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Health Sector Governance and Reforms in India

Abstract

The background of India's health policies, since independence, shows a systematic documentation that envisaged ambitious health governance comprising of the delivery of a public health program by the central government and primary, as well as secondary health care by the state governments. It is therefore surprising to find that none of the ambitions has been realized. The delivery of public health programme today is limited and uncoordinated, whilst primary and especially secondary care is of a poor quality and unaffordable to the bulk of the population. The health care sector has required much more intervention. Recent reforms have made some progress in addressing some of the lacunae but are still handicapped by the pervasive dominance of the private sector which severely limits the choice of policy tools available to the government. An attempt is made to assess India's health policy reforms and argue that the policy instruments used were inconsistent with the goals it was trying to achieve.

Introduction

Health and healthcare need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Clearly, health is not the mere absence of disease; but good health confers freedom from illness on a person or group of people – and the inherent ability to realize their potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well-being. The health of populations is a major or key issue in public policy discourse, distinct in every mature society, often determining its ultimate deployment. This includes a cultural understanding of ill health and well-being, the extent of socio-economic disparities, reach of

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health services, overall quality and costs of care and current bio-medical understanding about health and illness.

Health care covers not only medical care but also all aspects of pro preventive care too. It cannot be limited to care only rendered by or financed out of public expenditure- within the government sector but must also include incentives and disincentives for self-care by the citizens and care paid to the private sectors to get over ill health. In India, currently, private out-of-pocket expenditure dominates the cost of financing health care, and so, the effects are bound to be regressive. Healthcare at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible hand of the market. Nor can it be established on considerations of utility, maximizing conduct alone.

To contextualize the above governance of healthcare thus requires special attention and critical assessment through which a larger goal can be achieved. Governance is increasingly seen as the foundation for good practice, successful organizations and ethical behavior at any given point of time. The essential prerequisite of governance is that the responsibility is first defined within an organization, and then, that the responsible persons defines the outcomes that are required, measures them, reports them and then judges them accordingly.

Governance in healthcare occurs at many levels and with numerous professional organizations monitoring as well as changing the practice and behavior of healthcare professionals. Hospitals and health care delivery organizations are subject to inspections. One may raise a question of whether governance and management are one and the same for healthcare purposes. The answer is a critical one to address, and therefore, a multi-dimensional approach would probably help us to understand governance more.

Governance and management are definitely not one and the same. Management is a goal oriented activity inside any organization. Governance on the other hand is made from outside. Governance is abstract in character, an architecture resulting from and dealing with multiple organizations. It can be simplified by Information Communication Technology application.

The Alma Ata Declaration in 1978 gave an insight into the understanding of primary health care. It viewed health as an integral part of the socio-economic development of a country. It provided the most holistic understanding of health and the framework that States needed to pursue, to achieve the goals of development. The Declaration recommended that primary health care should include at least: education concerning prevailing health problems and methods

of identifying, preventing and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health and provision of essential drugs. It emphasized the need for strong first-level care with strong secondary- and tertiary-level care linked to it. It called for an integration of preventive, promotional, curative and rehabilitative health services that had to be made accessible and available to all people, and this was to be guided by the principles of universality, comprehensiveness and equity.

In one sense, primary health care reasserted the role and responsibilities of the State, and recognized that health is influenced by a multitude of factors and not just the health services. It also recognized the need for a multi-sectoral approach to health and clearly stated that primary health care had to be linked to other sectors. At the same time, the Declaration emphasized a complete and organized community participation, and ultimate self-reliance of individuals, families and communities assuming more responsibility for their own health, facilitated by support from groups such as the local government, agencies, local leaders, voluntary groups, youth and women's groups, consumer groups, other non-governmental organizations, etc. The Declaration affirmed the need for a balanced distribution of available resources (WHO 1978).

Keeping this well delineated definition in mind, we can now discuss whether this holistic concept has been utilized as a framework by our policy-makers to develop various health policy documents, health committee reports and the five-year plans since Independence so as to have a proper impact on the health system. After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. As with most post-colonial nations, India too attempted to restructure its patterns of investment. During that time, India's leaders envisaged a national health system in which the State would play a leading role in determining priorities and financing, and providing services to the population. 'If it was possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about' (Bhore Committee Report 1946).

