Restructuring Public Sector Hospital Services
Marginalising the Poor

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The paper examines the state of public sector hospitals, how they are being compelled to transform into profit churning units through reforms, and in the process alienating poor and the underprivileged groups mentioned above from public hospital inpatient care.

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> *The difference between then (25 years ago) and now is that then the patient used to die quietly in the village, but now they die in the hospital. Then there was no big expense. Now the family remaining behind is ruined because of the high expenses. The new* 'dava-daroo' *(medicine) is both helpful and it is a curse.* – former Sarpanch, Barda village, Udaipur district[1]

Expenses on medical care have become one of the important and fastest sources of impoverishment in India. Public sector hospitals where services were nearly free previously are no longer free. Erstwhile it provided better access to the poor. The 1990s showed a decrease in the utilisation of public sector hospitals for indoor care both in rural and urban India. Nonetheless large section of deprived communities (SC, ST, OBC, women, children, rural and urban lower and lower middle class) is dependent on public sector hospitals for inpatient care. In the mid nineties, a series of market-based reforms were applied to the public sector hospitals at the district level. This transition from state financed and provided services to market based reform measures are transforming the near universal, comprehensive publicly funded and provided curative care. In recent times (end 2005) with the revision of user fees and levying charges on many tests and medical investigations which were previously free in AIIMS, New Delhi has led to oppositions from the different sections of employees (doctors, nurses, scientists, karmacharis and students union). The decision to hike fees deprives majority of the patients coming to seek tertiary level curative care in AIIMS.

Health is listed as a state subject in the Constitution and hence the main role of providing care falls on the states. The state government largely funds hospitals. In the fifties and sixties there were efforts to have efficient, effective and responsive public health system. In the course of time, problems within the public health services developed inhibiting the proper functioning of the health units at different levels of care. Though medical care receives greater attention than preventive care, in the

1980s public hospitals saw a great deal of neglect and this has toppled the middle and apex care system in the country. Maintenance of the hospitals has not received with much attention. Not only has resource allocation been poor, administration, maintenance, supply of drugs and other essentials, staff allocation and behaviour and technical up gradation did not keep pace with time. In spite of the lapses in the delivery of in-patient care there is still a demand for public sector hospitals as in the private sector user fees are very high.[2] Public sector hospitals required reform, taking cognisance of the above problems faced and its commitment for the collective with appropriate means to contain costs. Rather than this, public sector hospital reform came as a part of the structural adjustment programme that opened these hospitals to market strategies. They have become areas for unregulated expansion of the private sector through provisioning of different services ranging from clinical to non-clinical and ancillary services. These transformations in hospitals across the different parts of the country came about with the implementation of the State Health System Development Project funded by the World Bank. Even in the areas where the project was not implemented, the characteristics of private sector and competitive market had been applied.

The three tier health care system built by the state is under the onslaught of market driven strategies creating bottlenecks in the referral chain, jeopardising access to and utilisation of curative care services and comprehensiveness of health care for the bottom 400 million. Privatisation and applying business like managerial skills for greater efficiency and improving the quality of care simplifies the complexities of the hospitals and confines intervention strategies to selective privatisation and management autonomy. Therefore looking at reform strategies the paper examines the state of public sector hospitals, how they are being compelled to transform into profit churning units through reforms, and in the process alienating poor and the underprivileged groups mentioned above from public hospital inpatient care.

Scenario of the Public Sector Hospitals

Types of Public Sector Hospitals

From the colonial days, in 1947 the State inherited hospitals and dispensaries built across the different parts of the country that were developed under the then colonial

State and a few wealthy philanthropists. Inherited hospitals ranged from teaching hospitals to non-teaching general and specialised hospitals like for women, children and for communicable diseases. After independence, there was no organised health care service infrastructure. It was Bhore Committee Report that provided the plan for health service infrastructure development comprising of peripheral health centres, secondary hospital units and district hospital. It was proposed to be developing in two phases - short and long term. The units as envisaged were hierarchical in terms of nature of care to be provided with an inbuilt referral system. Years following independence saw the development of the health care infrastructure from primary health care units to tertiary level institutions. Keeping the essence of Bhore Committee Report recommendation different levels of health service units were developed.

