Management Case

describes a situation faced, a decision or action taken by an individual manager or by an organization at the strategic, functional or operational levels.

Nagar Panchayat Hospital

M S Sriram

The case discusses the issues of autonomy and accountability in the healthcare division of a local self-government. It highlights the underlying tension between the elected representatives' need to control the division and the executive's need for basic functional and financial autonomy in developing and maintaining the division as a useful and responsive facility to the public. It raises questions as to the concept of cost and responsibility centres in local self-governments and what happens when one of the responsibility centres starts generating revenue and becomes a truly profit centre. Since the basic nature of the service is more of a responsibility — do the surpluses generated by the new profit centre get ploughed back to the same facility or should it get into the general pool of the Panchayat? If the argument is that it should be ploughed back to the responsibility centre to improve the overall facilities of the division, then should the objectives of the division be redefined and what should be the most appropriate institutional mechanism to grant autonomy for a division that is doing well? How would these mechanisms work in the long run? The case tries to sensitize the discussants to the issues and tensions that emerge in a well-managed division of a local-self-government. It also raises the larger issue of autonomy and accountability in democratic institutions.

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> My hospital is certainly making surpluses every year. The number of patients registering has been on the rise —it was around 12,000 registrations in 1993 and now it is more than 25,000 per annum. We have also increased the registration fees — though it adds only very little to the kitty — and I can see that the daily collections have also significantly gone up. Now the problem is that the Panchayat is not ploughing the surpluses back into healthcare. I would like to do an analysis of my contribution to the Panchayat and at least get my division's money reinvested here.

Dr Balchandani, the Chief Medical Officer (CMO) of the Nagar Panchayat Hospital, Vallabh Vidyanagar.

The Panchayat

The residents of the township elected the members of the Panchayat. Elections were held once in five years and 21 members were elected to run the body. The members were collectively responsible for the overall civic amenities of the township. For operational convenience and flexibility, there were several sub-committees of five members each within the Panchayat to oversee the day-to-day operations of the different divisions. The Panchayat had several divisions that attended to the civic administration of the township. It collected levies and taxes and octroi and was responsible for the general upkeep of the township including maintenance of local roads, sewage systems, water supply, primary health systems, education, and registration of births and deaths in the area. The major sources of revenue for the Panchayat were from octroi (close to 60% of its revenue inflows).

For specific purposes, the Panchayat also received budgetary support from the state. For

instance, as far as the staffing was concerned, salaries of 34 approved posts out of the total 134 persons employed by the Panchayat were directly met by the state government's budgetary support. The Panchayat had to raise resources to pay the salary of the rest of the employees. Similarly, there was a proposal to abolish octroi across the state for which the government had proposed that the shortfall in revenue for the Panchayat — as a result of this action — would be made good through budgetary support.

Apart from the budgetary support, the Panchayat also had inflows from returns on investments, penalties, donations, and borrowings. The major expenses of the Panchayat were also classified under broad heads representing the functional responsibility of different divisions of the Panchayat.

The Hospital

The Nagar Panchayat Hospital was a part of the local civic administration. While the Panchayat administration was overall incharge of the hospital, for operational convenience — like several other divisions — a health committee was set up which would deal with all operational and minor policy issues. The CMO was in charge of the day-to-day operations. Though the CMO was overall in charge of the hospital, he did not have powers to make any policy decisions including decisions such as raising the fee, buying equipment or making fresh recruitment.

The objectives of the Nagar Panchayat Hospital were:

- To provide domiciliary medical support to the residents of the township, including the slum dwellers around the town.
- To provide immunization services under the maternal and child health programme.
- To undertake preventive programmes for checking outbursts of epidemics.

The hospital focused on providing quality healthcare at an affordable cost. The sources of revenue were through fees and donations. The charges were Rs 5 per registration for general consultation and Rs 15 for special consultation, both of which were valid for three months. In addition, the hospital received revenues from dispensing medicines through its pharmacy and from conducting pathological tests in its laboratory. It also had a small stream of income as fees for usage of the Ambulance and Death Service van, but these receipts hardly met the costs incurred. There was also some inflow as donations to the hospital. This normally went to the general pool of the Panchayat.

