

**DECENTRALISATION OF THE HEALTH CARE
SECTOR IN KERALA : SOME ISSUES**

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ABSTRACT

Kerala is in the forefront of decentralisation of powers following the 73rd and 74th Constitutional Amendments. The existence of a large number of health care, educational and other institutions in every Panchayat in Kerala has necessitated decentralisation of every sector as part of the overall decentralisation. The government order of 1995 has transferred the health care institutions at various levels to the local self government institutions (LSGI).

This study seeks to analyse decentralisation of the health care sector in Kerala and the associated problems as perceived by the elected members. The study argues that three basic problems of decentralising the health care sector, namely spill over effect, role and relevance of a pre existing body (Hospital Development Committee or HDC), and the level of minimum health care service to be provided by the health care institutions, have not been adequately addressed.

The problem of benefit spill over is quite serious with regard to the secondary health care services accessed from the Taluk Head Quarters Hospitals, which have been brought under the Municipal Councils. The problem arises from the concentration of hospital beds in municipal towns. The system of "matching transfers" might address the problem of benefit spill over but it will introduce a new problem owing to the inequality in the distribution of hospital beds across the taluks of the state. A separate fund on the lines of the "social investment" fund in Columbia might address this problem. Alternatively, private health care sector may be drawn in through a reimbursement scheme so as to ensure a minimum level of service.

The presence of HDC in a decentralised system is difficult to sustain. Its continuance comes in the way of a proper functioning and accountability of the LSGI with regard to the provision of health care services. How exactly the functions of HDC should be integrated with the LSGI calls for further discussion.

JEL Classification : I10, O2

Key Words: decentralisation, benefit spillover, minimum level of service

I. Introduction

India has a long history of experimenting with decentralisation. The 73rd and 74th Constitutional Amendments adopted in 1992 is a watershed in the Indian decentralisation experiment¹. These amendments required the Indian States to delegate some administrative functions and taxation powers to local bodies. Among the States, Kerala was in the forefront of decentralisation of powers. It set up a committee to suggest amendments to Kerala Panchayati Raj and Municipality Acts of 1994 to make the decentralisation process more operational and comprehensive. Parallel with the Committee's work and the legislative moves to translate these suggestions, the ruling Left Democratic Front involved the local bodies in the formulation and implementation of the Ninth Five Year Plan through a campaign.

Given the relatively large size of the population under the lowest unit of local self-government institutions (LSGI)- the Village Panchayat- and the existence of large number of health care, educational and other institutions in every Panchayat, decentralisation of every sector becomes

¹ Adopting the amendments soon after initiating Structural Adjustment Program raises a question as to the relationship between the two. Is there a relationship? It is a question worth pursuing.

an important component of the overall decentralisation. Decentralisation of these sectors, and in particular the health care sector, depends to a large extent on the vision from the top and perception of the administrative and political process from the bottom. A fairly clear idea of the vision from the top may be had by an analysis of the statements of policy makers, legislative measures passed, and administrative fiats issued. It is the perception of the elected representatives at the level of the LSGIs and the administrative functionaries, which will be instrumental in operationalizing decentralisation at that level. This study seeks to analyse decentralisation of the health care sector and the associated problems as perceived by the elected members. The study confines itself to a discussion of allopathic medical institutions. The study is based on detailed interviews with a number of elected representatives from selected locations, both rural and urban, and physicians working in the Primary Health Centres and Taluk Hospitals. The study argues that three basic problems of decentralising the health care sector, namely spill over effect, role and relevance of a pre existing body (Hospital Development Committee), and the level of minimum health care service to be provided by the health care institutions, have not been adequately addressed.

The paper is organised in eight sections. Following this introduction, Section 2 provides a brief account of the broad decentralisation effort being made in Kerala and the situation with regard to the decentralisation of the health care sector. Section 3 discusses the problem of decentralisation in general and that of the health care sector as perceived by the elected representatives and physicians working in health care units. Section 4 analyses the problem of benefit spill over in the context of concentration of hospital beds in municipal towns. Section 5 discusses the inequality in access to health care across the taluks of Kerala. Section 6 takes up the question of Hospital Development Committees in the decentralisation environment. Section 7 discusses the

decentralisation experiences elsewhere in the world. Section 8 is the conclusion.

