Workshop on
PUBLIC HEALTH IN INDIA : CRISIS, CHALLENGES AND OPPORTUNITIES

with particular focus on States of Karnataka and Madhya Pradesh

{Held at St. John's Medical College, Department of Community Health }

9th March, 1998

Sl. No.	Name	Signature
1.	Dr. N. H. Antia, Director, Foundation for Research in Community Health, Pune.	
2.	Dr. Abraham Joseph, Professor and Head, Department of Community Health and Development, Christian Medical College, Vellore.	
3.	Dr. Jayaprakash Muliyil, Professor, Department of Community Health and Development, Christian Medical College, Vellore.	
4.	Mr. R. Gopalakrishnan, Secretary to Chief Minister and Coordinator, Rajiv Gandhi Missions, Government of Madhya Pradesh.	
5.	Dr. Ashok Sharma, Divisional Joint Director, Department of Public Health and Family Welfare, Government of Madhya Pradesh, Indore.	

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Sl. No.	Name	Signature
6.	Dr. G.V. Nagaraj, Additional Director of Health Services, Government of Karnataka.	
7.	Dr. S. Subramanya, Project Administrator and Ex-Officio Additional Secretary to Government, Health and Family Welfare Department, Karnataka Health Systems Development Project, Bangalore.	
8.	Dr. Murugendrappa, Joint Director (Malaria & Filaria) , Department of Health and Family Welfare, Bangalore.	
9.	Dr. Mary Olapally, Principal, St. John's Medical College, Bangalore.	
10.	Dr. Dara Amar, Professor and Head, Department of Community Health, St. John's Medical College, Bangalore.	
11.	Dr. M.K. Sudarshan, Professor and Head, Department of Community Health, Kempegowda Institute of Medical Sciences, Bangalore.	
12.	Dr. D.K. Srinivasa, Consultant - Medical Education, Rajiv Gandhi University of Health Sciences, Bangalore.	

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Sl. No.	Name	Signature
13.	Dr. J.S. Bhatia, Professor - Health Management, Indian Institute of Management, Bangalore.	
14.	Dr. Ravi Kapur, Visiting Professor, National Institute of Advanced Studies, Bangalore.	
15.	Dr. Jayashree Ramakrishna, Additional Professor & Head, Department of Health Education, National Institute of Mental Health and Neuro Sciences, Bangalore.	
16.	Dr. Mohan Isaac, Professor and Head, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bangalore.	
17.	Ms. Sujatha De Magry, Director, International Service Association, Bangalore.	
18.	Dr. Sukant Singh, Consultant - Community Health, Christian Medical Association of India, Southern Regional Office, Bangalore.	
19.	Dr. Pankaj Mehta, Associate Dean and Professor and Head, Department of Community Medicine, Manipal Hospital, Bangalore.	

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Sl. No.	Name	Signature
20.	Dr. C.M. Francis, Consultant, Community Health Cell, Bangalore.	
21.	Dr. V. Benjamin, Consultant, Community Health Cell, Bangalore.	
22.	Dr. Arvind Kasturi, Assistant Professor, Department of Community Health, St. John's Medical Colege, Bangalore.	
23.	Mr. As Mohammed, Assistant Professor of Statistics, Department of Community Health, St. John's Medical Colege, Bangalore.	
24.	Dr. H. Sudarshan, President, V.H.A.Karnataka, Bangalore & Honorary Secretary, Vivekananda Girijana Kalyana Kendra, BR Hills.	
25.	Ms. T. Neerajakshi, Promotional Secretary, Voluntary Health Association of Karnataka, Bangalore.	
26.	Dr. Kishore Murthy, Management Consultant, Bangalore.	

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Sl. No.	Name	Signature
27.	Dr. Ravi Narayan, Coordinator, Community Health Cell, Bangalore.	
28.	Dr. C. Siddegowda, Additional Director - AIDS, Department of Health and Family Welfare, Bangalore.	
29.	Dr. B.Y. Nagaraj, Joint Director - TB, Department of Health and Family Welfare, Bangalore.	
30.	Dr. S.M. Junge, Joint Director - Leprosy, Department of Health and Family Welfare, Bangalore.	
31.	Dr. G. Gururaj, Head - Dept. of Epidemiology, NIMHANS, Bangalore.	
32.	Dr. Gita Sen, Professor - Indian Institute of Management, Bangalore.	
33.	Dr. Lessel David, Danida Team Member.	

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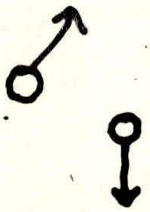
Sl. No.	Name	Signature
34.	Ms. Sangeeta Mookherji, Danida Team Member.	
35.	Ms. Victoria Francis, Danida Team Member.	
36.	Dr. Kris Heggenhougen, Danida Team Member.	
37.	Dr. Birte Holm Sorensen, Danida Team Member.	
38.	Dr. Bjarne Jensen, Danida Team Member.	
39.	Dr. Suresh Ambwani, Danida Team Member.	
40.	Mr. Esben Sonderstrup, Danida Team Member.	

WHY C[illegible]LABORATE:

FACTORS: RISK BEHAVIOUR.

- LACK OF INFORMATION
- PREVALENT MISBELIEFS
- POOR PERCEPTION OF RISK.
- POOR HEALTH SEEKING BEHAVIOUR.
- LACK OF EMPOWERMENT
- HEALTH – LOW PRIORITY.

- INEQUALITY – FINANCIAL



- 
- INDUSTRIALISATION
- CULTURAL 'SHOCK' (?).

- HUGE POPULATION
- HUGE GEOGRAPHICAL AREA.
- DIVERSE CULTURES.
- HIGH ILLITERACY.
- >450 LANGUAGES & DIALECTS.
- URGENT NEED.
- POOR AIDS AWARENESS · PERHAPS "DISEASE".
- BEHAVIOUR CHANGE DEPENDS ON TOO MANY FACTORS.

ONCE  →

- MEDICAL CARE

HCW – I don't Care

HIV + – why should I

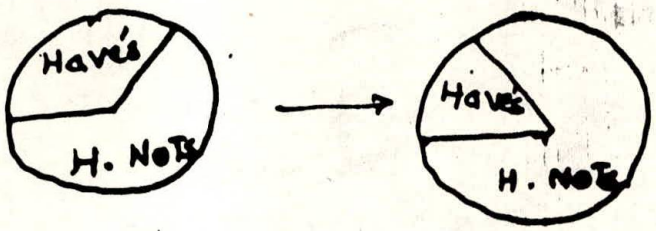
c/o HIV

- SOCIAL

→ Care [illegible] Orphans / Orphanages.

SUPPORT TO "SINGLE" FAMILIES

ECONOMICAL

- COST OF MANAGEMENT - UNMANAGABLE
- Loss OF DIRECT INCOME
- 

APPROACH . MULTISECTORIAL.

LET US DIVIDE (WORK) TO RULE. LEST HIM SHALL RULE TO DIVIDE.

GOVT (GO) :

- LACKS CREDIBILITY ? ABERRANT ATTIT. −
- LESSER GRASS ROOT SUPPORT. MULTISECTORIAL DIVISION.
- POOR FLEXIBILITY.
- "DELAY" TIME LARGE.
- LACK OF MOTIVATION. INERTIA.
- MORE IN CARE & EVENT RELATED PREVN.

+

- HUGE INFRASTRUCTURE.
- PUBLIC ACCOUNTABILITY ++
- FINANCIAL RESOURCES ++

NGO

- SMALL INFRASTRUCT -URE.
- PUBLIC ACCOUNTABI -LITY +/−
- POOR FINANCIAL RESOURCES.

+ −

- CREDIBILITY ++/−
- GRASS ROOT SUPPORT ++/−
- HIGH FLEXIBILITY.
- QUICK DECISION MAKING
- HIGH MOTIVATION − POTENTIAL +++
- MORE IN H. PROMOTION THAN CARE.

GO + PLUS NGO + = HEALTH PLUS.

MEDICAL CARE.

- INSTITUTIONALI.. | GO | NGO
- AT PATIENT. | GO | NGO
- HOME BASED | N/GO.

COUNSELLING | N-/GO

HIV DISEASE AWARENE.. | GO | NGO → ALL ELECTRONIC MEDIA.

GO ⌒ GO

N(GO).

AGENT OF CHANGE HIV :-

WHEN CAN IT BE EFFECTIVE:

- Commitment +++
- EQUAL PARTNERSHIP.
- OPTIMUM FLEXIBILITY.
- SELF-SUFFICIENCY - (DIRECTION)

NGO NETWORKING - VITAL.

- EXPERIENCE: POOR SUSTAINABILITY.
  - Jealousy.
  - Rivalary.

Common Problems:

NGO's

- FLY BY NIGHT OPERATORS.
- WORK DONE LESS (SIGN) + DISPROP. CLAIM (Sym
  - NEN ? NGO.
- CORPORATE NGO's. ? charity.

- HIFI, "ENGLISH" CULTURED", LOCAL "LINGO-PHOBIA".
- PROGRAM CHOICE - ? MONITORING INDICATORS.
- TARGET GROUPS INTENSIVE FOCUS ON.
  - CAPTIVE, DISADVANTAGED
    - CSWs.
    - 'PWA' - Hostages. etc.
- Future [redacted] But some see it. (present) [redacted]
- Empowerment → 'BLAME OTHERS' → FUNDING AGENCIES LIFE DIFFICULT.
- " DEPENDENCE " SYNDROME. CHANGE THE "SHIRT"
- "VISIBILITY" CRISIS.

GC.

- PROMOTE, PROMISE / LURE BUT "NO PAY".
- SUFFERS FROM "PARKINSONISM."
- FAVOURITISM - ONE & ANOTHER.
- POOR PRODUCTIVITY - INCENTIVE OR,
  POOR - PRODUCTIVITY INCENTIVE.

FUNDING AGENCIES : DONOR CONSORTIUM Vs INDEPENDENT.

IN THE NEXT 5 yr plan, we have almost identified the executing agency for NACP. It is NOT WHO Assisted NACO BUT.

HIV ASSISTED MICROBES.

DO YOU WANT TO HALT THE EXECUTOR.

(1)

THE CONTINUED COORDINATED

USE of MEDICAL
SOCIAL
EDUCATIONAL
VOCATIONAL
} MEASURES

FOR TRAINING
&
RETRAINING
THE INDIVIDUAL TO THE
HIGHEST POSSIBLE LEVEL
OF FUNCTIONAL ABLITY.

REHABILITATION

RESTORATION TO ESTEEM, IN
REPUTATION TO FORMER RIGHTS.

PALLIATIVE CARE WHEN?

1) INFORMED DECISION

2) QUALITY OF LIFE

3) FINANCIAL

PALLIATIVE CARE

1) PROPHYLAXSIS TO BE CONTINUE

2) COMMON INFECTIONS TREATED

3) SYMPTOM CONTROL

4) SERIOUS INFECTIONS NOT TREATED

HOME BASED CARE.

CHIKINKATA

OBJECTIVES

1) PT with AIDS A CHOICE OF BEING CARED AT HOME

2) TO SUPPORT AIDS pt with RESPECT TO DIGNITY, RESPECT AND PRIVACY

3) TO PROVIDE OPTIMUM COMPORT AND PERSONAL HYGIENE TO AIDS VICTIMS

4) EMOTIONAL SUPPORT TO FAMILY AND CARE GIVERS

'TEAM'

- NURSING
- SOCIAL WORKER
- COUNSELLOR
- PASTORAL CARE

} VOLU
- TER

& QUIPMENT

FUNCTIONING.

COMPONENTS OF HOME CARE

- MEDICAL x NURSING
- COUNSELING
- PASTORAL
- SOCIAL SUPPORT
  - TRANSPORT
  - INCOME GENERATION
  - MATERIAL SUPPORT
  - RELAXATION
  - SOCIAL CONTACT

COSTS

	HOSPITAL	HOME
89	$174	$85
91	$73	$28

ADVANTAGES

1) LESS HOSPITALISATION
2) PT has CONTROL
3) HEALTH EDUCATION OF THE COMMUNITY
4) HELP FROM COMMUNITY.
5) REDUCTION OF STIGMA.

DISADVANTAGES

1) DENIAL OF TREATMENT
2) COSTS OF HOME VISITS
3) MAINTENANCE
4) VOLUNTEERS
5) STIGMA.

CARE OF DYING

- CONCEPT OF HOSPICE
  - NEED
  - COST

SUPPORT GROUPS

CARE OF THE CAREGIVER

- TRADITIONAL ROLE
- HIV DISEASE 'ROLLER COASTER'

CARE NEEDS

PRACTICAL
- ASSISTANCE IN DAILY LIVING
- KEEPING TRACK OF MEDICATIONS
- INTERACTION W HEALTH SYSTEM
- LEGAL
- BUSINESS AFFAIRS

EMOTIONAL
- HOPE
- SAFE SETTINGS
- SUPPORT DURING DEATH

ROLE OF CARE GIVER (CG)

1) PREMATURE ROLE
2) CARRER DEVELOPMENT AFFECTED
3) CG MAY BE HIV POSITIVE
4) FINANCIAL BURDEN

BURN OUT DIPRESSION

1) TASK OF ADJUSTMENT
2) LOSS
3) SHIFT IN RESPONSIBILITY
4) UNEXPECTED
5) UN CONTROLLED DISEASE
6) ROLE CONFLICT
7) FATIGUE
8) OWN ILLNESS

CARE OF CG

1) INCREASE MORALE
2) HELP TO ANTICIPATE
3) TEACH SKILLS FOR CARING
4) STARTGIES TO COPE WITH MULTIPLE PROBLEM

1) ENhancement Progeamme
2) STRESS MANAGEMENT
3) DEVECOP COPING MECH
4) COUNSELLING
5) NETWORKING

Dr. M. K. Sudarshan

GROUP I : PUBLIC HEALTH EDUCATION AND TRAINING

Com H 4 - 7

ISSUES (& CHALLENGES)

- SCOPE OF PUBLIC HEALTH
- ADVOCACY FOR PUBLIC HEALTH
- TRAINING POLICY
- APPROACHES TO TRAINING

OPPORTUNITIES

- STRENGTHEN HFPTCs & OTHER TRG. CENTRES (WITH PH QUALIFIED PERSONNEL)
- ESTABLISH SCHOOL OF PUBLIC HEALTH (MULTI-DISCIPLINARY)
- M. PHIL - 2 YEAR COURSE (LINKED TO A STATUATORY UNIVERSITY)

- STRENGTHEN EXISTING
  - BASIC UG / PG TRAINING PROGR.
  - INDUCTION & INSERVICE TRAINING
- EXPLORING DISTANCE LEARNING MODE (OPEN UNIVERSITIES)

Dr. Dara Anaya

HEALTH INFORMATION SYSTEM AND PUBLIC HEALTH RESEARCH

GROUP - II

ComH - 449 - 6.

- PURPOSE OF INF. GENERATION
  - A. PROCESS
  - B. QUALITY
  - C - MANAGEMENT.
- TRAINING OF DATA GENERATORS TO ANALYSE / UTILISE DATA AT LOCAL LEVELS.
- MEANS OF GENERATING QUICK RESPONSE FROM DATA WHICH ENHANCES
  - GREATER UTILITY
  - GREATER INVOLVEMENT
  - EMERGENCY REACTION.
  - MOTIVATION.
- INFORMATION NEEDS
  - LOCAL NEED OF INFORMATION
  - STATE / NATIONAL NEED.
- METHODS OF DATA UTILIZATION AT EACH LEVEL.