Operationally, all receipts in the hospital had to be deposited in the Panchayat each day. Any expenses to be incurred for the hospital would be released by the Panchayat office in the form of a cheque. After many negotiations, the CMO was able to convince the Panchayat that a separate bank account had to be opened so that the income streams of the hospital could be separately identified and managed. While a separate bank account was opened, it was still managed by the accounts department of the Panchayat. However, most of the receipts and payments of the hospital division were captured separately and it was possible to identify the contribution of the hospital in the accounts of the Panchayat.

While it was not necessary that all the payments pertaining to the hospital be within the limits of the receipts, the CMO, in order to avoid unnecessary criticism, always tried to ensure that the division stood on its own. There was also a concern expressed by the Panchayat members that if the hospital was not on its own, there was a possibility of the District Panchayat (Zilla Panchayat - ZP) wanting to take over the day-to-day operations of the hospital, which the Panchayat members wanted to avoid. Though the concern about some activities being "cost centres" was somewhat misplaced, the CMO found it difficult to negotiate on every new activity he wanted to take up. It was argued that the concern was misplaced because the Panchayat was in any case having surpluses in most of the years. A perusal of the past 12 years data indicated that there was a surplus in the

Panchayat in seven out of the 12 years and also on a consolidated basis.

Since this latent concern of self-sufficiency and its effect on the functional autonomy was always on the mind of the CMO, he had ensured that the revenues of the hospital went up. The hospital had been generating around less than 10 per cent of the total revenues of the Panchayat in the past. The hospital's revenues had not only grown in absolute terms, but also in terms of its share. It had significantly increased from an average of 10 per cent of the Panchayat's total revenue receipts in the first six years (1979-88 to 1992-93) to an average of 15 per cent of the total receipts of the Panchayat in the next six years (1993-94 to 1998-99).

The hospital had a total staff of nine members, including the CMO. The staff strength had remained static, even though the activities under the hospital and the number of registrations had significantly increased. Most of the staffing for the Panchayat was done centrally. Once appointed in the Panchayat, the employees were fully accountable to the elected representatives and, therefore, the staff were never transferred elsewhere. This, however, was not true with the ZPs. Therefore, the Panchayat was relatively sure of the CMO continuing with the Panchayat in the foreseeable future.

Apart from this, there was a possibility of hiring additional staff on the rolls of the Panchayat — without the support of the state government on an *ad hoc* basis — if the Panchayat members passed a resolution to this effect. The only issue in all such appointments was that the costs of such employees had to be met from the resources of the Panchayat and they could not depend on state support.

Background

In the past five years, the hospital had seen significant progress in terms of its physical infrastructure and operations. The accounting and operating systems of the Panchayat, however, remained the same. In 1992-93, the hospital was catering to a township having a population of around 50,000 that had now increased to above 70,000. It was getting a budgetary support from the Panchayat and was seen as a cost centre.[1] The hospital was making operating deficits and the challenge then was to make it a self-sustaining unit. In order to address the issues facing the Panchayat, Dr Balchandani had floated a summer project for the students of a leading business school. Two students of the school had done a detailed analysis of the finances of the hospital and had suggested three significant measures[2] to make the hospital sustainable through self-financing which are a follows:

1. Pharmacy Division

Streamline the pharmacy within the dispensary. The students found that the cream of the earnings came from the dispensing of medicines but an inventory management system was not in place. There were several fast moving medicines that would be out of stock for a long time before they were reordered. Part of the reason was that the CMO had very little time to devote to this business and the employees working in the division were in a position to take proactive stand only with some working inventory model in place. The students analysed the movement of stocks for about a week and then scanned the market for some low cost generic medicines. They then struck deals with these suppliers and put the delivery schedules and contact numbers of the suppliers in the stock register that was to be updated every day. This small measure resulted in significant improvements in the stock situation. With this, the hospital was not only able to sell medicines at prices less than the prevailing market but also make sufficient margins.