2. Decentralisation in Kerala

The left movement has played a major role in instituting a process of decentralised planning and governance in the state of Kerala. There were repeated attempts, largely initiated by the left-led governments, to introduce legislative measures for political and administrative decentralisation at various points of time- in 1957, 1967, 1979, and 1991. However, these measures either proved to be stillborn or short lived (Nagaraj 1979; Raj 1993). Political fragmentation and instability were partly responsible for this. Perhaps, a more important reason for this was that these efforts were largely confined to enacting legislation, with no serious effort to institute popular, and representative administrative structures below the state level to translate the legislative measures into action (Isaac and Harilal 1997). The 1991 experiment went a step ahead to form elected representative bodies at the district level called district councils. The 1991-92 annual plan provided for an increased plan outlay of Rs. 250 crores to be implemented by the newly formed district councils. However, this experiment too was short lived. In the elections to the state assembly held later in 1991, the left coalition lost power, and the new government headed by the Congress Party “lost no time in amending the legislation setting up district councils to such an extent that they were totally emasculated” (Raj 1993).

The 73rd and 74th Amendments to the Constitution in 1992 is a watershed in that they left no room for the successive state legislatures to change the LSGI according to their whims and fancies. They brought about a uniform three-tier structure- district, block/taluk, and village- in the rural areas. Only for small states with population less than two million was the intermediate tier optional. The amendments also introduced the

concept of township for smaller urban centres, that is, rural areas in the process of urbanisation.

The Amendments stipulated that the LSGI were to have a uniform 5-year term and in the event of dissolution elections were to be held within six months. The elections were to be organised by an independent election commission. There was to be reservation for scheduled caste/scheduled tribe in proportion to their population, and one-third reservation for women, in membership and chairpersons at all levels. A separate schedule was added to the Constitution (11th Schedule) listing 29 subjects that could be devolved to the LSGI. Every state government was to periodically appoint a state finance commission to determine the share of state government revenues and sources for local revenue for LSGI, so that they can carry out duties devolved to them.

The LSGIs were to be involved in planning: “The Constitution assigns to the panchayat the function of planning for social justice and economic development as the primary objective”. A new constitutionally mandated structure, the District Planning Committee, was to be formed in every district. Two-thirds of the membership of the Committee was reserved for representatives of the District Panchayat and the urban local self-governments.

The Left Democratic Government assumed power in May 1996 and making use of the opportunity provided by the constitutional amendments initiated two moves towards effective decentralisation. The very first move even before passing the enabling legislation, was “to empower the panchayats (rural local bodies) and municipal bodies to draw up the Ninth Five Year Plan schemes within their respective areas of responsibility”. The first step towards planning from below was the People’s Campaign for Decentralised Planning initiated in August 1996.

The campaign was conducted in a number of phases involving grama sabhas -the lowest unit electing a representative- and ward conventions, development seminars, task forces, and preparation of panchayat plans. In the process a shelf of projects could be built up, prioritised and worked into annual plans. The Planning Board has laid down certain broad guidelines regarding the sectoral allocations to be made by the local bodies. Despite these guidelines, “the tendency to choose certain preferred projects- like roads, milch cattle distribution and drinking water, housing etc.- still continues” (Nagaraj 1999: 7). It is also evident from the plans of 1997-98 and 1998-99 that public health was not a major item in the planning exercises. The allocation for public health was 2.93 percent (of the total plan outlay) in the first year and 1.96 percent in the second year (Isaac 1999).

The second move was essentially a legislative one. A Committee on Decentralisation of Powers (known as S B Sen Committee) was set up to suggest amendments to Kerala Panchayati Raj and Municipality Acts, 1994 to make the decentralisation process more operational and comprehensive. Some measures for decentralisation have already been taken on the basis of the interim report of the committee and others are being contemplated. As per the government order dated September 18, 1995, following the Panchayatiraj Act, the Primary Health Centres and Government Dispensaries have been transferred to the Village Panchayats; Block PHCs, Community Health Centres, Taluk Headquarters Hospitals and Government Hospitals to Block Panchayats; and CHCs, Government Hospitals and Taluk Headquarters Hospitals in Corporation and Municipal areas to the Corporation Councils and Municipal Councils. While the officials are under the supervision and disciplinary authority of the local bodies during their tenure with them, their cadre conditions remain undisturbed. Further, the government shall continue to pay the salary, allowances and other dues to the employees

and officers transferred to the local bodies from government. Thus, the new system envisages dual control over the staff.