- INCREASING COMMUNITY ACCOUNTABILITY
  - ↓ PUNITIVE RESPONSE
  - ↑ REWARD FOR QUALITY INFORMATION.
- INTERSECTORAL INFORMATION MATCHING THROUGH DIFFERENT TECHNIQUES.
- CORRECATING LOCAL CULTURAL PERCEPTIONS WITH COLLECTED INFORMATION.
- FINDING APPROPRIATE QUESTIONS TO ASK.
- ACTION ORIENTED PUBLIC HEALTH RESEARCH FOR PROBLEMS IDENTIFIED LOCALLY.
- <u>HEALTH RESEARCH AREAS</u>:
  - ALTERNATIVE SYSTEMS OF HIS.
  - EMPOWERING IMPLEMENTERS TO EXAMINE HEALTH INFORMATION.
  - STRENGTHENING CURRENT MONITORING → (TRUE) SURVEILLANCE.
- DETERMINING ESSENTIAL NO. OF RECORDS.
- FEEDBACK SYSTEMS IN BOTH DIRECTIONS.
- DEVELOPING COMMON MULTISECTORAL DATA FORMS

MR. MURALI | ComH44-5 | GROUP 3

DECENTRALISATION IN THE HEALTH SECTOR - PANCHAYATRAJ AND HOSPITAL AUTONOMY:

- PANCHAYAT RAJ INSTITUTION TO BE ENCOURAGED
- POWER BE GIVEN INTERMS OF INFO. & MONEY
- HELP THEM TO IDENTIFY THEIR NEEDS, SET PRIORITIES AND WORKOUT PLAN OF ACTION IN ACCORD WITH THE SITUATION

* WITH REF. TO KARNATAKA:

- CAPACITY BUILDING OF MEMBERS OF PRI
  - HEPING IN PLANNING
  - TO HELP IN DECISION MAKING
  - TO ENSURE PARTICIPATION OF NGO, GO & INTERNATIONAL AID AGENCIES
  - TO HELP PRI to COME UP WITH BROAD DEV. ACTIVTIES/ SPECIFIC HEALTH PRG./ BUILDER HEALTH PRG.
-

*AUTONOMY OF HOSPITALS:

- AUTONOMY CAN BE MIS-USE OF POWER IF PEOPLE ARE NOT ABLE TO DEAL.
- USER FEE INSTITUTIONS MIGHT LEAD TO INEQUITY IN SERVICES
- DE-CENTRALISED MANAGEMENT OF HOSPITALS COULD BE DONE BY CONSTITUTING PEOPLE FROM THE NEIGHBOURHOOD.
- USER FEES TO BE LINKED TO PATIENT RELATED. (i.e. TO IMPROVE INFASTRUCTURE AND MAINTENANCE).

* FOCUS SHOULD BE NORTHERN KARNATAKA (i.e BIJAPUR, GULBURGA, BIDAR, RAICHUR, BELLARY AND BELGAUM).

* COMMUNITY HEALTH SYSTEM BE INITIATED IN DISADVANTAGED AREAS.

Dr. Jayashree Ramakrishna

Grp IV Community Participation & IEC

ComH 409-4

- In what areas DAW/DA support ?
- Conceptualization → Direct Activity
- Relationship between community part. + I.E.C
- I.E.C – "pill", campaign, epidemic
- Short term compulsion vs. long term vision
- Organisation at local level - health committee / gram panchayat
- Conflict bet. local bodies & health functionaries
  e.g. Jamkhed & Bellary
- Policy decision to include health in panchayat training - I.E.C to support
- Govt should try to locate NGO partners
- Mass Media – TV - how exploit

- Good for awareness
- Need to make it interactive for learning
- Follow up & methods for changing behaviour

- Need to link this creation/maintenance of service
- Folk media appropriate but also need to test
- Research before developing IEC component/strategy
- Situational analysis of functioning at PHC level - examine constraints + potentials
- Going to scale - translating small scale e.g. to programme - what has the best chance of being translated e.g. BR Hdls. VGKK project.
- Examine NGO + Govt collaboration SEWA rural

EQUITY

Commitment to equity

||

Support for the "All" in

Health for All

ETHICS

* Benevolence

* Non-maleficence

* Justice

* Autonomy

EQUITY ORIENTED POLICIES

* Selection, training and deployment of health personnel

* Reorienting training

* Selection and use of technologies

* Selection of populations
  - greatest burden of ill - health
  - disadvantaged and marginalised

* Gender sensitiveness

* Reduction of health disparities

ENVIRONMENT: Determinants of Health

* Physical
* Social
* Economic
* Political

ENVIRONMENT : Hazards to health

* Chemical
* Microbiological
* Physical

***Local**

***Global**

Com H 49.8

WARNINGS SINCE 1975

Srivastava Report/
ICSSR - ICMR Report,
JNU / FRCH / VHAI/
CHC.

GOVT. EXPERT COMMITTEE - 1996 ON

PUBLIC HEALTH SYSTEM

(GOI / MHFW)

CRISIS IN PUBLIC HEALTH

EXPERT ARTICLES - 1990S

EPW / NMJI
HA/HFM/Lancet
Malaria Report
(CHC/VHAI)
ICHI Report

SECUNDERABAD MEETING - August 1997

Public Health Crisis and Challenges

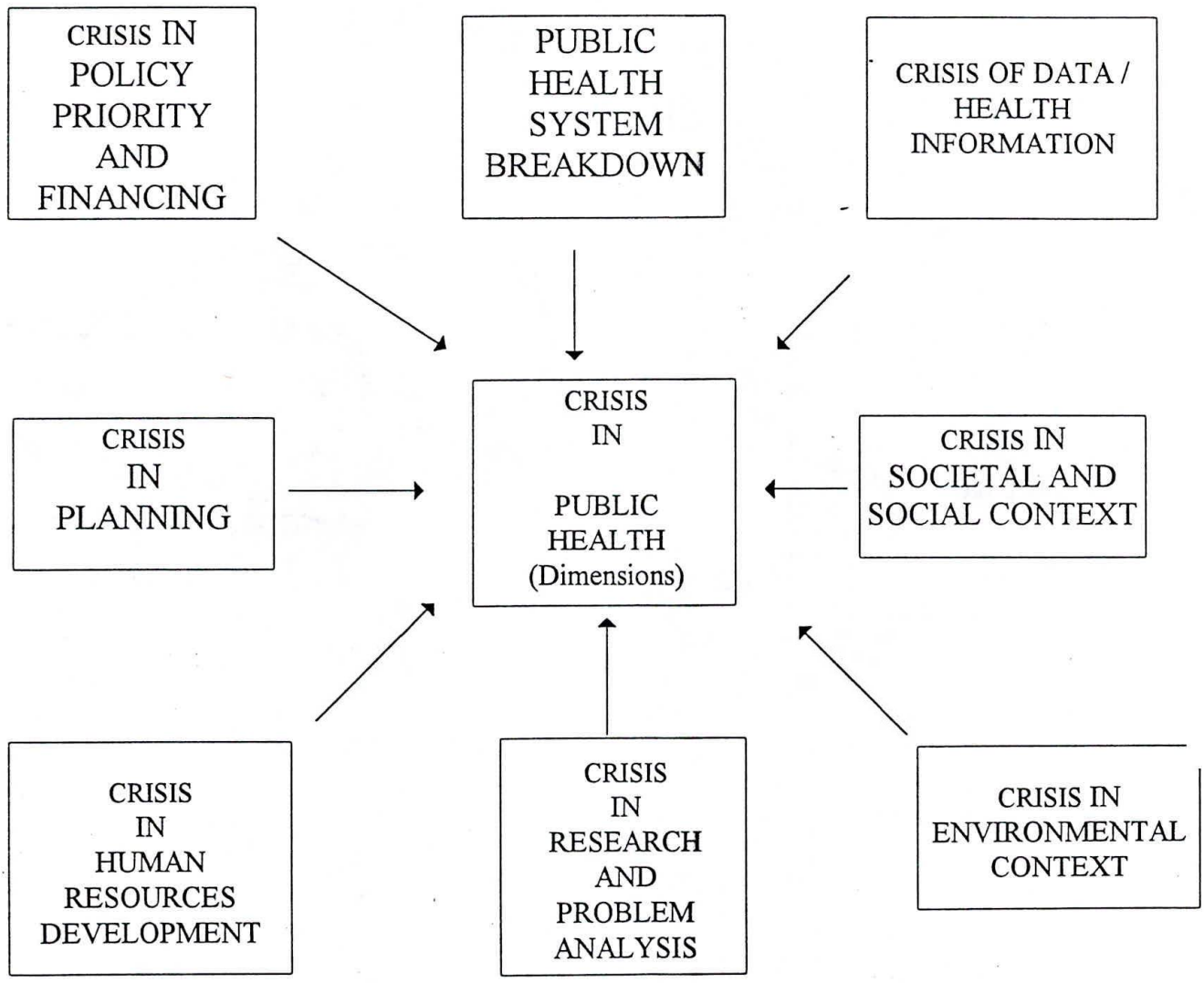
(Network of Public Health Professionals
Govt./NGO/ICMR/NPs)

opinion polls

BANGALORE DIALOGUE - MARCH 1998

Public Health Crisis/Challenges/Opportunities

(Dialogue with Danida Health Sector Mission)


CRISIS IN POLICY PRIORITY AND FINANCING
PUBLIC HEALTH SYSTEM BREAKDOWN
CRISIS OF DATA / HEALTH INFORMATION
CRISIS IN PLANNING
CRISIS IN PUBLIC HEALTH (Dimensions)
CRISIS IN SOCIETAL AND SOCIAL CONTEXT
CRISIS IN HUMAN RESOURCES DEVELOPMENT
CRISIS IN RESEARCH AND PROBLEM ANALYSIS
CRISIS IN ENVIRONMENTAL CONTEXT

PUBLIC HEALTH SYSTEM BREAKDOWN?

- SHORTAGE OF WORKERS / DOCTORS
- REDUCTION IN BUDGETS
- OVERBURDENED HEALTH WORKERS (ANMs - EXPLOITATION)
- CORRUPTION / SCAMS / MISUSE OF FUNDS
- POLITICAL INTERFERENCE
- DECISION MAKERS WITHOUT PUBLIC HEALTH COMPETENCE / ORIENTATION
- CENTRALISED TOP DOWN PLANNING
- CENTRE / STATE RESPONSIBILITY - AMBIGUITY
- INADEQUATE / UNREALISTIC PLANNING

Source : Secunderabad Meeting - August 97.

MARKET ECONOMY IN HEALTH

* TOP DOWN PROMOTION OF TECHNOLOGICAL FIXES!

* MARKET INTERESTS IN DECISION MAKING

* INTERNATIONAL PUBLIC HEALTH COLLABORATION / COOPERATION

  Often becoming subservient to:

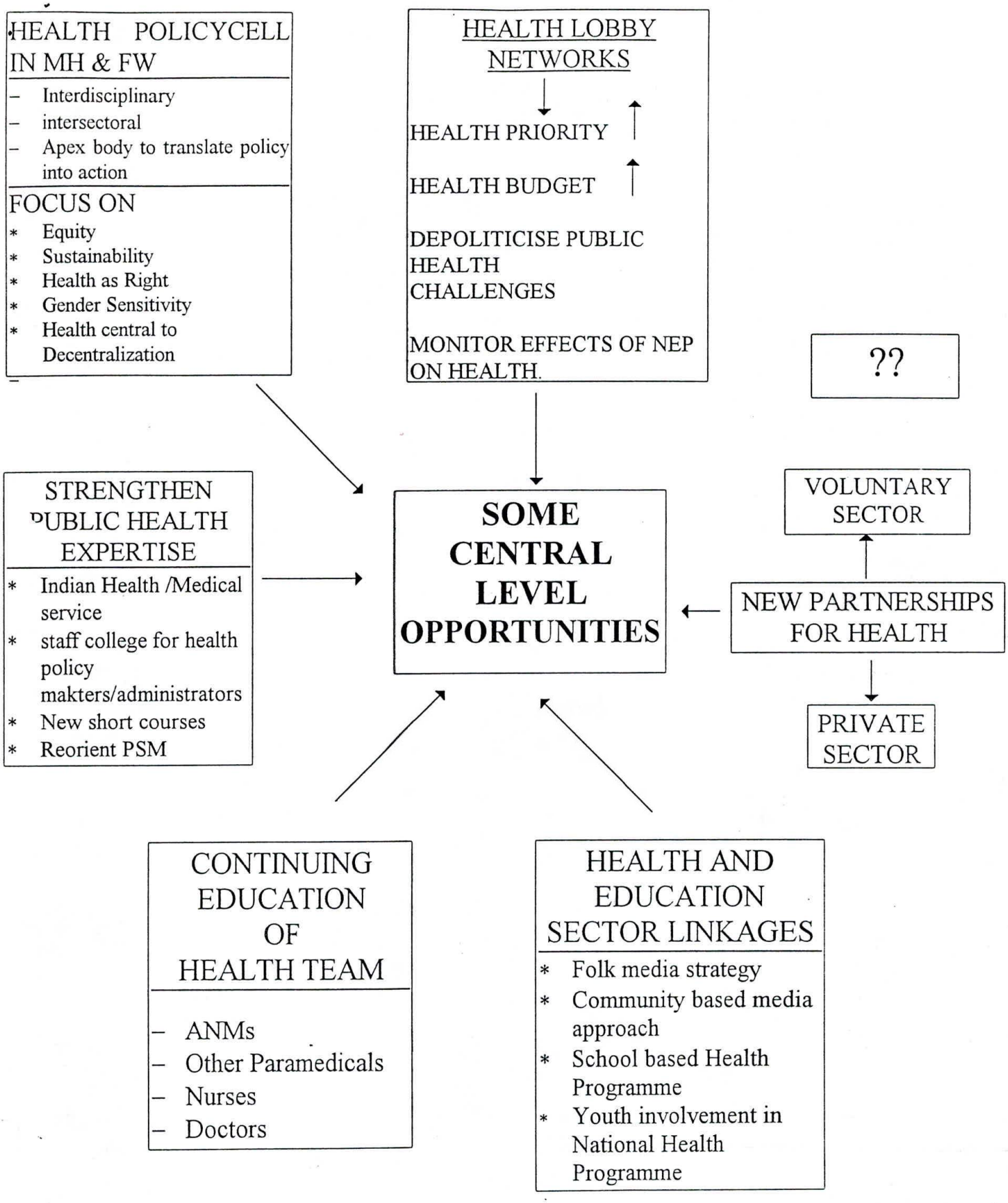
  * AGENDAS OF VISITING CONSULTANTS
  * RESEARCH PRIORITIES OF COLLOBORATERS
  * "GUINEA PIGS" for Research
  * FUNDING AGENCY CONDITIONALITIES!

* GRANTS TO LOANS!!

