Role of Non-Governmental Organizations in Healthcare Sector of India

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List of Abbreviations

CSO	Central Statistical Office
ICNPO	International Classification of Non-Profit Organizations
NAD	National Accounts Division
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NPI	Not-for-Profit Institution
NSS	National Sample Survey
OPD	Out-Patient Department
PHFI	Public Health Foundation of India
RBI	Reserve Bank of India
RMNCH	Reproductive Maternal, Newborn and Child Health
RoW	Rest of the World
SHA	System of Health Accounts
SHA	State Health Accounts
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

Who are the non-governmental organizations?

Non-governmental organizations (NGOs) are called by various names across the world, such as third sector organizations, non-profit organizations, voluntary organizations, charitable organizations, community-based organizations and so on with slightly modified scope and coverage. In India, they are often called as not-for-profit institutions, and officially defined as *(a) organizations that, (b) are not-for-profit and, by law or custom, do not distribute any surplus they may generate to those who own or control them, (c) are institutionally separate from government, (d) are self-governing and (e) are noncompulsory*.

To what extent are NGOs spread across India?

As per the official information available from census of not-for-profit sector by National Accounts Division of Central Statistics Office, Government of India, about 3 million NGOs are registered with competent authorities with a rural-urban distribution of nearly 60:40. However, only about 0.7 million of them could be physically traced out by the Central Statistics Office with a visit about 70% NGOs during 2007-08. It has been observed in a group of 19 major states, five states - Uttar Pradesh, Andhra Pradesh, Kerala, Tamil Nadu and Maharashtra - account for 58% of NGOs in India. Bihar, Manipur and Chhattisgarh are the three bottom ranked states among the group of states. This group encompasses around 92% Health-NGOs in India, the top four states with respect to the Health-NGOs being Andhra Pradesh, Maharashtra, Rajasthan and Tamil Nadu.

What functions do NGOs play in the health system?

The primary focus of NGOs in the health sector are:

- establishing healthcare institutions,
- fulfilling health and social needs of groups like women, elderly and vulnerable local communities,
- dealing with specific health issues such as alcoholism,
- promoting health rights,
- performing preventive health programs, and
- managing health finance and administration.

Some NGOs operate internationally and are concerned with global health issues. Some NGOs in India also play an important role in providing health care at the times of emergencies and natural disasters.

How do NGOs generate resources?

A common feature of NGOs is that those who pay them are often not the beneficiaries of their outcomes. NGOs generate resources from institutional and individual donors to facilitate achieving key goals and deliver outcomes to the targeted beneficiaries. According to Indian official estimates for the reference period 2007-08, NGOs generate about 70% of total revenue from grants and donations; the present study based on the primary survey for the reference

period 2013-14 found that figure to be about 78% of total revenue. Nevertheless, the grant component is individually the highest part in revenue receipts during both 2007-08 and 2013-14. However, in a few states like Tamil Nadu, own operations of NGOs generates most revenue, followed by grants and donations.

Donation is individually the highest and major source of revenue in Bihar, Kerala, Madhya Pradesh and Punjab. Grant is found to be the major source in Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Karnataka, Maharashtra, Manipur, Rajasthan, Orissa, Delhi and West Bengal.

Among single purpose grants received by the non-governmental sector, about 31% is assigned to HIV/AIDS, followed by health system management (29%) and then programs related to RMNCH (18%). Other specific programs comprise TB control (6%), specified fevers such as dengue and malaria (5%), programs for disabled persons (4%), special focused programs for tribals (3%).

What are the health activities of NGOs?

The study observed that around one per hundred organizations primarily or subsidiarily involved in health activities has a hospital. The corresponding figures for outpatient clinics are around 9% and health system supportive services are about 11%. An overwhelming number of NGOs, about 84%, are found in outreach activities. The outreach activity is the main health activity for more than 60% of NGOs functioning primarily in health sector.

The outreach activities is the main health activity of about 88% of subsidiary health-NGOs in India. Generating awareness to targeted population is the major sub-component of outreach for Indian NGOs. Around 68 out of 100 NGOs have reported health awareness as their outreach activity. The health sector functioning of NGOs is not a mutually exclusive set of activities; an organization may play roles in several health activities simultaneously.

How much money is spent on health by NGOs?

It is estimated that the current health expenditure of non-governmental sector in the country was INR **10,091** crore in 2013-14. This constitutes about 2% of total health expenditure and around 0.09% of gross domestic product in India with reference period 2013-14. Three major states, namely Andhra Pradesh, Maharashtra and Tamil Nadu together account for 40% of health expenditure by NGOs in India. In spite of having a significant number of health-NGOs in Rajasthan, the share of the state to total health expenditure by NGOs is at a moderate level because a majority of those NGOs are tiny in size. Furthermore, though the state of Uttar Pradesh has maximum number of NGOs, it appeared fifth in terms of the share of health expenditure by NGOs since there were fewer organizations with primary focus on health.

What healthcare services are provided by NGOs?

Preventive care is the most common activity provided by the NGO sector in India. In most states, other than Kerala and Manipur, maximum funds are directed towards preventive care. In Kerala, maximum funds are spent for curative care, with preventive care being the second highest. In

Manipur, health system supportive services in terms of management and financing dominate other expenses.

Expenses for rehabilitative care and ancillary services (like lab/image test) are not significant, except in a few cases, such as rehabilitative care in Karnataka and ancillary services in Rajasthan, Madhya Pradesh, Manipur and Uttarakhand. In the NGO sector, curative care is found at a moderate level, and constitutes second highest level of expenditure in most of the states. In curative care expenditure of NGOs, outpatient care covering hospital outpatient and ambulatory clinic constitutes the highest share of around 41%, followed by hospital inpatient care of around 36%.

Chapter 1

Non-Governmental Organizations in Healthcare System

1.1 Background

Non-governmental organizations (NGOs) typically possess a very distinctive feature as private institutions serving public purposes (UN 2003). They are called by various names across the world, such as not-for-profit institutions, third sector organizations, voluntary organizations, community-based organizations, charitable organizations and so on. Though their nature and focus of activities has changed over time, they have gained prominence in a wide spectrum of activities cutting across economic, social, cultural and scientific domains. Nowadays, non-governmental sector is recognized as a major social and economic force in almost all countries.

The importance of evolving non-governmental sector is well explained in the literature of political economics as government and market failure theories. Sociological studies emphasize on them as a most important institution improving social integration and being an integral part of democratic society. The positive attitude towards non-governmental sector is also predominant in health sector. The World Health Organization has acknowledged NGOs in terms of increasing recognition to complement government programs and creating an effective people's voice in respect of health service requirements and expectations (WHO). With the adoption of a decentralized framework to improve health sector performance, many countries across the globe have opened up the opportunity for participation of NGOs in providing health services.

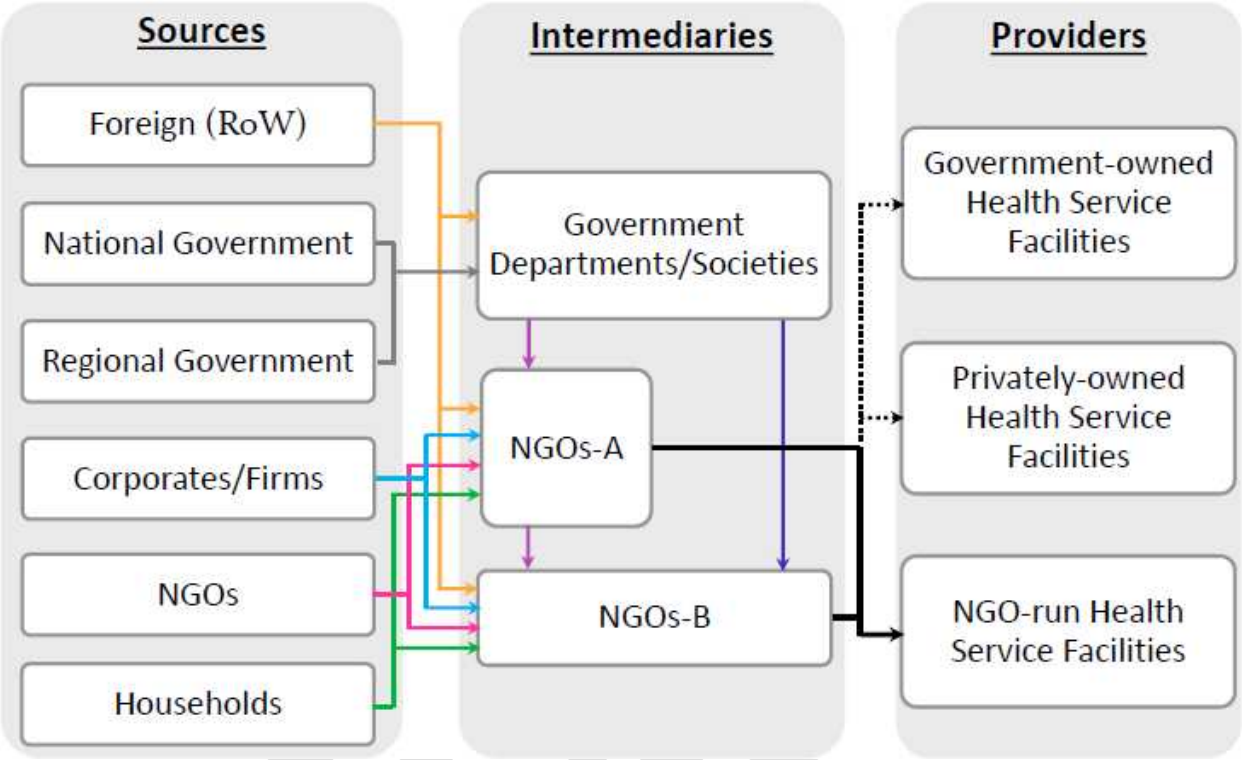
However, the tasks of NGOs in healthcare sector are related to specifics of a particular country, namely the extent of civilization development, institutional framework, culture and tradition, resources and needs etc. In high income countries, NGOs are typically more specialized and largely involved in clinical research, health advocacy and lobbying. In countries with low and middle income, NGOs activities are focused on service delivery, raising awareness and prevention campaigns (Azenha 2011).

1.2 Financial Architecture

NGOs obviously require funds for the activities they run. A very common feature of NGOs is that the beneficiaries of their outcomes are often not the payers. They generate resources from donors to facilitate achieving key goals and deliver outcomes to the targeted beneficiaries. For NGOs involved in health sector activities, the framework of resource mobilization can be depicted by way of fund flows from primary sources, financial intermediaries and healthcare providers. There seem to be five sources from which funds may be generated by the NGOs. As depicted in Figure 1.1, except for government fund, all other funds can be received directly by the NGOs. Government departments and societies play an intermediary role for transfer of government fund to NGOs. Inter-NGO fund transfers are often found – typically large NGOs, represented by NGO-A in the figure, channel domestic and/or foreign resources to small NGOs like NGO-B working closely at the community level. NGOs also have their own (permanent and/or ambulatory) facility to provide healthcare to the targeted groups of population. They may also

purchase healthcare for the targeted beneficiaries from public/private facility providers, though it is a not very common phenomenon. Different entities involved in the financial flow of health activity by NGOs are outlined in the figure.

Figure 1.1: Pattern of fund flow for non-governmental organizations



External Resource: Foreign fund is an important component for financing domestic healthcare activities, especially in the developing world. There are two main channels: (1) domestic counterparts of international NGOs through which external funds come to achieve stated objectives and (2) funds from international development agencies or donors which are routed via government agencies or directly received by NGOs as grant for achieving stated welfare projects. In rest of the world (RoW) scheme, therefore, NGOs are both primary receiver as well as intermediary agent like government agencies to run the scheme.

Government Resource: The ways to flow funds from national and regional governments to NGOs are: (1) government financial grant for schematic projects to NGOs and (2) participation of NGOs in the provision of a government scheme. Because of the specific strengths associated with non-governmental sector, especially strong grassroots links, field-based development expertise and ability to motivate people, several welfare programs are now designed by government agencies with the involvement of NGOs.

Corporate Resource: This is a private institutional fund available to NGOs for social development. NGOs may be able to attract corporate houses to take part in their innovative and development programs. As a voluntary or legal social responsibility, private firms donate to or sponsor NGO-run development programs.

NGOs' Own Resource: Self-financing of the NGO sector can be defined as procurement of revenue by internal entrepreneurial methods, i.e. strategies used by NGOs to generate some of their resources to run the missions. Common self-financing methods in NGOs are membership fees, service charges, product sales, ancillary business ventures, factor income like rental and dividend, etc. Some NGOs may well create endowments and corpus funds for smooth running of their activities.

Households Resource: The individual level donation is commonly termed as household resource transfers to the NGOs. Nevertheless, there are some overlapping components of household resources with self-financing resources of NGOs. For example, service charges or product sales are eventually borne by households. Similarly, membership fees are usually paid by individual members.

1.3 Global and Local Perspective

Since the mid-seventies, the non-governmental sector has experienced a phenomenal growth in both developed and developing countries. This is perhaps caused by the policy shift towards decentralized agenda of both national and international development agencies. It is estimated that over 15 percent of total overseas development aids are now channeled through NGOs (World Bank 1995). Decentralization has opened up important avenues for NGOs to participate in social sector programs. Governments in the developing world especially found the non-profit sector as increasingly prominent, innovative and grassroots driven with the desire and capacity to pursue participatory and people-centered forms of development and to fill up the gaps left by governments in meeting the needs of vulnerable citizens. International development agencies such as UN-organizations and the World Bank have recognized the involvement of NGOs for introducing innovative approaches and promoting community participation (WHO 2001).

NGOs working directly with local communities can play an important role in extending project uptake and reach and can facilitate greater awareness of diverse stakeholder views. Fernandez et al. (2005) have evaluated the community mobilization approach of several non-governmental organizations in Latin American and Caribbean countries, and found community members are geared up and trained to disseminate health promotion and disease prevention information on a wide range of health promotion topics.

There is a great variety of NGOs in healthcare system in particular, in terms of size and operation. At the national level, NGOs in developing countries are primarily focused on:

- Establishing healthcare institutions,
- Fulfilling health and social needs of specific groups like women, elderly and vulnerable local communities,
- Dealing with specific health issues such as alcoholism,
- Promoting health rights,
- Implementing preventive health programs, and
- Managing health finance and administration.

Some NGOs which operate internationally are concerned with global health issues. In some countries, NGO-run hospitals are designated by national governments as district-level hospitals responsible for providing hospital services for the entire district. In Tanzania, for instance, a number of missionary hospitals are designated as district hospitals, which are managed jointly by government and church representatives (Gilson et al. 1994). In Nepal, some church-run hospitals are upgraded at the district level with government funding to cover a part of their operating costs. In Malawi, church-run hospitals have been given the responsibility for managing several health services (Banda and Simukonda 1994). In Ethiopia, seven percent of health facilities are operated by healthcare NGOs, most of which are at the primary level. They provide financing and general curative, preventive and rehabilitative healthcare services (Wamai 2008).

In India, NGO-run hospitals are heterogeneous and vary in terms of ownership, financing and costs. In recent past, in about ten health-oriented projects of the Ministry of Health and Family Welfare, Government of India, NGOs have actively taken part as health service providers to the financing agent (fund management) based on their level of capacity (for instance, Mother-NGO Scheme). All those NGO-schemes are now under the provision of flexi-pools in National Health Mission (NHM). Besides, some NGOs (especially the national counterparts of international NGOs and faith-based organizations) might have their own health financing schemes. Those that are present in rural areas and part of development programs, function for the community by providing primary and secondary services. For example, SEWA-Rural in Gujarat, was assigned the responsibility of providing community-based health services in a district covering 40 villages with a population size 35,000. In the mid-eighties, the State Government of Gujarat turned over the services of ten health sub-centers to this NGO with a block grant (Dave 1990). Berman and Dave (1994) reviewed that despite substantial government grant, VHS hospital in Tamil Nadu collected 57 percent of revenue from patients as user fees. Nundy (2005) pointed out that the out-of-pocket payment by patients is a common source for taking care of recurrent costs in NGO-run hospitals in India. Most primary health centers and dispensaries run by the non-governmental sector, however, charge a nominal fee from the users. NGO-run secondary and tertiary-level hospitals charge fee for service from those who can afford in order to cross-subsidize; but those in urban areas are sometimes inaccessible to many.

Alongside health care facilities, NGOs are also involved in several preventive care activities, perhaps more than curative care. As a case study, Nanjunda and Dinesha (2011) showed how several NGOs are involved in creating health awareness among tribals through various community-based approaches including door-to-door information flow, street plays, visuals and debates in tribal panchayats. Indeed, the nature and focus of individual NGOs vary extensively, and it becomes difficult to make generalization about the sector as a whole. A further level of complexity arises for the existence of non-governmental sector because of several legal provisions in India.

1.4 Scope in Contemporary Perspective

In India, there are currently two broad regulatory frameworks for NGOs:

- public goods provision (Societies Registration Act and its state variant, Public/Private Trusts Acts, section 25 of the Company Act) and
- religious purpose (Wakf Acts, Religious Endowments Act and Charitable and Religious Trusts Act).

An overwhelming number of NGOs in India are covered under the Societies Registration Act and Trusts Act (CSO 2012). In addition, there are informal associations working at grassroots level without being registered in the legal provision but may be counted as a part of the NGO-sector. Such heterogeneity and plurality of the NGO sector has a long history in India, with instances even from the ancient past.

At the policy level, the role of non-governmental sector has been explicitly mentioned since the Seventh Plan. The national policy document recognized this sector by emphasizing its legal status. A non-profit organization, however, can be registered under any of the acts available for this sector based on its scope. The unit whether registered as a trust or society or other provisions such as section 25 of the Companies act, the Indian Income Tax Act gives it equal treatment in terms of exempting its income as 'charitable purpose of general public utility' and granting it to issue tax-exemption certificate for domestic donors. Foreign contributions to the non-profit sector are governed by Foreign Contributions Regulation Act, 1976 (CSO 2009).