The smooth functioning of the institutions is to be ensured by the constitution of certain committees. There are supposed to be Standing Committee for Health and Sanitation at the level of the Municipal Council and Municipal Corporation in the urban areas, and Block Panchayat, and District Panchayat in the rural areas. The Standing Committees shall deal with matters relating to public health and health service, sanitation, environment, dangerous and offensive trades, education, arts and culture and sports. At the District Panchayat level, a Management Committee shall be constituted for every public health institution transferred to it by the government.

The current situation with regard to the medical institutions is that they have been brought under the administrative control of the LSGI. The LSGI receive intergovernmental transfers, the criteria being population size, area, and the proportion of SC/ST population. The Taluk Hospitals and District Hospitals also have duly constituted Hospital Development Committee (HDC), which collect user charges on some services and carry out some regular maintenance, cleaning and repair.

As regards private institutions in the health care sector, registration with the LSGI is mandatory. Unregistered private hospital or paramedical institution may be punished. There is also provision for collecting fees for services provided to private hospitals.

3. Perception of Decentralisation of the Health Care Sector

Decentralisation can take place only with the understanding of and the need for it at the level of the LSGI. In order to assess this perception and understanding few Panchayats and Municipalities were selected; elected members and doctors working in the PHC and Hospitals

in these locations were interviewed to assess their understanding of the current set up, the envisaged set up and their vision of the future.

Two districts of the state were selected and in each district one municipal town and one or two Panchayats were selected. The districts selected were Kasaragod and Alappuzha. The Kasaragod and Mavelikara Municipal towns were selected for the survey. In addition, one coastal and another interior Panchayat in Kasaragod, and a coastal Panchayat in Alappuzha were selected. The selection was aimed at capturing the heterogeneity in terms of economic activity, literacy and population size and composition.

Many elected ward members and doctors working in the hospitals were contacted and talked to individually. The common themes emerging from these discussions are presented below.

The most important theme coming through all the discussions was regarding the general usefulness of the decentralisation effort. Decentralised planning is generally appreciated. It was mentioned that LSGI received substantial funds the spending of which could be decided by them. Corruption is thought to be less and project implementation was considerably faster. But it was also mentioned that there was considerable problem in co-ordinating with the line departments. Not enough numbers of staff are available to implement projects was a theme which repeatedly came up in Kasaragod, but not in Alappuzha.

As regards the health care sector, it was mentioned that lack of expertise hinders preparation of projects and that as of now projects are mostly prepared by the doctors working in the PHC or hospitals. The projects were mostly in the nature of spraying DDT for malaria control, medical camps, and distribution of first aid kits. Some larger guidance and discussion would be of great help was indicated.

As regards the working of the public medical institutions, there were complaints of lack of proper staff deployment hindering the functioning of medical facilities. Infrastructure available for inpatient care is not being used owing to the absence of staff. There were also complaints of poor service and substandard medicines and supplies. These complaints were heard mostly in Kasargod. In these cases none of the elected members knew how exactly to tackle the issue and the powers they really have under the decentralised administrative system to change the working. Despite such poor functioning, everywhere elected representatives were advocating provision of preventive, curative and Family Planning services through the PHC and other public medical institutions. In Mavelikara, members talked about the Hospital Development Committee and the ineffectiveness of its working. Their contention is that it has been working independently of the Municipal Council and hence ineffective. In Kasaragod, not many elected members knew about the functioning of the HDC.

Everywhere in Kasaragod, ward members talked about the need to introduce proper user fee, but nobody could tell us about the modalities of it. There was also talk of cross subsidisation and exemption for the poor, or those below the poverty line. In Mavelikara, one of the members argued strongly against the introduction of user fee. In Kasaragod, one of the members dismissed the whole thing as 'public hospitals are for the poor; why bother about them'.

Private health care sector also came up for discussion. All the members we talked with agreed that involving private sector must be thought of, but how is the question. Bargaining with private hospitals is thought to be tough and there is no way private medical expenses- even by the poor- could be reimbursed by the LSGI in their current dispensation. In this connection one of the members in Kasargod also expressed the need for LSGI to evolve some sort of a health insurance.