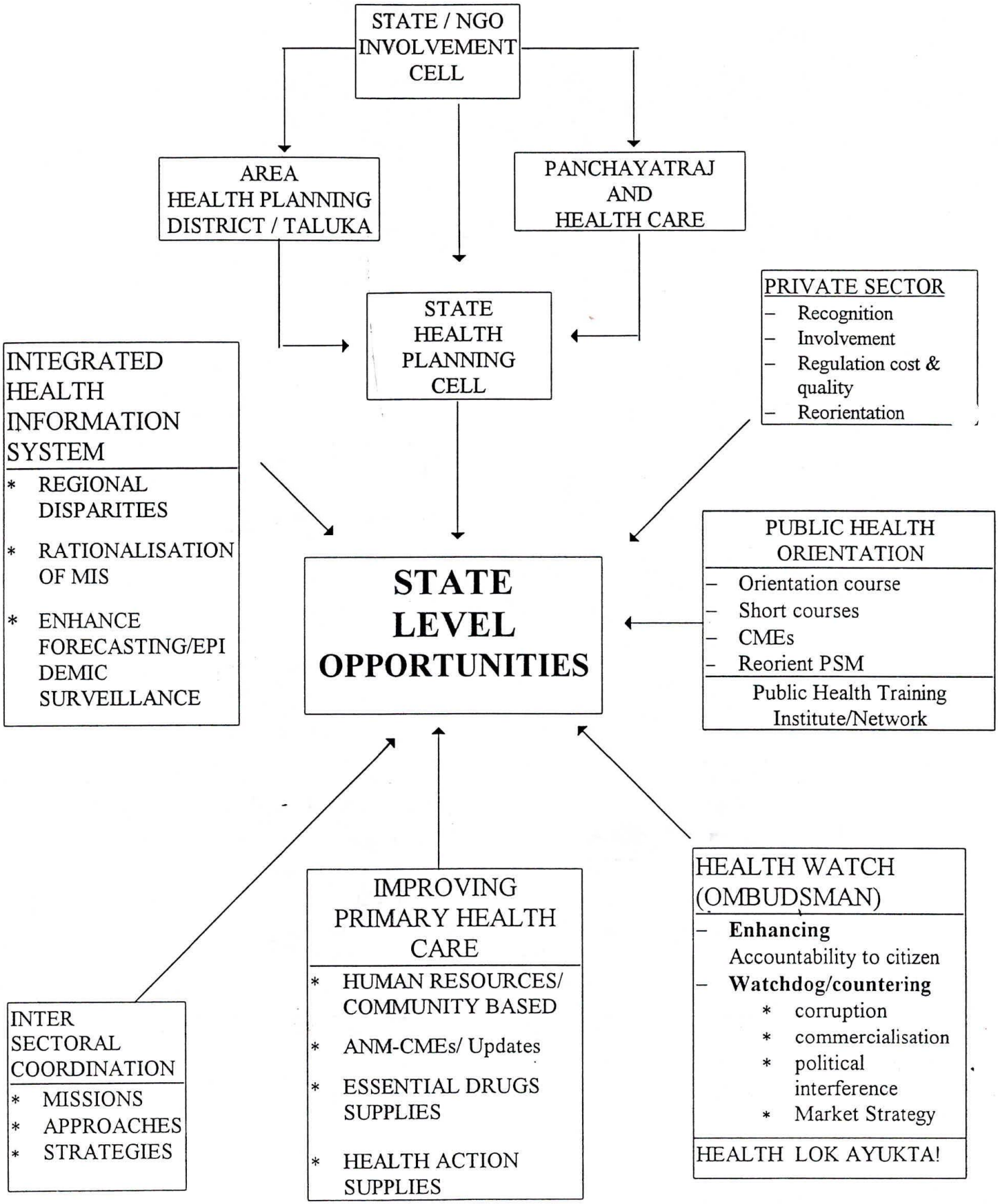
* ILL HEALTH EFFECTS OF NEO-LIBERAL ECONOMIC POLICIES

(From Solidarity to exploitation!!)

Source: Secunderabad meeting - August 1997.



OPINION POLL
MARCH 1998


STATE / NGO INVOLVEMENT CELL
AREA HEALTH PLANNING DISTRICT / TALUKA
PANCHAYATRAJ AND HEALTH CARE
STATE HEALTH PLANNING CELL
PRIVATE SECTOR
– Recognition
– Involvement
– Regulation cost & quality
– Reorientation
INTEGRATED HEALTH INFORMATION SYSTEM
* REGIONAL DISPARITIES
* RATIONALISATION OF MIS
* ENHANCE FORECASTING/EPIDEMIC SURVEILLANCE
STATE LEVEL OPPORTUNITIES
PUBLIC HEALTH ORIENTATION
– Orientation course
– Short courses
– CMEs
– Reorient PSM
Public Health Training Institute/Network
INTER SECTORAL COORDINATION
* MISSIONS
* APPROACHES
* STRATEGIES
IMPROVING PRIMARY HEALTH CARE
* HUMAN RESOURCES/ COMMUNITY BASED
* ANM-CMEs/ Updates
* ESSENTIAL DRUGS SUPPLIES
* HEALTH ACTION SUPPLIES
HEALTH WATCH (OMBUDSMAN)
– Enhancing Accountability to citizen
– Watchdog/countering
* corruption
* commercialisation
* political interference
* Market Strategy
HEALTH LOK AYUKTA!

PUBLIC HEALTH IN INDIA: CRISIS, CHALLENGES AND OPPORTUNITIES

(with particular focus on States of Karnataka and Madhya Pradesh)

Group I

Public Health Education & Training

1) Dr. D.K. Srinivasa {Chairperson}
2) Dr. Abraham Joseph {Key discussant}
3) Dr. Murugendrappa
4) Dr. B.Y. Nagaraj
5) Ms. Sujatha de Magry
6) Dr. M.K. Sudarshan
7) Dr. Dara Amar
8) Dr. Sukant Singh
9) Danida Team Member
10) Danida Team Member

Rapporteur : Dr. A.R. Sreedhara (CHC)

Group II

Health Information System & Public Health Research

1) Dr. R.L. Kapur {Chairperson}
2) Dr. Jayaprakash Muliyil {Key discussant}
3) Dr. G.V. Nagaraj
4) Dr. Ashok Sharma
5) Dr. G. Gururaj
6) Dr. Ravi Narayan
7) Mr. As Mohammed
8) Dr. Gita Sen
9) Danida Team Member
10) Danida Team Member

Rapporteur : Dr Denis Xavier (CHC)

Group III

Decentralisation in the Health Sector (including Panchayatraj & Hospital Autonomy)

1) Dr. J.S. Bhatia {Chairperson}
2) Dr. N.H. Antia {Key discussant}
3) Mr. Gopalakrishnan
4) Dr. S. Subramanya
5) Dr. C.M. Francis
6) Dr. Mary Olapally
7) Dr. Kishore Murthy
8) Dr. H. Sudarshan
9) Danida Team Member
10) Danida Team Member

Rapporteur : Mr. Murali (CHC)

Group IV

Community Participation & Communication (including IEC)

1) Dr. Mohan Isaac {Chairperson}
2) Dr. Arvind Kasturi {Key discussant}
3) Dr. C. Siddegowda
4) Dr. S.M. Junge
5) Dr. Jayashree Ramakrishna
6) Dr. V. Benjamin
7) Ms. Neerajakshi
8) Dr. Pankaj Mehta
9) Danida Team Member
10) Danida Team Member

Rapporteur : Dr. Rajan Patil (CHC)

COMH 46.9

Workshop on

PUBLIC HEALTH IN INDIA : CRISIS AND CHALLENGES

: with particular focus on States of Karnataka and Madhya Pradesh

{Held at St. John's Medical College, Department of Community Health }

9th March, 1998

LIST OF PARTICIPANTS

SPECIAL INVITEES

1. Dr. N. H. Antia, Director, Foundation for Research in Community Health, Pune/Mumbai.
2. Dr. Abraham Joseph, Professor and Head, Department of Community Health and Development, Christian Medical College, Vellore.
3. Dr. Jayaprakash Muliyil, Professor, Department of Community Health and Development, Christian Medical College, Vellore.
4. Mr. R. Gopalakrishnan, Secretary to Chief Minister and Coordinator, Rajiv Gandhi Missions, Government of Madhya Pradesh.
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18. Dr. Sukant Singh, Consultant, Community Health, Christian Medical Association of India, Southern Regional Office, Bangalore.
19. Dr. Pankaj Mehta, Associate Dean and Professor and Head, Department of Community Medicine, Manipal Hospital, Bangalore.
20. Dr. C.M. Francis, Consultant, Community Health Cell, Bangalore.
21. Dr. V. Benjamin, Consultant, Community Health Cell, Bangalore.
22. Dr. Arvind Kasturi, Assistant Professor, Department of Community Health, St. John's Medical Colege, Bangalore.
23. Mr. As Mohammed, Assistant Professor of Statistics, Department of Community Health, St. John's Medical Colege, Bangalore.
24. Dr. H. Sudarshan, President, Voluntary Health Association of Karnataka, Bangalore and Honorary Secretary, Vivekananda Girijana Kalyana Kendra, BR Hills.
25. Ms. T. Neerajakshi, Promotional Secretary, Voluntary Health Association of Karnataka, Bangalore.
26. Dr. Kishore Murthy, Management Consultant, Bangalore.
27. Dr. Ravi Narayan, Coordinator, Community Health Cell, Bangalore.
28. Dr. C. Siddegowda, Additional Director - AIDS, DHFW, Bangalore.
29. Dr. B.Y. Nagaraj, Joint Director - TB, DHFW, Bangalore.
30. Dr. S.M. Junge, Joint Director - Leprosy, DHFW, Bangalore.
31. Dr. G. Gururaj, Head, Dept. of Epidemiology, NIMHANS, Bangalore.
32. Dr. Gita Sen, Professor, Indian Institute of Management, Bangalore.
33. Dr. Lessel David, Danida Team.
34. Ms. Sangeeta Mookherji, Danida Team.
35. Ms. Victoria Francis, Danida Team.
36. Dr. Kris Heggenhougen, Danida Team.
37. Dr. Birte Holm Sorensen, Danida Team.
38. Dr. Bjarne Jensen, Danida Team.
39. Dr. Suresh Ambwani, Danida Team.
40. Mr. Esben Sonderstrup, Danida Team.

PUBLIC HEALTH IN INDIA: CRISIS, CHALLENGES AND OPPORTUNITIES

(with particular focus on States of Karnataka and Madhya Pradesh)

Date : 9th March, 1998

Venue : Department of Community Health, St. John's Medical College, Bangalore - 560 034.

Facilitation : Society for Community Health Awareness, Research and Action (CHC), Bangalore in collaboration with Department of Community Health, St. John's Medical College.

Objective : Interactive workshop with Danida Health Sector Identification Mission

Timings : **9 am to 5 pm**

Programme

9.15 - 9.45 am	***Session I***	***: Introduction to Workshop***
	Chairperson	: Dr. V. Benjamin
	Welcome	: Dr. Dara Amar, SJMC
	Self Introductions	
	Expectations of Workshop	: Dr. Ravi Narayan, CHC
		: Mr. Esben Sonderstrup, DANIDA Health Sector Mission
9.45-10.45 am	***Session II***	***: Introduction to Theme***
	I. Crisis & Challenges of Public Health in India - an overview	: Dr. Ravi Narayan
	II. Core Values in Public Health - A policy reflection	: Dr. C.M. Francis
	III. Clarifications / comments	: Participants

10.45-11.00 am Tea

11.00-12.45 p	*Session III*	: ***Group Discussions : Identifying Opportunities***
	Group I	: Public Health Education and Training
	Chairperson	: Dr. D.K. Srinivasa
	Key Discsussant	: Dr. Abraham Joseph
	Group II	: Public Health Research & Health Information System
	Chairperson	: Dr. Ravi Kapur
	Key discussant	: Dr. Jayaprakash Muliyil
	Group III	: Decentralization in the Health Sector (including Panchayatraj & Hospital Autonomy)
	Chairperson	: Dr. J.S. Bhatia
	Key discussant	: Dr. N.H. Antia
	Group IV	: Community Participation & Communication (including IEC)
	Chairperson	: Dr. Mohan Isaac
	Key discussant	: Dr. Arvind Kasturi

{Each group will have a mix of participants from governmental, non-governmental and academic/research backgrounds and some members of the Danida team (see separate list)}

12.45-1.30 pm Lunch and Fellowship

1.30 - 3.30 pm	**Session IV**	:	Identifying Opportunities for Strengthening Public Health Sector
	Chairperson	:	Dr. C.M. Francis

{A member from each group will present key ideas & suggestions from that group, followed by clarifications and interactive discussions with all the participants}

3.30 - 3.45 pm	Tea		
3.45 - 5 pm	**Session V**	:	How could DANIDA assist at Central & State levels : with special reference to Karnataka and Madhya Pradesh (Wrap up)
	Chairperson	:	Dr. N.H. Antia
	Vote of Thanks		

THE PUBLIC HEALTH CRISIS IN INDIA

1. PREAMBLE

The Re-emergence of Malaria as a significant public health problem in the country since the 1970s and the increasing occurrence of outbreaks and epidemics especially in the 1990s, is leading to an urgent reappraisal of the countrys public health policy and a deeper understanding of the larger 'public health crisis that has been evolving in the country over the last two decades. Some elements of this crisis are:

1.1 The Socio-Epidemiological Imperative

There is a growing concern that the 'situation analysis and 'problem solving processes in the past, with regard to communicable diseases control strategies have focused predominantly on the techno-managerial aspects and less on the important socio-economic-cultural-political context of the problem.

There is therefore urgent need to strengthen these dimensions of problem analysis and solution so that a more comprehensive, effective, sustainable strategy is evolved to tackle the challenge of Malaria.

1.2 The Political Economy of Health

There is a growing concern in health planning and health policy circles that the 'market economy often drives policy decisions more significantly, than rigorous socio-epidemiological problem analysis. In National health programmes supported by International public health cooperation and collaboration, this also means that approaches and priorities are often promoted that are at variance from the recommendations of National expert committees and technical evaluation reports. These distortions taking place primarily because International public health linkages are themselves getting market determined.

It is therefore important to understand the political economy of health in a National and International context before evolving strategies / programmes.

1.3 The challenge of Decentralization

There is a growing concern that the country has reached the limits of National, centralised planning and with the recognition of the great diversity in situations and challenges at regional and state levels *there is need for a more concerted effort at decentralised planning with a flexible framework that responds to regional needs and disparities in the health care situation.* This is even more relevant to National disease control programmes especially when a disease like Malaria shows a diversity and focality in its epidemiology .

1.4 The need to move Primary Health Care beyond rhetoric to grassroots initiatives at community level

There is a growing concern that inspite of a National commitment to Primary Health Care and to integrated, comprehensive health care approaches, National health programmes are too vertical, too top down and inadequately integrated into the basic health services structure. This also means that policy alternatives or thrusts such as Decentralization and Panchayatraj; community participation; community based

approaches; involvement of general practitioners and the NGOs (both voluntary sector and private sector); inter sectoral coordination; and equity issues; are included in the formulation of strategies but remain rhetorical and not adequately translated into actual guidelines for action.

There is therefore need to promote community based approaches that ultimately strengthen the health infrastructure at the grassroots.

1.5 The Threat of the New Economics

There is a growing concern that larger economic issues be they corruption at all levels of the delivery system or the more recent trends towards privatization and commercialization and cutbacks in governmental expenditure on welfare is leading to a continuous worsening of the general health infrastructure and human power situation in the country affecting the sustainability and effectiveness of health care programmes. This is much more than just an infrastructural development or 'administrative/management lacunae issue and there is need to address this matter urgently since it affects all health and welfare programmes in the country.

The effects of the new economic policies need to be monitored carefully and the distortions in the planning process produced by market forces need to be countered.

1.6 The Urgent need for Right of Information

There is a growing realisation that health and development programmes in the country have failed to make the impact they were expected to, because of the failure to generate and sustain an awareness creation and educational process that would enable and empower the people and particularly the more marginalised sections of the community to access and utilize the services available and actively participate in the development and decision making processes for the further evolution and growth of such strategies. Without the spread of 'critical information leading to inadequate public participation programmes have floundered on inertia and red-tape. *There is therefore need to support a process of demystification linked to the Right of information.*

1.7 The need to Widen the Dialogue and Participation in the Planning Process

In the light of all these background concerns and emerging needs for effective policy responses, and keeping in mind the urgent need to widen the dialogue and participation in the planning process, we have reviewed the Malaria situation and are offering certain complementary/supplementary comments and suggestions in all those areas where we feel there is need for newer perspectives and alternative approaches. We have drawn upon the resources of a wide network of individuals/groups who constitute an alternative sector eager to share their experiences and perspectives with the mainstream planning process.

By doing so we hope that the voluntary sector would have contributed to the development of some complementary strategies for action, to tackle the Malaria situation in the years to come and actively supplement the efforts of the NMEP by the evolution of more indigenously determined responses to problem analyses and problem solving.

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- Source: TOWARDS AN APPROPRIATE MALARIA CONTROL STRATEGY
Issues of Concern & Alternatives for Action

(A VHAI/CHC PUBLICATION)

ISSUES AND RECOMMENDATIONS RELEVANT TO THE PUBLIC HEALTH CRISIS

* * * * *

1. STRENGTHENING THE SOCIO-CULTURAL-ECONOMIC-POLITICAL DIMENSION OF PROBLEM ANALYSIS

We recommend therefore that Health Economists must be actively identified and involved in situation assessment and programme planning so that decisions about choices and alternatives, and effects, are based on more rational economic and socio-cultural indicators.