In the first 30 years public sector hospitals that developed can be classified into different categories i.e firstly by the type of government control (central, state, municipal), secondly by different state departmental control (railway, police, jail, ESIS) and thirdly by the kind of clinical care hospitals cater to (general and specialised). Thus according to the first classification there are centrally controlled hospitals, state general, district level, sub-divisional hospitals, block level referral hospitals and municipal hospitals. Different state government departments also own and provide hospital care like those established by the railways, police, jail and ESIS. By the type of clinical care provided there are general and specialised hospitals (like for women, children, communicable diseases, cancer etc.). General hospitals also have specialised units of clinical care. Within the general hospitals some are teaching hospitals. All these hospitals provide both chronic and acute care in varying degrees. Of these categories, teaching hospitals are the most privileged in terms of the varying range of clinical and diagnostic facilities, beds, manpower and financial resource availability. In the recent years many of the municipal hospitals are facing closure.

Distribution of Public Hospitals

In spite of the Bhore Committee's three-tier health service framework, after independence health service development favoured hospitals without strengthening the basic primary health care services both in rural and urban areas, resulting in weak basic and comprehensive health care service. The provision of curative care in PHCs

and CHCs were also neglected and hence the notion of referrals from the lowest level of care to next level of care never took off. Community Health Centres that were to act as rural hospitals also could never function at its optimum level. Optimum utilisation of the primary health units was lacking. This resulted in increasing reliance of the people on middle and tertiary level care. It is within this context we locate the development of public hospitals.

In 1951 there were 2,694 hospitals and 1,17,000 beds.[3] From 1950 to 1980 it was the expansion period of public sector hospitals. By 1980 the number of hospitals in the country increased by 2.4 times,[4] almost more than double. Indoor capacity of the hospitals also increased. In 1973 government owned and financed 79.4 percent of hospitals and had 77.47 percent of beds. In seven-year span from 1973 to 1980 private ownership of hospitals almost doubled from 20.6 percent to 43.92 percent and in relation to it government hospital growth was slow, around 34 percent. Beds increased by 43 percent. During the same period ownership of public sector hospitals reduced from 79.4 percent to 56.08 percent in 1980, but the decline in public hospital beds was not that drastic (71.64 per cent).[5] This sector did not expand uniformly across the states. The major expansion of the government hospitals and beds took place in Tamil Nadu, Maharashtra, Punjab, Gujarat and West Bengal that were comparatively better off states economically over the rest. From the mid seventies public sector expansion of hospitals declined with simultaneous expansion of the private sector. In 2001 the government ownership of hospitals declined drastically from 30 percent in 1990 to 0.98 percent with share of 60 per cent beds.[6]

It is important to understand the distribution and growth pattern of the hospitals across the states and also it is crucial to understand the sectoral distribution (rural and urban) of hospitals not only to observe the dichotomous situation but to recognize what is the situation of the rural and urban hospitals with respect to its capacity to handle the health complexities and do only the required referrals. Referrals not only mean the facility of an ambulance but appropriate recommendation of cases to the next higher level of care. The bed strength of the urban public sector hospitals is more than the rural hospitals. More than the bed strength what is significant is to look into how the facilities in the rural public sector hospitals have been improved to meet the needs of

the people, availability of the doctors, medicines, and other disposables. In rural areas due to underdevelopment of the preventive and public sector ambulatory care rural hospitals with small bed strength face pressure and often due to absence of proper care the district hospitals and urban secondary and tertiary hospitals have to meet up with this pressure. This also compels the rural and urban lower and middle class people to depend on the private sector for curative hospitalised care. Thus sectoral analysis of the public sector hospital within the framework of public health would help us to better comprehend actually which ones need to be strengthened.