The discussions with the doctors working in the PHC and Taluk Hospitals revealed that after decentralisation it is not necessary to approach the District Medical Officer for some purchases and items of work. The LSGI could carry out many items of work; but they are not being carried out is another story. In Kasaragod no definite motive for not doing was mentioned but in Mavelikara it was hinted that works which do not fetch monetary benefits to some members are not taken up. In both the towns, there was resentment against spending scarce municipal funds on the hospital, the services of which are used not only by people residing within the town but also outside.

Overall, the policy issues discussed very often in the context of health sector reforms have all come up in one way or the other in the discussions with the members. Charging users of publicly provided health services; some form of risk coverage; role of non-government health care services; and greater financial and management autonomy for LSGI have all been discussed. The most crucial of these has been the management question, which has been posed variously as non co operation by the line departments, and lack of disciplinary power, for which no clear solutions have been suggested, or thought of. The common problems associated with decentralisation have also come up for discussion. Members of Municipal Councils complaining about the services of Taluk Headquarters Hospitals being utilised by those residing outside is the well-known problem of “benefit spill over”. The problem with HDC is that of accountability of Municipal Councils in the presence of pre existing institutions. A comment such as, “government hospitals are for the poor, why bother about them” is on account of not defining the minimum level of service for specified population groups. Each of these problems perceived by the members and functionaries shall be elaborated and translated into the language of decentralisation in the next section.

4. The Problem of Benefit Spill Over

The principle of decentralisation says that local governments should generally provide services whose benefits are restricted to a single jurisdiction. But changing service technology and improvements in public and private transport may reconfigure the geographical spread of benefit areas, which may not match the administrative boundaries. In such situations spill over effects occur and intergovernmental transfers are justified. The services for which substantial spill over into neighbouring jurisdictions occur, such as health and education, purely local financing would lead to under provision of these services from a national perspective².

In the current Kerala situation, where Taluk Hospitals are brought under the Municipal Councils, spill over are very large owing to two factors. Firstly, Kerala has a better network of roads and very high density of motor vehicles. Secondly, the medical institutions providing secondary care services are largely located in municipal towns. As regards the network of roads (as of 1994), the road length per 100 square kilometres is about 353 kilometres in Kerala compared to the all India average of 63 kilometres. The road length per lakh of population is 473 kilometres in Kerala in comparison with the all India average of 245 kilometres. The vehicle density is also very high in Kerala. The number of buses per lakh of population in Kerala is 105 compared to the Indian average of 50.

² There is another way to solve the spill over problem as spelt out by Tanzi (1995): "... this spill over problem can in part be solved through a reciprocity rule especially if services can be standardised across regions. In such a case the existence of the spill over does not reduce the advantage of providing the service locally, but the standardisation of the services eliminates one of the basic reasons for decentralisation" (Tanzi, 1995: 12). The standardisation option is neither feasible nor advisable in the context of health care in Kerala as we argue later.

Benefit spill over is not a serious problem with regard to Primary Health care services as the distribution of Primary Health Centres (PHC) is fairly widespread, with at least one PHC per Village Panchayat. Whatever the Panchayat spends on the PHC would largely benefit the residents of the Panchayat, with few exceptions³. The problem could, however, be quite serious with regard to the secondary health care services accessed from the Taluk Head Quarters Hospitals, which have been brought under the Municipal Councils.

The seriousness of the benefit spill over may be brought out by the following facts. The concentration ratios (share of hospital beds in municipal towns in the total for the Taluk) for the taluks of the state showed that in 11 taluks, over 75 percent of the hospital beds are located in municipal towns. In 25 taluks, the ratio is between 50 & 75 percent and in 19 taluks the ratio is below 50 percent (Table 1). In eight out of 11 Taluks in the first group, nine out of 25 taluks in the second group, and five out of 19 taluks in the third group, benefit spill over is not a problem because the hospitals/ health centres are brought under the Block Panchayat. Thus, in 33 out of the 55 taluks, for which comparable data could be tabulated, benefit spill over is a serious problem.

The seriousness of the benefit spill over problem may also be brought out in terms of the proportion of taluk population residing in the municipal towns. Out of the 33 taluks referred to above, in none is the share of population of municipal towns above 18 percent of the taluk population. Mostly, the municipal towns are small accounting for 10 to 15 percent of the taluk population. In these small towns are located large

³ We have also come across cases of spill over of services of PHC and the Panchayats complaining about it.

hospitals providing secondary care services, which are accessed by the population of the taluk at large. Very often the Taluk Hospitals are the only public secondary care providers for the entire taluk population, as the PHC's with beds provide only primary care.