[1] Sriram, M S; Jairath, Divya and Sinha, Prashant (1995). "Nagar Panchayat Hospital (A)," *Vikalpa,* Vol 20, No 3, July-September.

[2] Jairath, Divya and Sinha, Prashant (1994). *Strategies for Mobilization of Resources for the Nagar Panchayat Hospital,* Report of the Management Traineeship Segment-I, Anand: Institute of Rural Management.

2. ***Maternity Unit***

Ensure that the occupancy rate of the 10-bed ward on the first floor was high enough. The strategy was to attract poor women to use the hospital's maternity services and along with that promote the concept of a small family. The CMO had found out by experience that the best time to get the women to willingly agree for a tubectomy operation was soon after the delivery. In view of the overall welfare aspects, it made strategic sense to keep this division up and about.

3. Equipment Purchase

The CMO wanted to purchase a Radiography unit. The students recommended that any capital equipment including Radiography unit be sought as a grant either from the Panchayat or from the state government or from a private donor. Their calculations clearly indicated that an investment of this sort would not pay back the hospital early enough because it was assumed that it would be used only for captive patients and no private doctor would be using the Panchayat's Radiography as a referral.

The hospital had implemented each of these recommendations in right earnest. The revenue from laboratory fees had more than tripled and the revenue from the sale of medicines had nearly quadrupled, from around Rs 2.90 lakh in 1993-94 to Rs 11.57 lakh in 1998-99. The operating deficit of the hospital had initially reduced significantly from 53 per cent of the revenue in 1993-94 and the division was earning a surplus in the last three years. In 1998-99, the surplus was nearly 20 per cent of its total revenue (Exhibit 1). All these figures were without considering the cash donations received by the hospital, which was pooled with die other general donations of the Panchayat. The donations received in the form of assets were never accounted in the Receipts and Payments account. All such donations directly went into the Assets Register of the Panchayat.

Growth

In the past years, the occupancy rate in the maternity ward had gone up. There was a consultant gynaecologist visiting the hospital thrice a week. The CMO hired a second consultant gynaecologist to attend the hospital on the other days so that both would be alternately available in cases of emergency. The labour room and the operating room for tubectomy were renovated. The labour room was air-conditioned and some background music was also put in place to make the atmosphere soothing. All the necessary equipment was in place and the occupancy rate of the maternity unit as well as the number of family planning operations went up significantly. Exhibit 1 gives the trend in increasing expenses incurred on family planning under a separate head. There was also a matching income from the state for having carried out these operations. The number of patient registrations was increasing and the mood of the staff in the hospital was upbeat.

In fact, as stated earlier, one significant aspect that was not visible in the Receipts and Payments accounts of the Panchayat was the amount of equipment that the hospital had built up out of the donations received in kind. In the past five years, the hospital — apart from the air-conditioned labour room — had made investments for an ENT specialist to visit the hospital regularly and had upgraded the ophthalmology division. The hospital had also set up special facilities for immunization programmes and was carrying out public awareness campaigns as a part of its agenda in the areas of population control, family welfare, and polio prevention. A new Radiography unit was also added to combat the increasing incidence of tuberculosis. In addition to the above, there were other significant additions in the form of equipment — a Sonography unit and an Electrocardiogram (ECG) were added with private donations and some donation from the local Member of Parliament. The out-patient department was being readied to get a consultant dentist as well. All these services were being offered at almost 50 per cent of the prevailing market price.

