

# Public-Private Partnership and User Fees in Healthcare: Evidence from West Bengal

BIJOYA ROY, SIDDHARTA GUPTA

Increasing cost of medical care has emerged as the second biggest cause of rural indebtedness in India. A user fee at the point of service delivery is now common even at the basic primary healthcare level. Focusing on rural hospitals in West Bengal, this article examines the structure of user fees and compares it across a set of basic diagnostic services delivered by public sector healthcare institutions, public-private partnerships and the private sector. Revised user charges, and a restrictive exemption and waiver policy under the PPP framework has produced exclusionary effects in the primary healthcare system in the state.

We are grateful to Imrana Qadeer for her valuable comments on our draft paper.

Bijoya Roy ([bijoyaroy@gmail.com](mailto:bijoyaroy@gmail.com)) is with the Centre for Women's Development Studies, New Delhi and Siddharta Gupta ([siddharthagupta@rocketmail.com](mailto:siddharthagupta@rocketmail.com)) is at the Centenary Hospital, Kolkata.

Inequality is very much the sign of our times... Inequalities of access and outcome increasingly dominate the healthcare arena, too

– Farmer 2004.

In 1999-2000, around 32.5 million persons in India fell below the poverty line (BPL) due to out-of-pocket (OOP) expenditure with greater and deeper impact in poorer states and rural areas (Garg and Karan 2008).

In 1987, the World Bank, in its report “Financing Health Services in Developing Countries: An Agenda for Reform”, recommended the introduction of user fees in government healthcare services, steering the debate towards the financial efficiency of these institutions rather than addressing the financial crisis of the poor households and critically analysing the financial schemes of the government healthcare system (Arhin-Tenkorang 2000). During the 1990s, there were a series of policy documents<sup>1</sup> which promoted the implementation of user fees in government healthcare in India.

In the following decade, the World Bank shifted its stance to a “no blanket policy on user fees” (World Bank 2004). Studies from the healthcare system in Africa had begun to show discouraging impacts of user fees. International donor communities also engaged with a number of multilateral and bilateral organisations, academicians, and civil society organisations on the issue of direct payment, i.e., user fees in healthcare facilities, its impact on poor households and on the removal or gradually abolishment of user fees (Save the Children 2005; Meessen et al 2009; Yates 2010).

## Impact of User Fees: Some Evidence

For almost a decade and a half, health sector reforms have swept across all the states in India. In government healthcare institutions, user fees at the point of service

delivery have been implemented in order to ensure efficient utilisation of services, check undue demand, and generate revenue. During this period, healthcare costs emerged as one of the major obstacles for the poorer households.<sup>2</sup>

User charges from different services in healthcare institutions acts as a deterrent for the chronically poor households to access care, to comply with the treatment protocol, and makes already poor people poorer (Leive and Xu 2008). Evidence from Africa shows that user fees have implications for lower utilisation of healthcare services by women, children, and other vulnerable or marginalised sections of the population (Nanda 2002).

In Andhra Pradesh, between 2001 and 2004, the proportion of the poor utilising hospital services showed a marked decline, particularly for hospitalisation, followed by outpatient department (OPD), surgeries, deliveries, and laboratory and diagnostic services. Apart from this declining trend, another worrying aspect was low utilisation by the scheduled caste and tribe (sc/st) population over the same period. In 2000-01, a similar trend was noted in the utilisation pattern of outpatient and inpatient services of the public health facilities in Maharashtra (Mahal and Veerabhadraiah 2005).

In the context of making the public sector hospitals autonomous, proponents of user fees see it as a revenue mobilising avenue. However, revenue generated from a user fee has not been very encouraging (Pearson 2004; Gilson, Russell and Buse 1995). In a district hospital of West Bengal, from 2002-03 to 2005-06, the share of user charges to the total expenditure showed a decline from 2.1% to 1.8% and the major share of revenue was generated from diagnostic services (Roy 2007).