Priorities in Resource Allocation to Public hospitals

From the mid-1970s onward the growth, expansion and development of the public sector hospitals began to take backseat. In the eighties it became stagnant and quality of care began to deteriorate. The underlying causes of its deterioration can be identified within the changing socio-economic and political forces of the society. One of the contributing factors for its poor performance was the consistent low level of financial commitment by the State and the distorted priorities in health care expenditure.

Investment in urban areas has largely focused on curative care and in rural areas they were routed for preventive and promotive health care. Due to the inefficient resource allocation public sector curative care in rural areas has failed to develop and is minimal. As of 1990-91, 33.4 per cent of health care expenditure was allocated to the rural sector, taking into account all government expenditure. The central government allocated 29 per cent of health care expenditure to the rural sector and 33.79 per cent of all state governments total health care expenditure was allocated to rural areas. The per capita allocation between rural and urban sector shows abysmal disparity levels with Rs.25.90 per capita allocation for rural areas as against Rs.151.86 per capita in the urban sector, almost 5.86 times more than the rural areas.[7] The priorities in resource allocation between the rural and urban areas are highly distorted and this trend further extends to resource allocation between curative, preventive and other services. Financial resource allocation for urban Maharashtra shows allocation of 61.8 per cent of the health sector expenditure and three-fourth (74.59 per cent) of it was incurred on medical care (teaching hospitals, ESIS, medical education) and capital

expenditure was around 3.05 per cent[8]. Rural people are hence exposed to the exploitative private market. Similar trends would be also observed in other states as well. In India between the state and the central government health budget the former bears a major share of hospital budget that is, curative care. As of 1991 – 92 hospitals consumed 97 per cent of the state budget.[9]

In 1951 almost 44 per cent of the revenue expenditure was on hospitals and dispensaries. Seventies was the expansion phase when it increased to 45.37 per cent (mid-seventies) and by 1985 revenue expenditure declined to 37 per cent. In 1985 per capita revenue expenditure on curative care was as low as Rs.12.02.[10] Teaching hospitals, urban state general hospitals, specialised hospitals in urban areas were better off compared to the rural hospitals leaving rural people particularly women, children, socially backward population (schedule caste and tribal) at the mercy of the private sector. The capital expenditure in 1975 for hospitals and dispensaries was 3 per cent of the total health expenditure. Till 1985 the capital expenditure remained consistent.[11] The low capital expenditure for a decade casted a huge impact on the quality of care, patient care provided and utilization pattern of the public sector hospitals and dispensaries. This triggered the decadence of public sector hospitals. Between 1984-85 and 1990-91, the real expenditure and per capita expenditure for medical care increased almost by 44 per cent and fell marginally in the following two years. During this period in order to balance the fiscal deposit in the central budget, grants to states, maintenance spending and capital expenditure were brought down. Effects of cuts in state budget were felt on non-salary and maintenance expenditure component of the health budget. This drastically affected the public sector hospital base care and consecutively the salary component of the budget increased.[12] In Kerala too the pattern of government spending between 1977-78 and 1991-92 showed an increase in revenue expenditure throughout the 1980s with a decline in capital expenditure after the mid-1980s. During this duration supplies also projected slower rate of growth with cut backs from the late-1980s. This affected the district and taluk level hospitals particularly from the beginning of the 1990s. In the tertiary sector the supplies mildly increased but became stagnant in the 1990s. This increased the salary share in revenue expenditure and erosion of quality care in secondary level institutions.[13] Without realisation of the cuts in state health budget it is often said that

the salary component occupies the major share and casualisation of jobs is recommended as one the cost saving measures.

