oswal, Fortis, Escorts, etc.) are entering the health sector in a big way in urban Punjab, mainly to generate high profits. The Punjab Government is lending state support to them by providing the land at concessional rates in the PUDA developed urban colonies (Bhat, 2000).

Many micro level studies also concluded that a large majority of people suffering from illness/disease preferred to, instead of public sector institutions, private clinics for treatment even when they are unqualified/untrained (quacks). A recent study on the utilization pattern of health services in rural Punjab, based on the primary survey of 180 rural households (2007-08) spread across 18 villages located in three districts of Punjab, namely, Jalandhar, Bathinda and Fatehgarh Sahib, reveals many interesting facts. The study highlights that about one-third of patients (33.44 percent) used public health centres, and the remaining two-thirds (67.56 percent) preferred private hospitals/nursing homes/clinics/chemists, etc for getting treatment. With regard to grading of public/private health facility, the data reveal two main trends. One, a small proportion of rural patients (18.10 percent) received treatment from private hospitals and a little more than one-fifth patients (20.86 per cent) got treatment from private clinics/RMPs. **Two**, a little less than one-third of patients (31.91 per cent) got treatment from the unqualified health providers (called quacks in popular parlance). Almost similar pattern of utilization was observed in another study (Singh, 1991).

Another study reveals that in more than three-fifths surveyed

villages in Punjab (62 per cent); the rural respondents had reported easy access (near home) of public health facilities during the time period survey. However, about one-fourth of households (24 per cent) used public health facility for treating minor ailments (cough, cold, fever, wounds, loose motion, etc.). In the case of major ailments (surgery, fractures, complicated deliveries, strokes, etc.), more than two-fifths households (42 per cent) preferred public health facility for treatment. Cheap treatment and easy access were the main reasons for the villagers to show preference for the utilization of public health services. Interestingly, only a small proportion of households (less than 3 per cent) who used of public health institutions were fully satisfied with the service (Paul, et al., 2004). It means that private health sector is the major reckoning force in the treatment of diseases/injuries in rural Punjab.

Further, the dismal picture of public health institutions can be gazed from the large number of sanctioned posts of doctors, paramedical staff and district level health officers (on supervisory and monitoring duty) are lying vacant. These sanctioned posts in Punjab's health department are deliberately kept vacant by imposing a ban on new recruitments, not due to the non-availability of qualified health personnel, but largely due to pressures of globally determined economic policy and resource crunch faced by the state. It revealed that about one-fifth of posts (18.68 per cent) in health department of Punjab are lying vacant in 2005. Interestingly, one-sixth posts of medical officers (16.80 per cent) are also lying vacant, despite a large number of qualified doctors are unemployed and available for work in the state. Similarly, more than one-sixth of sanctioned positions of paramedical staff (18.38 per cent) and about one-fourth of posts of drivers (22.93 per cent) has remained vacant. Indeed, it is true that more than one half of sanctioned post of the district level health extension staff (56.47 per cent) that provide a crucial link to maintain quality checks in health related fields have remained vacant.

NON-FUNCTIONAL RURAL HEALTH SECTOR AND CONSEQUENCES

From the 1990s onwards, when the globalization has gained importance and become indispensable in India, many health sector reforms were introduced to bring strategic but favorable changes in

health care delivery system. Under the health sector reforms, cutbacks in public welfare expenditure, donor driven priorities, techno-centric public health interventions and increasing reliance on private sector in providing health care have become the hallmark of new health strategy (Qadeer, 2000). All these forces could not bring cheers to the illiterate, the poor, the downtrodden living in rural Punjab and the slum dwellers in urban Punjab. For instance, when cuts are imposed on public health expenditure, not only the secondary and tertiary care units are deprived of resources, but inevitably the CHC/PHC units also suffer immensely. When cutbacks in the social sector as a whole (education, rural development, social welfare and nutrition, etc.) and dwindling subsidies to the public distribution system (food rationing) were imposed, it meant an additional loss of inter-sectoral support to the poor people. In such scenario, populations living at subsistence levels and below poverty line became even more vulnerable. Some researches convincingly demonstrated that in rural areas ill-health has become a major cause of indebtedness (Planning Commission, 1999).

A cursory look at Plan Documents of Punjab state has shown that already there are glaring deficiencies in the availability of machinery, equipments, appliances, buildings and residential accommodation, etc. in state owned rural health institutions. In fact, there is little community participation in the health sector and the decentralization at the village level has not taken place. In rural Punjab, the entire burden of health care (Promotive, preventive and curative cares) falls on rural CHCs/PHCs, which are not adequately equipped and not acceptable to the people as evidenced by their health seeking behavior in case of illness/disease (Singh, 1991). Recent policy changes under the influence of globalization have, further, led to the withdrawal of government support of funds to rural health sector. The distribution of rurally located health institutions by type and bed strength lent support to these conclusions. The data reveal that a large majority of rural health institutions in Punjab (around 90 percent) fell in 0-4 bedded category between 1986 and 2005. Further, there were 111 rural hospitals in 1986, and their number had decreased to 73 in 2005. Of them, more than four-fifths were of small size having bed strength of 11-30 beds during 1985-2005 period. There is only one large sized

hospital at Beas (a rural location situated on the bank of River Beas) having 300 beds, but run by the Radha Swami Satsang – a philanthropist organization. One may, thus, safely conclude that an overwhelming majority of rural health centres are primarily consultation clinics. Hospitalization and emergency services (Indoor treatment) are almost non-existence in these rural institutions. The data provided by the Chief Medical Officer (Civil Surgeon), Patiala district revealed that in all rural PHCs and dispensaries located in Patiala district, no bed occupancy was reported during 2005-06. This finding could be true for all of rural Punjab's case. Thus, rural people are deprived of easily available, cost effective and better quality treatment of public health services near their homes in rural areas of the state.