Another issue is the proportion of a user fee utilisation in government hospitals. In Andhra Pradesh, between 2001 and 2004, even though the proportion of user fees utilisation increased, it was still less than 100%, and acted as a support to meet the gap “in the face of declining contribution from the state governments” (Mahal and Veerabhadraiah 2005). However, the impact of a user fee needs to be evaluated in the

context of changes in accessibility to health-care services that take place with every revision of the user fees/charges (Roy 2007).

### PPP and Paid Diagnostic Services

In recent years, little has been done to arrest the increasing cost of medical care. In government medical colleges and hospitals (at the state, district and sub-divisional levels), a user fee has become universal with the removal of public subsidy. A number of studies on user fees focus on its effect in terms of service utilisation by different age groups (children under-five, women), impact on quality of care, as revenue generating source and efficiency (Khun and Manderson 2008; Praveenlal et al 2005; Nanda 2002; Gilson, Russell and Buse 1995). Studies have reflected little on the structure of user fees in different states for outpatients' department, indoor and diagnostic services across the different levels of public sector healthcare, on the waiver and exemption policy and thus how it affects the access to clinical, diagnostic and other non-clinical services.

West Bengal has one of the highest shares of OOP expenditure in outpatient care in the country. In rural areas, OOP accounts for more than 80% of the increase in poverty (Garg and Karan 2008). Around 72% of the state population resides in rural areas. Post mid-1990s, user fees have been revised thrice (1995, 1998 and 2002). Since 2002, graded user fees were introduced in the secondary and tertiary level care, and over time, existing exemptions on services for different patient categories were eroded (Roy 2007).<sup>3</sup> In 2004, under the public-private partnership (PPP) framework, the government hospitals in the rural areas introduced paid diagnostic services. In early 2010, a differential user fees was introduced for the same services directly provided by the public sector hospitals and those provided by the PPP model within the premises of the government rural hospitals.

This article attempts to study the content of PPP with respect to provisioning of diagnostic services in the rural hospitals of West Bengal, their user fees structure and how PPP and user fees work together. It delineates the differences in user fees for the same set of services delivered by public sector health-care institutions, PPP, and the private sector respectively. Second, the article assesses

the potential impact of the differential user fees on accessibility to diagnostic and pathological services with the emergence of a diverse set of providers, the degree and scope for universalisation of these services. This is primarily based on the review of PPP policy documents for diagnostic services in rural hospitals and block primary health centres (BPHCs) in West Bengal. Primary data was collected from two private providers (based in Kolkata and Murshidabad districts respectively) to whom PPP diagnostic services were contracted out.

### Healthcare Policy in West Bengal

Years of poor public financing of the primary healthcare facilities have resulted in poor functioning and provisioning of services, which the National Rural Health Mission (NRHM) envisages to address. In West Bengal, financing priorities are still skewed towards the tertiary care which the government intends to reverse, following the National Health Policy (2002) guidelines. The State Health Systems Development Project II introduced wide-ranging reforms in the state's public health sector, bringing about significant changes in the provisioning pattern of services (clinical and non-clinical) and their financing mechanism. The health-care reform policy proposed to provide "affordable health and preventive services" by actively engaging "in partnership with PRI, CSO, NGO, donor group agencies, private sector and other development partners".<sup>4</sup> This mooted the notion of minimal provisioning by the state and restructuring of provisioning through multiple providers.

Rural hospitals – which also act as the first referral unit – lack adequate and well functioning diagnostic centres (both pathologic and imaging services). This has hindered the delivery of effective preventive and curative care, and consistently forced patients to access private diagnostic providers of questionable quality or discontinue care, resort to self-medication, or adopt other ways to save cost, as found among the poor patients in Ghana (Asenso-Okyere et al 1998). Responding to the dearth of basic diagnostic services, the state government in 2004 initiated the provision of diagnostic services in rural hospitals by outsourcing it to the private sector under the PPP model. This was done in two phases. In the first phase, out of the proposed 19 diagnostic

centres, it was started in 17 rural hospitals. In the second phase, i.e., after 2006, it was extended to another 77 rural hospitals in 17 districts. This new system has bifurcated the clinical care and diagnostic service provisioning system in rural hospitals (Government of West Bengal 2006).