Table 1. Distribution of Taluks by Concentration of Hospital Beds in Municipal Towns, Kerala, 1997.

Concentration (%)	Number of Taluks	Number of Taluks Where Spill Over is a Problem.
>75	11	3
50-75	25	16
<= 50	19	14
Total	55	33

Source: Government of Kerala. **Government Allopathic Medical Institutions: Kerala 1997**. Directorate of Health Services, Thiruvananthapuram.

The better transport network and the location of health care institutions within municipal towns and the associated level of service have given rise to spill over. The benefit leaking to residents outside their jurisdictions has led to complaints by elected representatives and the question often asked is, 'why should we be spending for somebody else'? This problem could have been addressed with a well-designed fiscal transfer system: "Successful decentralisation cannot be achieved in the absence of a well-designed fiscal transfer program. The design of these transfers must be simple, transparent, and consistent with their objectives" (Shah 1998: 149). The grant design suggested by Shah to

compensate for benefit spillovers is “open ended matching transfers with matching rate consistent with conditions on standards of service and access” (Shah 1998 Table 4.7). The transfer of Plan funds as of now takes population, area and Schedule Caste/ Schedule Tribe population as criteria and the size of health care institution is not one of them. That is why the conflict discussed above arises, as the local authority’s financial resources are often not commensurate with their responsibilities.

5. The Inequality in Access to Health Care

The system of “matching transfers “ might address the problem of benefit spill over but it will introduce a new problem owing to the inequality in the distribution of hospital beds across the taluks of the state. How serious is the problem of unequal distribution of hospital beds?

To get an idea of the inequality in distribution of hospital beds, taluks were cross-tabulated by the number of beds per 10,000 population and per 10 square kilometres of area (Table 2). Out of the 61 Taluks tabulated, 17 Taluks have fewer than 7.5 beds per 10,000 population and per 10 square kilometres area, and an additional 11 taluks have fewer than 7.5 beds per 10 square kilometre area. The inequality in distribution is serious enough to affect the access to secondary health care services.

The 11 taluks for which bed population ratio is above 7.5 there is a problem of physical access as indicated by the low bed-area ratios. The problem of physical access is especially serious, as less than 50 percent of the medical institutions in these Taluks have hospital beds. Further, the concentration of hospital beds (50-75 percent slab of Table 1) in municipal towns is also high in these taluks. Thus, physical access is a serious problem in 28 of the 61 taluks listed in Table2.

There is a striking regional dimension to the unequal distribution of hospital beds. The 28 Taluks where physical access is comparatively

Table 2. Distribution of Taluks by Population-Bed Ratio and by Area-Bed Ratio, Kerala, 1997.

Number of beds per 10,000 Population	Number of Beds per 10 Square Kilometre Area			
	< 5	5 - 7.50	7.51-10.00	
<5	Quilandy Kunnathur, Ranni	Tirur		
5.01-7.50	Alathur, Devikulam Udumbanchola, Peerumedu Kasaragode, Hosdurg Taliparambu Sultan Battery, Eranadu	Badagara, Perinthalmanna, Ottappalam, Adoor	Pathanapuram, Kottarakkara	
7.51-10.00	Mannarkkad Nedumangadu	Talassery, Thalappally	Palakkad Mallappally	Ponnani, Cherthala, Chavakkadu, Karthikappally, Aluva, Thiruvalla, Chirayinkil, Chengannur, Kodungalloor
10.01-15.00	Vythiri, Chittoor Thodupuzha Kozhencherry	Kunnathunadu, Meenachil	Kothamangalam, Kanjiappally, Kuttanadu	Neyyattinkara, Kannur, Paravur, Kollam, Vaikom, Changanassery, Karunagappally
15.01-		Mananthavady		Kozhikkode, Thrissur, Cochin, Kottayam, Ambalapuzha, Mavelikkara, Trivandrum, Muvattupuzha Kanayannur, Mukundapuram

Source: Same as Table 1.
India, Registrar General. **Census of India, 1991, Kerala:** Series 12. Directorate of Census Operations, Kerala.

poor are located in the northern districts of the state, and in Idukki and Pathanamthitta in the south. The 12 taluks, which are at the bottom of the scale by both the criteria are all located in the northern districts, with the thirteenth taluk, namely Adoor, falling in Pathanamthitta. Thus, the inequality in the distribution of hospital beds has a strong north–south dimension.