However , we would caution that the `economic' criteria should not supersede other criteria and costs should not become the determining factor at the cost of social need and equity issues. The plea is for `economics' to be an important complementary part of the planning process but not the central core.

There is therefore an urgent need to respond to this lacunae and we suggest the following:

- Behavioural science, approaches and socio-anthropological and socio-economic/health economic research competence must be urgently built into the `problem analysis' and `problem solving' structures at all levels.

- Well planned, multidisciplinary operations research must be initiated and a more wholistic effort strongly rooted in the social sciences must be encouraged.

- From Action research, practical, realistic operational guidelines can be evolved on all the above areas and these then incorporated into the planning process, the training process and the action process at all levels.

2. HEALTH EDUCATION

Creating awareness and building up a knowledge base amongst communities are the commonly accepted forerunners to the involvement of communities and building up their capabilities to act collectively and individually towards a common goal. Although the need for the same clearly comes out of all the planning manuals, the commitment to this activity is not adequately visible in terms of the time, manpower, efforts or budgets earmarked for the same.

It is suggested that:

- There must be a quantum jump on the manpower, effort, time, resources and budgets allocation for Health Education.

- The most vulnerable and high risk groups are usually illiterate and have no access to radio or television. In view of this, socially relevant and low cost alternatives addressing these

particular target groups should be used. Folk artistes, itinerarant performers and street theatre artists can be used to pass correct and specific messages to entertainment - starved rural communities. These artistes can be employed under various employment guarantee schemes or tribal development plans.

- Posters and videos do have their role but cannot be allowed to overshadow the other forms of communication mentioned above because of the irrelevance to the most vulnerable and deserving section of the community.

- Teachers and school children need to be specifically targeted for specific health education as the long term effects on their action potential are the most beneficial and effective.

- The Government has in recent years produced many useful booklets/pamphlets, videos and other useful health education materials. These are however used only within the government system. There is urgent need to make them available freely on a much more open basis to all groups outside the government system who wish to be involved in Awareness building.

- Communication centres within the voluntary sector may be encouraged to use these materials, adapt them to local/regional needs, translate them into the local vernacular and work on alternative approaches to communicate the key messages and facts in other interactive, low cost ways.

3. DISTRICT PLANNING / DECENTRALIZATION

There is a growing realisation that the regional disparities / differences are so wide and the development process including health service development so diverse that planning at regional level and at district level particularly is not only necessary but also relevant.

The whole renewed development and emphasis of the Panchayatiraj concept and structure also emphasises the urgent need and opportunity for this.

Finally the concept of involving the grassroots community in the planning process now considered to be more relevant, favours this shift as well.

To support this shift of emphasis, we suggest the following action :

- The urgent development of capacities and capabilities to undertake district planning.

- The urgent training/orientation of Health Centre staff particularly Mos in the ability to make local plans based on local data and to involve the panchayat/community in the planning process.

- The urgent training/orientation of emerging panchayat leadership to participate meaningfully in the health planning process.

- Community level plans could be a short term goal to support the long term goal of district plans.

4. LOSS OF PUBLIC HEALTH SKILL / COMPETENCE

The health programmes in India is being greatly affected by the crisis of "Public Health" in the country, marked primarily by the increasing disregard of 'public health competence' and public health perspectives in health policy and health care decision making.

At Central and State levels there is increasing marginalisation of technical leadership with public health competence, by their clinical counterparts and both these groups by lay generalist administrators. Decisions that therefore need sound epidemiological and technical background are now being increasingly taken by those who are not adequately qualified to do so. Specious arguments based on management/economic/or other extraneous factors are therefore being allowed to modify policy planning process.

This is further compounded by the inadequate support to public health training in the country whose growth in quantity, quality and diversity today are totally out of context of the large needs in the country.

It is therefore suggested that:

- Serious effort be made to strengthen public health training in the country;
- Ensure that key decision makers in health care services and policy making bodies have public health competence and orientation;
- Encourage existing Public Health and Preventive and Social Medicine/Community Medicine/Community Health courses in the country to be more field oriented in their priorities and skill development; and
- Build inservice training and continuing education programmes for all categories of health personnel in public health skills/knowledge including communicable disease control focussing on national programme related issues.

5. CORRUPTION / POLITICAL INTERFERENCE IN POLICY DECISION MAKING

While techno-managerial and some epidemiological causes of programme inadequacy and/or failure have been constantly highlighted in all evaluation/reviews/studies of the 'implementation gap' in national health programme - two extraneous factors that are important, known to most researchers, experienced by most programme planners and programme implementors but inadequately tackled or even described because of the difficult nature of the problem are the following:

a) Corruption manifested particularly at the time of tender, bulk purchase, appointments, and transfers. These involve bribes and pecuniary benefits to decision making leadership. Often there are well developed systems with the collections shared by a larger section of the system.

b) Political interference in decision making at all levels even to the point of disregarding technical expertise. This is the bane of Indian Public life today. The involvement of lobbies of drug companies, insecticide manufacturers, irresponsible trade unionism, staff and all sorts of extraneous influences seem to be at play when variances from policy statements and actual realities are discovered by evaluators/researchers.

While these are part of a larger problem, we suggest:

- A policy of greater transparency in decision making involving tenders and contracts associated with drug/pesticide purchases from the private companies.
- A greater sharing of information / with increasing emphasis and legal sanction to right of information. These will go a long way to allow consumer groups and social activists to play the necessary watchdog role on the system particularly in these aspects.

6. INTERNATIONAL PUBLIC HEALTH COLLABORATION

Many major public health problems in India, are serious global problems as well. It will require concerted national efforts, strengthened by regional collaborative efforts and the resource support and linkages of international funding agencies and international Public Health co-operation.

In the present global scenario and the evolving market phenomena, there is a growing danger that funding will get linked to marketing of specific products or approaches at the cost of a more integrated / comprehensive strategy.

We suggest that the international project linkages, project funding, should primarily

- Strengthen national capacity to deal with the problem.
- Build national infrastructure especially trained and skilled multidisciplinary manpower.
- Be rooted in approaches/strategies responding to local needs and socio-economic-cultural-political realities of the country and arising primarily out of local experience.
- Prevent national strategies/projects becoming subservient to the priorities/needs of international funding agencies, institutions and resource persons whose understanding of local socio-epidemiology is often rather limited and who may inadvertently promote the research, training and programme agendas of their own institutions/agencies rather than being supportive of local expertise.
- Ensure that projects/linkages are transparent and subject to collective peer group dialogue and interaction among all those who are seriously involved and interested in the public health problems in the country.

Source : **Towards An Appropriate Malaria Control Strategy**
Issues of Concerns and Alternatives for action

(A VHAI / CHC PUBLICATION).

STATE OF PEOPLE'S HEALTH IN KARNATAKA

The Voluntary Health Association of Karnataka in collaboration with the Government of Karnataka and the Voluntary health Association of India has brought out a report entitled the '*State of People's Health in Karnataka*'. It was in response to the needs of the people interested in health of the people of the State to have a reliable source of information. In 18 chapters contributed by knowledgeable resource persons, the book deals with various aspects of public health and health care services in the State and compares it with the situation in India and the neighbouring states. The book has brought out a number of recommendations to improve the health of the people.

Regional disparities

The northern districts are backward in health and development. It is necessary to pay special attention to the people of the area, to enable them to catch up with the more developed districts. It is also necessary to have a more equitable distribution of health care.

Community Participation

The community must be organised to take action for health. The people and peoples' representatives (under Panchayat Raj and Municipalities Act) must be trained to plan and take decisions. The health functionaries must accept the rights of the people to plan, make decisions and ensure the implementation of the plans.

Equity with quality

The quality of care, Governmental, Voluntary or Private must be acceptable. There has to be equity, with health for all.

Value-based education

The education of all health personnel must be value-based with competence and commitment and the training must be close to the people to be served. The practice must be ethical.

Public Health

It is essential to have a public health approach, with improvement in the environment, reduction in pollution of all kinds and health awareness among all the people, leading to health action. Lifestyles must be healthy. There is need for improvement in the quantity and quality of water supply and proper disposal of waste.

Nutrition

Malnutrition must be corrected. This is especially important in the early formative years.

Alternative Systems of medicine

All recognized systems of medicine should be supported, leaving the choice and utilisation to the people.

Special needs

The special needs of the vulnerable groups such as the tribals, urban poor, women, children, elderly, disabled and other disadvantaged persons must be met urgently.

The special needs of the girl child and women during adolescence, reproductive age and later must be met.

Mental health

Mental health care needs to be integrated with primary health care.

Rational Drug Use

The efforts to have an essential drug list and formulary appropriate for each level of use and expertise must be supported.

The supply of essential drugs through a revamped Government medical stores and supply system must be strengthened.

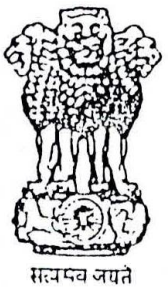
Information regarding Rational Drug Use must be disseminated widely among all prescribers and users through well-thought out campaigns.

Voluntary Organisations

Karnataka has a large number of voluntary organisations involved in health and development. Government should see them as equal partners. They should be seen as innovators, issue raisers, trainers and enablers of people to take action for better health.

The book is available with

Voluntary Health Association of Karnataka,
#60, Rajini Nilaya,
2nd Cross, Gurumurthy Street,
Ramakrishna Mutt Road, Ulsoor,
Bangalore - 560 008.



REPORT

OF

THE EXPERT COMMITTEE ON PUBLIC HEALTH SYSTEM

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI-110 011.

JUNE, 1996

Annex - 1A

LIST OF THE MEMBERS OF THE EXPERT COMMITTEE

1.	Prof. J S Bajaj, Member, Planning Commission.	Chairman
2.	Dr Jai Prakash Muliyil, Deptt. of Community Medicine, Christian Medical College, Vellore.	Member
3.	Dr Harcharan Singh, Ex-Adviser (Health), Planning Commission.	Member
4.	Dr N S Deodhar, Ex-Officer on Special Duty, MOH&FW, 134/1/20, Baner Road, Aundh, Pune.	Member
5.	Dr K J Nath, Director, All India Institute of Hygiene & Public Health, Calcutta.	Member
6.	Dr K K Datta, Director, NICD, Delhi.	Member-Secretary

List of the officials who assisted the committee

1. Dr. Prema Ramachandran,
   Advisor (Health),
   Planning Commission

2. Dr. Dinesh Paul,
   Deputy Advisor (Health),
   Planning Commission

3. Dr. A C Dhariwal,
   Joint Director,
   N.I.C.D., Delhi.

4. Dr. S P Rao,
   Chief Medical Officer,
   N.I.C.D.,Delhi.

CONTENTS

EXECUTIVE SUMMARY

E-1.0 INTRODUCTION

India is a large country with around 900 million population in 25 states and 7 Union Territories. Historically India had a rich public heath system as evidenced from the relics of Indus Valley civilisation demonstrating a holistic approach towards care of human and disease. The public health system declined through the successive invasions through the centuries, intrusion of modern culture and growing contamination of soil, air and water from population growth. With the establishment of British rule and the initiation of practice of Western medicines in India strong traditional holistic public health practice in India went into disuse bringing disease-doctor-drug orientation. The so-called modern public health practice of the advanced European and industrialised countries was primarily set up around cantonments, district and State Headquarters in British India.

E-1.1 By the time India achieved independence socio-political and economic degradation reached to an extent where hunger and mal-nutrition were almost universal; 50% of the children died before the age of five, primary health care was very rudimentary or non existent and the state of public health was utterly poor as evidenced through life expectancy at birth around 26, infant mortality rate 162, crude death rate around 22, maternal mortality rate around 20. Only 4.5% of the total population had access to safe water and only 2% of the people had sewerage facility. Number of medical institutions were few and trained para professionals like nurses, midwives, sanitary inspectors were barely skeletal in numbers. The picture on the nutrition front was very grave. Food production, its distribution and availability of food per capita were all unsatisfactory. MCH services, school health services, health care facilities for the industrial workers, environmental health were all far from satisfactory.

E-1.2 Under the Constitution, health is a state subject and each state has its health care delivery system. The federal government's responsibility consists of policy making, planning, guiding, assisting, evaluating and co-ordinating the work of various provincial health authorities and also supporting various on-going schemes through several funding mechanisms. By and large health care delivery system in India in different states has developed following independence on the lines of suggestions of the Bhore Committee which recommended delivery of comprehensive health care at the door step of the population through the infrastructure of primary health centres and sub centres. During the last eight 5 year plans following independence a large network of primary health care infrastructure covering the entire country has been established. In addition, several national health and disease control programmes were initiated to cover a wide range of communicable diseases namely, malaria, filaria, tuberculosis, several vaccine preventable diseases like diphtheria, pertussis, tetanus, polio, measles etc. and to also cover some important non-communicable diseases like iodine deficiency disorders,

control of blindness, cancer, diabetes etc. The progress was periodically reviewed through constitution of several committees like Mudaliar Committee, School Health Committee, Chadha Committee, Mukherjee Committee etc. To provide more thrust on the improvement of environmental health and sanitation the responsibilities pertaining to water supply, sanitation and environmental related issues were transferred to the concerned ministries of Urban Development, Rural Development and Environment and Forests. Major initiatives were taken up in our efforts to reach Health for All by 2000 A.D. on the lines of policy directives enunciated in National Health Policy. Eighth plan starting in 1992-93 clearly emphasised that the health facilities must reach the entire population by the end of 8th plan and that the health for all paradigm must not only take into account the high risk vulnerable group i.e. mothers and children but also focus on the under privileged segments both within and outside the vulnerable group. All the efforts put through the last four and a half decades following independence made significant dent in the improvement of health indices viz. IMR 74 (1994), water supply urban area 84.9%, rural area 79.2% (1993), sanitation urban area 47.9% (1993), rural 14% (1994), crude death rate 9.2% (1994), expectation of life at birth Male 60.4% (1992-93) and female 61.2% (1992-93). Significant number of doctors and para medical staff are available and the food productions have been raised from 50 million tonnes in 1950 to 182 million tonnes in 1993-94 increasing the per capita availability even in spite of large population growth from 394.9 gm in 1951 to 474.2 gm in 1994.

E-1.3 In spite of this significant development and impressive growth in health care, enormous health problems still remain to be tackled and addressed to. Though mortality has declined appreciably yet survival standards are comparable to the poorest of the nations of the world. Even within the country wide differences exist in the health status in the states like Bihar, Orissa, Madhya Pradesh, Rajasthan to that of Karnataka, Maharashtra and Punjab which have done exceedingly well in terms of quality of human life. Major problems facing the health sectors are, lack of resources, lack of multi-sectoral approach, inadequate IEC support, poor involvement of NGOs, unsatisfactory laboratory support services, poor quality of disease surveillance and health management information system, inadequate institutional support and poor flexibility in disease control strategy etc.

E-1.4 In the background of the above and also in the light of the observations in recent times following review of the rural health services, national programmes like malaria, tuberculosis, UIP etc. concern has been expressed that whether our efforts will succeed in achieving the goal for reaching Health for All by 2000 A.D. In fact experts are of the opinion that Health for All by 2000 A.D. is not a distinct possibility. It may have to be revised backwards by a decade or two. The concern has been further compounded following the recent outbreaks of malaria and plague indicating poor response capability of the existing public health system in meeting the emergent challenges of the modern days particularly the threat posed by new,

emerging and re-emerging human pathogens. In this context, the Government of India constituted an expert committee to comprehensively review the public health system in the country under the chairmanship of Prof. J.S. Bajaj, Member, Planning Commission to undertake a comprehensive review of (a) public health system in general and the quality of epidemic surveillance and control strategy in particular, (b) the effectiveness of the existing health scheme, institutional arrangements, role of states and local authorities in improving public health system, (c) the status of primary health infrastructure, sub centres and primary health centres in rural areas specially their role in providing intelligence and alerting system to respond to the science of outbreaks of disease and effectiveness of district level administration for timely remedial action and (d) the existing health management information system and its capability to provide up-to-date intelligence for effective surveillance, prevention and remedial action. The committee had four meetings in addition to interaction between the members of the expert committee. The summary of the observations and recommendations suggested by the committee are summarised here.