When the PPP project was started, the state health department allowed the private providers to conduct 29 diagnostic tests, which were charged and were at par with the rates fixed for the district and sub-divisional hospitals. Initially, the list of mandatory tests were categorised into three sections. The first comprised a set of 24 tests; the second had a set of five advanced tests; and the third allowed the private party to expand provision by including "additional tests", in consultation with the Block Health and Family Welfare Section and the District Health and Family Welfare Section.

In 2010, the list of mandatory tests was increased from 29 to 44, and the prices were revised upwards. At the same time, in the district and subdivisional hospitals, user charges for the same set of diagnostic tests remained unrevised and were less than the revised rates of diagnostic tests delivered through the PPP in rural hospitals. Private patients were "entitled to levy and collect prices as per the prevailing market rates". The state government supported the latest revision and increase of user fees in rural hospitals:<sup>5</sup>

...the increasing costs of reagents, chemicals and other materials, required for diagnostic tests as well as steep rise in overhead costs... [has made it necessary] to review and revise the rates/prices of diagnostic tests undertaken in such diagnostic facilities established under PPP in rural hospitals/Block Primary Health Centres.

This withdrawal of state financing and privatisation of diagnostic services has rather strengthened the position of the private sector within the public sector, thus gaining greater credence to operate. Increase in the user fees of PPP services reflects the sustainability concerns of private service providers operating in rural areas, where the market is apparently thin. A discussion with the private providers revealed that they wanted to be assured of a minimum number of tests and patients referred by the rural hospital to make it viable in the face of the enormous commercial pressures of the market.

The terms of agreement with the private operator is granted for a period of five years which suggests a mutual long-term contractual understanding between the private operator and the State. In this new relationship, the service user in the peripheral healthcare units has a limited role and choice to operate within. In most of the cases, in-house diagnostic facilities in rural hospitals have been closed down or are not there at all, except for those diagnostic tests mandatory under the national health programme, like malaria, leprosy and tuberculosis. The technicians were also transferred elsewhere. Therefore, by privatising diagnostic services, stipulating user charges and rationing access, the state has pushed the responsibility of financing basic diagnostic services on the shoulders of the users themselves.

### Differential Pricing

Table 1 (p 77) shows three set of price structures for the approved diagnostic services offered in three healthcare settings (1) rates as fixed by the state government for diagnostic services in district and subdivisional hospitals, (2) rates as fixed by the state government under PPP in the rural hospitals (rates in 2010 are the revised user charges), and (3) diagnostic rates in the private sector. Post-2010, there is a marked difference in the prices of diagnostic services, with the increased PPP rates higher than those prevailing in the district and subdivisional hospitals, and less than the market rates. Some of the diagnostic tests have been clubbed together to lower the costs. In the course of fieldwork, it was gathered from the private providers that the rates quoted are not necessarily the subsidised rates. The rates in the open market for the same set of diagnostic services are more as they cover marketing cost and other charges which become gratuitous when the private providers' outlet is established within the government healthcare premises. Experience in one of the outsourced PPP diagnostic centres in a rural hospital (Islampur, Murshidabad) showed that often people coming for diagnostic tests cannot pay the user charge at once. They pay in instalments and this practise has been accepted by the private provider in order to sustain the service.

In the user fees policy, exemptions and waivers are built in to enhance the equity in service access, availability and financing. The present user fees policy under the PPP scheme in the rural hospitals does not exempt any service of the user fees. In terms of providing a waiver to individuals incurring no cost, the PPP agreement only specifies that patients from the BPL category will not be charged, but this too has conditions attached. Though the agreement introduces free services, it rations them for BPL patients:

Free services in each month will not exceed more than 20% of the patients under BPL category out of the total number of patients in the diagnostic centre in the previous month. The provision will be for each month and unutilised provision (if any) will not be carried forward to the next month (Government of West Bengal 2009).

