DRAFT

Development of a Medium Term Health Sector Strategy and Expenditure Framework for Andhra Pradesh

Report of Phase 1

International Health Systems Group
Harvard School of Public Health

May 29, 2002

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6. A.P. has made exciting advances in broader social development activities, including the mobilization of community and women's groups for social and economic development. There are also successful, though relatively small scale, efforts to link social development with health programs and goals. The team identified this as a key area for further development as part of the MTSEF. We feel that achieving the ambitious health goals of Vision 2020 will require movement beyond the formal governmental health care delivery system.

7. Another key area is strengthening the role of district and local governments in health, through well-designed decentralization of funds, authorities, and accountability and involvement of civil society institutions. This will also require significant new investments in capacity-building, monitoring, and evaluation.

8. A.P. has a large, widely dispersed, and diverse private health care provision sector which is barely being tapped for its potential to enhance coverage and impact with priority health interventions. The DoHMFW could initiate some immediate actions to strengthen the contribution of private providers in improving health outcomes.

Tables 5 and 6 in the Summary Report list some of the key recommendations for short- and medium-term action emerging from the team's work. These can provide the basis for specific planning for Phase 2.

Proposal for Phase 2

The team proposes that the GoAP steering committee and DfID staff review this report to decide on whether to proceed with Phase 2. A timetable for Phase 2 is proposed in the main report. Phase 2 should be planned for 12-18 months. It could begin at the end of July 2002 with a launch workshop to which this Phase 1 report and its recommendations for short- and medium-term actions would be a major input.

Phase 2 would assist the GoAP to produce the MTSEF reports it needs by October 2002 and March/April 2003. Phase 2 would also develop some of the background analysis needed to plan and cost priority reform innovations as recommended by the team. It could include initial investments in field experiments that could be continued under a possible Phase 3. GoAP should consider that a serious program of sectoral reform should be planned for at least a 3-5 year period, with continuous technical support inputs.

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Development of a Medium Term Health Sector Strategy and Expenditure Framework for Andhra Pradesh

Summary Report

Peter Berman and Team Members

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Summary Report

1. Background, Description of Task, and Situation Analysis

1.1 On behalf of the Department of Health, Medical, and Family Welfare (DoHMFW), Government of Andhra Pradesh (GoAP), the United Kingdom's Department for International Development (DfID) contracted the International Health System's Group (IHSG) at Harvard School of Public Health to provide technical support to a first phase (Phase 1) of the development of a Medium-Term Strategy and Expenditure Framework (MTSEF) for the state. The DoHMFW appointed a steering committee to oversee this work. An IHSG team of seven advisors worked with government counterparts and other stakeholders during April 20-May 10, 2002. This report presents the results of the Phase 1 work and proposes further work under Phase 2, as per the Terms of Reference of the task. Annexes to this report provide the individual advisor reports produced under Phase 1.

1.2 The IHSG team included the following people and main areas of focus:

Prof. Peter Berman: Team Leader and Private Sector Health Care Delivery
Dr. Ajay Mahal: Team Coordinator and Health Sector Financing
Dr. Thomas Bossert: Organization and Governance
Mr. Shiv Kumar: Organization and Governance
Dr. Marc Mitchell: Government Health Care Delivery
Dr. Vimla Ramachandran: Social Development
Dr. Hilary Standing: Social Development
Dr. Prasanta Mahapatra: Burden of Disease and Health Priorities

The team was supported by Ms. Terri Saint-Amour, Ms. Seedang Simonin, and Ms. Naomi Burns at IHSG.

1.3 The IHSG team entered into a process of strategic planning for health in A.P. in which there had already been a substantial amount of work since 1999, as indicated in the reading list in Annex __. Some of the highlights of that previous work include:

- Vision 2020 – a major policy statement on government goals from A.P.'s dynamic Chief Minister, Mr. Chandrababu Naidu, which includes a prominent chapter on health and one on governance. Vision 2020 sets forth ambitious goals for health status improvements and good governance and lays out a set of priority strategies for achieving them.

- GoAP internal efforts to "operationalize" Vision 2020 and monitor progress in achieving its goals. The DoHMFW and major divisions within it have produced operational goals and targets for achieving Vision 2020 results and periodic reports on achievement of quantified targets. It is expected that budget allocations to departments and divisions will be based in part on progress in these measurable indicators.

- Strategic planning exercises involving the DoHMFW, DfID, the World Bank, and the European Commission. To date these have included:

  i. DoHMFW strategy documents including a Health and Family Welfare "Approach Paper", "Health Policy", and "Health Sector Strategy".

  ii. DfID consultants and advisors who have explored the potential for sectoral assistance strategies, reviewed health financing and health policy issues generally, and reviewed specific health programs such as Reproductive and Child Health and Tuberculosis Control.

  iii. EC consultants reviewing specific health program and governance issues.

  iv. Several strategic planning workshops in the state, involving state stakeholders, government counterparts, and international organizations and producing reports on health sector strategy and specific proposals.

  v. Ongoing World Bank review of priority health problems and programs.

- Recent development of a major sectoral assistance instrument (US$350M loan and credit) for budgetary support to GoAP, including agreement that these funds would provide support to health and education and that the GoAP would double its own sectoral allocation to "primary health care" over five years. GoAP has agreed to produce a strategy and expenditure framework reflecting these plans.

1.4 Thus, the IHSG team entered onto the scene receiving a very large and impressive body of previous work in goal-setting, analysis, and strategy development. After reviewing this work, we found ourselves asking several questions: What was perceived to be missing or still needed in terms of a MTSEF? Who held these views and was there a concensus among key stakeholders? What, if anything could we contribute to this process which would be useful in improving health system performance and outcomes for A.P.?

1.5 DfID also clarified our relationship with our clients. The IHSG was clearly asked to work with the DoHMFW under the leadership of Ms. Rachel Chatterjee and a steering committee to assist that department and the GoAP more broadly in formulating its strategy and expenditure framework.

To clarify the situation to which we are trying to respond, let us pose, and answer, several key questions.

a. Who wants what from a MTSEF for A.P.?

1.6 All stakeholders share the same basic goal for developing a MTSEF for A.P.: a feasible planning framework which will guide investment and implementation to improve health system performance in the state. Vision 2020 provides the basic statement of health outcome objectives – a key element of health system performance. Vision 2020 also lays out a view of governance improvements needed to achieve these outcome gains.

1.7 But there are some differences between stakeholders in their specific expectations for a MTSEF. We have identified two key dimensions across which these differences lie: the contrast between "systemic" and "programmatic" strategies for improving health system performance; and the contrast between shorter-term strategies and medium and longer term strategies.

1.8 The "systemic" view seeks to identify strategies which will change some of the underlying determinants of health system performance, such as the overall level of financing, the incentives which drive the performance of administrators and health care personnel, and the organization of institutions. The "programmatic" view focuses on the operational constraints to improving existing programs, for example the need for more supplies and transport, better training, filling staff vacancies, etc.

Let's examine some examples of these different views.

1.9 Vision 2020's health goals are very ambitious. The DoHMFW is profoundly challenged by these goals. The government's health care delivery system faces many problems. The causes of these problems are diverse, but include some very fundamental conditions, such as years of low investment and expenditure on health in the state, a complex administrative structure, and many bureaucratic constraints to better performance.

1.10 One natural reaction to this possible mismatch between high expectations and low capacities can be seen in some of the DoHMFW's initial strategy documents, which propose major new public investments to renovate facilities, build up staff (including a new program of community health workers), and other expansions of the existing primary care delivery system. These "programmatic" strategy proposals were not well received by the aid agencies. They were perceived as being requests for simply "more of the same", without a clear strategy for how this would improve performance.

1.11 One the aid agency side, there is a clear bias towards thinking about "systemic" changes

which is expressed through their comments at state-level strategy meetings and the reports of their consultants. They are thinking about new strategies for assistance, such as sectoral aid and financing changes tied to the new sectoral assistance instrument. They are promoting broader linkages with other social development and poverty alleviation initiatives, strategies which build on underlying governance changes such as panchayati raj and janmabhoomi, and more effort to link government health strategies with the private sector and major reforms in health care financing.

1.13 A third dimension is introduced by the urgent pressures on the DoHMFW and its key units and officers (Directorate of Health, Commissioner of Family Welfare, APVVP) to develop and monitor specific operational and performance indicators on a regular basis. The Chief Minister shows strong personal interest in this process and future budget allocations have been tied to reported performance achievements. This performance monitoring activity increases the pressure on the DoHMFW to look for short-term strategies to improve performance indicators. Conversely, medium- and longer-term strategies which may require some research and analysis, or about which there is significant uncertainty, become relatively less attractive as priorities. This message came through very clearly from our meetings with Mrs. Rachel Chatterjee.

1.14 Yet another dimension concerns the views of stakeholders outside the DoHMFW and interested aid agencies. This includes government departments with broader poverty and social development focus, NGOs, panchayati raj institutions, and other elements of civil society. This dimension was examined by the members of our team dealing with social development and governance, although this was limited by the time available. It is clear from our investigations, however, that a MTSEF for health cannot be limited only to those institutions that make up the formal government health care service delivery institutions. The development of a MTSEF must be done with significant input from a wide range of stakeholders.

b. How can the MTSEF process address these concerns?

1.15 Our response to these concerns is to propose a balanced strategy with both short and longer-term elements and both systemic and programmatic elements. We feel that stakeholders in the GoAP cannot (and should not) focus solely on the systemic issues, nor should they focus solely on the urgent programmatic issues.

1.16 We also propose a process through which institutions in A.P. can work together to consider these options and develop specific implementation plans.

1. Overview of Health and Health Sector Situation in Andhra Pradesh

1.16 Recent national and state-level analyses of health and the health sector have provided a reasonably current and consistant picture of the overall situation in Andhra Pradesh. It is not the intention of this report to restate this information or provide another substantial

analysis of these issues. But review of a few key points are important to set the stage for development of a MTSEF.

a. Health status in A.P. is about average in All-India comparisons but lags behind the performance of other southern states.

1.18 As shown in Table 1, for these key child and women's health indicators, A.P. 's performance is somewhat behind the achievements of the other southern states it views as appropriate comparators. It is this lagging position that provides one of the key stimuli to emphasis given by the Chief Minister to health goals in Vision 2020.

Table 1: Comparative Health Outcome Indicators (1996-8)

	Infant Mortality Rate	Child Mortality Rate	Total Fertility Rate	% of Children with Anaemia (6-35 months)	% of Women with Anaemia (15-49 years)
All India Average	**67.6**	**94.9**	**2.9**	**74.3**	**51.8**
Andhra Pradesh	**65.8**	**85.5**	**2.3**	**72.3**	**49.8**
Karnataka	51.5	69.8	2.1	70.6	42.4
Kerala	16.3	18.8	2.0	43.9	22.7
Tamil Nadu	48.2	63.3	2.2	69.0	56.5

Source NFHS II, as reported in Pearson, et al "Impact and Expenditure Review, Part 1.", Draft, DfID, 2002.

1.19 Table 2 provides a comparison of some key health service output indicators. Interestingly, on many of these A.P. performance well above the all-India average and sometimes above the levels of neighboring southern states.

Table 2: Comparative Health Service Indicators

	% Children Receiving All Vaccinations	% Married Women Using any Contraceptive Method	Sterilisation	% of Pregnant Women Receiving at least 1 Ante Natal Check Up	% of Pregnant Women Receiving at least 2 Tetanus Toxoid Injections	% Pregnant Women Receiving Folic Acid	% Instit. Deliveries	% of Births Attended by Health Professional	% of Children Receiving at least 1 Vitamin A Supplement
All India	42.0	48.2	36.0	65.4	66.8	57.6	33.6	42.3	29.7
Andhra Pradesh	**58.7**	**59.6**	**57.0**	**92.7**	**81.5**	**81.2**	**49.8**	**65.2**	**24.8**
Karnataka	60.0	58.3	52.1	86.3	74.9	78.0	51.1	59.1	48.4
Kerala	79.7	63.7	51.0	98.8	86.4	95.2	93.0	94.0	43.6
Tamil Nadu	88.8	52.1	46.0	98.5	95.4	93.2	79.3	83.8	16.2

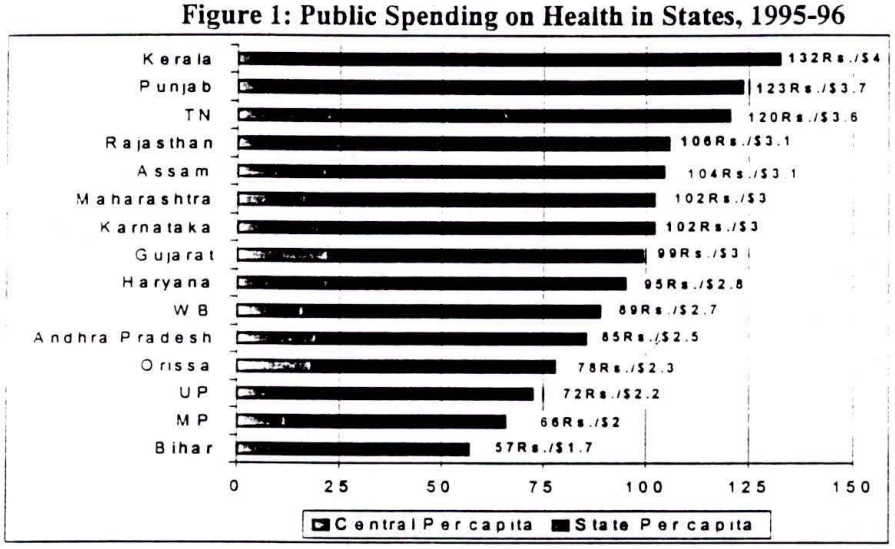
Source: NFHS 2, 1999, as reported in Pearson, et al "Impact and Expenditure Review, Part 1.", Draft, DfID, 2002.

b. Government health expenditure in A.P .is relatively low

1.20 In terms of overall health expenditure, A.P. also shows a below average level of public spending, lagging behind other southern states in both absolute (Rs. Per capita) and relative (Percent of SDP) terms. Figure 1 presents of these figures.

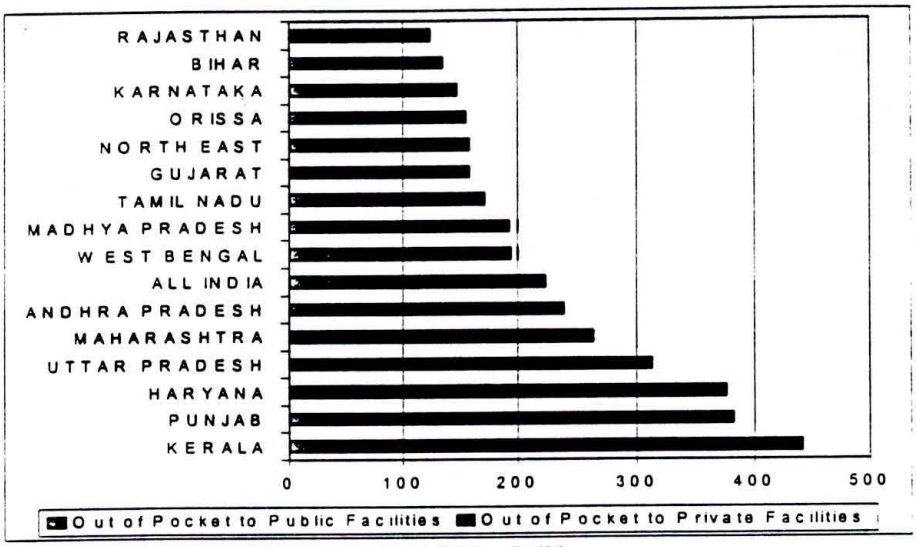
1.21 In terms of private spending, A.P. is somewhat above the all-India average, as shown in Figure 2. This may reflect the relatively lower level of public spending and an above average propensity to consume health care. It also probably represents an above average out-of-pocket financial burden, which survey data suggests significantly affects the poor.

Figure 1: Public Spending on Health in States, 1995-96



Source: World Bank, 2001 "Raising the Sights", New Delhi, citing Selvaraju 2000.

Figure 2: Private Spending on Health in States: 1995-96 (Rs.)



Source: World Bank, 2001 "Raising the Sights", New Delhi.

c. Government Health Care Delivery Faces Significant Systemic Constraints

1.22 In terms of health system capacity, A.P. has an overall structure of governmental health facilities similar to that found in other Indian states. It has benefitted in recent years from significant new investments in government hospitals at the "first referral" level, using a loan from the World Bank.

1.23 The private health care sector is discussed in some detail in Annex . Recent studies suggest that private health care is much larger than regular government data suggest, but it is not clear whether this indicates that A.P. has a large private sector relative to most Indian states or simply has compiled more complete data.

1.24 One key issue in public health care delivery is shown in Table 3 – the issue of vacant posts. A.P. has a significant number of vacant positions in government health facilities, both physicians and paramedical staff. The latter is particularly important in terms of ability to deliver services through the major communicable disease control programs.

Table 3: Cadre Strength - Department of Health

	Sanctioned	Working	Vacancies
Doctors	2478	1996	482
Paramedical	16,862	14,640	2,222
Gazetted Officers	710	563	147
Ministerial & Others	7157	6545	612

Source: Pearson, et al "Impact and Expenditure Review, Part 1.", Draft, DfID, 2002.

2. Health System and Governance Innovations in Andhra Pradesh

1.25 As stated above, we believe a MTSEF for A.P. must balance "systemic" and "programmatic" reforms in a strategy that includes both actions that can be carried out quickly to improve health system performance as well as actions that may require more information, analysis, and testing. Systemic reforms need to be considered for two important reasons. First, we believe that simply increasing government funding of existing health programs, institutions, and strategies is a necessary, but is not a sufficient approach to improving performance – there are important underlying constraints to better performance that cannot be addressed in this way. Systemic changes in governance and management of the public health system are needed to be able to implement many of the operational improvements which can lead to performance gains. And second, there are significant systemic changes taking place outside the health system – for example, panchayati raj, the expanding private health care sector, and major programs of social mobilization such as *janmabhoomi*, which offer potentially greater opportunities for performance gains than those available within the government health system alone.

1.26 Fortunately, the GoAP and the DoHMFW are quite receptive to ideas of systemic reform and innovation. Indeed, A.P. has been a leader among states in India in developing certain health system innovations. Some recent examples of these include:

i. The APVVP, a para-statal commissionerate which manages all government district and first-level referral hospitals in the State, with some independence from government rules and regulations – a type of "hospital autonomy" strategy.

ii. Development of other para-statal entities to manage procurement of drugs and supplies and physical facilities and capital investment programs (APHMHIDC) and traditional and Indian systems of medicine facilities (APYP).

iii. Introduction of option for contracting of medical and paramedical staff to fill vacancies in government posts.

iv. Development of user fees in public hospitals and other facilities

v. New law on regulation on private health care providers, with specific rules and procedures currently being developed.

vi. Development of financial incentives in the family welfare program for poor households: *sukhibava*, to encourage institutional deliveries by poor mothers; and *arrogyaraksha*, a type of financial health insurance coverage for families with two children who accept to have sterilization.

vii. As in other states in India, increased use state and district-level "societies" to manage specific disease control activities such as TB, HIV/AIDS, etc.

viii. The strong commitment to performance monitoring developed for Vision 2020 itself is an indication of the interest of the GoAP in reforming the governance and management of the public sector.

1.27 These and other initiatives indicate that the GoAP is not averse to implementing institutional reforms and innovations. The more relevant question is whether these reforms have been designed and selected based on an analysis of their likely impact on the health system performance outcomes which have been given priority in A.P. In our view, while A.P. has had significant reform initiatives, it has not had a coherent program of systemic reform designed to address priority health and other goals.

3. A Diagnostic Framework for a Medium Term Health Sector Strategy

1.28 There have been several efforts to put forward a strategy for the health sector in A.P. We can identify the following:

i. Vision 2020 identifies the following health goals: IMR to 10, CMR to 20, life expectancy of 68.1 and 70.6 years for men and women respectively, TFR of 1.5 and population growth rate of .8 percent per year. To achieve these goals a seven-point set of "key priorities" is proposed: "providing universal access to primary health care; encouraging private investment in tertiary health care; focusing on specific programs to promote family welfare, particularly the health of women and children, and family planning; focusing on improving health levels in disadvantaged groups and backward regions; ensuring a strong prevention focus; enhancing the performance of the public health system; and formulating a State IEC program, which includes leveraging the electronic media

DoHMFW has been instructed to develop specific plans for "operationalizing" Vision 2020 and for monitoring performance towards achievement of the Vision 2020 goals. Much of this operationalization and performance monitoring relates to increasing coverage with existing service delivery and public health programs. One important new initiative proposed under Vision

2020 is expanding the development of Village Health Workers in Tribal Areas.

ii. Two recent DoHMFW documents propose health sector strategies: "Strategy Paper on Health and Family Welfare" (January 2001) and "Strategy Document on Health Policy" (no date). Two reports are also available from strategy development meetings: "Health Strategy Meeting with DfID, March 13, 2001" and "Proceedings of the Strategy Development Workshop for Health Sector in Andhra Pradesh, April 24-25, 2001." Our review of these documents suggests that much of what they contain are proposals for increasing public expenditure on existing institutions and service delivery programs with a focus on more inputs and expanding the numbers of areas covered by different activities.

iii. Although it preceded at least one of these meetings, the report by Pearson et al "Impact and Expenditure Review: Health Sector, Part 2 Policy Analysis", while commenting positively on the development of quantified health goals and inclusion of some innovative strategies, offered a sharp critique of these efforts. The critique included comments that the specific strategic proposals were unrealistic, not clearly linked with the goals of Vision 2020, lacked an analysis of constraints in the health system, were not well prioritized, lacked a financing and monitoring plan, and didn't specify a process for further development and implementation. DfID response to these efforts also indicated dissatisfaction with the types of strategies proposed.

1.29 These previous benchmarks represent a not-inconsiderable effort of human and other resources to develop a health sector strategy for A.P. This effort did not result in development of a satisfactory strategy. These activities were followed by the current contract to IHSG. How can we encourage progress beyond the current state of discussion, learning from previous experience?

1.30 Developing a MTSEF requires devising a technically and politically feasible strategy that, based on available evidence, has the potential to improve the performance of the health system of A.P. in terms of a set of socially desirable outcomes. This strategy must also be financially feasible in an environment of very limited resources and where the amount of discretionary resources is likely to be only a modest share of the total. In A.P. one must also consider: the high profile goal statement of the Chief Minister in Vision 2020 and the associated efforts to have the DoHMFW operationalize and monitor efforts to achieve those goals; and the potential to mobilize significant new resources committed in the state's five-year financial plan.

1.31 The MTSEF should be based on[1]:

- Identification of health system performance *problems* in terms of *ultimate outcomes* and *intermediate outcomes*

- A *diagnosis of the causes of these problems*, based on evidence and an explicit logical framework

- Linkage of the diagnosis (the causes of problems) to specific areas of health system policy, policy change, and intervention strategies to improve performance – the *control knobs* of the health system. This would be the technical basis for the MTSEF.

- Development of a plan for implementing change and the costing of that plan, with reference to the available resources. This would be specific content of the MTSEF.

1.31 To be effective, these steps should be carried out in collaboration with colleagues in A.P. and accepted by them as viable and useful basis for action. This is not a small exercise in a place as large and complex as an Indian state, especially if one wants to develop a substantive causal analysis and identify appropriate interventions based on evidence. Phase 1 of this exercise can make some progress on steps 1-3 above and offer some recommendations on step 4. But a further process of consultation with counterparts in A.P. and more detailed planning and analysis will certainly be needed to develop a full MTSEF.

1.32 Figures 3 and Table 4 outline the key elements of the diagnostic approach that we began to develop in A.P. as part of the Phase 1 work. Figure 3 provides an overview of the diagnostic approach. It begins, properly, with the ultimate outcomes of health system performance that A.P. seeks to achieve with its health strategy.

1.33 It is important that the strategy be based on a frank and serious assessment of goals. At this time, the main basis for this is the Vision 2020 document, which emphasizes major health outcomes such as IMR, CMR, MMR, and overall life expectancy. Vision 2020 also highlights the importance of improving these outcomes among the poor and disadvantaged populations of the state.

1.34 The goals outlined in Vision 2020 are very ambitious. It is certainly impossible to achieve these goals without having a major impact on the health conditions of the poor. It was also noted by several members of our team that the health status gains highlighted in Vision 2020 depend significantly on factors which the health care system can affect only

[1] This framework is based on Roberts, Hsiao, Berman, and Reich Getting Health Reform Right, forthcoming 2002.

to a limited extent, such as nutritional status, age at marriage, and women's status.

1.36 Vision 2020 also includes objectives and strategies related to increasing access and improving quality of hospital-based services through government efforts, as well as increasing private participation in the development of tertiary services. These strategies would likely have only a limited direct affect on the priority health outcomes at population level.

1.36 Figure 1 adds to the Vision 2020 outcomes another dimension of health system performance – financial protection for the poor from the high costs of illness and health care. This is typically one of the implicit goals of free public service delivery, especially free or highly subsidized inpatient treatment, which has been a high priority in A.P. through the first referral hospital project.

1.37 Figure 1 links these ultimate outcomes to intermediate outcomes, which are typically the more observable characteristics of the health care system. These are related to a diagnostic and causal analysis and then back to strategies for change. Change strategies are developed by drawing on the evidence and technical content of different dimensions of reform, which we conceptualize as the five health system "control knobs" shown in the right-hand panel.

1.38 The "Strategies for Change" panel (second from right) represents one of the key conceptual results of our Phase 1 work. Development of the MTSEF must find a balance across several important dimensions of potential strategy development. It must be substantive enough to make a difference, yet not so complex or comprehensive that it is not feasible to plan or implement. It must address health care system factors, but also broader social development factors. It must provide guidance on actions that can be undertaken immediately or in the short-term, but also address longer-term strategies. It must consider both "systemic" and "programmatic" changes.

1.39 Under "Strategies for Change" we have listed 4 major headings:

- **Improving the functioning of governmental health care services and programs.** (Focus more on programmatic and short-term changes, with some attention to systemic and longer-term changes).

- **Strengthening broader poverty and social development programs, decentralization and governance reforms and their linkages with health outcomes and health programs.** (Focus more on social development and non-health-system determinants of outcomes and performance, improving management skills, strengthen merit motivations, developing local accountability and responding to local health status needs. Both shorter and longer-term changes).

- **Development of new policies and strategies to enhance the contribution of private providers.** (Mainly systemic changes but some programmatic changes, with both shorter and longer-term actions).

- **Development of new financing strategies to mobilize resources and improve the use of resources.** (Mainly systemic changes but some programmatic changes, with both short and longer-term actions).

We believe these provide a substantive yet feasible agenda for MTSEF development.

1.40 Table 4 expands the central panel of Figure 3, the diagnostic and causal analysis of factors determining health system performance. In Table 4 we have listed some of the main factors identified by team members in their reports. Much greater detail and discussion of these and other factors are contained in the individual reports, which are annexes to this summary report.

Figure 3:
Broad Diagnostic Fraemework for A.P. MTSEF

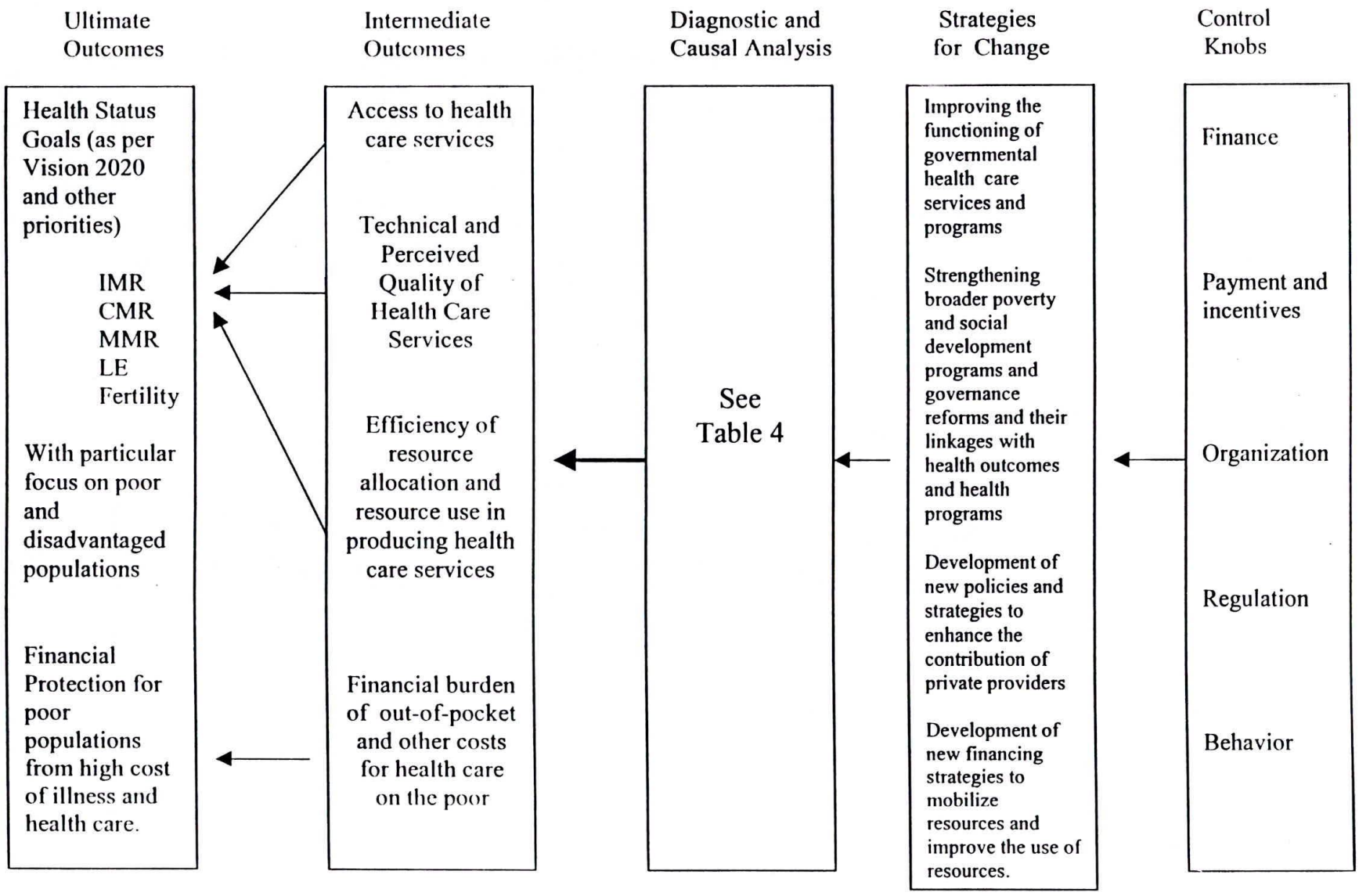


Table 4
Some Causal Factors in Poor Performance Highlighted in Team Member Reports

Government Service Delivery

Limited ability to deliver services in communities: e.g.

- Weak support for ANMs, community-based workers
- Overemphasis on facility-based approach
- Poorly designed target focus in programs
- Weak management skills and systems
- Inadequate information systems
- Low motivation of health staff at all levels
- Unfilled staff positions
- Lack of essential supplies and other inputs
- Lack of financial and other incentives for peripheral workers

Weak linkage with broader social development and poverty alleviation programs

Some priority outcomes closely linked to broader social conditions such as age at marriage, literacy and education, nutrition.

Private Sector Service Delivery

Widespread access to unregulated , less-than-fully-qualified providers, especially for lower income groups

High rates of utilization of unqualified providers for health needs given high priority for achieving targeted outcomes

Limited participation for qualified and less-than-fully-qualified providers in information and outreach activities to address priority health outcomes

Lack of information on numbers, types, and roles of private providers and weak regulation of private health care providers

Governance, Organization, and Decentralization

Lack of significant deconcentration of authority and responsibility to district levels limiting management flexibility by health staff to promote efficiency and responsiveness

Lack of significant devolution of authority and responsibility to PRI and health advisory committees limiting local responsiveness, accountability and participation and discouraging mobilization of local resources

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Lack of significant devolution of authority and responsibility to PRI and health advisory committees limiting local responsiveness, accountability and participation and discouraging mobilization of local resources

Complex and (likely to be) inequitable allocation of resources from state to districts ending up exaggerating existing inequities in resources and income among districts

Civil Service rules of recruitment, promotion and incentives that discourage initiatives, good performance, efficiency and responsiveness to patients

Lack of sufficient training and lack of consistent training capacity especially in management and financial control at all levels

Poor worker motivation, lack of appropriate organizational culture, and avenues of corruption in staffing selection and promotion and procurement.

Lack of staff in essential positions in state and district administrations .Lack of essential skills and training in some state, district, and lower level institutions.

Complex organizational structure of line departments, commissionerates, societies with unclear lines of responsibility and accountability in relation to service delivery activities.

Broader Social Development Linkages

Insufficient coordination and linkage between health priorities and interventions and community-based social mobilization programs, especially women's empowerment initiatives

Insufficient targeting of resources to poverty groups and disadvantaged populations. Inadequate attention to role of gender and socio-economic factors as causal factors in poor outcomes that need to be addressed to improve outcomes.

Models exist for more successful collaboration, but their implementation is limited

Lack of effective forum for NGO involvement in health program strategy and development

Health Financing

Low level of government health spending overall in comparison with other Indian states.

Imbalance between plan and investment spending and ability to support ongoing recurrent costs of existing facilities and programs, especially personnel and consumable supplies and drugs. This is exacerbated by mandated wage increases for government employees.

Lack of adequate information on total health financing and non-government flows to health sector

Inadequate efforts to develop new resource mobilization strategies, such as locally-controlled health funds

Weak resource mobilization through user charges and insufficient attention to issues of equity and access effects of charges impacting on poor

5. Preliminary List of Short- and Medium-Term Actions

1.41 Team member reports (Annexes 1-7) contain sections listing short-term and medium-term actions recommended for inclusion in the medium-term strategy. As shown in Figure 3, these recommendations have been bundled under four broad areas of strategy.

1.42 Short-term actions are those which our team feels can be initiated quickly and require little new information, analysis, or experimentation. However, they will require that choices be made on priorities. They also require detailed planning and budgeting, a key task for Phase 2. These short-term actions can be expected to provide some improvements in terms of the intermediate outcomes which should offer some benefits in terms of better performance on the ultimate outcomes. They emphasize more the programmatic changes.

1.43 The medium-term actions are those which require more information, analysis, planning, and experimentation. These actions emphasize more the systemic changes, addressing more complex underlying causes of poor performance, broader social development linkages, and changes which may be more difficult to design and implement. Again, choices need to be made on priorities and detailed planning and budgeting is needed once specific action strategies are determined.

1.44 We are very concerned to preface these recommendations with a strong caveat. The suggestions in Tables 5 and 6 were formulated based a short field visit and the information that was available prior to and during that visit. They should not be viewed as a comprehensive strategy, but rather as an initial set of ideas towards the development of such a strategy. They can provide the basis for discussion and decision-making by the

Table 5
Recommendations for Short-Term Actions as Part of Health Sector Strategy

Government Service Delivery	Broader Social Development and Governance Linkages		Private Sector Service Delivery	Health Financing
	Decentralization and Governance Strategies	Links to poverty, gender, broader social development and civil society		
Expand community-based distribution channels for essential commodities Community-based disinfection of water supplies Targetted community-based disease control activities focussed on specific problems in specific areas Public awards and notice for communities with successful health mobilization Closer links of	Pilot greater authority to district institutions in running priority health programs. Develop matching grants program to encourage district and local level financing and innovations. Revise formula for resource transfers to districts to focus more on areas with higher health needs in relation to priority outcomes. Increase representation of civil society on district-level health	Create forum for review, discussion, debate about between social development stakeholders and health program stakeholders. Assure that health sector has representation on government task forces/working groups on poverty and social development. Increase information, education, and treatment activities through community groups, health melas Expand coverage to	Create senior state-level post with responsibility and budget for developing government-private provider collaborations to address priority health problems. Create state-level committee to review current govt-private collaborations and propose strategy. Should involve key stakeholders. Assess *Sukhibhava* program for cost and effectiveness. Implement recommendations.	Develop state and district health accounts for planning on ongoing basis. Includes training and capacity building for health accounting and computerizing accounts. Define and cost appropriate benefit package for different financing scenarios. Assess current user charges implementation in terms of resource mobilization, contribution to health care quality and efficiency, and impact on poor.

supervision and cooperation between ANMs and PRIs Narrow and focus work assignments of ANMs New ANM training and better supply of commodities New models for ANM residence either by improving housing in village or providing transport for them to live in nearby towns. Restructuring efforts to address maternal mortality, for example, developing emergency transfer services for high risk deliveries with community involvement Increasing the reproductive health elements of the family welfare service package	committees. Monitor performance of PRI institutions related to health programs. Strengthen performance monitoring system. Strengthen role of advisory boards . Make contract employment are reality through higher payments and incentives for remote areas. Review experience with user fees to reform for significant contribution to health facilities.	scale with positively evaluated community programs like urban link volunteers. Link health with efforts to reduce child labor. Develop more disaggregated health and monitoring data capturing socio-economic and gender aspects, not only geographical differences. Develop database on NGO activities in health and use this to increase involvement of NGOs in priority programs.	Assess current efforts to integrate private providers in all disease control programs. Fill gaps and inaction caused by lack of staff, operational resources, attention. Require all disease control programs to develop action plans for govt-private collaboration. Launch new DoHMFW initiative to provide information and health promotion materials on priority problems to private providers. Develop training programs for private providers on disease control priorities and strategies.	Focus new finances on non-salary inputs to PHCs. Increase advocacy to raise government allocation to health. Enforce rules on care for poor in public hospitals

Shift from focus on output targets to better performance measures. Major push to introduce reproductive health approach throughout family welfare program, with new training, activities, etc. Restructuring of provision and financing of drugs and supplies to assure adequate inputs at primary level with more co-financing at secondary and tertiary levels. Major replanning of role of institutional deliveries in reducing MMR. More focus on effective treatment of communicable diseases.		Develop initiative to strengthen skills and capacities of ANMs, moving towards a "women's health service". Review and develop strategies to deal with underlying issues like age at marriage and chronic undernutrition.	Develop accreditation and quality assurance scheme for private providers and diagnostic facilities. Experiment with new finance and organization strategies for private providers, e.g. family doctor model with new financing approach in rural areas. Develop state database on private and NGO providers, including fixed practice LTFQ providers. Develop and test strategies to involve LTFQ providers in priority health programs. Monitor and evaluate new initiatives.	mandal panchayat oversight of PHC.

6. Some Thoughts on Priorities

1.45 Sending a team of seven experts to think about strategy in a large Indian state with a wide range of potentials and problems is a sure recipe for a long list of ideas and proposals. Predictably, our team offers many ideas on things that ought to be done and could be done.

1.46 Collectively though, we are concerned that launching too many initiatives across too broad a front could lead to a lot of activity but not much progress. We have proposed four broad areas for strategy development and action to introduce some focus. But this is not sufficient. We strongly that the subsequent steps of consultation and planning identify a manageable set of priorities to move forward. The following are some thoughts on areas that could be given high consideration.

- Assuring adequate financing for health interventions. Annex on Health Care Financing argues convincingly for both short and medium-term action to assure that funds are channeled to priority health needs. There are clear contradictions in the GoAP's current strategies – proposed increased financing for primary care, but real constraints to increasing the government's overall health expenditure envelope. The DoHMFW needs to move aggressively in the short-term to assess what it needs and put forward claims for additional resources, rather than waiting for others to define the constraints. For the medium-term, new strategies of finance, payment, and organization must be developed and tested to move beyond the limited potential of a bureaucratically-organized public delivery system.