Dr Balchandani explained his strategy in cutting out the red tape of the bureaucracy and maintaining his own autonomy:

I have been discouraging cash donations — essentially because this flows into the general budget of the Panchayat and one is not sure that it will flow back to the healthcare facilities here. It is a tough job to negotiate with the Panchayat members and buy equipment because they are driven by complex considerations beyond just healthcare facilities in the town. They most often do not appreciate the utility of some equipments, not to mention the procedural hassles of getting multiple quotations or going through a tendering process and later being answerable to the audit chaps. There is also a danger of diversion of the money received as donation to the hospital. In fact, once a donation raised by me was used up to get the gutter lines repaired because the Panchayat had run out of cash. So, I have been suggesting to our donors to donate equipment, medicines, and other things in kind. I sometimes even assist them in buying these gifts for the hospital. This ensures that the donations raised by me gets back to the healthcare facilities of this township.

As it was difficult to get more staff into the hospital because the posts had to be approved and appointments had to be made through the state machinery, the CMO had found an innovative way of overcoming the problem. He would appoint specialists using his goodwill on a retainership basis and find a donor to pay them directly. The cash would never flow into the books of the Panchayat at all. While this strategy worked for getting specialists, it was not possible for the hospital to hire support staff in this manner. Also, since the working hours of the hospital did not coincide with the office hours of the Panchayat, it was not always possible to get somebody posted in the office to work in the hospital. Then, there was also a question of basic capability to work in a hospital. But, as the operations of the hospital were getting more and more scaled up, it was getting more and more difficult for the CMO to use informal means to solve his day-to-day problems. He had reached a stage where the hospital was now big enough to demand some systemic change.

Over a period of five years, the healthcare facilities in the township had significantly improved. This was one of the reasons why the Panchayat administration did not devote much attention to the hospital. It was apparent that low cost healthcare was getting lesser priority of the Panchayat. Being an educational township, the emphasis was more on other civic amenities in the town. A perusal of the finances of the Panchayat in the last five years indicated that there was a significant increase in the expenses on road maintenance, sewage, and the staff salaries of the Panchayat. In the last three years, there was also an increase in borrowings meant for improving the infrastructure of the township. The other source of increased inflow was in the form of grants which was for specific purposes and none of these was in any way related to health.

The Issue of Functional Autonomy

In the past three years, the hospital had made cumulative surpluses — after taking into account all outflows including capital outflows — of around Rs 5 lakh. The surplus made by the hospital was entering into the general pool of the Panchayat. As the Panchayat itself was running short of finances in these years, it was obvious that the non-health related activities of the Panchayat were being cross-subsidized by the hospital. This was a total reversal of the situation compared to the position about six years ago. "So my concern for further investments in health and greater financial and operational autonomy is not entirely misplaced," Dr Balchandani said.

Amidst all this, the expenses on the hospital remained somewhat static as a proportion of the total payments of the Panchayat. On the non-recurring side also, the Panchayat had made significant investments in the construction of a water tank, a community hall, and in the purchase of a water tanker and some other equipment, but none in the health sector.

In fact, one of the arguments why the Panchayat did not make these investments was that the CMO never even approached the Panchayat for the facilities. Manjulaben Machi, the President of the Panchayat and Jeetubhai Patel, the Vice-President, maintained that the CMO never approached them with any such request and, therefore, there was no reason for them to act on their own. If the CMO wanted any additional staff, the Panchayat could always consider the issue and take a view on what could be done. The basic concern was whether enough revenues could be generated on a continuous basis to maintain the additional staff. On the issue of equipment purchase also, Patel maintained that they were willing to ensure that the CMO got what he wanted, if in case the donations happened to flow into the general pool of the Panchayat. However, he maintained that since the CMO was doing a good job, they were not uncomfortable with the present arrangement. Considering that the choice of how to go about the development of the hospital was entirely left to the CMO, there had to be no reason for any complaints whatsoever.