According to this waiver policy, the private provider will screen BPL patients with high risks at the peripheral level, exclude and minimise the highly vulnerable group. Apart from this, the PPP agreement remains vague about the other categories of patients who are entitled to the waiver policy in the public healthcare system. For example, children with orthopaedic problems in Kolkata receive a 50% exemption from the user charges; and treatment cost for children below one year is exempted since 2007. This group remains excluded from the waiver category of this PPP programme. Over and above, studies have shown that targeted exemptions and waivers do little to address the financial consequences of health services (Masiye et al 2010). User fees and lack of exemption can together increase the cost of care. For those financially at risk, it can defer the diagnosis and treatment process till it becomes serious.

Thus, by revising the rate charts, increasing the price, and introducing targeted waiver categories, the government worked at the behest of the private players, lest they runaway from the PPP units.

### Conclusions

This current practice of diagnostic service provisioning through PPP in the rural hospitals of West Bengal paves the way for market-oriented reforms in the first healthcare referral units that also form part of the expanded primary healthcare set-up.

In the process of restructuring healthcare provisioning, these units are emerging as subsequent points of engagement with the private sector after secondary and tertiary level healthcare institutions. Diagnostic services across the three levels of public healthcare in West Bengal have been selectively privatised under the PPP framework. At the secondary and tertiary level, high technology-based diagnostic services have been outsourced (Roy 2007) and at the primary healthcare level, basic pathological and diagnostic services. This leads to the emergence of the mixed public-private system, making it more fragmented.

First, the state government has redefined its engagement with the health sector by shifting its responsibility of direct provisioning and financing of diagnostic services in the rural hospitals. Private provisioning of diagnostics in these hospitals at a cheaper rate compared to the market, and rationed access to BPL population may change the profile of the users by bringing in those who would otherwise go to district hospitals. But more importantly, it increases the likelihood of pushing the very poor and the marginalised further into the periphery. This will not only act as a barrier for women and children who have little power to decide with regard to spending resources but also can deter from getting milder cases to the rural hospitals due to increase in the OOP expenses.

For example, pyogenic meningitis, a common killer disease in rural West Bengal, requires early diagnosis and prompt initiation of treatment. Due to lack of infrastructure at the PHC level, many patients are to be referred to the block and district hospitals, and even medical colleges. Analysis of the cerebrospinal fluid for cytological, bacteriological and biochemical examinations is essential for the treatment, failing which the patient may die in short time. These tests have been included in the PPP list and the patient is to pay for it.

The OOP expenditure at the PPP centres acts as a stumbling block for the poor as they will be forced to spend in public healthcare settings when early and proper laboratory diagnosis is most vital for treatment and/or referral of fatal cases. The practice may actually lead to loss of such patients. A recent study from West Bengal shows that the poorer the households, the more limited is