- Focusing reforms on priority needs and populations. Improving the operational performance of government health services, strengthening capacities and roles of local governments, and effective linkages with broader social development and poverty alleviation programs can all contribute to better outcomes, both in the short- and medium-term. Would it not make sense to link these different strategies together with a focus on several priority health needs and populations (specific communicable diseases, or children's infections of the poor, for example), rather than view them "top-down" as broad strategies. The recent work by the World Bank to identify the pathways resulting in poor outcomes may be helpful in this focus. The critique of this approach – that it leads to wasted efforts through excessive "vertical" strategies, also needs to be considered.

- A serious commitment to making decentralization work for health. One of the constraints to comprehensive action is the limited capacity of the DoHMFW at state level to manage widespread innovation will still running an immense vertical delivery system. Even APVVP, one of the state's major reforms, does not go that far in reducing centralized management and control, although it does move this somewhat out of the direct bureaucratic line. One strategy for increasing the potential for innovation and change is to give greater authority to district and mandal panchayat institutions. However, as Annex on decentralization highlights, this requires

substantial commitment to proper design and strengthening capacities at lower levels of government and in civil society.

- Learning how to build on the existing capacities of private health care providers. One of the most striking facts emerging from recent health systems analyses in India is the high level of access to ambulatory care treatments in both rural and urban areas. Even highly disadvantaged populations do obtain care for many priority problems. But they do so mainly from non-government providers. This "access" to care often means poor quality and a high out-of-pocket cost burden. But shall this private provision capacity, which far exceeds that of government services, be ignored? This is a major task for medium-term development which may offer great potential for improved outcomes.

7. Proposed Work Plan for Fuller Development of a Medium-Term Strategy and Expenditure Framework

1.47 The situation analysis, strategic and diagnostic framework, action recommendations, and individual team member reports contained in this Phase 1 report provide the basis for a more substantial process of developing a MTSEF, in collaboration with colleagues in A.P. This section of our report proposes how Phase 2 of this process could proceed.

1.48 The DoHMFW in A.P. is working with several deadlines which must be considered in planning Phase 2. A draft (at least preliminary) strategy and expenditure framework is expected to be prepared by September 30, 2002, as part of the state's obligations under the structural adjustment loan/credit. A more fully developed work plan may be needed by end December. A complete MTSEF is expected by late March/early April 2003.

1.49 Another key step is for colleagues at DfID and GoAP to review this report and decide to proceed with Phase 2. In practical terms, moving ahead with Phase 2 also needs DfID to put in place additional funds and a new contract or contract extension with IHSG.

1.50 We propose that Phase 2 be planned as a 12-18 month exercise, beginning on July 29, 2002 . The following work plan is put forward for discussion:

May 30	Receipt of draft Phase 1 report by DfID and GoAP
May 31-June 20	Review and discussion of report, comments back to IHSG. Final report submitted. Decision to proceed with Phase 2.
June 20- July 20	IHSG proposes core team and consultant list for Phase 2, along with specific TOR and budget. Negotiations with DfID and GoAP. Final agreement and approval of Phase 2 contract.

Week of July 29	Launch workshop for Phase 2 in A.P. Working groups address four main strategy areas, develop work plans and working teams for developing MTSEF
August/September	IHSG team and GoAP counterparts initiate work on specific areas of MTSEF. Preliminary strategy and expenditure framework draft completed by September 30, 2002. This based on significant work to define resource envelope for financing strategy and indicative costs for main areas. Some stakeholder consultations organized during this period.
October, 2002 – March, 2003	IHSG core team, consultants, GoAP counterparts continue work on specific areas of strategy development and costing. More extensive stakeholder consultations organized during this period. Draft MTSEF prepared by end March.
April, 2003- July, 2003	IHSG core team, consultants, GoAP counterparts continue work on strategy, with focus on medium-term activities, design of pilots and experiments, and monitoring/evaluation activities. Develop and cost proposals for pilots and experiments for review by DfID, World Bank, others. Draft MTSEF revised and completed based on final consultations with stakeholders and GoAP counterparts.
August, 2003- January, 2004	Further investigations, field set up of pilots and experiments, secure funding for development of medium-term strategies, including implementation, monitoring and evaluation. Lead into Phase 3.

a. Staffing the Plan

1.51 In order to implement this plan, human resources must be allocated to these tasks by the IHSG team and the GoAP. We propose that the GoAP steering committee could be the nodal point for collaboration, under the direction of the Principal Secretary, Health, Mrs. Rachel Chatterjee. We request that Mrs. Chatterjee appoint a senior officer as liaison with the IHSG team.

1.52 If IHSG involvement is requested, Prof. Peter Berman could serve as the Team Leader/Principal Investigator and Dr. Ajay Mahal as the Team Manager. IHSG will propose a core team of 4-6 advisors, including both external and Indian members. Dr. Prasanta Mahapatra would also be part of this core team. The core team will make a significant commitment of time to Phase 2. The Institute of Health Systems could provide a Hyderabad-based counterpart organization, as it did during Phase 1 and we would involve other leading Hyderabad-based experts.

1.53 In addition to the core team, a larger team of short-term consultants and advisors will be identified, including both external and Indian consultants. This team will represent a broader range of skills and specialties, as needed to develop different components of the strategy. For example, this team might include experts in specific areas of disease control (such as TB) or reproductive health, in health financing, in private sector regulation, or in training. DfID, IHSG, and GoAP would need to work out appropriate mechanisms for identifying and hiring consultants to work on specific tasks.

1.54 Taking a longer view, A.P. should envisage at least a 3-5 program of sectoral investments and reform, which would likely require ongoing technical support and significant budget allocation.

References

Annexes 1-7, Individual Team Member reports.

Pearson, M. Impact and Expenditure Review, Part I, Financing and Part II, Policy Issues, Draft, DfID, New Delhi, 2002.

World Bank, 2001, Raising the Sights for India's Health System, Washington, World Bank, Report No. 22304.

Annex 1

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Report of Social Development Team

Hilary Standing and Vimala Ramachandran

Annex 1

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Report of Social Development Team

Vimala Ramachandran and Dr. Hilary Standing

A1.1 Andhra Pradesh has made significant progress on a number of social development issues and is seen as a forerunner in the area of women's mobilisation through self-help groups, getting children out of work and into school and in bringing the administration closer to people. Innovative approaches and bold administrative measures have borne fruit on several fronts - noteworthy among them being state-specific guidelines for extending credit to women's groups (self-help groups) and more recently (2001) the decision of the state government to cross-check system generated statistics through household surveys to not only estimate the number of children who are out of school (never-enrolled and dropped out) but also devise context specific strategies to reach out to the hardest to reach and ensure universal school participation. This section of the report reviews social development issues and highlights select state level strategies with the hope that the health sector can indeed learn a great deal from other social sectors and also forge meaningful convergence at the ground level – thereby initiating more consultative and inclusive decision making and priority setting processes. The GoAP has set out a clear and ambitious vision for the future well being of its citizens. A particular challenge for the health sector in meeting this vision is to shift the health delivery system to reach out to and respond to the needs of the disadvantaged / vulnerable through an outcomes focused rather than a target focused approach

1. Current situation/underlying concepts /approaches:

a. Andhra Pradesh - poverty and social profile[1]

A1.2 Andhra Pradesh has made much progress in economic and social development over the last 3-4 decades. Between the 1960s and 1990s, overall life expectancy rose from 45 to 62.6. The number of deaths per thousand population fell from 15.8 to 8.3 between 1970s and 1990s. Between the mid 1970s and mid 1990s, the infant mortality rate halved - from 123 to 63.

[1] This section draws upon unpublished studies produced by the CESS and very kindly provided to us by Ms. Lipika Nanda of the Society for the Elimination of Rural Poverty. Documents include White Paper on Eradication of Rural poverty, and Strategy Paper on the Eradication of poverty in Andhra Pradesh, 2001.

In terms of its poverty profile, AP nevertheless represents a mixed picture, with areas and sectors of strong economic growth and areas of relative stagnation and associated high levels of deprivation. Approximately 30% of the population is considered to be in poverty. This is particularly acute in rural areas. Although there are different estimates of the numbers of rural poor in AP, the GoAP uses a head count ratio of 27%. According to recent analyses, this is due to lack of creation of off farm employment in rural areas, particularly in the last decade. This in turn has meant that rural wages have stagnated. This has serious implications in a context where there are high levels of landlessness and near landlessness.

A1.3 Poverty is prevalent both geographically, in particular districts and in particular segments of the population, notably scheduled castes/tribes and among women and children. The GoAP recognises that poverty is multi-dimensional and includes non-income indicators like literacy, health status, maternal and infant mortality, lack of voice etc.

Table 1: Social and Economic Development Indicators for Southern States

Indicators	Andhra Pradesh	Karnataka	Kerala	Tamil Nadu
Literacy				
1981	34.1	43.9	78.9	52.6
1991	44.1	56.0	88.9	62.3
1997	54.0	58.0	93.0	70.0
Rank for 1997	11	8	1	4
Female Literacy				
1981	23.3	31.7	73.4	39.4
1991	32.7	44.3	86.2	51.3
1997	43.0	50.0	90.0	60.0
Rank for 1997	8	7	1	4
Infant Mortality				
1981	86	69	37	91
1991	71	73	17	58
1997	63	53	12	53
Rank for 1997	7	4	1	4
Per capita income				
1980	1544	1687	1694	1680
1990	1995	2298	2109	2513
1997	2450	2936	2725	3249
Rank for 1997	9	7	8	5

Note: The ranks given in the table are based on ranking for 14 states, Abstracted from Economic Survey 1999-2000, Ministry of Human Resource Development (1997-98), World Bank (2000) – see footnote 1 for source of data

A1.4 These figures are indicative of the mixed picture in AP. While it compares favourably with some northern states, it lags behind its southern neighbours. Education and health indicators are particularly poor for the level of economic development. Median years of schooling attained by 50% of the population, is only 2.3 years (MIS, GoAP and Unicef. 2001). Drop out rates from primary education have been going down steadily but the number of children dropping out of the system is still quite high. Out of

every hundred children enrolled in Class-I, only 60 complete Class-V and 42 go on to complete Class-VII. The drop out rate is higher for girls. Drop out rates among SCs. & STs. are coming down but only 32% of SC children and 18% of ST children complete Class VII.

A1.5 Literacy levels are low in AP in comparison to its economic status, and particularly low for women. There is an estimated 180 lakh illiterates in the age group of 15-50 years and 109 lakh adult illiterates in the 15-35 years age group. Within the state, overall and female literacy rates are relatively high in the Coastal Andhra region and particularly low in the Telangana region. Only 16% of SC females and 7% of the tribal female population in rural areas were literate in 1991.

A1.6 Infant mortality rates in the rural areas remain high. Urban rural differentials in IMR persist and decline in fertility indicators in rural Andhra Pradesh continues to be slow. IMR in the rural areas declined marginally from 73 to 70 in the 1990s. IMR is particularly high among tribal populations – at almost double the state average. The most recent NFHS survey (1998-99) indicates that fertility rates are also declining in both urban and rural areas. However, the decline is slower in rural areas. While fertility in urban areas has already reached replacement level (TFR: 2.07), in rural areas it is about 10% above the replacement level (TFR: 2. 32).

A1.7 Nutritional status in AP compares poorly with other southern states and this has particularly worrying consequences for the health of the poor. Table 2 shows that there has been a steady decline in cereal and milk consumption in AP. Table 3 gives trends in malnutrition in AP for under fives. While severe malnutrition has decreased by 10 percentage points in the last 20 years, aggregate levels of moderate malnutrition have remained more or less constant.

Table 2: Trends in average consumption of foodstuffs and nutrients (gr./CU/day)

	Cereals & Millets	Pulses	Milk and Milk products	Protein	Energy
1975-79	568	31	98	59.8	2447
1988-90	534	28	82	55.7	2340
1996-97	496	30	76	51.6	2161
RDA	460	40	150	60	2425

Source: National Nutrition Monitoring Bureau (NNMB) (see footnote 1)

Table 3: Trends in nutritional (weight for age) status of 1-5 year old (% of total cohort)

	Nutritional grades		
	Normal & mild	Moderate	Severe
Boys 1975-79	34.1	49.1	16.8
Boys 1988-90	48.2	44.9	6.9
Boys 1996-97	43.6	49.6	6.8
Girls 1975-79	43.2	42.7	14.1
Girls 1988-90	48.1	43.7	8.2
Girls 1996-97	47.2	45.3	7.5

Source: National Nutrition Monitoring Bureau (NNMB) (see footnote 1)

A1.8 Rates of child labour are very high in AP, especially among SCs and STs. The Multiple Indicator Survey found that 16% of children aged 5-14 are engaged in economically productive labour. Rates for SC children are 20.8% and for ST children are 23.7%. They are in turn markedly higher for girls (22.7 and 31.5% respectively). The bulk of this is in the agriculture and livestock sector, but there are also significant numbers of children working in manufacturing and domestic service. A Participatory Poverty Assessment of five towns in AP found that boys work particularly in hotels, factories and fishing, while girls work in domestic labour and agriculture (DFID 2001)

A1.9 The same study noted the limited options for the working poor, especially women, in AP, with a concentration in health harming occupations such as beedi rolling, construction and in some specific communities – commercial sex work. They are also vulnerable to higher levels of crime and personal insecurity, indebtedness and inability to access key entitlements such as ration cards and credit.

A1.10 Looking beneath the aggregate figures for the state, AP is characterised by considerable inequalities at district level, as table 4 shows. However, while social and economic indicators at district level show some broad convergence, it is by no means exact, particularly for female literacy. This almost certainly suggests the importance of other factors, such as the social profile of the population and the different performance of districts in terms of their health and education sectors.

Table 4: Poverty and Human Development Indicators at the District Level in Andhra Pradesh

Districts	Rural Poverty 1993/94	Infant Mortality 1991	Female Literacy 1991	Rank Rural Poverty	Rank Infant Mortality	Rank Female Literacy
Karimnagar	13.5	35	23.4	1	2	17
Cuddapah	16.2	44	32.4	2	5	9
Nizamabad	16.2	41	21.4	3	4	19
East Godavari	18.8	54	42.3	4	11	3
West Godavari	21.1	65	47.0	5	16	1
Medak	22.2	52	19.3	6	10	21
Nellore	22.8	46	37.0	7	8	4
Chittor	23.1	60	36.4	8	15	8
Khammam	23.8	47	30.5	9	7	10
Prakasam	24.2	46	27.1	10	6	12
Ranga Reddy	24.6	56	36.9	11	12	5
Krishna	24.6	30	45.5	12	1	2
Nalgonda	28.9	58	24.9	13	13	15
Visakhapatnam	30.0	73	34.6	14	19	7
Warangal	31.4	59	26.1	15	14	13
Adilabad	32.5	51	20.6	16	9	20
Kurnool	35.3	68	26.0	17	17	14
Guntur	36.9	38	35.9	18	3	6
Srikakulam	38.5	77	23.5	19	20	16
Ananthapur	39.1	70	27.6	20	18	11
Mahbubnagar	39.7	77	18.0	21	21	22
Vizayanagaram	40.8	99	22.5	22	22	18
Andhra Pradesh	27.4	73	32.7			

Note: Poverty ratios are estimated from Central and State sample of NSS round 1993-94. The rural poverty line for Andhra Pradesh is Rs.187.39. Source: see footnote 1

b. *Health and poverty linkages*

A1.11 There are strong linkages between poverty, health and social development. As was noted, poverty is a function not only of income but also of factors like health, education, nutrition and access to basic needs and services. The health and nutritional status of people and the utilisation of health services is influenced by the extent of poverty, social and gender inequality, good governance and geographic location.

A1.12 Known and documented links between health and poverty: There is now clear agreement on the ways in which poverty and poor health status interact and reinforce each other. These hold irrespective of context. These links are noted below:

- Poor people are more likely to suffer ill-health as a consequence of their greater exposure to environmental risks – lack of sanitation, clean water, safe waste disposal, appropriate housing, greater occupational hazards

- Ill health is also a major cause of poverty. If the working poor lose their productive capacity, household income is severely compromised. Household health expenditure on serious illness has emerged as a major cause of impoverishment among the rural poor where there are no safety nets or social protection measures to absorb the shock.

- The poor pay proportionately more of their income for health care than the better off, experience poorer quality services and are more likely to live in areas where facilities and qualified, competent personnel are fewer.

- Gender inequalities reinforce poverty and health links, particularly in reproducing inequalities in access to household and community resources for managing health care.

- Many communicable diseases are "diseases of the poor." For instance in AP, much of the malaria burden is in the predominantly forested, tribal areas. TB rates are particularly high among tribal men (Prasad et.al.), reinforced by poor living conditions. HIV/AIDS is more prevalent among migrant labourers. Diarrhoea and respiratory diseases remain major causes of infant mortality and morbidity among the poor.

- Poor nutrition has complex and wide ranging effects on health status throughout the life cycle of human reproduction.

- Poor people have less social and political voice. They are less likely to know their entitlements and to make demands on government and on agencies that provide services.

c. Other social and health indicators in AP

A1.14 Patterns of marriage and childbearing in AP both reflect and reinforce the poverty profile and lead to poorer health outcomes. Age at marriage is very low and compares unfavourably with other southern states. In the age group 15-19, 54% of women are ever married. The Multiple Indicators Survey (MIS) puts the mean age at marriage as 15.3 (14.7 in rural areas and 16.7 in urban areas). Mean age at marriage of illiterate women and for scheduled caste and scheduled tribe women is about 14, while for high school graduates and above, it is 19.2, testifying to the critical importance of completed years of education in raising the age of marriage.

A1.15 Early marriage also means early childbearing, with the first pregnancy typically following one year to 18 months after. 62.8% of women married before the age of 20 have experienced pregnancy. This is the major contributing factor to the very high rates of pregnancy wastage in first pregnancies (17%). As many as 23% of pregnancies to women aged 15-19 did not end in a live birth (MIS). This pattern of very early marriage and childbearing combines with a high use of terminal methods of contraception after two or three closely spaced live births. Of the 60% of couples reporting use of any method of contraception, 58% are using sterilisation.

A1.16 According to the MIS survey, rates of institutional delivery in rural areas are still low. A notable finding is the insignificance of PHCs / sub centres in deliveries. Even in rural areas, significant numbers of women are opting to deliver in private hospitals. While in urban areas, half of all deliveries are taking place in private facilities.

Table 5: Place of delivery, women aged 14-59 who delivered in the year preceding survey

Place of delivery	Rural	Urban
Government hospital	13.8	32.7
Private facility	33.4	49.0
PHC/sub centre	00.0	00.0
Home	51.3	15.0
Missing	1.6	3.3

Source: MIS, GoAP and Unicef, 2001

A1.16 Immunisation coverage is a cause for concern. Coverage for some individual vaccines is high, but only 46% of children aged between 12-23 months are fully immunised (53% urban, 46% rural). Only 32% of SC/ST children are fully immunised, compared to 49% for the rest of the population. No significant gender differentials were found (MIS).

A1.17 Sanitation facilities are severely lacking in rural areas in particular. Only 17% of households use any type of toilet facility. More than 50% of all households dispose of a child's faeces in the house yard. In urban areas, 13% of households reported that children defecate in open drains (MIS).

A1.18 Overall, in terms of utilisation of health facilities, numerous studies have noted the desertion of public sector facilities by both the poor and the better off in favour of both self-treatment (or no treatment), and increasing use of the private sector, particularly the commercial sector. The withdrawal of the poor from the public sector is a matter of serious concern. They are least able to afford private alternatives and most in need of good quality, accessible and affordable services.

A1.19 AP's poverty profile therefore presents both paradoxes and challenges, particularly for improving health status. As the government has clearly recognised, just as poverty is multi-dimensional, so is health status. ***Actions to improve health status in AP are thus intrinsically linked to actions for reducing poverty and require co-ordination across a wide range of agencies.*** Many of these measures require broader social transformation, such as reducing gender inequalities in access to social and economic resources, and will take time to bear fruit. But shorter-term actions can also be taken to increase the responsiveness of the health and other social sectors to the needs of the poor and vulnerable, which could have a significant impact on health outcomes. Table 6 gives one example of the way in which, in the context of the prevailing poverty situation, a specific health problem links to both immediate and broader determinants and actions. The same exercise can be done on other common health problems.

2. Poverty alleviation, income generation and health[2]

A1.19 It is commonly believed that increased income would lead to improvement in health status and that effective poverty alleviation programmes is a necessary precondition for overall progress on the social development front. While increased income is essential for overall improvement in nutritional levels, as seen in the preceding sections, social and gender relations exert powerful influence on access to and utilisation of health services. Andhra Pradesh has initiated a wide range of anti-poverty programmes and has been one of the pioneers in women's mobilisation. In the last few years state government initiatives to bring development administration closer to the people through the *Janmabhoomi* programme have attracted considerable national and international attention. This section gives a broad overview of significant poverty alleviation initiatives in the state and assesses the potential opportunities for synergy with the health sector.

A1.20 There are 21,943 Village Gram Panchayats, 1095 Mandal Panchayat and 22 Zilla Parishads (District Panchayat Office). The administrative arrangements are made in such a way that 300-400 Panchayats come under ??and 82 Divisional Panchayat Office in the state. Each District Panchayat Office difference between district and divisional? has 900 to 1000 Gram Panchayat in its jurisdiction. The government has recently (January 2002) appointed one full-time Panchayat Secretary (combining the revenue and panchayat functions) to function as an assistant to the political functionary in the Gram Panchayat. Rs 364 crores per annum is routed through Panchayat Raj Institutions (PRIs). A number of rural employment programmes are implemented through them. For example the Jawahar Gram Samruddhi Yojana (creation of durable community asset and through employment), a joint GOI-GoAP programme implemented in a 80:20 sharing basis is implemented through PRIs. Similarly the Employment Assurance Scheme and Sampoorna Gram Swarajya Yojana (also a wage employment schemes) are routed through Panchayats. However, recent reports indicate that – apart from wage employment schemes, most other poverty alleviation programmes have their own implementation structure, and they are not necessarily routed through PRIs.

A1.21 A wide range of poverty alleviation programmes are underway in AP – Central Sector Schemes as well as State Government Schemes / Programmes. An indicative (not exhaustive) list of programmes is as follows:

a. Women's Self-help Groups

A1.22 In 1991 Government of India launched a Total Literacy Campaign in many districts across the country – including Nellore District of Andhra Pradesh. The literacy movement essentially involved those who have been denied education and literacy for generations – and interestingly, for the first time in Independent India we had a programme that was only meant for the poorest of the poor - those who were bypassed by educational process. Women participated in very large numbers. The anti-liquor

[2] This section draws upon Note On Rural Development Activities In AP – Presentation Prepared For The Parliament Consultative Committee, Panchayat Raj and Rural Development Department, GoAP, April 2002, AP-DPIP documents.

movement (1992) spread like fire, the rest is history. Government declared a ban on arrack in April 1993 (which was subsequently revoked in 1996). Rural women leaders of Nellore and Anantapur Districts of Andhra Pradesh (India) demonstrated how literacy, empowering organization building and credit go hand in hand. Here was a group of women who started their journey with a literacy movement and then moved on to an anti-alcohol (anti-arrack) movement and then got together in groups of 15 to 20 to start a savings movement (Podupulakshmi). Their journey taught many of us in India a valuable lesson – people's access to funds for income generating activities or to credit would be meaningless without awareness and self-confidence. One charismatic leader declared:

"Literacy campaign made us aware,
Anti-arrack movement gave us confidence; and
Podupulakshmi empowered us."

(Saving group members, Atmakur Mandal, Nellore District, India August 1995)

A1.23 During recent interactions with rural women leaders associated with Mahila Samatha Programme of Andhra Pradesh they explained that empowerment does not "happen" automatically. Credit, productive assets and skill cannot be used to the benefit of the poor unless they are aware, confident and powerful as a collective to resist the landlords, moneylenders, unscrupulous middlemen and even development functionaries! On the flip side it is also true that a state of heightened consciousness in the absence of means to access productive resources could led to social unrest and frustration. Awareness, education and strong sense of self-worth enable the poor, especially women to articulate their needs and negotiate this unequal world from a position of strength. Each aspect of development is inextricably linked to the other.

A1.24 Poor women's access to institutional credit is almost negligible. When they do have access, transaction costs (including bribes, repeated trips to the bank, documentation, collateral etc.) is high. The smaller the loan amount, the greater the transaction costs – thus making institutional credit unviable for poor households and women who seek small loans. Most poor people's interaction with banks and other financial institutions is known to be disempowering – and grassroots workers remind us that even an apprehension of loss of dignity keeps the poor (especially women) away from formal institutions. Recognition of these interlinkages led to developing a strategy to enhance women's collective strength, self-confidence, awareness and ability to negotiate formal institutions. These were recognised as necessary pre-conditions for the poor to access institutional credit. Without that they will become victims of middlemen.

A1.25 In the last ten years governments and donors alike have promoted savings and credit as the magic formula – leading to a big rush to fund women's self help groups in India. Andhra Pradesh is the leader in this movement, which has seen an unprecedented spurt of Women's Self Help Group. Recent estimates point to the existence of 4.21 lakh groups covering 55.80 lakh women (GoAP, April 2002). This accounts for almost 50% of all existing groups in the country! While they are organised under different programmes and schemes – both government and non-government, the main focus is on formation of thrift and credit groups with a view to access small loans for both emergency

consumption needs as well as production. Government estimates indicate that the groups have mobilised 1300.58 Crores as corpus and in the year 2000-01 the Government of India has contributed Rs 4 Crores towards revolving fund, GoAP has invested Rs 44 Crores (which have been channelled to 44,000 groups) and the groups have been able to access up to Rs 500 Crores from Banks and Financial Institutions.

A1.26 This has been a remarkable achievement for the state. Review of studies and documents reveal that this movement got a tremendous boost from a number of social movements:

- The Cooperative Development Federation (earlier known as Samakhya) was a trailblazer in this area and worked in several districts to establish credit and thrift groups of women in the 1980s and 1990s.

- The Total Literacy Campaign of the early 1990s led to the establishment of Podupulakshmi groups in several districts.

- DWCRA – a GOI programme helped support a very large number of groups in the state. This scheme was adapted to the specific needs of AP and implemented with a great deal of flexibility right through the 1990s. This scheme has since been merged with *Swarna Jayanti Swarojgar Yojana* (SGSY) in April 1999. Between 1999 and 2002 this programme alone accounted for a disbursement of Rs 221.5 Crores (Source GoAP, April 2002).

A1.27 While no independent estimates are available, government sources point out that over 50% of the groups are active and women members have been able to enhance their income by Rs 2000/- per month. While there has been no comprehensive sample study / survey on the impact of the SHG movement on health and education, analysis of loans taken by women indicate significant expenditure on health and hospitalisation.

b. Swarna Jayanti Swarojgar Yojana (SGSY)

A1.28 This programme provides the umbrella for the integration of existing poverty alleviation programmes and encompasses a wide range of employment and resource management programmes. The total allocation in the FY 2001-02 (GOI + GoAP) was Rs 52.65 Crores. It is noteworthy that additional allocations (over and above budgetary allocations) of Rs 4.16 Crores pushed up expenditure to Rs 61.33 Crores. It is estimated that 146997 beneficiaries were reached in 2001-02 (Source: GoAP). Among the individual schemes / programmes that are now subsumed under SGSY are:

i. Technology and Training development Centres (GOI Programme) in 22 rural Districts, with an outlay of Ts 15 Crores at the ratio of GOI:GoAP of 75:25.

ii. Permanent Marketing Centres, also a GOI programme with a centre-state ratio of 75:25 involving an investment of Rs 12.3 Crores. DWCRA Bazaars and other rural marketing fairs are organised under this programme.

iii. Economic generation through coir production through Women SHGs involving an investment of Rs 14.5 Crores, shared by centre and the state government at the ratio of 75:25.

iv. Poverty alleviation through improved agriculture technology in Chittoor District, a 100% GOI funded project.

v. Technologically Qualified Global Workers (apparel production), another GOI programme is underway in the districts of Medak, Ranga Reddy, Nalgonda and Warangal. The investment in this programme is to the tune of Rs 3.2 Crores.

vi. Indira Awas Yojana – a rural housing programme for BPL families has been brought under the ambit of SGSY.

c. Rural Poverty Reduction Projects

A1.29 A number of rural poverty eradication programmes have been initiated over the years. In 1996 the UNDP assisted South Asia Poverty Alleviation Project (SAPAP) covered 20 Mandals in 3 districts – this project demonstrated that the poor both have the ability to help themselves and they can play a positive interventionist role in their development. Positive results in this project (which formally concluded in 2000) led to the design of World Bank assisted DPIP / APRPRP in August 2000 – this project is known as Velugu in AP.

A1.30 The overall objective of Velegu is to enable the 'poorest of the poor' to articulate their needs; access and influence the quality of service; and create their own opportunities to improve their livelihoods in a sustainable manner. The strategy adopted in this programme is as follows:

- Focus on the 'poorest of the poor' across the State in selected Mandals,
- Address the livelihood issues of the poorest of the poor with a focus on land and water management of degraded areas,
- Support greater convergence of health, education, nutrition and natural resource management,
- Anti-poverty programs to be responsive to the needs of the poor using a bottom up and contextualised approach, and

- Evolve institutional arrangements to include other stakeholders such as local Government and civil society.

A1.31 This programme is currently underway in 141 Mandals, reaching out to 3779 habitations, 10,000 women's self-help groups have been formed and they are federated as Samakhyas in 29 Mandals. This programme has adopted a community-based approach and works through Community Investment Fund, where decision making on usage is devolved to community based groups. Eradication of child labour by getting children back to school through intermediate bridge courses has been integrated into this programme.

d. Drought Prone Area Programme (since 1975, GOI: GoAP 50:50 share) and Integrated Wasteland Development Programme (IWDP)

A1.32 Since 1991 has attempted to mobilise stakeholders in land and water related issues. These programmes were reviewed and revised by GoAP in 1995-96 on the basis on the recommendations of Hanumantha Rao Committee. A significant change is that Watershed is seen as a concept that integrates conservation, management, budgeting of rainwater, using a holistic framework to link food security and soil / water conservation. The government involved NGOs in a big way to develop and manage the community based Watershed Development Fund. These groups have been linked to NABARD to enable farmers to access agricultural credit.

e. Rural Water Supply and Sanitation Programmes

A1.33 This programme is reported to have covered 44,120 rural habitations (fully) and 17,619 (partially). Government reports point out that 7,993 rural habitations still do not have any safe source of water.

f. Mahila Samantha (a part of Government of India Mahila Samakhya – Education for Women's Equality Programme

A1.34 While this programme does not strictly fall within rural development and is located in the education sector – the main objective of this programme is to enhance the capabilities of women to negotiate their world and the system from a position of strength. This Central Sector Scheme is implemented in 7 districts of AP and covered 1200 villages through formation of women's groups at the village level and Mandal level / District level federations of women groups. In the last three years this programme has tried to forge linkages with food security, agricultural development and health, essentially empowering rural women's groups to play a positive interventionist role in community development initiatives and weaving in gender and equity concerns in mainstreaming programmes. Managed by an autonomous (government created) society, this programme has the potential to work across sectors and departmental boundaries.

4. Linkages between poverty alleviation programmes and health

A1.35 Notwithstanding significant achievements of poverty alleviation programmes in the state, recent evidence points that they have not made the desired impact on health outcomes. As noted in the sections above in the absence of reliable public health care services in rural areas, the poor are increasing accessing private healthcare providers. According to NFHS-II (1998) 68.7% of poor household who recently visited any health facility went to private hospitals / clinics and only 26.8% visited any government facility (Government hospital, dispensary, CHC, PHC, Sub Centre and Camp). An overwhelming proportion of people who went to government facilities did so for MCH and FP services. Over 62% of below poverty line families financed hospitalisation in the private sector by borrowing money or selling assets (World Bank 2001). NSSO data 52 round, 1998) point out that 24% (rural) and 21% (urban) respondents cited financial problem as a reason for untreated ailments.

A1.36 A recent qualitative study conducted under the aegis of Velugu (Dr Ranga Rao, 2002) lists the reasons cited by respondents for delay in seeking healthcare. They are:

- Denial of sick role for reasons of explicit symptoms
- Denial of sick role till the social and economic role performance is effected
- Delay in view of work demands and social responsibilities, particularly in case of women
- Delay due to lack of assistance in case of women, children and aged
- Lack of knowledge of appropriate facility
- Lack of financial resources
- Problems of physical access
- Preference to seek treatment from local providers including magico-religious practitioners in view of prevailing concepts of supernatural causation for diseases

A1.37 It is more than apparent that poverty alleviation is a necessary but not sufficient condition for improvement of health status of the poor. There is compelling evidence showing that there is an urgent need to forge formal linkages between existing poverty alleviation programmes and the health delivery system. Velegu has taken this on board and has recently initiated action to integrate healthcare access issues into their programmes. The qualitative study cited above was commissioned to facilitate need based planning for closer linkages between health care and poverty alleviation programmes of the government.

A1.38 Rural poverty reduction programmes in AP acknowledge that each aspect of development is inextricably linked to the other and with growing awareness and control over earnings women will reach out to health care facilities. Poor women have little access to institutional health services; as a result many of them seek out private doctors - where unethical practices for profit subject them to unnecessary medication and operations. Support systems built for savings, credit and institutional finance have not been able to respond to the health needs and the health delivery system has almost no links with the SHG movement in Andhra Pradesh. Building workable and ground level linkages between the two programmes could indeed make a difference in the lives of the poor – especially poor women for whom health of their families and their own health are indeed important issues. The Society for Elimination of Rural Poverty – the management system created for the implementation of Velugu has started planning for community based health insurance programmes for the poor. These initiatives are at a very preliminary stage – therefore this is an opportune time to forge closer inter-sectoral linkages.

5. Community Based Convergence in the Health Sector

A1.39 Andhra Pradesh has, in the last fifteen years, acknowledged the value of community-based convergence. While the savings and credit movement is well known, smaller initiatives in the health sector are yet to receive national attention. Three important initiatives undertaken by the government are noteworthy:

a. IPP VIII – Community-NGO-Government Partnership for Health

1. Under the aegis of the IPP VIII programme funded through a World Bank loan, an effort was made to enhance the utilisation of urban health care services by building a bridge between poor women and urban health posts. The focus of this programme was to improve the utilisation of government healthcare delivery services by making it more accessible to the urban poor. To this end, the Municipal Corporation of Hyderabad worked with 19 local NGOs to identify and train link volunteers – one for 20 households. These voluntary workers were trained and supported to interface between the community and service providers. Simultaneously, the government made efforts to enhance the basket of services and make urban health posts functional. This model has now been extended to 72 municipalities under IPP VIII Extension Project (World Bank funded). This programme has been documented as "best practice" and has recently generated a great deal of interest among health policy / planning community.

b. Community Health Worker Scheme under the Tribal Health Plan:

2. Acknowledging that the primary healthcare delivery system has been unable to percolate into all tribal villages, a village based

Community Health Worker was appointed to respond to the health needs of tribal groups. The focus was on training CHWs to manage routine maternal and child health problems, including minor ailments. Like the urban link volunteers, the CHWs are also expected to work as a liaison between community and health delivery system. They are also expected to support the ANM / PNC on MCH tasks (distribution / awareness) and TB (Dots – awareness and observe consumption of drugs). The scheme provided for one worker for 1000 population. Recent evaluation of the programme has been mixed – while the programme seems to bring the health delivery system closer to the people, the persistent absence of doctors from tribal areas has affected the credibility of the programme. Given the educational status of tribal groups, 54% CHW are illiterate and most of them are in the 15-35 age group. Sample survey conducted in the area reveals that 68.8% of the respondents are illiterate, (40.2% female) and only 22.8% of respondents went up to primary, 3.3 % up to middle and 5% up to high school level. The silver lining is that this trend seems to be receding and in the 6-14 age group 8.1% girls and 2.6% boys were illiterate.

A1.40 Only 18.5% households surveyed had access to safe drinking water from a hand pump, 0.5% to covered well, 28.3% to uncovered well and 52.7% to surface water. What is indeed distressing is that 99.3% do not have access to any sanitation facilities and 65.9% dispose wastewater in the open. Among total deaths occurred in the last one year 22% were due to Malaria. The evaluation report points out that the community is fairly positive about this programme, however irregular payment of honorarium, poor training and irregular supply of drugs continue to pose serious challenges. Given that majority of the CHWs are illiterate, records are not maintained. The sample study showed that pre-puberty marriage had come down and that there has been modest improvement in ANC check up (94% availed of 3 ANC check ups as different from 67% in control area), 69% took IFA tablets, 62% TT injections and better nutrition during pregnancy etc. 96% deliveries at home and 30% attended by ANM, 10% by CHW, 24% observed the 5 cleans. However, there has not been much change in matters related to delivery care, newborn care and breast-feeding. (Source Evaluation of the scheme, sample survey conducted in 2001)

c. Women and Health Training for Women Leaders in the Community

A1.41 The MOHFW, GOI (Department of Health) supported a training programme on women and health issues for women leaders in the community. A committee comprising of women's health practitioners developed a module and World Health Organisation funded the training programmes. This programme is yet to be evaluated and the impact assessed. What was interesting in this initiative was that it involved the Mahila Samantha

programme of AP and led to closer linkages between the health department and a women's empowerment programme.

d. NGO – government collaboration in the health sector.

- The non-profit sector, popularly known as the NGOs encompasses a wide range of organisations and can be broadly categorised as follows:

- Development oriented organisations working among the poor with the objective of enabling women and men to participate in development processes and those involved in mobilising people to demand services and information; implementing specific projects and programmes through grants from the government or donor agencies. Andhra Pradesh has a large number of such broad based development groups.

- Social action groups that emerged as part of the different people's movement with a focus on advocacy and mobilisation, organising and networking for impacting and changing laws, policies and development programmes. Given the interesting political history of AP, there are a significant number of advocacy groups focusing on human rights and social justice issues. The women's movement in the state is considered a forerunner in the country.

- Resource groups, training organisations, and research / development planning organisations that generate and disseminate information and research, build national and global networks and provide professional consulting services in the development sector.

A1.42 For almost fifteen years now the health sector has worked with a number of established organisations which function as Mother Units to channel government funds to smaller organisations. This concept was introduced under IPP IX and has since 1996 been adopted as an integral part of GOI's strategy to involve NGOs in health and family welfare. While a comprehensive list of NGOs supported under this programme is not yet available, it is reported that a wide range of service delivery organisations, charitable hospitals, medical practitioners have received grants from the government.

A1.43 Since the introduction of the RCH programme in 1997, NGOs have been involved in advocacy, counselling, raising community demand for RCH services and improving service delivery through innovative approaches that are complementary to government services.[3] Across the country, Government of India supports 650 field NGOs through 57 Mother NGOs (330 districts across 22 states) – 7 of these Mother NGOs are from Andhra Pradesh. The state government does not actively participate in either selection or monitoring the work of NGOs supported by GOI. There is little evidence on the impact of these programmes and therefore we are not in a position to assess effectiveness of this strategy. However a recent review of the programme recommended that NGOs could

[3] Aide Memoire: World Bank Mid-Term Review Mission of the RCH Programme, November 2000

play a crucial role in 'medium and low-performance states' in augmenting the pool of trained paramedical workers – given that availability and accessibility of skilled midwives continues to be the most important barrier to safe motherhood. Based on this feedback the Government of India (MOHFW) in collaboration with UNICEF and Sida are piloting a midwife training and capacity building programme in Medak District of AP and Bidar District of Karnataka. This pilot project is being designed in collaboration with a local NGO – Academy of Nursing Studies, Hyderabad.

A1.44 In the last three decades there has been an appreciable growth in the NGO sector partly because national and international foundations and bilateral donors have come forward with financial support and grants. Many of them have done path-breaking work in the area of public health, women's health and community based programmes. While the government has acknowledged the importance of community participation in the health sector and has even supported NGOs and community-based groups – the public health system is yet to work in collaboration with community based groups.

A1.45 In addition to the 7 Mother Units and 100 field NGOs supported by GOI, a large number of NGOs are today working with the government in the health sector. For example over 100 NGOs are involved with the HIV/AIDS programme, 192 with the Urban Slum Project (IPP VIII extension), 43 in Mahboobnagar District health project, 19 in the Hyderabad City IPP VIII programme and 7 in Ranga Reddy District urban slums project of the government.