Further, the availability of government doctors and paramedical staff in rural health institutions is very much regressive. Although this could not be substantiated for want of aggregate data pertaining to the number of doctors and paramedical staff posted in the rural areas, yet the actual position of these persons in five (5) Development Blocks in Punjab state highlighted that 21 posts of doctors (32.8 percent) out of 64 sanctioned posts in these Blocks were lying vacant. Similarly, out of 123 sanctioned posts of paramedical staff, 22 posts (17.89 percent) were lying vacant. As regards the availability of doctors and paramedical staff during the stipulated duty hours, the less said is better. Almost all the Block studies are unanimous to the large-scale absenteeism among the staff of these medical institutions under study. In many cases, the absenteeism was in connivance with the senior officers and patronage of other influential and well-connected persons who, often, reside in cities and towns. Apart from the problem of absenteeism, all the block plan documents reveal: (a) poor and inadequate physical facilities, (b) non-availability of doctors round the clock; (c) non-availability of essential and basic medicines and lab test facilities; and (d) no arrangement for disaster management and emergency services in rural areas.

It is more deplorable that many of such non-existent facilities in public health facilities are no longer on the agenda of the Punjab

government. As a consequence of non-functional rural health infrastructure, the gaps in rural-urban health facilities are being filled in by the mushrooming growth of quacks in rural areas that are playing havoc with the health of rural people, especially the poor, by charging exorbitant high prices for sub-standard treatment and medicines. That is why very wide gap still existed in rural and urban health indicators and infrastructure. Although all the health indicators have shown positive development over the time period of study, yet the rural-urban differences are clearly visible. For instance, during the triennium ending 2004-05, the birth rate in Rural Punjab was 21.6 per thousand live births compared to urban Punjab' birth rate of 18.0 per thousand live births. Similarly, the rural death rate was 7.3 per thousand compared to 6.1 per thousand in urban Punjab during the same period. As regards infant mortality rate, it was 53.7 per thousand live births and 38 per thousand live births in rural and urban Punjab respectively during the triennium ending 2004-05. Similarly, the gap between populations served per bed is very wide in the state; as 1555 persons and 624 persons were served per bed in rural and urban areas respectively (see Table 1).

VI

The study clearly established that, when the LPG policy began to dominate in India, public investment on social sectors in Punjab, especially to the public health sector has been withdrawn, particularly during the early 1990s and onwards. Public health expenditure as proportion of the NSDP in the state never crossed more than 1 percent for the most of years against the normative ratio of 3 per cent of the state/national income accepted in the country. Moreover, dominance position of the central government in financing Punjab's planned health expenditure as well as in determining state's health priority programmes has bad consequences (cutbacks in funds) for the more crucial 'public health and sanitation' programmes, which are more relevant for the state. Consequently, no visible expansion and improvements in the public health infrastructure both in rural and urban areas has been seen since 1991, except establishing the PHSC to upgrade secondary health care in the state. Still, very wide gaps are found in rural and urban health indicators in the state.

In Punjab, an overwhelming majority of public health infrastructure and services, due to lack of funds, faulty planning and poor governance, has become non functional and has shown gross under-utilization pattern. And, rural institutions continue to be starved of essential medicines, test facilities, first aid kits, etc. and are primarily consultation clinics. Emergency and hospitalization services are almost non-existent in majority of these rural institutions. The rural people, especially the poor, are deprived of easily accessible, cost-effective and better quality treatment of public owned health services near their homes.

The rich and emerging middle income groups, who have become health conscious and have capacity to pay, began to patronize private hospitals/nursing homes for getting specialized treatment. In rural areas, the gap is being filled by the mushrooming growth of quacks that provide sub-standard medical treatment at exorbitantly high costs. Growing private health sector is largely unmonitored and unregulated, with no norms with regard to quality or price of treatment. Even the new National Health Policy 2001 did not mention any of policy parameters in the fixation of charges and the standard of treatment provided by these private institutions. Further, inequities in income have resulted in differential access as well as utilization of health services in the state. These trends will seriously jeopardize the human resource development in the state and, subsequently, the formation of human capital, its improvement and maintenance and future economic growth in the state.

In nutshell, global forces in the state have negatively affected the working of public health institutions, favoured the role of private sector health services and implemented donor-driven priority programmes in the state. In the end, it is suggested that Punjab state should urgently take a long-range view of the health sector and integrate it to the other components rural development strategy. For this, state health policy should have the triple task of (a) raising the demand for 'improved health'; (b) improving the quality of public health services; and (c) controlling the ever-growing reliance on private health sector. Moreover, the community participation (through PRIs and Local

Bodies) should be enhanced in functioning and supervision of the whole public health system to make it more accountable to the users.

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