Despite several legal provisions and gaining prominence to serve society, this sector remains unaccounted for. In national accounts, contribution of non-governmental sector is implicitly included in the accounts of respective institutional units like corporates and households which the NGOs are serving. In the past, the Reserve Bank of India (RBI) had conducted a sample survey on private non-profit units with reference period 1986-87 but the same did not give much useful evidence. In order to meet the demand for statistical information on non-governmental sector, the Fourth Economic Census had started to assign a specific code for NGOs. Though the economic census provides a very basic directory information, the extent of the non-profit organizations with their operational area and employment group may be fairly counted from the Fifth Economic Census, which defined this sector with more clarity (CSO 2012). The National Sample Survey (NSS) in recent rounds collected comprehensive information, but the same is limited by scope and coverage, and also incompatibility of definition with the Economic Census.

1.4.1 Conceptualizing Non-governmental Sector

Defining the non-profit-sector is a great challenge across the world including in India. Aside from non-governmental organizations, other common terms interchangeably used for them in national policy documents and elsewhere across the globe are not-for-profit institutions (NPIs), voluntary organizations (VOs), community-based organizations (CBOs), charitable organizations, civil society organizations (CSO), third sector organizations and so on with slightly modified scope and coverage. Given the complexities of non-governmental sector, the Johns Hopkins University Comparative Non-Profit Sector Project and United Nations Statistical Division have undertaken a worldwide initiative to develop a handbook on NPIs under the System of National Accounts.

In line with the international efforts to improve economic statistics, National Accounts Division of Central Statistics Office under the Ministry of Statistics and Programme Implementation, Government of India, had prepared a satellite account to estimate the role of non-profit sector in economy during 2007-08. This is an innovative and comprehensive study specially designed for the NGO-sector through census approach. The study officially defines the non-profit sector as consisting of:

> *(a) organizations that, (b) not-for-profit and, by law or custom, do not distribute any surplus they may generate to those who own or control them, (c) are institutionally separate from government, (d) are self-governing and (e) are noncompulsory (CSO 2009, 2012)*

In this definition, organization means the entity has some institutional reality. As an organization it does not exist primarily to generate profits directly or indirectly, and is not guided by commercial goals and considerations. By economic activities, non-profit institutions may accumulate surplus but any such surplus must not be distributed among the controllers. Institutional separation with government specifies that such organizations are not part of the government machinery and do not exercise governmental authority in their own right. Self-governance indicates the organization has its own internal governance procedures and enjoys a meaningful degree of autonomy. Finally, non-compulsory is associated with the fact that membership and contribution are not mandatory by law or otherwise, such as determined by birth.

1.4.2 Classifying Non-governmental Sector

The non-profit organizations so defined under national accounting framework may serve any institutional units of the economy, namely government, corporate and household. This 'serving purpose' classification defined in the System of National Accounts (SNA) is more specific and related to the 'objectives that institutional units aim to achieve through various kinds of outlays' (UN 2000). Accordingly, NGOs are grouped into three classes:

- NPISG (non-profit institutions serving government),
- NPISC (non-profit institutions serving corporates) and
- NPISH (non-profit institutions serving households).

Another formal classification of this sector is a more general one in terms of economic activities. National Accounts Division of Central Statistics Office (CSO-NAD) has followed the International Classification of Non-Profit Organizations (ICNPO), which arranged the NPIs into 12 broad activity-groups:

- culture and recreation,
- education and research,
- health,
- social services,
- environment,
- development and housing,
- law/advocacy and politics,

- philanthropic intermediaries and voluntarism promotion,
- international activities,
- religious,
- business and professional associations and
- not elsewhere classified category.

In spite of that, one critical issue remains, which is related to mutually non-exclusive nature of economic activities for the NPI-sector. An individual non-profit establishment may simultaneously be involved in several activities under the 12 broad groups defined in ICNPO. Further, there could be several NPIs varying in terms of size but operating under the same economic activity with varying focus. Therefore, a systematic approach is required for an in-depth study of the non-profit organizations that are indeed heterogeneous and diverse in functioning. A further complexity arises while assessing this sector within the Indian healthcare system, which is itself very multifarious involving multiple stakeholders to meet a variety of needs and expectations of a large population belonging various socio-economic and cultural groups.

Chapter 2

Size and Structure of Non-Governmental Organizations

2.1 Overview

A very preliminary survey of the private non-profit sector in India, conducted by the Society for Participatory Research in Asia under Johns Hopkins University Comparative Non-Profit Sector Project, placed the number of such organizations at 1.2 million (Tandon and Srivastava 2005). This estimate, however, was not very appealing because of its limited coverage of merely four states and ambiguous sample frame involving the Fourth Economic Census (Rao 2005).

Lack of reliable directory information for non-profit sector was perhaps the main reason that the first ever survey of NPIs by RBI in 1988 was not aimed at building up estimates for this sector. Given the fact, CSO-NAD two-phase study in 2007-08 could be considered a comprehensive one designed for the NGO-sector through the census approach.

In Phase-I, the study mainly compiled NPI information from the original records available with the registering authorities in different states and union territories (CSO 2009). Records of about 3 million NGOs were received from competent authorities with rural-urban distribution of almost 60:40. Out of the total NGOs, only around 5% were present before the seventies. The rest 95% were registered after the seventies:

- 5% in seventies,
- 17% in eighties,
- 35% in nineties and
- 35% in the first decade of the current century.

The NGOs mentioned the following economic activities:

- Social services (41%),
- Education and research (19%),
- Culture and recreation (12%) and
- Health (2%).

Since there is no formal provision of deregistration of non-operational NGOs, the Phase-II of the CSO-NAD study was to trace the functioning non-profit organizations with reference period 2007-08. Around 71% of registered NGOs were physically visited using a scheduled questionnaire, and 0.69 million were traced. The rural-urban ratio was found to be 62:38. Apart from Gujarat and Maharashtra where visit rate was fairly low, all major states and union territories were visited.

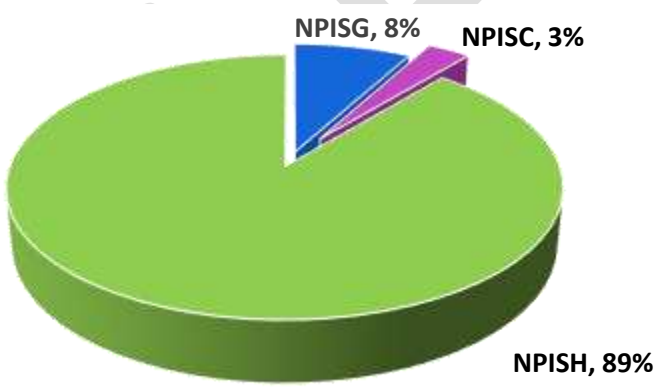
The CSO (2012) report on the Phase-II study, however, is not very comprehensive for financial estimates; only broad pattern at all-India level has been presented. An in-depth financial estimate though, can be found from the recent round of NSS on Un-incorporated Non-agricultural Enterprises during 2010-11. This survey covered only 234 sample-NGOs in health sector out of their estimated population of around 17,000 (on an average just about 7 samples

per state). The under-representation of sample NGOs in NSS round is serious as in a recent NGO-Partnership initiative by the Planning Commission of India about 30,000 NGOs signed up under the health category. It is therefore hardly possible to use the NSS information for estimating financial aspect of the health sector NGOs. In spite of the limitations, these official estimates, namely CSO-NAD and NSS, offer a praiseworthy idea about the current status, size and financial pattern of the non-governmental sector.

2.2 National Profile

A proper picture of the current non-profit sector will emerge when the Sixth Economic Census information appears in the public domain. According to the special census on NPIs by CSO-NAD in 2007-08, an overwhelming portion (89%) of live organizations are serving households (NPISH), and about 4% of them (estimated from the NPIs directory information of CSO-NAD) have primary focus on the health sector. They are almost equally distributed in rural and urban areas. The distribution of NGOs by institutions they serve is depicted in Figure 2.1. We can see that 8% are serving governments (NPISG) and 3% are serving corporates (NPISC).

Figure 2.1: Distribution on NGOs by institutions serving

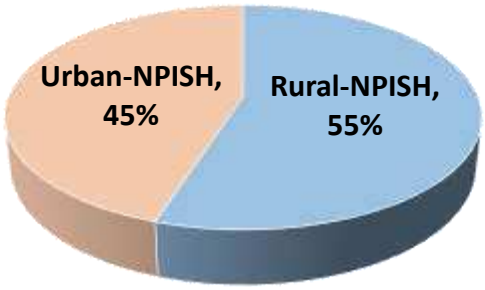


Source: CSO (2012)

NPISGs and NPISCs have limited involvement with societal groups as they serve their respective institutions. For example, State Health Society, functioning under the National Health Mission in different states, is an NPISG registered under the Societies Registration Act with a memorandum of association. Business associations like the Federation of Indian Chambers of Commerce and Industry (FICCI) are categorized as NPISC.

On the other hand, NPISH attains particular interest in national and international policies because they are primarily focused on development programs involving community participation. In view of that, the basic information of NPIs from CSO-NAD for major states has been analyzed. Based on the data of 20 states shared by CSO-NAD, it is found that rural-urban distribution of NPISH is 55:45. As depicted in Figure 2.2, this distribution is based on the location of organizations traced by their addresses (CSO 2012).

Figure 2.2: Rural urban distribution of NPISHs



Source: Authors' estimation on twenty major states from CSO (2012)

2.3 Extent across States

The distribution of NPIs as per CSO (2012) for registered organizations in the first phase and traced as live in the second phase across states and union territories is presented in Table 2.1. We arranged them in descending order based on the number of Health-NPIs, and made a subgroup of the states/ union territories that comprise at least 200 Health-NPIs.

There are 19 states in this subgroup (states like Jammu & Kashmir, Himachal Pradesh and Jharkhand are kept beyond the scope of the subgroup due to unavailability of detailed information from CSO-NAD). Nevertheless, the subgroup covers all major states and more than 94% of NPIs in India for both first and second phase of study by CSO-NAD.

Table 2.1: Registered NPIs in first and second phase of CSO Census

State	Registered NPIs (Phase-I)	Traced NPIs (Phase-II)	Health NPIs (Phase-II)	Registered NPIs (Statewide %)	Traced NPIs (Statewide %)
Andhra Pradesh	434,294	65,045	2,615	13.7	9.4
Maharashtra	484,004	38,319	2,395	15.3	5.5
Rajasthan	100,272	20,336	2,071	3.2	2.9
Tamil Nadu	141,322	39,720	2,007	4.5	5.7
Uttar Pradesh	439,740	214,981	1,674	13.9	31.0
Madhya Pradesh	85,752	27,472	1,621	2.7	4.0
West Bengal	169,136	35,497	1,380	5.3	5.1
Punjab	48,933	34,436	1,350	1.5	5.0
Odisha	133,573	38,345	710	4.2	5.5
Kerala	326,392	44,273	560	10.3	6.4
Bihar	22,272	3,694	491	0.7	0.5
Delhi	60,687	10,127	404	1.9	1.5
Gujarat	172,215	9,109	383	5.4	1.3
Assam	73,181	8,949	377	2.3	1.3
Manipur	14,692	8,793	317	0.5	1.3
Uttarakhand	49,954	11,167	290	1.6	1.6
Karnataka	192,487	20,268	285	6.1	2.9
Chhattisgarh	39,901	3,607	250	1.3	0.5
Haryana	60,132	20,784	208	1.9	3.0
Subgroup Total	**3,048,939**	**654,922**	**19,388**	**96.4**	**94.3**

State	Registered NPIs (Phase-I)	Traced NPIs (Phase-II)	Health NPIs (Phase-II)	Registered NPIs (Statewide %)	Traced NPIs (Statewide %)
Jammu & Kashmir	5,452	1,573	462	0.2	0.2
Himachal Pradesh	39,642	15,917	308	1.3	2.3
Jharkhand	4,141	2,867	253	0.1	0.4
Tripura	5,493	1,599	152	0.2	0.2
Meghalaya	15,449	3,904	83	0.5	0.6
Puducherry	14,986	3,583	72	0.5	0.5
Nagaland	7,330	2,280	53	0.2	0.3
Goa	6,598	3,267	25	0.2	0.5
Chandigarh	3,488	367	10	0.1	0.1
All India	**3,164,329**	**694,186**	**21,121**		

Source: CSO (2012); Andhra Pradesh includes Telangana. States/union territories with very small number of NPIs, like Mizoram and Andaman, are not presented here.

The subgroup encompasses around 92% Health-NPIs in India. Andhra Pradesh, Maharashtra, Rajasthan and Tamil Nadu are the top four states with more than 2,000 health-NPIs in each state.

In phase-I, Maharashtra, Uttar Pradesh, Andhra Pradesh and Kerala were the top four states with more than 10% of NPIs. In phase-II, Tamil Nadu replaced Maharashtra in the group of top four. This may be because Maharashtra is one of the states with very low rate of visit contrary to Uttar Pradesh, Andhra Pradesh and Kerala, where all NGOs have been visited to trace them in phase-II. Maharashtra though has a considerable number of organisations, about 5%, even with a very low rate of visit. Uttar Pradesh has the highest number of organizations (31%). Bihar, Manipur and Chhattisgarh are the three bottom ranked states in the subgroup in both phase-I and II.

2.4 Legal Status

In India, no specific laws govern volunteerism. However, it is formally covered under several legal provisions in the form of non-profit sector regulations in terms of nature, expression, scope and target groups (CSO 2009). As mentioned earlier, two broad regulatory frameworks exist:

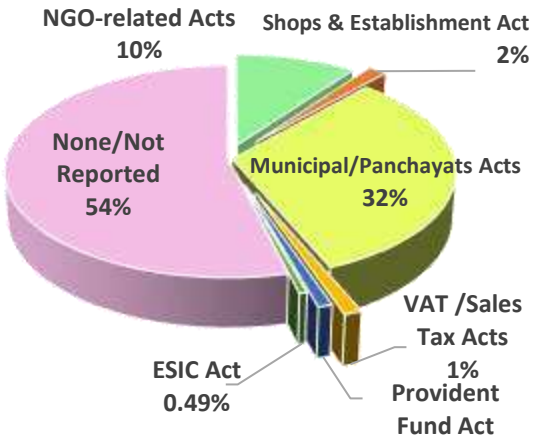
- Provisions for organizations that work for the larger public good and
- Provisions for religious non-profit organizations.

The CSO-NAD NPI-Census 2007-08 in its terms of reference covered the first category, specifically societies and trusts, which are about 90% of registered NPIs in India. Further, an organization may well be registered under several acts simultaneously for the smooth functioning of its operations. It is found that a large number of NGOs are registered under Societies Registration Act. Only 2% are exclusively governed by the Trusts Act.

A general pattern of legal status for the NPIs can be estimated from the NSS 67th Round unit-level data (though this has several limitations and hence cannot be comparable).[1] The survey found that about half of these self-reported private NPIs were unregistered, 32% were registered with local authorities (municipalities and panchayats). Merely 10% of organizations were registered under any Acts applicable to the NPIs such as Societies Registration Act, Trusts Act and Charitable Act. Nevertheless, there is a clear incongruity in NSS information towards the scope and coverage of NPIs.

Figure 2.3: Distribution of NGOs by legal status

Source: CSO (2012)



Source: NSS 67th Round

Indeed, it is almost impossible to arrive at any statewide picture of formal NPIs with NSS numbers (just about 80 out of 1,870 self-reported sample-NPIs). As per the CSO-NAD NPI-Census, however, in the subgroup formed of major states, Maharashtra has all organizations registered under both Societies Registration Act and Trusts Act. Gujarat has around 90% of organizations under Trusts Act. These two states were, however, subjected to a very low rate of visit at the time of tracing organizations during the second phase. In the rest of the states, an overwhelming number of organizations are registered exclusively under the Societies Registration Act.

Table 2.2: Distribution of NGOs by legal status across major states

State	Societies Act	Trusts Act	Both Societies & Trusts Acts
Andhra Pradesh	93.9	3.3	2.8
Assam	100.0	0.0	0.0
Bihar	98.0	0.5	1.5
Chhattisgarh	98.2	1.1	0.7
Delhi	99.7	0.1	0.1
Gujarat	0.0	89.4	10.6
Haryana	100.0	0.0	0.0
Karnataka	100.0	0.0	0.0
Kerala	98.5	1.1	0.5
Madhya Pradesh	92.3	4.1	3.6

[1] NSS 67th Round on Unincorporated Non-Agricultural Enterprises is a more general kind of survey which roughly covers self-reported nongovernmental sector into the scope with loosely used definition.

State	Societies Act	Trusts Act	Both Societies & Trusts Acts
Maharashtra	0.0	0.0	100.0
Manipur	97.5	0.4	2.1
Odisha	100.0	0.0	0.0
Punjab	98.8	0.2	1.0
Rajasthan	99.4	0.2	0.5
Tamil Nadu	100.0	0.0	0.0
Uttar Pradesh	99.8	0.1	0.0
Uttarakhand	99.6	0.3	0.1
West Bengal	99.6	0.1	0.3
India	89.6	2.3	8.1

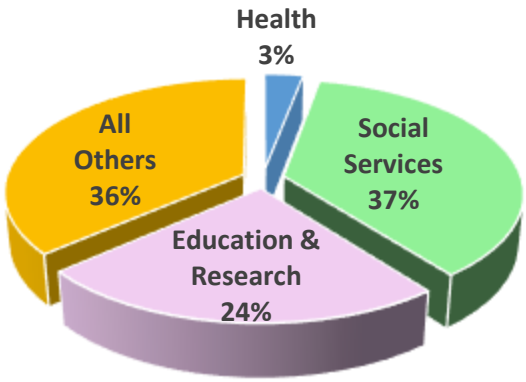
Source: CSO (2012)

2.5 Operational Areas

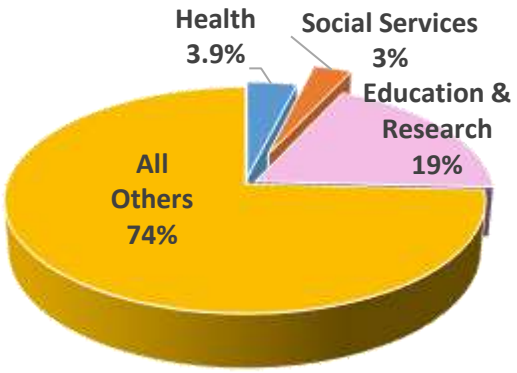
In line with the ICNPO, while NPIs are broadly classified into 12 broad operational areas by CSO-NAD, a sizable number is found in social services (37%), followed by education & research (24%). Only 3% NPIs are primarily involved in health sector activities. It is a common phenomenon in almost all states (CSO 2012). The comparative distributions across areas of operation from NSS 67th Round estimates are social services as 3%, education & research as 19% and health is around 4%. Though the health sector figures between CSO and NSS are moderately comparable, there is a huge inconsistency in other operational sectors, such as social services.