A1.46 Discussions with NGO leaders in the state reveal that there is no forum for structured interaction between the government and NGOs in the health sector. Over the last two decades, the Government has recognised the importance of exploring the potential of organisations and institutions that work directly with the people with a view to bring social sector programmes closer to their needs. This is an important issue among development practitioners. Since the Seventh Five Year Plan, Government of India has publicly acknowledged the potential of voluntary organisations and lamented over the inherent constraints of development administration. In reality, however, the voluntary sector has been seen as an effective agent for delivery of services. Government's perception of the sector as spelt out in the Seventh and Eighth Five Year Plan documents was summarised as follows:

> "Volags[4] can introduce innovative approaches in programmes for rural development, poverty alleviation, relief and rehabilitation, education, health, family planning, social welfare, women's development, release of bonded labour, non-conventional energy and water conservation as well as water use.
> Volags can deliver services at relatively low costs by using local resources and mobilising funds as well as labour from the community.

[4]Acronym for Voluntary Agencies

> Volags can provide communication lines between government and people, pass on government funds to village-based groups and provide feed-back on development programmes and emerging issues. People can be energised by Volags to demand quality services from government programmes."[5]

A1.47 While the importance of involving Volags to reach out to people has been recognised, the limitations of non-governmental organisations to reach the unreached is a cause for concern. Issues of outreach, especially to remote areas and less developed regions continue to pose a problem. It has been observed that developed regions have more organisations and that remote areas are invariably left out even by the voluntary sector. Some districts / states are saturated with voluntary organisations, while there are pockets where it is difficult to find even one good agency.

A1.48 The government does not have a uniform policy or pattern for supporting NGOs, it varies across sector. Some departments have a range of grant-in-aid schemes for NGOs, some others have developed mechanisms to involve NGOs in ongoing programmes. Some officials view non-government organisations with suspicion and others go out of their way to create opportunities for government-NGO collaboration. For example, officials administering health and family welfare projects have expressed concern over retired government servants, doctors and PSM professors setting up NGOs. One GOI department has issued an internal circular to carefully scrutinise agencies set-up by retired civil servants. On the one hand the government recognises the enormous potential of NGOs and at another level it is also apprehensive about inherent problems of accountability.

A1.49 There is a growing realisation that NGOs cannot possibly provide all the answers to complex and vexing issues of decentralisation and development. Addressing the challenge of reaching the unreached, GOI appointed the Ashok Mehta Committee in 1977 to enquire into the working of the Panchayati Raj Institutions (PRI) and suggest measures to strengthen them so as to enable an effective system of decentralised planning and development. This committee did not see voluntary organisations as the answer to decentralised development and called for the need to look at PRIs as political institutions that would delegate power to bodies closer to the people and build strong accountability systems. NGOs, it was felt, cannot substitute local self-government institutions.

A1.50 Government - NGO collaboration in the Health and Family Welfare sector has been fraught with innumerable problems. At one end of the spectrum are agencies, which have worked with missionary zeal in leprosy eradication, blindness and tuberculosis, and at the other end are organisations that have taken grants to further their own commercial agenda. While the former are widely admired and appreciated by the government, the latter have been viewed with suspicion. In between are a host of agencies, charitable

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[5]Gulati and Gulati: Strengthening Voluntary Action in India: Health-Family Planning, the Environment and Women's Development, Konarak Publishers, New Delhi 1995 (page 67)

trusts, missionary institutions and so on, which have been working either with or without government support. The dividing line between a profit oriented hospital and a charitable trust is rather thin. A very large percentage of private hospitals have been registered as charitable trusts[6].

A1.51 Many commentators have argued that regulation and support of charitable and voluntary efforts in health cannot be done efficiently without a mechanism to categorise non-governmental institutions / agencies. Policy level interventions are needed to introduce differentiated registration mechanism for non-governmental organisations working in the health sector. Needless to add, this would have to be based on research and survey of a specified range of agencies, their outreach, size, funding sources, management (whether they charge for services and if so what is the proportion of free services to paid services).

A1.52 The Medium term Health Strategy for AP could play a catalytic role in initiating debate on the above. Some base-line research followed by a working group to discuss avenues for collaboration, exploring ways and means for categorise organisations on the basis of the nature of their work, outreach and capacity, differentiated registration and areas for support could be considered. Paying lip service to NGO involvement in the absence of mechanisms to harness their potential to complement and supplement public health services has been counterproductive.

A1.53 Over the years it has become evident that the government perceives NGOs primarily as service providers and not as partners in policymaking, strategising and programme development. On the other hand many NGOs perceive themselves as catalysts in the development process, providing services being just a part of a much larger identity. While there may be instances of close collaboration between government and voluntary groups, by and large the relationship has been fraught with mutual suspicion. Over the last decade there have been efforts to allay suspicions and create opportunities for meaningful partnership. The relationship between the two has been particularly stormy in health and family planning.

A1.54 NGOs are not an undifferentiated mass - while NGOs involved in family planning and population related activities have worked in close collaboration with the government, a host of women's organisations, human rights groups, rural development agencies and the like made it a point to publicly distance themselves from the family planning programme of the government. The main irritant was a target-based approach that gave primary importance to the realisation of method specific family planning targets. However, in the changed scenario where targets themselves have been abolished, the distance between the two constituencies has considerably reduced. Given new opportunities, it would be possible to delineate specific areas of collaboration or partnership, namely:

[6] There is a lot of anecdotal evidence of such "trusts" receiving grants from MOHFW, GOI under the sterilisation ward / hospital scheme, family planning services scheme and so on.

- Drawing upon micro level experiences in the non-government sector with a view to adapt the generic lessons to state-wide programmes. Essentially this involves systematic efforts to forge linkages between micro level experiences and macro policies and programmes of the government. Government's resolve to move towards a holistic reproductive health approach with an emphasis on quality of care provides a golden opportunity to forge such linkages;

- Given "hands on" experience of voluntary organisations, the government could draw upon them to participate in planning, design and monitoring health sector programmes and adapting them to different regions of the state. In this context the key issue is how NGOs can be strategically located in government programmes, keeping in mind the comparative advantage and specific expertise of voluntary groups.

- Recognising that the entire weight of all service delivery programmes fall on the shoulders of the extension worker (ANMs for example). Ensuring a good working relationship between the community and service providers is a difficult task. NGOs could be involved in building such bridges and help develop support systems for field level functionaries.

e. NGO-Government collaborations - some lessons:

A1.55 There is a wealth of experience in the non-government sector in the country. Taking NGO models and "implanting" them into the government system has been a major problem area. However, drawing generic lessons and creating a supportive environment for replication has met with remarkable success in some parts of the country. Notwithstanding a few successful efforts at replication, by and large we have repeatedly failed to replicate micro-experiences at the macro level. At this stage we can identify a few necessary steps for successful replication, namely:

i. Ensuring appropriateness of replication: Successful innovations are based on some basic principles, some specific factors and the people who made it happen. When large systems attempt to replicate innovations, they fail to distinguish the generic from the specific. This is essential in order to identify the elements that can be replicated and those that cannot. Identifying generic principles and adapting them to specific circumstances, regions, structures and so on, are often ignored.

ii. Standardisation: . Most governments are keen to standardise models. Even when they genuinely try to replicate innovations, they expect to weave the innovation around the existing administrative structures. Culture, social structure, religion, terrain, level of development, administrative ethos, and political sensitivities - all these factors determine the outcome.

iii. Creating cohesive team that shares the objective: One of the "secrets" of successful innovations is that organisational objectives is the overriding goal

of all its segments. Eligibility criteria and rules are not sealed in straightjacketed norms without any decision-making powers at the functional level. Vimala – I can't quite follow the argument hereWhen the government attempts to replicate a "successful model" it is important to recognise that the poor cannot be expected to understand and appreciate *reasons of state*. It is the state that should create the enabling conditions for the poor. Administration of a people-centred programmes demand a qualitatively different degree of commitment and teamwork.

iv. Recognition of the need to "own" and identify with the "model": When any large system, government or otherwise, takes a "model" for implantation, they fail to recognise that the "secret" of successful innovations is that people who have been central to its conception and birth are also given the authority to implement it. There is a sense of ownership of the idea. Bureaucracies do not see an organic link between the birth of an idea or plan and its implementation. In most governments and large organisations a planning wing draws up a blue print, the finance division the budget, while an anonymous structure implements. Very little effort is made to ensure that programme managers identify themselves with the "model" or the "concept".

v. Creating appropriate structures and management systems: Most of the problems revolve around the people who administer a programme. Most successful experiments attribute their success to careful selection of project functionaries, creation of learning opportunities, training, avenues for professional fulfilment and growth and above all commitment to work among the poor. Aptitude and commitment are taken as the starting point. Sensitive management involves:

a) Appropriate rules, regulations and structures.

b) Continuity of programme administrators, especially the leader.

c) Dynamic and sensitive leadership.

d) Anticipating and overcoming bottlenecks, ensuring meaningful feedback - especially of problems.

e) Affirmation and support to field based workers to sustain enthusiasm and commitment.

A1.56 Discussions on avenues for meaningful collaboration invariably leads to reiteration of the need to involve NGOs in planning, programme designing, training, monitoring and so on. Government officials plead their inability to do so on a large scale - citing vast areas of the state without appropriate NGOs as a major bottleneck. As it stands now, the government does not have before them a comprehensive listing and rating of the range of non-governmental organisations working in the health sector.

Available lists do not give policy makers and administrators enough qualitative information for decision-making. We cannot even start to think of ways and means to involve them without comprehensive information on their numbers, range, outreach and quality.

A1.57 As a start, it may be useful to attempt a categorisation of non-governmental and private institutions providing health care services - with a view to identify agencies and organisation doing innovative work in primary health-care in rural / urban / tribal areas, those with training capabilities, those with expertise in planning and managing large programmes and so on. Such region-specific information could strengthen government ability to initiate collaborative programmes in some areas.

A1.58 State-wide experience of working closely with NGOs and civil society organisations like Self Help groups could be valuable in the health sector – and this needs to be explored seriously and systematically.

6. Challenges and Constraints:

A1.59 The overarching challenge faced by Andhra Pradesh is to improve the health and nutrition status of the poor – the state cannot attain the goals enunciated in Vision 2020 goals without giving this issue the attention it merits. It is known beyond doubt that the burden of health services disproportionately falls on the poor and non-availability of financial resources remains one of the main reasons for untreated illness thereby resulting in sharp increase in morbidity – especially in the last ten years. This burden is compounded in a situation of unequal gender relations and inequalities in social situation / status. The following issues can be identified as central to taking a broader, developmental approach to improving health:

a. The need to make clear links with the overall poverty reduction vision of the government

A1.60 Limited linkages between health and other poverty alleviation programmes of the government, even though access to good quality and reliable healthcare is identified as a priority by poor women – as evident from literature on self-help groups in Andhra Pradesh;

b. The need to tackle health problems through a broader, multi-dimensional frame, not just through the health sector

A1.61 Other social practices exert a significant influence on health outcomes – age at marriage (15.3 in AP), 23 % of pregnancies of 15-19 do not end in live births, vulnerability of poor women to HIV and AIDS – given existing gender relations.

A1.62 Provision of services and infrastructure is a necessary not a sufficient condition – there is a need to create enabling mechanisms where poor people are empowered (through community action) and enabled (through financial and insurance mechanisms)

to improve their nutritional status (through linkages with PDS) and access public health services.

c. The need to shift health resources to disadvantaged populations

A1.63 Nutritional status is of grave concern – influencing health outcomes, especially among poor women and children. This is directly linked to maternal, infant and child mortality. While there has been significant reduction in IMR from 123 in 1970 to 63 in 1998, IMR is still high in tribal areas (120).

A1.64 National Health Accounts, Beneficiary Impact Analyses and Public Expenditure Reviews all need to be brought to bear on understanding current resource allocations and how they can be reorientated

d. Horizontal and vertical fragmentation (including duplication) within the health system - across programmes and within different inputs.

A1.65 Many programmes and structures are in place however there seems to be little backward / forward linkages within programmes and across vertical programmes. For example yhe primary-secondary level interface is particularly bad and with each sector there is little coordination between training, staff deployment, availability of equipment / supplies that match the specialisation of staff etc..

A1.66 At primary level, on the other hand, too many tasks have been focused on one front line cadre. The Auxiliary Nurse Midwife (ANM) continues to be the primary service provider but her multiple responsibilities include immunisation, safe delivery (pre and postnatal check-up of pregnant women), community needs assessment, contraception motivation and distribution, survey of eligible couples and maintenance of CPR registers along with infectious diseases control. Non-availability of skilled medical personnel – including nurse-midwives – remains the major bottleneck to universal access to first level of care.

e. Fragmentation across sector-wise programmes – poverty alleviation / women's empowerment, sanitation, water etc.

A1.66 A number of programmes are also engaged in health interventions, in parallel with the health sector. Opportunities for inter sectoral / intra sectoral linkages to enhance access to healthcare are yet to be explored seriously.

f. The need to understand the emerging inequalities / different patterns of health status – not just geographical but also socio-economic and gender

A1.67 Evidence of greater vulnerability of the poor to communicable diseases, given existing situation with respect to access to safe drinking water, sanitation and other public

health measures. Compelling evidence is available in tuberculosis and malaria programmes of the government.

A1.68 Absence of socially disaggregated (and within each by gender) data in the health sector makes it difficult to target services. There is a need to go beyond generic categories of SC and SC and factor in income, education and power relations.

g. The need to involve disadvantaged groups in improving access to functioning / effective / quality government services.

A1.69 There is little space for informed debate on people's expectations from the public health system. We are yet to devise mechanisms to tackling issues of accountability of providers, rights and entitlement of people and dignity and respect for the poor, especially poor women. NGO experiences in the area of micro-planning and health-mapping are yet to tried out in the public sector – this is not only a big challenge but could emerge as a unique opportunity in a district based RCH programme of the government.

A1.70 If poverty, social justice and gender issues are to be brought centre stage in the health sector then active citizens involvement in priority setting is critical. One of the challenges facing the reform process in the state is to approach the problem of access from below and explore how services can reach the needy – thereby integrating gender and social equity issues into health sector reforms.

7. Potential strategies and approaches

A1.71 We note three key areas where strategic action is needed:

a. Pilots in the health sector – ensuring that learning from the many innovative pilots is made available and informs the main system of health care delivery

b. The creation of more effective systems for monitoring health outcomes

c. The need for health sector representation in the development and management of poverty reduction programmes / strategies emanating from other sectors and departments

A1.72 Two specific areas for action, building on existing initiatives are:

a. *Linkages with women's empowerment / SHG movement in AP:* Given the wealth of experience in AP with women's mobilisation, the health sector needs to seriously explore how existing women's organisations, federations and forums can be leveraged to enhance awareness about health and nutrition issues on the one hand and enable poor rural women

to gain meaningful access to public healthcare delivery services on the other. Among the concrete ideas that could be explored are:

i. Community pharmacies run by Mandal level women's federations;

ii. Group insurance for primary health care and comprehensive maternity, disability, accident insurance;

iii. Periodic health camps to create awareness and also enhance access to curative care.

b. *Building on the positive experience of IPP VIII and other micro initiatives in urban areas,* there is an urgent need to design similar programmes in rural areas. For example the community link volunteers model could provide the much-needed bridge between poor rural women and children and the health delivery system.

8. Items for Action:

A1.73 These recommendations are made keeping in mind that reduction in maternal and infant mortality cannot be achieved through interventions in the health sector alone. There are no magic bullets or immediate solutions – involving the people in planning for their own health and empowering them to take greater control of their lives is essential.

a. Immediate

A1.74 Forge workable linkages with existing poverty alleviation and women's empowerment programmes, a) by creating a platform to systematically debate health and nutrition issues – especially maternal and infant mortality – in existing women's groups / federations and other community based groups formed in different sectors (SHGs, APRLP, Velegu, Mahila Samatha) and b) by ensuring that government task forces, working groups on poverty reduction have representation from the health sector.

A1.75 Implement information and education activities through existing forum / channels, health *mela* and extension camps for diagnosis and treatment by using the methods and experiences of community based groups in developing appropriate communications strategies. Need to transfer responsibility and funds for health information / education and other communication activities to women's organisations / community based organisations.

A1.76 Go to scale with positively evaluated experience with link volunteers (IPP VIII) in rural and urban areas.

A1.77 Forge workable links with ongoing government efforts to combat child labour through education and awareness. Working children are not only the poorest but at health risk – nutritional, occupational (cotton plucking, beedi rolling, stone quarry) and vulnerability to violence.

A1.78 Gear the system to collect / process disaggregated information – by socio-economic groups, vulnerable groups and within each by gender. This will enable the system to target services to the most needy. This can be done economically through more effective use of existing statistical sources in the state and at district level and through a selective, sentinel site approach to disaggregation. Field level staff spends a disproportionate amount of their time on detailed, routine data entry. The likelihood is that most of this is not used in any systematic way for planning purposes. Nor are health functionaries involved in making decisions on local priorities based on the data they collect. Make use of NHAs, BIAs or PERs to understand existing resource allocations and how they can be more effectively targeted.

A1.79 Develop the information base on NGOs operating in health and health related areas, documenting their capacities. Use this to develop a systematic approach to NGO involvement in health.

b. Medium Term

A1.80 Work with poverty alleviation programmes to design community based health insurance schemes linked to SHGs / women's groups. AP could emerge as the forerunner in the country, given existence of 4.21 lakh SHGs in the state. Explore the possibility of creating community pharmacies through SHGs.

A1.81 Involve women's groups and PRIs to take up annual health mapping and micro-planning (including evaluation of previous years plans / achievements) using PRA techniques – leading to creation of Mandal level health plans. Link these to a reorientation and simplification of the system of data collection at facilities level to create meaningful information for local level priority setting.

A1.82 Plan adolescent (girls and boys) health and nutrition awareness programme by interfacing with education department – valuable nation and state experience with Peer Educators and Youth Forum could provide a good base. Especially valuable to combat maternal and infant mortality and HIV and AIDS.

A1.83 Create a time bound plan to enhance the skill and technical capacity of ANMs – who are the first level of caregivers in the community. Simultaneously, enhance pool of community based (volunteer) health workers who can provide support to ANMs and work as a link between the people and the health delivery system. Consider reorganising the ANM cadre into a women's health service – the evidence suggests that their skills have been diluted by the move to multi-purpose working and the need to service larger populations, resulting in a less effective and less popular service from the users' point of view. Address issues of human resource development for this cadre, in particular the

need to create a proper career structure for ANMs (rather than the parallel structure which has emerged de facto of male supervisors whose skill base is also relatively low). This requires revisiting training content and length, catchment areas and criteria for promotion and advancement.C

c. Long Term

A1.84 Develop a long-term strategy to address social issues like early marriage by forging links with the education sector to ensure that all children are retained in school at least up to grade 10.

A1.85 Develop a comprehensive, appropriately targeted nutrition strategy for the state, beginning with the creation of a nutrition task force drawn from all the relevant delivery sectors and research organisations

9. Resource Planning

A1.86 Discussions with people involved in poverty alleviation programmes reveal that there is really no shortage of resources for community mobilisation and nor is there a shortage of avenues for credit to SHGs in AP. This has been identified as a priority and the government has demonstrated commitment to make resources available for such programmes. Forging linkages is more important that allocating funds in the health sector for social mobilisation and health education. The question is one of targeting available resources and ensuring a functioning healthcare delivery system.

10. Avenues for Research

A1.87 Document and disseminate learning from other programmes / sectors and how these experiences can inform the health sector.

A1.88 Study on the impact of SHGs and women's mobilisation on health awareness, health seeking behaviour and analysis of loans taken for health emergencies. This could feed into the medium-term plan to forge closer links between health and poverty alleviation programmes of the government.

A1.89 Commission research on occupational health of working children – including girls working on cotton farms – pollination, plucking etc.

A1.90 Prepare a status report on NGO experiences in the health sector and those working in other areas but with the inclination / capacity to work in the health sector.

A1.91 Synthesise existing knowledge on health status and health seeking behaviour among tribal populations and identify priority information gaps

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DRAFT

Annex 2

Support for Development of A P Medium Term Health Strategy for Andhra Pradesh

Government Health Care Delivery

Marc Mitchell

Annex 2

Support for Development of A P Medium Term Health Strategy for Andhra Pradesh

Marc Mitchell, M.D.

1. Improve Public Health Care Service Delivery

A2.1 Over the past 30 years, Andra Pradesh has made remarkable gains in improving the health, educational and economic opportunities of its population through a series of investments and reforms to its public infrastructure. Yet, during the past decade, many of these improvements, particularly in health have stagnated, with the result that Andra Pradesh now has fallen behind many of its neighboring states in measures such as infant mortality, immunizations rates, maternal mortality, and effectiveness of disease control programs such as TB, Malaria, Acute Respiratory Infections, and Diarrheal Disease.

A2.2 There may be many reasons for the relative inability of the health system to impact more effectively on these critical indicators of health. These include:

- The inability of the public health services to deliver services at the community level where they are needed;
- The inability of health programs to link to communities and community organizations that are needed for effective impact in programs that require changes in social behavior such as institutional deliveries, HIV/AIDS, or birth spacing.
- The importance of social measures such as age of marriage, illiteracy, and undernutrition that contribute significantly to the rates of infant and maternal mortality and are largely outside of scope of the health system directly;
- The outdated and ineffective system of targets and incentives for specific health activities such as malaria slides that have no impact on morbidity or mortality and influence the behavior of health workers in ways that are counterproductive to program effectiveness;
- The lack of motivation and accountability of health staff at all levels of the system leading to wholesale absenteeism by staff from their posts and little productive activity even when staff are physically present;
- The general lack of confidence by the public in the government health facilities caused by the chronic lack of doctors and medicines, and the poor motivation and

often imperious attitude of health staff towards their clients, especially poor women, or those who are from tribal areas;

a. Current Approach

A2.3 As in most states in India, the delivery of primary health services in Andra Pradesh has largely focused on the development of a comprehensive health infrastructure based on facilities at the district, mandal, primary health care, and sub-center levels. Considerable effort has been put into the improvement of these a facilities, particularly at the district and primary health care facility level, and with the introduction of the APVVP structure for both District and larger CPC hospitals, there has apparently been considerable improvement in the functioning of these facilities.

A2.4 Because of this **facility based approach to health care**, and the hierarchical supervisory and administrative structure that accompanies it, each type of facility is dependent on the effective functioning of the staff and systems at the next level up for supervision and support. Thus, the ANM at the sub health center relies on the Primary Health Center and its staff for supplies and supervision, the PHC is linked to the CPC hospital for referrals and technical guidance, and the district hospital is meant to provide both specialist medical services and administrative support to the entire system. Unfortunately, due to acute shortages of staff, especially doctors, and confusing and often conflicting supervisory structures, these linkages do not easily occur, and thus to a large extent, each facility, and each service provider below the district level is effectively on their own, with little guidance and often little support. The result is that peripheral staff, confused about their roles, and frustrated with their inability to delivery effective services do not adequately serve their communities.

A2.5 In an effort to focus attention on certain national priority programs, The Government of India provides direct funding for a variety of **Vertical programs** such as family welfare, malaria, tuberculosis, and other infectious diseases. These programs are implemented through the state infrastructure, and rely heavily on the staff at the district level for coordination and the multipurpose health workers at the community level. For a variety of reasons, these programs are not working effectively. One problem is that the state of Andra Pradesh has not fully funded the positions in these vertical programs so there is a lack of staff, especially at the local level. A second problem arises at the district level where the multitude of programs each compete for very limited resources with the result that programs are not fully implemented and these priority programs are not having the desired effect on disease control in the state. A third difficulty of these vertical programs is that the current policy is toward integration of program activities at the state level, so that the status of these vertical programs is confused, and it is not entirely clear how they are meant to be integrated into the state program, particularly at the district level where there are separate staff and resources for each program.

A2.6 India for many years has emphasized the use of **targets** as planning and management tools, especially in the area of family planning, but in other development

areas as well. Unfortunately, the heavy emphasis on targets often means that staff place undue emphasis on meeting the numbers rather than actually achieving the underlying goals for which the targets were set. Certainly this has been the case in the area of family planning where targets has meant pressure on women to have sterilization procedures following their second child, with financial incentives provided to those who agree. However, this strategy underemphasizes other elements of family planning or reproductive health, so that there is virtually no information or demand for other types of family planning and little emphasis on spacing births to protect both the mother and child. Further, the targeting, done at particular times of the year draws off personnel from its regular duties, so that other types of programs are often neglected at critical periods and the entire system goes from crisis to crisis rather than a steady flow of services that would be both more efficient and more effective.

A2.7 An effective health delivery system requires the underpinnings of good **management systems** in areas such as logistics, information, personnel, financial. management and control and planning. While this initial study did not provide sufficient time for a review of all these systems, some preliminary observations can be made.

- Record keeping, while copious, does not seem to provide mangers anywhere in the system with the types of information they need to make the system work better. There are several reasons for this which include the disassociation of information among the diverse vertical programs, the lack of communication between different levels of the system, the lack of data about the private sector activities (that account for ¾ of all service delivery), the manipulation of data to show progress on key targets, and the lack of data processing at most levels of the system.

- Personnel systems, based on the rules of the public service and dominated by the unions provide little incentive for good work, and protect those who abuse the system for their own benefit. There is little accountability, and staff generally are poorly motivated and underperforming.

- The logistics system, recently revised and semi-privatized appears to be functioning much better than it did previously with the exception of the lack of adequate resources for drugs and supplies at the PHCs.

- The financial management system is being reviewed by another member of the team.

b. Constraints to Effective Service Delivery

A2.8 There is understandable concern about the relatively **high rates of infant, child and maternal mortality, low coverage of disease control programs**, and apparent dissociation between the recent economic development of the state and the plateauing of health indicators. There may be many factors that explain this, but one is the relative inefficiency of the system to reach its target population either through the integrated programs run out of the PHC or the vertical programs run through the district medical

office. One reason for this is the limited staff actually available at the community level, including both ANM, the male multipurpose health worker, or any type of effective supervisory system. Another constraint is the limited number of doctors who are available at the RHC and who have the enthusism and resources to promote the activities at the community level. Another problem at the community level is that despite the many types of organizations present there such as self help groups, nutrition groups, parashad health committees, and others, there is not a clear mechanism for these groups to link up with the formal health structure and utilize the resources that could be made available for better health.

A2.9 Because of the structure and rules of the public service system, promotion, and assessment is based almost solely on longevity, personal contacts and in some cases cash payments in exchange for preferred postings. For this reason there is little to no accountability by public servants either to their clients whom they are meant to serve or to their immediate supervisors who have little say over salary, promotions or placements of staff. Managers at each level have little control over staff or resources at the next level and little incentive to ensure that things run smoothly throughout the system. The premium is on not causing trouble rather than on achieving results, and in any case, there is **little accountability** throughout the system except in cases of gross mismanagement.

A2.10 There remains a strong bias toward the use of **financial incentives to influence client behavior**. These include incentives to deliver at a government health facility, to have sterilizations after the second child, have antenatal care, etc. There is little evidence that these incentives actually achieve the desired goals, and may make it more difficult to help clients really understand both their options and rationale for the choices that they make at the moment and in the future. In addition, it puts the health staff into the difficult position of deciding on the entitlement to various payments rather than of providing information and assistance.

A2.11 The **role of the ANM** has shifted considerably in the past decade leaving both the community and the ANM frustrated. Originally conceived as a front line maternal health worker able to perform deliveries, give antenatal and post natal care, and provide family planning advice, the ANM today, in her new role as multipurpose health worker is expected to also provide information on disease control, water and sanitation, nutrition, and curative services to a wider population of approximately 5000 people with a shorter training of 18 months (previously it was 24 months) and with virtually no technical supervision. To a large extent, the dilution of her activities has distanced her from the community which she serves, leaving her with little support and considerable frustration in her ability to carry out her work. This difficulty is significantly compounded by the fact that the doctor at the Primary Health facility is usually not present, and virtually never comes to supervise the ANM, and typically there is no suitable building for the ANM to work in at the village.

c. Potential Strategic Approaches

Short Term

A2.12 Although the relatively poor performance of the government health system of Andra Pradesh will require fundamental systemic changes in the long run, there are many specific targeted activities that could be implemented immediately that would have a significant impact on key vital indicators.

A2.13 Perhaps the single most important change that is urgently needed is to support **linkages between the many community and women's groups and specific health programs.** AT the present time, the PHC system is not reaching the communities and so programs such as safe motherhood or malaria control are not having the desired impact. Thus as a first priority, the community, self-help, or women's groups that are active in each community must be given both the authority and the resources to assist in their own health programs. Examples of how this could be achieved are:

- Mechanisms must be developed to get basic drugs and supplies to the communities such as chloroquine, ORS, antibiotics for ARI, and contraceptive supplies such as pills and condoms. This could be done through a program of community pharmacies, through enhanced use of ANMs or through some other mechanism. It is a relatively simple matter to teach mothers and other members of the community to recognize symptoms such as fever, cough and dehydration, and the dangers of over use of drugs such as chloroquine, trimethaprim-sulfa or ORS are far outweighed by the increased mortality of underuse. In the long run, trained providers should be made more available through the PHC, but in the immediate term, one can simply not wait for this to occur.

- Many villages have access to well water, but many of these wells become contaminated during certain times of the year. It is a relatively simple matter to make disinfectants such as chlorine available to community groups on a periodic basis to reduce the incidence of water-born disease and diarrhea in the community.

- Not all villages have the same public health problems, and communities need to be encouraged and supported to develop specific, integrated disease control program approaches based on local issues and priorities. In areas of high malaria or encephalitis, programs that include vector control could be supported and managed by the communities, while those areas with high incidence of TB could be trained in the need for contact tracing and the DOTs program. The point is not to try to teach each community about all of public health, but rather to identify the particularly high priority disease problems for individual communities and teach local groups specific activities to control these diseases.

- One way that these types of programs could be encouraged is through the use of ratings and prizes for those communities or community groups that achieve the best

results or undertake innovative approaches to health programs. Communities could be rated in a manner similar to that being done for ARVVH hospitals (ABC) and annual awards could be given to the community group in each district that has the best results or more innovative approach, with cash prizes given to the winning communities. This type of publicity may contribute to the dissemination of new approaches and foster appropriate competition among communities to achieve better health results.

A2.14 A second immediate priority must be to regain the **trust of the ANM's by the community** and to make them more productive. In the past, when their role was clear as part of the family welfare program, and their training and supervision was adequate, they were a respected part of the community. Today, with their reduced training, their limited supervision, and their expanded role, they are both frustrated and unsupported. To regain their support, several actions are suggested:

- The role of the ANM must begin with a linkage to the communities she serves, and this must be made explicit to both parties. Under the program of decentralization, it must be the parishad that supervises the ANM rather than the staff of the PHC, and this must be made clear at the outset. At the same time, the MOH must make clear to the parishad what the ANM can and cannot do, and the ways in which the community must support the ANM in her role in the community.

- There must be developed a more realistic scope of work for the ANMs based on the perceived needs of the community and the skills that the ANMs actually possess. This would include family planning counseling and service delivery, included a much stronger focus on spacing through use of pills, condoms, injectables, and IUDs, and antenatal care. Further, as part of the antenatal care program, money that is designated for pregnant women to enhance nutrition could be administered through the ANM or the local mothers groups so that the funds are actually used for this purpose rather than being dispersed after delivery. Other nutritional advice or supplementation could also be given to pregnant women by ANMs.

- It is also suggested that ANMs be given basic training in the treatment of common health problems similar to that described above for community groups. Thus, they could be provided with chloroquin for malaria, ORS for diarrhea, and trimethaprim sulfa for acute respiratory infections.

- Given the number of communities that an ANM must serve, and the lack of suitable facilities for them to live, it is unrealistic to expect that they will live at the health sub center which is most often a run down, rented structure without water or electricity. Rather it would be more appropriate to have the ANM live in a nearby town where there is suitable housing, and then facilitate her regular visits to the communities by providing either transportation, or more likely some type of stipend for public transportation.

A2.15 The current program of **safe motherhood** is based on outdated assumptions and is not working. The fundamental assumption that high risk pregnancies can be identified before delivery has been shown repeatedly to be incorrect, and thus a program that provides emergency services to all women must be made available. This is the reason for the push to "institutional" deliveries, in which women give birth in a facility equipped to handle obstetric emergencies such as hemorrhage, eclampsia, infection, and obstructed labor, and are able to provide emergency treatment including cesarean section. However, in Andra Pradesh these types of services are not available even at the PHC, since PHCs do not provide Cesearean sections, and further the doctor is most often absent. For this reason, considerable rethinking is required about what to do about the high rates of maternal mortality in Andra Pradesh. One short term option could be for each community, depending on its proximity to a hospital, the availability of private vehicles, and of telephone service might develop an emergency response plan based on local conditions. This would mean that the local midwife or someone else in the village would be able to recognize when to get help and an immediate response would be set in motion that would transport the woman to the nearest hospital where appropriate action could be taken. In those communities that are too distant or do not have sufficient transportation, more intense efforts could be made to encourage "institutional" deliveries in an institution that can actually deliver emergency obstetric care.

A2.16 Another immediate action that would have a profound impact on both maternal and infant mortality would be the **introduction of a reproductive health program** in Andra Pradesh. Unfortunately, the family welfare program in most areas continues to be to encourage women to have 2 children as soon as they are married (often at age 15) and then a sterilization. This approach leads to high maternal mortality and infant mortality due to the young age of the mothers and the close spacing of the births. While the long term solution to this problem must be more and better educational opportunities for girls and stronger cultural inhibitions against teenage marriage, an interim step that would have some impact would be to substantially increase the information and availability of temporary methods of contraception to all women but especially to adolescent girls. There are numerous ways this could be done including the use of ANMs, teachers, and youth organizations at the community level.

A note on Infant Mortality

Perhaps the single most commonly used measure worldwide of the effectiveness of a health system is that of infant mortality: the number of children who die from any cause during their first year of life. One of the reasons that infant mortality is widely used is that it is relatively easy to measure, and is a good summary measure of a wide variety of elements that contribute to the health of a population. Unfortunately, it is a very poor measure of many of the specific interventions of a public health program in the short term, and is often misunderstood and misused for that reason.

To understand this point, it is important to understand that most infant deaths occurs during the first few hours or days after birth and are the result of prematurity, small birth weights, difficulties that occur during delivery, or problems associated with fetal development during pregnancy. In some countries, neonatal tetanus is also a significant contributor to neonatal death. Thus measures such as childhood immunizations, feeding patterns of children and effective treatment of childhood illnesses such as diarrhea and respiratory infections, while important, will not change the patterns of neonatal deaths that typically account for over half of all infant mortality. Rather, factors such as the age, parity, nutritional status, immunization status (for tetanus toxoid), malaria parasitemia and anemia of the mother will have a profound impact on the levels of infant mortality and thus measures to reduce infant mortality need to focus on the condition of the mother well before she becomes pregnant rather focusing primary attention on either the antenatal or neonatal period.

Medium and Long Term

A2.17 Many of the changes that are needed for substantial improvement of the health system and its impact on health indicators will require structural changes in incentives for staff, approaches to disease control, prioritization of resources, and changes in regulations and laws that inhibit access to quality health services at the primary level, and will need to be part of an overall restructuring of the health system as invisioned both in the Vision 2020 document and in the strategy developed as part 2 of this exercise. Further, many of these changes have already been discussed fully in documents such as *Impact and Expenditure Review: Health Sector (parts I and II) by DFID*, and *The ECTA Situational Analyusis 2001/23, August, 2001* by the European Commission. Thus, rather than going into depth about what these changes might be, I will simply highlight some of the critical areas that will need to change:

- Perhaps the single greatest blockage to good care is the absolute lack of accountability of the staff either to do their work effectively or even to be present at their post. Promotions are based solely on years of service, those in the most senior positions are simply marking time until they retire. They have no incentive to take

risks that might improve the quality of care, and rather invest their time in preparing for their post retirement careers. A better system must be put into place that makes providers and managers accountable to their clients and their superiors and ensures better services are delivered. At the same time, one must be more realistic about the conditions of services of those doctors who are working in difficult conditions at PHC or other types of rural facilities. Without proper schools for their children, appropriate housing or water or electricity it is unrealistic that doctors places at such posts will remain, and over the long term, efforts must be made to make these types of services, especially schooling, available even in remote areas. Further, doctors who do go to live in these remote areas must be given incentives such as fast track career rewards for specialist service, or enhanced promotion opportunities within the public service. Other types of rewards for working in difficult environments might include choice in subsequent placements, conferences, and priority for specialist training positions.

- The current emphasis on decentralization puts a very high premium on the capacity and commitment of the **DHMO** to make the system work effectively. Yet these doctors are not trained for the position in areas such as management or public health, and typically this position is the last before senior doctors retire after long years of service. There is a critical need for younger, well-trained, energetic DHMOs in these positions. One mechanism to do this would be to require specialist training in public health, and to make public health management a specialist position with all the rank and privileges of other specialists.

- Overall, the entire health system is highly reliant on **doctors** at every level. Yet, both in India and in other countries, studies have shown that doctors are often unwilling to go to remote areas, do the more tedious tasks required in primary care, and are less sensitive to the needs of their clients, especially those who are too poor to pay for services. Many of the tasks done by doctors in India could be done more cheaply and better by nurses or other non-physician providers, and this type of approach to many elements of service delivery should be considered.

- Over the years, India has come to rely on the use of **targets** for many of its development goals as a way to make clear its priorities. However, as has been clearly demonstrated in the area of family planning in India, these targets often lead to inappropriate behaviors by staff driven to meet their monthly or yearly quotas. Further, because of the high pressure to make their targets above all else, staff often provide unreliable information about their actual numbers so that planners do not have accurate information about what is actually happening in the field. Rather than the reliance on a small number of targets in areas such as sterilizations, a more sophisticated array of performance measures must be constructed that give a better measure of actual performance and are less easily misreported by staff.

- As discussed above, the **family welfare program** in Andra Pradesh is basically to offer incentives to women to have a tubal ligation at an early age after they have had their desired number of children. This is reinforced with cash incentives. This is the

antithesis of a reproductive health program that provides women with choices about the timing and number of children, and services regarding all aspects of reproduction. A complete rethinking of the way that reproductive health is actually practiced and delivered in Andra Pradesh should be considered with a major retraining of staff at all levels in terms of how to best meet the needs of their clients. Over the long term, this approach would have a dramatic impact on infant and maternal mortality, incidence of sexually transmitted disease, and the education and productivity of women in the society.

- One of the problems faced at most PHCs is the lack of **adequate supplies of drugs** especially antibiotics. This results in lack of confidence in the system by the population and the inability of PHC personnel to give treatments for priority illnesses such as respiratory infections, sexually transmitted disease, or maternal sepsis. While it is recognized that the funding for drugs is limited, at present a disproportionate amount of the total pharmaceutical budget goes to tertiary level hospitals that serve only a very small segment of the population. Further, the net effect of the current system is that the poor, who primarily use PHC facilities have to buy their drugs, while the middle and upper classes who are the more frequent users of tertiary care do not pay. This trend should be reversed, with higher co-payments for drugs at tertiary care levels, and with a reorientation of the budget for pharmaceuticals to place a higher percentage at the PHC level.

- The current program for institutional deliveries at PHCs is not realistic for several reasons. First of all, there are not enough beds, and further, PHCs, under the current plan cannot perform Cesarean sections since there is not provision for anesthesia at these facilities. Further, it has been repeatedly shown that the high-risk approach to identification of potential obstetric problems does not work and should be abandoned. If Andra Pradesh is to significantly reduce maternal mortality, a rethinking of the approach to institutional deliveries is needed where the emphasis is on how to save lives and have safe deliveries rather than emphasize unrealistic strategies that look good on paper but do not work..

- The current **disease control programs** seem to put a higher emphasis on surveillance than on treatment. While surveillance is obviously important, a greater emphasis on sentinel surveillance may free up resources to place higher emphasis on treatments or personal protection strategies such as the use of impregnated bednets for mosquito control. Again, the emphasis must be on the reduction of morbidity and mortality rather than unrealistic strategies that aim for eradication of disease. Furthermore, the entire question of how the vertical disease control programs are to be integrated into the primary health care system needs to be reconsidered at the state, district, PCH and local levels.