E-2.0 PUBLIC HEALTH SYSTEM IN INDIA

E-2.1 Federal Set up

The federal set up of public health system consists of Ministry of Health & Family Welfare, the Directorate General of Health Services with a network of subordinate offices & attached institutions and the Central Council of Health & Family Welfare. The Union Ministry of Health & Family Welfare is headed by a cabinet minister who is assisted by a Minister of State. It has three departments namely, Department of Health, Department of Family Welfare and Department of Indian Systems of Medicines. The Department of Health deals with the medical and public health matters including drug control and prevention of food adulteration through the Directorate General of Health Services and its supporting offices. Director General of Health Services renders technical advice on all medical and public health matters and monitors various health schemes. Director General of Health Services also renders technical advice on family welfare programmes. The functions of the Union Ministry of Health and Family Welfare are to carry out activities to fulfil the obligations set out in the 7th Schedule of the Article 246 of the Constitution of India under Union and Concurrent list.

The federal government has set up several regulatory bodies for monitoring the standards of medical education, promoting training and research activities namely, Medical Council of India, Indian Nursing Council, Pharmaceutical Council etc. In addition to the Union Ministry of Health & Family Welfare, Planning Commission has a Member (Health) of the rank of a Minister of State who assists the Ministry of Health in formulation of plan through advice and guidance and the expert guidance is also available for monitoring and evaluation of the plan projects and schemes.

E-2.2 State level

The State governments have full authority and responsibility for all the health services in their territory. The State Ministry of Health & Family Welfare is headed by a Minister of Health & Family Welfare either of a cabinet rank or a Minister of State. Often he/they is/are assisted by a Deputy Minister depending upon the political situation. The Health Secretariat is the official organ of the State Ministry of Health & Family Welfare and is headed by a Secretary/Principal Secretary/Commissioner as the case may be. State Health Secretariat is assisted by a technical wing called the State Health Directorate. Earlier all the functions pertaining to health and family welfare and medical education were integrated. However, now in many states directorates of public health services, posts of Director of Public Health, Director of Family Welfare and Director of Medical Education have been separated and they report directly to the Secretary.

E-2.3 District Level

The principal unit of administration in India is the district which is under a Collector/ District Magistrate/Deputy Commissioner. The size of the districts vary widely from less than 0.1 million to more than 3 million and the district public health system is headed by the Chief Medical and Health Officer/District Health Officer.

E-2.4 Community Health Centre/Primary Health Centre/Sub Centre

Apart from the headquarters of the district having district hospitals and the office of the Chief Medical and Health Officer, the district has a network of hospitals, dispensaries, community health centres, primary health centres and sub centres to cover the entire population of the district with regard to health care delivery services. It has also the network of hospitals and dispensaries under the Indian Systems of Medicine and Homoeopathy.

E-2.5 Health is a multi-ministerial responsibility. Many of the activities undertaken by the other ministries have tremendous impact on the health of the people. Several policy initiatives related to agriculture, urban development, industrial packages have far reaching health linkages involving higher morbidity and mortality. The same need to be analysed through appropriate health impact assessment studies for guidance of policy makers.

E-2.6 Many of the areas under the National Health Policy have not yet been implemented. During the last decade massive changes have occurred through destruction of ecological system, rapid urbanisation, large population growth, industrial revolutions etc. leading to changes in health and demographic scenario. Appearance of new, emerging and re-emerging health

problems has been causing concern. This calls for review of the National Health Policy.

E-2.7 India is a large country with diverse socio economic situations. Therefore, uniform health care delivery system is not likely to yield the desired results. Therefore, continued efforts to develop alternate strategies should be there so that the same could be appropriately dovetailed within the overall framework of the health care delivery system to obtain better results.

E-2.8 73rd and 74 Constitutional amendments have provided immense administrative and managerial authorities to the Panchayats and municipalities. The same should be fully exploited with appropriate delegation of financial authorities to improve the public health system.

E-2.9 Several ministries are involved in public health related activities. Hardly any appropriate inter-sectoral co-ordination and co-operation mechanism exists.

E-2.10 In the present organisational set up of the Ministry of Health & Family Welfare there are several areas of duplications and there is excessive bureaucracy. Not enough number of senior public health positions exist. Many of the important positions requiring public health responsibility are being managed through non-Public health professionals. For several key areas like environmental health & sanitation, manpower planning hardly any component exists in the DGHS.

E-2.11 Indian Systems of Medicine & Homoeopathy has large number of professionals. They are not being appropriately exploited to supplement the modern health care delivery services particularly in the area of awareness, community participation etc.

E-2.12 Rapid urbanisation has led to phenomenal growth in urban population. 25-30% live now in urban area. Though tertiary care services are available but primary care is grossly neglected here leading to higher morbidity & higher mortality amongst urban poor and slum dwellers and to also over straining of tertiary care health services.

E-2.13 Earlier practice of integrated delivery of health care services is being eroded through creation of separate directorates in several states leading to disintegrated pattern of medical and health administration. Growth of bureaucracy as evidenced through placement of bureaucrats as Directors of Health Services or as heads of primarily medical and health organisations is also responsible for erosion of public health machinery.

E-2.14 Epidemiological support services and public health laboratory facilities at the district level is grossly inadequate..

E-2.15 Referral services in the community health centre is poor. Public health specialised services in the community health centre is totally lacking.

E-3.0 EPIDEMIOLOGICAL SURVEILLANCE SYSTEM

E-3.1 Epidemiological services were grossly inadequate prior to independence but have since developed to a great extent, concurrently with the national control/eradication programmes for various diseases like malaria, tuberculosis, leprosy, cholera, vaccine preventable diseases, filaria etc. However, there is a conspicuous lack of uniformity in the lists of diseases which are notifiable in different states and also from the view point of primary agency responsible for reporting. Cholera, yellow fever and plague which are under International Health Regulations are notifiable throughout the country. The other important diseases which are notifiable in one state or the other are viral hepatitis, enteric fever tuberculosis, influenza, meningitis, Japanese Encephalitis, rabies, diphtheria, leprosy, measles, poliomyelitis etc. Notification system in operation in various states is usually supported through certain legal provisions. The position with regard to legal provisions also varies from state to state and some state governments do not have any specific act excepting invoking the Epidemic Diseases Act 1897. In urban areas the responsibility lies with the municipal health authorities. Common defects in notification are delay and inaccuracy in reporting the cases and under reporting.

E-3.2 Epidemiological investigations have a key role to play in effective control of diseases. For co-ordinating and carrying out such investigations, epidemiological units/cells have been established in a number of states but there are states where such units have not been established yet. Public health laboratories play a premier role in verification of diagnosis, in assisting epidemiological tracing of the spread of the outbreak and in understanding the natural cycle of the disease. In most of the states, public health laboratories are not functioning very efficiently and there is hardly any facilities for virus isolation work in these public health laboratories.

E-3.3 Wide variation in the notification system being implemented by various states/UTs make the data lack in epidemiological quality and thus hardly offers inputs for an effective response. The data generated through the massive rural health infrastructure and hospitals and dispensaries are received late and are non-uniform with scanty laboratory support. It includes also no reporting and truncated reporting from several areas due to complete blackout of surveillance in time & space due to variety of reasons viz. non-availability of health personnel, apathy of health personnel, poor management, errors in reporting etc.

E-3.4 Surveillance data generated through the system and through various programmes are considered at best indicative of trend rather than the actual situation in the community and mortality and morbidity numbers reported are grossly under estimated.

E-3.5 Though major national health and family welfare programmes have institutional support services but such support mechanism is grossly inadequate to meet the challenging needs of the modern programme management. With large amount of information being generated covering various areas of development and various scientific disciplines, there is an urgent need for their appropriate analysis, understanding and dovetailing to make the on-going programmes more modern and updated. Unfortunately, in several of the programmes such formal mechanism does not exist. Though a large number of medical colleges, national and referral institutions are there not much has been done in the context of harnessing the expertise through a formal linkage mechanism.

E-4.0 STATUS OF CONTROL STRATEGIES FOR EPIDEMIC DISEASES

E-4.1 Appropriate guidelines for detection of outbreak and early warning signal mechanism for epidemic prone diseases are not nationally available. It is usually provided by NICD on *ad hoc* basis.

E-4.2 Though several diseases with epidemic potentiality are covered through national disease control/eradication programmes like National Malaria Eradication Programme, Universal Immunisation Programme, there is no centrally sponsored or central scheme to tackle epidemic prone diseases in general. National Malaria Eradication Programme provides guidelines with respect to detection and containment of epidemic of malaria and kala-azar and so also several of EPI targeted diseases have appropriate guidelines for epidemiological investigations. Guidelines have provisions of initiating control measures but none of the guidelines have a component of generating early warning signal and thus helping in identification of outbreaks early. For many of the diseases like poliomyelitis, cholera, viral hepatitis, adequate diagnostic support services are not available as a result many of them are not detected and reported. Even in most of the medical colleges facilities for identifying new sero types of cholera are not available.

E-5.0 EXISTING HEALTH SCHEME

E-5.1 There are large number of schemes functioning in the country like Development of health infrastructure, Training of professionals and para professionals, Village health guide, Mini health centre, Rehbar-i-Sehat scheme, Child survival and safe motherhood scheme including UIP, Programme of Acute Respiratory Infection, ORT, etc. in addition to several major diseases control/eradication programmes covering diseases of public

health importance like malaria, leprosy, tuberculosis etc. under communicable diseases and blindness control, iodine deficiency disorders, cancer and diabetes etc. under chronic diseases. In addition to the above programmes under the Ministry of Health and Family Welfare there are several schemes under other ministries like Ministry of Rural Development, Ministry of Urban Development, Ministry of Environment & Forests and Ministry of Welfare to cover wide areas of environmental health, water supply, sanitation and child health.

E-5.2 All the schemes have been aimed to improve the public health system. Large number of agencies are involved. Co-operation and co-ordination between these agencies are grossly inadequate and thus many of the programmes do not give satisfying performance.

E-5.3 Multiplicity of funding mechanism, poor administrative & financial authority at the peripheral points, multiplicity in administrative authority lead to poor performance.

E-6.0 NATIONAL FAMILY WELFARE PROGRAMME

E-6.1 India was the first country to have an official family welfare programme which was initiated in 1952. Since then, during the subsequent eight five year plans, family planning as a measure of population control has been receiving high priority attention in each of the five year plans. During the 3rd five year plan (1961-66), family planning received a major boost and it was declared the very centre of plan development and in the year 1966 a separate Department of Family Planning was established in the Ministry of Health and the extension approach was further modified into an integrated approach and thus family planning became an integral part of MCH and nutrition services. The National Health Policy has indicated a long-term demographic goal of achieving replacement level fertility (net reproduction rate of 1.0) by the year 2000 A.D. which would necessitate achieving a birth rate of 21 per thousand, death rate of 9 per thousand and annual population growth rate of 1.2 per cent. The 7th plan document visualised the goal of reaching the same by 2006-11. However, keeping in view the level of achievement the 8th plan document has envisaged to achieve the same by 2011-16.

E-6.2 The family planning programme has not been able to achieve fully the demographic goals which are vitally linked with improvement of public health system in the country. States which have done exceedingly well on the demographic front have also done well on the health front.

E-6.3 Creation of a separate department leading to disintegration of earlier integrated way of functioning has not improved performance.

E-6.4 Poor referral services to a great extent are responsible for high maternal and infant mortality Only few first referral units are functional.

E-6.5 India is a vast country. Efforts of the government alone can not meet the needs. Though a large number of NGOs are functioning well in the country, not much efforts have been made in that direction to involve them more effectively in the delivery of health & family welfare services.

E-7.0 ENVIRONMENTAL HEALTH AND SANITATION

Though environmental health and sanitation received priority attention in all the successive plans but level of environmental health and sanitation both in rural areas and in urban areas continues to be poor in spite of significant achievements in terms of coverage and quality of service. This has been largely due to large population growth, urbanisation, industrialisation, population movements and ecological changes. Following the Bhore Committee recommendations an Environmental Hygiene Committee was constituted in 1948-49 and in 1953 a national level technical body (Central Public Health Engineering Organisation) was established in the Ministry of Health to undertake national water supply and sanitation programme. In 1973 the subject of water supply and sanitation was transferred from Ministry of Health to Ministry of Works and Housing and local self government (presently redesignated as the Ministry of Urban Affairs and Employment). The Water (Prevention and Control of Pollution) Act of 1974 was another milestone in the prevention and control of water pollution in the country. For implementation of the Act, a Central Pollution Control Board at the national level and State Pollution Control Boards at the state level were established in 1974. The Act was amended in 1988. The Air (Prevention and Control of Pollution) Act, 1981 amended further in 1987 has provided an instrumentation to improve the environment. In 1981 International Drinking Water Supply and Sanitation Decade was launched. In addition to that centrally sponsored rural sanitation programme and several other programmes were also initiated by different ministries. In spite of all these efforts, recurring outbreaks of gastrointestinal disorders and haemorrhagic dengue fever etc. and large scale outbreaks of malaria and plague in recent years point towards insufficiency in our efforts in improving environmental health and sanitation. The low level of urban, peri-urban and rural sanitation is a matter of deep concern. Multiple operating agencies with poor co-ordination between them have added to poor programme efficiency.

E-8.0 ROLE OF HEALTH AUTHORITIES IN EPIDEMIC REMEDIAL MEASURES

E-8.1 Health is a state subject and the entire health care delivery services including epidemic remedial measures are primarily through the State

governments who have the constitutional authority and obligations to implement the health care delivery services. The municipalities and the local authorities and the State governments though have the constitutional authority and obligations to effectively implement the public health programmes but they are unable to function satisfactorily in that direction because of paucity of resources, non-availability of the expertise in terms of personnel and institutional support etc. and also due to appropriate perception of public health problems. Many of these local bodies do not have requisite financial authorities.

E-8.2 Municipal Bye-laws and the local bye-laws are widely in variation from one and another and many of them are outdated. Many of the provisions of municipal bye-laws and local bye-laws though technically sound but do not yield desired results because of poor implementation.

E-9.0 CURRENT STATUS OF HMIS & ITS ROLE

9.1 Initially HMIS was started in the states of Haryana, Gujarat, Rajasthan and Maharashtra on pilot basis in one district each of the states. The system was manual and the data which was generated as a result of implementation of the pilot project proved very useful. On the basis of the achievement of HMIS which was known as HMIS Version 1.0, the programme officers of various State Governments and experts from the related fields were consulted and the inputs for each level of institution responsible for health care delivery were designed and developed.

E-9.2 During the year 1988-89 National Informatics Centre set up Satellite based computer communication network called NICNET and the HMIS was again modified and modified computerised formats designed and developed in the shape of Version 2.0 were implemented. It has become fully operational in Haryana, Sikkim and in several other states it is in different stages of implementation.

11. RECOMMENDATIONS

11.1 Short-term

11.1.1 Policy Initiatives

11.1.1.1 Review of National Health Policy

The National Health Policy was formulated and adopted in 1983. During the years since then major changes have occurred through continuing population growth, rapid urbanisation, industrial revolution, changing health and demographic scenario, appearance of new, emerging and re-emerging health problems etc. Two important constitutional amendments namely 73rd and 74th have been passed giving more responsibility and authority to municipalities and panchayats and thus providing appropriate tools to the community to deal with health, water supply and sanitation etc. more effectively. In view of the same, the National Health Policy needs a careful and critical reappraisal. The committee, therefore, recommends constitution of a Group of Experts to prepare the draft of the new National Health Policy by the end of 1996.