Further, given the comparable distribution of health sector operation in the two official sources of information, the NSS 67th Round NPI-samples in the health sector (NIC 2008 2-digit codes 86 and 87) are too small to arrive even at any national level estimate. In NSS 67th Round, there are just about hundred plus samples with primary involvement and a few as subsidiary involvement that appeared under health sector activities, and a majority of them are unregistered NPIs. It would therefore be hardly appealing to refer to NSS information on NPIs hereafter in this study.

Figure 2.4: Distribution of NGOs by operational activities



Source: CSO (2012)



Source: NSSO 67th Round

At the state level, in the distributions across operational areas within the sub-group of major states as per CSO-NAD, it is observed across all states that maximum organizations are involved in 'social services', except in a few states like Kerala and Odisha. Though NPIs' involvement in the health sector is not very noteworthy, yet there are many states such as Bihar, Rajasthan, Chhattisgarh, Maharashtra, Madhya Pradesh, Tamil Nadu, Assam, Gujarat, Andhra Pradesh, Delhi, Punjab, West Bengal and Manipur, with a share under health activity above the national average of 3%. The proportion of NPIs operating primarily in the health sector is highest in Bihar (13%) followed by Rajasthan (10%). It is lowest in Uttar Pradesh (below 1%).

Table 2.3: Distribution of NGOs by activities across major states

State	Health	Social Services	Education & Research	All Others
Andhra Pradesh	4.0	37.8	16.8	41.4
Assam	4.2	36.3	8.5	51.0
Bihar	13.3	51.2	20.8	14.7
Chhattisgarh	7.4	35.8	17.9	38.9
Delhi	4.0	32.8	18.3	44.9
Gujarat	4.2	38.4	25.0	32.3
Haryana	1.0	50.8	22.9	25.3
Karnataka	1.4	39.6	19.0	40.0
Kerala	1.3	18.2	2.2	78.3
Madhya Pradesh	5.9	27.1	44.6	22.5
Maharashtra	6.3	33.6	31.8	28.3
Manipur	3.8	27.5	7.5	61.3
Orissa	1.9	13.0	15.0	70.1
Punjab	3.9	51.1	10.1	34.9
Rajasthan	10.2	22.6	54.0	13.3
Tamil Nadu	5.1	31.3	7.1	56.6
Uttar Pradesh	0.8	43.8	38.2	17.2
Uttarakhand	2.6	34.1	23.1	40.2
West Bengal	3.9	31.3	11.4	53.5
India	**3.0**	**36.5**	**24.1**	**36.4**

Source: CSO (2012)

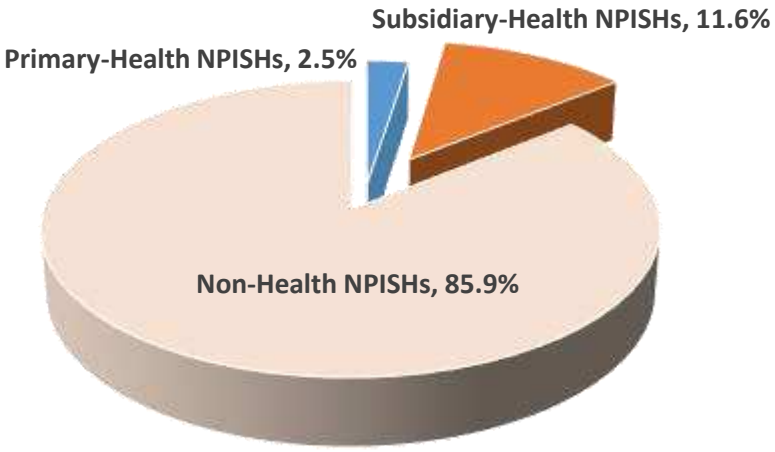
A non-profit organization may simultaneously operate in several areas. Health sector being of interest to this study, it is observed that some NPIs are engaged primarily in health sector activities and some are involved subsidiarily. One can therefore group the organizations in a mutually exclusive way:

- primary-health activity group,
- subsidiary-health activity group and
- non-health activity group.

Further, focus may be given to those organizations serving households because other categories, namely NPISG and NPISC, serve their respective founders. About 2.5% of NPISHs carry out their

operations primarily in the health sector vis-à-vis an overall share of 3% NPIs. About 11.6% of NPIs have reported their first or second important activity under the health sector. Expectedly, an overwhelming number of NPISHs (around 86%) are non-health organizations (see Fig. 2.5).

Figure 2.5: Distribution of NGOs by involvement in health activities



Source: Estimated from CSO (2012)

The ordering across states is almost the same in terms of NPISHs and NPIs involved primarily under the health sector. Interestingly, Uttar Pradesh, which is at the bottom in terms of primary-health NPISHs and NPIs, appears at the top for subsidiary involvement in health activity. The bottom ranked state for subsidiary-health NPISHs is Haryana (0.3%). An overwhelming number of states however, appear with moderate level presence of subsidiary-health NPISHs. Indeed, all the states have a majority of non-health NPSHs, ranging between 73% (Uttar Pradesh) to 99% (Haryana).

Table 2.4: Distribution of NGOs by involvement in health activities across major states

State	Primary-Health NPISHs	Subsidiary-Health NPISHs	Non-Health NPISHs
Andhra Pradesh	3.5	5.6	90.9
Assam	4.1	11.4	84.5
Bihar	9.0	17.1	73.8
Chhattisgarh	2.7	2.2	95.1
Delhi	3.8	4.1	92.1
Gujarat	4.1	5.4	90.4
Haryana	1.0	0.3	98.7
Karnataka	1.4	1.7	97.0
Kerala	1.2	2.7	96.1
Madhya Pradesh	4.6	8.8	86.6
Maharashtra	6.3	4.3	89.4
Manipur	3.4	5.9	90.7
Orissa	0.9	5.1	94.0
Punjab	4.1	1.5	94.4
Rajasthan	7.4	2.7	89.9

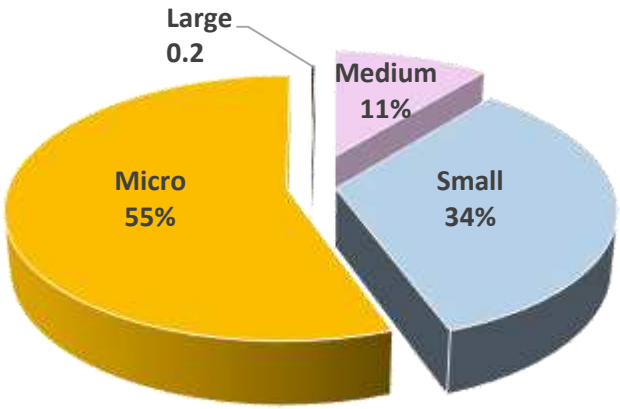
State	Primary-Health NPISHs	Subsidiary-Health NPISHs	Non-Health NPISHs
Tamil Nadu	3.4	2.0	94.6
Uttar Pradesh	0.7	26.0	73.3
Uttarakhand	2.7	4.2	93.0
West Bengal	3.9	11.8	84.4
India	**2.5**	**11.6**	**85.9**

Source: Authors' estimation from detailed directory information by CSO (2012)

2.6 Employment Status

Size-based classifications suggest a majority (55%) of NPISHs are 'micro' – run wholly by volunteers. A moderate percentage (34%) of NPISHs are 'small', with hired employment size below 20. 'Medium' size NPISHs, where employment size ranges between 20 and 100 are just above 10%. There are only about 0.2% 'Large' size NPISHs, run by hundred plus hired workers. It is evident that the 'micro' and the 'small' together account for around 90% of the organizations, and it is almost the same for all the states.

Figure 2.6: Distribution of NGOs by employment size



Source: CSO (2012)

While the distribution pattern of large, medium and small plus micro size-categories for NPISHs is almost the same across the states, there is an indecisive pattern among micro and small, which together comprise an overwhelming part of NPISHs.

States like Assam and Bihar have nearly the same share of micro and small NPISHs. Haryana, Karnataka, Uttar Pradesh, Odisha, Rajasthan and Uttarakhand have more small; rest of the states have more micro than small NPISHs.

The largest share of medium size NPISHs is found in Uttar Pradesh, followed by Haryana and Bihar. West Bengal has the lowest share (about 0.3%).

The largest share of large NPISHs is found in Haryana (1%). Several states have the lowest share (around 0.1%).

Table 2.5: Distribution of NGOs by employment size across major states

State	Large	Medium	Small	Micro
Andhra Pradesh	0.5	4.2	27.2	68.1
Assam	0.5	5.7	41.5	52.4
Bihar	0.6	10.5	43.7	45.2
Chhattisgarh	0.7	4.7	35.0	59.5
Delhi	0.4	1.0	6.3	92.4
Gujarat	0.0	0.4	19.5	80.1
Haryana	1.0	13.4	76.6	9.0
Karnataka	0.6	6.0	72.9	20.4
Kerala	0.1	0.5	7.9	91.6
Madhya Pradesh	0.1	2.3	26.9	70.8
Maharashtra	0.4	1.6	7.3	90.7
Manipur	0.2	6.6	19.8	73.4
Orissa	0.3	7.3	64.8	27.6
Punjab	0.1	1.4	14.6	83.9
Rajasthan	0.3	5.3	63.3	31.0
Tamil Nadu	0.4	1.6	9.4	88.6
Uttar Pradesh	0.1	31.0	66.4	2.4
Uttarakhand	0.2	2.7	60.8	36.3
West Bengal	0.1	0.3	11.2	88.4
India	0.2	10.6	33.6	55.5

Source: Authors' estimation from detailed directory information by CSO (2012)

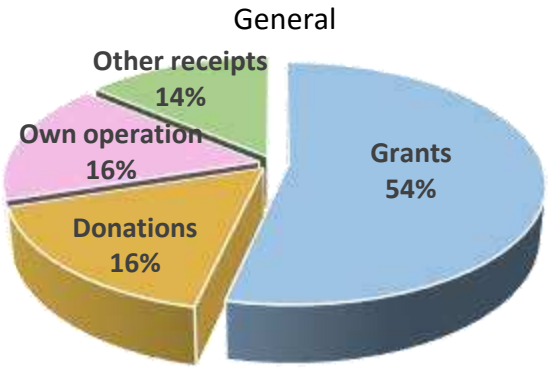
2.7 Revenue Generation

As per the financial information available at an all-India level in CSO (2012), the revenue receipts of NPIs may be arranged into four broad groups:

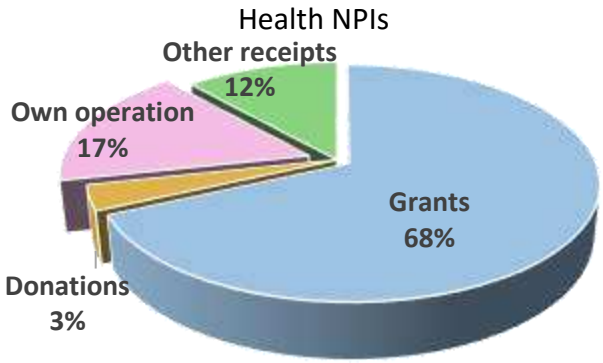
- project grants from several government and non-government sources,
- donations and offerings mainly received from public,
- income from own operation like sale of products and services and
- other receipts like membership fees, dividends, and interests.

It is observed from the figures that grants are a major source of revenue for NPIs in general as well as health sector NPIs in particular. While both general-NPIs and health-NPIs are almost at the same level for own operation, there is a wide gap in donations; health-NPIs receive only 3% donations whereas general NPIs receive 16%.

Figure 2.7: Extent of revenues by sources for general and health NGOs



Source: CSO (2012)



Source: CSO (2012)

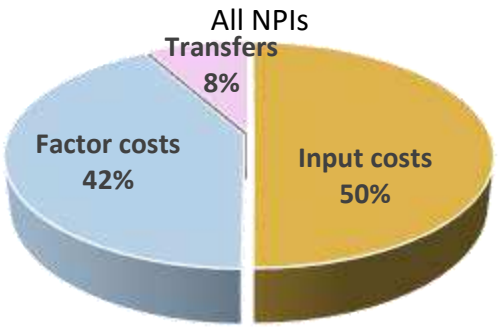
2.8 Expenditure Pattern

Based on the information available with CSO (2012), the current expenditures of NPIs could be grouped into three broad heads:

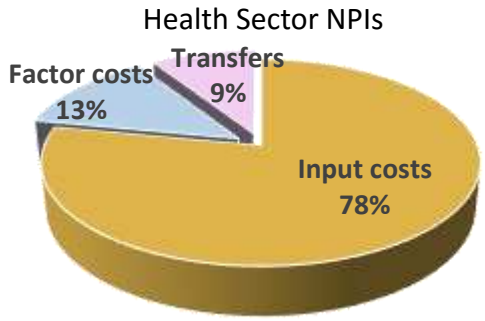
- cost incurred for purchasing the inputs,
- payment to factors in the form of salary/honorarium, rent and interest, and
- transfer to others (because non-governmental organizations may often play an intermediary role as part of their operations).

It is observed that in general, input costs account for half of the current expenditure of NPIs. The input costs for health sector NPIs is, however, much higher – around 80% of current expenses. Transfers are almost the same for both general-NPIs and health-NPIs. Health NPIs incur 13% factor costs while general NPIs incur 42% factor costs.

Figure 2.8: Extent of expenditure in general and health sector NGOs



Source: CSO (2012)



Source: CSO (2012)

Chapter 3

Study of Health Financing for Non-Governmental Organizations

3.1 Study Outline

The contribution of the non-profit sector reported in the last National Health Accounts (NHA 2004-05) was barely 2% of the total health expenditure comprising all entities in India. This figure is based on the information available with the FCRA Wing of the Ministry of Home Affairs, Government of India. Evidently, the non-availability of required information in FCRA statistics, especially on diversified functions that voluntary sector might play as provider of healthcare service, source of healthcare revenue or financing agent to channelize funds, has constrained estimation of health expenditure by NPIs in an inclusive manner (NHA, 2009: 18). Disaggregated information at this level is not available in any of the official statistics like CSO-NAD and NSS 67th Round. The present study is therefore designed to deal with the data gap for health sector NPIs in India.

The study is a first attempt to estimate comprehensively the health expenditure of non-profit organizations by different functional roles as provider/source/agent of health system with an implicit objective to provide figures for national and sub-national health accounts, which are being producing by NHSRC (National Health Systems Resource Centre) and PHFI with reference year 2013-14.

All these reports, however, followed the global framework of health accounting, called SHA 2011 (System of Health Accounts). In this framework, the functioning of a health system in an economy has been arranged into a tri-axial setup involving the following:

- consumption,
- provision and
- financing.

Accounting of any axis essentially represents total the health expenditure of a country in the sense that what is consumed must be produced and hence be financed. All the functional roles from provisioning to financing in a health system may well be found for non-profit sector worldwide. In India, non-governmental organizations play roles such as:

- provider of healthcare services through own facilities,
- agent or intermediary for managing several healthcare schemes, and
- run own health financing schemes (outlined earlier in Section 1.3).

Within this wide spectrum, there are some rural community-based organizations that offer health services at the primary level; at the other end are trust/society hospitals for tertiary level care. For the purpose of health sector functioning, NGOs may well be grouped into three broad mutually exclusive sets:

- primary health-NGOs (major/sole activity is health),
- subsidiary health-NGOs (secondary/sub-activity is health) and

- non-health NGOs (hardly any direct activity on health).

In the health sector activity, however, there are several sub-classifications. Following the International Classification of Non-Profit Organizations along the System of Health Accounts (SHA 2011: 130, UN 2003: 94), health activity covers the following:

- hospital services (general/specialized/mental health),
- ambulatory health services (outpatient care),
- rehabilitative/long-term healthcare,
- ancillary services (lab/image test, ambulance),
- preventive care (maternal & child health, family planning & counselling, occupational & school health, disease prevention programs and other public health services),
- medical goods provision,
- health research and training,
- health system administration/financing.

Since healthcare services may be provided by the non-profit sector at below market prices or economically insignificant prices, the accounting framework of national health accounts (SHA 2011) and national income accounts (SNA 2008) considered only non-profit organizations serving the households (NPISH). The other groups that serve governments or corporates (NPISG and NIPSC) are typically funded and reported by their respective sectors from the accounting point of view, and hence beyond the scope of the present study.

For this study, a national-level primary survey has been conducted involving NPISHs functional in all states under the subgroup based on CSO-NAD with the aim of collecting comprehensive information, and the same can be fitted into the national as well as state health accounts in India. Given the specific scope of this survey, research design was focused on primary health-NGOs, followed by subsidiary health-NGOs and then non-health NGOs (see Research methodology in Annexure-I). Notably, the endeavor here is to estimate a representative health expenditure by the non-governmental sector at both state and national levels. The main research questions investigated here are:

- how financial resources are generated by the non-profit sector to function in the healthcare system and
- how much resources are utilized to provide different types of healthcare.

The estimated results are offered in the following subsections with some basic profiles of the non-governmental organizations.

3.2 Observed Profile

The basic profile of the non-profit sector is presented in terms of the following:

- legal status,
- registration versus functioning,
- location of operation and

- functional activities.

This part of the analysis gives a glimpse of 'third sector' organizations in India including individual state level picture.