DRAFT

Annex 3

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Governance Aspects of the Health Systems In Andhra Pradesh

N. Shiv Kumar and Thomas Bossert

Annex 3

Governance Aspects of the Health Systems In Andhra Pradesh

N. Shiv Kumar and Thomas Bossert

This note focuses on the governance aspects of the health system in Andhra Pradesh. This is a preliminary paper for discussion and not a complete commentary or a detailed analysis of the situation. It is derived from a review of documents, a series of meetings and two field visits. Much more analysis will be necessary to strengthen some of the hypothesis and research required in some cases. This sets a base for discussion and the authors are happy to know of any gaps in understanding.

A3.1 The Government of Andhra Pradesh has produced a vision 2020 document, which sets out clearly the health outcomes that the Government seeks to achieve by year 2020. It also sets out some important governance principles which are to be used in achieving these outcomes. The GoAP has set up a task force on good governance and also established a cabinet sub-committee on administrative reforms. Some key statements of intent in the Vision 2020:

- A SMART Government – Simple, Moral, Accountable, Responsive and Transparent
- Refocusing Government priorities and spending to focus on key priority development areas (like basic education, primary healthy care....)
- Reducing administrative and other non-developmental expenditure and leaving market forces to govern areas where state intervention is not required;
- Decentralising government and increasing participation in planning and decision making;
- Introducing electronic government to demystify procedures and improve citizen-government interface;
- Strengthening policy making capabilities and improving performance in the public sector
- Talking a lead in persuading the Central Government to initiate regulatory and other reform;
- Undertaking a range of fiscal reform initiatives (prioritising spending, better management of expenditure, making tax administration efficient, encouraging private sector participation...)

A3.2 Andhra Pradesh state health system has been built over time, with changes being made continuously to help function better. Several sub-departments and institutions have been created over time, with varying roles and resources, to implement or support parts of the system. There are multiple layers of management, sometimes with cross cutting roles. The existing health system is complex, but largely designed to be meet emerging needs.

A3.3 The health department has a history of carrying out several changes (small and medium) introduced by the state government to improve effectiveness. Some have been successful, some not followed through in implementation and others very much in paper. The department has several external limitations – two crucial ones being the centrally sponsored schemes and their design which sometimes offers less flexibility and more vertical structures and secondly on human resources, the department will have to operate within the broader civil service rules[1] of the state.

A3.4 The Health Department was set up in 1922[2]. The Andhra Pradesh Government operates through 272 departments / sub-departments[3]. The Health Department has about 10 directorates (or sub-departments):

a. Directorate of Health Services (DHS)
b. The Commissionerate of Andhra Pradesh Vaidya Vigyan Parishad (APVVP)
c. Directorate of Family Welfare (DFW)
d. The State AIDS Control Society (SACS)
e. Directorate of Institute of Preventive Medicine (IPM)
f. Directorate of Insurance Medical Services (DIMS)
g. Directorate of Drug Control Authority (DCA)
h. Directorate of Indian System of Medicine and Homeopath (ISM)
i. Directorate of Medical Education (DME)
j. Autonomous universities and institutes (three)

A3.5 Primary Health Care is provided by the DHS. Secondary and tertiary health services are provided by the APVVP, a separate legal entity. Directorate of Family Welfare and the State AIDS Control Society implement the centrally sponsored schemes / programmes (and a few of the state governments'). Directorate of IPM is involved in production of vaccines, implementation of PFA and diagnostic services. Directorate of Insurance and Medical Services operates the Employee State Insurance hospitals and scheme. Directorate of Drug Control authority (DCA) is the regulatory authority for drug control. The ISM directorate manages the Indian System of Medicine. DME manages medical education along with three autonomous universities and institutes.

A3.6 In a predominantly 'technical' department staffed by medical professionals, health management plays a crucial role, especially in a important function of the government - public health provision. Governance aspects of the health system has a vital role to play in ensuring equity and availability of services, especially efficiency and effectiveness of services delivered. The next few pages analyse the above issues in AP's health systems context, suggest recommendations (short and medium term).

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[1] Except in independent Societies
[2] Some parts of it operational from 1802
[3] Some times referred to as Directorates

1. Analysis of the Situation

a. Role and Strategic Balance

A3.7 The **purpose** of the Health Department could be articulated as:

- Providing quality, accessible, equitable, affordable and guaranteed health services to the poor, both in rural and urban areas.
- Facilitating, partnering and providing regulatory frameworks for private sector and civil society health services.

A3.8 The **role** of the department broadly are:

- Service provision, esp. to the poor and marginalized
- Infrastructure and facility provision
- Quality assurance – of service and infrastructure
- Targeted subsidies and safety net for high cost Medicare for the poor
- Facilitation of private sector and civil society in health care
- Regulation of Medicare to make it ethical and equitable

A3.9 Key **outcomes** would be:

- Reduced mortality and morbidity
- Satisfaction of the users of public services
- Regulated private medical care that is ethical

A3.10 Of the above, the focus of the department is on infrastructure and service provision. Little is being done in other areas. There is a need to bring in a coherent strategic balance within the department – both in terms of resources (time, budgets and personnel) and management attention. Future planning will need to balance these issues and look at the best way of attaining the purpose. This may mean shedding a few activities like manufacturing vaccines, some of which are higher price than the private and moving into more strategic areas. Currently the Government is involved in complex activities surrounding health. Ways will need to be found to do less, but to do more strategic aspects. Primary Health care, which is a key component has been under performing for variety of reasons. With the establishment of the PRI institutions, the department has the opportunity of devolving this part of health care (which is managed in an average manner), while taking more strategic and support responsibilities. There is substantial scope to rationalise activities within the department.

A3.11 Government has largely left tertiary care to the private. It also needs to have a plan of how it will involve the private and civil society in other parts of the health delivery system, without losing sight of its primary responsibility towards the poor and their Medicare needs.

A3.12 The department follows historical budgeting. The sub-departments submit their budget and the department takes an overall view (with the Finance Department) and sanctions fixed budgets to the sub-departments. The line items are fixed and very little flexibility exists[4]. Nearly 70-80[5] % of all costs salaries. Other fixed costs include rent, electricity, etc. Barely about 5-10 % are controllable costs. Programme costs which include drugs, actual service delivery are still low. The function of planning for health is limited to budgeting. Strategic planning is limited to the Secretariat and Directorates, with little participation from various ranks. Most activities are carried out based on historical basis and new activities are added based on state or centrally sponsored schemes. Budgeting is mainly historical, with little innovation or flexibility. Most of the changes to the department's working have been ideas and suggestions from the Secretariat / Directorate, which are then followed through by other arms of the Government. This very important function is given least importance in terms of time. Problem resolution is ad hoc and some critical issues (like private practise and its effects) go undecided for several years.

b. Reform orientation

A3.13 The Government of Andhra Pradesh is known for its reform orientation. The Health Department in particular has been open to reforms. The Vision 2020 – provides an overarching framework. Between 1983-88 the government initiated several reforms in the health sector. There is emerging evidence of impact. It is significant that these reforms were not under pressure from external donors or the Bank, but internally initiated and funded by the Government.

A3.14 Leadership quality and commitment to change, both at the political and administrative level is energetic and enthusiastic. Willingness to change and try new ideas exists at almost all levels. There are already several initiatives introduced, some of which are bearing impact. Few examples of initiatives - Introduction of user fees, the autonomy for retention of user fees, hospital autonomy, performance indicators for outcome, incentives for better performing hospitals, increased allocation to Primary Health Care (PHC) and formation of Advisory Bodies at various levels. The history of reform orientation and the current enthusiasm to change is a useful base to begin.

A3.15 There is a wide range of poverty alleviation programmes and initiatives in the social sector (primary education, child labour), food security etc. Learning from these experiences are available for the Government. The strong civil society base – 4.21 lakhs women's SHGs (51.8 lakhs members) and 1300 Crores of corpus are major strengths. The voluntary sector resource base is large - Government already working with 200-300 NGOs in the health & family welfare sector. Other women's empowerment programmes – government and non-government and their extensive coverage are great opportunities for making the Government more responsive.

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[4] Except in vertical programmes of HIV & TB where some flexibility exists under the Societies

[5] Quoted in several discussions. Actual figures need to be verified and most accountants assure is very near this figure of 80 %

A3.16 The reform process in Andhra Pradesh has been in fits and starts. Some initiatives have been followed through with considerable thought and action (hospital autonomy, user fees), some with limited follow through (Advisory Boards) and some others with limited thought, introduced and withdrawn (meritocracy).

A3.17 The reform process is positioned interestingly – with opportunities ahead. There is also the need to carefully plan, consult stakeholders widely, increase the remit of the department in some cases (like regulation) and make the department more manageable by reducing structures and functions that are less than effective.

c. Political Systems (representation & influence)

A3.19 In 1994, GoAP enacted the AP Panchayati Raj Act. Going with the 73rd and 74th Constitutional Amendments, the AP Government has made some attempts at devolution. Decentralisation and devolution has been rather slow in the State of Andhra Pradesh. Currently there are 21943 Gram Panchayat (GPs), 1095 Mandal Panchayat (MPs) and 22 Zilla Panchayat (ZPs). They have an extremely limited role to play in representing the aspirations of the people. The GoAP has decided to bring field staff of fourteen line departments with the PRI structure. This move has been in paper and the implications of it not fully discussed.

A3.20 The PRI elections have been held regularly. Last election was held about six months back. Some positive developments include appointment of Panchayat Secretary to assist the GP Sarpanch and provision of other executive officers for running the PRIs.

A3.21 GoI schemes like food for work and other schemes meant for PRIs provide some revenues to the PRIs. The GoAP provides about Rs 332 crores to the PRIs as Grant in Aid, based on a per capita formula recommended the State Finance Commission. Other than this the GPs are allowed to raise their local resources through Professional Tax, Property tax, Advertisement tax, etc. The revenue generation ability varies from GPs. Some which are closer to main roads and which are 'substantial' in size are able to raise revenues through taxes. Even these GPs are not self sufficient. Many of the smaller and remote GPs face a credibility problem in terms of collection of taxes, due to local opportunities being less. Local community members trust in their abilities to run the local resources may be limited.

A3.22 In health, the concept of Advisory Boards is a step forward in representation. But without control over the budgets and staff, the PRIs will have an extremely limited role to play in influencing or directing the local health resources to serve their needs.

A3.23 The political space for the PRI leaders and that of local MLAs is undefined. Hence there are potential conflict areas. For example the local MLA and the CEO of ZP are in the Advisory Board of the District Hospital. Both are elected representatives. Their roles will need to be more sharply defined.

A3.24 The limited nature of PRI empowerment has meant weak PRIs, with limited resources and activities. This also means low credibility. Even within some of the activities are devolved to PRIs, there is a tendency to take back in the name of efficiency, or provide supervision through district collectors or subvert the process through GOs or other mechanisms. The chain of 'Low abilities of PRIs, therefore lesser devolution and more supervision' needs to be broken for better and effective devolution, accompanied with capacity building and provision of adequate powers.

A3.25 Corruption is a worrying aspect of the PRIs, especially to the Government. As institutions, they are yet to take off and are far off from political maturity. Hence the Government has also taken more and more steps to restrict PRI functioning, in order to avoid corruption. One case in point is the GO restricting purchase of bleaching powder and bulbs to a set % of the total budget. This GO was issued because the GoAP felt that there was misuse of monies in these heads of accounts. Such pro-activeness though appreciable, weakness the local institution further.

A3.26 The seriousness of the GoAP on devolution is difficult to judge. Many of the reforms that the government is aiming can be more effective if the devolution process is managed better.

A3.27 Reg. Decentralisation – please see note on subject by Dr. Tom Bossert (Annex ?)

d. Accountability and transparency

A3.28 To improve accountability, local advisory boards have been set up by the department. These advisory boards consist of community representatives, the department staff, elected representatives and civil society representatives. These boards have been formed through a GO and are supposed to operate at sub-centre, PHC and hospitals. At the district hospital, a separate Society has been formed with similar representation. The advisory bodies have been formed in 2001 with a view to encourage local participation and ownership. It is not clear how effective these bodies have been and how much of inputs have gone into building these bodies. Discussions reveal that the effectiveness of these bodies vary substantially. Many are not fully aware of their roles and rights. Meetings are not regular and there is still confusion on the role of the Advisory Bodies vs. a vs. established monitoring and accountability mechanisms. For example, the role of the District Hospital Supervisor who is in-charge of the CHCs and Area Hospitals vs. a vs. the Advisory Board. The role and effectiveness of the Advisory Body needs to be studied more in detailed during the next phase.

A3.29 Though Advisory Bodies provide for participation, it is not designed for control or remedial action. The current situation which many studies, field visits have highlighted is the vexed problem of non-availability of doctors, especially for emergencies and the complete lack of accountability of all PHC & Sub-centre staff to the community that they seek to serve. Here the past experience of the Government is relevant. In 1970s the system of the Rural Dispensaries (now PHCs) were reporting to the Block Development Office. This meant local community control over their resources,

esp. human. In many of the interviews, the department staff interested in local level community control feel that this system 'worked'.

A3.30 Without the involvement of local communities in the management of the PHCs and structures below, it is unlikely centralised control mechanisms will work. Goal of guaranteed and quality services can happen only if the Government devolves (see section on decentralisation for more details).

A3.31 In the case of district hospitals, the societies have been empowered to collect user fees (within a broad charter) and other revenues and retain them for local use. User fees is still a very small percentage of the total costs (about 2-3 %). This move by the Government of guiding the hospitals to collect user fees and also allowing them to use the resources locally is a very positive move. Such mechanisms need to be strengthened further through other support mechanisms, which will enable the hospitals to move increasingly towards better efficiencies.

A3.32 The quality of public health service in AP is still poor compared to rest of India. Some key statistics from a study of public services – State of India's Public Services – Public Affairs Centre, Bangalore:

- Only 61 % of households feel that they have easy access to health care (National average 73 %). AP is one among the lower ranking states
- Only 59 % report paramedics available during first visit to Government Health Centres. 23 % report paying bribes to access Government health care facilities.
- In the overall ranking of performance of Government health care services (using several parameters), AP is one among the lower ranked states.

A3.33 Quality of service delivery, customer orientation, measurement and reward and disincentive systems are not in place. Advisory Board, though a positive direction, will need to be supplemented with independent data on customer satisfaction studies, which are conducted on regular basis on quality, access, equity, costs of health services, both in rural and urban areas. Internal information systems will be insufficient and inappropriate to address this issue. There has to be mechanisms in place which will flag issues of staff availability, quality, etc in a more systematic way – for both Advisory Body and Government to take remedial action on.

A3.34 The current system geared for service provision – not guaranteed service delivery. To provide guaranteed services, starting from policy statements (E.g. of Government assurances of medical personnel 24 hours), operational systems, training and several other initiatives will need to be in place. Only then will the government ensure guaranteed services to poor and also know when and where it is not happening.

A3.35 Corruption is a grave challenge to the department's work (like in other parts of the Government). It appears that there is corruption involved in recruitment, transfers, procurement, travel, training, incentives paid to communities. Many of the posts within the department are available for a price. This has apparently lead to severe de-motivation

of staff, especially those who are unwilling or unable to pay bribes for their promotion or transfer. For the department to be effective, ways will need to be found to tackle the issue.

A3.36 MIS for each programme and directorate varies. While reporting systems at District to state has changed over the years, record keeping and MIS at the PHC and sub-centres have changed very little over the years. Being a hierarchical structure, every level is supposed to supervise the next level. Supervision and monitoring are through targets, reviews and field visits. The department is heavily oriented towards quantitative targets. Recently performance indicators at outcome level have been introduced. Reviews of health department are usually conducted along with other departmental reviews (by the Collector, the Chief Minister). Health is usually reviewed in the last part and according to department staff not allotted sufficient time

A3.37 Performance assessment systems for both individuals and institutions exist, the later being a recent development, mainly for the APVVP hospitals – A comprehensive hospital information and gradation system, based on indicators[6]. Other parts of the department are usually measured based on quantitative targets. The performance indicator led performance assessments are taking root now. In the case of individuals, the annual appraisal exercise is the route for performance assessment. The appraisal system is not used for increments, which are routine in nature. The appraisal mechanism is weak, with many of the critical parameters to evaluate performance missing. Though meritocracy was tried out briefly, experience was not successful. It would be useful to examine why it failed. Currently, promotion is based entirely on seniority, to most posts. Individual performances have little relevance as there is little reward and punishment.

A3.38 System for internal learning needs to be strengthened. While measuring performance, reviews are important to know how far we have travelled, important aspect is the ability of the department to learn from its successes and failures. An atmosphere of embracing error and learning from mistakes is very essential. Current functioning only encourages people to hide mistakes, not learn from them. In many senses, mistakes made in one district are not passed on to others, and is repeated in other districts. Sharing and learning atmosphere is critical for the department to be effective and learning systems will need to be instituted.

A3.39 The department also plays a limited regulatory role. The Prevention of Food Adulteration Act is implemented by the department, through IPM. There are a number of Food inspectors whose job it is to test samples and prosecute offenders. The other regulator is Drugs Control Authority (DCA). The department's regulatory role for the private sector health system is yet to be planned.

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[6] Developed by IHS

e. Focus on Poor and Marginalized

A3.40 Please see note on Social Development written by Ms Vimala Ramachandran and Dr. Hillary Standing (Annex ?)

2. Key Management Issues

A3.41 Management aspects within the health systems have a vital role to play in ensuring efficiency and effectiveness. Broadly the areas covered are planning, monitoring, human resource, financial management and logistics.

a. Staffing

A3.42 The State Government has frozen all recruitments and any new appointments require special clearance. All new appointments have been on contract basis at various locations. The contracted staff are paid about 90[7] % of the basic salary of the permanent staff salaries. It is not clear how the contracting aspects have been thought through (in terms of legal and other risks for the Government). As transfers effected were many, the department froze transfers.

A3.43 Each of the sub-departments are headed by a Director. In case of HIV/AIDS, the programme is housed in an independent Society. Other than this, all others are sub-departments of the Government.

A3.44 The Directorates report to the Secretariat – Health Secretary. Each Directorate is organised differently. The structure is hierarchical, with matrix like structures at the District level.

A3.45 Much of the structure is for:

- Public Health Service delivery in rural areas
- Vertical programmes like HIV or TB
- Teaching institutions and hospitals attached to them
- Hospitals (mainly secondary care)
- Allied services (diagnostic, vaccine production)

A3.46 The staffing of the directorate and the district structures have been built more out of history than any focus on its role. To fulfil its role, there Government will need to examine structures which are more facilitatory. Past programmes especially vertical programmes have lead to specialised staff being appointed and the Government is carrying substantial excess staff on this count. While Govt has been rationalising its working at State level, there has been very little changes at the District. For example, with the leprosy problem reducing, the focus on the programme at state level has come

[7] Which increases to 95 % in year two and then 100 % in year 3

down. Deputy DM&HOs assigned have also been given additional responsibilities. However Leprosy workers continue their work in a limited fashion.

A3.47 Some positions have short supply, and others excess. Technical positions, especially of doctors in short supply. In the case others like support staff they are in excess. There are close to 1000 posts vacant in the state. In one district, there are about 81 support staff in the DM & HO office alone. Clarity at the district level on overall role is also necessary. Without a careful functional review, it will not be clear how much excess or under staffing is there. In the case of DM & HOs, there are 12 of the 22 posts vacant. This appears strange given the fact that there is adequate amount of Deputy DM & HOs available for promotion. One reason some observers point out is corruption.

A3.48 Government appointments are banned and all new (necessary recruitments) are on contract basis. The contract staff get about 90 % of the gross salary of a full time employee. Contract staff should be paid higher, as it is not a permanent position. Where it has been difficult to attract staff (e.g. PHC Medical Officers), it appears illogical to pay even lesser than the Government scales, which itself is perceived to be low paying.

A3.49 Transfers, like recruitment is also banned. But most parts the department circumvents this problem by deputing persons to different locations. Staff report that the system of transfers have been politicised and is a major source of corruption. On the other hand, transfers are inevitable process of management, however minimal they are. The department will need to work out mechanisms to solve this problem.

A3.50 The Government needs to carry out an exercise to identify ghost workers, as this is a strong possibility due to years of supply led staffing management there may be workers on roll but not working in the field.

A3.51 Several studies and experienced persons opine that low motivation is one of the key problems faced by the department. As in other parts of the Government, performance is not rewarded, and in fact punished with more work. Promotion is based on years of service. By the time a person reaches supervisory position, it takes 10-12 years of service. There is little incentive or disincentive - treating all individuals in the same way. In the past, the Government had made an attempt at meritocracy and it is understood that the experiment failed (more investigation needed). The recent efforts of grading hospitals in APVVP along with other initiatives to separate the performers and the non-performers is very good start. This will need to move further in recognising individuals who perform and those who don't. There are examples (at least in APVVP) where non-performers or persons absenting themselves have been terminated. Such action within department has been rare, showing that there is a need to build both the incentive and the disincentive systems strongly. This is an area where changes will have cross departmental implications. Working rules cannot be changed only for one department. But change will not happen if it does not start somewhere. Solutions will need to be found to get around this problem.

b. Training

A3.52 With over 500,000 Government staff, AP Government is attempting to systematise the training aspects. There are several agencies which focus on imparting training. The ones which address the Health Department needs can be divided into two parts – within the department and outside institutions. Below is a partial list of important organisations and departments offering training for health department:

Name	Who it trains ?	Details
District Training Team	Trains supervisory staff and other district teams	Within the departmental structure
Indian Institute for Health and Family Welfare	Health (esp. RCH) and family welfare staff	Independent Central Government organisation
Institute of Health Systems	Different levels of health functionaries and others	Wide range of technical and some managerial training programmes
Dr. M. Channa Reddy HRD Institute	All Government staff and sometimes Ministers	Independent organisation of the State Government – identified as the 'apex' training institutions.
National Institute for Rural Development (HRD Wing)	Different levels.	Main HRD and rural development related.
Nurse / ANM training colleges	ANMs, Multi-purpose workers	Private and NGO based. Multiple training institutions. An EC study estimates about 140 of them.
Administrative Staff College of India (ASCI)	Mid level managers	With at least 5 years experience

A3.53 The current structure has District Training teams (in all districts) which are headed by a Deputy DM & HO level staff, with at least 3 members working with them. There is training infrastructure at the districts and the district training teams use to train staff of the department, mainly in medical and technical matters.

A3.54 Training is a very important component which has not been given sufficient attention. The training needs of staff are not scientifically and systematically measured and a broad action plan in place. Training is more an ad hoc effort, with no clear linkage to the jobs that they do. Also training is not co-ordinated with other parts of human resource management – consequently there are persons trained in advanced courses who are about to retire or get transferred, supervisors are not consulted before their subordinates are nominated (supervisors refuse to relive their staff for training) and so on.

A3.55 Training needs of staff at different levels are complex. In health department, there is technical training (skills required for their jobs), managerial and administrative training for management esp. supervision. In most cases, the ad hoc trainings conducted cover

the technical aspects. Even here there is a lot that can be done to improve the training quality and assessing impact. The most important management skill of supervision is not being imparted in a regular basis. Most supervisors, especially those in highly complex functions such as the DM & HO do get regular management training. Consequently, they apply only their long experience in technical matters in managing their unit.

A3.56 Training institutions in Andhra Pradesh are fairly strong especially in the technical and HR functions. In Management and administrative aspects there is a need to develop health system oriented training programmes, that affect real issues on the ground (one example has been already developed by HIS). The demand for training supervisors and the technical staff on management issues is great and mechanisms to understand and address these needs required.

A3.57 There is also a need to integrate career growth, transfers, promotions and training. Without training getting integrated with the position, there may be substantial wastage of time in training the wrong persons in the right skill or the other way around. Each post will need to have specific skill requirements and as and when these positions are occupied, training needs to be made pre-requisite.

A3.58 Attention needs to be given to induction training, wherein new recruits are adequately trained before they are positioned. In some cases this is happening through the existing training institutions in AP. There is scope to improve this. Joining procedures will need to be modified to include training as a pre-requisite. Departmental training needs assessments and plan need to be systematised.

c. Support services

A3.59 There are various support services that the department uses:

- Transport
- Training
- Diagnostic

A3.60 Transport is handled by a Deputy DM & HO specifically posted for this purpose at the District level. These officers are charged with providing transport facilities for the departmental staff. This includes personnel mobility, ambulances, mobile clinics, IEC vans, etc.

A3.61 For Training – see para on training. Diagnostic – This service is largely provided by the area and district hospitals. There are diagnostic services run by IPM at the state level. The Government should critically examine the possibility of outsourcing these services so that it can concentrate on its core functions.

d. Work culture

A3.62 The work culture of the health department is of grave concern. The overwhelming atmosphere is that of bureaucracy, low customer orientation[8], lack of motivation, chaotic methods of working and poorly managed schedules (and therefore low individual productivity). Corruption is well known and accepted part of the system.

A3.63 When new responsibilities are assigned, most of the staff complain of overwork. It is true that some of the staff have multiple responsibilities and cannot do complete justice to their role. There are many who are under worked too. Only a careful work study (as part of a functional review) will provide answers on work and time aspects.

A3.64 Staff members and other observers point the Government way of doing things – the systems for working to be extremely restrictive, process oriented than output and rejects innovation or quick action. Combine this with audits, which concentrate on vouchers, giving little credence to the function and are seen more as a fault finding mission. Genuine actions are suspected for foul play. Speed and innovation are main suspects for 'other interests'. As one staff member put it eloquently – "*if I have to do anything, especially something innovative, I have devise the most devious methods and plot in Machiavellian way and manipulate people and systems to get it done. Not always do I have the energy and motivation to do it. And if I get caught doing something useful, I may also be punished*"

A3.65 Most staff at supervisory level, especially DM & HOs feel that they spend inordinate amount of time waiting for bosses, who summon them on short notice. Time spent on waiting in corridors and in meetings are probably higher than time spent on supervision. Also ad hoc querying is another major time waster for staff down the line.

A3.66 The health department has multiple stake holders, reference points and review parameters. The ability to interact with multiple stakeholders, while updating its knowledge on technical matters, being sensitive and responsive to needs of the community are skills which will need to be build more systematically.

A3.67 The role of medical profession within the health department has always been a point of debate. From the period where the department was oriented in service delivery to a point where there are facilitatory roles, the transition of roles need to be managed better. The medical professions role in department, perceptions and mind blocks surrounding a larger perspective of health care for state (which is more than plain medical) needs to be examined further.

A3.68 Many feel that the sub-optimal performance of the department is borne out of the work culture, cynicism that nothing will change and the realism that nothing much has changed over years. This will need to be addressed, if effectiveness has to be improved.

3. Recommendations

[8] A recent EC study found that out of 13+ PHCs visited unannounced, none had any staff in the hospital.

A3.69 The department has initiated several changes. Many of them are excellent in their approach and needs to be continued. Some are in the right direction, and improvements will make them better. While introduction of some of the changes will require substantive research and piloting.

A3.70 Interventions clearly valuable now and can be implemented immediately:

- Indicator led performance monitoring system. Targets like family planning needs to be comprehensively introduced for other areas of health care, so that a balanced review of performance is possible[9]. Removing the targets – especially those which are input based. Substituting them with more comprehensive targets based on outcomes. Review mechanisms at various levels, which are not pushed from top.

- Advisory boards. Systematic strengthening of their capacity and realisation of their roles. This would involve upgrading the selection process to assure transparency and representativeness of members, special training programs to clarify tasks and responsibilities of advisory board members, and greater involvement of the community in selection of members.

- Contract employment. Government could consider a higher mark-up salary for contract staff to make contract attractive. Also have variable mark ups, based on demand and supply for the specific position. (For example for doctors, the mark-up could be 1.5 in disadvantaged areas, whereas for posts where there is adequate supply .9)

- User fees in hospitals and their retention for local level use - Measures to increase collections and providing better quality of service[10]. Training in collection methods, motivational incentives, and development of improved reporting system.

- Introducing e-governance and right to information on health

A3.71 Interventions which could be implemented through pilots in selected districts:

- Select two to three pilot districts (modest performers – neither best nor worst) to develop an exceptional administrative structure and local participation process to pilot major changes in these processes. This could be achieved through the creation of a "district corporation" and the transfers of personnel selected by merit criteria.

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[9] Right now, a skewed importance on family planning

[10] Focus here is not coverage of costs – but on collecting contributions so as to make 'customers' demand better services.

- In these districts responsibility of running PHCs and sub-centres would be transferred to Mandal Panchayat (along with funds and staff). The pilots would provide technical assistance support the Mandal Panchayat in take over and management but be designed for sustainability, transparency and monitoring.

- In the pilot districts, create a single district level health society (which encompasses all activities of the department). This society will encompass all activities of health within the district and will work closely with the private sector and civil society. This would be developed along with a policy on guaranteed services (on lines with Citizens Charter)

- In the pilot districts, the seniority promotion system would be replaced with a performance based incentive and merit promotion system to be designed with attention to transparent objective and negotiated (between supervisor and supervisee) methods of merit judgements. In addition the pilots would develop capacity building based on TNA and TQM, including independent surveys on customer satisfaction, doctor availability and community evaluation of PHCs.

- In the pilot districts, a new referral/counter-referral system – between the primary and secondary sectors -- would be developed. In addition, feedback systems at sub-centre and PHC level to the PRIs and department

- In the pilot districts, implement flexible budgeting at district level with some earmarked budgetary ranges for priority programs and upgraded financial control systems. These budgetary processes would also include planning and implementation monitoring.

- In order to develop these pilot programs an initial comprehensive functional review will be necessary – feeding into administrative and staff reforms.

- For upgrading training programs the pilots would be used to develop management modules and training. Developing and implementing a supervisory course (at each level, focus on management). Review of curriculum of medical profession (inclusion of public health and administration in more stronger ways)

- Developing of a computerised monitoring system for the department.

A3.72 Areas of intervention where additional data and analysis are needed to develop strategy

- Performance indicators – How they warp performance at field level

- Transparency initiatives – how to make health department transparent

- Financial control systems and their effectiveness

- Human resource shortages – A comprehensive strategy to address them
- Training Needs Analysis
- Management abilities and capacity building requirements of PRIs to manage health institutions
- Detailed study of functioning of health department, with relevance to its role and objectives (rural and urban).
- Recommendations on rationalisation of functions and outsourcing.

Annex 4

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Report of Decentralization Team

Thomas Bossert and N. Shiv Kumar

Annex 4

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Thomas Bossert and Shiv Kumar

1. Decentralization Issues

A4.1 Decentralization is a means toward the ends of improving the equity, efficiency, quality and financial soundness of a health system. We should not be pursuing decentralization if it will not achieve these ends. Experience in many countries shows that decentralization can be designed to achieve these objectives if it is done in ways that assign appropriate degrees of responsibilities and powers to appropriate levels of administration and appropriate arenas of local accountabilities. The trick is to define "appropriate" in each of these cases.

A4.2 If the decentralization process is appropriately designed and implemented it is likely that it can improve the delivery of services and result in improved performance indicators for health status. It is a systematic change that can contribute to the operationalization of performance of programs designed to improve health status. There are five basic reasons that decentralization can improve health status:

- First, centralized systems tend to impose rigid programs that are often not fine tuned enough for addressing major local health problems. Localities have different sets of health problems that local health officials know better than the far away bureaucrats of central offices. **Given greater choice over local priorities local officials can make more appropriate decisions to address local health problems.**

- Second, most management studies show that large centralized organizations rarely can develop local management skills to make more efficient use of scarce resources leading to waste and make available savings for priority programs. **Decentralization of management decisions can encourage local health officials to make more efficient decisions that allow saving resources for more appropriate health programs.**

- Third, centralized systems discourage innovation and staff initiative leaving health officials with low motivation and low morale. Decentralized systems can encourage local staff to take initiatives to solve local health problems in new ways. **Having authority and responsibility is often a motivating experience that is more important than material incentives.**

- Fourth, decentralization by allowing local participation through committees and local governments encourages accountability of local officials to norms, standards and local priorities. Community participation has little impact if the community does not have some control over important decisions. Without decentralization there is little chance that community participation can be more than a simple extension of health service through "free labor". Many countries have experienced "participation fatigue" where community participation soon falls off since there is little encouragement for local decision making. **With greater roles in decision making, community participation can make the linkage between communities and health services into a valued and meaningful interaction and can hold local health staff accountable for attendance and responding to local priorities, and transparent and corruption-free service.** This meaningful participation can build the important trust and exchange between health staff and the community that is now called "social capital" (see below) that are key to the changes in social behavior needed to improve health status.

- Fifth, **decentralization to local governments can be a significant means of mobilizing additional resources from local taxes and other local sources.** When local governments take additional responsibility for health services they often learn that their communities will hold local officials accountable for providing better health services. This democratic political dynamic often encourages even the poorest communities to allocate additional resources to health care services. If the system remains centralized local officials can often simply blame the central government for failures and resist shifting local resources to health services.

A4.3 In sum, decentralization is an organizational reform that, when done in the correct manner, can result in improved health status by prioritizing local health problems, encouraging efficiency and savings that can increase resources available for priority health programs that address health status problems, motivate staff to solve local health problems, and allow meaningful community participation that can result in more accountability, increased mobilization of local resources and better linkage between health services and the community that is essential for the social behavior needed to address health problems.

A4.4 In this report we will briefly describe the current type and degree of decentralization in AP, raise key issues and constraints of the current system, specify areas where existing information needs to be supplemented with new studies and describe some activities of short and longer term that would overcome problems and develop the appropriate degrees of responsibilities and powers to be assigned to specific levels of administration and government.

A4.5 Decentralization raises three fundamental questions: who gets new responsibilities and powers and what kinds of responsibilities and how much power is transferred to them. To answer the first question about who gets new responsibilities we distinguish between the transfer of responsibilities within an administrative structure such as the

Ministry of Health (often referred to as deconcentration) and the transfer of responsibilities to elected and executive bodies of local governments (devolution). The first type may also involve some participation of local representatives – NGOs or community committees. Devolution however involves increasing the responsibility and accountability to local governments and their elected representatives and often includes the ability to mobilize local tax revenues.

A4.6 To answer the questions of what responsibilities and how much power we use an approach called "decision space" which assesses the range of choice (from narrow to wide) allowed for each of a series of key functions (in financing, service organization, human resources, targeting and governance).

A4.7 Recently the concept of "social capital" has been introduced as a factor which might affect the effective performance of government projects and strengthen democratic practices. This concept overlaps with social organization parts of this report in that it emphasizes the importance of the involvement of the population in voluntary associations and the development of trust in public institutions. We will discuss the relevance of this concept in relation to the governance issues of decentralization and more broadly the organization of the ministry.

2. Current status of decentralization in AP

A4.8 Decentralization in AP involves processes and responsibilities shared between the state government, the central national government, district offices of the ministry and of the district collectors, health advisory committees/societies for facilities, the municipal governments and corporations and the three levels of panchayat raj institutions (PRI).

a. Role of central government of India in health

A4.9 While health is seen as primarily the responsibility of state governments in India, the central government plays a strong role in defining some of the key functions by its control of the civil service rules, its training and promoting of IAS officers who staff key positions in state government. It also controls some grants to the state for specific budget lines and for specific programs that influence health administration and programs and can impose hiring freezes on permanent public staff positions. In addition, specifically for the health sector, it controls and finances major vertical programs such as immunization, TB, HIV/AIDS, leprosy, and malaria. In the case of the HIV/AIDS vertical program the central government funnels funds through societies involving civic society rather than through the state government administration and in the case of the TB program that imposes vertical requirements on district health office including the requirement that personnel be assigned full time to TB program activities. These mechanisms of control – staffing, training, financing of specific vertical programs impose significant limits on what a state can do and provide a template of bureaucratic structures that may impose major constraints difficult to overcome at the state level if a state reform involves changes in administrative structures and financing.

A4.10 On the other hand the central government has promoted devolution within the states through a recent constitutional amendment which charged the states with increasing decentralization in rural areas through a three tiered system of panchayat raj: the district (or z....) panchayat, the mandel (formerly "block") panchayat and the gran panchayat.. This amendment has been applied differently in different states with some states – Kerala and Gujarat in particular – moving ahead rapidly in devolving a wide range of responsibilities to the local PRIs. AP has not moved very far in this devolution of authority, responsibility and accountability as will be seen below.

b. AP State level "decision space"

A4.11 Since health is on the "state list" of responsibilities there is considerable formal choice allowed to state officials in many functions. In financing, the state can decide its own health budgets with an allocated portion of national government revenues and with local state taxes. The state decisions on allocation of state budgets assigned to health have been declining from 4.4% in 1994-5 to 3.4% in 2000-1. Within the health budget the state also has the power to assign resources to different budget heads (salaries, etc.). This authority however is limited in practice by the large current assignment of funds to salaries (70%) which is difficult to modify in the short term. There are also other mechanisms of "matching grants" from central national authorities and from international donors like DFID and World Bank loans which require assignment of state resources as counterpart funding. The actual range of choice over the short term for state decision-makers may in fact be quite limited – perhaps in the 10-20% range. This is particularly important if the general funding sources are likely to be limited over the medium term.

A4.12 The state can define the organization and rules of service delivery within some general guidelines from the national government. The existence of vertical national programs has had a significant impact on the fragmentation of administration and the inefficiencies of district management as will be discussed in our report on management. However, the role of different types of facilities and how they are organized appears to have been flexible enough to allow for the creation of a semi autonomous administration of secondary hospitals and some clinics under the APVVP.

A4.13 The state also has some flexibility in human resource management. There is a separate state civil service cadre and the state can hire and fire many different categories of staff. Promotion policies also appear to be a province of the state government with past experiments briefly initiating merit promotion replacing the tradition of seniority. (this experiment was apparently reversed by political and union pressures) However, the promotion rules of both the state and the national (IAS) civil service severely the range of choice for key positions in the bureaucracy. Most positions must be filled by the most senior official in the promotion pool rather than by merit or by ability to fill new policy requirements.

A4.14 The state may define the priority target populations and can use mechanisms such as the state "white card" system to define populations to be favored by different policies and subsidies.

A4.15 State role in defining how the health system is to be governed have resulted in different states assigning different roles to panchayat raj institutions, municipal governments and roles of involving civil society in committees and societies. However, the central government can make requirements for staffing (such as in the vertical TB program) and in general the state governments have not varied from the staffing patterns established by central IAS rules. In some ways, state control over the districts in the short and medium term is restricted by the authority vested in the IAS officers who fill the most powerful position of District Collector and who impose national policies on the districts through that authority.

A4.16 Overall, compared to other health care systems we can say that the state "decision space" is in the "moderate to wide" range of choice for almost all functions – not as wide as some other countries and not as narrow as most.

State Decision Space – For Discussion
[this is based on rapid analysis and should be revised after review]

	Range of Choice		
Functions	Narrow	Moderate	Wide
Finance			
Sources of Revenue		X	
Allocation of Expenditures	X		
Choices about Fees and Tariffs	X		
Service Organization			
Required Programs/Norms		X	
Hospital Autonomy			X
Drug Supply and Logistics Systems			X
Insurance Plans	X		
Payment Mechanisms to Institutions			X
Contracts with Private Providers			X
Human Resources			
Salaries		X	
Contract Staff			X
Civil Service		X	
Access Rules			
Targeting	X		
Governance Rules			
Local accountability			X
Facility Boards			X
Health Offices		X	
Community Participation			X

c. Level of state resources and allocations to local levels and mobilization of local resources

A4.17 Decentralization often involves changing the allocation rules for resources in the health sector. One of the central issues of allocation is to assess the level of local funding in relationship to higher level funding. In AP the state controls an increasing proportion of the total public sector funding for health (from 55% in 1995-6 to 68% in 2000-1) with the National Government controlling the rest through grants and schemes for specific vertical programs. (see Annex on Financing) Of the state portion, only a small percent comes from local tax revenues with the rest coming from intergovernmental transfers from the national government.