Public Sector Hospitals Under Transition

The health sector came under immediate pressure with the implementation of structural adjustment programme in the nineties. The major constraint was felt in health care expenditure. Both at the central and the state level resource allocation was compressed. There were cuts in the centre's transfer to the state budget and the adjustment was not uniform across the states.[14] The real expenditure declined by 14 per cent in 1993 following adjustment.[15]

Prolonged compression of capital expenditure in public sector hospitals had affected the proper functioning of the clinical and non-clinical departments. Increasingly public hospitals were attributed as institutions of inefficiency, user dissatisfaction, fraud, corruption and drain of better health care personnel to the private sector. Referral system also collapsed. In spite of the poor performance of these hospitals, the state did little to improve the hospital conditions and improve the access to hospital base curative care for the poor people. For the first time the Ninth Five-Year health plan elucidated separately and elaborately the nature and constrains of rural primary health care, community health centres, secondary and tertiary level hospitals. The different levels were dealt with as individual economically viable institutions. This explicit pattern of dealing fell very much in line with the recommendations made by World Bank in 1993.[16] One key advice was to scale down the state's role in provisioning and financing of curative care at the secondary and tertiary level institutions, signifying a radical shift in public sector role. Moreover cost recovery in these institutions, partial privatisation through diverse private providers, casualisation of certain jobs, increase in pay beds were some of the major recommendations for the public sector hospitals.

By 1992 the Government of India (GOI) and the World Bank had entered into a dialogue for health sector development policy. The restructuring of the public health sector at the secondary level was initiated in 1995. World Bank (WB) implemented State Health System Development Project in Karnataka, West Bengal and Punjab in

1995. WB provided loan to GOI through its concessional lending window International Development Association (IDA).[17] The total cost of the project was around US$416.7 million. IDA would finance US$350.0 million / 88.7 per cent (without tax) of the total project costs. The Governments of the three project states would finance the balance of US $66.7 million (US$44.5 million + all taxes US$22.2 million). IDA provided this as credit to GOI that is further lent to three state Government, 30 percent as grants and the rest 70 percent as loan with 12 percent interest per annum over 20 years. The Government of Karnataka, West Bengal and Punjab have to pay US $25 million, US$ 25.3 million and US$ 16.4 million respectively. The project financed civil works, equipment, furniture, vehicles, medical, laboratory supplies, machines, other supplies, MIS/IEC supplies, professional services, training, studies, evaluations, and workshops, operational expenses and salaries of incremental staff on declining terms.[18]

Table 1: State Health System Development Project with World Bank Assistance

	States	Duration of the project	With effect from	Project Outlay Rs. (in crores)
1	Andhra Pradesh	6 & ½ years	01.03.1995	608
2	Karnataka	5 & ½ years	27.06.1996	546
3	Punjab	5 & ½ years	27.06.1996	425
4	West Bengal	5 & ½ years	27.06.1996	698
5	Orissa	5 & ½ years	18.09.1998	415.57
6	Maharashtra	5 & ½ years	14.02.1999	727
7	Uttar Pradesh	5 & ½ years	01.07.2000	495

Source: Government of India (Various Years) Annual Report, Ministry of Health and Family Welfare, New Delhi.

Reform is largely donor driven where the implementing country and its people have little space to voice their opinion. Reform failed to address the structural, financial issues, shortage of manpower, clandestine nexus between the public and private sector, working conditions of the staff that were having an impact on the efficient functioning of the public sector hospitals. With this project state governments, already under the expenditure compression, now faced new difficulty with regard to pay back of the principal amount and the interest money levied on it. This adoption of a business model to hospital reforms added new financial burdens on the state governments. Now the focus of the hospitals shifted from integrated planning to income generation and performance oriented work.

Market Principles for Public Sector Hospitals

Creation of Markets and Private Providers

The goal is to improve efficiency level, cut costs in the hospitals and hence endeavour to save finance, manage within that clinical and non-clinical services to save the treasury. Emphasis is laid to improve the various services. Improvement guidelines are set by the structures and incentive characteristic of the private sector. Doctors, nurses, epidemiologists and related people have little say in this business like planning of curative care.