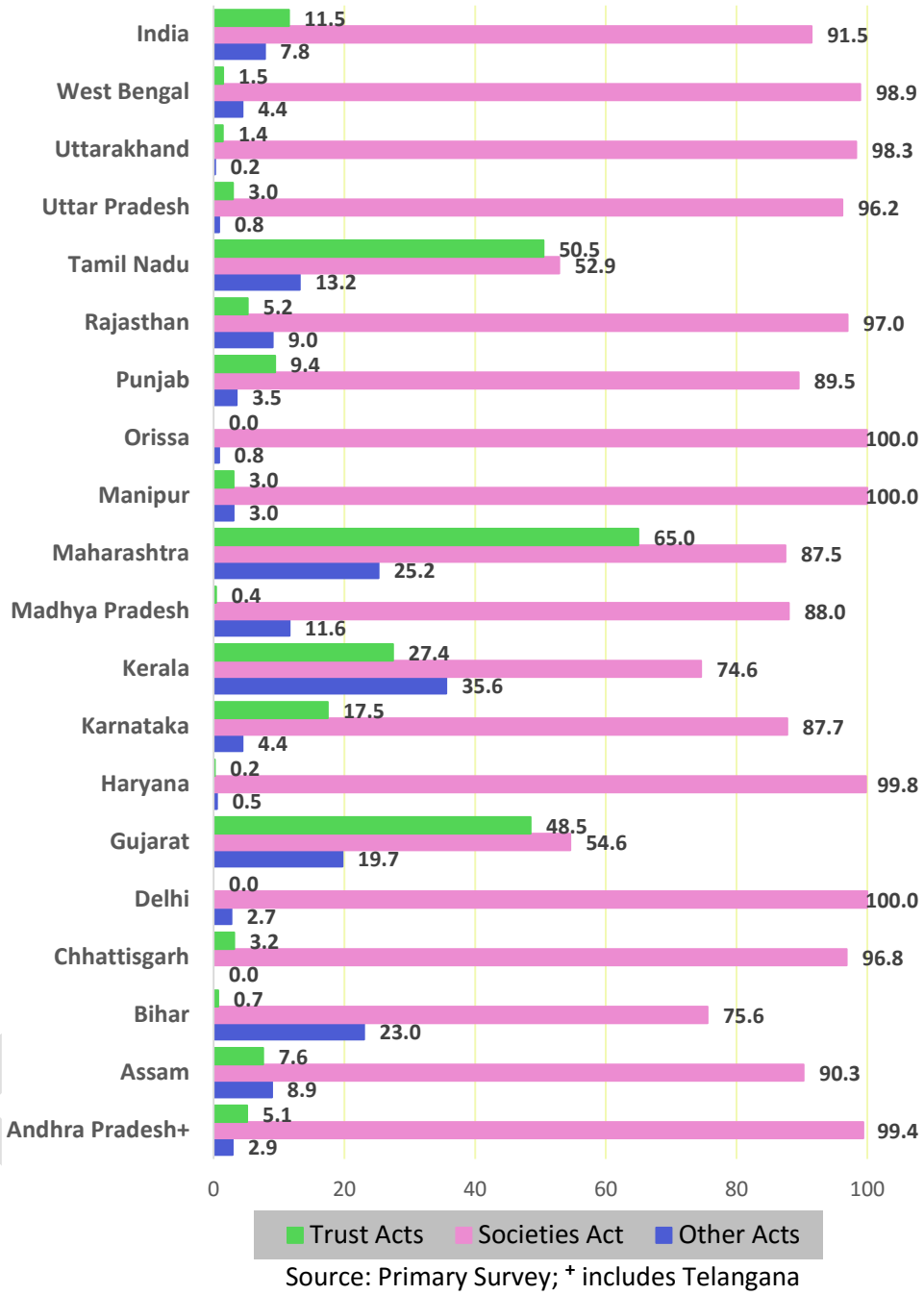
3.2.1 Legal Status

It is observed from the following figure that more than 90 out of 100 non-governmental organizations are registered under the Societies Registration Act, about 11 out of 100 under the Trusts Act and just around 8 out of 100 are registered under other specified acts relevant for the non-profit sector. The states follow almost the same pattern as the national level.

In states like Delhi, Orissa and Manipur, all the organizations are registered under Societies Registration Act, and some of them are also registered under other relevant acts for NPIs. It may be mentioned, there is a provision of simultaneous registration of an organization under different acts, and hence the sum of reported results for the three categories (societies, trusts and others) would usually exceed hundred.

In two states, namely Gujarat and Tamil Nadu, about 50 out of 100 organizations are registered under the Societies Registration Act. In these states, along with Maharashtra, about 50 out of 100 organizations are also registered under Trusts Act. The results here are fairly consistent with the estimates discussed earlier in Section 2.4, Legal Status from CSO-NAD NPI Census 2007-08.

Figure 3.1: Observed pattern of NGOs by legal status across states



Source: Primary Survey; + includes Telangana

3.2.2 Registration and Functioning

In India, it is possible for an organization to function without registration or vice versa. One can also register and function at the same time. The following table reveals that around 64% of Indian NPIs were registered and started functioning in the same year. In states like Andhra Pradesh, Delhi, Haryana, Odisha and Uttarakhand, more than 90% organizations were simultaneously registered and started functioning. In states like Gujarat, a sizeable number of organizations started functioning after a time lag after having been registered with competent authorities. The reverse cases are also found in some other states such as Assam and West Bengal where the organizations started functioning and then registered themselves with relevant acts for NPIs.

Table 3.1: Observed pattern of registration versus functioning for NGOs across states

State	Registered before functioning	Functioned before registering	Registered and functioned simultaneously
Andhra Pradesh+	1.0	0.8	98.3
Assam	0.6	70.7	28.8
Bihar	12.7	19.0	68.3
Chhattisgarh	9.2	48.6	42.2
Delhi	0.3	0.6	99.1
Gujarat	61.4	0.0	38.6
Haryana	1.8	0.4	97.9
Karnataka	17.0	0.5	82.5
Kerala	26.2	0.0	73.8
Madhya Pradesh	3.6	7.9	88.5
Maharashtra	15.5	6.7	77.8
Manipur	26.2	38.5	35.3
Orissa	1.2	0.5	98.3
Punjab	12.2	26.5	61.3
Rajasthan	39.8	16.8	43.4
Tamil Nadu	5.5	9.1	85.5
Uttar Pradesh	26.2	16.9	56.9
Uttarakhand	4.6	4.9	90.5
West Bengal	1.0	85.1	13.9
India	**10.2**	**26.2**	**63.7**

Source: Primary Survey; + includes Telangana

3.2.3 Operational Location

Non-governmental organizations may have their head office anywhere, in rural or urban locations, and they may operate in one or both areas. Unlike the CSO-NAD survey that emphasized the location of office, this survey collated information with respect to location of operation irrespective of their official location.

It is observed in the following table that about a half of the NGOs have operational location in both rural and urban areas, and another half are almost equally and exclusively distributed in rural or urban areas. State-wise, the facts are moderately different from national level. For example, there is hardly any organization that exclusively works in urban areas of Odisha. There are very limited rural only organizations in Delhi, Manipur, Uttar Pradesh and Uttarakhand.

Table 3.2: Observed pattern of operational location for NGOs across states

State	Rural Only	Urban Only	Both Rural & Urban
Andhra Pradesh+	48.8	25.5	25.8
Assam	40.2	32.8	27.0
Bihar	38.1	9.5	52.5
Chhattisgarh	14.7	72.2	13.0
Delhi	0.7	1.8	97.5

State	Rural Only	Urban Only	Both Rural & Urban
Gujarat	17.0	25.7	57.4
Haryana	22.9	12.9	64.3
Karnataka	39.7	23.1	37.2
Kerala	59.1	15.3	25.6
Madhya Pradesh	13.6	6.1	80.3
Maharashtra	32.3	59.0	8.7
Manipur	1.6	15.2	83.2
Orissa	69.3	0.0	30.7
Punjab	10.5	29.0	60.5
Rajasthan	17.4	14.4	68.2
Tamil Nadu	12.8	32.6	54.6
Uttar Pradesh	2.3	23.3	74.4
Uttarakhand	4.9	14.3	80.8
West Bengal	33.3	18.1	48.5
India	**25.4**	**24.2**	**50.4**

Source: Primary Survey; [+] includes Telangana

3.2.4 Functional Activities

As mentioned earlier, the ICNPO and CSO-NAD has classified the non-profit sector into 12 broad groups based on their operational activities. In India, however, only the following of those 12 broad activities are prominent (in decreasing order of importance):

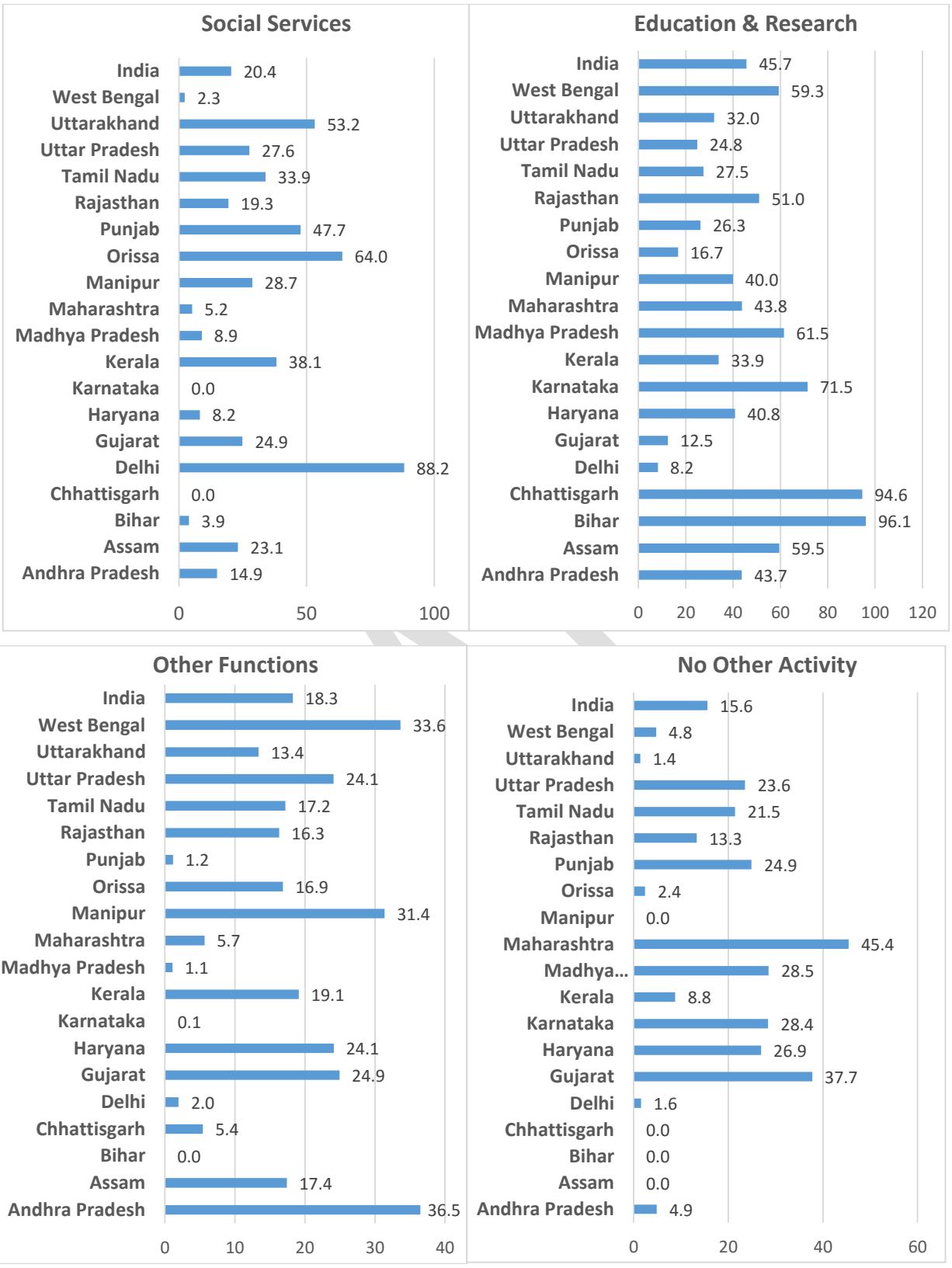
- social services
- education and research and
- culture and recreation.

As the focus of the present study is the health sector (whose share is hardly 3% of the nonprofit sector), we are presenting here the areas of operation of those organizations that are primarily focused on health activities. Following set of figures represents the second most important activities of primary health-NGOs.

It is observed that around 46% of those NGOs are involved in education & research and about 20% are engaged in social services at the national level. Around 16% however exclusively operate in the health sector since none of them have reported any subsidiary activity.

At the state level, such a pattern is widely varied ranging between 8.2% in Delhi to 96.1% in Bihar for education & research. The figures for social services ranges from almost nil in Chhattisgarh to about 88% in Delhi.

Figure 3.2: Observed pattern of NGOs by major operational areas across states



Source: Primary Survey; + includes Telangana

3.3 Details of Health Activities

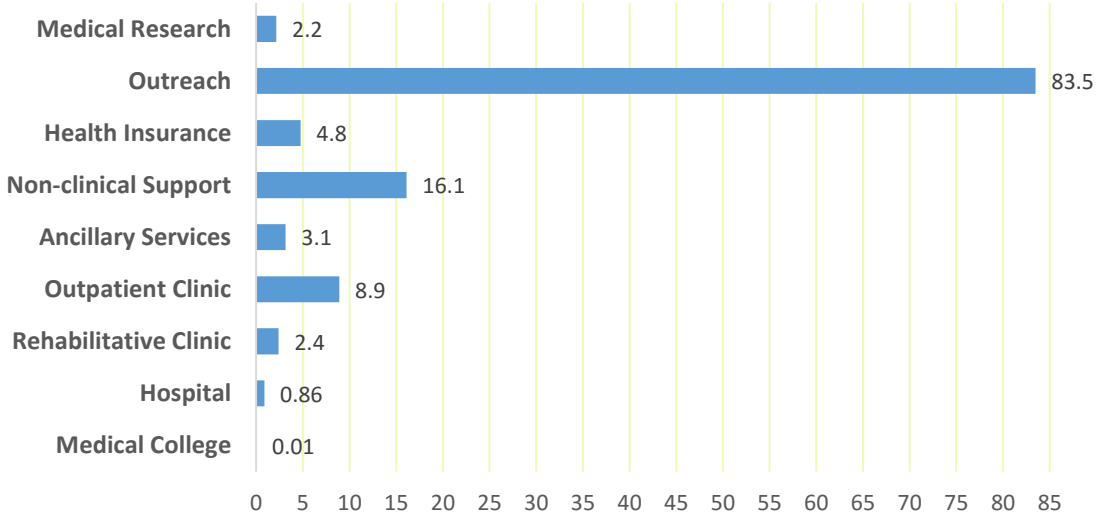
Health activities are arranged into nine broad groups:

- medical education,
- hospital services,
- rehabilitative clinic,
- outpatient clinic,
- ancillary services like lab/image tests,
- nonclinical medical support like health system management/financing,
- health insurances for targeted population,
- outreach activities for preventive and public health care, and
- engagement in medical research.

It is observed among the NGOs that around one per hundred organizations primarily or subsidiarily involved in health activity has a hospital. The corresponding figure for outpatient clinics is around 9% and support services is about 11%.

Nevertheless, a large number of NGOs, (about 84%) are engaged in outreach activities. Again these activities are mutually non-exclusive, and hence the sum of activities reported in the following figure would exceed a hundred. This is because an organization may jointly be engaged in several health activities, such as, hospitals usually have both inpatient and outpatient services with some other health activities as well.

Figure 3.3: Observed pattern of activities under health for NGOs



Source: Primary Survey

3.3.1 Main Activities under Health

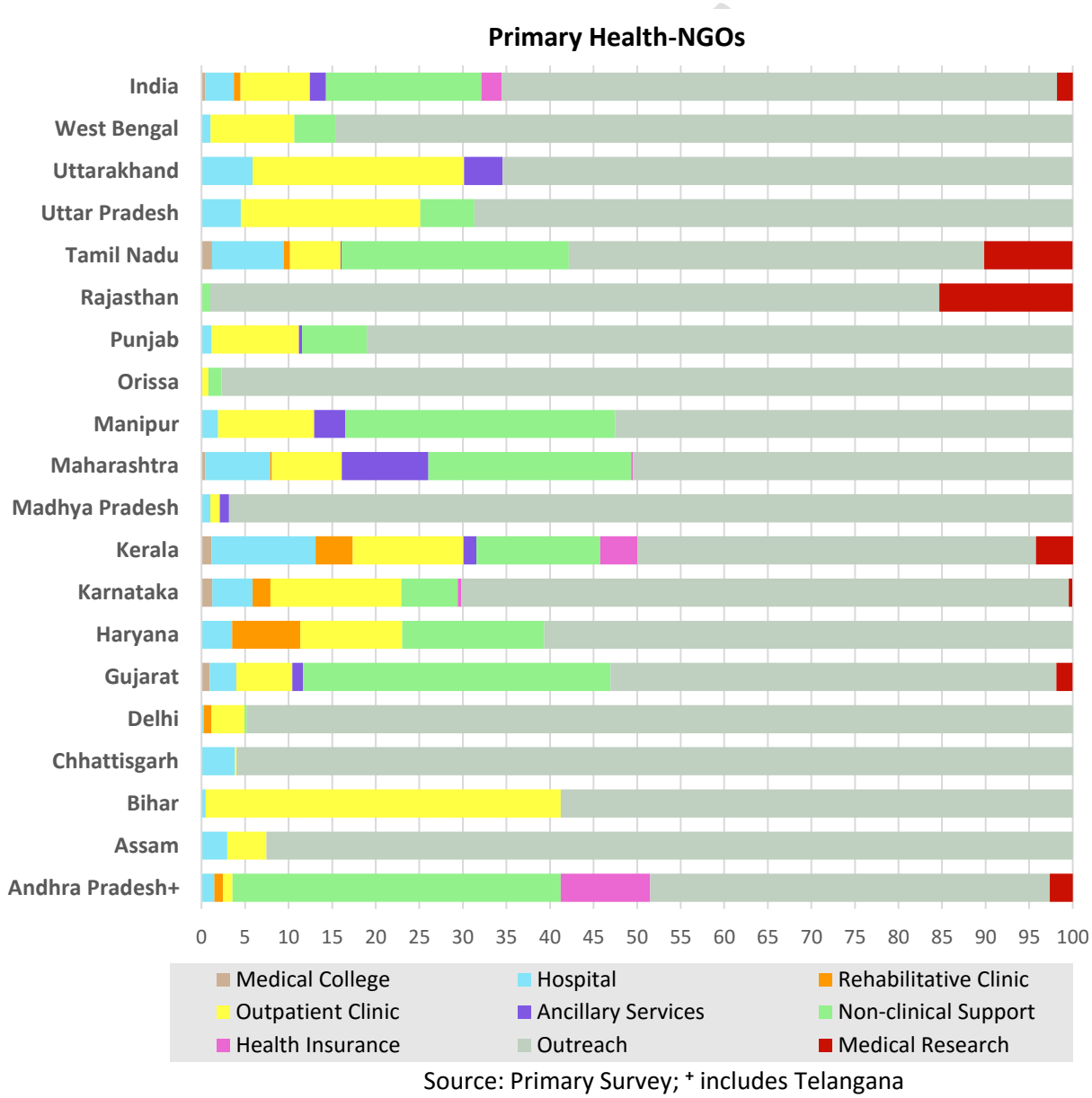
Given the fact that organizations can engage in several health activities simultaneously, the main health activity is analyzed for primary and subsidiary health-NGOs separately. In the following figures, it is observed at all-India level for the primary health-NGOs that 3.3% have hospitals as main health activity, 8% have OPD clinics, 17.8 % have health management/financing, and so on. Nevertheless, the outreach activity is the main health activity for more than 60% of NGOs operating primarily in health sector. The outreach part is about 88% for subsidiary health-NGOs in India.