The emphasis of the first health report, i.e. the Health Planning and Development Committee's Report, 1946 (popularly known as the Committee Report) was more explicit on the role of the State. It was a plan equivalent to

Britain's National Health Service. Report was based on a countrywide survey in British India. It was the first organized set of health care data for India. The poor health status was attributed to the prevalence of insanitary conditions; malnutrition as well as under nutrition leading to high infant and maternal mortality rates; inadequacy of the existing medical and preventive health organizations; lack of general and health education; unemployment and poverty, all of which produced adverse effects on health and resulted in inadequate nutrition; improper housing and lack of medical care. Inter-sectoral linkages were well discussed with nutrition, housing and employment as essential precursors for healthy living. It considered that the health program in India should be developed on a foundation of preventive health work and then continue to proceed in the closest association with the administration of medical relief. The Committee strongly recommended a health services system based on the needs of people, the majority of whom were deprived and poor. It felt the need for developing a strong basic health services structure at the primary level with referral linkages. It also recommended the need to invest in the pharmaceutical sector to develop indigenous capabilities and reduce excessive reliance on multinational companies.

India was therefore one of the few developing countries which adopted a health policy that integrated the principles of universality and equity. Community participation and cooperative efforts to promote preventive and curative health work was important to achieve a vibrant health system. The Committee felt that large sections of the people were living below the normal subsistence level and they could not afford to pay for or contribute to the health services. It was decided that medical benefits would have to be supplied free to all at the point of delivery and those who could afford to pay should channel contributions through the mechanism of taxation. Though the report stated that '...it will be for the governments of the future to decide ultimately whether medical service should remain free to all classes of the people or whether an insurance scheme would be more in accordance with the economic, social and political requirements of the country at the time (Bhore Committee Report 1946), one point was apparent-that no individual should fail to secure adequate medical care, curative as well as preventive, just because of the inability to pay for it. They recommended that State Governments should spend a minimum of 15 per cent of their revenues on health activities.'

The National Planning Committee (NPC) set up by the Indian National Congress in 1938 under the chairmanship of Colonel S. Sokhey stated that the maintenance of the health of the people was the responsibility of the State, and the integration of preventive and curative functions in a single state agency was

emphasized. The Sokhey Committee Report was not as detailed as the Bhore Committee Report but endorsed the recommendations of the Bhore Committee Report and commented that it was 'of the utmost significance.'¹

The objectives of the First (1951-56) and Second Five-Year (1956-61) Plans were to develop the basic infrastructure and manpower, as visualized by the Bhore Committee. Though health was seen as fundamental to national progress, less than 5 per cent of the total revenue was invested in health. The following priorities formed the basis of the First Five-Year Plan: provision of water supply and sanitation; control of malaria; preventive health care of the rural population through health units and mobile units; health services for mothers and children; education, training and health education; self-sufficiency in drugs and equipment; family planning and population control. Starting from this first plan, vertical programmes started, which became the centre of focus. The Malaria Control Program, which was made one of the principal programmes, apart from other programmes for the control of TB, filariasis, leprosy and venereal diseases, was launched. Health personnel were to take part in vertical programmes. However, the first plan itself failed to create an integrated system by introducing this verticality.

The concern of the Health Survey and Planning Committee (Mudaliar Committee 1962) was limited to the development of the health services infrastructure and the health care at the primary level. It felt the growth of infrastructure needed radical transformation and further investment. Another major shift came in the Third Five Year Plan (1961-66) when family planning received priority for the first time. The increase in the population became a major worry and was seen as a hurdle to the development process. Although the broad objective was to bring about progressive improvement in the health of the people by ensuring a certain minimum level of physical wellbeing and to create conditions favorable for greater efficiency, there was a shift in focus from preventive health services to family planning. During the Fourth Plan (1969-74), efforts were made to provide an effective base for health services in rural areas by strengthening the PHCs. The vertical campaigns against communicable diseases were further intensified.

During the Fifth Plan (1974-79), policy-makers suddenly realized that health had to be addressed with equal importance as the other development programmes. The Minimum Needs Program (MNP) promised to address all this but became an instrument through which only health infrastructure in the rural areas was to be expanded and further strengthened. It called for integration of peripheral staff of vertical programmes but the population control program got further

impetus during the Emergency (1975-77) and most of the basic health workers got sucked into the family planning program. Meanwhile the Chaddha Committee Report (1963), the Kartar Singh Committee Report on Multipurpose Workers (1974) and the Srivastava Committee Report on Medical Education and Support Manpower (1975) remained focused on giving recommendations on how the health cadres at the primary level should be distributed. With the widespread disillusionment with vertical programmes worldwide and the need to provide universal health services came the Primary Health Care Declaration at Alma Ata in 1978, which India was a signatory to. The Sixth Plan (1980-84) was influenced by two policy documents: the Alma Ata Declaration and the ICMR/ICSSR report on 'Health for All by 2000'. The ICMR/ICSSR Report (1980) was in fact a move towards articulating a national health policy that was thought of as an important step to realize the Alma Ata Declaration. It was realized that a redefinition and re-articulation was necessary to get back onto track, an integrated and comprehensive health system that policy-makers had so far wavered from. It reiterated the need to integrate the development of the health system with the overall plans of socio-economic and political change.