The inequality in the distribution of hospitals would affect the access to a certain minimum level of secondary health care services. Let us illustrate the problem with the examples of our survey locations. A person residing on the outskirts of Mavelikara would be able to access the services of a large hospital within 10 to 15 minutes at transport costs of 5 to 50 Rupees (depending upon the mode of transport). Comparable level of service would be accessible to a person residing in one of our rural survey locations in Kasaragod only with a time delay of over one hour at transport costs ranging from 25 to 300 Rupees depending upon the mode of transport. In addition to the direct cost the opportunity cost would also be very different. Thus, the issue is one of unequal physical and economic access to a minimum level of service. This goes against one of the basic tenets of transfers:

“Transfers may, for example, be designed to equalize revenue effort, or expenditure levels, or outcomes in terms of services provided. Such equalization may be desired for purposes of income distribution, or to ensure that for the same revenue effort, citizens obtain the same expenditures (or outcomes) regardless of where they live, or to provide at least minimum standards of key public services to everyone, or to provide everyone with an equal opportunity to access public services” (Bird and Vaillancourt 1998: 29).

In a situation of unequal size and unequal geographical distribution of health care institutions, one way to get over the unequal access problem

is by transferring resources to equalize the level of services offered by upgrading existing facilities and by setting up new facilities at proximate locations. Then, decentralisation has no role and the state government can take it upon itself to provide the service (ref. Footnote 2 above). The upgradation and extension of medical facilities is not going to be easy in a situation of fiscal squeeze.

Another way is to incorporate the private health care sector into the system. For example in both the locations of our survey in Kasaragod, private hospitals exist, the services of which are being used by the people. The local Panchayat may reimburse the cost of treatment. Such an attempt would fit in with one of the principles guiding transfers,

“The basic principle that should guide the design of a system of inter governmental transfers is not to finance particular government entities but rather to contribute to an effective provision of services to the people” (Bird and Fiszbein 1998: 181).

This would also be one of the ways of bringing the private health care sector within some regulatory environment, beyond the mere registration discussed in Section 2 above.

6. Decentralisation in the Presence of Hospital Development Committees

The Hospital Development Committees (HDC) came into being since 1984 when the Government accepted the recommendations of the High Power Committee on Health Services (Pai Committee). The recommendation followed from the Committee’s assessment of the functioning of Hospital Welfare and Advising Committees which had been in existence since 1977, and Hospital Advisory Committees earlier. The HDCs, “are envisaged as a body keeping constant vigil on the working of the institution concerned and standing by ready to render

whatever assistance is necessary by way of voluntary services or financial contribution so as to meet exigencies and to ensure steady development of the institution” (Government of Kerala 1979). The main objective of HDCs was to establish rapport between the public and the staff so that hospitals function smoothly. For this purpose democratic constitution of the Committees was underscored.

The HDCs were to have the following rights and responsibilities.

To find out defects, if any, in the amenities and functioning of the institutions and devise ways of remedying them. To strive to maintain orderliness and cleanliness in the institutions and their surroundings. To organise voluntary Blood Banks and Drug Banks, public comfort stations and bystanders’ dormitories, to run canteen and medical stores to provide supplies at fair prices. The Pai Committee also recommended systematisation of the user charges for medical services. The Committee recommended the collection of full cost from the rich, 50% from the middle class and no charge, from the low income group. The responsibility of collecting user charges has come to be vested with the HDCs.

As part of the decentralisation, the health care institutions have been brought under the administrative control of the LSGI, but the only source of local resource (in the case of the Taluk Hospital and above) is not within its control. The HDC still collects the user charges and attends to some regular repair, maintenance and cleaning functions. As the powers assigned to the HDC to spend the collected resources are rather limited, often the balance is remitted to the treasury. For example, in Mavelikara, during 1997-98 an amount of Rupees 312386 was collected out of which Rupees 138665 was spent and the balance amount of Rupees 173700 was remitted to the treasury. The existence of HDC goes against one of

the basic principles of effective service provision. To be effective, "... it is important to ensure that those responsible for the provision of a service have a clear mandate, resources to finance it (including, wherever needed, own resources), and flexibility to make decisions, and are held accountable for results" (Bird and Fiszbein 1998: 181). In the Kerala case, none of the above conditions are satisfied. The Municipal Councils are not provided with adequate resources to finance the health care services; they have no access to the limited own resources collected by the HDC; and flexibility to make decisions is lost owing to the presence of HDC; and hence cannot be held fully responsible for results.