In district hospitals, state general and sub-divisional hospitals reforms have classified health services into clinical, non-clinical and ancillary services. Services have been categorised, creating scope for the penetration of private sector in the public sector creating market within it. All these services are no more seen within an integrated frame where each service contributes to the other. Ancillary services like diet, laundry, scavenging, and security are conceived as separate entities. In tertiary hospitals, district hospitals and sub-divisional hospitals these services are first to be outsourced and in house services are stopped. Prior to this public hospitals dealt with the private sector in these services. But the then interaction was limited only to the private sector providing the raw material. For example in diet service private providers were selected to give vegetables, milk, meat and fish and cereals. Presently the private organisations provide the entire service and they also appoint the personnel. In West Bengal the public sector personnel who were working in the diet section have been appointed for some other job. And no further recruitment is being done for posts like cooks, dieticians, stewards and sweepers. These services have vulnerable unskilled public workforce and are the first ones to be contractualised.[19]

Hospitals are under-funded and outsourcing of the above services is seen as cost saving initiatives. Expenditure saved is measured as the efficiency level for the hospital. The saving thus produced is at the cost of indirect provisioning of the basic services by the state that are vital in offering quality care to the patients. Hospitals in NHS had to show 3 per cent as efficiency saving from their annual budget leading to the outsourcing of ancillary services and freezing of low wage jobs. Pollock finds out that hospital authorities and trusts in Britain had to redirect funds from the clinical

care to the new contracting, monitoring and new accounting work.[20] Thus, putting patient care at stake and focussing on those aspects of care those are profit churning.

Though there have been inadequacies in the direct provisioning of services but now with outsourcing the administrative, monitoring and financial management work of the state will increase. These activities increase pressure on the state machineries and operating costs. The state will have to rely and have faith on the private sector in the provisioning of services properly to those below poverty line. Monitoring and administration of the outsourced activities is a difficult task for existing state body as they are by themselves facing shortage of personnel with increased workload. This acts as an additional burden to them.

After outsourcing of ancillary services in hospitals, now it is the turn for the diagnostic services. In public sector hospitals, public-private partnerships were conceived for the provisioning of certain specialised diagnostic services like CT Scan, MRI etc. The state health department in West Bengal had signed an understanding with the private sector for the provision of CT Scan and MRI services at the tertiary level hospitals. The public hospital provides with the space, water, and electricity to the private organisation. The private sector would provide treatment to the hospital patients (outdoor and indoor) and private patients as well. The user charge is fixed for the public hospital patients and to the private patients they are at the liberty to charge more. The number of patients who will be provide free treatment / partially free treatment per month are fixed.[21] Only 6.8 per cent of the total 515 patients referred from the government hospitals through the proper channel to the teaching hospitals in Kolkata where the facility is made available are allowed free Scan or MRI facilities. Rest 93.2 per cent of the referred patients are paid patients, thus free care is provided to a negligible few. In one of the medical colleges in Kolkata in practice the facility has been made further restrictive by limiting it only to the in patients of that teaching college hospital apart from the patients referred from the other government hospitals.

Apart from ancillary and diagnostic services it is now turn for the clinical services to be outsourced. It is yet an area that has not been touched upon except in Punjab at the hospital level. Clinical care is one of the most sensitive zones in terms of location of

the highest paid personnel in the public health sector. In Punjab specialities like ENT, dental, skin, psychiatry, physiotherapy, ophthalmology has been outsourced.[22]

Conflicting Working Environment

Outsourcing / public private partnerships have provided spaces at cheaper rates to the private sector to expand their market juxtaposed with the public sector services within the same premise. This is creating two types of workers within the same institution and in certain departments contractual and permanent workers have to work together. This factor is vital for hospital like set ups as human beings are the only channel of providing service to the patients. Contractual workers appointed by the private enterprise receive consolidated amount per month without any benefits. Majority of the contractual workers who have been employed for ancillary services are paid very low in comparison to the public sector employees and are not entitled to any benefits and leave. They have to work on *'no pay no leave basis'*. This dichotomous working situation within the same premise will bear implication on quality of care in the long term and in the nature of relationship the workers would share. As one of the heads of the district hospital in West Bengal had put it

> The public hospital authorities though aware of these situations do not want to look into such situations. As long as the work gets done it is fine. Our hands are also tied due to shortage of manpower.