It recommended that the Government formulate a comprehensive national health policy dealing with all dimensions e.g., environmental, nutritional, educational, socio-economic, preventive and curative. The National Health Policy (1983) attempted to incorporate all these. Provision of universal, comprehensive primary health services was its goal. A large number of private and voluntary organizations who were active across the country in the health field were to support the Government in its efforts to integrate health services. Evolving a decentralized system of health care and a nationwide chain of epidemiological stations were some of the main recommendations.

Once again, a selective approach to health care became the focus when a strong lobby, questioning the financial repercussions of the primary health care approach came up. Verticality was reintroduced as an 'interim' arrangement and interventions of immunization, oral rehydration, breastfeeding and anti-malarial drugs were suggested². This was seen as a technical solution even before comprehensive primary health care could be realized. UNICEF too came out with its report on the state of the world's children's health and suggested immunization as the spearhead in the selective GOBI-FF (growth monitoring, oral rehydration, breastfeeding, immunization, food supplements for pregnant women and children, and family planning) approach (Rifkin and Gill 1986).

Program-driven health policies were once again the central focus. Hence, the plan documents emphasized on restructuring and developing the health infrastructure, especially at the primary level. The Seventh Plan (1985-90)

restated that the rural health program and the three-tier health services system need to be strengthened and that the government had to make up for the deficiencies in personnel, equipment and facilities. The Eighth Plan (1992-97) distinctly encouraged private initiatives, private hospitals, clinics and suitable returns from tax incentives. With the beginning of structural adjustment programmes and cuts in social sectors, excessive importance was given for vertical programmes such as those for the control of AIDS, tuberculosis, polio and malaria funded by multilateral agencies attached with specific objectives and conditions. Both the Ninth (1997-2002) and the Tenth Five-Year Plans (2002-2007) start with a dismal picture of the health services infrastructure and go on to say that it is important to invest more on building good primary-level care and referral services. Both the plans highlight the importance of the role of decentralization but do not state how this will be achieved.

The National Health Policy (2002) includes all that is wanted from a progressive document and yet it glosses over the objective of NHP 1983 to protect and provide primary health care to all. The Policy document suggests that the integration of vertical programmes, strengthening infrastructure, providing universal health services, decentralization of the health care delivery system through Panchayati Raj Institutions (PRIs) and other autonomous institutions, and regulation of private health care but fails to indicate how it achieves the goals. It encourages the private sector in the first referral and tertiary health services. However, to understand the health right within the framework of standard setting one has to know the delivery of health services in the public sector.

Delivery of Health Services in the Public Sector

Health Systems; an end in themselves or a means to achieving certain ends? Worldwide, there seems to be a consensus on measuring health systems in terms of improving the health status, enhancing patient satisfaction and providing financial risk protection. 'In 2000, the World Health Organization (WHO) further expanded the definition of health. It includes a reduction in disparities for improving health status and sharing the financial burden in accordance with the ability to pay as being a fair form of health financing'³. There is, however, notwithstanding the evolved standards, little consensus on what constitutes an ideal health system in universally acceptable terminology to enable better inter country comparisons. This is because, unlike any other sector, health systems are highly contextualized and influenced by various exogenous factors such as societal values, epidemiology and disease burden, availability of financial resources, technical capacity, individual preferences and the nature of demand.

Technological innovation in the health sector has improved the quality of life but has also increased costs. In countries that have no social insurance and where the role of the state is limited, people spend a substantial proportion of their incomes on seeking medical treatment, and in the process, get impoverished, thus widening disparities in the health status. To contain spiraling prices and distortions created by market failures such as moral hazard, asymmetry in information, induced demand etc., countries resort to multiple policy instruments. Health systems have five aspects or knobs that interact with each other and influence its basic nature and direction: (i) financial (tax, user fees, out-of-pocket expenditure, insurance), (ii) payment systems (how providers are paid: salary, per service rendered, capitation), (iii) organizational (manner in which the delivery systems are organized/structured), (iv) legal (regulatory frameworks) and (v) social (access to health information, advertising).⁴ The effectiveness with which these instruments of state policy are designed and used determines the extent to which the health system is equitable, appropriate or fair. The health system in India consists of a public sector, a private sector and an informal network of providers of care operating within an unregulated environment, with no controls on what services can be provided by whom, in what manner, and at what cost, and no standardized protocols to help for measuring the quality of care. There are wide disparities in access, further worsened by the poor functioning of the public health system.

Evolution of the Health System in India: An Overview

The evolution of India's health system can be categorized into three distinct phases:

- Phase I (1947-83)-when the health policy was based on two principles: (i) that none should be denied care for want of ability to pay, and (ii) that it was the state's responsibility to provide health care to the people.
- Phase II (1983-2000)-when the first National Health Policy of 1983 articulated the need to encourage private initiative in health care service delivery, while at the same time expanding access to publicly funded comprehensive primary health care.
- Phase III (post-2000)-which is witnessing a further shift that has the potential to profoundly affect the health sector in three important ways: (i) utilization of the private sector resources for addressing public health goals; (ii) liberalization of the insurance sector to provide new avenues for health financing; and (iii) redefining the role of the state from being only a provider to a financier of health services as well.