A4.18 The state allocates approximately 60 % of its health budget to primary care, with 40% to secondary (APVVP) hospitals and tertiary care. Around 70% of the budget is assigned to salaries – not an excessively large amount compared to other countries but one that limits the resources available for drugs and other operating costs as well as limiting investments to those primarily funded from outside loans and grants.

A4.19 An important issue is how the state (and national) governments assign resources to the different districts. Financial assignments to districts from some funding sources are reported to be formula driven -- based largely on population size. (for more details on allocations to districts see Annex on Health Financing) With a variety of funding sources from the central and state governments it is difficult to assess the actual total funding that is assigned to each district and difficult to assess the real expenditures to determine how well the current formulae are implemented. Since the budgetary process has been described as based on historical budgets, it is likely that the formulae have been distorted over time even if a formula was initially used for assignments. It is also likely that there is considerable variation in the per capita allocations to each district. None of the formulae take into account the variations in the size of the population that is covered by private providers so that districts with higher use of private sector will end up with higher per capita public resources for the population that is served by the public facilities. Since wealthier districts are likely to have higher use of private sector, this means that the public facilities in these districts will have more resources per capita served than will poorer districts.

A4.20 Municipalities are expected to contribute to health systems by supporting water and sanitation activities and in most municipalities funding a health center which provides services and programs similar to the Primary Health Clinics in rural areas. Municipalities assign budgets to health and within the health sector according to state guidelines and their budgets have to be approved by the state. It appears however, that these guidelines are not strictly enforced – with many municipalities spending more on salaries for municipal workers than the guidelines allow.

A4.21 In rural areas there is a general impression that there are few possibilities of mobilizing local tax revenues for health care. The tax base at the district and municipal

levels are very limited and tend come mainly from property taxes. Local democratic processes tend to discourage raising local taxes. Funds at the community level tend to be focused currently toward traditional functions of sanitation and water supply and have not normally been allocated to health systems. However, there have been some reported cases of effective mobilization of local community resources for health systems. There were distinct rankings of panchayat raj according to size and wealth which suggest that some areas may have significant resource base that might be tapped for health (such as areas with minor minerals which are taxed). A project designed to strengthen local community organizations around health was quite effective in making health a community priority and quite unexpectedly the community agreed to take on 50% of the costs of running the local health activities from local funds. These models suggest that some poor communities can prioritize health care and provide resources and that some wealthier communities may have sufficient funds to be expected to take on more of the burden for funding health services if they are given a role in controlling those services.

A4.22 A concern in decentralization as pointed out in the Annex on Health Financing is that localities with more resources may increase their funding for health at rates that increase inequalities among localities. While this may occur in some situations, there are mechanisms to allow for local mobilization of resources and provide compensation to improve equity. State and national grants can be based on a formula that takes into account some of the local capacity to collect local taxes and favor the poorer districts. Also a system of matching grants from state and national sources can be used to encourage mobilization of local matching funds and the matching requirements can be adjusted to the local capacity to mobilize resources. For instance, matching grants can require higher percentages of local counterpart funding from wealthier communities and low percentages from poorer communities.

d. "Decision Spaces" below the state

i. District "deconcentration"

A4.23 A District Health Advisory Committee has been created in the process of decentralization of the ministry. This committee is made up of the DMHO, the District Collector, District Revenue Officer, Hospital Superintendent, the local MLA, the president of district panchayat and representative of NGOs. It is a mechanism for coordinating health and other sectors under the District Collector and an arena for the participation of some key local health stakeholders such as the Nursing Home societies, IMA, and other NGOs and an elected representative from the district panchayat raj.

A4.24 It is difficult to assess how effective these committees are in increasing the accountability of the health system to the local population and interests. It seems likely that the DMHO and District Collector dominate the agenda and control the meetings in most situations. Since most of the participants are unelected, and those that are not ex-officio members are chosen by the District Collector that local "voice" in these arenas is quite limited.

A4.25 A similar mechanism of local accountability is introduced into the APVVP structure at the facility level where the hospital advisory committee includes the District Collector, MLA, President of Panchyat, President of local IMA, Superintendent of Hospital and representatives of NGOs.

A4.26 The "decision space" at the district level varies by function and institution.

A4.27 For financing functions, the DMHO and his team have little control over their budgets – they submit budgets to the state on the basis of the historical budget plus minor percentage increases. These budgets are returned to them with strict budget "heads" and they do not have the ability to transfer funds from one head to another. The facilities under DMHO do not generate funds (no fees for these facilities) and there is no consistent mechanism for other local contributions. By contrast the APVVP hospital boards are assigned a budget and are allowed to manage its line items throughout the year. They also collect and retain fees (around 5% of total non-salary budget) and can allocate them with few restrictions.

A4.28 Decisions about service delivery are also quite limited for DMHO since many of the norms and standards are established either by central or state vertical programs. By contrast the APVVP hospitals are given some flexibility to define programs as long as they are within the norms of hospital standards. The hospitals are also ranked by ability to achieve several performance indicators and are given incentives or sanctions based on achievement of these objectives that are defined by the state level APVVP.

A4.29 Human resource decisions allow some choice to DMHO who can hire and transfer (but not fire) paramedic staff (ANM, lab technicians, etc) in the district. The DMHO also can transfer medical staff within the district for disciplinary purposes (see management section). Apparently however, the DMHO cannot force medical staff to take positions in rural health centers, except for formal disciplinary purposes.

A4.30 In APVVP, human resource decisions are made by the hospital board and Recruitment decisions have been left to the boards and have not been reversed by the state APVVP, even though it has the appointment authority. However, firing decisions are retained by APVVP and have been exercised in a significant number of recent cases.

A4.31 Again, however, the seniority rules limit the range of choice over hiring staff for key positions, leaving transfers and bureaucratic delays as the major mechanisms that district teams have for managing human resources. Bureaucratic delay – sitting on files – is apparently a major means of displaying displeasure with an official and a mechanism used for exacting unofficial payments for staff assignments.

A4.32 Since hiring for permanent staff has been frozen – or rather severely discouraged requiring a major effort to get state approval for exceptions – the districts have been encouraged to hire new staff on contract. However, the terms of contracts are set at the state level and the low salary levels and lack of benefits has limited the ability of districts to attract new staff.

A4.33 Rules for targeting and for governance structures are defined at the state level. However, the selection of members of the health societies and committees appear to be the province of the DMHO with the District Collector.

District Decision Space – Illustration for Discussion
[this is based on rapid analysis and should be revised after review]

	Range of Choice		
Functions	Narrow	Moderate	Wide
Finance			
Sources of Revenue	X		
Allocation of Expenditures	X		
Choices about Fees and Tariffs	X		
Service Organization			
Required Programs/Norms	X		
Drug Supply and Logistics Systems	X		
Payment Mechanisms to Institutions	X		
Contracts with Private Providers		X	
Human Resources			
Salaries	X		
Contract Staff		X	
Civil Service	X		
Access Rules			
Targeting	X		
Governance Rules			
Local accountability		X	
Facility Boards	X		
Health Offices	X		
Community Participation		X	

ii. PHC and Sub-centre committees

A4.34 PHC have their own health advisory committees that involve the elected representatives of the mandel panchait raj and other community members as well as the PHC doctor. These committees do not have much of a role in decision making at the PHC level – nor does the Doctor. However, they are a venue for linkage with the local NGOs and local elected officials and have been effective arenas for mobilizing local labor. In some cases local elected officials (MLA) are able to provide additional resources for renovation and other small capital investments.

A4.35 In general, however these committees have mainly been used to mobilize communities for health activities and not to engage the community in local decision making, accountability or monitoring.

A4.36 In sum, in these sub-district advisory committees there is little decision space and almost no control of resources – either from ministry or from local sources.

iii. The Panchayat Raj Institutions

A4.37 In rural areas there are three PRIs functioning: the district, mandel and gran panchayats. At each level there are elected officials who choose their leader or president and a counterpart from the state administration. Very little control of the assigned 14 line department activities have been shifted to these institutions. They have some local own source revenues and some assigned revenues but no funds have been shifted from department budgets and no responsibilities have been shifted to date. There is discussion of shifting control of some personnel salaries and some supervisory responsibilities but to date nothing has been approved. In the health sector this might mean that the budgets for the paramedical personnel at the health center, sub unit and health post levels would be transferred to the PRIs. Currently however, while the PRIs have taken some initiatives in water and sanitation activities that may support some health ministry activities, there is no official role.

A4.38 The PRIs have had a historical precedent in AP. Reportedly 20-30 years ago there were Block entities which controlled PHCs. They controlled the budgets and personnel. This experience is reportedly to have causes major problems between the administrators of Blocks and the DMOs since the administrators who held the budgets and authority were of a lower civil service rank than the doctors. Gradually this authority was centralized at the state level.

iv. Urban Health Systems

A4.39 In the urban health systems run by the 110 municipalities and seven municipal corporations (excluding the Hyderabad Commission) there are significant responsibilities shifted to the municipal budgets. Budgets are assigned according to a formulae based on population and poverty indicies according to seven municipal categories: corporation, selection grade, special grade, and grades 1-3. The municipalities are allowed to collect and retain certain fees such as water fees. Municipalities are administratively managed by an IAS Municipal Commissioner who reports to the state Municipal Commissioner. There is also and elected municipal council or corporation which approves budgets and provides some local accountability.

A4.40 Municipalities have traditional responsibilities for sanitation and water supply as well as funding around one urban health clinic in each municipality. There are 80 urban health clinics in the state which are similar to Primary Health Clinics in rural areas. While administratively under the Municipal Commissioner, these clinics are supervised also by the DMHOs of the Ministry of Health and Family Welfare and are expected to

complete the norms and activities assigned by the state and national programs. They report their utilization data through the Ministry of Health and Family Welfare districts. Their financial reporting however it through the Municipal Commissioner.

A4.41 Municipalities have some control over their budgets and human resources. There are state guidelines for assigning a percentage of budgets to health and limiting expenditures on administrative staff. These guidelines however appear not to have been enforced up to now. However, municipal budgets must also be approved by the state which may limit their range of local choice. Municipalities also have some role in local taxation. The municipal council must approve any new taxes – which municipalities appear reluctant to do. However, the state may change the tax rates for existing taxes, forcing the municipalities to collect more revenue. Recently the property tax rate has been increased by the state, increasing local property taxes by around 30%.

A4.42 Municipalities may hire staff if they respect state defined merit hiring practices. The Municipal Commissioner sits on the hiring board, imposing a powerful state appointed official in this process.

e. Human resource capacities for decentralization at local levels

A4.43 Human resource organizational skills will be discussed more in the management section. Here we focus on skills and capacities required for decentralization of several key functions. Technical skills in public health and disease specific activities are a general concern in centralized and decentralized systems. However, decentralization that involves greater responsibilities in financial and human resource functions requires significant upgrading of skills in financial control, financial decision making, human resource management and in leadership and diplomacy in working with local civic groups and elected officials. As we note in the management section these skills are not generally well developed in any of the training programs – pre-service, induction and continuing education. The training program for APVVP officials seems to have been more developed than others in these senior management issues.

A4.44 Furthermore, the process of promotions by seniority has not encouraged the promotion of effective managers or leaders – indeed as staff are promoted to managerial positions late in their career, the managerial positions tend to be held by officials near retirement. These officials have an incentive to maintain the current system and not to make any risky decisions that might lead to disciplinary actions that would affect their pensions.

f. Social capital

A4.45 As is noted in the reports on social organizations, there appear to be quite a vibrant number of community organizations that are currently mobilized around health issues in some measure. It is clear however that these groups are not strongly "linked" to the formal government and health system mechanisms. With some major exceptions, they are not currently encouraged by the health system officials. The central exception is

the HIV/AIDS program which has given voluntary organizations a major role by the central government in receiving and controlling funds and in directing activities. However, even the HIV/AIDS societies are controlled by a board convened by the Secretary of Health and Family Welfare – which until recently met very infrequently. It is generally believed that if there are better relations between the community organizations and the public health organizations that this can be a means of building "social capital" and the trust necessary to encourage social changes that can result in better health status.

g. Current studies

A4.46 There is one study of decentralization in the health system that compares AP with Gadjarat completed by NIRD for DFID. We were unable to assess the quality of this research. There are reports on different aspects of the system – especially panchayat raj -- but none of them have done a systematic review of the situation.

h. Performance Systems and Indicators for Decentralization

A4.47 With the current emphasis on performance indicators, those activities that do not have clear indicators may be left aside in the focus on the indicators that are monitored. Therefore if there is a priority on developing and implementing greater degree of decentralization, on local accountability and on greater involvement and linkage to the civic society organizations, performance indicators for these activities need to be developed. There does not seem to be a system for assessing the degree or effectiveness of decentralization. There are no reporting requirements to systematically assess the health advisory committees and societies. Nothing to determine the actual membership, the representativeness of the participants, participation levels in meetings, satisfaction of participants, and their impact on decisions.

A4.48 As will be noted in detail in the management section, there is little information on the training and capacities of local health staff in management, financing, leadership and diplomacy skills required for effective decentralization.

3. Issues and Constraints

a. Financing mechanisms need to be revised

A4.49 It is likely that the current allocation of funds to districts is not equitable among districts and may favor the more advantaged districts. The current formulae seem to be implemented in various ways and certainly do not account for the population that is served by the public facilities. What is needed is a "needs based" formula that compensates for inequalities in need for public sector services.

A4.50 There are few incentives for local officials to provide own source revenues for health care. Health is seen as a state responsibility and not one that requires local tax

revenues. Incentives could be put in place to encourage local authorities to match grants and to take on greater responsibility in return for greater choice over health services.

b. Limited "decision space" at the district level

A4.51 Despite some increase in decision making powers at the district level there are still several formal and other informal control mechanisms that have limited the range of choice. In some cases these limits are likely to be good in that they will prevent ill advised decisions from being made and in other cases it is likely that widening the decision space can make for greater accountability, more flexible and efficient decisions and potential for mobilizing local resources.

A4.52 In particular, district managers should be given greater control over their budgets so that they can make transfers from one budget head to another during the year. Greater control over hiring, firing and transfers should be made, within a system that has clear norms for merit recruitment and promotions. More flexibility on local priority setting, monitoring as well as a role in accountability and promotion of health staff might encourage greater local participation and greater mobilization of local financial resources.

A4.53 There are however, some constraints on budgetary processes and human resource management imposed by national and state laws making it a long process to change these constraints. Political will to make changes in control of human resources and to shift budgetary allocations to panchayat raj will be needed. An exception may be made for a pilot effort to demonstrate the effectiveness of significant increase in decision space in the areas of finance and human resource management. It might be possible to make the medical officers ex officio members of panchayat raj health committees in order to overcome the historical problem of having to report to administrative officers who are of inferior status.

c. PRI and Committees/Societies and Social Capital

A4.54 With so much of the decision space limited by central and state rules, there is less incentive for local governments and civil society groups to participate in local arenas of governance in the health sector. Until greater powers are transferred to local panchayat raj there is likely to be little incentive for local officials to mobilize new resources or reallocate budgets to the health sector.

A4.55 The current proposed transfer of responsibilities to the PRI has some possible negative effects. Control of hiring by local communities without proper safeguards and enforcement could result in the hiring of unqualified personnel and the introduction of new venues for patronage and political influence in staffing decisions. Supervision by technical staff is still an important requirement for upgrading quality and skills of local health staff and should not be entirely turned over to the PRI.

A4.56 It may be that local communities that have greater unity and trust among the members and greater experience of voluntary organization – such as larger numbers of

effective participatory NGOs- may have greater "social capital" and be able to participate more effectively in local decision making through health committees/societies and through the panchayat raj.

d. Human resources capacities for decentralization are weak

A4.57 The current level of skills in the key capacities of financial and human resource management and skills of leadership and diplomacy for engaging the civil society are lacking. Current training in these areas have not been taken full advantage of and the level of these courses needs to be upgraded. The models provided by APVVP may show the way toward an expanded training program. Distance learning methodologies may make it possible to provide some of the training to staff in the field so that they do not have to travel away from their work for long periods.

4. Suggested Studies for Phase II: What do we need to know more about?

a. Current allocations of finances to districts, municipalities, and panchayat raj institutions

A4.58 There is no clear understanding of the levels of funding available at the district, municipal and panchayat raj levels. While funding from some sources are said to be based on formulae it is not clear what the formulae actually are nor if they are being fully applied. With so many different sources and with little clear idea of the portion of the population in each district that is served by these public services, it is necessary to have an overall assessment of the distribution of resources to each district. This analysis could be followed by development of a "needs based" formula to compensate for variations among the districts and to lead to more equitable funding.

b. Legal and regulatory restrictions at the national level

A4.59 Investigation of legal and regulatory restrictions on budgetary and human resource decisions that are controlled by national government and cannot be changed at the state level

c. Details of actual "decision space"

A4.60 Need to have a clearer and more systematic study of actual practice of "decision space" at district level – could be done by a survey instrument based on other studies implemented by HSPH

d. Assess other experiences in India

A4.61 Comparative analysis of decentralization in other more decentralized states like Kerela and Gajurat.

e. Assess options for mobilizing local resources

A4.62 Studies of current local government budgets and proposed increases to PRI

f. Assess current human resource capacity and skill needs

A4.63 As part of study on management, assess human resource capacities in skills needed for decentralization (see Governance Annex for details)

g. Assess current capacity to train human resources in needed skills

A4.64 Review and evaluate ASCI program for APVVP and other training programs (see Governance Annex for details)

5. Possible Options

a. Immediate

A4.65 Pilot in 2-3 districts with greater decision space allowed at all levels – including health committees/societies. This pilot would experiment with transfers of budgets for personnel and some supplies to the panchayat raj, shifting some accountability and incentives for performance to these institutions, placing medical officers ex-officio on panchayat raj health committees, and other innovations. It would also expand local authority of the municipalities in the districts. It would involve major new capacity building training of the district staff and of participants in health committees/societies, municipalities and panahayat raj. (see Governance Annex for additional details)

A4.66 Increase the number and representativeness of local civic society groups and elected representatives in health advisory committees/societies in all districts

A4.67 Provide "matching grants" and greater responsibility for decisions at the local level to encourage use of local tax revenue mobilization for health in municipalities and wealthier panchayat raj.

A4.68 Introduce more equitable "needs based" formula accounting for use of private sector and indicators of disease patterns

A4.69 Develop appropriate performance indicators including indicators of decentralization and participation of civic society

b. Medium and long term

A4.70 Develop major high quality management training program for district level officials (perhaps based on ASCI program for APVVP)

A4.71 Introduce legal and regulatory reforms to create new system of merit recruitment and promotion in the state human resource system.

A4.72 After review of pilot districts effectiveness, replicate the effective models in a phased sequence, including specific training programs, to eventually cover all 22 districts.

A4.73 Combine with initiatives of good governance and PRI reform.

DRAFT

Annex 5

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Private Health Care Provision in Andhra Pradesh

Peter Berman

Annex 5

Private Health Care Provision in Andhra Pradesh

Peter Berman

1. Introduction

A5.1 This paper is one of a set of background papers to support development of a medium term health sector strategy and expenditure framework for the state of Andhra Pradesh. It is based on a brief field visit to the state and review of recent studies and papers. Because of the limited time available for this exercise, it is not intended to be a comprehensive analysis but rather an initial review, with recommendations for short and medium term strategies that could be followed. Development of several of these strategies would require further investigations.

A5.2 The focus of this paper is on private health care provision, its role in Andhra Pradesh's health system, and the potential for enhancing its contribution to improving health outcomes in the state. A separate background paper on government health care delivery by Dr. Marc Mitchell combines with this one to cover the area of health care organization.

A5.3 The next section of this paper discusses of how to define private health care provision and a proposes a notional typology of providers that may be relevant to Andhra Pradesh (A.P.). Information is not available on all the different types of providers. The third section presents what is known about the numbers and distribution of private providers in A.P., based on several recent studies. The fourth section summarizes recent evidence on the role of private health care providers in A.P. and compares A.P. with other states. This includes evidence on health expenditures and the shares accounted for by private providers and health care utilization, including inpatient treatment, outpatient treatment, and public health and preventive services. The fifth section describes several innovative programs by state and district governments to involve private providers in priority health programs and also discusses the views of several key stakeholders. Finally, the last section proposes several short and medium-term strategies that might be developed to enhance the positive contribution of private providers to State health and financial protection goals.

2. Private Providers in A.P.: Some Definitions

A5.4 The concept of "private" providers is essentially one of ownership and is usually defined as a negative. Private providers are those who are not owned by government. However, this simple notion is sometimes complicated by the fact that providers in government-owned facilities sometimes engage in private activities, for example, if a PHC doctor were to charge private fees for services delivered in the PHC. In essence, this activity is outside of government ownership – the PHC doctor is acting in a private role.

A5.5 Private providers come in many sizes and shapes. A locally-relevant typology is a useful basis for policy development, since not all private providers are relevant to each specific health program or priority. A typology should consider at least three elements: the type of health care organization (e.g. its size and complexity), the system of medicine followed, and the incentive or motivation regime that drives provider behavior (this is usually related to ownership and the for-profit, not-for-profit orientation)[1].

A5.6 A.P. (and India more generally) has a particularly diverse set of private providers, touching on all the dimensions just cited. One convenient break-up is that between hospitals, ambulatory care clinics and practices, and free-standing diagnostic facilities. Hospitals are identified as facilities which provide inpatient services, whereas ambulatory care clinics and practice provide only outpatient services – acute illness care and personal preventive services. Diagnostic facilities are intended to provide only supportive services – tests and investigations as requested by a hospital or ambulatory care clinic. In A.P., diagnostic facilities may also sometimes function like ambulatory care clinics. The following table proposes some of the key provider types in A.P.

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[1] Berman, P. and R. Rannan-Eliya. "Factors Affecting the Development of Private Health Care Provision in Developing Countries. Phase I: Review of Concepts and Literature, and Preliminary Field Design," Major Applied Research Paper No. 9, Health Financing and Sustainability Project, Abt Associates, Inc., Bethesda, MD, October 1993.

Table 1: Typology of Providers in Andhra Pradesh

	Type of Organization		
Ownership and System of Medicine	Hospitals	Ambulatory Care Clinics and Practices	Free-standing Diagnostic Facilities
Government-owned			
Allopathic	E.g. APVVP hospitals	E.g. CHCs, PHCs, SCs	NA
Indian Systems of Medicine	Government-run ISM hospitals	Government-run ISM clinics	NA
Private Not-for-Profit Owned			
Allopathic	NGO hospitals and those run by other societies	NGO primary care clinics and programs	NA
Indian Systems of Medicine	ISM hospitals run by societies?	NGO and society-run ISM clinics?	NA
Private For-profit Owned			
Allopathic qualified	Private hospitals and nursing homes	Physicians clinics and individual physician practices	Facilities with diagnostic equipment (e.g. x-ray, ultrasound, CT scan and laboratories.
Allopathic unqualified[2]	NA	RMPs, LMPs, all types of "village doctors" practicing allopathy, including those who practice allopathy combined with other systems.	NA?
Other systems of medicine qualified	For-profit ISM hospitals	For-profit ISM clinics and individual practices of ISM doctors.	NA
Other systems of medicine unqualified	NA	ISM practicioners who have not completed formal qualification, including those who practice ISM combined with allopathy.	NA

NA = not applicable

[2] The term "unqualified" can be misleading. Elsewhere I have described these providers as "less than fully qualified" (LTFQ) (see Berman, P. "Rethinking Health Care Systems: Private Health Care Provision in India" *World Development*. 26(8):1463-1479, 1998), recognizing that some of them have significant practical training. This is confirmed by the recent study by the Institute of Health Systems, discussed below.

A5.7 Within a typology like this it may be important to divide some of the key types even further. For example, there is clearly a huge difference between APVVP's district hospitals with hundreds of beds and personnel and small private nursing homes in a physician's house with 5-10 beds and one or two nurses.

A5.8 There are some important categories of this typology for which even basic data are not available. There is almost no information on unqualified allopathic providers beyond a small study done by the Institute of Health Systems in 2000. There is no comprehensive list of private for-profit qualified clinics and individual practices in the state. There is almost no information on private for-profit diagnostic facilities, especially the extent to which these facilities may diagnose, prescribe, and treat patients.

3. Some Current Knowledge on the Number, Distribution, and Characteristics of Private Providers in A.P.

A5.9 There are several potential sources of information that could be used to describe the private provision sector in A.P. The Indian Medical Association, A.P. Branch maintains a list of members, which account for about one-third of the physicians in the state. However, this is not updated regularly and also does not include information on practice types and location. It is likely that at the district level this information could be developed further.

A5.10 The Institute of Health Systems (IHS) has created the A.P. Health Institutions Database (APHIDB), which includes both government and private providers[3]. The APHIDB was established between 1992-94, based on a private hospital survey (1992) which was then followed up with several additional data collection efforts such as reviewing government registration data and a mail survey. HIS has tried to update the database when it can, using information compiled in other surveys it has done. The APHIDB mainly covers private hospitals, but has some information on private clinics as well.

A5.11 In 2000 IHS conducted a of study private providers sampling three areas of A.P.: Hyderabad city and surrounding Ranga Reddy District, Warangal District, and Visakhapatnam District[4]. This study collected information on private hospitals, clinics and practices, and free-standing diagnostic facilities. It also developed an opportunistic sample of "alternative private practicioners", ambulatory care providers of ISM, homeopathy, allopathy, and combinations, including some less than fully qualified providers. This dataset is one of the most detailed on private health care provision in India. Due to the lack of any comprehensive database on private providers, it is difficult to gauge the representativeness of this study.

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[3] Mahapatra, P. "An Overview of Private Hospitals in Andhra Pradesh: Data from the AP Health Institutions Database (APHIDB), 2001." Institute of Health Systems, Hyderabad, 2001.

[4] Mahapatra, P. "Structure and Dynamics of Private Health Sector: Implications for India's Health Policy", Institute of Health Systems, Hyderabad, 2002.

a. Hospitals and beds

A5.12 The IHS[5] database recorded about 95,000 hospitals beds in A.P. in 2001. 32 percent are in government institutions, 63 percent are in private for-profit institutions, and only 5 percent are in private not-for-profit institutions. Data from the IHS survey show that almost all of the private for-profit facilities are proprietary, i.e. owned by individuals, rather than corporate, including the large private hospitals.

A5.13 Over 85 percent of total beds are located in the Coastal and Telengana regions of the state. In Rayalaseema, the share of private hospital beds is well below the level in the other two regions and public and private beds are approximately equal in share in that region.

A5.14 Private for-profit hospitals includes the category "nursing homes" which are typically smaller institutions[6]. 86 percent of for-profit hospitals and nursing homes are under 30 beds, and 38 percent are between 10-20 beds. The database includes even smaller institutions, and 32 percent were reported as having 1-10 beds.

A5.15 The location of these facilities reflects their small size. 71 percent are located in Mandal headquarters and 5 percent in village headquarters. In other words, three-quarters of these institutions are located at the same level of PHCs or below. It is not possible to assess what is the capacity of these institutions with the data as currently reported, but this would be an important issue to investigate further if there was interest in involving these providers more in public health activities.

A5.16 Some data are available on the distribution of private hospitals across the state. Figure 1 shows that private for-profit beds are dominant in Coast and Telengana regions, but that government beds are the largest share in Rayalaseema. The Institute of Health Systems has also analyzed the distribution of beds by district against the CMIE index of development for each district. These distributions are shown in Figure 2, for all districts in A.P. and then again for all districts with Hyderabad removed, since there is a large concentration of beds in Hyderabad. There is clearly a strong correlation between general development at the district level and the intensity of private bed provision.

A5.17 The IHS survey of private providers collected information on the date of established of these providers and whether they have grown in size. The data suggest that significant growth of formal institutions began during the 1970s and has continued up to today.

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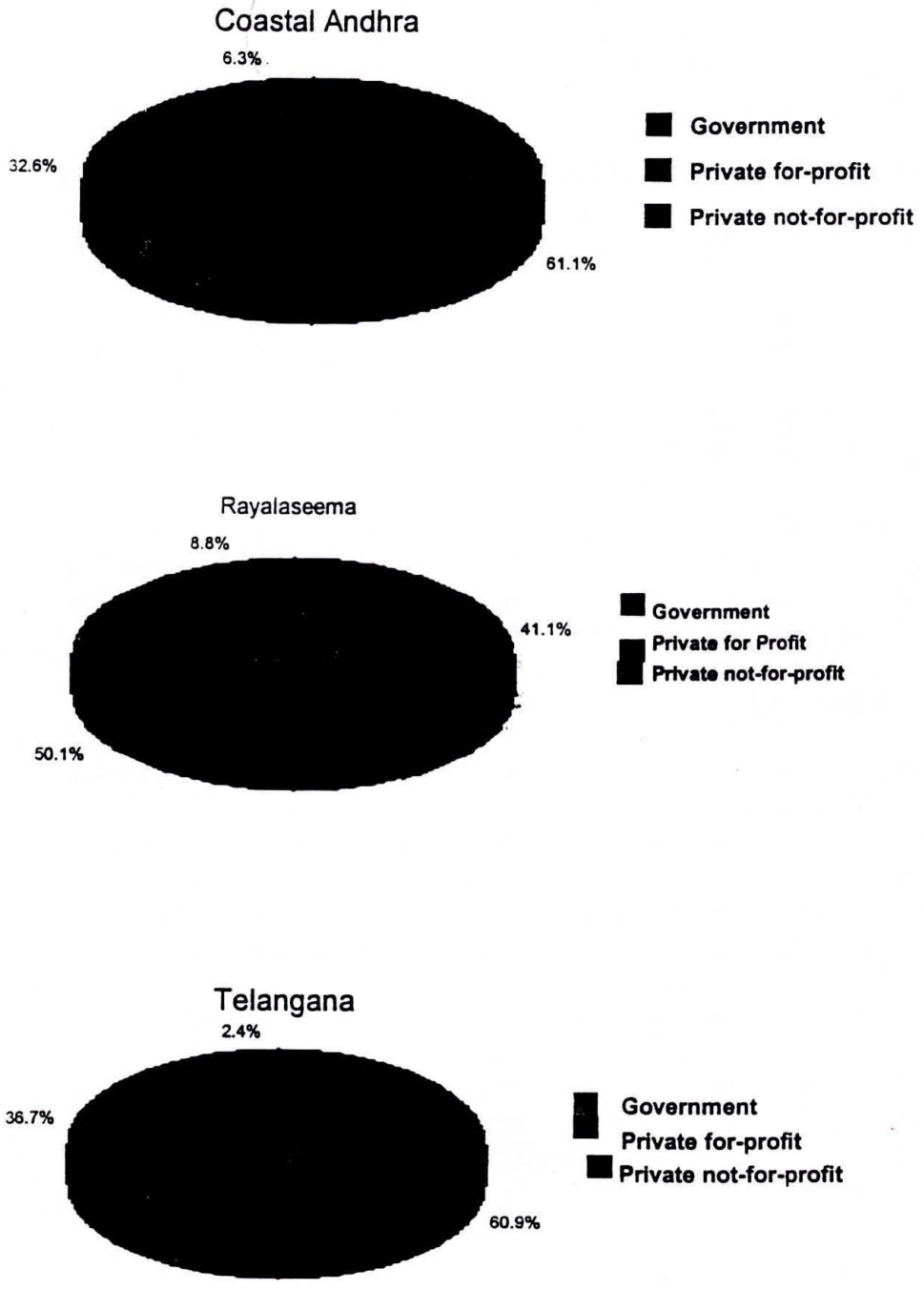
[5] This section draws on data reported in Mahapatra, 2001 cited above.

[6] Many nursing homes would probably not meet strict criteria for definition as "hospitals", since they may lack specialist services or capacity to carry out some clinical tasks typically associated with hospitals. India defines "hospital" to include institutions of 10 beds or more, which is a low threshold by international standards.

Figure 1: Distribution of Hospital Beds in A.P. by Ownership and Region

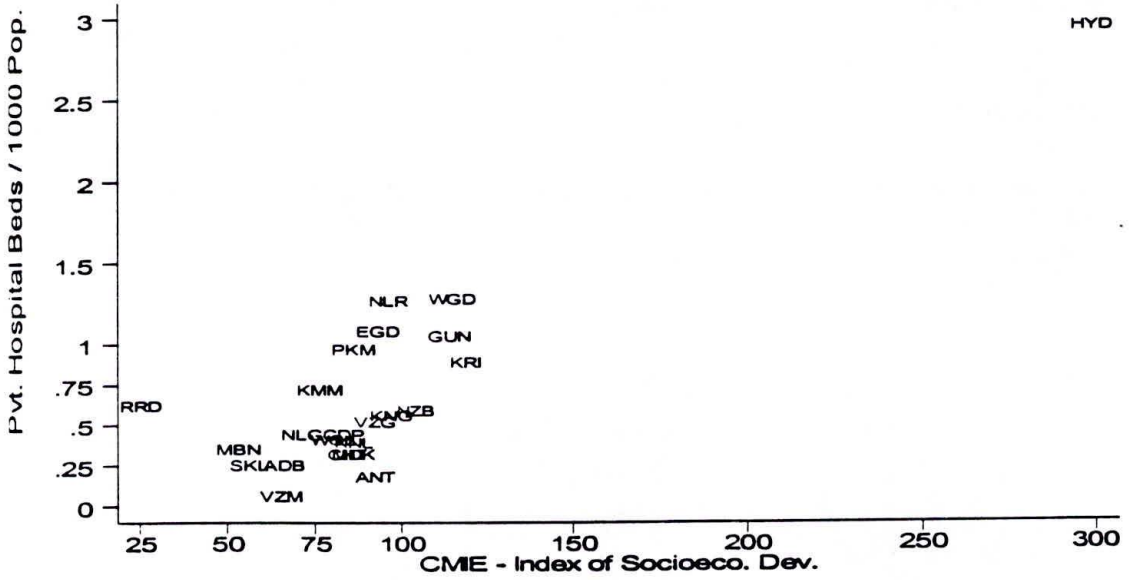


Source: Institute of Health Systems, APHIDB, 2002. Note, numbers differ slightly between APHIDB 2001 and 2002 reports.

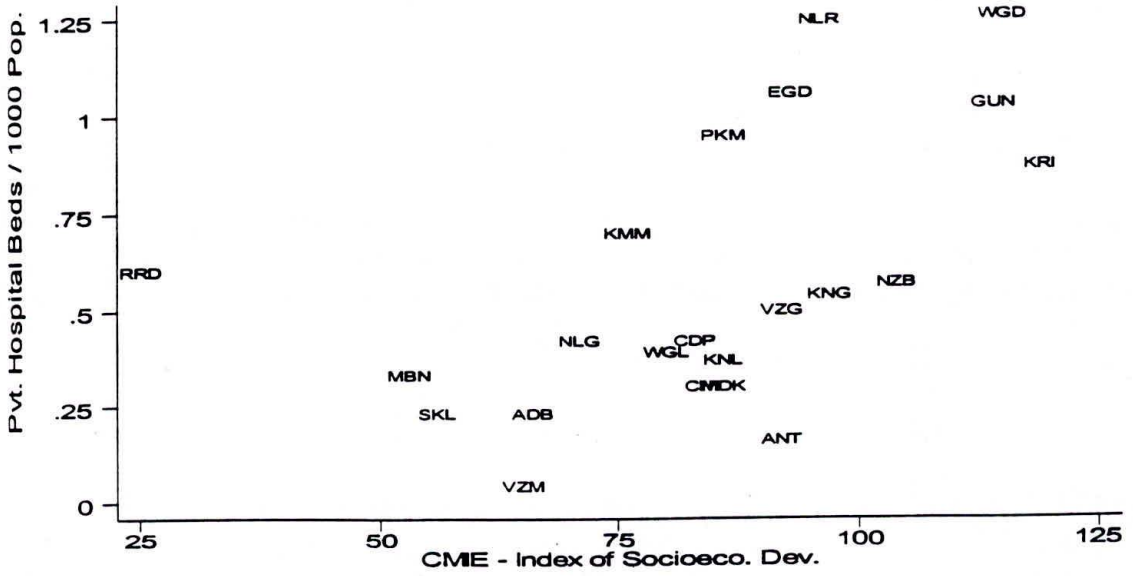
Figure 2:Private Hospital Beds per 1000 Population in A.P. Districts, According to Index of Socio-economic Development

a) All A.P., b) A.P. without Hyderabad

(a)



(b)



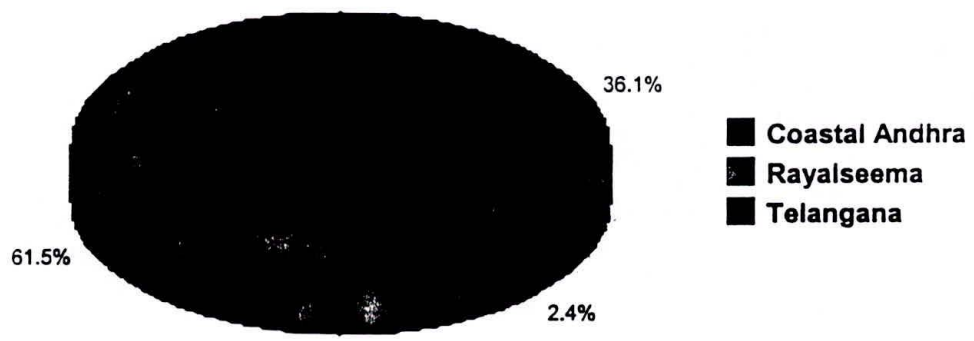
Source: Mahapatra, Sridhar, and Rajshree, Structure and Dynamics of Private Health Sector: Implications for India's Health Policy, Institute of Health Systems, Hyderabad, 2002, pp. 36-37.

b. Clinics and Practices

A5.18 Much less information is available on ambulatory care facilities than on hospitals. The APHIDB does compile data on ambulatory care institutions, but this data is probably not complete and comprehensive. At present there is not a well-functioning registration system for ambulatory care facilities even of qualified practicioners.

A5.19 Figure 3 presents some of the distributions available from the APHIDB, according to regions of the state. This distribution suggests that most of the private ambulatory care facilities are located in the Telangana region, but it is likely that this is an artifact of the data available.

Figure 3: Distribution of Non-hospital and Non-nursing-home Facilities by Region



Source: Institute of Health Systems, APHIDB, 2002.

A5.20 The IHS survey provides some further detail on the types of services offered by ambulatory care clinics. The range of services overall is quite broad, with the three most common categories general medicine, general surgery, and pediatrics. A minority of private clinics (ranging from 10-18 %) also provide public health services, including family planning, immunization, antenatal care, and treatment of communicable disease.

c. Diagnostic facilities

A5.21 The only data available on these are from the IHS surveys. The surveys distinguish between "extramural" facilities, i.e. those that provide only diagnostic and laboratory services, and "intramural" facilities, those that provide these services as part of a health care institution, such as a hospital. Intramural facilities may still sell diagnostic services in the market to those coming from outside the institution.

A5.22 Extramural diagnostic facilities provide a wide range of tests including pathology, biochemistry, imaging, cardiology, and microbiology. For the first four of these categories, 70-80 percent of freestanding facilities provide at least some tests. 69% offer ECG, 38% offer ultrasound, 65% X-ray, and 70-80% various types of laboratory testing of pathology and biochemistry.

4. The Role of Private Providers in Health Care Expenditures and Utilization

A5.23 Over the last decade, several major national studies have developed and strengthened the evidence base on the role of private health care providers in India's health system. The National Sample Survey (42nd and 52nd Rounds, 1986-87 and 1995-96 respectively) provides national and state-level estimates on utilization of inpatient and outpatient services and household out-of-pocket spending. NSS data is very comprehensive, but may under-report overall health care use and does not allow much discrimination between different types of private providers other than hospitals and "doctors"[7]. National market and economic surveys by the National Council for Applied Economic Research complement these data. The India Family Welfare Surveys I and II provide utilization information on personal preventive services and population-based public health interventions, also measuring private provider outputs for these services. These national surveys are complemented by many smaller state and local studies which provide much richer detail, but less coverage and representativeness.