The HDC itself suffers from two additional handicaps. Firstly, HDC was made a democratically constituted body by translating the political party composition of the state legislature to each of the HDC by nominating members of all political parties represented in the assembly. Such translation of macro representation to the micro units has led to several incongruities in the current context. Two examples shall suffice. The Kasaragod Municipal Council has a number of Bharatiya Janatha Party (BJP) members whereas the HDC has no representation for the BJP as they are not represented in the Assembly. The Mavelikara Municipal Council has no member belonging to the Muslim League but the HDC has a Muslim League representative. These incongruities have led to situations wherein elected representatives watch helplessly the doings of nominated members undermining the emerging system.

The second problem pertains to the cost of collection of user charges. In the Kasaragod HDC, there are three sanctioned posts of which two have been filled. In the Mavelikara HDC there are two persons charged with the responsibility of collecting user charges. In Kasaragod, each is paid a daily wage rate of Rupees 60, and in Mavelikara the payment is a monthly lump sum amount of about Rupees 600. If a regular

administrative structure had been in place, with a regular salary at the current minimum pay scales, the net resource availability would have come down considerably. Many Taluk Hospitals with lower number of beds would have found the collections hardly enough to pay the salaries of the HDC staff. The user charges as applicable to different income classes have also not undergone any systematic revision over a long period. There does not seem to exist any proper system to compute these rates, or set income slabs qualifying for fee exemption.

The presence of HDC in a decentralised system is difficult to sustain. Its continuance directly comes in the way of a proper functioning and accountability of the LSGI with regard to the provision of health care services. How exactly the functions of HDCs should be integrated with the LSGI calls for further discussion.

7. Decentralisation of the Health Sector -Experience Elsewhere

Decentralisation of the health sector is one of the policy reforms discussed in the **Agenda for Reform** (AFR) of the World Bank published in 1987. AFR discusses decentralisation in the context of Structural Adjustment Program and the squeeze on government expenditure. The specific circumstance was the difficulty of attracting private health practitioners to low income rural areas and the role of government health care services in such areas. By decentralisation is meant granting greater financial, and management autonomy to local units of the system. Decentralisation gives local units greater responsibility for planning and budgeting, for collecting user charges and for determining how collected funds and transfers from the central government will be spent.

Decentralisation and greater local control does not mean complete financial independence of each individual facility. Budgetary transfers from the higher levels of government will be required. The exact mode

of these transfers and the purposes for which they have to be used need to be worked out carefully depending upon the country circumstances.

The decentralisation idea, as well as practice, predate the **Agenda for Reform** and have a long history. We present below brief accounts of some of them, which are relevant in the Kerala context.

China had used each of the four approaches proposed in AFR in the Co-operative Medical System, which existed prior to the recent liberalisation. Liberalisation of the health sector has meant privatisation in China. “Currently, at least 90 percent of the rural population in China has no coverage for curative care services, which means that households bear the entire financial costs (called medical fees in China) when they or their families seek outpatient and inpatient care” (Chen et al., 1993: 734-5).

The Chinese state-sponsored compulsory Government Insurance Scheme and the Labour Insurance Scheme (both introduced in 1952) covered most urban workers. Rural residents were covered by a rural co-operative insurance system. It did not mean direct payment by the households. The production brigade reserved 3 to 5 percent of the total incomes for health care and welfare funds, before distributing cash to farmers. The “barefoot doctors” or village doctors covered their own costs through charges to patients for curative services and drug sales. The rural co-operative insurance system has collapsed after liberalisation: “After the introduction of the production responsibility system, each household decided on its own production and received cash directly from the market.....Then, there was no cash withholding system and no efficient channel to collect health and welfare funds for Co-operative Medical System operations” (Chen et al., 1993: 733).

Chile decentralised the government-run health system and created private health insurance institutions in the late 1970s. Responsibility for operating primary care services was devolved to the country's 325 municipalities. The Ministry of Health transferred its primary care budget and about half of its personnel to the municipalities, which could also draw from local tax revenue and Municipal Common Fund. The government also encouraged private health insurance funds (known as ISAPREs). The municipalities expanded primary care services and the ISAPREs introduced more competition.