Phase I (1947-83)

At the time of Independence, malaria affected almost a quarter of India's population; virulent diseases such as smallpox, plague and cholera were rampant, maternal mortality was over 2000 per 100,000 live-births and longevity of life was less than 32 years (Bhore 1946). While the public sector consisted of a few city hospitals, the private sector consisted largely of individual practitioners of Indian systems of medicine and licentiates practicing in villages, as family doctors. With meager resources, this period saw the effective containment of malaria, bringing down the incidence from an estimated 750 lakh to less than 20 lakh, eradication of smallpox and plague, halving of the maternal mortality rate (MMR), reduction of the infant mortality rate (IMR) from 160 per 1000 live-births to about 105, containing epidemics of cholera and increasing longevity of life to almost 54 years. Institutes of excellence such as the All India Institute of Medical Sciences (AIIMS) were set up for research and quality training, making India an exporter of highly trained medical doctors. These gains were in no small measure due to the strong foundation of public health on which the health system was grounded and the highly professionalized cadre of public health specialists who provided leadership from the front, camping in villages in hostile environmental conditions, whether to eradicate smallpox or supervise the malaria worker.

However, under the overarching influence of modernization that characterized the post-colonial phase of global development, the urge to be on par with the western norms of modern medicine proved to be too strong to resist. India, unlike China, missed the opportunity to launch public health campaigns to promote, at the community and individual household levels, healthy lifestyles alongside the expanding public investment to assure universal access to water, sanitation, nutrition and education. Instead, and more particularly during the 1960s and 1970s, public health campaigns were focused only on promotion of the small family norm and family planning. India also failed to utilize the strengths of the traditionally used and accepted modes of medical treatment and gave undue emphasis to allopathy, gradually laying the foundation for an expanded market of the western style of curative services, which are urban based as well as expensive.

Phase II (1983-2000): The National Health Policy of 1983

Despite the remarkable achievements in disease control, the failure to control the population, the lack of access to basic health facilities in rural areas, and the international commitment to focus on providing comprehensive primary care as envisioned by the Alma Ata Declaration in 1978, led to the formulation of

the National Health Policy of 1983. Limited resources to meet the growing demand of health services led to the mobilisation of the private sector to shoulder some part of the burden. An estimated Rs 6500 crores worth of subsidy in terms of exemptions in customs duty for import of equipment, subsidized inputs such as land, etc. were extended to stimulate private investment in health.

Alongside, the focus of state policy shifted to primary health care to reduce the iniquitous urban-rural divide and expand access to the rural populations, particularly the poor. Lack of resources resulted in segmenting health into independent silos of disease control programs rather than visualizing health care as a continuum of service. Such segmentation led to simplistic formulations of the role of state being confined to primary health care and a selected list of diseases and health interventions, rather than being responsible for the well-being and health of the people. This phase witnessed an expansion of health facilities for providing primary health care in rural areas and the implementation of national health programs (NHPs) for disease control under vertically designed and centrally monitored structures.

The adoption of this twin strategy had its advantages. With less than Rs 200 per capita investment (2000), prioritization of interventions that benefit the poor and entail wide externalities, provided a moral and technical justification. Besides the establishment of health facilities in accordance with a population norm, guinea worm was eradicated and the disease load due to infectious diseases reduced and deaths averted. During the 1990s, with assistance from the World Bank, NHPs were up scaled with impressive outcomes: the cure rate of tuberculosis (TB) under the Directly Observed Treatment, the (DOTS) program doubled and averted an estimated 50 lakh deaths, leprosy was eliminated except in 70 districts, the incidence of cataract as a cause of blindness reduced from 80 per cent to less than 50 per cent and the number of polio cases decreased drastically from 29,709 to about 100.

Fiscal stress gave rise to innovation; various States attempted to improve the overall performance of public health facilities by a combination of policies-improved availability of inputs, greater flexibility in spending; defining responsibilities and rationalizing performance outputs; widening the scope for involvement of local bodies, non-governmental organizations (NGOs), etc. Table 2 gives a broad idea of the policy areas, the direction and nature of such innovations and names of the pioneer states. The initiatives taken and the outcomes are impressive when analyzed in reference to wide disparities in income and socio-cultural behavior, a fast-changing economic scenario, comparatively unstable political environment (in several States) and a near