A5.24 These data sources have been summarized and reported in detail in several recent national policy studies, especially World Bank (1995), World Bank (2001), and Misra, Chatterjee, and Rao (2001). Some of the key findings are reproduced here for reference, wherever possible highlighting the position of A.P. in the national picture.

a. Private Financing

A5.25 Health financing in India is dominated by household out-of-pocket spending, estimated to account for 75-80 percent of total spending during the 1990s. Comparison of the NSS 42nd and 52nd rounds suggests that the share of household in total spending may be rising.

A5.26 Table 2 and Figure 4 present two recent estimates for government and private spending at state level that allow comparison of A.P. with other states. The two estimates are for different years, use different data, and show highly different figures in terms of rupees per capita. Nonethess, both show that A.P. spends below the national average in terms of government spending and above the average in terms of private spending. The first table shows only Kerala with a higher per capita private spending level than A.P.

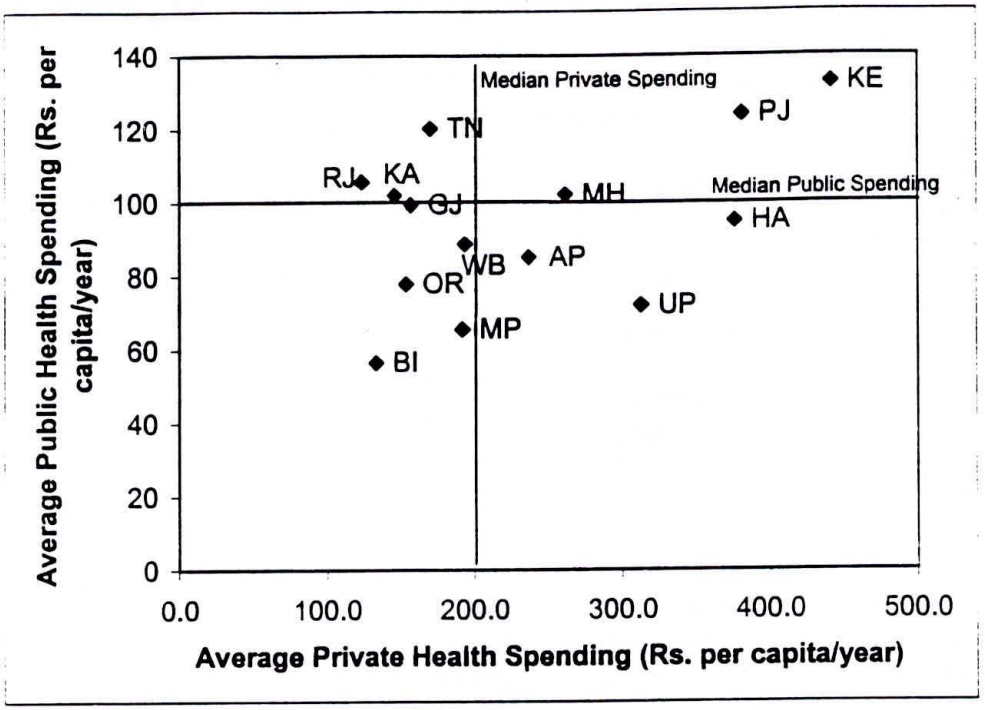
[7] Use of the term "doctor" in national surveys should not be assumed to mean qualified allopathic or ISM physicians. One cannot distinguish from these data qualified and unqualified "doctors."

Table 2: Health Spending for Major States in India, 1993

State	Per Capita Annual Health Exp.			Government Health Expenditure as % of NSDP/NNP	Household Health Exp. as % of Household Income	Total Health Exp. as % of NSDP/NNP
	Govt	Household	Total			
Jammu & Kashmir*	238	325	563	4.5	NE	10.7
Kerala	111	482	593	1.8	11.9	9.5
Himachal Pradesh	209	370	579	3.2	6.7	8.9
Bihar	51	223	274	1.4	6.1	7.5
Orissa	74	276	350	1.6	8.2	7.4
Andhra Pradesh	**66**	**421**	**487**	**1.0**	**7.8**	**7.4**
Karnataka	93	360	453	1.3	8.8	6.5
Rajasthan	83	196	279	1.6	4.2	5.4
Uttar Pradesh	55	175	230	1.2	4.5	4.9
Gujarat	78	259	337	1.0	4.7	4.4
Madhya Pradesh	63	168	231	1.2	6.9	4.3
Tamil Nadu	100	202	302	1.4	6.5	4.2
West Bengal	73	154	227	1.2	3.4	3.8
Haryana	83	267	350	0.8	4.1	3.4
Punjab	110	282	392	4.5	6.2	3.2
Maharashtra	85	259	344	0.8	5.4	3.2
Assam	66	96	162	1.1	2.4	2.8
All-India	**84**	**250**	**334**	**1.4**	**6.0**	**5.5**

Note: Estimates for Jammu & Kashmir are based on the previous NCAER survey of 1990.
NSDP – Net State Domestic Product, NNP – Net National Product
Source: Pearson, 2002, citing Shariff et al. (1999:56).

Figure 4: Public and Private Per Capita Health Expenditure Across the Different States, 1995-96



Source: World Bank, 2001

A5.27 Almost all out-of-pocket spending goes to private providers, since user fees in public institutions are not universal and are generally low. This is shown in Figure 5 below. This may be somewhat misleading, if households are purchasing medical goods and services privately in conjunction with treatment delivered in public hospitals.

A5.28 It is not clear from the available national data the shares of out-of-pocket spending going to the different types of providers, since the national surveys don't measure this carefully. But it is likely that a very large share of the total goes to unqualified providers, pharmacies, and sources of retail drugs and commodities, and a much lower share to qualified allopathic and ISM physicians.

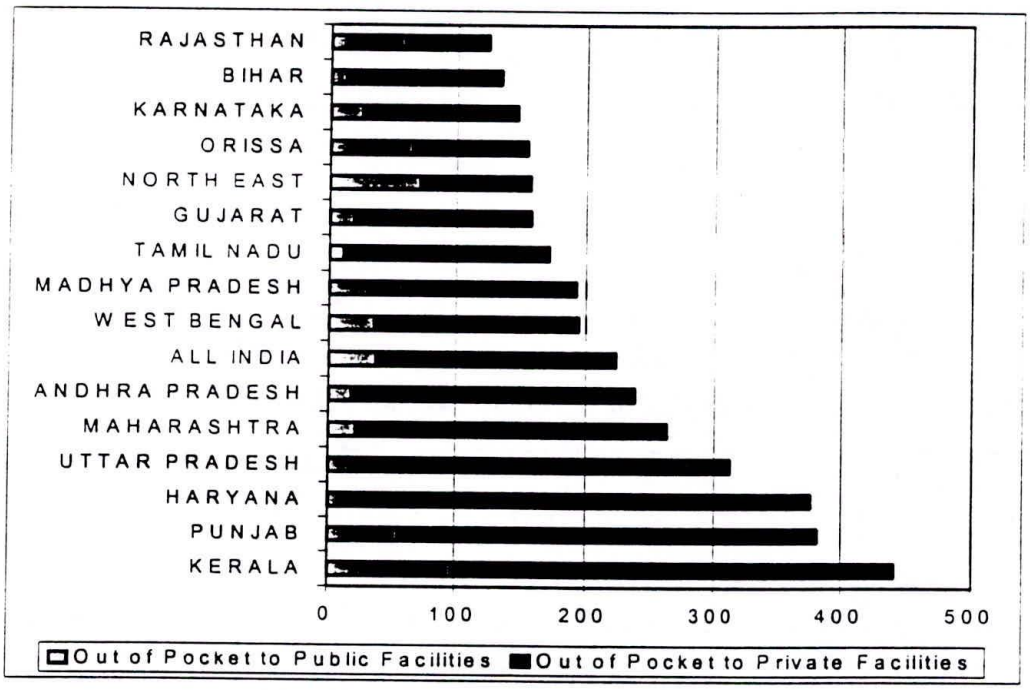
A5.29 All-India data, reported in World Bank (2001) and its background papers, shed some light on the impact of this out-of-pocket spending burden on different groups in the population. Analyses like this can be done for A.P. with the available household survey data, although I was not able to produce these tables for this report. General results from the all-India analysis probably apply to A.P.

A5.30 Out-of-pocket spending rises as a share of total household consumption expenditure from lower to higher expenditure households (3.8% of total spending for the poorest quintile, 6. 6% for the richest.) The line is flatter when only non-food

expenditure is considered, since this is a smaller share of total spending for poor households.

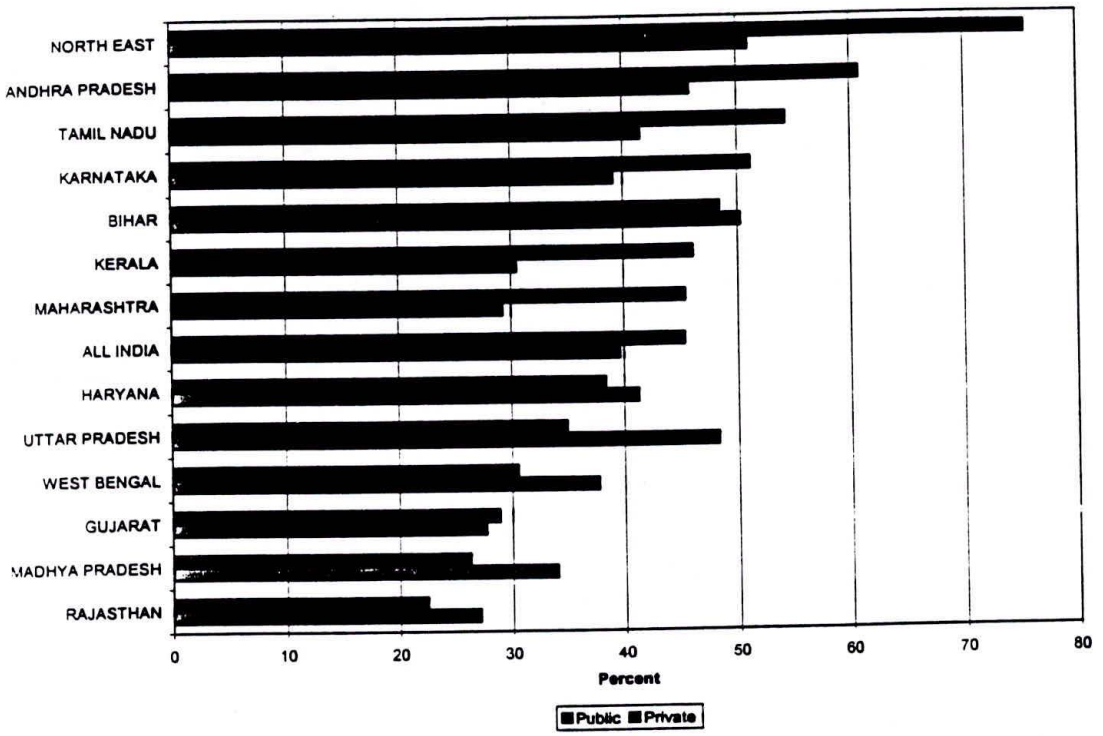
A5.31 More telling is the evidence from national surveys on the impact of significant out-of-pocket spending on the poor. Figure 6 shows one result reported in World Bank 2001 which suggests that the impact on the poor in A.P. of spending related to hospitalization is relatively high, compared with other states.

Figure 5: Out-of-pocket spending to Public and Private Facilities



Source: World Bank, 2001

Figure 6: Hospitalized People below the Poverty Line Who Financed Their Care in Public and Private Hospitals from Borrowing or Sale of Assets by State, 1995–96 (percent)



Source: World Bank, 2001.

A5.32 Health care utilization data from recent national surveys provide further evidence of where this high out-of-pocket burden comes from As shown in Figures 7 and 8 below, there is considerable use of private hospital and ambulatory treatment services in A.P., in comparison with other Indian states. Table 3 compares some relevant indicators between A.P. and all-India estimates. In general, A.P. shows higher levels of private service use than the all-India average and a high out-of-pocket burden related to that use.

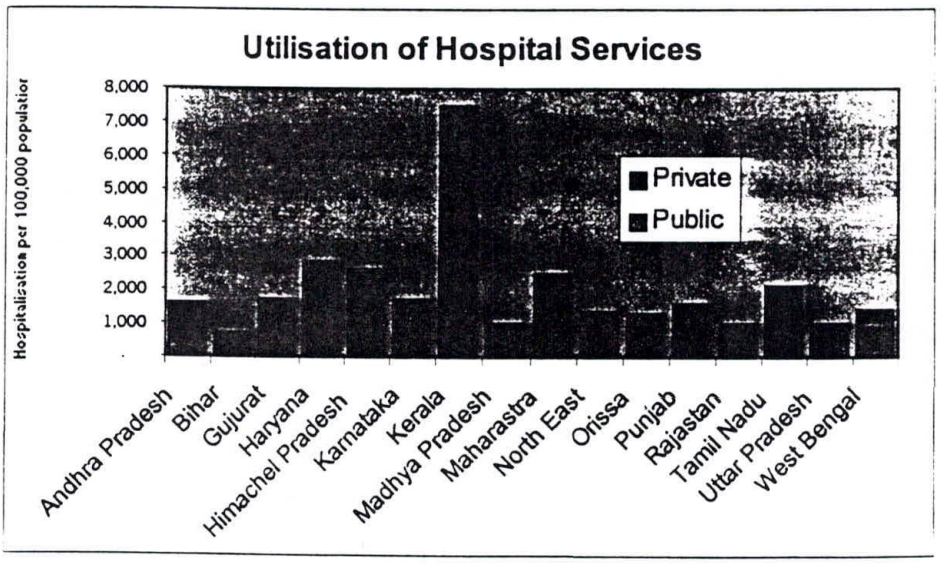
A5.33 The two recent rounds of the National Health and Family Welfare Survey provide further evidence on the role of non-government providers in personal preventive services. I was not able yet to produce these tables for A.P., but Figure 9 below shows the all-India breakdown for a range of services. With the exception of immunization, private providers are a significant source of several other preventive services which are typically seen as almost entirely the province of public providers.

Table 3: Select Health Care Utilization Indicators

Indicators	Andhra /India	Inpatient Care				Outpatient Care			
		Rural		Urban		Rural		Urban	
		1986-87	1995-96	1986-87	1995-96	1986-87	1995-96	1986-87	1995-96
% Used Govt. Facility	Andhra	30.8	22.2	41.7	35.4	21.6	22.0	22.6	19.0
	India	59.7	43.8	60.3	41.9	25.6	19.0	27.2	20.0
% Received Free Hospital Bed/Medicine	Andhra	33.3	21.9	41.3	36.8	20.8	20.1	24.2	8.5
	India	60.7	41.6	55.2	38.2	17.5	7.7	19.7	9.3
Cost of Treatment (Rs.)	Andhra	686	6428	781	4886	67	165	63	172
	India	853	3202	1183	3921	75	176	81	194
Treatment Cost Ratio between Private and Govt. Facility	Andhra	2.2	3.8	5.2	5.4	1.8	4.1	4.2	2.3
	India	1.6	2.1	2.4	2.4	0.7	1.4	0.9	1.2

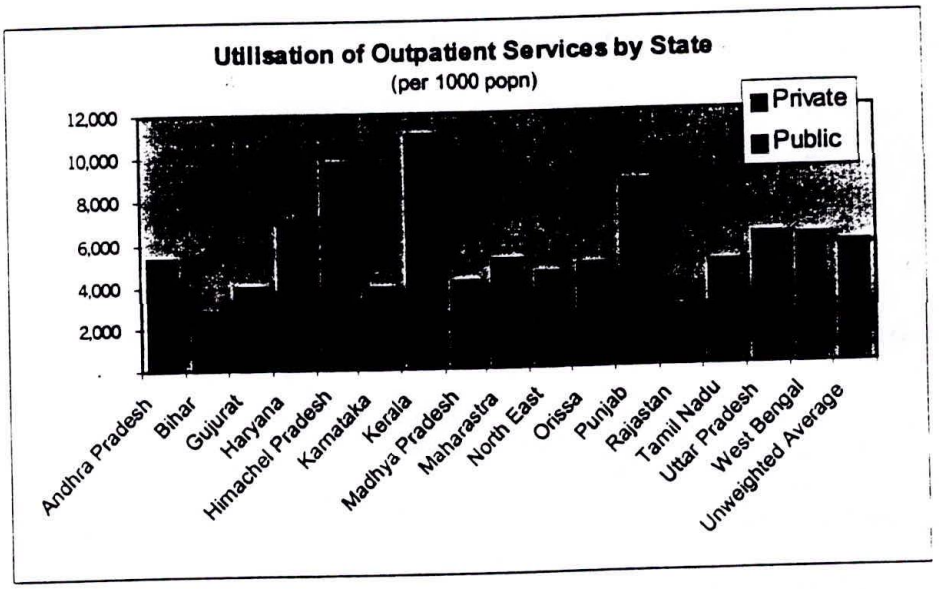
Source: Pearson, M. Impact and Expenditure Review, cited from:
1986-87: Sarvekshana, Vol. 15(4), Issue No. 51, April-June 1992.
1995-96: NSS Report No. 441, August 1998.

Figure 7



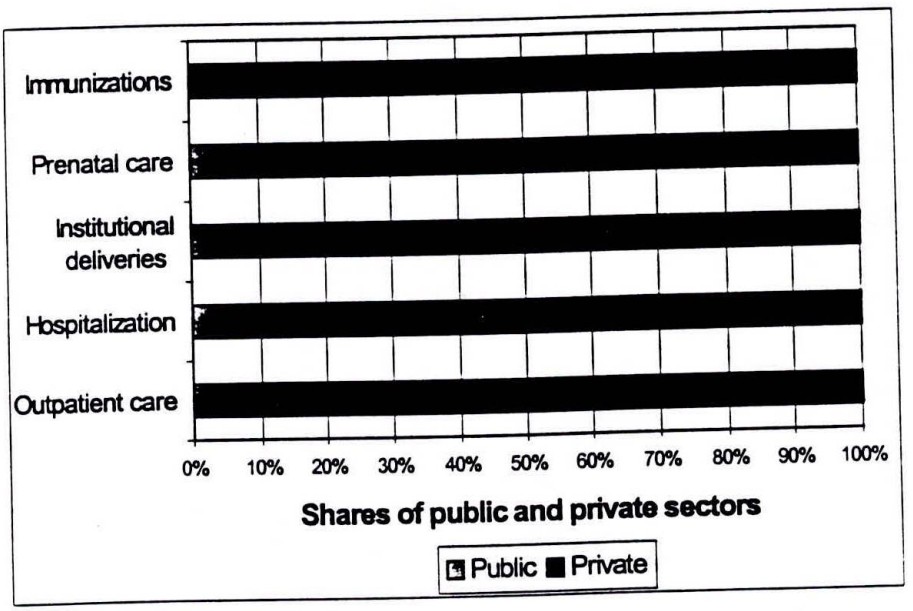
Source: Pearson, M. Impact and Expenditure Review, Part II, Policy Issues, Draft, DfID, New Delhi, 2002.

Figure 8



Source: Pearson, M. Impact and Expenditure Review, Part II, Policy Issues, Draft, DfID, New Delhi, 2002.

Figure 9



Source: World Bank, 2001.

5. Current Efforts to Involve Private Providers in A.P.'s Health Programs

a. Examples of innovative approaches

During a brief visit to Hyderabad, I learned something about several efforts to link government health programs with private providers.

A5.34 Sukhibhava. This program provides cash subsidies to help low income women offset the costs of institutional deliveries. It provides them with Rs. 300 when they deliver in a a public facility. The objective is to increase the share of institutional deliveries by low income women. I am not sure whether this subsidy can be obtained if a private facility is used?

A5.35 Arrogyaraksha. This program provides health insurance coverage for the whole family when couples with two children agree to sterilization. Families pay Rs. 75 for the coverage and are entitled to 5 years coverage totaling a possible Rs. 20,000 in benefits with a limit of Rs. 4000 per year. The benefits can be used in either public or private providers. Approximately 200,000 beneficiaries per year participate in this scheme.

A5.36 Social marketing of contraceptives and other family welfare related commodities. The Family Welfare program uses commercial distribution points to increase access to contraceptives and other commodities, such as oral rehydration solution. (ORS still true in A.P.?)

A5.37 Assistance to private providers delivering immunizations. Private providers can receive vaccines from government supplies. (Still true in A.P.?)

A5.38 Provision of Directly-Observed Therapy Short-course (DOTS) by private physicians. The Mahavir Trust and Mahavir Hospital in Hyderabad have for several years run an innovative program to enroll private physicians in case-finding, diagnosis, and treatment using DOTS. The program enables private physicians to refer suspected TB cases for proper diagnosis. Patients diagnosed positive are then referred back to their physicians for supervised treatment. Physicians "retain" their patients, but are assisted by the program in assuring observation of patients taking medication. This program is felt to be quite successful, but has not been expanded beyond its current site. The state TB control society reported that the program requires a lot of effort from the Mahavir Hospital and depends a lot on the leadership of Dr. K.G.R. Murthy, which may not be forthcoming easily from other sites.

A5.39 Other innovations in TB control

a) Collaboration with NGOs (about 14)

b) Experimentation in Medak town with RMPs who are willing to refer patients to DOTS program.

c) New GoI guidelines on involving private providers in DOTS, for referral, as DOTS providers, and in microscopy; and

d) State society has "public-private mix" consultant, has proposed full-time staff for Hyderabad, and there may be other posts in budget.

A5.40 New state act on regulation of private providers. The state government has just passed an act providing for the regulation of private providers throughout the state. The specific rules are still being drafted by the DoH in consultation with stakeholders such as the IMA. This could provide the legal basis for development of a state-level database on private providers and steps towards registration and accreditation.

A5.41 In order to fill vacant medical officer posts, the state has created a mechanism for hiring doctors on contract. However, few doctors have taken up this offer, reportedly because the compensation levels are too low.

b. Views of the Indian Medical Association

A5.42 I was able to meet with the state office of the IMA during my visit. IMA-A.P. has 14,000 members, about one third of all physicians in A.P. Most of these are private doctors in general practice, since most government doctors would not join and there are separate organizations for the specialties. The state IMA is involved in several ways with government health programs, including continuing medical education efforts, participation in the RNTCP with DfID support, and participation in expanding Hepatitis B immunization in collaboration with the Bill and Melinda Gates Foundation.

A5.43 The IMA representatives voiced some clear views about certain issues.

- Regarding the new regulation act, there was concern that the rules recognize the different circumstances of physicians' practices in cities, smaller towns, and villages and not impose to rigorous uniform standards that cannot be met in the more remote areas.

- There was concern that ISM doctors also practice allopathy and that they are trained in ISM colleges to do so by allopathic doctors.

- The policy of contracting doctors to fill vacant medical officer posts in government was condemned as being a "bogus policy", since these posts lack adequate supplies and other inputs and the payment rates were too low to attract doctors to this service.

6. Suggestions on Short and Medium Term Strategies to Enhance the Contribution of Private Providers

a. Short term strategies

A5.44 These relate to things that the state government and especially the Department of Health and the Commissioner of Family Welfare could do now, with only modest additional investigation or analysis. It is noted where these activities could be contracted out. The main thrust of these recommendations is to expand efforts by DoH, CoFW, and state-level disease control societies working at state, district, and local levels to involve private providers in health promotion, case finding and diagnosis, treatment and other clinical services related to priority health conditions for which control programs have a significant "primary treatment" component. This includes TB (also linked to HIV/AIDS), malaria, sexually-transmitted diseases (also linked to HIV/AIDS), diarrheas, acute respiratory infections in children. Private providers could also play a much larger role in health promotion and education efforts addressing emerging chronic disease epidemics such as diabetes, cardio-vascular disease and cancers and their related risk factors in tobacco use, diet, etc.

A5.45 I would recommend that the state government envisage a large "crash program" to involve private providers, since these people currently see and treat the vast majority of cases even for priority public health problems. However, we may not have sufficient information at this time to know exactly what to do. It would also not be desirable to load an addition set of major work tasks onto disease control officers who are already dealing with large national programs. Thus, the short-term recommendations balance some new actions with developing more capacity for action and assessments of current activities.

- Create senior post at state level for an officer who would have as primary responsibility the development of government-private provider collaboration in relation to public health program priorities

- Create state-level committee/commission to review current efforts at government-private provider collaboration and to make specific recommendations on new initiatives. Committee should include senior DoH and CoFW officers, new state-level officer (see previous), disease control socieities' directors, and private sector stakeholders including representatives of ISM and allopathy (e.g. IMA), RMPs, and voluntary sector. Committee should have some resources to engage consultants and contract for review papers and case studies.

- Assess accomplishments of Sukhibhava program. Is it reaching the poor? Is it reaching high risk pregnancies and births? Are mothers reaching facilities who are capable of providing the necessary clinical inputs. This could be done as an epidemiological case-control study covering villages where Sukhibhava has been made available and comparing women and births who accessed Sukhibhava with those who didn't. A cost-effectiveness assessment should also be done. [Could contract out]

- Implement changes in Sukhibhava program as per evaluation. Expand coverage if program proves effective and efficient.

- Assess current efforts to integrate private providers in disease control programs and health promotion efforts. These efforts may be hampered by the lack of specific initiatives or programs to develop such integration as well as by the lack of staff at district level to devote significant time to such efforts. For example, the RNTCP (TB control) reported that there are many efforts to involve private providers in the districts and the GoI has now issued formal guidelines for doing so in terms of case-finding/referral, microscopy, and treatment observation. These include working with qualified and alternative private providers. But efforts in the districts are constrained by the many demands on the district TB control officer. Working with private providers in very time intensive, requiring visits, discussions, supervision, etc. [Could contract out.]

- Require major disease control programs (TB, Malaria, HIV/AIDS, STDs) to develop action plans for government-private provider collaboration

- Launch new initiatives for government-private provider collaboration in pilot districts, with additional finance for district level staff, transport, training, supervision, etc.

- Launch new initiatives in health information and promotion to reach private providers with up-to-date information about government disease control strategies, recommended case-finding and treatment practices, etc.

- Develop training materials for private providers, for example short, focused (half-day, 2-3 hours?) Continuing Medical Education (CME) type sessions. [Could contract out.]

b. Medium-term strategies

A5.46 These are strategies which require significant further investigation and analysis, or experimentation/piloting before larger scale implementation.

A5.47 There are three basic goals to the medium-term strategies: expanding successful government-private provider collaborations to state-wide implementation; experimenting with new initiatives to engage private providers through changes in health care organization, incentives, and regulation; and creating the infrastructure of people, capacity, and information to develop, sustain, and monitor these efforts.

i. Expanding government-private provider collaborations.

A5.48 The prerequisite for making progress in expanding collaborations is being able to identify successful collaborations, understand what makes them work, and provide the inputs needed to implement them over a wider area.

A5.49 Current programs must be inventoried and assessed for their contributions to higher coverage and improved health outcomes

A5.50 Resources for wider implementation of collaborations must be allocated and organized effectively. The development of a state-level officer charged with this task is one step in this direction. State government also needs to determine what resources are needed at district and mandal level and how these can be made available. Funds could be budgeted from the annual increases in primary health care expenditure to which GoAP is committed. Should these be organized as programs within the state budget? Should they be funded through the societies? Could a new society for government-private collaboration be developed?

ii. Experimenting with new initiatives.

A5.51 This area of work is potentially quite broad. We should analyze strategies in terms of their impact on the determinants of increasing health benefits/outcomes, especially of the poor, and improving financial protection of the poor. These determinants are:

A5.52 Access and coverage of the services that address the priority health problems. This is related both to physical access, but also to financial access and the perceptions of the population about quality of different types of providers.

A5.53 Technical (clinical) quality of services.

A5.54 Efficiency in resource use, in the sense that inefficient services waste resources that could be used more productively.

A5.55 Reducing the out-of-pocket burden of the poor for essential services.

A5.56 There are several areas where development of new initiatives could be launched:

- Developing an accreditation and quality assurance scheme for private providers and diagnostic facilities, especially in relation to the priority health programs. This would:

- Call on state government to establish basic quality standards for primary care providers, certify or accredite providers who meet these standards, and provide mechanisms through which providers can improve their quality to meet accreditation standards or attain higher standards.

- Create a scheme of for allowing private providers to publicly advertise their accreditation. This might include agreement on standard (and modest) charges for patients related to priority health programs.

- Support public notice of accreditation with public information efforts to encourage patients to use accredited providers.

- There are some recent international experiences, for example, Indonesia's creation of accredited private family planning providers. This type of effort would help address quality issues, but may have little impact on access/coverage or financial protection, unless it is tied to reforms in patient charges of some type of public subsidy for patients.

A5.57 Developing new financing and organization strategies for primary care coverage. In its study on the private sector, IHS proposed that A.P. could develop a new approach to primary care coverage based on a "family doctor" model. In this model, each patient or family would be affiliated with a primary care provider. These providers could be in government facilities or private providers. They would be paid by capitation. Low income families would have their capitation paid for or subsidized by the government. A pilot project along these lines is now being developed under the poverty alleviation program, with some funding through a World Bank loan. This type of initiative could address all of the determinants of poor outcomes listed above, but will require significant investment. It could be linked to experiments with new financing approaches, such as a District Health Fund, with funding from government and households.

A5.58 Involving LTFQ providers (such as RMPs and village doctors) in priority health programs. This is a controversial area. Some efforts are already being implemented through the disease control programs in the districts (e.g. TB), but there are legal issues and opposition from the IMA. Nonetheless, these providers are the main source of initial treatment for most of the priority health problems. Achieving significant increases in coverage without involving them may be difficult. The types of involvement include training, providing supplies and other inputs, referral linkages, accreditation to participate in disease control programs, and government financing (subsidies) for their work in these programs. Some of this is already being done, but there is no documentation or evaluation of these efforts.

iii. Creating Capacity to Implement Innovation and Essential Information/Evidence on Private Provision

A5.59 *Development of state database on private providers.* The APHIDB developed by the Institute of Health Systems is a valuable resource. The state government should either take on the responsibility for enumerating and registering all private providers or contract that task out to voluntary organization. Registration should cover all hospitals, nursing homes, private clinics and practices of qualified allopathic and ISM providers, fixed practices of LTFQ providers such as RMPs and not-fully-qualified ISM providers, pharmacies, and free-standing diagnostic facilities. In other words, all health establishments. Part-time and itinerant practicioners can be excluded. The database should include information on address, ownership, qualifications, main types of services offered, availability of ancillary services (diagnostics, drugs), etc. This database should be updated periodically.

- The database could be used to develop an information and outreach program to at least inform private providers about priority public

programs, referral and clinical guidelines and practices, and opportunities for collaboration. It could be used by district officers to develop new initiatives.

- There are risks in developing such a database. If providers feel that this will be used to take legal action against them, they will not be willing to provide information. The state must find ways to address this concern in its outreach to providers.

A5.60 *Providing human and financial resources.* The activities discussed above (and others that might be forthcoming in discussions) essentially comprise a major new initiative for the state in government-private provider collaboration. This initiative has major potential for improving health outcomes, given the large role played by private providers in A.P.'s health system and their significant role treating most major priority problems and even reaching poor populations. But to achieve this potential, development of government-private provider collaboration must be evidence-based in planning and evaluation. The capacity to implement new strategies in pilot areas and the state as whole must be provided.

A5.61 Can this activity be accomplished by adding tasks onto the work of the existing disease control program staff? Without having done a specific analysis of their workload, it is difficult to say. But state authorities should expect that a serious effort to build up government-private provider collaboration will require a major new initiative, with staff, funding, and other inputs. To my knowledge, no other state in India has launched a serious state-level cross-cutting program of this kind. Can A.P. make a commitment in this area, allocating significant additional resources over the next 3-5 years? This would require at least the following:

- Significant financial commitment to a new program for government-private provider collaboration, cutting across the current major vertical lines of disease control and family welfare.

- Creating posts and allocating staff at state and district levels to work on this program.

- Setting up the capacity to design, monitor, and evaluate innovative projects. This could be contracted out to one or several of A.P.'s very competent non-governmental organizations.

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Annex 6

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

The State of Health and Burden of Disease in Andhra Pradesh, about 2000 AD

Prasanta Mahapatra and C.K. George

Annex 6

The state of health and burden of disease in Andhra Pradesh, about 2000 AD

Prasanta Mahapatra and C.K. George

1. Introduction

A6.1 The Vision 2020 document of the Government of Andhra Pradesh (GoAP) sets out ambitious goals to achieve improved population health status and access to responsive basic health services. The Department of Health, Medical and Family Welfare of GoAP has initiated a number of exercises to define and operationalize the objectives set in Vision 2020. The GoAP is in the process of developing a Medium Term Financing Strategy for Health intended to serve the State for a minimum period of five years. Such a strategy would set out the framework within which the GoAP will operate in the health sector.

A6.2 Taking stock of the population health status, it's past trends, and measurements of disease burden of various population subgroups of the State are essential inputs for setting of priorities for the reform process. This will enable the development of targeted interventions that will provide these groups the necessary support for their survival, growth, development and sustenance. In this paper, we first review the population health status in Andhra Pradesh using conventional indicators and then present an estimate of disease burden in the State using the Disability Adjusted Life Year (DALY) as a summary measure.

2. Conventional Indicators of population health status

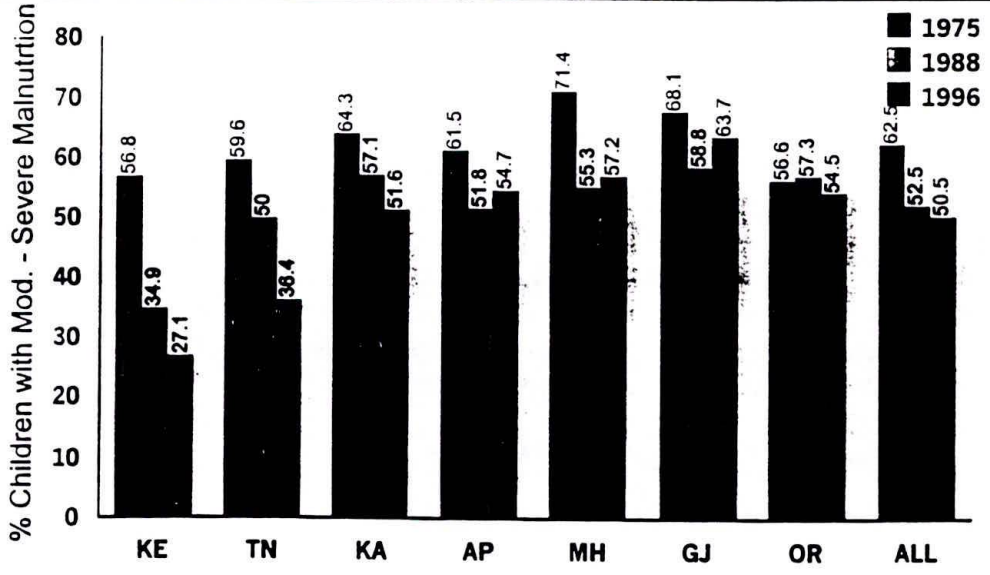
A6.3 The World Health Organization (1981) identified five broad indicators to measure health status of a population. These include; (a) nutritional status of children, (b) infant mortality rate (IMR) (c) under five child mortality, i.e. mortality below five years age, (d) life expectancy, and (e) maternal mortality rate (MMR). IMR, under five child mortality, and life expectancy represent various aspects of general mortality. If we group these together, the health status indicators listed above reduce to three sets, namely; (a) nutritional status, (b) general mortality, and (c) maternal mortality. These three groups of indicators are used here to describe the health status of the State. In addition we have included Total Fertility Rate (TFR), since fertility is an indicator of the level of reproductive activity which has important implications on reproductive health. TFR is also an indicator of the State's population policy goals, which are intricately linked with the health sector.

a. Nutritional status

A6.4 Nutritional status is a positive health indicator (WHO, 1981 p32). There are many ways to measure nutritional status. Among these, the weight-for-age status of the preschool children is considered to be the most sensitive indicator of community nutrition. For adults the body mass index (BMI) is considered more appropriate.

A6.5 The National Nutrition Monitoring Bureau (NNMB) measures nutrition status in 10 states including Andhra Pradesh on a continuous basis. The NNMB has so far conducted one reference and two repeat surveys to assess changes in nutritional status of population in the study states. The reference survey took place in 1975-79 and the two repeat surveys took place during 1988-90 and 1996-97. Figure-1 shows time trend of moderate to severe malnutrition prevalence among preschool children in different states, based on weight-for-age. In AP, as in most other NNMB states, there has been an improvement in nutritional status over the years. However still 50% of children in AP are suffering the burden of moderate to severe malnutrition.

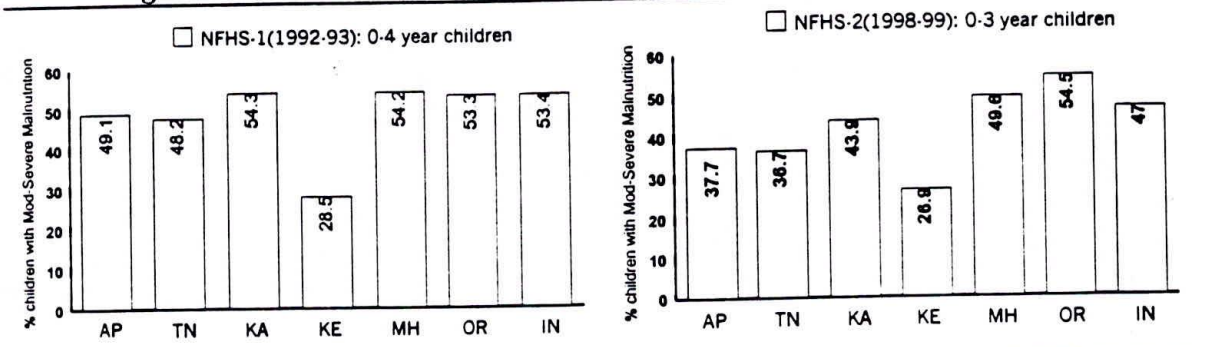
Figure 1. Malnutrition among preschool children in AP and other states.



1 Source: The figure is based on Weight-for-age data from NNMB Repeat Surveys 1975-79, 88-90, and 96-97, reproduced from Mahapatra and Reddy, Health Status in AP, IHS Working Paper WP- 43/2001 (1-28).

A6.6 The National Family and Health Surveys (NFHS) provides estimate of prevalence of malnutrition among preschool children. The figure-2 compares the prevalence of moderate to severe under nourishment in AP and other states according to the two NFHS surveys. The first NFHS survey (left chart) show that Kerala had the lowest prevalence of under nutrition and all other NNMB states including AP had a higher but similar prevalence of malnutrition. The second NFHS survey shows that the states have somewhat differentiated probably on account of differences in interventions and programme implementation.

Figure 2. Under nourishment in preschool children according to NFHS.

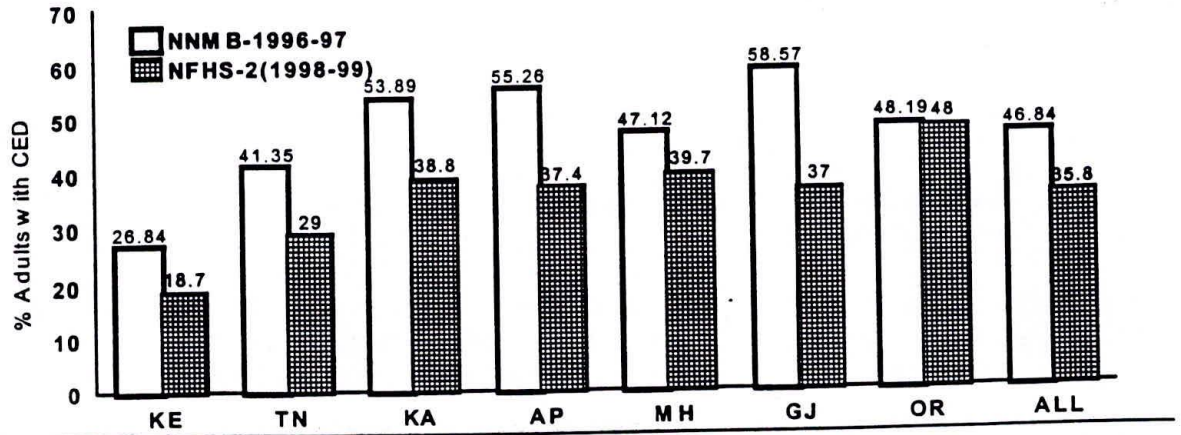


l Source: The figure is based on data from NFHS-1 and NFHS-2 (India) p-286, table- 10.10 NFHS-2 p-270 table- 7.17, reproduced from Mahapatra and Reddy, Health Status in AP, IHS Working Paper WP- 43/2001 (1-28).