As expected, health activities such as hospital or outpatient clinical services are fairly low in subsidiary health-NGOs as compared with primary health-NGOs.

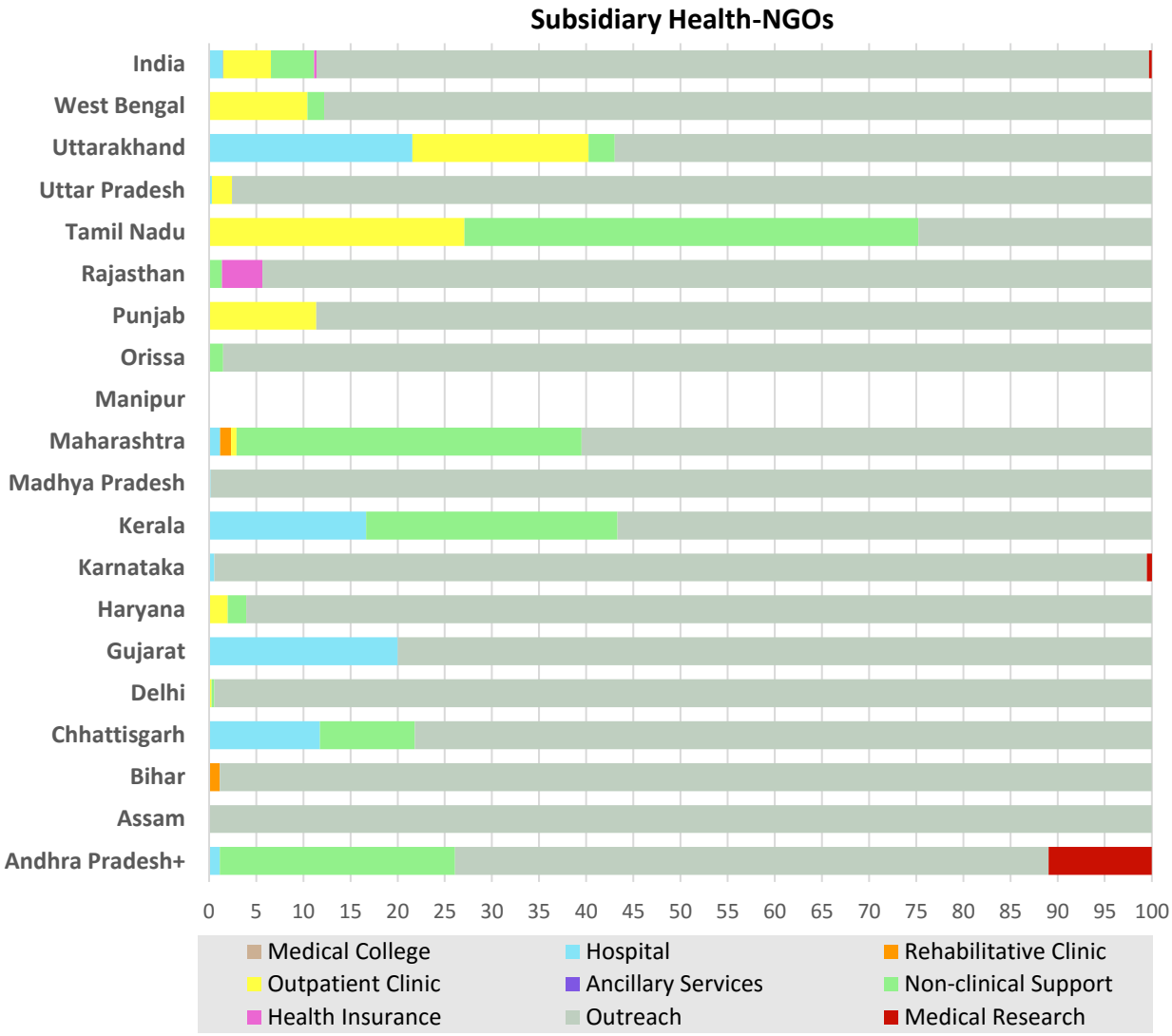
At the state level, in 9 out of 19 states, outreach activity appeared as the main health activity for more than 90% of the subsidiary health-NGOs.

In five out of 19 states (Assam, Chhattisgarh, Delhi, Madhya Pradesh and Odisha), outreach activity appeared as the main health activity for more than 90% of primary health-NGOs.

Figure 3.4: Observed pattern of activities under health across states for different NGOs



Source: Primary Survey; + includes Telangana



Source: Primary Survey; + includes Telangana

3.3.2 Details about Outreach Activities

Clearly, outreach is the main health activity for most health-NGOs in almost all major states. A detailed analysis of the outreach activities is presented in the following table. Generating awareness among the targeted population is the largest sub-component of the outreach program. Around 68 out of 100 NGOs reported health awareness as their outreach activity. Except a few states such as Maharashtra, Manipur, Orissa and Punjab, the dominant outreach activity of NGOs in all other states was health awareness.

About 40 out of 100 NGOs in Bihar and Manipur held camps for minor surgeries as a part of outreach activities, whereas in Assam, Chhattisgarh and Kerala, health camps for diagnostic check-up were found to be prominent.

At the national level, diagnostic camps were the second largest outreach component for NGOs, with about 35 out of 100 NGOs reporting them. Child immunisation and antenatal-postnatal (ANC-PNC) camps were not held by NGOs from many states. Child immunisation camps were

seen in only a few states such as Bihar, Manipur and to some extent in Rajasthan and Uttarakhand.

NGOs from Kerala, Tamil Nadu and Maharashtra held camps for ANC-PNC. Only about 20 out of 100 NGOs at national level reported blood donation activities, with wide state-level variation ranging from just 1% in Manipur and Uttar Pradesh to about 60% in Bihar.

Table 3.3: Observed pattern of outreach activities for NGOs across states

State	Health awareness	Surgical Camp	Diagnostic Camp	Immunization Program	Blood Donation	ANC-PNC
Andhra Pradesh+	65.4	16.1	7.4	16.2	49.4	0.8
Assam	93.9	0.8	89.7	13.4	21.0	3.6
Bihar	78.8	46.7	48.5	30.7	60.6	16.1
Chhattisgarh	80.4	7.9	80.4	7.2	29.3	5.4
Delhi	94.9	1.5	45.2	1.8	42.3	2.1
Gujarat	60.8	5.2	8.8	22.4	19.5	14.2
Haryana	67.7	3.3	32.8	0.0	5.1	2.8
Karnataka	75.1	17.5	22.4	3.0	47.1	3.9
Kerala	78.6	23.6	78.5	22.1	41.4	33.3
Madhya Pradesh	93.1	0.1	61.3	6.6	9.1	7.4
Maharashtra	27.9	14.5	35.1	18.0	23.7	24.5
Manipur	27.7	39.8	3.0	31.9	0.9	3.0
Orissa	40.2	0.2	55.7	0.1	25.6	2.3
Punjab	41.1	6.8	34.5	12.3	5.4	0.3
Rajasthan	65.6	2.4	15.4	24.1	30.6	19.7
Tamil Nadu	78.1	10.1	67.0	20.9	52.7	35.5
Uttar Pradesh	82.5	8.1	6.4	3.9	1.0	0.9
Uttarakhand	71.3	10.4	60.0	26.3	12.4	19.4
West Bengal	79.1	8.0	47.8	16.9	4.3	0.5
India	**67.8**	**7.6**	**35.1**	**10.9**	**20.2**	**7.2**

Source: Primary Survey; + includes Telangana

3.4 Pattern of Revenue

In the non-governmental sector, grants and donations are important sources of revenue to run NGOs. CSO (2012) observed that during the reference period 2007-08, NPIs generated about 70% of the revenue from these two sources. Our survey for the reference period 2013-14 confirmed that the maximum revenue (about 78%) was generated from these two sources. The grant component was individually the highest part in revenue receipts during both 2007-08 and 2013-14. Notably, the present study finds that the gap between grants and donations has shrunk. The contributions of own operation and others are respectively 7% and 15.2% at national level.

In the following table, we find that 55% of the revenue of Tamil Nadu NGOs came through own operations, which was the highest. Grants (22%) and donations (19%) were other sources of revenue in the same state.

Donation is the largest source of revenue for NGOs in Bihar, Kerala, Madhya Pradesh and Punjab, whereas grant is largest source of revenue for NGOs in Andhra Pradesh, Assam, Chhattisgarh, Delhi, Gujarat, Karnataka, Maharashtra, Manipur, Orissa, Rajasthan and West Bengal.

Table 3.4: Observed pattern of revenues for NGOs across states

State	Grant	Donation	Own operation	Others (rent/interest etc.)
Andhra Pradesh+	70.7	12.4	4.0	12.9
Assam	43.0	19.5	13.4	24.0
Bihar	30.4	62.9	6.2	0.6
Chhattisgarh	38.5	21.2	17.5	22.8
Delhi	75.7	4.9	3.8	15.5
Gujarat	60.5	23.1	8.0	8.5
Haryana	28.2	15.9	16.9	39.0
Karnataka	43.8	16.2	2.8	37.2
Kerala	14.0	51.9	18.8	15.3
Madhya Pradesh	35.9	59.9	1.0	3.2
Maharashtra	57.2	25.8	7.4	9.6
Manipur	50.2	23.3	22.6	3.9
Orissa	93.8	2.8	0.0	3.4
Punjab	16.2	63.7	13.7	6.4
Rajasthan	84.3	10.4	1.9	3.3
Tamil Nadu	22.4	19.0	54.5	4.1
Uttar Pradesh	24.1	41.3	32.8	1.9
Uttarakhand	39.5	43.8	13.3	3.4
West Bengal	50.0	37.7	7.6	4.7
India	**47.6**	**30.2**	**7.0**	**15.2**

Source: Primary Survey; + includes Telangana

If we disaggregate NGOs on the basis of size, grant still remains the major source of revenue for almost all types of NGOs. For micro NGOs, donation is the highest, followed by grant; for small and medium NGOs, grant is the highest, followed by donation. For large NGOs, apart from grant, other income (such as rent and interest) appeared as an important source (about 27%).

Table 3.5: Observed pattern of revenues across size of NGOs

	Grant	Donation	Own operation	Others (rent/interest etc.)
Micro	33.9	41.0	13.0	12.1
Small	56.0	21.8	4.9	17.3
Medium	47.5	35.2	5.6	11.6
Large	50.7	13.1	8.8	27.4

Source: Primary Survey

3.4.1 Composition across Different Types of Organizations

The composition of revenue receipts is depicted in the following set of figures with more details relating to each type of organization considered in this study, namely primary-health NGOs, subsidiary-health NGOs and non-health NGOs.

As expected, health grant appears as the largest source of revenue for primary-health NGOs and non-health grant is the largest source of revenue for the rest. Non-health NGOs receive more non-health grant than do subsidiary-health NGOs.

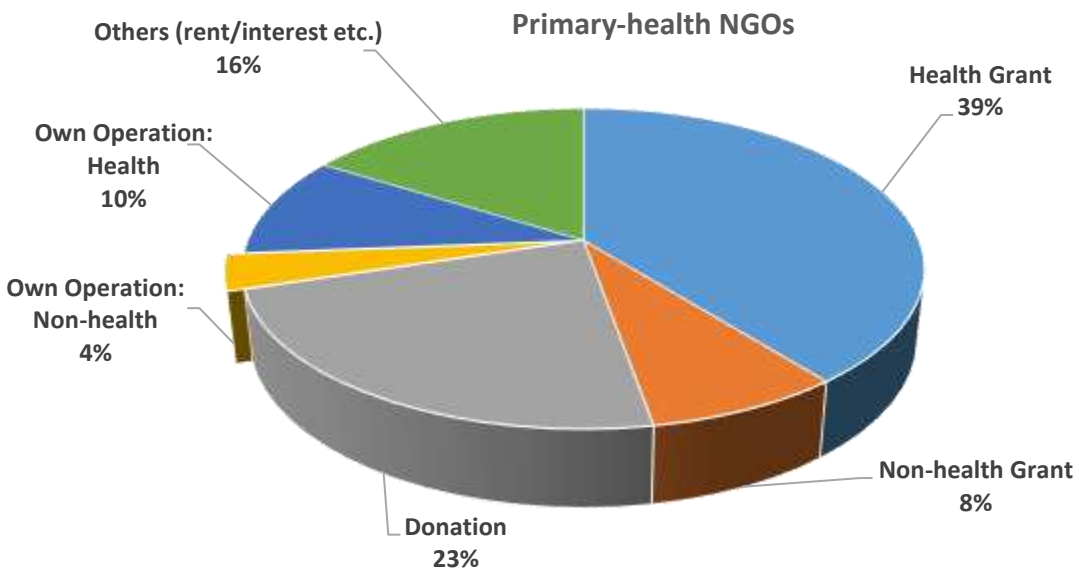
The non-health NGOs considered in this study being relatively big in size, donations contributed around 33% of their revenue. Around 29% of the revenue of subsidiary-health NGOs came from donations as did 23% of the revenue of primary-health NGOs.

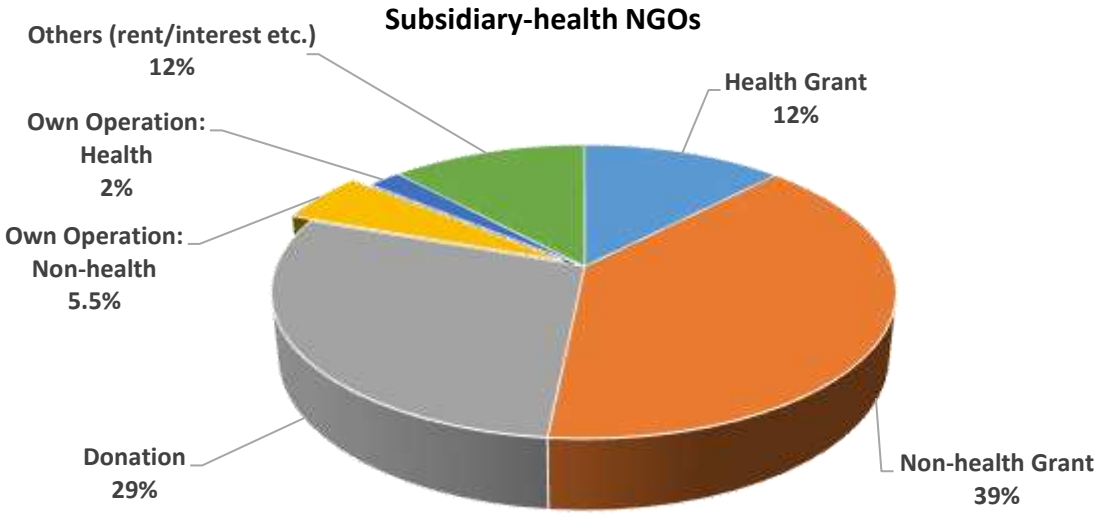
Given the fact that the health grant for non-health NGOs is almost nil, the returns from own operations related to health is also negligible for them. The return from health operations is important for primary-health NGOs.

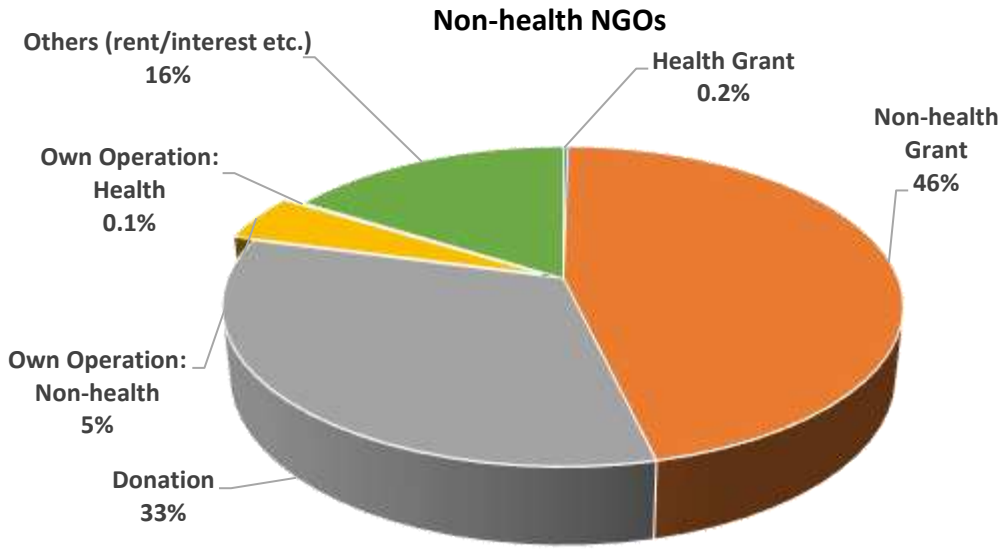
NGOs of all the three groups get almost similar returns (between 4% and 5.5%) from their non-health operations.