stagnant average per capita investment in primary health care of Rs 105. Despite the reduced health spending as a result of fiscal pressures that States faced during this period, most of them took advantage of available opportunities to achieve whatever they could, underscoring the fact that a limited level of investment can only give a commensurate level of outcome. Notwithstanding the above factors, five serious omissions occurred in the public health policy: (i) the private sector was encouraged without provisions for regulations, standards and accreditation processes; (ii) there was an absence of surveillance and epidemiological surveys to get a more accurate understanding of the changing profile of disease prevalence and incidence, which is necessary for measuring risk factors, designing interventions and launching information campaigns to reduce risky behavior; (iii) advantage was not taken of the 73rd and 74th Constitutional Amendments for decentralizing program implementation to the local bodies/community for increasing accountability in the system; (iv) neglect of research and development to promote technological innovation; and (v) inadequate investment in developing the critical mass of required skills and human resources. In other words, the governments ran public health programs that would have been more cost-effective for the communities and local bodies and in the process neglected their more fundamental responsibility of governance- of laying down a framework, defining the rules of the game and monitoring systems to see that no player takes undue advantage in the health sector.

Phase III (post-2000): National Health Policy II, 2002

By the year 2000, India had still not achieved 13 out of the 17 goals laid down in the first National Health Policy of 1983. Analysis of the 52nd Round National Sample Survey (NSS) on the utilization of health services showed that during 1986-96, there was a decrease in the utilization of public facilities for outpatient care from 26 per cent to 19 per cent; a decrease in access to free care from 19 per cent to 10 per cent and an increase in the number of people not seeking health care due to financial incapacity.

State-wise comparisons showed that the poorest people in the poorer States of UP and Bihar had to pay substantial amounts for outpatient treatment resulting in low utilization of public facilities, indicating an appalling breakdown of the public health system. On the other hand, in Assam and Orissa, a large proportion of people did not avail any treatment at all. If these statistics are considered along with the number of untreated ailments due to financial reasons, the picture is dismal, as it further reiterates the failure of the public health system in providing risk protection to the people who are in real need of it. Since the average cost of

outpatient treatment for every episode of illness is equivalent to three to five days' wage of one earning member of the family, this is a virtual breakdown of the system.

Alarmed by the falling levels in the utilization of public facilities, and to reduce the burden of disease affecting the poor, the government brought forth the National Population Policy (2000), the National Health Policy (2002), and the AYUSH Policy (2000), reiterating its resolve and commitment to achieve a set of goals by 2010. The goals envisaged were: to increase public investment in health from the current level of 0.9 per cent to 2 per cent 3 per cent; to increase the utilization of primary care facilities from less than 19 per cent to over 75 per cent; to reduce the MMR by three quarters from the current level of over 540 per 1000; to reduce the IMR from 62 per 1000 live-births to less than 30, eradicate polio, eliminate leprosy, reduce deaths on account of TB and malaria by over 50 per cent, etc. Many of these objectives are in consonance with the Millennium Development Goals (MDGs) for 2015. The following section will highlight the inherent issues that may constrain the government from achieving these goals within the given time-frame unless addressed on a priority basis and immediately. Some of the relevant data presented below has already been discussed above.

Organizational Structure of the Public Health Sector Delivery System

There has been a clear absence of any deliberate strategy to use the organizational tool for achieving public health goals, except family planning, until the Sixth Five-Year Plan when, under the Minimum Needs Program, concerted efforts were made to focus on expanding access to primary care in rural areas. Thus, built over several years, the public health delivery system consists of a large number of dispensaries, primary health care institutions, small hospitals providing some specialist services, large hospitals providing tertiary care, medical colleges, paramedical training institutions, laboratories, etc.

The failure to improve the health status, to be accountable and responsive to people's needs or to protect them from financial risk has brought into focus the functioning of the public health system, underscoring its failure in fulfilling many such legitimate expectations. The focus of this section is to understand the causal factors that have led to such a failure. These causal factors can be divided into three broad groups:

1. Poor goal setting and lack of formulation of strategic interventions;
2. Management Failures;
3. Limited role of the State.

Goal-setting and Strategic Interventions

The public health system is inaccessible, disconnected from public health goals and inadequately equipped to address people's expectations. For the majority of citizens, the public health system is out of their reach due to distance, lack of money, lack of confidence in the system or the availability of a cheaper alternative. The organizational structure requires a villager to travel an average distance of 2.2 km to reach the first health post for getting a Paracetamol; over 6 km for a blood test and for nearly 20 km for proper hospital care. Given the poor road connectivity, the unreliability of finding the provider at the health centre, the indirect costs for transport and wages foregone, the marginal cost of availing a public service far outweighs that of getting some treatment from the local quack. Further, even when accessed, there is no continuity of care guaranteed⁵. In other words, the segmentation of the health system into primary, secondary and tertiary, administered and monitored by different bodies, with no coordination in their working, has resulted in the dilution of the concept of the integral nature of health care wherein curative services have become a continuum of the preventive health care, promoting health