A6.7 Overall, under nutrition among preschool children is still an important problem in AP. About 40 to 50% of preschool children suffer from under nutrition. Poor nutrition is a risk factor for many infectious diseases like ARI, Diarrhoea etc.

A6.8 Body mass index (BMI) is an indicator of energy deficiency or obesity in adults. Persons with BMI less than 18.5 kg/m^2 are considered to suffer from chronic energy deficiency (CED) and those with BMI greater than 25 kg/m^2 are the obese. Figure-3 shows that chronic energy deficiency among adults of AP was comparatively higher than the average for all NNMB states.

Figure 3. Chronic Energy Deficiency (CED) in adults of AP and other states, 96-97, 98-99



Source: Figure is based on Body mass index (BMI) data from NNMB Repeat Survey 1996-97 and NFHS-2 , reproduced from Mahapatra and Reddy, Health Status in AP, IHS Working Paper WP- 43/2001 (1-28).

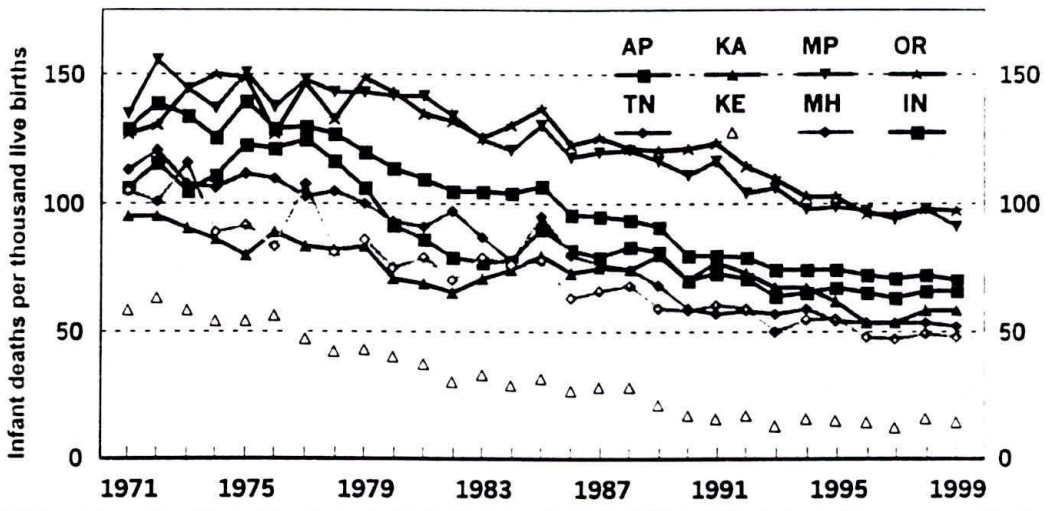
b. General mortality level (IMR and Life Expectancy):

1) Infant mortality Rate

A6.9 The Infant Mortality Rate (IMR) is a sensitive indicator of population health as well as socio-economic development. In addition, IMR is a sensitive indicator of the availability, utilization and effectiveness of health care, particularly perinatal care (WHO, 1981)

A6.10 The IMR of the state registered a consistent decline from 110-120 in 1970s to 66-70 in 1990s (Figure-4). The reduction of IMR in AP (red line in fig-4) has been keeping pace with the national trend. However performance of the state has been much less than that of the neighboring states. Kerala started with a lower level of IMR during the 1970s and has experienced consistent improvements over time. Tamil Nadu started with a level of IMR similar to AP. The decline of IMR in Tamil Nadu is higher than in AP. Both states started with similar levels of IMR in 1970s and improved the same more or less similarly during the 1980s. During 1990s, Tamil Nadu continued its improvements in IMR but Andhra Pradesh appears to have slowed down, resulting in a gap of about 10 infant deaths per 1000 live births between the two states.

Figure 4. Infant mortality trend in AP and other neighbouring states



1Source: SRS Annual Reports, 1971 - 1999, reproduced from Mahapatra and Reddy, Health Status in AP, IHS Working Paper WP- 43/2001 (1-28).

A6.11 Though AP has performed reasonably well in reducing IMR, it has definitely not been able to exploit the full potential available to it. Of particular concern is the slow down in reduction of IMR in the state, during the 1990s.Despite the overall decline in infant and child mortality, 1 in every 15 children born in Andhra Pradesh during the mid 1990s died within the first year of life.

2) Life Expectancy :

A6.12 Life expectancy is an indicator of socioeconomic development in general and long-term survival (WHO, 1981). Life expectancy of a population at a given age is the average years of life lived by those reaching that age. For example life expectancy at birth of 60 years means that all children taking birth in the population can on an average expect to live for 60 years. Life expectancy at birth is highly influenced by the IMR, particularly if it is at a high level.

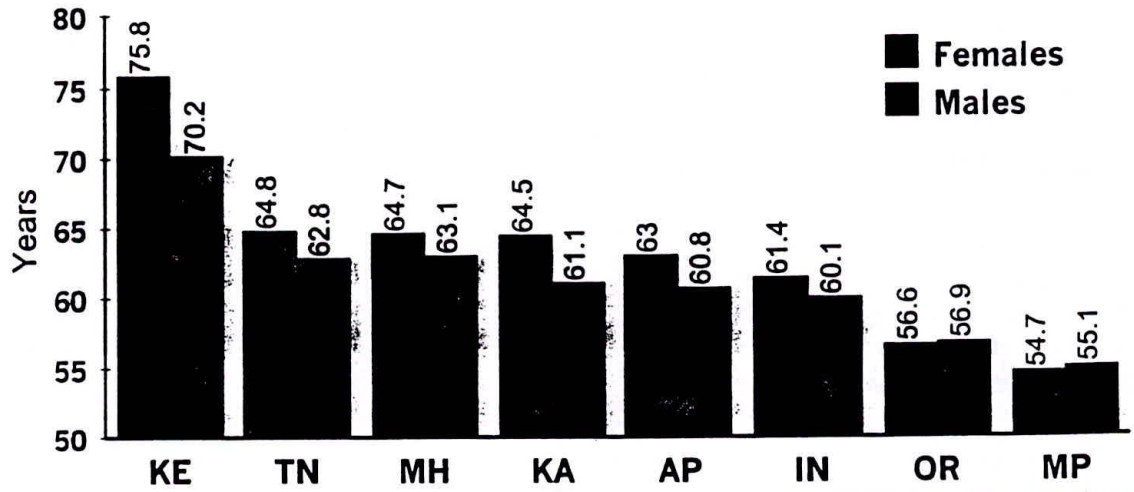
A6.13 Table-1 shows estimates of life expectancy for Andhra Pradesh, Kerala and India at different points of time. Though expectation of life at birth was low in the state during 50s, by 70s it was slightly better than the national average, suggesting a significant improvement in the health status of people. There after life expectancy at birth in AP has remained slightly above the national average.

Table 1. Life Expectancy at Birth of Andhra Pradesh, India and Kerala

Period	AP	Kerala	India
1951-61	36.9	48.3	41.2
1961-71	44.4	48.8	47.7
1971-81	55.7	65	54.4
1989-92	60.6	72	59.4
1992-96	62	73	60.7

Source: Table based on SRS mortality data, reproduced from Mahapatra and Reddy, Health Status in AP, HIS Working Paper WP- 43/2001 (1-28).

Figure 5. Life expectancy at birth in AP and other states, 1992-96



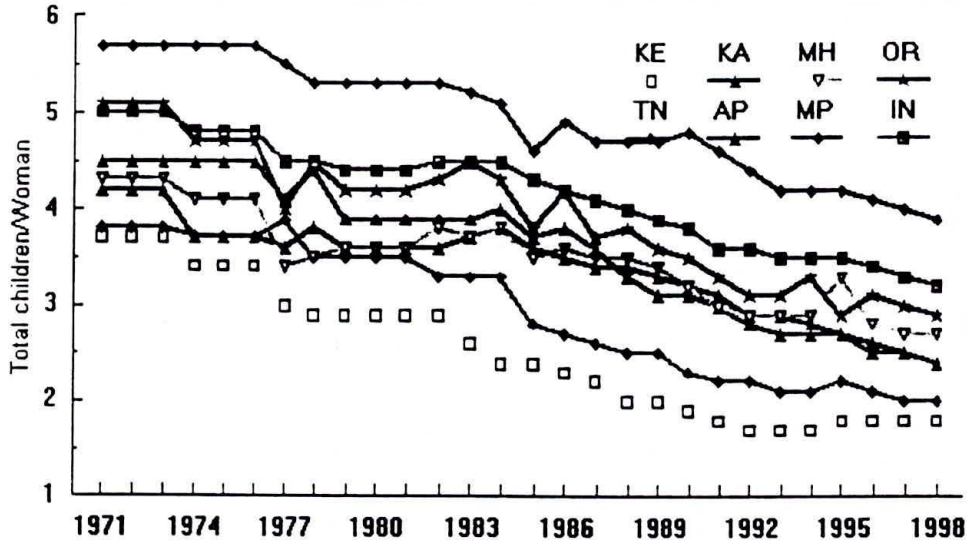
Source: Figure based on SRS mortality statistics, reproduced from Mahapatra and Reddy, Health Status in AP, IHS Working Paper WP- 43/2001 (1-28).

A6.14 Figure- 5 shows female and male life expectancy estimates for AP and other states, for the period 1992-96. Life expectancy in AP is slightly better than the all India average, but is the lowest among the south Indian states. Life expectancy at birth is the best in Kerala, and better than AP in Tamil Nadu, Karnataka, and Maharashtra.

3) Total Fertility Rate

A6.15 Total Fertility Rate is mostly used by demographers to analyze trends of fertility. Reduction in fertility levels is viewed as an indicator of improvements in reproductive health. Figure-6 shows total fertility rate of Andhra Pradesh and other states. There is a constant decline of TFR from 1970s to 1998. All India TFR was 5 in 1971-73 and declined to 3.2 in 1998. The TFR of AP was 4.5 in 1971-73 and it has decreased to 2.4 in 1998.There is ample scope for further decline of TFR in AP considering the much lower fertility levels attained by the southern states in India like Kerala and Tamil Nadu (1.8 and 2 respectively).

Figure 6. Total fertility rate (TFR) in Andhra Pradesh and other states 1971-1998



Source: Figure based on SRS Annual Reports for the period 1971-1998, reproduced from IHS (2002), Reproductive health services and sector reform : Draft Action Plan

4) Maternal Mortality

A6.16 Maternal Mortality ratio (MMR) reflects the risk to mothers during pregnancy and childbirth. It is influenced by general socioeconomic conditions, nutrition and sanitation, as well as by maternal health care.

A6.17 Precise estimates of maternal mortality rate (MMR) in Andhra Pradesh are not available. The NFHS did collect data to estimate maternal mortality rates. Both NFHS- 1&2 give MMR estimates at the national level. All India estimates of MMR ranges from 400 to 500 deaths per 100000 live births (IIPS, 2000 p196). Mahapatra and others (2002) have computed MMR using

estimates of maternal deaths in AP during the 1990s by Mahapatra (2000) and an estimate of live births in AP on 1991 census population and SRS estimates of CBR. This would imply that MMR in AP might be around 260 per 100000 live births.

A6.18 A more interesting aspect of the cause of death estimates shown in table-2 is the large number of deaths of young and adult women due to non-maternal causes. About 4400 woman die of maternal causes. But 8500 women commit suicide every year. This is about twice the number of maternal deaths. Another 3000 women die on account of fire accident or violence. These deaths have intricate relationship with status of women, socioeconomic vulnerability and poor power equation of women.

Table 2. Major causes of death among women in reproductive age group of 15-44 years, for the year 1991 in AP.

Cause of death	Number of female deaths		
	Rural	Urban	Total
All causes	44109	8049	52158
Maternal Causes			
Maternal Hemorrhage	462	82	544
Maternal sepsis	462	118	580
Hypertensive disorders of pregnancy	599	4	603
Obstructed labour	308	7	315
Abortion	1044	56	1100
Other maternal conditions	890	389	1279
Other major causes			
Self-inflicted injury (suicides)	8544	94	8638
Fire accidents	1763	1645	3408
Violence	1215	349	1564
Estimated maternal deaths	3765	656	4421
Estimated births in 1991	1288453	436446	1729208
Maternal Mortality Ratio	**292**/ 100000 live births	**150**/ 100000 live births	**256**/ 100000 live births

Source: Mahapatra, Estimating National Burden of Disease, 2000, Appendix: 3-7.1 and 3-8.1.

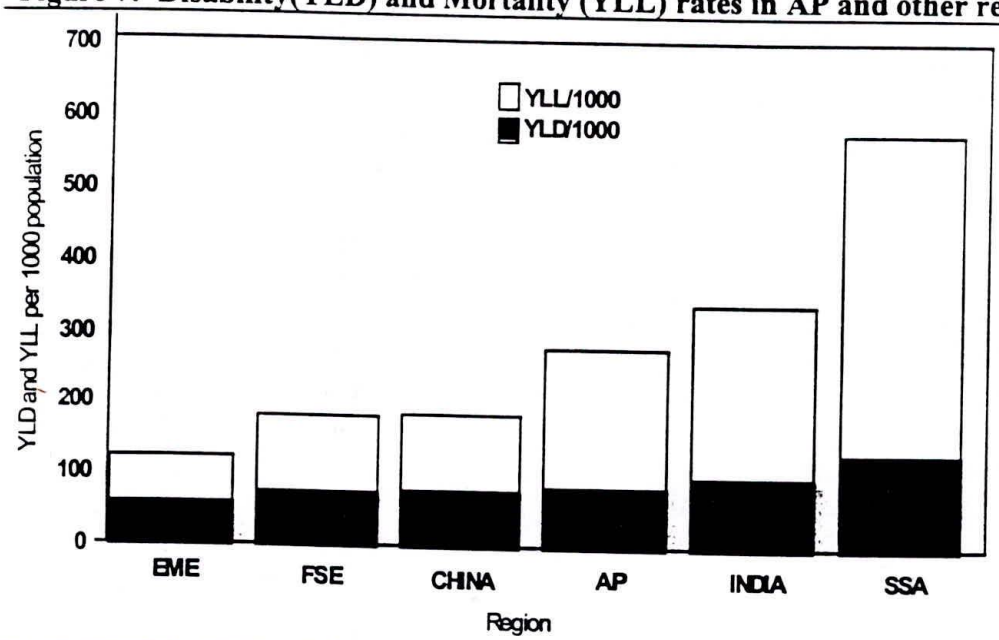
3. Summary measures of population health and the burden of disease in Andhra Pradesh

A6.19 With epidemiological transition from communicable diseases to non-communicable and degenerative disease, measurement of non fatal outcomes assumes importance. Summary measures of population health are designed to incorporate mortality experience of a population with the level of morbidity in a single number. These can either be measures of healthy life expectancy like the 'disability adjusted life expectancy' (DALE) or health gaps like the 'disability adjusted life years' (DALY) lost due to disease. The World Bank's World Development Report, 1993 titled "Investing in health" used the disability adjusted life years (DALY) measure to estimate burden of disease in different parts of the world. The World Health Organization started using summary measures like the DALY and DALE starting with the World Health Report 1999. In Andhra Pradesh, Mahapatra (2000) has estimated the burden of disease in

the state during the 1990s using similar methodology. An overview of the burden of disease in AP during the 1990s, is presented here, using estimates from the AP Burden of disease study based on expert rated disability weights (Mahapatra, 2000).

A6.20 The overall burden of disease in Andhra Pradesh in terms of DALYs lost is estimated to be 277 DALYs per 1000 population in Andhra Pradesh. The rate of loss is 293 DALYs/1000 for males and 269 DALYs/1000 for females (Mahapatra 2000). The break up of burden of disease into crude YLL and YLD rates by region is shown in Figure 7. It is seen that the variance of burden of disease rates among the regions is mainly on account of the premature mortality component in their disease burden. In EME, burden is equally attributable to premature death and disability, while in SSA over three quarters of the burden of disease is due to premature mortality. In India and Andhra Pradesh, close to 70% of the disease burden due to premature mortality.

Figure 7: Disability(YLD) and Mortality (YLL) rates in AP and other regions, 1990's



Source : Estimates for AP taken from Mahapatra (2001) The burden of disease in Andhra Pradesh 1990s; estimates for other regions from Murray and Lopez ; 1996 Annex tables 7 and 8

A6.21 Table 3 shows age sex distribution of disease burden in terms of YLL: YLD ratios. In contrast to developed regions, premature mortality is the predominant cause of disease burden in all age groups in India. The YLL: YLD ratios for Andhra Pradesh are comparable with overall estimates for India. In Andhra Pradesh, infants and children in the 0-4 age group are particularly more vulnerable to death (YLL: YLD ratio = 4.14 in females and 4.65 in males).

Table 3 YLL : YLD ratios by age and sex for different demographic regions, 1990s

Region	Sex	Age Groups by sex				
		0-4	5-14	15-44	45-59	+60
EME	M	1.62	0.54	0.61	1.54	2.68
	F	1.37	0.46	0.28	0.81	1.99
FSE	M	2.57	0.98	0.82	2.39	3.72
	F	2.07	0.76	0.36	1.06	2.75
SSA	M	8.32	2.89	1.54	1.66	2.52
	F	7.44	3.11	1.2	1.51	2.43
CHINA	M	2.27	1.01	0.79	1.68	2.67
	F	2.56	0.88	0.57	1.16	2.35
INDIA	M	5.29	1.07	1.08	1.98	3.18
	F	5.84	1.64	0.79	1.6	3.01
AP	M	4.65	0.62	1.65	2.73	6.38
	F	4.14	0.73	1.13	2.13	5.35

Source : Estimates for AP taken from Mahapatra (2001) The burden of disease in Andhra Pradesh 1990s; estimates for other regions from Murray and Lopez ; 1996 Annex tables 7 and 8

Note: Table 9.8 in Mahapatra, (2000), page 251, shows YLL : YLD ratios for 0-4 year males in Andhra Pradesh as

0.83. We have recomputed the figures using YLL and YLD estimates given in Appendices 9-3.2 and 9-3.3 of Mahapatra ((2000). The ratio shown in Table 9.8 of Mahapatra (2000), page 251, was a result of computation error.

A6.22 Table- 4 shows ten leading causes of burden in rural and urban areas of the state. Six leading causes are common to both the areas. These are (a) lower respiratory infections, (b) diarrhoea, (c) low birth weight, (d) ischaemic heart disease, and (e) falls and (f) tuberculosis. Poor nutrition, lack of safe drinking water and sanitation are common risk factors for three of these, namely lower respiratory infection, diarrhoea, and low birth weight. Four of these (a, b, c, and f) are already included in various public health and disease control programs of the state. The results obtained here reinforce the desirability of those programs.

Table-4 Leading causes of disease burden (DALY) in rural and urban AP,1990s

Rural: Cause	%	Urban: Cause	%
Lower respiratory infections	8.4	Falls	6.91
Diarrhoeal diseases	6.94	Low birth weight	6.32
Low birth weight	6.8	Lower respiratory infections	5.98
Ischaemic heart disease	6.09	Tuberculosis	5.34
Falls	5.45	Diarrhoeal diseases	4.00
Self-inflicted injury	4.24	Ischaemic heart disease	3.77
Tuberculosis	4.1	Fires	3.47
Cerebrovascular disease	2.56	Birth asphyxia or trauma	3.21
Bacterial meningitis	2.39	Road accidents	2.96
Epilepsy	2.24	Unipolar major depression	2.91
Road accidents	2.15		

Source: Reproduced from Mahapatra, 2000; The Burden of Disease in Andhra Pradesh, 1990s. Table-6.1

A6.23 Table 5 shows the leading causes of burden due to premature mortality. Most of the leading causes of overall disease burden, for example, lower respiratory infections, diarrhoeal diseases, low birth weight, tuberculosis, etc are repeated here. In addition, malaria appears as a leading cause of mortality in rural areas.

Table 5 Leading causes of premature mortality (YLL) in AP, 1990s

Rural: Cause	%	Urban: Cause	%
Lower respiratory infections	11.43	Low birth weight	9.74
Diarrhoeal diseases	9.26	Lower respiratory infections	9.4
Low birth weight	9.01	Tuberculosis	7.86
Ischaemic heart disease	8.49	Ischaemic heart disease	6.18
Self-inflicted injury	6.00	Diarrhoeal diseases	5.84
Tuberculosis	5.12	Birth asphyxia or trauma	4.17
Cerebrovascular disease	3.25	Road accidents	3.59
Bacterial meningitis	3.22	Fires	3.58
Cirrhosis of the liver	2.63	Cerebrovascular disease	3
Malaria	2.47		
Road traffic accidents	2.22		

Source: Reproduced from Mahapatra, 2000; The Burden of Disease in Andhra Pradesh, 1990s. Table-6.2

A6.24 Table 6 shows leading causes of disability in the state. Falls and fires are among the leading causes of disability. This reflects the fact that falls and fires not only cause loss of life, but also produce a lot of disability. Protein energy malnutrition is a major cause of disability. The burden is on account of developmental disability suffered by children due to poor nutrition. Unipolar major depression is yet another leading cause of disability to be viewed along with the fact that suicide is a leading cause of premature mortality. Cataract blindness, for which a control program is under implementation, is also among the leading causes of disability.

Table-6: Leading causes of disability (YLD) in Andhra Pradesh, 1990s

Rural: Cause	%	Urban: Cause	%
Falls	16.43	Falls	16.22
Unipolar major depression	6.66	Unipolar major depression	7.14
Epilepsy	5.64	Epilepsy	5.85
Cataracts	3.65	Schizophrenia	3.37
Fires	3.26	Fires	3.32
Schizophrenia	3.00	Cataracts	2.98
Protein-energy malnutrition	2.66	Lymphatic filariasis	2.53
Lymphatic filariasis	2.39	Protein-energy malnutrition	2.45
Obsessive-compulsive disorders	2.23	Obsessive-compulsive disorders	2.4
Chlamydia	2.16	Chlamydia	2.37
Abortion	2.11	Abortion	2.32

Source: Reproduced from Mahapatra, 2000; The Burden of Disease in Andhra Pradesh, 1990s. Table-6.3

4. Vision 2020 goals and current health status

A6.25 The Vision 2020 document has set specific targets for four health indicators, namely (a) Infant Mortality Rate (b) Child Mortality Rate (c) Total Fertility Rate and (d) Life Expectancy. In Table 7, we compare the Vision 2020 goals for the year 2020 with corresponding status in 1990's. To achieve the Vision 2020 goals for reduction of infant mortality the State has to reduce infant mortality by about 46 infant deaths per 1000 live births over about a twenty-year period. During the 1970's IMR in the State was about 110 to 120 per 1000 live births. Thus it took three decades for the State's IMR to reduce by about 40 to 50 infant deaths per 1000 live births. If we assume that the decline in IMR is linear, as has been the case in AP so far, it will take another two decades to realize reduction in IMR to about 20 infant deaths per 1000 live births. As the mortality level declines, further decline in mortality becomes difficult to achieve. Hence the Vision 2020 goals regarding reduction of IMR appears achievable, but will require a more streamlined and efficacious approach.

Table 7 Comparison of current levels and Vision 2020 goals for selected Indicators

Indicator	Current level (1990s)	Goals for year 2020
Infant Mortality Rate(per 1000 live birth) (1999)[1]	66	20
Child Mortality (per 1000) (1999)[1]	21	10
Total Fertility Rate (1998)[2]	2.4	1.5
Life Expectancy (Male) (1998)[2]	60.8	68.1
Life Expectancy (Female) (1998) [2]	63	70.6

Source:[1] NFHS data from IIPS (2000); [2] SRS Annual Report (1999); [3] GoAP, Andhra Pradesh: Vision 2020

Note: The Vision 2020 document reads; "This vision will translate into the following key health and development indicators by 2020: infant and child mortality rates of 10 per 1000 (live births) and 20 per 1000 respectively;"(GoAP, Vision 2020, pg. 92). Mortality experience world over shows that IMR is usually higher than Child mortality rate even in low mortality developed countries. Hence IMR of 10 per 1000 live births and Child mortality rate of 20 per 1000 appears implausible. We assume that the figures have been switched in the Vision 2020 document by a typographical error. Hence we work with the assumption that the Vision 2020 goal is for an IMR of 20 per 1000 live births and Child mortality rate of 10 per 1000.

5. Summary and Conclusion

A6.26 A significant proportion of the disease burden in Andhra Pradesh is on account of premature mortality. The top causes of disease burden in AP, during the 1990s include (a) lower respiratory tract infections (LRI), (b) diarrhoeal diseases, (c) low birth weight (LBW), (d) tuberculosis and (e) falls were. Three out of these five, namely: LRI, diarrhoea, and LBW, are public health problems for infants and children. They should serve as stark reminders to the persisting problems of poor nutrition, water supply and sanitation. Tuberculosis, another infectious disease, continues to be a major problem. Currently there are many programmes seeking prevention and treatment of these problems. For example: the reproductive and child health programmes, programme to build awareness about usefulness of oral rehydration therapy, tuberculosis control programmes. Obviously, the agenda to control diseases due to infection - malnutrition - poor hygiene complex remains unfinished.

A6.27 Demographic changes in age profile of the population due to rising life expectancy, and urbanization with accompanying lifestyle changes have led to an epidemiological transition in the State. Non communicable diseases contribute significantly to the disease burden in Andhra Pradesh. Ischaemic heart disease, cerebrovascular disease and cirrhosis of the liver are leading causes of premature mortality in the State. Neuro-psychiatric conditions like unipolar major depression, schizophrenia, obsessive-compulsive disorders, and epilepsy are a major cause of disability in the state. The implications of such a health transition does not bode well for Andhra Pradesh. On one hand the State has to deal with the unfinished agenda of "diseases of poverty" and on the other it has to gear up to meet the challenges posed by the increasing prevalence of risk factors for non communicable diseases like smoking, excessive drinking and sedentary life styles.

A6.28 Injuries, unintentional and intentional, contribute significantly to the burden of disease in Andhra Pradesh. There is hardly any discussion about falls as a major public health problem. Lack of attention on falls as a major cause of disease burden, we believe, is largely due ignorance about the size of problem attributable to falls. Self-inflicted injury and fire accidents emerged as major causes of disease burden in the state. Suicides, mostly among adolescents and young adults are largely due to problems of adjustment due to many factors during the transition phase of a person's life. The high burden on account of fire accidents, particularly among women, is consistent with widespread social ill of bridal harassment, dowry etc. A large proportion of suicides among young women is probably due to the same factors. The high level of disease burden due to road accidents is a cause for concern. Unless appropriate preventive measures are taken urgently, the burden is bound to increase on account of the lack of adequate infrastructure to meet the needs of a rapidly increasing automobile population and the laxity in enforcement of mandatory traffic regulations.

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Annex 7

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Financing Health in Andhra Pradesh

Ajay Mahal

Annex 7

Financing Health in Andhra Pradesh

Ajay Mahal

1. Introduction

A7.1 The note has three main objectives. The *first* is to bring together information on the overall magnitude of funds, public and private, likely to flow into the health sector in Andhra Pradesh over the course of the five-year period 2002-7. We are concerned not only with funds available for spending on activities usually referred to as "health care", preventive and curative, but also with activities that likely have a significant impact on the population's health, such as improvements in water and sanitation, nutrition, and pollution control. Of special interest is the magnitude of funds available to the Department of Health, Medical and Family Welfare, other state government departments, and various local governments for activities that impact on health, which will be a key input for developing a medium term health strategy and expenditure framework. A *second* set of objectives is to evaluate the use of these funds – including the degree of flexibility that these different public sector entities possess with regard to the disposal of funds available to them, and the rules used to distribute the funds across the different districts/regions of Andhra Pradesh. Both of the above goals will be useful as a means to assess ways in which financial planning can be undertaken to support a variety of short- and medium-run strategies to improve the health of the people of Andhra Pradesh. Many of these strategies have been discussed in the other background papers that form part of this Annexe. In addition, this paper has a third objective – to provide the basis for and suggesting the introduction of new strategies that lead to a more equitable and effective use of existing funds for health care, as well as helping raise additional funds.

A7.2 In addressing these goals, the author had the benefit of access to a recent and comprehensive impact and expenditure review of the health sector in Andhra Pradesh, as well as additional preliminary work on the costing of health sector strategies and the development of a "resource envelope" for the Andhra Pradesh health sector supported by the Department for International Development (DfID 2001, Pearson 2000a,b). A recent fiscal reforms strategy paper prepared by the Department of Finance of the Government of Andhra Pradesh also proved very useful in developing the arguments of this paper (GoAP 2002a). This background paper takes advantage of the several excellent ideas presented in this earlier work, and builds on it in areas that could do with further discussion and analysis, such as health sector financial resources available to districts and local bodies.

a. The Economic Setting

A7.3 It is a tautology to state that much of the private and public spending on health (and related activities) in Andhra Pradesh is closely tied to its overall economic performance, and indeed, to the economic performance of India as a whole. Higher incomes make health care more affordable to individuals and households, and are also more likely to be associated with increased tax revenues, so critical for improvements in the fiscal situation. Prudent fiscal management, however, does require more than just increased revenues. How and where public monies are spent is also crucial, so that the fiscal circumstances can act as an independent barrier to health spending by the public sector.

A7.4 We begin with an overview of the economic and fiscal situation in Andhra Pradesh. The post-reform period in India, the 1990s, has been characterized by an annual average rate of growth of real gross domestic product (GDP) that is somewhat higher relative to its magnitude in the 1980s – 5.7 percent in the latter period, and 6.3 percent in the 1990s, with a slowdown in the last few years.[1] This fact, coupled with declines in the average annual rate of growth of population during the 1990s, implies that the rate of growth of real GDP per capita has speeded up as well in the post-reform period, from 3.1 percent in the 1980s to 4.2 percent in the 1990s. Relative to India taken as a whole, Andhra Pradesh did rather well in the 1980s, with its real SGDP (State Gross Domestic Product) per capita growing at an annual average rate of 4.1 percent. Post-1993, the annual average rate of growth of real SGDP per capita in Andhra Pradesh has been about 4.3 percent (roughly similar to India as a whole), and its rate of growth of real SGDP, higher than the rate of growth of real GDP (all India). One net consequence of these trends is that the per capita income of Andhra Pradesh is about equal to the all India average. The latter half of the 1990s (1997-2001) has seen Andhra Pradesh perform better economically than the rest of India, with its real SGDP growing at 7.7 percent per year, higher than the 5.9 percent average annual rate of growth for India. These trends clearly indicate that over the last two decades, AP is keeping pace with all India performance, and if anything, has surpassed the latter in recent years.

A7.5 Andhra's relatively good economic performance is also reflected in the lower than average proportion of its population that lives below the national poverty line. According to estimates based on National Sample Survey (NSS) data for 1999-2000, nearly 11.1 percent of the rural population of Andhra Pradesh, and 26.6 percent of its urban population, lived below the poverty line, defined as the minimum amount of expenditure needed to purchase a basket of commodities providing a desirable level of calorie intake. In sum, 11.9 million people lived below the poverty line (5.8 million in rural areas and 6.1 million in urban areas) in Andhra Pradesh in 1999-2000, amounting to about 15.8 percent of its total population (GoAP 2002a, pp.1-2). By contrast, the proportion of population living below the poverty line in India as a whole was 26.1 percent in 1999-2000.

[1] Calculations based on data in GoAP (2002b, Annexture 2.9).

i. Intra Andhra Pradesh Patterns of Economic Performance

A7.6 Within Andhra Pradesh, there are significant differences in economic achievements across districts. These relate both to differences in the levels of per capita income, as well as differences in the rates of growth of real income per capita, across districts.

A7.7 While district-level GDP data for the most recent years are not yet available, data for the late 1990s indicate per capita income levels in Medak, Hyderabad and Ranga Reddy to be the highest, with others such as Mahbubnagar, Warangal and Srikakulam being the poorest. The richest district, measured in terms of per capita income, as of 1998 was Medak and it had a per capita income that was more than double that in the two poorest districts, Mahbubnagar and Warangal.

A7.8 The differences in per capita incomes across districts may be increasing over time. Data for the period 1993-98 indicate a correlation coefficient of +0.20 between the rate of growth of real per capita income in a district during 1993-98 and its level of per capita income in 1993. As one example, Hyderabad and Medak, two of the richer districts in 1993, experienced the highest annual average rates of growth of real income per capita, 7.3 percent and 6.5 percent, respectively during the period 1993-98, whereas Warangal and Vizianagaram, two of the poorer districts experienced annual average rates of growth that were 1.5 percent and 0.9 percent, respectively, over the same period.

b. Fiscal Situation

A7.9 The economic trends highlighted above suggest that at least on the revenues front, governments at the central and state levels in India are likely to have enjoyed some buoyancy, even if the situation at the district level is more complicated. Given, however, that the budgetary circumstances of governments depend on a host of factors on the expenditure side, further analysis is in order.

A7.10 In fact, the overall budgetary situation of the central and state governments in India has been rather bleak during the recently completed five-year plan period. The fiscal deficit of the central government alone averaged 5 percent of GDP during the period 1996-2001 (Planning Commission 2002). The major reasons for this include the implementation of the recommendations of the Fifth Pay Commission that have led to a high wage and salary burden of government employees, high interest payments on public debt, and the failure of revenues to keep up with expenditures owing particularly to the slowdown of GDP growth in recent years. The interest burden on public debt has worsened on account of government efforts to partly bridge the fiscal deficit by borrowing from the high interest bearing small savings deposits. According to estimates provided by the Planning Commission, the debt service burden of the central government has risen from 30 percent of its own tax revenues in the early 1980s to nearly 70 percent of its own tax revenues at the present time (Planning Commission 2002, p.12).

A7.11 The tight fiscal situation of the central government has meant the active consideration of a number of strategies to address it. The approach paper to the tenth five

year plan, for example, refers to a planned reduction in the number of government employees, with no new recruitment, over the plan period. Other suggested strategies include holding steady certain non-plan expenditures of the central government by means of reductions in subsidies on "non-merit" goods and user charges, and an acceleration of the disinvestments process of public sector undertakings (Planning Commission 2002, p.13). Moreover, the plan document also refers to promoting a linkage between states' performance on fiscal reform and at least some of the central government funding to states, with a view to ensuring more effective use of central government funds by the states.

A7.12 The fiscal situation at the center and the overall economic environment has obvious consequences for the fiscal health of the Government of Andhra Pradesh. This is so because central government grants and shared taxes account for nearly one-third of all receipts of the Andhra Pradesh government (GoAP 2002a, pp.5-6). A significant chunk of central funds take the form of shared revenues on the basis of the recommendations of the Finance Commission of India.[2] Moreover, central grants, which typically occur in three ways – centrally sponsored schemes, grants under article 275 of the constitution under the auspices of EFC for especially needy states/regions and "plan" grants (normal external aid projects, structural adjustment grants by donors) – also make a significant financial contribution to states. With the recent slowdown of the national economy, some squeeze in tax revenues that are to be shared between the center and the states, as well as other devolutions suggested by the EFC can be expected. Indeed, during the fiscal year 2001-2, Andhra Pradesh's receipts in centrally devolved taxes were lower than their budgeted estimates by nearly 9 percent (GoAP 2002a, p.5). More generally, transfers from the central government to Andhra Pradesh have declined in importance – from 5.2 percent of SGDP in 1995-6 to 4.6 percent of SGDP in 2000-1. Conversely, the role of own revenues (tax and non-tax) in total state revenues has increased from 54.9 percent in 1995-6 to 68.3 percent in 2000-1 (from 6.3 percent of SGDP in 1995-6 to 9.8 percent of SGDP in 2000-1). It is also unlikely that international donor funding will increase beyond existing commitments given the concern among central policymakers that funds for externally aided projects are focused on only a few selected states, with obvious consequences for inter-state resource inequity (Planning Commission 2002, p.14).

A7.13 Apart from the revenue crunch that it faces, the government of Andhra Pradesh is also faced with challenges on the expenditure side, as highlighted by the strategy paper on fiscal reforms published by the department of finance (GoAP 2002a). Its expenditures on revenue account *less* total revenues – that is, the revenue deficit – have increased in recent years, from 1.0 percent of SGDP in 1995-6 to 2.7 percent of SGDP in 2000-1. The fiscal deficit (all expenditures on revenue and capital account *less* total revenues) has also been increasing – from 3.1 percent of SGDP in 1995-6 to 5.4 percent of SGDP in 2000-1. As in the case of the central government, interest payments on state debt have increased sharply, from 1.9 percent of SGDP in 1995-6 to 2.8 percent of SGDP in 2000-1, reflecting an increasingly worsening public debt burden. Total state debt amounted to 28.6 percent of SGDP at the end of 2001, with loans guaranteed by the state government forming an additional 12.6 percent of SGDP. Pay revisions, natural calamities and

[2]The Eleventh Finance Commission (EFC) was the most recent of these constitutionally mandated bodies.

budgetary support to the power sector have also played a major role in the increased magnitude of revenue expenditures, which have gone up from 12.5 percent of SGDP in 1995-6 to 17.1 percent of SGDP in 2000-1.

iii. Fiscal situation of local governments

A7.14 Even if the financial situation at the level of the central and state governments is somewhat grim, local governments can provide services with their own revenues. This sub-section takes a preliminary look at the financial situation of urban and rural local governments in Andhra Pradesh.

A7.15 As of 1991, nearly 13 percent of Andhra Pradesh's population resided in its 117 municipalities and municipal corporations. Together, these urban local bodies had an estimated Rs.1,100 crore in receipts in 2000-1, a miniscule amount when compared to the resources of state government departments (about 5.5 percent of state government receipts and 0.9 percent of SGDP) in that fiscal year.[3] About 25 percent of these receipts took the form of plan and non-plan grants from the central and state governments, with the remainder raised through taxes and fees (including taxes collected by the state but "assigned" to local bodies) (GoAP 2001; Communication with Y. Srilakshmi, Municipal Commisioner). The share of plan and non-plan grants in total revenues of urban local bodies has been virtually constant during the period 1995-2000 (State Finance Commission 1997, pp.167-9). Three points are noteworthy with respect to the finances of urban bodies. First, they cover a significant portion of their current expenditures from their own revenues, whether collected or assigned. Second, the relatively small size of their own funding may reflect an inability on the part of urban local bodies to raise extra revenues locally, whether on account to a lack of access to remunerative sources of revenue, or lack of political will. Finally, the reliance on own sources of revenue suggests that the economically better off urban areas are likely to have local governments that are placed better in terms of resources, so that the existing pattern of financing local governments is likely to be inequitable. Preliminary analysis of municipality-level data provides some support to this hypothesis. The correlation between own revenues (per capita) in a municipality and the level of per capita in the district where the municipality was located was +0.33. On the other hand, there is some weak evidence to suggest that the central and state grants provided to urban bodies act to equalize inter-municipality equality – with the correlation between grants per capita and district-level per capita income being of the order of -0.21.

A7.16 Financial data on the more than 21 thousand panchayats (Gram, Mandal and Zilla) in Andhra Pradesh is not readily available for years after 1996 (State Finance Commission 1997). However, available evidence suggests that panchayats are dependent on central and state government grants to a much greater degree than urban local bodies. As per data for 1996, the year prior to the submission of the report of the First State Finance Commission of AP, 75 percent of all panchayat expenditures were funded by various central and state grants. The greater reliance on central and state government funding would suggest a more equitable allocation of resources among rural local

[3]There are 110 municipalities and 7 municipal corporations in AP.

governments than urban local governments. On the other hand, it may also signal a lack of flexibility in the use of funds if they are allocated to specific uses and dependence on the vagaries of the fiscal situation of the central government and the government of Andhra Pradesh.