Expanding Source of Income

The public hospitals need to meet the non-salary inputs on regular basis. Non-salary inputs are drugs, consumables, machines, linens etc. These non-salary inputs are vital in maintaining the standard and quality of care of the hospital. From the reform package it is evident that the state has squeezed its financial resources and to meet the costs of the new initiatives for which it has to pay to private providers there is need for financial resource. The state will augment its financial resources through private investment. Introduction and revision of user fees is seen as an avenue that will help in cost recovery and meet the recurrent costs. Now the near universal free curative care no more remains free. The private investment will come through people buying their treatment now. Studies on user fees across the world have shown that it always acts as a deterrent for the poor.[23] In spite of it the public sector has gone ahead implementing it and bringing different services under it.

Potentiality of user fee is being tapped through different avenues. The user fee is being associated with number of minor and major surgeries done per year in order to measure the expected revenue income. The World Bank[24] in its project proposal estimated the average mix of major and minor surgeries from the pay and general beds annually and the possible total revenue that can be earned. At the policy level revenue generated was connected with the in patient workload.[25] To bring about competitiveness, workload is related to the probable revenue income capacity that the public hospitals should aim at. Another avenue of user charge has been to allocate 30 per cent of beds as paying beds at the tertiary, district, state general and sub divisional hospitals and open pay clinics beside the regular OPD. The revenue earned from pay bed has been linked to the potential revenue earned from it. Planning thus gets related to monetary efficiency and not patient care oriented.

Emerging Complexities

Health sector reforms are part of the broader economic reforms. Hospital reforms are part of it where both state provisioning and financing are being altered. These reforms specifically targeted the public sector hospitals without strengthening the basic preventive and curative care provided at the primary health care units. They also fail to envisage hospitals as complex human service organisations. Such reforms comprise of selective privatisation of services (ancillary, diagnostics and clinical care), creating entry points for the private enterprise, cost cutting and recovery through user fees, downsizing of jobs, casualisation of labour and making the state payer of private services. Different services provided by public sector hospitals are treated as separate units of complex industry, reconfigured in isolation. Initiatives taken are bereft of the epidemiological needs, advancements made in surgeries, treatments, the knowledge that has been gained over time and the social and cultural context. The impact of these on public sector hospitals and poor people seeking care is huge.

With the gradual withdrawal of the State from the direct provisioning of the services in the public sector hospitals the burden of treatment is increasing for the poor patients for whom affordability is a major issue. Since in most of these hospitals avenues for income are few every possible service whether clinical or non-clinical is being charged. Immediately this pushes the marginalized sections into further

difficulties and they have to bear a huge opportunity cost also. With the move to increase paying bed the pressure on the free bed increases. Often more than two patients in one free bed or lying in a trolley is a common sight in any of the public hospitals. In patient care in private sector is costly and with the new reforms the same care also becomes costly in the public sector hospitals. Access to nearly free curative care for the poor further becomes distant. This is of relevance in case of women's health who is often compelled to access care when their health condition is critical. This forces the poor patients to opt either for the private sector or go for self-treatment. Self-medication is increasing either by relying on herbal medicines or buying medicine across the counter. With user fees there can be the danger of overprovision of services in the loner term.

In this circumstance it is not only the poor patients but also the providers working on contract basis are at risk. Their terms and conditions of work defy grossly the rules and regulations of those of the permanent public sector workers. Thus poor patients and contractual providers of services who are poorly treated are at the risk of marginalisation in the present public sector hospital reform.