**Table 1: Comparative Rates of Diagnostic Services: Public Sector Hospitals, PPP and Private Sector**

Name of the Tests as Classified in the PPP Agreement	Approved Rates (in Rs)				
	District and Subdivisional Hospitals A Since 2002 *	Diagnostic Centres Established under PPP in RH/BPHCS		Private Sector (2010)	
		B1	B2	C	
		2004	2010	At Beharmpore	At Kolkata
<b>Biochemistry</b>					
Blood sugar (fasting/PP/Random)	10	10	15	30	40
Urea	10	10	15	60	50
Uric acid	10	10	15		60
Creatinine	10	10	17	70	50
Serum Triglycerides		45	65	150	150
Serum Cholesterol	10	10	25	70	70
Liver function test	80	80	100	400	350
Urine albumin/sugar	8	8	10		10/10
Sugar, urea and creatinine (combined)	No such combined test under this memo	Not included	45	NA	NA
Lipid profile	120	Not included	150	450	400
CSF: Sugar, Micro protein, Chloride (each)	25	Not included	40	NA	40/50/70
<b>Haematology</b>					
Hb%, TC, DC, ESR	10	10	25	60	70
Platelet count	8	8	20	40	30
Reticulocyte count	8	8	20	50	60
Foetal Hb%	25	25	30	NA	150
Blood grouping and RH factor	15	15	20	80	70
<b>Pathology</b>					
PAP Stain	40	70	85	NA	200
Peritoneal/Pleural/Ascitic Fluid/ Other Body Fluids for Cytology (each)	50	30	50	NA	100
FNAC with Slide	120	80	150	200	350
<b>Microbiology</b>					
Blood culture	25	25	50	450	200
Urine culture	25	25	50	120	100
Stool culture	25	25	50	120	130
Pus culture	25	25	50	120	100
Sputum culture other than TB	25	25	30	100	100
Sputum/other Smears for AFB or gram Stain	20	20	30	40	50
Throat Swab culture	25	25	30	50	100
Conjunctival culture	25	25	30	50	100
<b>Serology</b>					
Australian Antigen	40	40	50	150	225
VDRL	10	10	20	60	60
Mantoux test	15	15	20	50	50
ASO Titre	50	50	70	Latex: 180 Quantitative: 350	150
Widal test	20	20	30	60	70
Pregnancy test	Free	20	25	50	60
<b>Clinical pathology</b>					
Stool/urine for routine examination	8	8	10	20	25
Stool for Occult blood	8	8	10	15	20
CSF Cell type and Cell count gram stain, AFB Cell type	50	50	60	NA	150
Semen analysis	35	35	50	120	125
<b>Radiological</b>					
USG upper abdomen	180	180	225	NA	300
USG lower abdomen	160	160	225	NA	300
USG whole abdomen	260	260	350	NA	500
USG pregnancy	160	160	200	NA	550
USG liver, GB Pancreas, Spleen	180	180	225	NA	550
USG-KUB	180	180	225	NA	500
Plain X-ray (per plate)	30	Not included	40	NA	80

\* These rates have remained unchanged since 2002.

Source: A: Annexure II to MemoNo.:HF/O/MS/121/W-10/2001 Dt 18 March 2002, Government of West Bengal.

B1: Schedule C Price Notification Standard Diagnostic Services, Dated 27 April 2009.

B2: Annexure to Memo No: HF/PPP/13/2009/ 15 Dated 28 January 2010, PPP Branch, Health and Family Welfare Department, West Bengal.

C: From the rate charts of the respective private providers.

NA: Not available.

the choice about the provider, and the more prone to medical care expenditure shocks even when the cost of care at public sources is less than at the private source (Mazumdar and Guruswamy 2009). Thus, user charges at the point of service delivery acts as an additional burden in their access to medical care.

Second, rather than committing to comprehensive care, PPP initiatives for basic diagnostic services at the level of rural hospitals bifurcate provisioning and create a parallel structure within the government set up. This is critical from the point of monitoring, administration and governance since that is often overlooked.

Third, experiences of waiver in public sector hospitals have raised the issue of actual beneficiary identification, information dissemination and monitoring of this process. As early as 1995, Gilson and Buse cautioned against the limited success of targeting mechanisms in user fees. Evidences show that exemption scheme at the secondary level care in Punjab (GOI 2005), West Bengal (Roy 2007) and Uttar Pradesh (Shariff and Mondal 2006) did not work as envisaged. In Tanzania, despite the exemption policy, only 20% of children below five years of age could avail of the waiver (Save the Children 2005). Many patients did not know the process of obtaining exemption certificates and found it cumbersome. The political interference and corruption in issuing those waiver certificates by the rural administrative authorities are also counterproductive. There is no system to appraise the stakeholders about the provisions of exemptions and waivers.