A7.17 While past data is useful in obtaining insights about the financial situation of local bodies, it may not be as accurate an indicator of the situation in more recent years in light of the constitutional amendments requiring a transfer of functions and financing to local governments, or of future prospects. An analysis of the recommendations of the state finance commissions is useful for this purpose, only one of which has submitted its report thus far. The First State Finance Commission (SFC), which submitted its report in 1997 for the period 1997 through 2000, suggested a variety of increases in funds to local governments, including by increasing the magnitude of general grants allocated on a per capita basis, after adjusting for interregional and inter-local body inequities, specific grants for maintenance of assets and the like. Overall, the magnitude of such increased transfers relative to total expenditures/revenues of the local governments was roughly 40 percent of their existing receipts in 1996-7, a not insubstantial sum. But as the SFC itself acknowledged, continuation of added grant money to local bodies from the state government was dependent on its fiscal situation.

c. The Medium-Term Fiscal Framework of the Government of Andhra Pradesh

A7.18 With local body own revenues comprising only a small portion of public spending in Andhra Pradesh, the medium-term fiscal outlook for its state government is the key indicator of the resource constraints faced by sectoral strategy in the health sector. This section reviews the government of Andhra Pradesh's own assessment of its fiscal outlook in the medium run and the strategies it proposes to adopt as part of this exercise (GoAP 2002a).

A7.19 Over the five-year period from 2002 to 2007, the GoAP seeks to reduce its fiscal deficit from 5 percent of SGDP to 2 percent of SGDP. There are additional five-year targets with respect to the size of the revenue deficit, public debt, and contingent liabilities and these are indicated in its strategy document (GoAP 2002a, p.18). It proposes to achieve these targets by addressing several of the key elements that underlie its adverse budgetary situation without imposing too much of a constraint on social sector expenditures. Indeed, "The overriding objective of Andhra Pradesh's fiscal restructuring program is to augment state revenues and redirect government expenditure away from less productive schemes towards investments in people to improve their quality of life and strengthen their social and economic assets through improved health, education and other social services." (GoAP 2002a, p.12).

A7.20 A major challenge in trying to achieve these objectives is the control of "establishment costs" (salaries *plus* pensions) that increased from 73.4 percent of the state's own revenue in 1998-99 to 78.7 percent of own revenues in 2001-2. This is proposed to be addressed by restrictions on hiring in the government that apply to all

sectors except for law and order, and essential health and education services, coupled with attrition via retirement and selective application of voluntary retirement packages. As a consequence, the share of establishment costs in the state's revenues is expected to fall from its current high levels to 61 percent by the year 2006-7. The government has placed an emphasis on human resource development and skill upgradation of employees rather than any radical downsizing of civil services. Thus, its strategy calls for reorientation, retraining and redeployment of existing staff.

A7.21 Another key factor influencing the budget is subsidies – the power subsidy for 2001-2 was "fixed" at Rs. 1,561 crores, but a drought situation in the state meant that there would have been an added burden f Rs. 876 crores during the year 2001-2 on account of additional power purchases. In the short-run the state intends to meet this shortfall by the securitization of outstanding dues to the creditors of the AP Power Finance Corporation by way of bonds guaranteed by the state government, although this will increase interest payments in the future. Over time, the government expects the power subsidy to fall to 0.5 percent of SGDP by 2006-7 from its current level of 2.1 percent of SGDP. Similarly, the subsidy on rice is expected to fall from its current level of 0.3 percent of SGDP to 0.2 percent of SGDP by 2006-7.

A7.22 Another key pillar of the government's strategy is its plan to privatize public enterprises and putting a cap on loan guarantees as a means to curtail its stock of public debt. The government has also allowed for plans to support voluntary retirement packages to employees in some of the public enterprises, such as the provision of loans to the concerned enterprises for this purpose – Rs. 180 crore for the fiscal year 2002-3, and additional amounts in each subsequent year until 2006-7.

A7.23 These declines in spending and the promotion of fiscal prudence are, apart from their expected impact on the fiscal deficit, expected to lead to additional funds becoming available for infrastructure development, especially in the transport and communication sectors. They are also expected to lead to increases in operational and maintenance expenditures form 1.7 percent of SGDP in 2001-2 to 1.8 percent of SGDP in 2002-3, and ultimately to 2.2 percent of SGDP by 2006-7.

A7.24 The government has also committed itself to increased spending on primary health and primary education, which comprised 2.1 percent of SGDP in 2000-1. As per its strategy document, "The government will aim to provide 1 percent of SGDP for primary health and 2 percent of SGDP for primary education to translate the policies laid down in the strategy papers on health and education." (GoAP 2002a, p.26). Objectives of poverty reduction, expansion of core social services to the poor and under-privileged communities are also emphasized, along with the amelioration of geographical disparities in development (GoAP 2002a, p.26).

iv. In sum

A7.25 The tight budgetary situation at the central and state levels limits the extent to which the central and state governments can spend significantly more on the health sector. There is a clear commitment though, on the part of the government to spend more on *primary health care* which, in a regime of reasonably fast growth of SGDP – say at 6.5 percent or more per year, the assumptions implicit in the department of finance calculations for its medium term fiscal strategy – also has implications for increased private spending for health, whether provided in the public or private sectors.

2. Total Resource Flows to the Health Sector

a. Some Observations on Data

A7.26 According to one recent estimate, current spending on health care (excluding water and sanitation, nutrition and pollution control expenditures) by the government of Andhra Pradesh accounts for only about 13-14 percent of all health spending (DfID 2001). Total spending, public and private, amounts to roughly 6.6 percent of SGDP. These estimates rely on data from a recent household level survey of consumer spending undertaken by the National Sample Survey Organization (NSSO), together with information from the demand for grants of the government of Andhra Pradesh, and ignores other types of spending, such as insurance premiums, spending by private firms on health and the like.

A7.27 Information on health expenditures, whether private or public, at the district level is even more difficult to obtain. Household expenditure surveys carried out by organizations such as the NSSO do not provide statistically robust results at the district level. At best, regional level estimates may be arrived at. Government expenditure data at the district levels, while technically in existence, is not readily accessible. Our discussions with the officials of the department of health, medical and family welfare suggest that obtaining this data might require field visits to all 23 districts in the state. Another concern is the need for better management and consolidation of financial data on health in the public sector, currently under the control of several different departments, with some not being recorded in budget documents at all – as in the case of the AIDS society. At the aggregate level, much greater effort is needed to collect information on the activities of private health insurers many of whom are already operating in the health sector. In general, such information is best collected in a systematic way by following a national/state/district health accounts framework. The recently crafted National Health Policy of India explicitly states the need to develop a national and state level health accounts for India.

b. Implications for Health Planning

A7.28 The much larger out-of-pocket health spending of households, relative to that of the government, much of it on curative care, has at least three implications for policy.

First, it suggests that the financial burden of ill health is likely to be quite severe for the population of AP, with the subsidized public sector delivery system not being able to effectively serve as an insurance mechanism. This calls for some renewed thinking about development of insurance mechanisms, within the public sector, or without, that promote financial risk pooling. Second, to the extent that a significant amount of private household spending is directed towards private health providers, who therefore impact on health outcomes, it calls for more pro-active policymaking towards the private sector, including regulatory strategies, as also co-opting it in efforts to improve delivery of services that are particularly desirable, such as TB treatment. Finally, the small size of the public sector spending suggests using public resources more effectively in ways that readily enhance major policy priorities of the government – such as better targeting of expenditures to the poor and backwards groups, public health and the like.

3. Public Financing for Health in Andhra Pradesh

A7.29 This section carries out a situation analysis and assesses the nature of government financing available for health over the medium-run – from 2002 to 2007. Two sets of health-related activities are emphasized. The first is simply public resources used for health care as commonly understood in the literature, whether preventive or curative. Curative care at the primary, secondary and tertiary levels, immunization and health promotion activities belong to this category. This second refers to items that likely have a major influence on health – such as improved nutrition, water and sanitation, pollution control and the like – but which do not always enter into standard calculations of health spending.

a. Recent Trends and Prospects

A7.30 Data on past and budgeted health spending was obtained from three sources – an impact and expenditure review undertaken by DfID, demand for grants submitted by the government in connection with its annual budgetary exercise, and a recent overview of the health sector undertaken by the department of health, medical and family welfare.

A7.31 Table 1 provides information on recent trends in public sector health spending. These estimates exclude expenditures incurred by local bodies on preventive and curative care from their own resources. Nor do they include health spending directed through district level societies that circumvent the state government's budgetary process (such as the AIDS control society), or in-kind grants, as for example under the Family Welfare program. Previous work suggests that these are still small relative to the overall size of the health budget (DfID 2001). The data clearly show that the overall size of the health budget has been keeping pace with GDP growth, and constitutes about 0.9 percent of SGDP as of now. As a proportion of total public sector spending, health spending has fallen a bit compared to the mid-1990s, but is still hovering around the 5-percent level. On two points, however, there can be no doubt. Total health spending has increased in real terms over time. Moreover, on a per capita basis, real public health spending has increased by nearly 40 percent over the period 1996-2002.

A7.32 Table 2 takes a closer look at three major components of public sector spending – medical education, medical and health, and primary health and family welfare. Broadly speaking, the first two can be thought to signify secondary and tertiary care, whereas the latter category includes most (but not all) elements of primary care. The table also provides estimates of the wage and salary burden under each of the main expenditure categories. The numbers in the tables and additional calculations based on the demand for grants by the health, medical and family welfare department suggest that the share of primary care in total public health spending has increased in recent years, from 57 percent in 2000-1, to 59 percent in 2001-2, and to 66 percent as per the budget of 2002-3.[4] Indeed, in the budget of 2002-3, an amount of nearly Rs. 1,000 crores is allotted to activities that could be reasonably be classified as primary care. This would amount to about 0.6 percent of SGDP in 2002-3, assuming that the state's domestic product grows at about 6.6 percent per annum next year, the assumption used by the department of finance for its medium term fiscal framework calculations.

A7.33 Table 2 highlights another key feature of the expenditures incurred by the department of health, medical and family welfare. Wages and salaries account for about 70 percent of the spending of this department, and even higher of its non-plan spending (80 percent). Previous work has already noted the considerable variation in the share of wages and salaries across expenditure line items. According to the impact and expenditure review undertaken by DfID (DfID 2001) salaries accounted for somewhat more than half of all non-plan spending of tertiary hospitals, whereas the salary component for APVVP hospitals was considerably greater at about 80 percent of all non-plan spending. The salary component of non-plan primary spending is even higher, at nearly 90 percent for each of the three financial years for which we were able to obtain estimates in Table 2. The large share of salaries in total public health spending, particularly at the primary care level, could have negative implications for utilization rates and the efficiency with which public sector financial resources on health are being currently utilized in Andhra Pradesh.

A7.34 Previous authors, policymakers and policy researchers have raised a number of legitimate concerns about the way in which public resources on health in Andhra Pradesh are being spent. One is the relatively fast growth of plan expenditures in the secondary care sector (under the AP First Referral Health Project), which although it has now come to an end, would impose a large recurrent non-plan expenditure burden on the government. This added burden appears not to have occurred in the budget for 2002-3 however. A second, related concern has to do with the disproportionately large share of the secondary and tertiary sectors in government spending. There is a clear effort on the part of the GoAP to address this concern in the 2002-3 budget, which raises the share of primary care spending to nearly two-thirds of the department of health, medical and family welfare spending on health from its previous year's share of 59 percent. A third concern is the small magnitude of resources committed to health care in AP (see, for example, DfID 2001, p.7). The large share of private financing of health care (some 87

[4]Primary care is taken to include expenditures undertaken under the heading of primary health and family welfare, plus additional amounts spent on prevention, on non-allopathic systems of medicine that are included under expenditure heads other than primary health and family welfare.

percent of all health spending in AP) is also indicative of the failure of the public sector to provide an insurance cover for needed expensive care to poor rural households especially when recent evidence suggests much greater utilization of public hospitals by urban households and better off groups among the rural population (Mahal et al. 2001). Fourth, the resource crunch in the public sector is a bottleneck in promoting better use of public sector funded primary care facilities (as well as hospitals) given that most of the allocations go for salary payments with not much left over for drugs, medical supplies and maintenance. A final issue of concern is the distribution of public funding on health in ways that address regional/district inequities in health status and service provision, cited as one of the goals of the Vision 2020 document.

A7.35 In addressing the concerns of the previous paragraph over the medium run, the first matter at hand is to assess the overall level of funding for health available to the government of Andhra Pradesh. What are the likely future trends in funds available for public health spending in Andhra Pradesh in the medium run? We disregard, for the moment, the own resources of local bodies, and donor and central government funds that circumvent the state budget, because they are relatively small in magnitude thus far (DfID 2001). In this setting, the three key determinants of expenditures in the future would be the budgetary constraints that face the government of Andhra Pradesh, the economic environment that underlies them and the priority it places on health.

A7.36 As to the overall budgetary constraint faced by the GoAP, this will be very tight as the government intends to sharply reduce its fiscal and revenue deficits as well as its debts over the medium run, as highlighted in the introductory section. However, an improvement in the economic situation, that is a growth in SGDP, would help ease the economic burden on the government, both my making its fiscal targets (all expressed as a proportion of SGDP) more manageable, as well as providing some boost to its tax and non-tax revenues that typically depend on economic performance (for example, sales tax revenues). The department of finance in its strategy paper presents forecasts of nominal SGDP up to the year 2006-7. Assuming that the inflation rate during 2002-7 continues to be the same as in the year 2000-1 (the most recent year for which such data are available), these nominal SGDP forecasts amount to assuming annual rates of growth of real SGDP increasing from 6.6 percent in 2002-3 in constant 0.2 percentage point increments to 7.4 percent by the year 2006-7. We assume these rates of growth of SGDP for the calculations that follow. As to the third determinant, the GoAP's recent fiscal reforms strategy paper envisages "primary health care" expenditures to increase to 1 percent of SGDP by the end of the mid-term plan period 2006-7.

A7.37 Provided that "primary care" is precisely defined, a rough estimate of the magnitude of government resources available to primary health care can be arrived at under the above assumptions. For our purposes, we take it that the magnitude of primary health care expenditures will be roughly Rs. 1,000 crores in 2002-3, slightly above the total amount budgeted under the primary health and family welfare head in the demand for grants of the department of health, medical and family welfare.

A7.38 Table 3 presents the resource profile for supporting public spending on primary health care under three different scenarios. Under scenario I, spending on primary health care as a proportion of SGDP is taken to increase from its 2002-3 level of 0.6 percent by 0.1 percent points each year so as to be 1.0 percent of SGDP during 2006-7. Under scenario II, a "pessimistic" counterpart of I, expenditure on primary health care as a proportion of SGDP is taken to remain at 0.6 percent for all subsequent years except 2006-7, when it jumps up to 1.0 percent of SGDP to meet the desired goals of the department of finance strategy paper. Scenario III is based on a conversation with the principal secretary (finance department) which suggested the possibility that a 0.04 percent point annual increase, starting from an initial level of 0.6 percent of SGDP, was a more realistic option. Scenario I offers the possibility of a fairly large increase in allocations to primary health care, averaging nearly Rs. 700 crore (at 2002-3 prices) annually during 2003-7. Under scenarios II and III, the increase is somewhat smaller, but still significant, averaging about Rs.400 crore (at 2002-3 prices) over the period 2003-7. In sum, if the assumptions and commitments outlined in the strategy paper of the department of finance were to come true, a fairly substantial increase will occur in financial resources allocated to primary health care, ranging from 40 percent to 70 percent of the budgeted amount in 2002-3.

A7.39 How about amounts to be allocated to secondary and tertiary care? Little is said on this issue in the fiscal strategy report, but the discussion with the secretary of finance appeared to point towards leaving unchanged the total amounts allocated to the health sector (taken as a proportion of SGDP). Under these circumstances, in the most optimistic scenario one could imagine total secondary and tertiary care spending remaining unchanged at their 2002-3 level of about Rs.550 crore annually during the plan period. If, however, the overall public sector health spending were to remain unchanged as a proportion of SGDP even as the share of primary health care is increasing, fairly drastic cuts in the amounts allocated to secondary and tertiary care may result, as indicated in table 4. Given that salaries are more or less protected scenarios I, and II, may imply unrealistic outcomes, and therefore may not be credible. In fact APVVP grants are not under threat (communication with principal secretary, finance). But if any squeezes do occur, one consequence may be increased reliance on user charges. If there is any movement towards raising resources in this manner, a careful assessment of the potential implications of user charges for equity in the financial burden of health care is called for. Another possibility is to look into raising resources by charging students higher fees in teaching institutions, since such education is typically heavily subsidized. This needs to be evaluated as well, in light of its potential political ramifications.

A7.40 As to user fees, receipts from user fees at APVVP hospitals are currently rather small – amounting to barely one percent of receipts from various sources in 1999-2000 (DfID 2001). There is also a "recent" directive from the department of health, medical and family welfare that request spending departments to attempt to collect user fees to at least the value of non-salary recurrent expenditure. In the case of teaching hospitals, this would imply the cost recovery of 40-50 percent of total expenditures, and for secondary hospitals, just under 20 percent. Given the possible equity issues involved, the Impact and Expenditure Review by DfID (2001) suggested that an even more modest set of user

fee rates than those underlying the above calculations could also do reasonably well – and potentially cover 15 percent of total costs (p.22). Little knowledge exists, however, of the impact of user charges on the utilization of health care by poor households in AP.

A7.41 A financial squeeze on public hospitals, particularly in the tertiary sector, could be thought of as further adversely affecting the chances of the poor to obtain subsidized treatment for catastrophic illnesses. Development of insurance schemes across large numbers of self-group groups (or a fund set with contributions at the district level) with possible subsidization of the premium contributions of the poor could be a way around this. The pooling of large sums of money could be used to help purchase such care on competitive terms from private/autonomous tertiary hospitals, and is also a way to bring in private resources to work with public contributions. But resources for the poor will have to be found. If the insurance scheme is voluntary, participants will have to be assured of the quality of care they will receive in return for their contributions to it. This might require pre-assessment via pilot projects before large-scale schemes are put in place. An interim measure could be to move towards implementing more effectively the requirement that private hospitals provide care to a pre-specified number of poor patients, in return for having previously received land and equipment subsidies from the government.

A7.42 Will the increased amounts to be allocated to primary care over the next few years be gobbled up by increased wage and salary costs of existing employees, leaving little for new initiatives? All else the same, there are two counteracting forces that influence the answer to this question. The first are standard increases in salary over time, as employees move into higher income brackets. The second is attrition on account of retirement, which would reduce the salary burden. To derive the net effect of the two would necessitate an analysis of the age-composition and earnings profiles of existing employees, an analysis that could potentially be undertaken once the data on the census of government employees in Andhra Pradesh becomes available. If we assume that the two effects will neutralize each other, the new resource allocation policy will leave open a lot of financial space for initiatives in the arena of primary care. Conversely, it would imply a sharp tightening of the secondary, and especially the tertiary care sectors. It is worth noting that additional financial flexibility could also be made possible by means of redeployment and retraining of existing staff, although early evidence suggests this to be a difficult option to exercise (DfID 2001).

b. A Note on Water and Sanitation, Nutrition and Anti-Poverty Programs of the Government of Andhra Pradesh

A7.43 Apart from "health care" as usually understood, the government also contributes to good health through a variety of programs to improve water and sanitation facilities in rural and urban areas, nutrition, occupational health and the environment. More generally, by the promotion of anti-poverty programs (and various employment and infrastructure development schemes) it helps contribute to the ability of individuals and households to afford improved nutrition and other inputs to promoting good health.

A7.44 Table 5 presents statistics on expenditures on water and sanitation, nutrition programs and worker safety in three departments of the government of Andhra Pradesh – panchayati raj and rural development, women's development and child welfare and municipal administration and urban development. These numbers do not include expenditures on related activities in other departments, as forestry and irrigation. Nor do they include expenditures that might be incurred by local bodies, rural and urban, from their own funds on any of these activities. To do so would require a careful disentangling of the expenditures independently incurred by municipalities and panchayats versus expenditures from state and central government grants specifically directed towards such purposes, the latter having been included in the estimates provided in Table 5. The preliminary estimates presented in Table 5 indicate that there is significant public spending that directly impacts health but does not show up in the budget of the health, medical and family welfare department.

A7.45 Also relevant in planning for better health are government efforts towards income generation and poverty alleviation. There is a wide range of programs addressing employment creation, social welfare and infrastructure development that are relevant in that their execution makes better nutrition, prevention and health care more affordable to households. Rough estimates by the author, using data in the demand for grants of the department of urban development and panchayati raj and rural development, suggest public expenditures (or budgeted amounts) in excess of Rs.2000 crores on such programs during the year 2002-3. Additional analyses would be necessary to get a more accurate picture of the expenditures incurred by the government of Andhra Pradesh on those activities.

c. Health-related expenditures of local governments and districts

A7.46 Local governments also spend on health-related activities. How much each local body spends on health also has implications for interregional and inter-district equity in government health allocations, apart from its impact on the overall magnitude of resources available for health. For that matter, the ways in which health and other state departments allocate budgeted funds across districts also impact on equity in resource allocation.

A7.47 As noted in the introductory section, expenditures by urban local governments accounted for only about 5.5 percent of total public sector spending in the year 2000-1, the most recent year for which such data are available. When it comes to health, the main type of spending by urban governments relates to water and sanitation services, sometimes in conjunction with a limited number (typically a single) dispensary for meeting basic ambulatory care needs. Data provided by the department of municipal administration suggests that nearly 40 percent of the municipal budget goes towards providing water and sanitation services in the municipalities and corporations of Andhra Pradesh. This would amount to roughly Rs.400 crore annually in 2000-1. Given that the total amounts devoted to water and sanitation by three major state-level departments of the government of Andhra Pradesh were about Rs.500 crore as reported in tale 5, it

appears that municipalities and municipal corporations play a crucial role in providing a key public health input.

A7.48 Data for health expenditures by rural local governments is not readily available, but it appears that the main role of these bodies, in so far as health is concerned, is to provide for water and sanitation. In the case of rural local bodies, though, it is likely that most of the funds for water and sanitation are obtained as grants from the state government. The paucity of own resources is possibly one of the major reasons underlying line items (in the demand for grants) requesting assistance for panachayats in the maintenance of water and sanitation facilities.

A7.49 What can one expect in the future? Own resources of local bodies will obviously increase as SGDP increases (along with district-level economic activity) lead to increases in revenues from income-elastic taxes – for example, surcharge on stamp duty, property tax, and the like. Increasing devolution of funds from the state could be another possibility, although likely to be constrained by GoAP's tight fiscal situation. Another concern has to do with the possibility of inequitable allocation of resources across regions and local bodies. The main argument for this view is that assigned (and locally collected taxes) are likely to be buoyant with respect to the economic environment in which the panchayat (or the municipality) exists. The introductory provided some evidence suggesting that municipalities that were economically better off (in per capita income terms) were also likely to be better placed with respect to own or assigned revenues. Although corresponding data for panchayats is not readily available, there is no reason to believe that the relationship between economic status and revenue position would be any different for rural local bodies. On the other hand, grants from the state government to urban governments were negatively correlated with economic position, suggesting a movement in the direction towards greater equality.

A7.50 While additional analysis is clearly needed to verify the robustness of these findings, there are some reasons to believe that allocations/grants to local bodies (other than assigned taxes) made by the central and state governments at least tend towards greater equity. First, untied grants made under the recommendations of the state finance commission (SFC 1997) are allocated on the basis of a formula that favors poorer local bodies. For instance, the formula used by the first SFC to allocate funds used the ratio 3:2:5:8 to distribute funds (on a weighted per capita basis) across four categories of panchayats – ordinary, advanced, backward and tribal. A similar type of weighting system is used for untied grants to urban local bodies as well, classified as municipal corporations, first grade municipalities, second grade municipalities, third grade municipalities and nagar panchayats. Second, there are special efforts to address the needs of poorer villages (as in rural water supply projects) and areas with significant populations of scheduled castes and tribes residents. Whether these allocation methods and the funds involved are sufficient to address the regional and district-level inequities in socio-economic and health conditions is an issue that obviously merits further analysis.

A7.51 A similar set of issues arises when the concern is with allocations to district level counterparts of the department of health, medical and family welfare. Data on public

health spending at the district level is not readily available, owing to the nature of the process by which financial data are put together in the first place. While no obvious formula is apparent in the allocation of funds, the government policy of using population-based norms for setting up CHCs, PHCs and sub-centers suggests the *de facto* application of a per capita allocation rule that does little to address regional inequities. Given the further possibility that medical personnel positions in the poorer and far-flung regions are likely to be disproportionately vacant, the logical outcome would be regional inequity in departmental resource allocation, even when the government sets lower population norms for health facilities in tribal areas (for example), or if the enhanced malaria initiative is launched in tribal districts.

A7.52 In thinking about potential areas for added financial support to local bodies, particularly in rural areas, one way to potentially promote greater use and accountability of medical facilities and personnel at primary health centers is to devolve the financing of such centers to panchayats. An alternative approach that has been suggested is to work with a UK type GP-fund-holding model (with contributions on behalf of the poor being made by the government) and private practitioners competing with primary health center personnel for government (and private funds). An evaluation of these alternative approaches in rural areas of AP could be potentially worthwhile.

4. Summary and Recommendations

A7.53 In light of the above, the government strategy will have to be a mix of information generation, some experimentation with new strategies to finance health care, and ways to address any regional/district inequities through the possible development of allocation rules to districts and local governments.

a. Short Term

i. Information for decision-making: Health Accounts

- State and district health accounts on an annual/bi-annual basis including the creation of local capacity to undertake them
- Computerization of Financial Accounts

ii. Information for decision-making: Costing

- Defining and costing an appropriate benefits package for purposes of insurance

iii. **Information for decision-making: Evaluating User Charges**

- Evaluation of user charges imposed at APVVP and tertiary hospitals, regarding impact on revenues, and utilization of facilities by the poor.

iv. **Possible reduction in public subsidies on medical education**

b. Medium Term

i. **Experiments with Insurance mechanisms**

- District Health Funds, Community Financing via Self-Help Groups

ii. **Allocation of primary health care funds across districts**

- Assess existing patterns of resource allocation to local bodies and districts; development and evaluate new allocation formulae

iii. **Improving primary care in rural areas (Experiment)**

- GP fund-holding (DPIP)
- Mandal panchayat oversight of primary health centers

iv. **Stricter enforcement of rules on care for the poor in private hospitals**

Table 1. Trends in Public Spending on Health (Plan + Non-Plan)

Indicator/Year	1996-7	1997-8	1998-9	1999-0	2000-1	2001-2	2002-3
Public Health Spending per capita (1993-94 Rs.)	83.0	83.8	93.2	106.7	105.3	110.4	112.7
Public Health Spending (Rs. Crores)	782	862	1,039	1,240	1,294	1,435	1,549
Public Health Spending (in 1993-94 Rs. Crores)	597	610	688	798	797	847	876
Public Health Spending/SGDP (percent)	0.87	0.89	0.90	1.00	0.94	0.94	0.92
Public Health Spending/Budget (percent)	5.6	5.3	5.2	5.7	4.8	4.8	5.0

Note: Estimates for 2001-2 and 2002-3 are based on projected rates of real GDP growth and projected inflation rates. The rate of growth of SGDP was taken to be 6 percent per year, whereas the rate of inflation (based on the SGDP deflator) was taken to be equal that of the latest year (2000-1) for which data were available. We do not include expenditures by local governments and by district level societies, which are small relative to the overall size of the health budget of the department of health, medical and family welfare.

Table 2. Public Health Spending in Andhra Pradesh: Salary, non-Salary Distribution

Category	2000-1		2001-2		2002-3	
	Plan	Non-Plan	Plan	Non-Plan	Plan	Non-Plan
Medical Education (Rs. Crores)	17.78 (11.98)	199.63 (150.94)	30.95 (11.55)	222.45 (149.63)	24.49 (14.41)	258.17 (171.04)
Medical and Health (Rs. Crores)	122.72 (>4.99)	246.53 (195.34)	148.46 (>4.12)	236.89 (194.38)	46.40 (40.51)	249.66 (204.37)
Primary Health and Family Welfare (Rs. Crores)	323.87 (186.50)	383.75 (345.40)	408.91 (183.40)	407.77 (367.01)	459.43 (214.42)	511.44 (454.68)
TOTAL	464.37 (>203.5)	829.91 (691.7)	588.32 (>1991.)	867.11 (711.0)	530.32 (269.32)	1,019.27 (830.11)
Plan + Non-Plan	1,294.3 (>895.2)		1,435.4 (>910.1)		1,549.6 (1,099.4)	

Note: Based on data provided in the demand for grants of the government of Andhra Pradesh. Numbers in parentheses indicate amounts allocated to wages and salaries.

Table 3. Forecasting Public Sector Resources for Primary Health Care, 2002-3 to 2006-7

Variable	2002-3	2003-4	2004-5	2005-6	2006-7
SGDP (In 2002-3 Rs. Crores)	165,784	177,129	189,607	203,345	218,487
Scenario I Primary Health Care/SGDP (percent)	0.60	0.70	0.80	0.90	1.00
Scenario I Primary Health Care (In 2002-3 Rs. Crores)	1,000	1,240	1,517	1,830	2,185
Scenario II Primary Health Care/SGDP (percent)	0.60	0.60	0.60	0.60	1.00
Scenario II Primary Health Care (In 2002-3 Rs. Crores)	1,000	1,068	1,144	1,227	2,185
Scenario III Primary Health Care/SGDP (percent)	0.60	0.64	0.68	0.72	0.76
Scenario III Primary Health Care (In 2002-3 Rs. Crores)	1,000	1,134	1,289	1,464	1,661

Table 4. Forecasting Public Sector Resources for Secondary/Tertiary Care, 2002-3 to 2006-7

Variable	2002-3	2003-4	2004-5	2005-6	2006-7
SGDP (In 2002-3 Rs. Crores)	165,784	177,129	189,607	203,345	218,487
Scenario I Primary Health Care/SGDP (percent)	0.60	0.70	0.80	0.90	1.00
Scenario I Secondary/Tertiary Care (In 2002-3 Rs. Crores)	550	416	256	71	-142
Scenario II Primary Health Care/SGDP (percent)	0.60	0.60	0.60	0.60	1.00
Scenario II Secondary/Tertiary Care (In 2002-3 Rs. Crores)	550	587	629	675	-142
Scenario III Primary Health Care/SGDP (percent)	0.60	0.64	0.68	0.72	0.76
Scenario III Secondary/Tertiary Care (In 2002-3 Rs. Crores)	550	522	483	437	383

Table 5. Expenditures on Water and Sanitation and Nutrition in Three Departments (Rs. Crores)

Category	2000-1		2001-2		2002-3	
	Non-Plan	Plan	Non-Plan	Plan	Non-Plan	Plan
Nutrition	10.1	140.9	9.8	238.3	10.7	289.1
Water and Sanitation	133.7	367.5	137.7	611.1	147.3	640.2
Other	11.6	0.7	12.6	1.9	11.7	1.3
Total	155.4	509.1	160.1	851.3	169.7	930.6
Grand Total	664.5		1,011.4		1,100.3	

5. People met

1. S.K. Arora, Principal Secretary (Finance)
2. Veena Ish, Secretary (Planning and Finance)
3. R.K. Parida, Secretary (Planning)
4. Rachel Chatterji, Principal Secretary (Health, Medical and Family Welfare)
5. N. Srinivas Rao (Officer on Special Duty, Finance)
6. I.Y.R. Krishna Rao, Principal Secretary (Panchayati Raj and Rural Development)
7. Harinarayan, Principal Secretary (Irrigation)
8. Anil Punetha (Commissioner for Rural Development)
9. Neelam Sawhney (Commissioner for Family Welfare)
10. Ms. Damayanthi (SPACS)
11. Lipika Nanda (Independent Consultant)
12. Dr. Ranga Rao (Independent Consultant)
13. Joint Director, National Malaria Programme
14. Lalit Dandona Director, Health Policy Unit (ASCI)
15. Y. Srilakshmi (Commissioner, Municipal Administration)
16. Dr. G. Hariprasad (Joint Director, National Blindness Control Programme)
17. Dr. R. Puroshottam Reddy (Joint Director, National Leprosy Control Programme)
18. Dr. Venkateshwarlu (Joint Director, National TB Control Programme)
19. Saroja Rama Rao, Director (Economics and Statistics)
20. Dr. Prakasamma (AP Nursing Academy)
21. Dr. K. Narayana (CESS)

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Annex 8

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Reading Materials and Background Papers

Annex 8

Reading Materials and Background Papers

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Annex 9

Support for Development of a Medium Term Health Strategy for Andhra Pradesh:

Terms of Reference/Scope of Work

Annex 9

Terms of Reference/ Scope of Work

Support for Development of Andhra Pradesh Medium Term Health Strategy (APMTHS)

Introduction

1. The Department of Health, Medical and Family Welfare (DoHM&FW) of Government of Andhra Pradesh (GoAP) is in the process of developing a Medium Term Health Strategy intended to serve the State for a minimum period of five years. The objective of this strategy is to operationalise the principles set out in the Vision 2020 document to meet the health needs of the population. In the context of possible sector support, DFID is interested in supporting the GoAP to define this Strategy for the Health Sector. These Terms of Reference broadly set out the nature of support to be provided to GoAP in carrying out this exercise.

Background

2. In January 1999, the GoAP released its Vision 2020 document, which sets out ambitious goals for the sector. A 'Strategy Paper' released earlier this year, and an earlier action plan, attempted to define and operationalise the objectives set in Vision 2020 but this remained a largely incomplete effort. GoAP has also initiated a number of very useful exercises, which began planning, and monitoring for the sector as a whole. These include the development of monitoring indicators, proposal and strategy development exercises, and impact expenditure studies.

3. The DoHM&FW with support from the European Commission (EC) is carrying out policy reviews (with Administrative Staff College of India, Hyderabad) in four key programmatic areas: Workforce management, Rational use of infrastructure, Decentralisation and Delineation and Performance based funding options. As part of the same programme the DoFW is coordinating the development of a State Action Plan (with Institute of Health Systems, Hyderabad) and will include the preparation of a basic package of services and designing interventions for the Family Welfare sector. The reports of these studies are due in March 2002. Similarly, the World Bank in their support to the State to operationalise the priority health outcomes within Vision 2020, are looking at undertaking focussed studies on utilisation of the private sector in AP. A diagnostic workshop has also been tentatively

planned for the end of March 02. At the macro level the State Government is in the final stages of negotiation with The World Bank and DFID for agreeing a $200 million programme for economic and public sector reform in 2002-03. As a milestone to be reached, GoAP have agreed to develop a medium term expenditure framework (MTEF) for the primary health and education segments by the middle of financial year 2002-03.

4. To summarise, the key steps that have been taken in the process leading to the development of the medium term health strategy and expenditure frame work are

Activity	**Date**
AP Vision 2020	January 1999
GoAP Strategy Document	2000
AP: Sector Approaches for Human Development (CAPE, ODI)	September 2000
GoAP Strategy Paper on H&FW	January 2001
Impact & Expenditure Review of the Health Sector – PE Analysis and Health Strategy Development and Policy Analysis	March 2001
Health Strategy Development Workshop	April 2001
EC Policy Reviews and State Action Plan	Due in March 2002
The World Bank support: ✓ Studies for operationalising Vision 2020 ✓ Diagnostic workshop	Ongoing March – April 2002
The World Bank and DFID funded programme for public and economic sector reform: ✓ Agreed Project Document	End February 2002
GoAP DOHFW led activities e.g. identifying monitoring indicators etc.	Ongoing

Note: Documentation relating to the above activities are available with DFID and will be provided to the consultants.

1. It will be seen that in the period since the initial terms of reference for development of APMTHS were drafted, many enabling developments have taken place, the most significant one being the progress of discussions on the $200 million World Bank-DFID funded programme for public and economic sector reform. These processes have created an acceptance in GoAP of the need to plan sectorally. A draft state budget for 2002-03 has also been released for public debate. The stage therefore is set to synthesise current knowledge to arrive at a holistic and costed Health sector strategy. Such a

strategy would set out the framework within which GoAP will operate in the sector, and also provide a context within which donor partners and others can programme their assistance.

GoAP Institutional Mechanisms

2. A Health Strategy Team has been constituted by the GoAP to coordinate and guide the Strategy development process. A Sector Reform Cell has also been set up as part of the EC Sector Investment Programme. To avoid duplication of efforts there has been broad agreement to combine these into a single functional body to guide the strategy development exercise. GoI has also agreed to input into the deliberations.

Objective

3. The overall objective of this consultancy is to help GoAP's DoHM&FW develop and document a medium term strategy and expenditure framework, which meets key objectives laid down in the Vision 2020, and addresses issues raised at the Strategy Development Workshop (Annex). This will require generation of different policy options that can be considered by DoHM&FW and taken forward in the medium term strategy.

Scope of Work, Output and Payment

4. The strategy development exercise will be done in two phases:

✓ Phase 1 – The team, after agreeing a Strategy outline, will
- Set milestones for the development of the Strategy,
- Specify clear components and activities to be included in the Strategy
- The resources needed to implement them, and the resources available
- Highlight critical information gaps

✓ Phase 2 – will involve taking the work from the Phase 1 forward and filling in the information gaps

At this stage the consultancy will be restricted to Phase 1.

1. To arrive at the content of the strategy, the process should include a careful analysis of

- The stakeholders who are affected by and influence the strategy
- The context within which the strategy will be implemented;

- The process, by which the strategy will be formulated, implemented and evaluated
- Capacity building requirements in the longer term.

1. The output from this consultancy will be an agreed Medium Term Health Strategy, which spells out the critical components within the medium term expenditure framework, the availability and requirement of resources, and highlights information gaps to be taken up as part of phase 2. The process and the outcome should have the full support and commitment of GoAP and should take account of the views and contributions of other stakeholders, particularly other donors like The World Bank and the EC.

2. Preparatory activities will include briefing by DFID India in New Delhi, and study of relevant literature. After consultation with key stakeholders the consultant team will arrive at the Strategy outline and a Plan of Work to complete the strategy development exercise. The Plan of Work should be agreed with GoAP and DFID latest by the end of the first week of the consultancy.

3. In Phase 2, the successful bidder will lead the process of filling in the information gaps identified in Phase 1 subject to successful completion of Phase 1 and subsequent negotiations.

Competency and Expertise requirement

4. The successful bidder will be able to demonstrate a wide range of skills, particularly the following:

   - Experience in supporting and facilitating Governments in the development of health strategies/plan, particularly health systems management and development.
   - Experience of working with Sector approaches in the developing country context.
   - Competence in public health management and planning, health economics, and institutional and social development.
   - Experience in managing and coordinating large programmes involving a range of partners like governments, civil society , communities etc.

Conduct of the Work

1. The consultant team will provide technical, process, and management inputs and will work under the overall guidance of the Health Sector Strategy team. A number of key institutions exist within the State like Centre for Governance Reform, Institute for Health Systems, Administrative Staff College of India

and the Indian Institute of Health and Family Welfare. The consultant team will consider developing strategic links with these and other relevant institutions.

2. As noted above, this consultancy will need to be undertaken on a highly participative and interactive basis with the personnel of DHM&FW, under the guidance of the Health Strategy Team. However, the consultants will be expected to work with a great degree of autonomy and independence.

3. All travel and administrative arrangements will be the responsibility of the consultants, keeping the Health Strategy Team informed of plans and movements. The Secretary (Health) will provide initial letters of introduction for the consultants to meet with key personnel in the GoAP/GOI/other stakeholders.

4. The consultants will provide the DHM&FW/GoAP with the Plan of Work in hard copy (10 copies) and electronically (1 copy) using Word 2000.