11.1.1.2 Establishment of health impact assessment cell

While the link between economic growth and better health is a strong one, growth in income and a developing economy do not necessarily ensure improved health status. Many developing countries are concerned with the possible health impact of economic restructuring and development policies. The Committee, therefore, recommends that there is a need to enhance the capacity and capability of the Ministry of Health & F.W. to undertake health impact assessment for major development projects, industrial units etc. so that the project/industrial authorities could be appropriately advised & guided to incorporate proper intervention measures/changes as the case may be. All large projects of different ministries should invariably have health component in the proposal itself and this should be examined and approved by the Ministry of Health & Family Welfare. Regular analysis of various public policies and practices of other ministries viz. agriculture, industry, urban development, rural development and environment, which have direct link with the health of the people, must be considered as an essential prerequisite for a meaningful inter-ministerial co-ordination.

11.1.1.3 Surveillance of critically polluted areas

In view of the population explosion and unplanned urbanisation and industrialisation, diseases due to ecological and

environmental imbalances are increasing. Health impact and environmental epidemiology related to air, water, and soil pollution need to be monitored and evaluated particularly in the critically polluted areas in the country. Ministry of Health and Family Welfare should initiate actions in this regard urgently, in co-ordination with the Ministries of Environment, Industry and Urban Development. Measures such as a properly maintained data-base, mapping of the vulnerable areas, immediate intervention where possible and continuing surveillance need to be initiated as a well structured programme of action.

This is particularly important in view of the large inputs provided by the Ministry of the Environment and Forests for 100 critically polluted towns and cities. Such surveillance will enable to understand impact of the interventions made and take appropriate corrective measures.

11.1.1.4 Search for alternative Strategy/ strengthening of health services/system research

India is a vast country. Uniform health care strategy for the entire country is not likely to succeed because of a variety of reasons: geographic, socio cultural, ethnic, economic etc. Therefore, a continuous search for alternative health care strategies needs to be undertaken by the health implementing agencies through appropriate health services research. At present, health system/services research receives very inadequate support and poor response from the health directorates. Therefore, the Committee recommends allocation of adequate funds to the Centre, UTs and State Directorate of Health Services enabling them to undertake or commission Health Services/System Research and Intervention Studies and to ensure that such research results are utilised to improve the health care delivery services.

11.1.1.5 Uniform adoption of Public Health Act by the local health authorities

Model Public Health Act revised and circulated in 1987 should be examined by all State health authorities, municipalities and local health authorities carefully and adopted/enacted to suit local and national needs. This will give a uniform, updated and modern tool to tackle many of the old and new, emerging and re-emerging health problems more efficiently. This is all the more important in view of the recent 73rd and 74th Constitutional Amendments providing enormous political, administrative and managerial authorities to local and municipal bodies so as to enable them to take care of human health and development.

11.1.1.6 Establishing National Notification System/National Health Regulations

The notification system as it exists today varies widely from state to state and within the state from area to area. The Committee recommends the constitution of a Task Force drawing experts from states, NGOs, and public health institutions to examine the existing notification system and prepare draft National Health Regulations for adoption by all states. This should be time bound and completed by 1996.

11.1.1.7 Joint Council of Health, Family Welfare and ISM & Homoeopathy

Indian Systems of Medicine and Homoeopathy should be appropriately involved in strengthening further the public health system of the country. Therefore, the committee recommends that the existing Joint Council of Health & Family Welfare should be further broad based to make a Joint Council of Health, Family Welfare and Indian Systems of Medicine & Homoeopathy.

11.1.1.8 Establishing an Apex Technical Advisory Body

In order to ensure a mechanism of continuing review and appraisal, the committee recommends to establish an broad based Apex Technical Advisory Body and advise the government accordingly.

11.1.1.9 Constitution of Indian Medical & Health Services

The Committee reinforces in the strongest terms the need to constitute Indian Medical & Health Services without any further delay. This has been a long felt need and was recommended as early as 1961 by Mudaliar Committee. Many of the central health programme managers have no formal education in public health and management and have never worked in the states, as a result they do not have appropriate perception of the problems of the states leading to poor professional communication and understanding between central and state government health programme managers. Creation of Indian Medical & Health Services will facilitate bridging this gap and improve technical leadership and management both at centre and state levels.

11.1.2 Administrative restructuring

11.1.2.1 Organisational set up of the ministry

11.1.2.1.1 There are presently three departments in the Union Ministry of Health & F.W. each headed by a Secretary, and the DGHS is headed by a technocrat. Co-ordination between departments is not satisfactory and several times it has been seen that they work in water-tight compartments and the interaction between different programme managers has often been found unsatisfactory. Even between the working of the DGHS and Department of Health there are several areas of duplication. Most of the functions of the Union Ministry of Health and Family Welfare are highly technical in nature and, therefore, require technical leadership of a high quality. The committee therefore, strongly recommends that the union Ministry of Health & Family Welfare may consider merger of the two departments of Health & Family Welfare and that the single department so created benefits from technical leadership as indicated above. The department of ISM and Homeopathy may also be similarly restructured.

11.1.2.1.2 The Department of Health & Family Welfare and DGHS should be restructured and reorganised; while doing so emphasis should be given to strengthen Planning, Food and Drug Division of DGHS. New Divisions of Environmental Health & Sanitation, Health impact assessment Cell and Health Manpower Division should be established.

11.1.2.1.3 All the major technical divisions under the Union Ministry of Health & Family Welfare and major institutions/organisations should have an advisory body to periodically review the functioning of these divisions, institutions and suggest an appropriate corrective step for improving their various activities.

11.1.3 Health Manpower Planning

11.1.3.1 The DGHS should have a strong Health Manpower Planning Division; appropriate institutional support mechanism by creation of a National Institute of Health Manpower Development may also be considered.

11.1.3.2 The committee reiterate that recommendations contained in Bajaj committee report of 1987 on health manpower planning, production and management should be implemented in right earnestness which will greatly strengthen public health system in the country. Primary health care provision being a team function, the training and continuing education of the professional and para professionals should have components of training/education of the

entire team together in addition to training of the individuals. This multiprofessional education approach will provide cohesive functioning of the team and improve quality and coverage of health services.

11.1.3.3 The Union Ministry of Health & F.W. is primarily responsible for public health services but it does not have requisite number of senior level public health professionals. Many programme managers at the national level are without any public health orientation or public health qualifications. The committee, therefore, recommends that positions requiring public health tasks should be filled by appropriate qualified public health professionals and until these professionals are available, these could be operated by general category health professionals through appropriate training in health services administration, management and epidemiology.

11.1.4 Opening of Regional Schools of Public Health:

There is a need to open new schools of public health so that more public health professionals and para-professionals could be trained. The existing public health schools also be appropriately strengthened. The committee recommends that at least four more regional schools of public health are set up in Central, Northern, Western and Southern regions. Duly modernised schools could be in the pattern of All India Institute of Hygiene and Public Health, Calcutta and School of Tropical Medicine, Calcutta.

11.1.5 Strengthening and upgradation of the Departments of Preventive and Social Medicine in identified medical colleges

Establishing new schools of public health will require several years in terms of obtaining resources, construction of buildings etc. For a vast country like India even establishing few more schools of public health will not be able to meet the entire needs. Therefore, it is recommended that some of the existing medical colleges who have very significant expertise in teaching of preventive and social medicine/community medicine should be further strengthened in the form of establishing an advanced centre for teaching of public health or upgrading the existing departments so that it can take up additional responsibilities of continuing education in public health subjects for health professionals and also to undertake responsibilites for producing more public health professionals to meet the demands of the country. In this context, it is strongly suggested that a centrally sponsored programme of upgradation of few identified departments of preventive and social medicine in the medical colleges could be taken up during the last financial year of this Plan and during the 9th Plan period at least 25% of existing departments may be similarly upgraded.

These centres could be linked through a network so that the facilities could be maximally utilised.

11.1.6 Reorganised functioning of the Department of PSM in Medical Colleges:

The system of providing an exposure to the community health care to the physicians through the Department of Preventive and Social Medicine at the medical college under the ROME scheme has not met with anticipated success as it provides very limited exposure to community health programmes. It is suggested that the State/District National health programme management focal points are posted for sometime in the Deptt. of PSM in medical colleges so that the programme managers get the benefit of updated academic and technical skills and the students are benefited from the practical experience of the programme managers at the field level. Similarly teachers of Preventive and Social Medicine should be posted in the district for some time to act as a focal point for national health programmes.

11.1.7 Establishing a Centre for Disease Control

To make the public health system more responsive to the needs of new, emerging and re-emerging health problems and also to meet the challenges of escalating epidemic of non communicable diseases the need for establishing a Centre for Disease Control at the national level is strongly felt. The committee, therefore, is of the view that National Institute of Communicable Diseases, Delhi should be substantially strengthened through capacity building into a National Centre of excellence for Disease Control on the pattern of similar advanced centres such as CDC, Atlanta.

11.1.8 Primary Health Care infrastructure in urban areas:

The basic health care infrastructure in the urban area which caters to the needs of 25% - 30% of the population is grossly deficient. In view of the recent initiatives to give more financial and managerial authorities to the municipal bodies, immediate attention need to be given to develop the health care infrastructure in urban area. The same will reduce stress and strain on the secondary and tertiary health care facilities available in the urban areas. The committee recommends that an Expert Group be constituted to suggest restructuring or even redesigning of health care infrastructure including referral and linkage upto and including tertiary care in urban areas.

11.1.9 State Level:

Creation of several positions of Directors at the State level has led to disintegration of earlier integrated pattern of medical and health administration. Earlier practice needs to be restored. It is also recommended that functioning of the Department of Health being mostly that of technical nature a technical man should be the head of the Department of Health instead of a bureaucrat.

The committee recommends that on the general principles suggested for reorganisation and restructuring of the Central Ministry of Health & Family Welfare and the Directorate General of Health Services, the State/UT health ministries and directorates should also be reorganised and restructured.

11.1.10 District level:

Every district should have a strong epidemiological services input through establishment of an epidemiological unit headed by an officer of the level of district epidemiologist and supporting staff. Establishment of this type of unit will also help initiating disease surveillance programme including early warning signal mechanism with appropriate laboratory support. The committee, therefore, recommends to establish such units if not already existing under the National Disease Surveillance Programme.

11.1.11 Establishment of a supervisory mechanism at the Sub-district level:

In many states district levels officers like district malaria officer, district family welfare officer and district health officer have been given responsibility to supervise all health & family welfare programme in part of the districts in addition to supervising the entire individual programme for the entire district. This has not given much dividend, because the officer does not give adequate attention to activities other than the specific health & family welfare programme through which his salary is drawn. In addition disease control strategies/interventions are becoming complex due to variety of reasons viz. addition of more and more sophisticated technologies, problems related to resistance to drugs, resistance to insecticide, ecological changes, management issues covering logistics, cost effectiveness etc. Therefore, supervision of the various health programmes has been suffering and there is an urgent need to institute appropriate supervisory mechanism at the sub district level.

11.1.12 Community Health Centres:

Community Health Centre is regarded as the first referral unit. The National Education Policy in Health Sciences as approved by the Central Council of Health & Family Welfare in 1993 has recommended placement of one public health specialist at the community health centre (CHC) level and if this is implemented the same will contribute immensely in strengthening the public health system and will offer suitable correction to present hospital based disease cure emphasis in health care delivery to make it disease prevention and health promotion oriented as enshrined in the National Health Policy statement. The availability of additional manpower in form of one public health specialist in all the CHCs may not appear immediately feasible at this stage of available public health specialist manpower. However, once a beginning is made and National Education Policy in Health Sciences is implemented in a time bound manner through an appropriate action programme, this will be possible in foreseeable future and thus disease control activities channelled through CHC will have more updated professionally competent support for better management of disease control programme and transfer of newer technologies for various disease control activities at the grass root level.

At the CHC there are four specialists and one PHC Medical Officer. Until such time as a Public health expert is available at CHC level, it is suggested that each of the specialists take up the responsibility of monitoring the public health programme pertaining to their speciality in the population covered by CHC e.g. obstetrician will supervise collection and reporting of data pertaining to Reproductive Health and Family Planning, Paediatrician for immunization and child survival, physician for communicable and non-communicable disease control programme, surgeon for disability limitation rehabilitation and blindness control programmes. The entire data pertaining to all programmes in the CHC population may be put together and reported by the PHC M.O who must be adequately trained in epidemiology and public health management. Thus with the existing staff improvement in MIS, disease surveillance and response and accurate reporting of data pertaining to PHC can be attempted in the CHC. This would also bring about increased awareness of the clinicians to the ongoing public health programmes and result in better integration of clinical curative and preventive medicine components of the important programmes.

11.1.13 PHC/Sub-Centre level:

The organisational structure of the health services at village level should be entrusted to the Panchayati Raj institutions which should decide the nature structure, and priorities of the organisation of

the health care delivery services at the village level depending upon the local situation, resource availability etc. This would ensure participatary management by the community with empowerment for decentralised area specific microplanning. Within such a framework, further co-ordination must develop at all levels of local self-governance.

11.1.14 Village level

With the 73rd and 74th Constitutional Amendments providing enormous political, administrative and managerial powers to take care of the health and development of the people, it is very important that the Village Health Guide scheme continues to be supported with appropriate strengthening through enhancement of honorarium and drugs so that they become more effective in handling the local health problems. The committee is of the considered opinion that the Village Health Guide in the new envisaged role as Panchayat Swastha Rakshak will provide useful support to the Panchayat system at the village level in enhancing community awareness and participation.

11.1.15 Prevention of Epidemics:

11.1.15.1 It may not be possible to completely prevent outbreak of diseases. However, epidemics can be prevented if an appropriate surveillance mechanism is established. In fact price of freedom from disease is appropriate surveillance. The Committee agrees with the recommendations of the Fourth Conference of the Central Council of Health & Family Welfare (1995) proposing initiation of a National Disease Surveillance Programme for strengthening of health surveillance and support services and recommends that this programme should be initiated as a centrally sponsored scheme within the existing health infrastructure with appropriate laboratory support involving already existing expertise in various national institutes, medical colleges, and district public health laboratories. Additional support needs to be provided to modernise laboratory support system through strengthening of conventional techniques and procedures, induction of rapid diagnostic tests, molecular epidemiology capability so that the public health system is updated and modernised to respond to any eventual public health emergency. Initiation of a national disease surveillance programme will improve notification system, institution of early warning signal mechanism and would enhance prompt response capability.

11.1.15.2 With the establishment of National Disease Surveillance Programme, several national institutes at the national, regional and state level alongwith several medical colleges and important public health laboratories will be appropriately linked so that the response

capability becomes faster and expertise available in these institutes promptly could be harnessed by the executive health authorities at the district level to respond to an epidemic situation. These institutions should be appropriately linked and strengthened to maintain an updated expertise for meeting any future challenges.

11.1.15.3 India has established a large number of health institutions at the national, regional and state level. Many of these institutions are suffering due to non-availability of resources and, therefore, even if the human expertise is available the same is unable to provide requisite response capability because of non-availability of support services and resources. Alternatively, in several institutions even if the modern equipments are available they are not being appropriately utilised because of the non-availability of human expertise because of poor allocation of resources, poor quality of continuing medical education, etc. The Committee, therefore, is of the opinion that during the 9th Plan a centrally sponsored scheme may be initiated to upgrade these institutions and laboratories through appropriate allocation of funds so that these institutions can modernise themselves through capacity building. This could be appropriately linked with recommendation under 11.1.7.

11.1.15.4 National Institute of Communicable Diseases prepares guidelines and procedures for outbreak investigations and epidemic disease surveillance but the same is either not available through out the country or not put to practical use under a regularly monitored programme. At present, such guidelines and procedures are usually provided on request to various health agencies. To be optimally useful, these guidelines need to be regularly updated. The entire mechanism as it exists today is on *ad hoc* basis. The committee, therefore, recommends that National Institute of Communicable Diseases should prepare these guidelines regularly under the supervison of a National Task Force, update the guidelines at predetermined interval and send to all health implementing agencies. The guidelines should include details of the mechanism of detection of outbreak and detection of early warning signal.