Similarly, NGOs of all the three groups get almost similar returns (between 12% and 15%) through rent, interest etc.

Figure 3.5: Observed pattern of revenues for different NGOs







As health grant is an important source for operating non-profit organizations in the health sector, it has been studied in detail. The following table presents the scenarios at the national level with state-specific breakups. While government grant forms the largest chuck of health grant, it is followed by grant from foreign sources. Corporate grant, including CSR (corporate social responsibility) money, and inter-NGOs funds together constitute about 15% of NGOs revenue.

It was observed during the survey that most of the organizations are only aware of their immediate funders, and hence it is not practical to trace the original primary source of the grant. As discussed earlier with reference to the fund-flow diagram in Section 1.2, there may be several intermediary channels, for example, foreign grants are often rooted through different tiers of government channels.

Table 3.6: Observed composition of grant receipts across states for NGOs

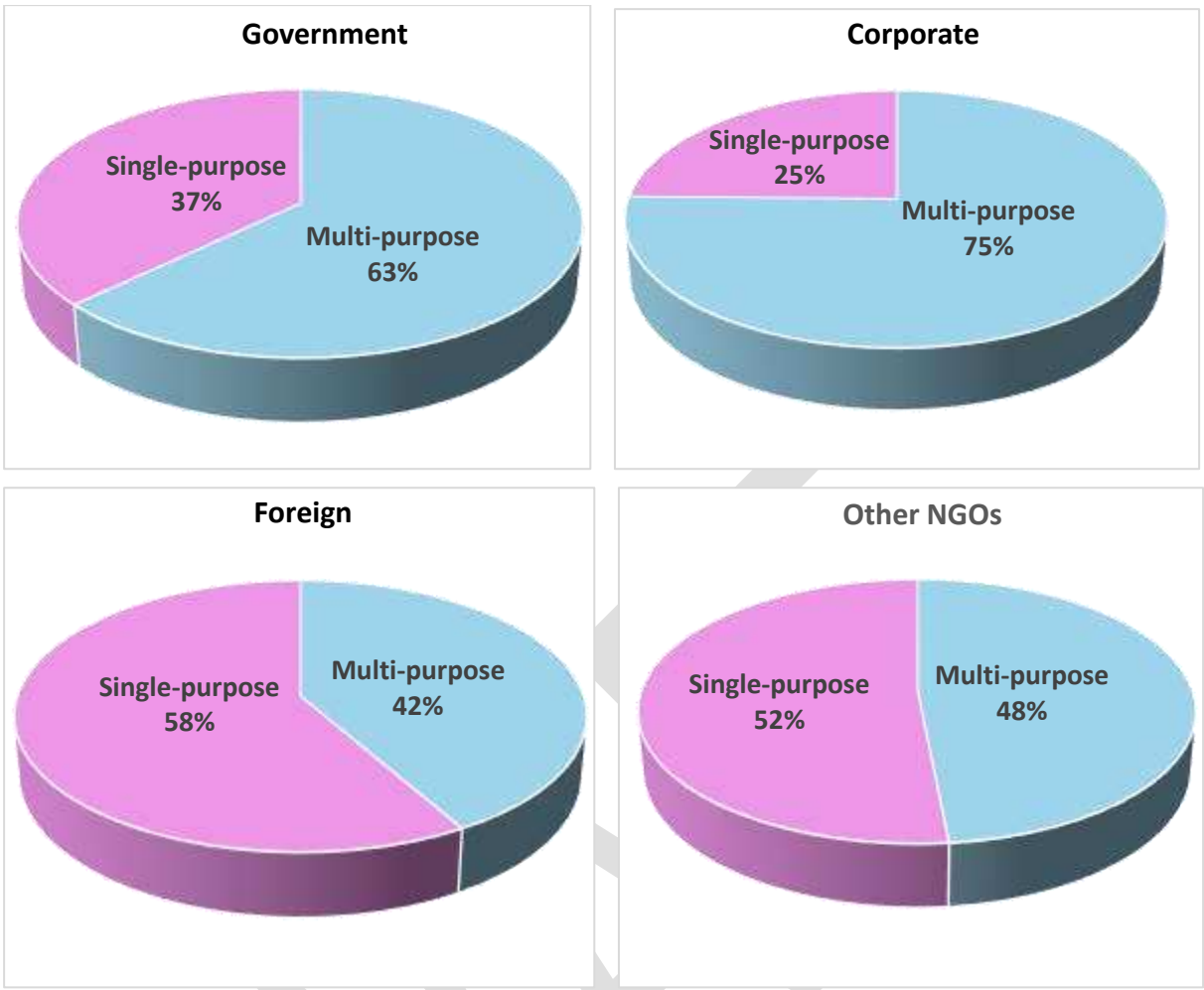
State	Government	Corporate	Foreign	Other NGOs
Andhra Pradesh+	37.4	0.5	62.1	0.0
Assam	96.5	0.3	3.2	0.0
Bihar	99.7	0.0	0.3	0.0
Chhattisgarh	67.6	0.5	31.9	0.0
Delhi	31.7	57.0	1.5	9.8
Gujarat	81.6	13.9	0.0	4.5
Haryana	52.5	2.0	0.0	45.5
Karnataka	97.9	0.0	0.3	1.8
Kerala	31.7	48.4	0.6	19.3
Madhya Pradesh	96.8	0.3	2.9	0.0
Maharashtra	52.2	22.5	0.0	25.4
Manipur	89.8	0.0	10.2	0.0
Orissa	20.9	64.0	2.0	13.1
Punjab	93.1	0.0	0.0	6.9
Rajasthan	26.7	47.8	1.9	23.6
Tamil Nadu	78.5	10.2	4.0	7.4
Uttar Pradesh	35.9	0.5	63.6	0.0
Uttarakhand	97.8	0.0	0.0	2.2
West Bengal	24.8	1.0	74.1	0.0
India	**54.7**	**9.3**	**30.1**	**6.0**

Source: Primary Survey; + includes Telangana

3.4.2 Composition and Purpose of Health Grants

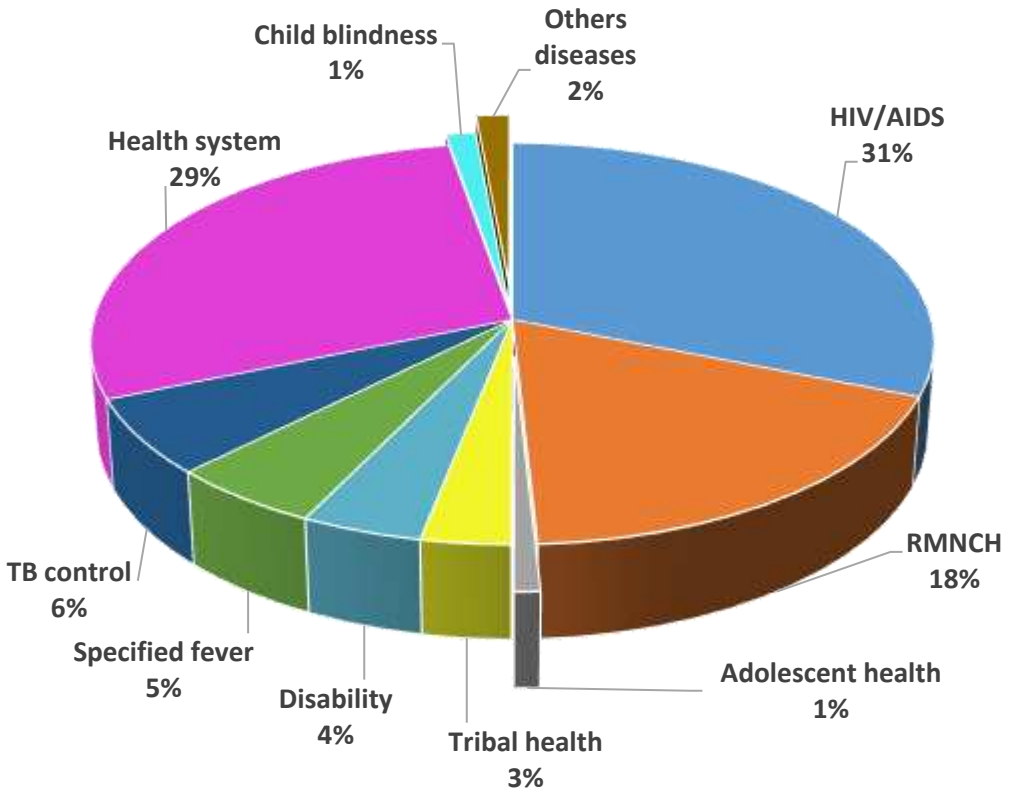
Non-profit organizations usually receive grants for specific purposes, such as for implementing public health programs by donor agencies. A grant may have a single or multiple purposes. The following figures show that 63% of government grants are received for multipurpose objectives. An overwhelming part of corporate grants is also received for multipurpose goals. Grants from other NGOs, however, have almost equal ratio between single and multiple goals. Foreign grants are relatively more focused on attaining a specific objective, 58% of grants are for single purpose.

Figure 3.6: Observed composition of grant receipts from different sources for NGOs



An analysis of multipurpose grants requires a sophisticated technique, especially developing appropriate distribution keys to apportion them into individual items. Grants with a specific objective are rather straightforward. The following figure shows that HIV/AIDS receives the largest share (31%) of single-purpose grant received by the non-governmental sector. This is followed by health system management (29%) and then programs related to RMNCH (18%). Other program-specific grants are given for TB control (6%), fevers such as dengue, malaria and so on (5%), disabled persons (4%), and tribals (3%).

Figure 3.7: Observed composition of single purpose grant for NGOs



Source: Primary Survey

3.5 Extent of Health Expenditure

Estimating the current health expenditure by private non-governmental institutions is the core of the study. We captured the expenditures of the non-profit sector on several health activities with a scheduled questionnaire and analyzed the result using the framework proposed by SHA (2011). The way to classify several expenditure items available through primary survey (see Annexure III for the questionnaire) using healthcare boundaries in SHA (2011) guideline is presented in Annexure IV. The current health expenditure is estimated by excluding medical education and research items and a few expenditure items are adjusted to avoid double counting (details about the estimation procedure is available in Annexure I: Research Methodology and Estimation).

Table 3.7: Estimated current health expenditure across states for NGOs

State	Current Health Expenditure	Current Health Expenditure- User charge adjusted	State's share in Current Health Expenditure	Share of current health expenditure to GSDP/GDP
Andhra Pradesh+	1,39,133	1,35,803	13.8	0.150
Assam	28,087	20,966	2.8	0.166
Bihar	25,932	21,098	2.6	0.079
Chhattisgarh	7,625	7,511	0.8	0.039

State	Current Health Expenditure	Current Health Expenditure- User charge adjusted	State's share in Current Health Expenditure	Share of current health expenditure to GSDP/GDP
Delhi	4,869	4,698	0.5	0.011
Gujarat	21,913	18,565	2.2	0.027
Haryana	2,974	2,856	0.3	0.008
Karnataka	63,425	59,458	6.3	0.084
Kerala	17,298	11,882	1.7	0.039
Madhya Pradesh	13,921	13,828	1.4	0.035
Maharashtra	1,22,069	1,11,844	12.1	0.075
Manipur	7,510	6,207	0.7	0.486
Orissa	9,626	9,626	1.0	0.035
Punjab	6,627	5,594	0.7	0.020
Rajasthan	30,939	30,939	3.1	0.056
Tamil Nadu	1,42,735	87,506	14.1	0.147
Uttar Pradesh	57,294	49,280	5.7	0.061
Uttarakhand	3,353	2,807	0.3	0.026
West Bengal	57,115	53,033	5.7	0.081
India	**10,09,078**	**8,91,482**	**100.0**	**0.089**

Source: Primary Survey; + includes Telangana

It is estimated that the current health expenditure of the non-governmental sector is INR **10,09,078** lakh with reference period 2013-14. Insofar as the framework of the national health accounts is concerned, a further adjustment is required for user-charges[2], thereafter the amount goes down to INR 8,91,482 lakh. This constitutes around 2.1% of the total current health expenditure and just around 0.09% of the value of national output (gross domestic product at current market price) in India with reference period 2013-14.

As depicted in the following table, three major states (Andhra Pradesh, Maharashtra and Tamil Nadu) together account for 40% of the total health expenditure by NGOs in India. Individually, each of them contribute more than 10% to the health expenditure.

The next group of states that contribute a moderate share to the total health expenditure of NGOs (about 5%) are Karnataka, Uttar Pradesh and West Bengal.

The next group of states that contribute a small share to the total health expenditure of NGOs (less than 2%) are Assam, Bihar and Kerala.

All other states have less than 1% share of the health expenditure. Although Rajasthan has a large number of health-NGOs, its share in health expenditure of NGOs is moderate because most of the NGOs are tiny in size. Likewise, Uttar Pradesh, though having the maximum number of NGOs

[2] It is a usual practice that the true estimate of non-governmental sector should exclude user charges collected as direct payment from the households to avail health services. Furthermore, India's total health expenditure in the financial year 2013-14 is estimated at INR 4,53,106 crore, of which INR 4,21,194 crore is recurrent in nature (NHA, 2016).

in India, is fifth in terms of the share of health expenditure by NGOs because the NGOs with primary focus on health are few.

Though the share of state's health expenditure to own state gross domestic product is considerably low and never goes beyond 0.5%, a moderate level variation is found among states. Two major southern states (Andhra Pradesh and Tamil Nadu) along with two north-eastern states (Assam and Manipur) are found above the national average share of 0.089%. A few major states like Karnataka, West Bengal and Maharashtra are very close to the national average value in terms of health expenditure by the non-profit sector to corresponding state gross domestic product.

3.5.1 Health Expenditure by Types of Care

As per SHA guidelines (2011), healthcare functions are arranged into five broad groups and the corresponding share of each healthcare function is presented in Table 3.8.

It is observed that preventive care is the most common activity provided by NGOs in India. In most states, except Kerala and Manipur, maximum funds are directed towards preventive care. In Kerala, maximum funds are spent for curative care, with preventive care being the second highest. In Manipur, health system support services in terms of management and financing dominate other expenses.

In the non-governmental sector, curative care is found at a moderate level and constitutes the second highest expenditure in most states.

Expenses for rehabilitative care and ancillary services (like lab/image test) are not significant, except in a few cases, such as rehabilitative care in Karnataka and ancillary services in Rajasthan, Madhya Pradesh, Manipur and Uttarakhand.

Table 3.8: Distribution of health expenditure by type of care for NGOs

State	Curative care	Rehabilitative care	Ancillary services	Preventive care	Health system governance/financing
Andhra Pradesh+	12.1	0.7	1.1	80.0	6.2
Assam	19.4	5.3	4.1	69.7	1.5
Bihar	40.6	3.2	1.9	53.2	1.1
Chhattisgarh	4.3	0	2.5	84.6	8.6
Delhi	12.8	0.6	1.9	81.7	2.9
Gujarat	34.2	5.1	6.4	42.0	12.2
Haryana	7.3	4.2	1.3	85.1	2.1
Karnataka	29.9	15.7	1.6	50.6	2.2
Kerala	54.1	1.0	5.0	33.1	6.8
Madhya Pradesh	6.2	2.2	14.3	77.2	0.03
Maharashtra	25.5	5.6	9.9	43.7	15.3
Manipur	23.0	0	13.1	11.6	52.3
Orissa	0.2	0.1	4.7	87.3	7.7
Punjab	32.0	0.2	7.3	52.8	7.7
Rajasthan	2.3	0	21.6	73.2	2.9

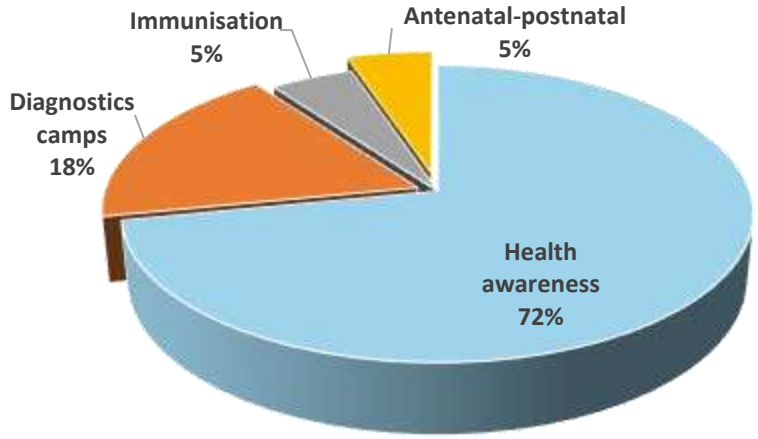
State	Curative care	Rehabilitative care	Ancillary services	Preventive care	Health system governance/financing
Tamil Nadu	35.7	1.1	1.7	57.5	4.0
Uttar Pradesh	14.0	0.3	3.9	81.4	0.4
Uttarakhand	37.0	3.2	11.6	46.4	1.8
West Bengal	17.8	1.2	2.2	41.3	37.5
India	21.2	2.5	3.9	62.5	9.9

Source: Primary Survey; + includes Telangana

3.5.2 Preventive and Curative Care Expenditure

Preventive and curative care together constitute around 84% of the health expenditure of the voluntary sector in India. Figure 3.8 presents the four preventive care activities. As expected, health awareness is found to be the highest among all outreach activities. The expenditure for diagnostic camps is 18% of the total preventive care expenditure, followed by expenses on immunization programs and antenatal-postnatal care, both of which involve 5% of total preventive care expenditure.

Figure 3.8: Observed composition of preventive care expenditure for NGOs



Source: Primary Survey

In India, the highest share of around 41% of the curative care expenditure of the NGOs is taken by outpatient care covering hospital outpatient and ambulatory clinics. This is followed by hospital inpatient care with a share of around 36%. The share of daycare is just about 5% at hospital level. However, NGOs in different states have different focus in terms of curative care expenditure.