In eight States, substantial investments were mobilized from the World Bank to upgrade, strengthen and establish hospitals at the district, sub-district and block levels. The comprehensive definition of the primary health infrastructure (Health for All Report of 1980) however got further distorted with the community health centers (CHCs) being rechristened as first referral centers (FRUs), divorcing them from their contextual framework. In Andhra Pradesh, Karnataka, Punjab, etc. the World Bank-funded CHCs were brought under the administrative control of autonomous Directorates dealing with secondary level hospitals while those CHCs not covered under the project continued to be administered by the Director of Health Services. An evaluation report of West Bengal, AP, Karnataka and Punjab showed that while these states were successful in improving the quality of care in urban and semi-urban areas (Table 5), an expected outcome, such as, for example, an increase in institutional deliveries was not realized. Had the focus been on establishing the referral system and linkages with the other World Bank-assisted disease control and Reproductive and Child Health (RCH), investments made for strengthening the health systems would have had a considerable impact on reducing maternal, neonatal and infant deaths, or deaths due to malaria, TB which require hospitalization. This experience clearly demonstrates that mere increase in investments in infrastructure does not automatically translate into better health outcomes.

It also underlines the urgent need for conceptual clarity on the expectations of the organizational structures that have been established and the urgent need

for standardization of facilities across the country. Shortage of funds has been primarily responsible for the non-availability of facilities in accordance with the norms set by the government; and inadequate provisioning of critical inputs such as drugs, equipment, facilities such as operation theatre, etc. Due to lack of budgets and the pressure to achieve targets, several States upgraded the two-roomed sub-centers to PHCs with no place for laboratory, examination, pharmacy, etc. Most of them are non-functional. There are PHCs with over 33 sub-centers and there are sub-centers which cover over 200 habitations. It is estimated that 25% of people in Madhya Pradesh and Orissa, and 11% in Uttar Pradesh could not access medical care due to hospital location reasons (NSS-India Health Report, 2003).

The question that arises then is to what extent was infrastructure an important determinant in health outcomes? Was there any association? Box 1 reveals the mockery we have made of the health care service delivery system by having sub-centers function in non-standardized places, denying dignity and privacy to women who visit the ANM for treatment and care. Some of the evidence gives the levels of utilization of the PHC facilities. It links outcomes with the infrastructure to examine if there is any such association. What emerges from the data is that while in the poorer performing States, the ratio of facilities to 100,000 population are on par with the rest of the States, and even better than that in Andhra Pradesh and West Bengal, the health outcomes are poor. This shows that it is not mere establishment of a physical facility but a combination of factors such as distance, availability and quality of skills, adequacy of infrastructure and access to alternative sources of care that seem to influence health-seeking behavior and determine outcomes which have been captured by a set of indicators such as complete immunization, percentage of those severely malnourished, full antenatal coverage, safe and institutional deliveries and finally, the IMR and the under-five mortality rate (U5MR). While it is clear that infrastructure development had little linkage to goal setting, it is also seen that policy interventions per se often lacked focus, were not based on hard evidence, and had weak institutional capacity to translate policy into action.

Weak Evidence Base for Interventions

Neither the Ministry at the Centre nor at the State level has adequate in-house capability to design research studies, collect data and analyze research findings of the various health interventions to enable evidence-based policy-making. Substantial resources are being spent on programmes and interventions, which have a poor evidence base. For example, there is no evidence to indicate the current burden of malaria, or maternal mortality. Similarly, hardly any studies

are available to assess the efficacy of the use of a drug or of a treatment protocol in different settings and conditions for formulating differential strategies to suit the diverse conditions prevailing in India.

Such non-availability of good quality research for evidence based policy formulation is one instance of the health delivery system failing to see the woods for the trees. For example, the principal goal of the National Reproductive Health Program is to reduce maternal mortality. Over 100,000 women die every year due to pregnancy-related reasons that necessitate skilled attendance and some surgical interventions. The international definitions of skilled attendants disqualify either the traditional birth attendants (TBAs) or the 18 months' trained ANMs. Surgical interventions on the other hand require some basic infrastructure such as access to blood, an operation theatre, access to personnel skilled in surgery and administration of anesthesia, etc. Hence, public policy should have been focused in all these years on making investments on development of the infrastructure and building-up of a professional and skilled cadre of attendants for facilitating safe and institutional deliveries. Instead, the focus was on prohibiting the available care in the form of TBAs and ANMs. The failure to link intervention with evidence has resulted in poor outcomes.