The reforms created some problems. Initially, municipal officials were not responsive to local needs and transfer of doctors created job insecurity. Many municipalities lacked the capacity to plan and manage primary health services. Because municipalities were reimbursed for each unit of service delivered, they tended to provide too much high cost curative care and costs exploded. The ISAPREs by targeting the richest segment of the Chilean society have "skimmed" the population for good risks. Since 1989, elections to the municipalities have been held so that popularly chosen and accountable officials look after primary health care services. Responsibility for hospitals is also being decentralised. Central funds are being allocated on a capitation basis and adjusted to favour poorest localities. The government is also beginning to regulate the ISAPREs.

Colombia has three elements to the system of intergovernmental transfers, namely *situado fiscal* (SF), *participaciones municipales* (PM) and *sistema nacional de cofinanciación* (SNC). Under SF, 24.5 percent of the national revenue (2.7 percent of GDP in 1995) is transferred to the departments (districts) to finance education and health in part in equal shares and in part on a population basis. Under PM, 15 percent of the national revenues (increasing by one percentage point to 22 percent by

2001) (1.7 percent of GDP) is transferred to the municipalities for “social investment” on the basis of a complex formula favouring smaller and poorer municipalities. The formula takes into account size of the municipalities, their location along the Magdalena River, number of inhabitants with unsatisfied basic needs, degree of relative poverty etc. PM transfers must be spent on “social investment” with at least 30 percent on education, 25 percent on health, 20 percent on water and sewerage. The SNC consists of four funds: the social investment fund; the rural development fund; the fund for urban infrastructure; and the fund for road infrastructure. It finances specified subnational governments that receive transfers from the national level but also quasi- public enterprises (that is, hospitals) and companies offering health insurance packages to the poor.

Five distinct policy objectives are addressed with the three transfer instruments. The first two objectives involve the provision of minimum service levels in education and health. A third important objective is to finance, at least in part, the cost of building the physical infrastructure necessary to expand the coverage of key services (water, education and health). In Colombia, arguably the principal objective of the transfer system is to guarantee the provision of minimum service levels of education and health to the population.

In Indonesia, since 1992, a serious attempt has been made in decentralisation by transferring some central and provincial responsibilities to the local level (Shah 1998: 118). The central grants currently finance 65 percent of the expenditure at the provincial level and 70 percent at the district level. These transfers are of two kinds: block grants (for general purpose local spending subject to some broad central guidelines), to each of the three main levels of local government-provinces, districts and villages; and specific grants for development expenditure on roads, primary schools, public health centres, and

reforestation. The criteria used for distribution of block grants are, area, population and equal shares. The specific grants are transferred, on the basis of length of road, condition of the road, and unit cost of construction and maintenance in the case of road improvement; according to the need for medicine, health centres and personnel in the case of health; and by the school age children and need for facilities in the case of primary school grant (Shah 1998: 123).

The discussion of the many cases of decentralisation of health care sector points to a few important findings. The intergovernmental transfers are often of the specific grant type and are with the specific objective of providing a minimum level of service. Voluntary health insurance has not worked very well in the two cases referred to. Reimbursement of health care cost leads to the provision of high cost care and the explosion of overall costs.

8. Conclusion

As every Village Panchayat in Kerala has at least one Primary Health Care centre and a minimum level of primary care is assured, the problem of benefit spill over is not serious at that level. Transfer of Plan funds to the Village Panchayat by population size, area, and SC/ST population, and payment of salary of health personnel by the government does not create problems of unequal distribution.

As regards secondary care, the concentration of hospital beds in Taluk Headquarters Hospitals, and the unequal distribution of hospitals across the taluks of the state is a given reality to be properly accounted for. Any scheme of transfer of funds to the municipalities, which takes due note of the size of the hospital, might solve the problem of benefit spill over, but it will aggravate the inequality of distribution. A separate

fund on the lines of the “social investment” fund in Colombia might address this problem. The objective should be the provision of a minimum level of service. Alternatively, private health care sector may be drawn in through a reimbursement scheme. However, the danger of any reimbursement scheme is the larger provision of high cost care, as the Chilean experience shows.

The problem of Hospital Development Committee cannot be wished away. The coming into being of democratically elected LSGI do not leave any room for the existence of democratically constituted bodies to establish rapport between the people and the health personnel. It has to be the responsibility of the LSGI. That is the way the LSGI can be made accountable.

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