However, Dr Balchandani had his own views on the matter. He was convinced that there was a necessity for a low-cost facility providing medicare facilities in the township and it had to be provided by the Panchayat. Firstly, this was of great importance because it was near an industrial township of Vithal Udyognagar and was host to two large slums where the poor of that area were living. Secondly, he suspected that there was a large incidence of tuberculosis and skin diseases. The skin-related problems were both because of the quality of water and the sexual habits of people. In fact, one of the concerns he had was that of a possibility of widespread prevalence of AIDS. There was no way one could attract a large number of poor to cooperate in the surveillance, prevention, and eradication programme unless they were attracted to the hospital for primary services. He was greatly successful in attracting patients to the hospital but was still dependent on some private laboratories for certain types of tests. Most of these tests were beyond the reach of poor slum dwellers and, therefore, it was of great importance that the hospital had several of these facilities so that there could be some cross-subsidization across the clientele of the Panchayat hospital. The CMO clearly felt that the health-related services were not getting their due attention in the Panchayat.

The elected members, however, maintained that they never wanted to interfere with the day-to-day functioning of the hospital and just wanted to help the doctor out. If the CMO was taking a proactive stance, they were supporting it. Over a period, the CMO had found his own ways of generating resources and sorting out his own problems and the members of the Panchayat really saw no role in the operational issues of the hospital at all. For all practical purposes, the hospital had much greater autonomy than any other division of the Panchayat. This was also a peculiar loop where the members of the Panchayat also felt that they would get very little political mileage from doing anything for the hospital because it would be essentially seen as the initiative of the CMO. So, the hospital was not seen by the administration as a thrust area.

"Now that I have made the hospital not only self-sustaining but also profitable, my next challenge is to channelize the surpluses into health-related activities in the township," Dr Balchandani said. The question before the hospital was that of autonomy. If the hospital had to provide the next level of services, it needed more staff, infrastructure, and resources. During the past five years, while the number of patients registering at the hospital had doubled as also the collections, there was not a single addition to the staff of the hospital. The CMO was the only physician and he was attending to more number of patients each day. He could not hire an assistant on the rolls of the hospital unless there were approvals from several layers above. He could not pay any incentive to his staff for working long hours, nor could he have a different wage structure. In fact, the CMO himself was getting an abysmally low salary which he cross-subsidized by being a consultant doctor on retainership with several public institutions in the town as well as in the nearby town of Anand.

While he was able to pull along with several informal arrangements, it was not possible to use this strategy any longer. He had promises of getting more diagnostic equipment and he needed technical people to operate them. The waiting time in the hospital was going up and patients were getting restive. The hospital had responded to this issue by putting up a television that kept the waiting patients entertained. But, still, the waiting time was constantly increasing. The patients were happy that other facilities were being provided locally at an affordable cost, but the basic consultation for usual coughs and colds was becoming difficult. There was a desperate need for somebody to share the burden with the CMC.

The whole operation depended solely on Dr Balchandani and he had to get some system reliability into the picture. The entire structure was too dependent on the goodwill and goodness of the CMO. He had constantly hesitated to ask for one more physician to share his load because he was unsure of the quality and commitment of the person who would come in.

The Panchayat was also not very keen to suggest an additional person to help the CMO out. Patel said that he was not sure that the new doctor will sustain the reputation built by the CMO and the move to get somebody else would be seen as politically motivated and would cost them dear, unless the person was brought by the CMO himself. But, as the activities kept expanding, the CMO had reached a stage where it was physically impossible for him to attend to all the patients and also look after the administration and building up of the hospital.

Alternative Models of Autonomy

One of the possibilities that the CMO was toying with was to get some form of autonomy to the hospital so that some decisions at least could be de-centralized and financial transactions be separated from the Panchayat. He was unsure if the members of the Panchayat would agree to any such proposal of autonomy.

The second possibility was to get autonomy by physically severing the hospital from the main budget of the Panchayat and handing over the day-to-day management of the hospital to a separate legal entity — possibly a trust — where some of the members of the Panchayat could be trustees. The trust, in turn, could get discretionary grants from the Panchayat on an annual basis. He was also not aware of any precedence in the country where the management of a division of the Panchayat was being handed over to a separate entity. If this happened, then it would be clear that all the actions including hiring of staff, incentive systems, and payments would be more professional. It would help the Panchayat members also — in the sense that they would not be seen as interfering with the internal affairs of the hospital. This was because the functional management of the hospital was not in their hands in any case.