Public sector hospitals are creating different tiers of care in the hospitals, one for the free patients and the other for the paid patients leading to discrimination based on the paying capacity. This trend is spreading fast across different levels of public sector hospitals and pursuit for efficiency, cost cutting and provision of quality care is forcing the poor sick to receive less care gradually and become further impoverished.

Notes

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[3] Duggal, R. et. al. (1992) *State Sector Health Expenditures A Database: All India and States 1951-1985*, FRCH, Bombay.
[4] Govt. of India (Various Years) *Health Information of India*, CBHI, DGHS, Ministry of Health and Family Welfare, New Delhi
[5] ibid
[6] Govt. of India (2000-2001) *Health Information of India*, CBHI, DGHS, Ministry of Health and Family Welfare, New Delhi
[7] Reddy K N and Seelvaraju V (1994) *Health Care Expenditure by Government of India – 1974 –75 to 1990 – 91: Growth, Structure and Priorities by programme and by Sector,* Seven Hills Publication, New Delhi.

[8] Duggal Ravi (2005) Public Health Expenditures, Investment and Financing under the Shadow of a Growing Private Sector as in Gangolli L V, Duggal R & Shukla A (ed.) (2005) *Review of Health Care in India*, Cehat, Mumbai.
[9] World Bank (1997) *India New Directions in Health Sector Development At the State Level: An Operational Perspective*, Report No. 15753-IN
[10] Duggal, R. et. al. (1992) *State Sector Health Expenditures A Database: All India and States 1951-1985*, FRCH, Bombay.
[11] ibid
[12] Tulasidhar V B 1994 Expenditure Compression and Health Sector Outlays *Economic and Political Weekly*, Vol.24 No.45
[13] Kutty V Raman (2001) Reforms and Their relevance: The Kerala Experience as in Qadeer I, Sen K, Nayar K R (ed.) *Public Health and the Poverty of Reforms: The South Asian Predicament.* Sage Publications. New Delhi.
[14] Poor States: Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh; Middle Income States: Andhra Pradesh, Assam, Karnataka, Kerala, Tamil Nadu and West Bengal; Rich States: Gujarat, Haryana, Maharashtra and Punjab.
[15] Tulasidhar op cit
[16] World Bank (1993) *World Development Report*, Oxford University Press, New York
[17] IDA is a subsidiary of IBRD or World Bank that provides developmental aid, loans and advice to the poorest less developed countries at less stringent terms than IBRD itself.
[18] World Bank (1996) *State Health Systems Development Project II Report* 15106-IN
[19] Diet service that was erstwhile provided free of cost is now charged. In West Bengal patients who can provide below poverty line certificate within the first three days of their admission are exempted from paying. Diet is charged separately for an adult person (Rs. 28) and child (Rs.14). The state government bears 50 percent of the cost and the patients bear the rest.

[20] Pollock A M., et al., (2004) NHS plc *The Privatisation of Our Health Care*, Verso, London
[21] The private organisation will have to scan not more than 35 indigent cases per month absolutely free of cost as may be referred as such through the Principal of Medical College, Kolkata excluding the charge of contrast and consumable materials.

[22] Government of India (2004) *Health Sector Reforms in India Initiatives from Nine States*, Bureau of Planning, DGHS, Ministry of Health & Planning, New Delhi
[23] Mohan, S., Andrews, S. (2002) User Charges in Health Care: Some Issues, *Economic and Political Weekly*, Sept. 14.
[24] World Bank (1996) *State Health Systems Development Project II* Report 15106-IN
[25] World Bank estimated 900,000 inpatient cases a year in Karnataka. Those inpatients below the defined poverty line and therefore 30 percent to be exempted from charges estimated at -- 270,000 patient cases. Of the remaining 600,000 or so cases, six percent or 36,000 will be in paying beds. The remaining 564,000 would be in general wards. Overall, increased revenues from inpatients might be around Rs. 11.6 million for bed charges, Rs.4.5 million for registration fees and Rs. 18.3 million for diagnostic services and surgery: a total of Rs. 34.5 million.