11.1.15.5 The system of civil registration of deaths, Model Registration Scheme, Sample Registration Scheme subsequently renamed as Survey of Causes of Death (Rural), certification of causes of death should be continuously improved by enlarging its scope and coverage so that it gives more relevant data in the context of the entire country.

11.1.15.6 The processing of weekly epidemiological statistics being provided by CBHI lacks an appropriate feed back channel to the various peripheral agencies. The same need to be developed in the pattern of MMWR (Morbidity Mortality Weekly Report) published by

CDC and National Institute of Communicable Diseases may take up the responsibility for the same and initiate action in this regard to prepare an MMWR type of Bulletin for rapid feed back to all participating agencies, experts etc. CBHI may continue to act as a nodal agency for diseases which are being reported on a monthly basis. The diseases under International Health Regulations and the diseases under National Health Regulations having epidemic potentiality should be the responsibility of NICD which has the due expertise in appreciating the problem and initiating action accordingly.

11.1.15.7 National Institute of Communicable Diseases, Delhi and Christian Medical College, Vellore have worked on Models of obtaining information involving peripheral health workers and physicians in the private sector respectively and if both the models with necessary modifications if any, can be appropriately dovetailed within the existing HMIS, the same will provide early warning signals for detecting an impending epidemic.

The HMIS was also reviewed recently in the 4th Conference of the Central Council of Health & Family Welfare held in New Delhi from 11-13 October, 1995 and the Council recommended undertaking an urgent expansion of HMIS to other states. It is desirable to develop health information system at the district level in order to improve all activities related to Community Health including those in the Environmental, Community Water Supply and Sanitation sectors which will directly lead to an improvement in the health and environmental status of the district's population. Population based information in respect of socio economic, environmental, cultural, demographic and epidemiological issues is vital for choosing priority areas of action and planning public health interventions and evaluating progress.

With the expansion of HMIS to other states and its establishment on a firm basis the epidemic intelligence component could be appropriately dovetailed within the HMIS and a few districts in some states be taken up where HMIS has been satisfactorily established incorporating the epidemic intelligence component in the light of the experiences of NICD epidemic prone disease surveillance project and NADHI Projects of CMC, Vellore on a pilot basis. If found successful, it will further strengthen the HMIS in its response capability. This could form part of operational research support to the proposed National Disease Surveillance Programme.

11.1.15.8 Epidemic Diseases Act 1897 covers the entire country. This Act is about 100 years old. However, not many times regulatory mechanisms are clamped under this Act because of improper professional perception of the nature and spread of the epidemic. If

appropriate provisions under the Act are clamped in time major epidemics could be averted. Therefore, the committee recommends that the Epidemic Diseases Act provisions should be made available to all the health authorities and the provisions under the Act could be continuously reviewed by a designated group to make it more comprehensive in the light of the latest scientific information available.

11.1.16 Upgradation of Infectious Diseases Hospitals

Every State has got one or more ID Hospitals. Most of these hospitals are inadequately staffed with poor maintenance. Many of them lack the basic diagnostic support services. There is an urgent need that facilities in these hospitals are appropriately reviewed and modernised to meet the requirements of infectious diseases management. These hospitals should also have some provisions particularly in the major metropolitan cities for management of cases suffering from dangerous human pathogens.

11.1.17 Water quality monitoring

Inspite of significant progress in the coverage of Urban and Rural Population with public water supply, reduction in the morbidity of water borne diseases, has not been commensurate with the investment made in the water supply sector. One of the key factors behind this failure is the total lack of water quality monitoring and surveillance in most of the rural areas and majority of cities and towns. A recent study by the UNICEF and the All India Institute of Hygiene & Public Health, Calcutta, has demonstrated the feasibility of a community based and affordable model of water quality monitoring and surveillance. Ministry of Health & Family Welfare should take up the matter with the Ministry of Rural Affairs and Employment and Urban Affairs and Employment to initiate a few pilot studies in different locations in the country to examine the feasibility of the same and develop National Action Plan, in this regard.

For full benefits of supply of safe and adequate water, domestic and personal hygiene should be of high order. Therefore, the committee recommends to launch massive IEC programme on personal, domestic and food hygiene practices including excreta disposal.

11.1.18 Urban Solid Waste

The committee endorses the recommendations of the 1995 Bajaj Committee Report of the High Power Committee on Urban Solid Waste Management in India, constituted by the Planning Commission with regard to collection, transportation and safe disposal of municipal

wastes including industrial and hospital wastes etc. The committee also endorses the suggestion of the Bajaj Committee, that it is essential to evolve a National Policy as well as an action plan for management of solid waste.

11.1.19 Inter-sectoral Co-operation:

Large number of health schemes are implemented through the Ministry of Health & Family Welfare. In addition, there are large number of schemes having tremendous impact on human health and quality of life. These schemes are being implemented through several other ministries. Some of the important ones which have a direct bearing on the Public Health System are Rajiv Gandhi National Drinking Water Mission (RGNDWM), Rural Sanitation, Accelerated Urban Water Supply Programme, Urban Sanitation, Urban Basic Services for the Poor, Urban Solid Waste Management, Sewerage and Sewage Treatment, Prevention of Water and Air Pollution, Nutritional Programmes like Integrated Child Development Services, Special Nutritional Programme, Balwadi Nutritional Programme, Midday Meal Programme etc. All these schemes have been conceptualised to improve the Public Health System. But as different agencies are involved and co-ordination between these agencies is not so easily achieved, the Committee is of the opinion that until and unless a formal mechanism of co-ordination and co-operation is established involving all concerned and guidelines indicating detailed responsibilities in respect of all participating units precisely defined, even inspite of individual schemes appearing to be technically sound, the same will not be able to deliver what is expected in terms of effective improvement in the Public Health System. The Committee fully believe that such mechanism is very vital in the implementation of the health schemes and will strengthen Public Health response capability significantly. The committee, therefore, recommends establishment of such mechanism on a formal basis with Ministry of Health & Family Welfare acting as nodal agency.

11.1.20 Nutrition

Interactive interdependence of nutrition, infection and health have been well recognised. The National Nutrition Policy formulated in 1993 has defined the Nutrition goals and the key areas of action. National Action Plan for Nutrition provides the sectoral and intersectoral interventions to achieve these goals. Appropriate indicators and institutional mechanism for monitoring the implementation and impact of the ongoing intervention programmes at local, district, state and national level need be developed, and internalised so that the efficacy and efficiency of the various strategies

can be assessed on a continuing basis and appropriate midcourse correction can be taken.

India is in a state of demographic, economic and social transformation. In this context it is essential that a mechanism of nutritional surveillance at local, district, state and national levels is built up so that early recognition and rapid remedial interventions of existing and emerging nutritional problems becomes possible.

11.1.21 Decentralised and uniform funding pattern:

Salaries for the ANMs in the periphery come from the family welfare budget and, therefore, they are subservient to the command of the Family Welfare Department and do not respond adequately for related work in the Department of Health for which instructions come from Department of Health. Similar is the situation in respect of male health workers who receive their salaries from the health budget and, therefore, they do not adequately respond to the instructions issued from Family Welfare Department until and unless specific incentives are provided and in that case he works for Family Welfare only for incentives at the cost of health related work. Therefore, this fragmentation of tasks and commands grossly affects the functioning of the health workers which in turn affects the efficient functioning of the public health system. Therefore there is an urgent need that both the departments are under unified command and the budgetary provisions are made through unified budgeting system. This will also enable adjustment of funds at the peripheral points depending upon the situation which will improve better utilisation of funds etc. There is also a quantitative distortion in the number of filled posts. As the salary for ANM comes from FW programme which is a 100% centrally sponsored one, the posts of ANMS have been created according to the norms. In contrast the salary for MMPW is from the State budget and often more than 50% of the posts are vacant and not filled up. This anomaly needs to be corrected immediately to ensure appropriate involvement of peripheral level functionaries in disease control programme as well as in FP programmes.

11.1.22 Non-Governmental Organisations (NGOs):

Non-governmental organisations (NGOs) contribute immensely in the development of public health system and the practices. However, the service coverage is limited due to financial and other constraints. If the NGOs and the private practitioners are effectively involved this will strengthen the public health system and significantly enhance the response capability of the health care delivery system. Therefore, the committee recommends that the NGOs should be

increasingly involved through an appropriately developed action plan with suitable funding.

11.1.23 Involvement of ISM & Homoeopathy:

India has over 5 lakh practitioners in indigenous systems of medicine and homeopathy. Despite the fact that India has a large number of practitioners in ISM&H, of whom a significant proportion are institutionally qualified and certified, this potential manpower resource is yet to be effectively drawn and optimally utilised for delivery of health care in the country. The committee, therefore, recommends their involvement in the health care delivery system to strengthen the public health services and endorses fully the Bajaj Committee Report on Health Manpower, Planning, Production and Management in 1987 in this regard. The practitioners of Indian System of Medicine can be gainfully employed in the area of National Health Programmes like the National Malaria Eradication Programme, National Leprosy Eradication Programme, Blindness Control Programme, Family Welfare and universal immunisation and nutrition. Within the health care system, these practitioners can strengthen the components of (i) health education, (ii) drug distribution for national control programmes, (iii) motivation for family welfare, and (vi) motivation for immunisation, control of environment etc.

11.2 Long-term

11.2.1 Broad set up of Ministry:

The recommendations of the Bhore Committee that the Ministry of Health should be under the charge of a separate Minister is being followed and is currently in practice. However, the members of the committee are of the opinion that the several activities linked with the human health are presently undertaken by Ministry of Welfare, Ministry of Human Resource Development, Ministry of Urban Development, Ministry of Environment, Ministry of Rural Development etc. The work of sanitation and environmental health was earlier with the Ministry of Health but now it is being undertaken by several ministries viz. Ministry of Environment and Forests, Ministry of Rural Areas and Employment, Ministry of Urban Affairs and Employment and Ministry of Chemicals. It has been further seen that the inter-sectoral co-ordination which is very vital in successful implementation of various programmes is not readily available through a formalised mechanism resulting in poor achievements under various programmes. Therefore, involving all the activities pertaining to human health, creation of a new ministry such as Human Welfare may require serious consideration. Alternatively a National Council of

Human Welfare be constituted under the chairmanship of Prime Minister of India, and other members being Deputy Chairman, Planning Commission, Ministers of concerned Ministries, eminent medical and health professionals and representatives of professional organisations and NGOs etc.

11.3 Funding

Appropriate budgetary provisions may have to be made in a phased manner in order to implement the recommendations of the committee during the 9th Plan and beyond.

ACTION PLAN FOR STRENGTHENING OF PUBLIC HEALTH SYSTEM

Taking into account the existing resources and manpower constraints, certain areas have been identified to strengthen the public health system in the country. The same have been given in the Short-term recommendations of the committee. The committee also proposes some action plans to implement the recommendations.

1. A Task Force should be constituted to review the National Health Policy and draft the revised National Health Policy for the consideration of the government. This could be initiated during the last year of the 8th Five Year Plan.

(MOH&FW)

2. Establishment of capacity and capability at the Directorate General of Health Services to undertake health impact assessment of major developmental projects to guide the respective ministries accordingly. This could be taken up during the IXth Plan.

(MOH&FW)

3. Surveillance activities with regard to human health in and around critically polluted areas should be initiated. This could be a part of overall health surveillance and support services and could be initiated during the IXth Plan.

(MOH&FW/DGHS)

4. India is a vast country. Uniform health care strategy will not be yield satisfactory results for all areas. Search for the alternative strategies needs to be continued on a long term basis to develop situation specific strategies for such identified areas. States/UTs should strengthen health system research through appropriate deployment of resources specially earmarked for the same during the IXth Plan.

(State/UTs)

5. All the states, municipalities and local health authorities should be addressed to modify their existing public health laws in the pattern of the Model Public Health Act revised in 1987 and circulated including any modification the local situation may demand. The same should be followed up meticulously so that during the next few years all over the country uniform public health practice codes are available.

(NICD/DGHS)

6. National Health Regulations need to be formulated and distributed to all states, municipalities and panchayats. A Task Force may be immediately established to draft the National Health Regulations in the pattern of International Health Regulations.

(NICD/MOH&FW)

7. To involve the Indian Systems of Medicine more appropriately within the health care delivery system the existing Central Council of Health & Family Welfare should be further broad and a Central Council of Health, Family Welfare and Indian Systems of Medicine and Homoeopathy may be formed.

(MOH&FW)

8. An Apex Technical Advisory Body should be constituted to advise the Ministry of Health & Family Welfare and the Directorate General of Health Services in all major technical issues periodically and also to review the major health programmes.

(MOH&FW/DGHS)

9. Indian Medical and Health Services should be immediately constituted. This has been a long pending demand of the medical professionals and it has been recommended time and again and there is an urgent need that this is considered immediately by the government for its implementation.

(MOH&FW)

10. Immediate action needs to be taken to set the process of administrative reorganisation of the Department of Health & Family Welfare and Directorate General of Health Services in the light of the recommendations made.

(MOH&FW/DGHS)

11(a) A Health Manpower Division should be established in the DGHS; a National Institute of Health Manpower Development may be established to provide appropriate institutional support mechanism to this important activity. This could be initiated during the IXth Plan.

(MOH&FW/DGHS)

11(b) The Bajaj Committee Report on Health Manpower Planning, Production and Management should be implemented without any further delay.

(MOH&FW)

11(c) Positions requiring public health task should be filled by appropriately trained/qualified public health professionals. In this connection Central Health Service needs to be appropriately restructured.

(MOH&FW)

12. Four Regional Schools of Public Health should be set up in the pattern of All India Institute of Hygiene and Public Health, Calcutta and School of Tropical Medicine, Calcutta to train more public health

professionals to meet the growing demands of the health care delivery services. This could be taken up during the IXth Plan.

(MOH&FW)

13. The existing departments of Preventive & Social Medicine in identified medical colleges should be strengthened and upgraded to take up the additional responsibility of continuing education for health and also to produce more public health professionals. This could also be taken up during the IXth Plan.

(MOH&FW/DGHS)

14. The committee suggest that the state/district national health programme management focal points are posted for some time in the Department of PSM in Medical Colleges so that the programme managers get the benefit of updated academic & technical skills and the students are benefitted from the practical experience of the programme managers at the field level. Similarly the teachers of preventive & social medicine be posted for some time as national health programme management focal point at district/state level.

(MOH&FW/DGHS)

15. A Centre for Disease Control be immediately established in the pattern of CDC, Atlanta and National Institute of Communicable Diseases should be substantially strengthened in this direction.

(NICD/MOH&FW)

16. The urban areas have very good tertiary facilities but primary health care infrastructure is very poor. The same needs to be established particularly to reach the under privileged, slums etc. The existing health outposts/dispensaries should be linked to secondary care centres and these in turn linked to tertiary care centres situated in the defined geographic area.

(MOH&FW/DGHS)

17. Reorganisation of the Directorate of Health Services should be undertaken in the light of the recommendations made. Process could be initiated immediately.

(MOH&FW)

18. A strong epidemiological unit needs to be established at the district level. The States which have not done so far should establish so under the National Disease Surveillance Programme. This also could be taken up during the IXth Plan.

(MOH&FW/DGHS/NICD)

19. Every States/UTs should establish a supervisory mechanism at the sub district level. This could be taken up during the IXth Plan.

(MOH&FW/State/UTs)

20. One public health specialist should be posted at Community Health Centre to make the health care delivery team more effective in delivering the national health programmes and other related services.

(State/UTs)

21. Through the 73rd and 74th Constitutional Amendments, panchayats have given more administrative and managerial authorities. To fulfil their obligations towards public health services, the health care delivery system should be channellised through them. This will necessitate establishment of health care delivery component at the panchayat level. This may require provision of some funds as one time grant to the panchayats.