Patel, of course, scoffed at the idea of financial autonomy. His argument was that the hospital already had sufficient autonomy and there was no need to insulate it from the Panchayat. He further argued that if the issue was that surpluses of the hospital were not being channelized into healthcare, it was essentially because the CMO was more proactive in getting more resources from outside rather than make a demand on the Panchayat. If the issue was pertaining to hiring of staff and providing incentives, then the Panchayat was willing to look into it. In fact, due to the possible abolition of octroi, there was likely to be a surplus of staff some of whom could be redeployed into the hospital. The third and the most significant issue was that of interference by the elected representatives and using the good performance of the hospital to score a political point. Here also he was of the firm opinion that no political party could politicize the hospital as an electoral issue because any perception of interference in the functioning of the hospital would make big news and would work to the detriment of the persons involved. To that extent, Patel conceded that the CMO was politically insulated due to his popularity with the public.

This was an argument that the CMO was willing to buy at this point in time. But his question was whether it was sustainable. What

would happen if Dr Balchandani disappeared from the scene? The entire system was built around the personal charisma of the doctor. The hospital should be able to stand on its own even if there were reasonably good quality doctors and other personnel who possibly did not command the type of reputation that Dr Balchandani commanded. Now that the hospital was becoming the star division of the Panchayat, there were bound to be predatory tendencies. With the abolotion of octroi, the risk of political interference in the hospital — then the largest revenue earner — would be very high.

The CMO knew that the 74th Constitutional Amendment had given much more teeth to local bodies such as Nagarpalikas and Nagar Panchayats, but was unaware if it permitted the Panchayat to transfer some of its assets and resources to a private body to operate autonomously. There was neither an enabling nor a disabling clause regarding this in the Act. Added to this was also the concern about the staff — would he be getting staff from the Panchayat on a deputation or would he then have his own staff? What would be the best way to ensure that the hospital worked as a professional body with adequate functional and financial autonomy, while being accountable to the duly elected body?

There was also this apprehension as to what would happen if the hospital made deficits, and whether it would then come from the Panchayat? Then, how would the administration agree to an arrangement where the Panchayat would only bear the costs and not the benefits? Similarly, if the autonomous trust did build up assets based on the income flows, to whom would these belong in case the arrangement fell through and had to be terminated? But, before thinking of any of the above, the CMO had to worry how to convince the Panchayat members that autonomy was, in fact, necessary.

Though it was easy for the CMO to still achieve his agenda of getting across low-cost medicare to the poor in the township by resigning from the Panchayat and floating an independent trust and attracting donations on the basis of personal goodwill, Dr Balchandani realized that by doing so, he was not promoting system sustainability. He also sometimes wondered if diversion of resources generated by the hospital to other divisions was at all a problem if he could continue to generate resources at the same rate of growth and make the hospital a conscious profit centre.

The CMO at one time also wondered if his approach in the past was the correct approach. Should he have taken the political leadership along in his dreams? Even now, should he look at the political leadership as allies rather than as predators? How could he take them along — while he knew that, as a medical doctor, he could afford to remain focused on the health-related work of the Panchayat, the political leadership had complex considerations of satisfying their multifarious constituencies?

Upon the suggestion of some well-wishers and professionals, the CMO did raise the issue informally with some Panchayat members including Patel and Manjulaben. He found that the response to the idea of functional and financial autonomy was lukewarm. While the Panchayat administration did not want to interfere in the day-to-day affairs of the hospital, because of the goodwill the CMO enjoyed in the area, they certainly did not like the idea of losing out the most efficient department of the Panchayat from their control. The CMO, in the meantime, was grappling with the dichotomy of accountability and autonomy.