Drawing from these experiences, it is really a matter of concern how the exemption and waiver policy would work in case of private diagnostic service at the first referral unit. This PPP agreement has no penalty clause for ignoring the exemption policy by the private provider, a problem further compounded by the widespread lack of supervision.

Fourth, experiences of removing user fees in Africa show that benefits surpass the costs (Nabyonga et al 2005). In West Bengal, 45% of the BPL families could not access OPD services due to economic barriers.<sup>6</sup> Lack of public sector investment in the diagnostic services at the PHC level will further increase the household expenditure,

however nominal the charges might be in the private outsourced outlet.

### Exclusionary Effects

The quiet privatisation of diagnostic services in government healthcare institutions is becoming a common phenomenon. This article brings to focus how PPP and user fees work together to produce exclusionary effects. Restricting the number of BPL patients reflects the implicit concern regarding sustainability of the private providers within the government set up in rural areas, and it is here that revised user fees play a vital role. The state requires to reappraise policies on direct provisioning and investment of basic diagnostic services at the primary level. Given the limited study on the structure of user charges in government healthcare institutions, exemption policy and its impact on utilisation across socially and economically marginalised groups, there is need for more research in this area.

### NOTES

- 1 See World Bank (1985, 1993, 1995, 1997).
- 2 On an average, hospitalised Indians spend 58% of their total annual expenditure. Over 40% people are heavily indebted to pay hospital bills, and hospital expenses push over 25% of hospitalised Indians below poverty line (see [http://mohfw.nic.in/NRHM/Documents/Mission\\_Document.pdf](http://mohfw.nic.in/NRHM/Documents/Mission_Document.pdf)).
- 3 Post-2002, new waiver categories were introduced. Previous waiver and exemption categories were abolished.
- 4 See [www.wbhealth.gov.in](http://www.wbhealth.gov.in)
- 5 Government of West Bengal (2010), GO No. HF/PPP/13/2009/15 dated 28 January 2010.
- 6 See [www.wbhealth.gov.in](http://www.wbhealth.gov.in)

### REFERENCES

- Arhin-Tenkorang, D (2000): *Mobilising Resources for Health: The Case of User Fees Revisited*, Centre for International Development, Harvard University.
- Asenso-Okyere W, A Adote, I Osei-Akoto and A Adunkonu (1998): "Cost Recovery in Ghana: Are There Any Changes in Health Seeking Behaviour?", *Health Policy and Planning*, 13(2): 181-88.
- Farmer, P (2004): "Pathologies of Power: Health, Human Rights and the New War on the Poor", (California: University of California Press).
- Garg, C C and A K Karan (2008): "Reducing Out-of-Pocket Expenditures to Reduce Poverty: A Disaggregated Analysis at Rural-urban and State Level in India", *Health Policy and Planning*, 24(2), pp 116-28.
- Gilson, L, S Russell and K Buse (1995): "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy", *Journal of International Development*, Vol 7 (3), pp 369-402.
- Gol (2005): *Report of the National Commission on Macroeconomics and Health* (New Delhi: Ministry of Health and Family Welfare).
- Government of West Bengal (undated): "Document 1: The Health Sector Strategy 2004-2013", Health and Family Welfare Department, viewed on 12 April 2007 (<http://www.wbhealth.gov.in>).
- (2006): "Information Brochure on Establishing Diagnostic Facilities in Rural Hospitals under Public Private Partnerships", Strategic Planning and Sector Reform Cell, Health and Family Welfare Department.