In the two neighboring southern states of Kerala and Tamil Nadu, inpatient care at hospitals is above 60% of the curative care, while it is about 40% in the two northern states of Delhi and Haryana. The inpatient care is between 30% and 34% of the curative care health expenditure in Andhra Pradesh (including Telangana), Assam, Gujarat, Karnataka and Uttar Pradesh.

Ambulatory camps for minor surgical procedures took the highest share of about 90% of curative care in Manipur but the expenses for the same were as low as around 1% in Uttar Pradesh. Except for a few states like Manipur and Odisha, outpatient expenditure is ranging from the modest to

greatest level in curative care for NGOs. Ten out of 19 listed states are above the national average and their share of curative outpatient expenditure ranges between 53% and 83% of the curative expenditure.

Table 3.9: Observed composition of curative care expenditure across states for NGOs

	Hospital Level			Ambulatory Level	
State	Inpatient care	Daycare	Outpatient care	Outpatient clinic	Surgical camps
Andhra Pradesh+	33.3	4.6	8.2	15.2	38.7
Assam	34.0	4.5	6.3	46.8	8.4
Bihar	0.4	NA	0.1	69.6	30.0
Chhattisgarh	NA	NA	NA	58.5	41.5
Delhi	44.8	5.7	6.3	33.3	9.9
Gujarat	32.8	5.0	11.9	41.9	8.4
Haryana	41.2	5.3	6.4	27.5	19.6
Karnataka	30.6	4.2	6.9	22.4	35.9
Kerala	63.1	8.6	14.3	4.4	9.5
Madhya Pradesh	16.0	5.6	34.3	34.6	9.5
Maharashtra	20.4	2.5	2.3	60.6	14.2
Manipur	NA	NA	NA	9.9	90.1
Orissa	23.1	2.7	1.6	–	72.5
Punjab	4.3	0.6	0.7	81.9	12.5
Rajasthan	NA	NA	NA	23.8	76.2
Tamil Nadu	63.8	9.3	19.5	4.7	2.7
Uttar Pradesh	30.0	4.1	7.2	58.0	0.7
Uttarakhand	2.1	0.3	0.7	80.1	16.8
West Bengal	6.0	1.0	3.2	76.7	13.1
India	35.9	5.0	9.2	31.7	18.2

Source: Primary Survey; + includes Telangana

Financial information of hospital level care is not available for a few states like Chhattisgarh and Rajasthan, even though there are hospitals run by NGOs (e.g. Sri Sathya Sai Sanjeevani Hospital in Raipur and Shri Jinkushal Charitable Hospital in Jaipur). Hence the total curative care expenditure in these states is estimated at the level of ambulatory care only using available sample information.

Chapter 4

Conclusion

In India, the non-governmental or not-for-profit organizations involved in health care sector are spread in both rural and urban areas with a primary focus of providing curative, preventive and rehabilitative care services through their established healthcare institutions and/or community level health camps in targeted areas. They are also involved in facilitating several public health programs by other institutions including governments. A very common feature among them is that the beneficiaries of their services are often not the payers. They generate resources from institutional and individual donors to facilitate achieving key goals and deliver services to the targeted beneficiaries.

The study estimates that an overwhelming part of the revenue of NGOs in India comes from grants and donations. However, in states like Tamil Nadu, revenue from own operations (user charges) is the highest, followed by grants and donations. Grant is found to be a major source of revenue in states like Andhra Pradesh (including Telangana), Assam, Chhattisgarh, Gujarat, Karnataka, Maharashtra, Manipur, Rajasthan, Orissa, Delhi and West Bengal.

With reference to single purpose grant receipts, it is found that two-third of the total resources are allocated almost equally to the HIV/AIDS and health system management. The reproductive, maternal, newborn and child health (RMNCH) programs are observed as another important path to flow funds to the NGOs. Other program-specific grants comprise control of tuberculosis, fever such as dengue and malaria, program for disabled persons and special focus programs for tribals.

In health care activities, the study observed that a majority of non-governmental organizations are involved in preventive care activities through outreach programs. Outreach activity is found to be the main health activity for majority of the organizations functioning primarily or subsidiarily in the health sector. Around one per hundred organizations primarily or subsidiarily involved in health sector activities has hospital services, and the corresponding figure for outpatient clinic is nine. As expected, preventive care appears as the highest and/or major health expenditure of NGOs in most of the states, except for a few cases. In Kerala, it is the second highest, first being curative care. Health system support services in terms of management and/or financing is dominant in Manipur. Rehabilitative care and ancillary services like lab/image test are not very significant for the NGOs. Of course, curative care is found at a moderate level, and it constitutes the second highest level of expenditure in most of the states.

In curative care expenditure, outpatient care covering hospital outpatient and ambulatory clinic constitutes the highest followed by hospital inpatient care. However nonprofit organizations operate simultaneously in several health activities, thus preventive versus curative cares are not mutually exclusive set of their health activities. Again, health versus non-health activities are also mutually non-exclusive for the non-governmental sector but some organizations have an exclusive focus on health care activities only.

4.1 Discussions and Policy Implications

In spite of several important health activities that non-governmental organizations, their contribution to the estimated national health expenditure appears to be just about two per cent in India. Statewide, three major states - Andhra Pradesh, Maharashtra and Tamil Nadu - together account for around half of the health expenditure of NGOs in India. Indeed, there is an extensive variation across the states in total health expenditure of NGOs. A moderate level of share is found for Karnataka, Uttar Pradesh and West Bengal followed by Assam, Bihar and Kerala.

For the non-profit institutions, however, financial contributions are not as imperative as their reach to the grassroots level of society. National and international policymakers are of the view that non-governmental organizations typically function at close quarters to exposed populations for their societal upliftment and development.

The present study also observed that the NGOs in India are predominantly involved in preventive health activities like community level camps for building health awareness and disease detection programs for underprivileged groups. There are several health schemes of the government that involve non-profit sector especially for implementation at community level and to reach socially excluded citizens.

However, some critical issues are associated with the non-governmental sector in general. In India, there is a lack of well-defined regulatory framework for NGOs. Several legal provisions are available simultaneously with hardly any monitoring mechanism of the stated objectives of organizations in successive periods. There is no provision to de-register an organization if it is not functioning, and the updated information is not readily available to the competent public authorities. Further, a large number of organizations who have the reach at grassroots level, especially small and micro in size, do not have the capability to maintain and audit their financial statements on a regular basis.

National statistical authorities have also given a very limited focus to account for this sector in their estimates. Indeed, an in-depth and updated information about non-governmental organizations is required to involve them in development programs. Only then would it facilitate policymakers to take advantage of the decentralized and participatory approach of non-governmental organizations. The present study therefore seems to be the first comprehensive attempt of this kind towards health sector functioning of not-for-profit institutes at national and subnational levels in India.

4.2 Strengths and Limitations of Study

This first ever study on the role of NGOs in healthcare system is based on a primary survey of all major states including national capital territory of India. Notwithstanding the very exclusive focus on health sector operations, the study covers a whole set of non-profit organizations differentially involved in healthcare activities. Representative number of samples are drawn randomly from different strata for more precise estimation. Furthermore, large organizations with primary focus on health activities are surveyed by the census approach. A comprehensive survey questionnaire has been designed to collect information including disaggregated levels of data on revenue and expenditure by sources/purposes. Both the ‘activity based’ approach and standard ‘gross value added’ approach have been used for apprehending expenditures of the

NGOs. Likewise, a set of scheduled questions has been used to collect revenue details including disaggregated information on health grants by sources and purposes. At the end, every effort has been made to validate information on revenue and expenditure with the audited financial statements of surveyed organizations. In spite of these facts, the study has some limitations as follows:

(1) The official sample frame used is fairly old since updated population is not available in the public domain till date. While the rates and ratios of available frame population have been adjusted with the provisional results of the *Sixth Economic Census*, a more precise estimate may well be obtained by using unit level information of the Sixth Economic Census.

(2) The sample size should be increased especially at the state level. The current samples seem to be good at national level. For more precise state-specific estimates, there is a scope to consider more samples at each strata, which could not be attained by the present study because of time and resource constrains.

(3) In spite of a comprehensive attempt, the lack of responses and inaccessibility, especially for large organizations involved primarily in health sector activities in a few states like Rajasthan and Chhattisgarh, might have undermined the estimates.

(4) There is a scope to improve the survey tools, especially for respondent organizations that are unable to furnish all applicable financial information needed for gross value added. This might restrict the analysis to activity based expenditure only.

4.3 Way Forward

Availability of evidences is very crucial for policymakers to plan and execute development schemes especially involving non-governmental sector. Indeed, the policy focus on decentralized and community participatory development strategy has led the official statistical agencies to undertake initiatives for strengthening evidence base of the NGOs. Official socio-economic surveys and census have now incorporated additional information regarding the non-profit sector. Such an effort is, however, not very comprehensive and hardly captures the non-profit sector in general. Further, a lack of clarity in the definition of the non-governmental sector in several official statistics limits creating robust evidences of the NGOs.

Nevertheless, the National Sample Survey Organization may take it forward in its national level survey of the un-incorporated non-agricultural sector by drawing statewide representative samples across operational activities of NGOs. Ideal and robust evidences may well be generated for the non-profit sector through an annual survey of the services sector, which is supposed to be initiated soon by the CSO. Of course, a few additional blocks of questionnaire and representativeness of samples would be required to make reliable estimates of the nonprofit sector using the existing/proposed official surveys.

Annexure-I: Research Methodology and Estimation

The health expenditure of non-governmental sector is intended to be estimated across all major States and Union Territories through a sample survey of registered NPISHs. Some important issues related to concept, coverage and sample design are as follows:

1. In line with the national accounting framework of India, a non-governmental unit is defined as a legal entity which is (a) an organization and (b) not allowed to distribute any profit, by law or custom, to those who own or control it, and (c) institutionally separate from government, (d) self-governing and (e) noncompulsory (CSO 2012). Though an organization may operate in different sectors like education, health, recreation, religion, culture and so on in mutually non-exclusive ways, and may be classified according to the purpose it envisages for itself, like governments, corporates and households, the scope of this study is to cover those serving the households and functioning differentially in the health sector.

2. By considering the sector of operations and envisaging the serving purpose, samples are drawn from three mutually exclusive groups: the first group is primary-health NGOs, a set of organizations primarily involved in health sector activities, and they are of prime interest in this study. The second group is subsidiary-health NGOs, those operating in health sector activities on secondary basis. Rest are the third group, non-health NGOs, which may occasionally spend on health as an activity or provide health benefits to their own employees, and hence get less importance in this study. We consider only a selected part of non-health NGOs that are fairly big in size[3].

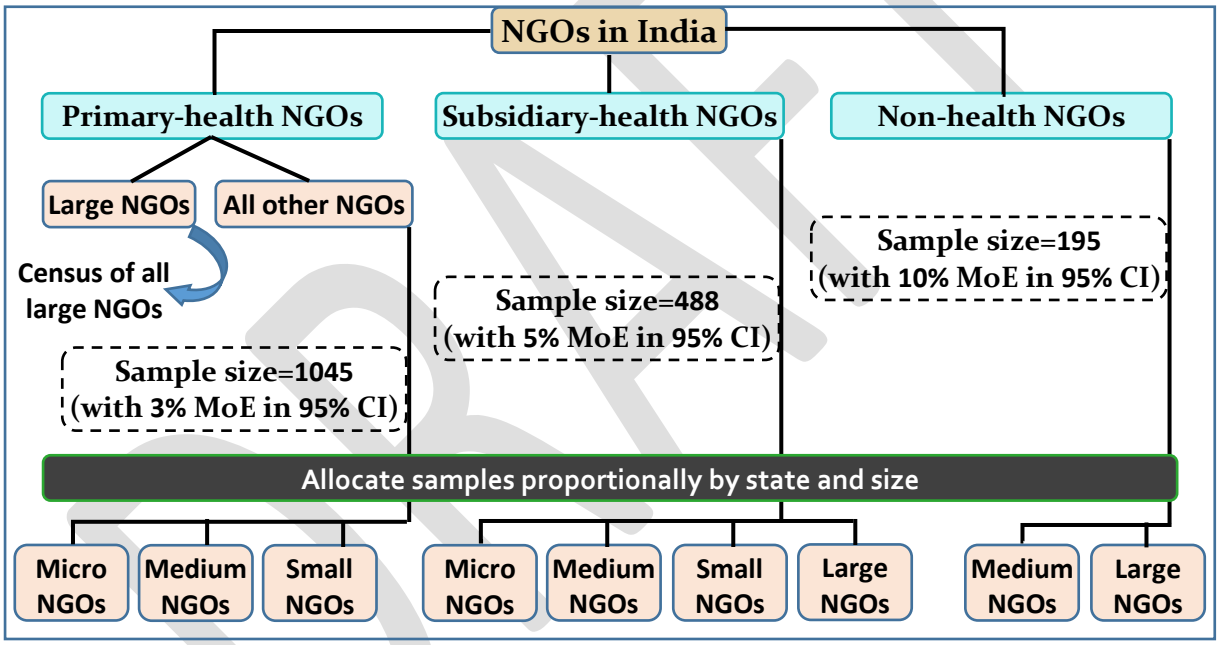
3. The survey questionnaire is especially designed to capture health expenditure of non-profit sector in terms of different roles played in health sector as provider of healthcare services, agent for mobilizing funds in health system and primary source of revenue for healthcare financing schemes. There are six broad blocks in the survey schedule comprising identification of particulars, basic information with detailed health activities, geographical coverage with employment size, receipts as non-grant and grant with details of health grants, expenditures on all possible heads of health activities, and some basic details on each of the healthcare facilities, as applicable (for more details, see survey questionnaire in Annexure-IV). The current health expenditure of an organization is estimated by covering all available expenditures on health activities excluding medical education and research part. To avoid double counting, inter-NGOs fund flows have been excluded. The identified variables of health activities are finally classified (see Annexure-V for details) in line with the guidelines of health accounting by SHA (2011).

4. For survey design, the study is not restricted to any particular official lists of NGOs because none of them are updated recently and/or relevant information for stratification is not readily available in the public domain. However, the Planning Commission list of signed up organizations in NGO Partnership System and Directory Information of major states from CSO-NAD NPI Census 2007-08 are consulted, and an approach of snowballing network is employed to trace relevant

[3] There are four types of NGOs classified on the size of employment: Micro-NGO involving only volunteers with no formal employment, Small-NGO encompassing employment size up to 20, Medium-NGO ranging employment 20-100 and Large-NGO with employment more than 100.

NGOs. As depicted in the following figure of sample design, the study follows a multi-stage stratified random sampling technique so that samples from different types of NGOs may assuredly be represented in the sample. Given the non-availability of auxiliary information for stratification except for CSO-NAD NPI Census, the same is used to allocate samples in different strata. Since the list of NGOs is fairly old in the CSO information and hence some NGOs may have stopped functioning and/or new NGOs may have appeared over the period, a state-level listing of traced NGOs with relevant stratification variables is being prepared by telephonic communications and snowballing networks, and the same is used to draw samples at different strata. Nevertheless, we relied on relevant estimates from the CSO information for stratification with the assumption that though the absolute values of different stratification variables may well be changed over time but their rates and ratios in a particular state would not have changed to a large extent.

A systematic presentation of sampling techniques for NGOs in India



5. The CSO Census of NPIs contains all required information like directory of NGOs across states/ primary and secondary areas of operation/serving institutions/size of employment, etc. As per the survey design, samples are drawn at an all-India level for each group and distributed across 19 major states as per the concentration of NGOs: Andhra Pradesh including Telangana, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Odisha, Punjab, Rajasthan, Tamil Nadu, Uttarakhand, Uttar Pradesh, West Bengal and Delhi.

6. Sample size for each group is determined separately as per the importance of the study. Since primary-health NGOs are expected to play a key role from provider of healthcare services to source of healthcare revenues, a more intensive sample plan is designed for them. The study covers all large primary-health NGOs. From the remaining primary-health NGOs comprising

micro/small/medium size, samples are drawn at 3% margin of error in 95% confidence interval and distributed proportionally at different stages of stratification (across states, and then size-based strata). A moderate level of samples are drawn (5% margin of error in 95% confidence interval) from the subsidiary-health NGOs and distributed accordingly. Since the large and medium NGOs are merely considered for non-health NGOs, samples are drawn at 10% margin of error in 95% confidence interval for them.

7. While the samples in each stratum are drawn randomly without replacement, we are ensuring at least 30 samples in each selected state and a minimum quota of two samples in each size based stratum for standard statistical analysis. Further, a particular stratum may be absent in the samples because none of the NGOs are operating in such stratum. Finally, if any non-response arises, a replacement is allowed with similar characteristics.

8. The 'blow-up strategy' from sample statistics (sample mean and ratio) is intended to use latest (sixth) Economic Census information to arrive at state and national level estimates. But, given the fact that unit-level information of sixth Economic Census is not in the public domain as of now, the CSO-NAD NPIs Census information may provisionally be used. Nevertheless, as per the sample design, the weighting patterns for aggregation as well as ratio estimate at state and national level are designed separately for respective groups of NGOs. Evidently, a multi-stage stratified random sampling is designed for surveying the NGOs. In this complex sample design, though proportional distribution is planned, aimed at statewide analysis and stratum-specific minimum quota, the sample distribution seems to be different from relative distribution of the population with respect to a variable in terms of both scale and proportion. In our stratified sampling process, suppose, the population size is N, and allocated total sample size is n among S identified strata, the objective of weighting sample data is to confine its representativeness in relation to the study population. Applying weight(s) to sample seeks the goal of making sample largely like the population. In stratified sampling therefore an integrated weight may be defined as a product of scale and proportional factors: $w_s = \frac{N}{n} \times \frac{N_s/N}{n_s/n} = \frac{N_s}{n_s}$, where the symbols have the usual meaning. As our sampling realizes hierarchical scheme (multi-stage stratification), weights are in principle computed in the same way at each stage, and the final sampling fraction would be the product of probabilities in successive stages: $f_{sh} = \frac{n}{N} \times \frac{n_s/n}{N_s/N} \times \frac{n_{sh}/n_s}{N_{sh}/N_s} = \frac{n_{sh}}{N_{sh}}$, here h is a sub-stratum under the stratum s. Inverse of this sampling fraction is usually termed as base/design weight ($w_{sh} = \frac{N_{sh}}{n_{sh}}$). Subsequently, the base weight may be adjusted by two other factors: non-response error and sampling variance reduction at the post-survey period; our sample design is self-correcting to these factors. In this formulation, the population total at state level may be estimated as: $Y_T = \sum Y_i = \sum_{i \in \boldsymbol{S_h}} \boldsymbol{w_{shi} y_{shi}}$, where the total of a population variable Y_T is estimated by the sample observations Y_i.