The organizational strategy consisted of three concepts: (i) Village-level clinics conducted by a professional health team consisting of a medical doctor, a trained nurse, laboratory assistant, etc. to provide antenatal care (ANC) and examine other ailments, with the auxiliary nurse attending to the mandatory registrations of all pregnant women, other public health duties and promoting institutional deliveries, etc; (ii) Investment in establishing well-equipped maternal and child health (MCH) clinics/hospitals for delivery; and (iii) a strong health management information system (HMIS) and monitoring system including a regular medical audit of every maternal death for taking corrective action. Compared to the above factors, India for several years promoted training of village-based TBAs, consistently lowered the quality of training and competencies of the ANMs and neglected supervision and monitoring.

Resorting to such low-cost solutions helped avoid committing resources required for the establishment of the requisite infrastructure and human resource development. The example of MMR is useful as it is a good proxy for demonstrating the effectiveness of the health system. A similar mismatch between goal and strategic intervention is evident in the case of reducing the IMR. While 40 per cent of deaths take place within one week of birth, and nearly 23 per cent on account of upper respiratory tract infections and diarrheal diseases, strategies required to address these causal factors have been overshadowed by the

immunization programs, particularly the one for polio. The single-point pursuit of polio eradication has resulted in adversely affecting the routine immunization program, which was initiated in 1986 as a Technology Mission for achieving full protection against all vaccine- preventable diseases by 2000. As per a household survey conducted in 1998 and again in 2003 (Indian Institute of Population Sciences 2004), the data for 220 districts showed that in the majority of the districts, there was either a declining performance or no improvement at all under the Universal Immunization Program (UIP).

Second, the high percentages of drop-outs for oral poliomyelitis virus (OPV3) indicated the wrong perception among mothers of the need to adhering to the immunization protocol (Table 6). Discussions with field staff seemed to suggest that this decline was largely on account of the emphasis given to polio, which not only commanded better resources and visibility in the media but also consumed nearly one-third of the time, 30 times the cost and exhausted the staff in 2003, the Government of India (GOI) had to dispatch half the departmental officers to oversee the Pulse Polio Initiative (PPI) Round due to resistance from the local staff which had got tired of participating in one campaign after another-4 rounds of PPI with each round requiring one whole month of preparation, two family health awareness programs camps of the National AIDS Control Organization (NACO), health *melas* of the GOI, leprosy household rounds for identification of left-out cases, registration of patients with guinea worm infection, RCH camps, family planning targets, and so on. Such isolated programmatic approaches have made it impossible to allow the health system to develop. Therefore, even as we get set to achieving zero polio prevalence in India, the question of whether vertically driven strategies implemented in a campaign mode, which are also resource intensive and neglect equally important public health functions, are worthwhile or not still remains unanswered.

Inadequate Capacity to Plan and Implement at the Centre, State, and District Level

Failure to develop a public health cadre and widening the eligibility criteria to include clinicians, without making public health training a mandatory requirement for working in posts that need public health skills, have adversely affected the implementation of public health programmes. Non-reservation of posts or the absence of a dedicated public health cadre have also reduced the employability of persons trained in public health resulting in an accumulated shortage of the critical mass of epidemiologists, biostatisticians and other personnel. With radiographers, orthopaedicians, surgeons working as an Additional Chief Medical Officers (ADMO) in charge of the RCH program or

programmes for malaria or TB, or IAS officers as project officers of HIV/AIDS, etc., the lack of technical capacity in providing the required level and quality of leadership at the State/district-level has been a serious handicap. Mavlankar (Mavlankar 1999), persuasively argues that one reason for the successful implementation of the maternal health strategies is that the availability of technical capacity to design and monitor at all levels, from the village to the Central Government. In India with a billion populations has one Director-level officer for MH in the Ministry of Health at the Centre. Besides the gross inadequacy of the number, technical posts in the Central Government are manned by personnel drawn from the Central Health Service with no fixed tenure or any pre-qualifications. For example, a Director of MH should have knowledge of public health, obstetrics and midwifery and related fields. While so the personnel of the Central Health Service have a distinct handicap of not only not having these technical qualifications but also no experience of working in a PHC or a CHC, made worse with no field training upon recruitment as is the case with Indian Administrative Service (IAS) officers.

Lack of technical expertise and non-availability of the critical mass or a minimal number at the Central and State levels are reasons for public health programs lacking in focused designing, development of national treatment protocols and standards, the non-integration with other related sectors/ such as TB with HIV, HIV with MH, MH with malaria, health with nutrition or water, etc.; or absence of technical leadership in States and districts on the operationalization of interventions based on technical norms; or assessing and building up of technical skills and human resources required by the program. Most importantly, this absence of adequate technical skills have also been responsible for the near absence of operational research for obtaining the evidence base for designing better targeted programs in keeping with the wide social and geographical disparities that characterize India. Instead, at the Central and State levels, almost 40% of the time of these ill-equipped officers in charge of complex programs is spent in attending to administrative duties.