- (2009): "Public Private Partnership Agreement: Annexure III", District Health and Family Welfare Samity.
- (2010): "GO No. HF/PPP/13/2009/15 dated 28 January 2010: Revision of Rates/Prices for Diagnostic Tests Conducted in Diagnostic Centres Established under Public Private Partnerships (PPP) in Rural Hospitals/Block Primary Health Centres", (Government of West Bengal: Health and Family Welfare Department).
- Khun, S and L Manderson (2008): "Poverty, User Fees and Ability to Pay for Healthcare for Children with Suspected Dengue in Rural Cambodia", *International Journal for Equity in Health*, 7:10.
- Leive, A and Ke Xu (2008): "Coping with Out-of-Pocket Health Payments: Empirical Evidence from 15 African Countries", *Bulletin of the World Health Organisation*, November, Vol 86 (11), pp 849-56.
- Mazumdar, S and M Guruswamy (2009): "Demand and Willingness to Pay for Health Care in Rural West Bengal", *Social Change*, December, 39(4), pp 568-85.
- Mahal, A and N Veerabhadraiah (2005): "User Charges in India's Health Sector: An Assessment" in *Report of the National Commission on Macroeconomics and Health* (New Delhi: Ministry of Health and Family Welfare).
- Masiye, F, B M Chitah and D McIntyre (2010): "From Targeted Exemptions to User Fee Abolition in Healthcare: Experience from Rural Zambia", *Social Science and Medicine*, Vol 71, Issue 4, pp 743-50.
- Meessen, B, D Hercot, M Noirhomme, V Ridde, A Tibouti, A Bicaba, C K Tashobya and L Gilson (2009): "Removing User Fees in the Health Sector in Low Income Countries: A Multi-Country Review", Health Section Working Paper (New York: UNICEF).
- Nabyonga, J, M Desmet, H Karamagi, P Y Kadama, F G Omaswa and O Walker (2005): "Abolition of Cost-Sharing Is Pro-poor: Evidence from Uganda", *Health Policy and Planning*, Vol 20 (2), pp 100-08.
- Nanda P (2002): "Gender Dimensions of User Fees: Implications for Women's Utilisation of Health Care", *Reproductive Health Matters*, 10(20), pp 127-34.
- National Rural Health Mission (2005-2012): Mission Document, Viewed on 29 March 2010 ([http://mohfw.nic.in/NRHM/Documents/Mission\\_Document.pdf](http://mohfw.nic.in/NRHM/Documents/Mission_Document.pdf)).
- Nyanator, F and J Kutzin (1999): "Health for Some? The Effects of User Fees in the Volta Region of Ghana", *Health Policy and Planning*, 14, 329-41.
- Pearson, M (2004): "Issues Paper: The Case for Abolition of User Fees for Primary Health Services" (DFID, Health Systems Resource Centre, London).
- Praveenlal, K, R A Arun Kishore, K S Shaji and B K Ajitha (2005): "Healthcare and User Charges: Study of Thrissur Medical College Hospital", *Economic & Political Weekly*, 12 February, pp 615-17.
- Roy, B (2007): "Private Investment in Public Sector Medical Care Institutions: A Study of the Processes in Tertiary and Secondary Level Care in Six Districts of West Bengal", PhD Dissertation, Jawaharlal Nehru University, New Delhi.
- Save the Children (2005): "Killer Bills Make Child Poverty History – Abolish User Fees: Briefing" (UK: Save the Children).
- Shariff, A and S K Mondal (2006): "User Fees in Public Health Care Institutions" in S Prasad, C Sathyamala (ed.), *Securing Health for All Dimensions and Challenges*, Institute for Human Development, New Delhi, pp 491-505.
- World Bank (1985): *Paying for Health Services in Developing Countries* (Washington DC: Booklet), February.
- (1993): *World Development Report: Investing in Health* (New York: OUP).
- (1995): "India Policy and Finance Strategies for Strengthening Primary Health Care Service", Report No 1304-IN, Washington.
- (1997): "India-New Directions in Health Sector Development at the State Level: An Operational Perspective", Report No 15753-IN, Washington.
- (2004): *World Development Report: 2004: Making Services Work for Poor People* (Washington: World Bank and OUP).
- Yates, Rob (2010): "Women and Children First: An Appropriate First Step Towards Universal Coverage", *Bulletin World Health Organisation*, Vol 88, pp 474-75.