Exhibit 1: Nagar Panchayat, Vallabh Vidyanagar — Classified Receipts and Payments Account

	1987-88	*1988-89*	*1989-90*	*1990-91*	*1991-92*	*1992-93*	*1993-94*	*1994-95*	*1995-96*	*1996-97*	*1997-98*	*1998-99*
RECEIPTS												
Dispensary Accounts												
Fees: OPD and Medicines	102467	155915	162099	169697	173260	184797	292512	419685	614428	922870	1069177	1156952
Ambulance and Death Service Fees	4289	1152	2985	8845	12524	16035	20890	30777	29783	37118	45826	60764
Laboratory Fees	10948	15346	21151	17797	25463	43776	47822	62491	88603	103902	125430	164935
Total Receipts(Dispensary)	117704	172413	186235	196339	211247	244608	361224	512953	732814	1063890	1240433	1382651
Drainage Division(Gutter)												
Drainage (Gutter) Tax	233700	358320	438775	557350	474800	771482	613052	574988	699073	436950	767909	714679
Gutter Constr and Connection Fees	56213	36927	18851	25454	18654	28305	13901	8254	35238	2025	18723	15807
Sanitary Cess and Other Receipts	27082	32132	46489	52192	45227	157389	112146	119663	109915	89148	148155	1563053
Total Receipts(Drainage)	316995	427379	504115	634996	538681	957176	739099	702905	844226	528123	934787	2293539
Receipts from Tax and Levies												
Octroi	68198	507727	484906	539666	456375	627511	973489	1402228	1833940	2594805	3255265	3697597
House Tax	590299	445386	721705	724170	1117237	850475	920985	883681	937323	1028606	1809965	1833733
Registration Fee and Penalty	950	2025	1200	2025	230	11100	51720	78784	95783	304581	406333	304429
Profession Tax	270	275	395	420	3710	1870	6115	7045	9720	14554	2475	1820
Total Receipts(Tax and Levies)	659717	955413	1208206	1266281	1577552	1490956	1952309	2371738	2876766	3942546	5474038	5837579
Receipts from Other Divisions												
Street Light Tax	94165	52780	88685	140200	77715	93520	209630	121828	146607	86500	138566	126217
Road Repair Charges	0	1501	2000	2486	800	900	1200	600	550	50300	116863	900
Miscellaneous Income	15153	17388	27887	40878	61772	21208	53949	28229	81012	140140	42879	121283
Other Fees	19259	9463	14704	17975	35670	36262	59800	52929	60453	72473	165872	178437
Total Receipts(Other	128577	81132	133276	201539	175958	151890	324579	203586	288622	349413	464180	426837
Receipts from Investments												
Interest on FDs and Dividends	5708	27156	84689	33990	55188	8989	44930	39874	45616	86757	50355	66282
District Scheme Interest	17650	7389	10586	11862	39841	17037						
Total Receipts(Investments)	5708	44806	92078	44576	67050	8989	44930	39874	85457	86757	67392	66282
Revenue Receipts	1228700	1681142	2123909	2343730	2570487	2853619	3422141	3831056	4827885	5970729	8180830	10006888
Non-revenue Receipts												
Loans	0	100000	100000	150000	0	150000	0	872500	622500	3570000		
Deposits	41500	37550	39680	56000	1500	19920	92125	84439	105769	456605	95159	53676
Donations and Grants	407101	851955	461592	814484	1479843	854850	234199	108734	737706	1102656	1562601	3472376
Refunds/Sale of Assets	12800	3450	21000	13000	23700	107622	33000	31147	135600	302643		
Non-revenue Receipts	461401	992955	622272	1033483.6	1505043	1132392	359324	224320	843475	2431761	2415860	7398695
Total Receipts	1690101	2674097	2746181	3377214	4075530	3986011	3781465	4055376	5671360	8402490	10596690	17405583

Exhibit 1 continued

Exhibit 1 Cpmtd.