The situation in the States is no better. A survey conducted in six States to assess the technical capacity of these States for maternal health (MH) programs, (or for that matter malaria) showed that except one Deputy Director-level officer in Kerala, in none of the other five States of Tamil Nadu, Maharashtra, Rajasthan, Gujarat and Chhattisgarh was there even one officer exclusively earmarked for monitoring the maternal health program (Mavlankar 1999). The situation in the districts is worse. The void in the unavailability of such capacity for surveillance and monitoring at district levels has temporarily been addressed under the TB control and Polio Pulse programs by taking persons on a contract basis-many

from the government itself, thus further weakening the already fragile technical capacity required for implementing the large number of government programs. In addition, there is also the question of the State Governments ability to sustain these program-based consultants after withdrawal of external support.

The collection and review of data is hardly given any importance, leave alone analyzing it for future planning. Monitoring is essentially confined to the bare minimum of NHP targets and now, polio pulse immunization targets. In the absence of any system of surveillance or epidemiological data gathering, planning interventions lack an evidence base and also make it impossible for the system to be responsive to felt needs. A study conducted in Zenana Hospital in Udaipur, Rajasthan found that during 1983-93 nothing had changed despite the improved road network and awareness levels.⁶

The researcher further observes that the failure of the system to provide ambulance services, which resulted in incurring expenditures on transport ranging between Rs.150 and 300, borrowed from moneylenders 'leaving the people poorer both materially and emotionally when despite their desperate efforts the woman's life could not be saved'. The study also showed that during this period while there was a drop in eclampsia, there was a six-fold increase of deaths on account of malaria induced anemia and abortions induced by unqualified practitioners 'Abortion and emergency obstetric services remain almost unavailable to the vast majority of the rural women.'

Inconsistent Procedures

Rules and procedures do not synchronize with objectives of a program or foster any accountability among the functionaries. For example, unsafe abortion is said to cause at least 8 per cent of all maternal deaths. Yet field surveys showed that untrained and unqualified providers in the informal sector routinely conduct illegal abortions. This flourishing clandestine business is because of government procedures that take over fifteen months for getting a centre certified the conflicting provisions such as the requirements for a person trained in medical termination of pregnancy to be working at the centre, but then having no facilities to train such private providers, etc. It is for such reasons that a large State like Rajasthan has only 338 certified private facilities with 78 per cent of them in nine districts, five districts having no private facility and six having one⁷. With no effective intervention to ensure government facilities having all the required skills, equipment and drugs, the number of deaths due to unsafe abortions remains high.

Management Failures

Management failure due to a combination of reasons such as low budgets, untimely and irregular supplies, corrupt practices and poor governance has adversely affected the functioning of the health system. The dispersed and disaggregated nature of responsibilities and conflicting job profiles make accountability a difficult proposition. While the Secretary of the Department of Health has no control on when and how much money will be made available to implement programs, the medical officer (MO) in the peripheral centre has no administrative powers over the front-line workers and other functionaries working under him. With most supplies such as vaccines and drugs being provided by the Centre for the NHPs, the States have little control to ensure outcomes, as in several instances procurement delays by the Centre can take as long as over one financial year, affecting the credibility of the system. All these factors have serious implications for the quality of management and efficiency.⁸

Conclusion

The overview of the plans and policy reports not only throws light on the gap between the rhetoric and reality but also the framework within which the policies have been formulated. There has been an excessive preoccupation with single purpose driven programs. Above all, the spirit of primary health care has been reduced to just primary level care. The health reports and plans mostly concentrated on building the health services infrastructure and even this lacked a sense of integration. Most of the policy reports miss out on the importance of a strong referral system. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation. The Bhole committee report and later, the Primary Health Care Declaration discussed the operational aspects of integrating the other sectors of development related to health. The multi-sectoral approach that is much needed and the inter-sectoral linkages that are essential for a vibrant health system have not been well thought out, and there has been no plan drawn out for it later. The outline of plan documents and their implementation have been incremental rather than being holistic. It is important to question whether it is only the low investment in health that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.

Technological advances, profitable investments and good policies can be turned to naught in the presence of a system lacking in leadership, direction and a core sense of integrity, pervading all the levels of health care. Unless all stakeholders are motivated by a set of values: of compassion and human concern

for the sick and ill and of not accepting a system which allows people to be denied health care due to circumstances beyond their control; the sense of equality and dignity in the health system will continue to reflect the cement and mortar issues of the expanding medical and drug industry, which can, in the absence of the guiding hand of the state, degrade human suffering into an opportunity for making profits. It then becomes critical to define the role of the State as the current utilitarian liberal approach of the health sector offers no acceptable solution. The issue is broader and needs to be examined within the context of the principles that underlie the concept of social contract of Rousseau or sense of justice of Rawls. If these principles enshrined in our Constitution are adhered to, then the State will need to intervene both intelligently and firmly.

Notes

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