Annexure-II: Sample Size across States

As per the survey design, samples are drawn at an all-India level for each group respectively and then distributed across 19 major states. There are 1,699 samples all together drawn at all-India level covering 1,139 primary-health NGOs, 344 subsidiary-health NGOs and 216 non-health NGOs. Notably, as depicted in the following table, in order to attain stratum specific reasonable samples, two individual strata at lower level may be merged within the same group of NGOs. For example, large and medium size NGOs are merged together for the non-health group in Manipur.

	Primary Health NGOs				Subsidiary Health NGOs				Non-Health NGOs		Total
	Micro	Small	Medium	Large	Micro	Small	Medium	Large	Medium	Large	
Andhra Pradesh+	61	23	4	10	12	2	5		14	5	**136**
Assam	37	9	3	1	8	4	2		8	2	**74**
Bihar	3	9	8	2	3	2	8	–	7	2	**44**
Chhattisgarh	8	7	2	1	6	3	2		5	2	**36**
Delhi	2	13	20	15	3	6	6	3	5	4	**77**
Gujarat	6	61	39	3	–	–	–	3	2	4	**118**
Haryana	8	9	4	–	4		2	2	6	2	**37**
Karnataka	13	7	3	3	5		4	2	9	6	**52**
Kerala	21	16	11	4	2		3	8	2	5	**71**
Madhya Pradesh	10	21	13	1	5	6	6	–	14		**76**
Maharashtra	39	174	69	8	8		7	5	7	7	**324**
Manipur	19	15	4	–	–	–	–	–	2		**40**
Odisha	6	6	7	2	6	6	5	–	4	2	**44**
Punjab	12	28	7	1	2	4	3	–	4	2	**63**
Rajasthan	6	20		2	3	8	2	–	3	2	**46**
Tamil Nadu	18	41	39	19	3	8	3	–	4	4	**139**
Uttar Pradesh	15	25	12	1	15	54	14	4	47	2	**189**
Uttarakhand	2	10	6	3	3	5	3	–	10		**42**
West Bengal	18	6	2	6	30	8	4	4	9	3	**90**
Total	**304**	**499**	**254**	**82**	**105**	**129**	**74**	**36**	**161**	**55**	**1,699**

Note: Sampling margin of errors finally achieved in the survey at all-India level are 2.87%, 5.28% and 6.66% respectively for primary-health NGOs (excluding their census sector), subsidiary-health NGOs and selected sampling section of non-health NGOs.

Annexure-III: Expenditure Breakups

CURRENT EXPENDITURE in 2013-14 (INR Lakh)		Andhra Pradesh+	Assam	Bihar	Chhattisgarh	Delhi	Gujarat	Haryana	Karnataka	Kerala	Madhya Pradesh	Maharashtra	Manipur	Orissa	Punjab	Rajasthan	Tamil Nadu	Uttar Pradesh	Uttarakhand	West Bengal	India
Total health expenditure		139133	28087	25932	7625	4869	21913	2974	63425	17298	13921	122069	7510	9626	6627	30939	142735	57294	3353	57115	1009078
Curative Care	Hospital – Inpatient care	3087	1798	38	NA	270	2183	65	5183	5714	138	5229	NA	5.0	86	NA	32092	2405	26	606	65686
	Hospital – Day care	428	237	5.0	NA	34	331	8.3	706	779	48	646	NA	0.6	11	NA	4658	332	3.9	103	9164
	Hospital – Outpatient care	763	331	6.6	NA	38	791	10	1169	1294	297	584	NA	0.4	15	NA	9834	579	9.3	324	16788
	Ambulatory – Clinic	1407	2476	7275	193	200	2790	43	3791	402	300	15559	170	–	1640	122	2357	4652	993	7789	58007
	Ambulatory – Surgical camps	3594	446	3132	137	59	561	31	6084	864	82	3647	1554	16	250	389	1368	54	208	1327	33214
Preventive care	Health awareness	85863	12591	7319	2449	2133	4043	2366	19105	2358	6922	30605	38	4064	1637	11934	74484	35988	872	10216	453645
	Diagnostics camps	19348	5190	3809	3256	1079	1541	129	6500	2542	3171	10699	37	3271	1268	2529	5840	8797	504	8889	114150
	Immunisation	3158	956	942	177	34	1673	–	594	351	354	4513	777	3.9	402	7572	736	1769	92	3612	31000
	Antenatal-postnatal	2952	827	1732	571	731	1954	36	5882	477	305	7472	21	1066	192	606	990	71	88	878	32377
Rehabilitative care		943	1476	828	–	30	1120	125	9972	174	304	6867	–	5.0	11	–	1583	195	106	682	25001
Ancillary service		1485	1162	501	187	93	1404	38	1029	861	1996	12113	982	456	482	6688	2453	2233	389	1280	39446
Community health insurance		8145	189	67	1.5	24	906	64	2209	325	–	5894	–	–	130	202	667	7.1	–	1.0	33472
Management/ financial support		7960	409	277	653	141	2615	59	1201	1157	0.4	18239	3930	738	503	897	5674	212	61	21408	97129

PUBLIC HEALTH FOUNDATION OF INDIA

Public Health Foundation of India

Schedule WP1.02: Survey on Health Expenditure by Non-Governmental Organizations for National and State Health Accounts

CONSENT TO PARTICIPATE IN STUDY

INTERVIEWER, PLEASE READ OUT: Namaskar, my name is *please say your name here* . I have come from the MART for collecting some information on behalf of Public Health Foundation of India (PHFI) to understand your Expenditure on Health at the NGO level. This will be very useful in preparing the National/State Health Account (NHA/SHA) for India. We will be asking you questions related to some basic information and health-expenditure related issues of your organization. We would appreciate your participation in this survey. The information collected would be kept confidential and anonymity of individual organization will be maintained. The information collected would be used only at the aggregate level of all the NGOs. The survey should take a short time (about 30-45 minutes) to complete. May I begin the interview now with your consent?

Oral consent given:

Yes →	**Continue interview**	
No →	**Stop interview**	

Running sample NGO-ID:

S		L	T	Sr			

S: 2-digit state code, L: 1-digit location code, T: 1-digit code of NGO type, Sr: 4-digit serial number in sample list

A: Identification Particulars (***to be filled by official of survey agency***)								
A.1	Name of NGO (official/registered name)							
A.2	State where NGO is located	Name:			Code:			
A.3	Serial number in NGO-sample list							
A.4	Location of main/head office of NGO (use code: Rural = 1, Urban = 2)							
A.5	Type of NGO (use code: Large primary health-NGO = 1, Primary health-NGO = 2, Subsidiary health-NGO = 3, Non-health-NGO = 4)							
A.6	Starting and ending dates of interview	Starting date (DD:MM:YYYY)	DD:	MM:	YYYY:			
		Ending date (DD:MM:YYYY)	DD:	MM:	YYYY:			
A.7	Name of the interviewer							

B.1: Basic Information of NGO			
B.1.1	Address of the NGO		
	District name & Pin code		
	Phone/Mobile number		
	Email ID & Web (*if any*)		
B.1.2	Name of the key informant		
B.1.3	Designation of the key informant		
B.1.4	Registration status (use code: Yes=1, No = 2) ***Multiple options possible***	Society registration act (including its state variant)	
		Public/private trusts act	
		Religious trust/endowment act	
		Indian charitable act	
		Wakf act	
		Section 8 or 25 of company act	
		Others(specify)____	
B.1.5	Year of registration and start of functioning	Registration: | | | | Functioning: | | |	
B.1.6	Location of operation (use code: Rural=1, Urban=2, Both=3)		
B.1.7	**Primary activity** in terms of annual financial flow (**Health =1, Non-health =2**)	**<u>Code as per B.1.8</u>**:	
B.1.8	Two most important **subsidiary activities**, if any (use codes)	First important	
		Second important	
B.1.9	Primary activity in terms of time devoted annually (Health =1, Non-health =2)		
B.1.10	Details of HEALTH activity (use code: Yes=1; No=2) ***Multiple options possible***	1 Medical college (maintained by trust)	
		2 Hospital	
		3 Clinic for rehabilitative and long-term care	
		4 Clinic or dispensary for outpatient care	
		5 Clinic for ancillary services like lab and/or image tests, ambulance	
		6 Non-clinical medical support like management/financial help	
		7 Health insurance scheme for community or targeted group	
		8 Outreach for health benefits of community	
		9 Research in medical and/or public health	
		10 Others-A (specify)____	
		11 Others-B (specify)____	
B.1.11	As per the above list of **HEALTH** activities, which is main activity (use serial no. from B.1.10)		
B.1.12	Units currently functioning in India	Within the state | | | Outside the state	
B.1.13	Accounting status in 2013-14 (use code: Audited a/c = 1, Unaudited a/c = 2, No a/c available= 3)		

<u>Code for B.1.8</u> (*<u>subsidiary activity</u>*): Health = 1, Education & Research = 2, Culture & Recreation = 3, Social (non-health) Services = 4, Environmental Services = 5, Housing & Development = 6, Law/Advocacy & Politics = 7, Business/ Professional Association = 8, International Activities = 9, Philanthropic & Voluntary = 10, Religious Activity = 11, Others = 12 [specify here]____, Not applicable = 99.

If code for question B.1.10–8=2 (i.e. no outreach activity by NGO), skip block B.2 below & go to C

B.2: Details about outreach activity related to health (use code: Yes=1, No=2)		
B.2.1	Awareness campaigns, enrolment drives, etc.	
B.2.2	Health camps for surgical procedures	
B.2.3	Health camps for diagnostics and general check-up of community/targeted groups	
B.2.4	Child immunization programmes	
B.2.5	Blood Donation Camp	
B.2.6	Antenatal and/or postnatal care of women (ANC/PNC)	
B.2.7	Others-A (specify) _____	
B.2.8	Others-B (specify) _____	
B.2.9	Others-C (specify) _____	

C: Geographical Spread of NGO across India

Put State Code = 100, if information is provided for all states together (*only when can't get state wise break up*)

State Code [use respective state code from instruction manual]	Number of Employees, of which			
	Regular	Part-time	Volunteers	Total
C.1	C.2	C.3	C.4	C.5

D.1: Aggregate Receipts		
Receipts	Amount in Rs. Lakh	
	2013-14	2014-15
D.1.1	D.1.2	D.1.3
Health Grants		
Non-Health Grants		
Receipts other than grants		
3.1) Public donation and Membership fees		
3.2) Sale of assets/products		
3.3) Own resources like rent, interest, etc.		
3.4) Others (specify) _____		
Total Receipts		

D.2: Details about Receipts (Health Grants)											
Grant Serial No.	Name of the Grant	Source of Fund	Purpose (use code, multiple codes possible)				Total Value of the Grant (in Rs. Lakh)	Time period		Amount of Receipts (in Rs. Lakh)	
								Initial Year	Terminal Year	2013-14	2014-15
D.2.1	D.2.2	D.2.3	D.2.4	D.2.5	D.2.6	D.2.7	D.2.8	D.2.9	D.2.10	D.2.11	D.2.12
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
100	**Total Health Grant**										

Code for D.2.3 (Source of Fund): Central Government=1; State Government=2; Local Government=3; Foreign Funder=4; Private Organisation/Corporate=5; CSR fund=6; Other-NGOs=7; Others=8 (specify) _____

Code for D.2.4-7 (Purpose of the Fund): HIV/AIDS=1, Reproductive, Maternal and Child Health=2, Adolescents=3, Tribal health=4, Disabled=5, Malaria, dengue, etc. =6, TB control=7, Health system management/monitoring=8, Child Blindness=9; Others (specify)=10 _____

E.1: Details about Expenditure		
Expenditure Details	Amount of Expenditure **(in Rs. Lakh)**	
	2013-14	2014-15
E.1.1	E.1.2	E.1.3
1. Medical college (maintained by trust)		
2. Hospital		
3. Clinic for rehabilitative and long-term care		
4. Clinic or dispensary for outpatient care		
5. Clinic for ancillary services like lab and/or image tests, ambulance		
6. Non-clinical medical support like management/financial help		
7. Health insurance scheme for community or targeted group		
8. Awareness campaigns, enrolment drives etc.		
9. Health camps for surgical procedures		
10. Health camps for diagnostics and general check-up of community/ targeted groups		
11. Child immunization programmes		
12. Antenatal and/or postnatal care of women (ANC/PNC)		
13. Blood Donation camps		
14. Research in medical and/or public health		
15. Other Expenditure on Health (specify) _____		
16. Expenditure on NON-HEALTH activities		
Total Expenditure of NGO		

E.2: Disaggregated Expenditure on Health (in Rs. Lakh)			
Head of expenditure		2013-14	2014-15
E.2.1		E.2.2	E.2.3
Total HEALTH expenditure			
Of which	Salary of medical officers (DOCTORS)		
	Salary of paramedics/nurses		
	Salary of other health personal		
	Medicines		
	Equipment		
	Other medical consumables (specify) _____		
	Maintenance costs		
	Other medical expenses like administrative costs		
	Health awareness of community (camp, poster, loudspeaker, etc.)		
	Others (specify) _____		
Grant/aid to others organizations/NGOs for their health activity			
Health benefits for own employees of NGO			

E.3: Coverage of Health Benefit to OWN EMPLOYEES (2013-14)							
Expenditure type	Regular		Part time		Volunteers		Total Expenditure **(in Rs. Lakh)**
	Eligibility code	No. of employees	Eligibility code	No. of employees	Eligibility Code	No. of employees	
Government funded social security schemes							
Private Voluntary or Group Insurance							
Reimbursement for outpatient care to employee							
Reimbursement for inpatient care to employee							
On-site doctor on call for employee							
Preventive health care programs for employee							
Any Other (specify) _____							

Eligibility Code: Only Employee=1; Employee, spouse and dependent children =2; Employee, spouse and all other dependents=3; Any Other =4(specify) _____, Not applicable=99.

F.1 Is there any health facility run by the NGO (Yes=1, No=2) _____

Terminate the interview if F.1=2

F.2: Details about Own Health Facility of NGO						
F.2.1	F.2.2	F.2.3	F.2.4	F.2.5	F.2.6	F.2.7
Facility serial number	State (use state code)	Type of facility (use code)	Ownership of facility (use code)	Number of general beds	Number Medical Officers (Doctors)	No. of Nurses & Other Medical Staff
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Code for F.2.3 (facility type): Clinic/dispensary with paramedics/nurses (other than doctor) =1, Clinic/dispensary with general doctor=2, Clinic/dispensary with specialists=3, General hospital=4, Multi-specialty hospital=5, Single specialty hospital=6, Lab/image testing center only =7, Others = 8 (*specify*) _____

Code for F.2.4 (ownership): Sole ownership= 1, Partnership with government= 2, Partnership with other private sector= 3, Tied up with other NGOs/charitable trusts=4, Others=5 (specify here) _____
_____

F.3: Details about Patient Load in own Health Facility of NGO																
F.3.1	F.3.2	F.3.3	F.3.4	F.3.5	F.3.6	F.3.7	F.3.8	F.3.9	F.3.10	F.3.11	F.3.12	F.3.13	F.3.14	F.3.15	F.3.16	F.3.17
Facility serial number	State (use state code)	Number of OUTPATIENTS treated					Number of INPATIENTS treated					Number of Emergency				
		Last week	Last month	2013-14	2014-15	2015-till date	Last week	Last month	2013-14	2014-15	2015-till date	Last week	Last month	2013-14	2014-15	2015-till date
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																

Thanks and Terminate

Annexure-V: NHA matrices cross-works

	Healthcare Function (HC)	Healthcare Providers (HP)	Healthcare Financing Scheme (HF)	Health Financing Revenues (FS)
Medical college (*education part*)	Education & Training is considered as part of capital expenditure			
Hospital (*including hospital part of medical college*)	HC.1.1, HC.1.2, HC.1.3	HP.1.1, HP.1.3	HF. 2.2.1	FS.6.3, FS.7
Clinic for rehabilitative and long-term care (simply rehabilitative)	HC.2.3	HP 3.4	HF. 2.2.1	FS.6.3, FS.7
Clinic or dispensary for outpatient care	HC.1.3	HP.3.1	HF. 2.2.1	FS.6.3, FS.7
Clinic for ancillary services like lab/image tests, ambulance	HC.4.1, HC.4.2, HC.4.3	HP.4.1, HP.4.2	HF. 2.2.1	FS.6.3, FS.7
Non-clinical medical support like management/financial help	HC.7.2	HP.7.1	HF. 2.2.1	FS.6.3, FS.7
Health insurance scheme for community or targeted group	HC.1.1, HC.1.3, HC.7.2	HP.7.2	HF. 2.1.2	FS.6.3, FS.7
Awareness campaigns, enrolment, etc.	HC.6.1	HP.6	HF. 2.2.1	FS.6.3, FS.7
Health camps for surgical procedures	HC.1.2	HP.3.4	HF. 2.2.1	FS.6.3, FS.7
Health camps for diagnostics and general check-up	HC.6.3	HP.6	HF. 2.2.1	FS.6.3, FS.7
Child immunisation programmes	HC.6.2	HP.6	HF. 2.2.1	FS.6.3, FS.7
Blood Donation Camp	HC.4.1	HP.4.2	HF. 2.2.1	FS.6.3, FS.7
Antenatal and/or postnatal care of women	HC.6.4	HP.6	HF. 2.2.1	FS.6.3, FS.7
Research in medical and/or public health	Medical & Public Health research is part of capital expenditure			

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