	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99
PAYMENTS												
Dispensary Accounts												
Hospital Staff Salary	102050	107597	126789	134645	155446	167995	187881	196162	236862	254048	335348	349863
Purchase of Medicines	58590	80651	112794	133703	145189	192175	270988	281767	445840	545250	549768	568831
Family Planning and Other Expenses	45180	38177	22430	29927	19434	42434	71941	68731	85438	120024	218943	124621
Expenses on Vehicles	10670	65893	11420	77767	20629	17812	23348	27100	24279	24676	29846	69091
Total Payments(Dispensary)	**216491**	**292318**	**273433**	**376042**	**340698**	**420416**	**554158**	**573760**	**792419**	**943998**	**1133905**	**1112406**
Drainage Division(Gutter)												
Staff Salary	251318	208001	305231	335971	399048	435846	490889	539759	796738	1079903	1324840	1577349
Electricity Expenses	169521	286112	303062	277462	342774	424533	466118	783172	907720	726004	1054871	931167
Expenses on Gutter Scheme	164184	157311	270096	170202	710814	471118	190735	178743	198405	882398	530860	1718556
Total Payments(Drainage)	**585023**	**651424**	**878389**	**783635**	**1452636**	**1331497**	**1147743**	**1501674**	**1902863**	**2688305**	**2910571**	**4227072**
Road Maintenance Division												
Road Construction	182972	472450	1020767	337235	1830650	1595204	357455	164088	256133	1758790	2838350	2019590
Electricity, Repairs, and Maintenance	165234	224621	202778	218365	289499	309828	500316	452983	505828	566994	663092	595522
Staff Salary and Sundry Expenses	8264	0	90975	82836	14065	16441	18245	20053	27429	45769	43203	57590
Total Payments (Roads)	**356470**	**697071**	**1314519**	**638436**	**2134214**	**1921473**	**876016**	**637124**	**789390**	**2371553**	**3544645**	**2672702**
Panchayat Office												
Staff Salaries	48485	114070	155255	161866	247572	241861	275883	319120	538073	1231538	1185611	1426539
Bonus and Other Allowances	23568	27125	24525	42262	40216	58345	67693	72758	84442	204612	171847	636174
Other Expenses	63016	156659	346999	91313	78450	94755	97105	136231	159070	300981	828281	842294
Electricity Expenses	8374	7571	0	7342	9483	9161	19280	12967	21220	22661	50785	30009
Tractor and Water Tanker Expenses	24296	25074	151156	24978	41019	52187	34848	38106	47857	59472	130574	317873
Payments for Petrol and Oil	6077	10303	2384	8366	8850	9829	75642	1000	5985	92201	118407	104876
Election Expenses										34924	201543	34204
Total Payments — Office	**173815**	**340802**	**680318**	**336127**	**425590**	**466138**	**570450**	**615106**	**1058190**	**1945669**	**2485505**	**3357765**
Revenue Payments	**1331799**	**1981615**	**3146659**	**2134240**	**4353138**	**4139524**	**3148367**	**3327664**	**4542862**	**7949525**	**10074626**	**11369945**
Non-revenue Payments												
Loan Repayments	16000	71050	157639	24000	18000	173476	105410	249340	2179414			
Asset Purchase	500	171111	10000	3144	256848	16600	33330	137080	975968	256769	427934	
Other Repayments	42500	39600	12600	43300	18600	89319	45000	9108	70201	146915	136450	293589
District Development Fund and Grants	0	5718	0	3000	59980	0	128690	221788	243200	50770		
Non-revenue Payments	**58500**	**45818**	**254761**	**213939**	**105724**	**364167**	**363766**	**369636**	**450481**	**1173653**	**642559**	**2900937**
Total Payments	**1390299**	**2027433**	**3401421**	**2348179**	**4458862**	**4503691**	**3512133**	**3697300**	**4993343**	**9123178**	**10717185**	**14270882**