

Resource allocation in decentralized health systems

Editor – As highlighted by Andrew Green and his coworkers in relation to Balochistan, Pakistan (1), budgetary mechanisms for resource allocation are often a neglected component of policies of decentralization. This is particularly true when a single sector is decentralized. Any attempt to develop a needs-based allocation mechanism may deal with this problem to some extent, and several other measures can also be taken to help the reform attain its objectives, such as increasing community participation and setting a clear agenda for decentralization. However, technical solutions alone, in the absence of wider political commitment, may not lead to change. The experience of political decentralization in Kerala state may throw some light on this aspect.

Kerala state in south-western India has among the world's best rates of life expectancy, infant mortality, and literacy, despite having one of the lowest per capita incomes (2). Recently, serious doubts have been raised about the sustainability of such high levels of developmental indices. Deterioration of the quality of care in public health services, high levels of morbidity, and the state's financial crisis appear to be signs of unsustainability in the Kerala model of development (3).

The newly constituted State Planning Board decided in 1996 to initiate a political decentralization process. This included financial devolution of 40% of the state's ninth five-year plan fund and transfer of decision-making powers to local elected bodies, which each represent an average of 20 000 population and control at least one health care facility. The transfer of responsibility for financing and planning to a politically elected administrative structure below the state level also required changes to the central and peripheral levels.

Kerala has some similarities with all four alternative allocative models suggested for Balochistan province (1). Since Kerala's decentralization is across many sectors, allocations to local bodies were only on the basis of total population and the presence of disadvantaged

communities. This is incremental in nature. However, each local body can allocate to different sectors including health, according to priorities, through a five-stage planning process that involves community representatives, bureaucrats, local-level experts, etc. At the start of the ninth five-year plan, an effort was made to identify the health needs of the local community by compiling information such as the perceived health needs of the people, local morbidity patterns, and hygiene and sanitary conditions. This information is the basis of planning for the next five years. However no formula has been developed based on the above information.

Changes in the public sector allocation to health that is expected in the ninth five-year plan compared with the eighth five-year plan are enormous: the 2.2% allocation to health is expected to increase to 5.02% (4). Moreover, increased community participation in decentralization activities is also expected to help the successful implementation of health projects. Data show that three million people participate in such activities each year.

But the reform is not without flaws, in particular due to the inability of local bodies to undertake long-term plans and difficulty in integrating local plans at the higher levels. ■

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Diethylene glycol poisoning in Gurgaon, Haryana, India, 1998

Editor – I refer to the article by Singh et al. in Vol. 79, No. 2 of the *Bulletin*, which documented the unfortunate deaths of children who were given a cough syrup contaminated with diethylene glycol (1). I should like to inform readers of the steps taken by state and national governments to avoid any other such incidents.

The events referred to occurred three years ago in one of the states in India (Haryana). After carrying out an in-depth investigation of the matter, the concerned State Drugs Control Administration filed a complaint according to the provisions of the Indian Drugs Act 1940. The issue relating to the use of toxic adulterant detected in the manufactured formulation is sub judice.

Meanwhile, the central Government reviewed the whole problem of the use of contaminants such as diethylene glycol in propylene glycol formulations. It cautioned all concerned, including government testing laboratories, to take adequate steps to control the quality of formulations containing propylene glycol. At present, samples of all such preparations are being analysed by the laboratories for detection of any toxic adulterant. ■

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1. **Singh J et al.** Diethylene glycol poisoning in Gurgaon, India, 1998. *Bulletin of the World Health Organization*, 2001, **79**: 88–95.