(Planning Commission/MOH&FW)

22. Village Health Guide Scheme should be strengthened and revamped to make it more functional to meet the demands of the health care delivery services. This will necessitate enhancing their honorarium and also the budgetary allocation for procurement of common drugs.

(MOH&FW/Planning Commission)

23(a). National Disease Surveillance Programme be initiated immediately with establishment of District Epidemiology Cell, establishment of linkage mechanism involving the medical colleges, referral institutions, district public health laboratories etc. Microbiology investigative facilities be also established at the district level.

(NICD/MOH&FW)

23(b). The coverage and scope of the Model Registration Scheme and Sample Registration Scheme should be enlarged to generate more scientifically valid data in the context of the entire country.

(RGI)

24. State ID Hospitals need to be upgraded and modernised to meet the reuirements of the infectious disease management. This could be taken up during the IXth Plan.

(Planning Commission/States/UTs)

25. In consultation with the ministries of Urban Affairs and Employment and Rural Affairs and Employment, the Ministry of Health should initiate water quality monitoring on the pilot basis immediately.

(MOH&FW/DGHS)

26. Ministry of Urban Affairs and Employment should implement the recommendations of the Bajaj Committee on Urban Solid Waste Management.

(MOUA&E)

27. Health being a multi ministerial responsibility a formal mechanism of inter-sectoral co-operation and co-ordination needs to be established involving all the concerned ministries.

(MOH&FW)

28. Nutrition surveillance shall be in-built part of National Health Surveillance and Support Services.

(MOH&FW/DGHS)

29. The female multi-purpose workers are funded through the National Family Welfare Programme and due to paucity of resources, the state health authorities have not been able to fill up the positions of male multi purpose health workers. This should receive high priority through higher allocation of funds.

(MOH&FW/State/UTs)

30. Involvement of NGOs is very important. They have been providing very useful services to the people at large. More of their involvement within the health care delivery system will improve the functioning of the various programmes. Therefore, every effort should be taken to involve the NGOs and to meet that higher allocation of funds are necessary.

(State/UTs)

31. The country has large number of practitioners of Indian System of Medicine and Homoeopathy. They should be appropriately involved within the health care delivery system to make it more effective.

(State/UTs)

Com H 49-16.

PUBLIC HEALTH IN INDIA: CRISIS AND CHALLENGES

(with particular focus on States of Karnataka and Madhya Pradesh)

WORKSHOP in BANGALORE ON 9TH MARCH 1998

VENUE: COMMUNITY HEALTH DEPT., ST. JOHN'S MEDICAL COLLEGE, BANGALORE - 560 034.

FACILITATION: SOCIETY FOR COMMUNITY HEALTH AWARENESS, RESEARCH AND ACTION, BANGALORE (CHC)

IN COLLABORATION WITH:. COMMUNITY HEALTH DEPT., ST. JOHN'S MEDICAL COLLEGE, BANGALORE.

TIME: 9 AM TO 5 PM

For: Danida Health Sector Identification Mission to India (16th February - 20th March 1998)

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BACKGROUND

- In June 1996, an *Expert Committee on Public Health System* constituted by the Ministry of Health and Family Welfare, Government of India, reviewed the 'situation' of the public health system' in the country and recommended an Action plan for strengthening of the public health system. In a comprehensive report, the Committee reviewed, the current status of public health in India; the epidemiological surveillance system including institutional support services; status of control strategies for epidemic diseases; the existing health schemes and National programmes; environmental health and sanitation; epidemic remedial measures and role of State and local health authorities; current status of health management information system and its role and derived short term and long term recommendations. Unfortunately, this report was not circulated and discussed as widely as it should have been.

- On 19th August, 1997, a year later 'public health' policy makers, trainers, researchers from Governmental and non-governmental background met in National Institute of Nutrition, Hyderabad for a Ross Centenary celebration workshop on the theme ***Public Health in India: Crisis and Challenges*** . This meeting which was a networking event of the Indian Alumni of the London School of Hygiene and Tropical Medicine, explored the crisis of public health in all its dimensions and considered some challenges for policy and action. It was a multidisciplinary dialogue and brought together resource persons working on malaria, tuberculosis, Kalazar, AIDS, filariasis, women and children health, reproductive health, IDD, nutrition disorders, cardiovascular disease, occupational health, health management, health economics, health planning and financing, vector control and international health. The proceedings of this

dialogue are to be released shortly at some launch workshops in different parts of the country in the next few months.

- The Danida Health Sector Identification mission which will be visiting India in the next few weeks will be exploring different options for possible future health sector programme support to India, especially pertaining to the States of Madhya Pradesh and Karnataka. The Society for Community health Awareness, Research and Action, Bangalore, which primarily facilitated the Hyderabad workshop, has been requested to host a one day interactive dialogue and workshop on *9th March 1998* bringing together public health professionals' and health policy makers who have multisectoral and multiregional experience to discuss the same theme particularly in the context of the states of Karnataka and Madhya Pradesh.

OBJECTIVES

The objectives of the workshop/interactive dialogue are:

1) To provide an opportunity for the Danida Mission to meet with knowledgeable Indian health professionals and discuss the state of public health in India, particularly in the context of the Expert Committee recommendations.

2) To discuss more specifically the state of health information systems, public health education and management training; public health research and the scope of decentralisation, including Panchayat Raj in health care.

3) To identify and informally discuss how Danida could be of assistance in a National or State health sector context.

PREPARATION AND METHODS

1) Invitees to the meeting will be a cross section of resource persons who have concern and commitment to improve the '*public health system*' in India. Within the short time available, an attempt will be to bring together a multidisciplinary group with experience, particularly in Karrnataka and Madhya Pradesh.

2) All invitees are requested to complete a short opinion poll on the key elements of the crisis and the challenges. This will be summarised in the introductory session to enhance the participatory nature of the dialogue.

3) All invitees will be sent *summaries of the Expert Committee report* (1996) and the *Hyderabad workshop proceedings* (1997) as background.

4) At the workshop, after the introduction , an initial presentation '*the Crisis and Challenges of Public Health in India*', will bring together the expert recommendations, opinion polls and literature review including proceedings of earlier workshops. In addition another reflection will emphasise the core values that should be central to policy, strategy and action.

5) The dialogue will then proceed in brainstorming sessions devoted to specific issues as indicated. For each issue, one resource person will make a 10-15 minute presentation to introduce the issue and its context and challenges. After these, participants will brainstorm and contribute to the identification of possible initiatives.

6) A final session will prioritize all the specific ideas which have emerged in the workshop with particular reference to the States of Karnataka and Madhya Pradesh and in the context of the Danida Mission.

7) To ensure the interactive nature of the workshop, Danida Mission team members will be invited to share their own observations and responses throughout the consultations, in the context of the discussions they have had at various levels during the travels in India.

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{A tentative programme is enclosed}

For the small number of outstation participants, suitable air/rail travel and local hotel accommodation will be provided.

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All confirmations, clarifications and follow-up may please be addressed to:

Dr. Ravi Narayan,
Society for Community Health Awareness, Research and Action,
Attention: Public Health Workshop,
367, Srinivasa Nilaya, Jakkasandra I Main,
I Block Koramangala,
Bangalore - 560 034.

Fax: (080) 55 333 58 (Mark Attn: CHC) Email: tnarayan@giasbg01.vsnl.net.in
Tel: (080) 55 315 18 (Off).

COM H 46.16

Programme

Workshop theme: Public Health in India: Crisis and Challenges
(with special reference to Karnataka and Madhya Pradesh)

9th March, 1998

Venue: Department of Community Health,
St. John's Medical College, Bangalore.

Time	Programme Schedule
9 am - 9.30 a.m.	Welcome, Introductions, and Objectives of Workshop.
9.30 a.m. - 10.30 a.m.	**SESSION : I** 1. Crisis and Challenges of Public Health in India 2. Core values in Public Health - A policy reflection (Clarifications / Comments)
10.30 a.m. - 10.45 a.m.	
10.45 am - 12.45 p.m.	**SESSION II** Identifying Opportunities for Strengthening ♦ Public Health Education and Training. ♦ Public Health Research and Health Information System
12.45 p.m - 1.30 pm	**Lunch**
1.30 p.m - 3.30 p.m	**SESSION III** Identifying Opportunities for strengthening ♦ Decentralization in the Health Sector (including Panchayat raj institutions and Hospital autonomy) ♦ Community Participation and communication (including IEC)
3.30 p.m. - 3.45 p.m.	
3.45 p.m. - 5 p.m	How could Danida assist at Central and State levels (with special reference to Karnataka & Madhya Pradesh)

An opinion poll

Public Health in India: Crisis and Challenges

(with particular focus on status of Karnataka and Madhya Pradesh)

A. The 'crisis' in Public health in India' is evident from:

1.

2.

3.

B. The causes of this crisis, today, are:

1.

2.

3.

C. To meet the challenges, the following initiatives should be taken:
Central level

1.

2.

3.

State level (keep Karnataka & Madhya Pradesh in focus)

1.

2.

3.

Date:

Note:

1. If space is not enough, please use reverse of the sheet.
2. The idea of restricting it to 3 responses on each section is to get a sense of priority, so please mention the top three ideas you would suggest in order of priority.
3. Please return this to Community Health Cell by 2nd March, 1998, Monday, by post or by fax.

Fax No: (080) 55 333 58 (Kindly mark Attn: CHC)
Postal Address: Community Health Cell, #367, Srinivasa Nilaya, Jakkasandra I Main, I Block Koramangala, Bangalore - 560 034.

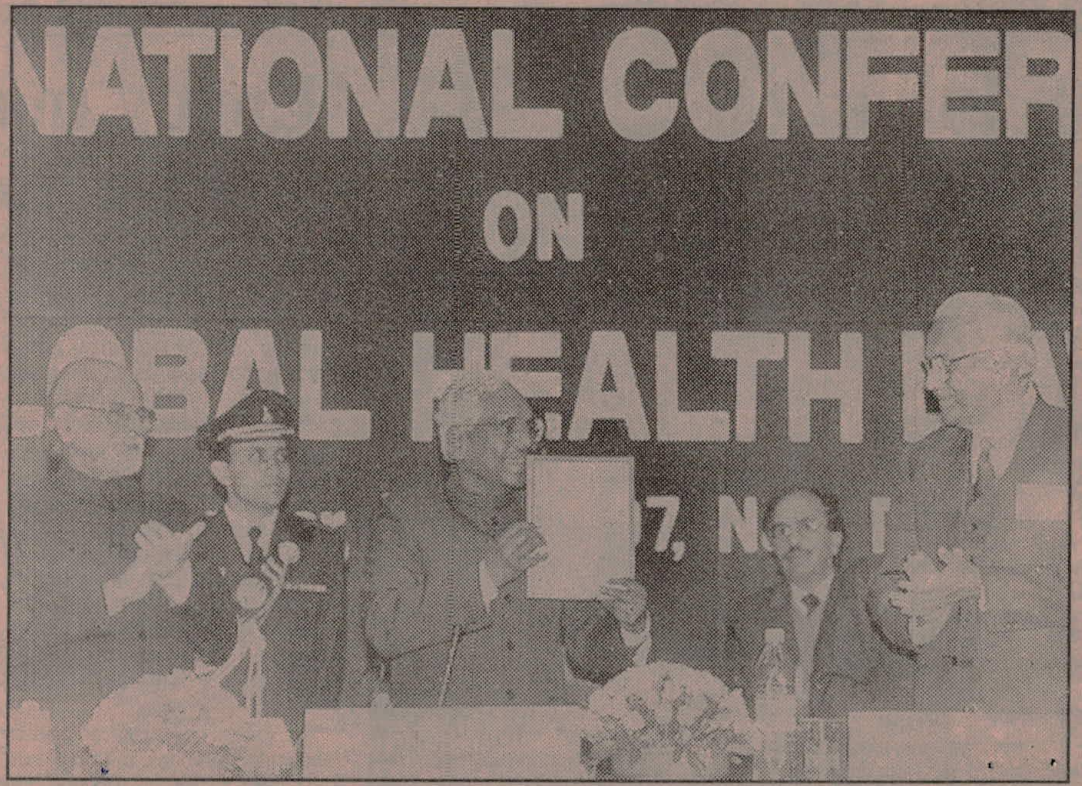
Call for laws to curb danger to public health

NEW DELHI, Dec 5 (PTI)

President K R Narayanan, said here today that laws and legislations will have to address the problem of regulating the general conditions which give rise to dangers to public health as well as the particular reasons that produce specific illnesses.

Inaugurating a three-day international conference on global health law, organised by the Indian Law Institute (ILI) and co-sponsored by the World Health Organisation (WHO), Mr Narayanan said in today's world, not only peace and prosperity were indivisible, but the health of the people is also indivisible.

Observing that the law of public health is based fundamentally on the laws of nature and on the principles of good living, Mr Narayanan said "public health law will have to leap the frontiers of countries and encompass the whole globe and humanity."



President K R Narayanan, Prime Minister I K Gujral and Chief Justice of India, Justice J S Verma applaud at the International Conference on Global Health Law organised by the Indian Law Institute in New Delhi on Friday. PTI photo

US commerce secretary, busine[illegible]

COMH 49.

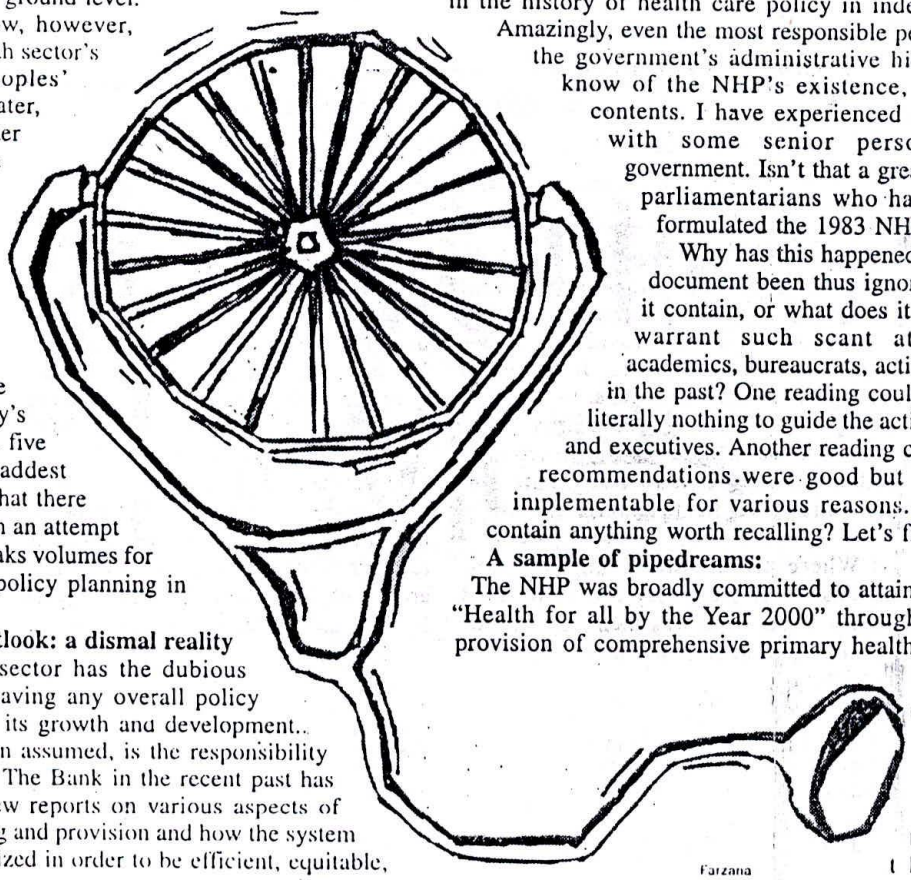
National pipedreams

Governments make annual policy pronouncements on everything from industry to sport. But strangely, public health policy is assumed to be the responsibility of the World Bank. The government's last statement on health, the National Health Policy document of 1983, must be the nation's most forgotten and forsaken document

by V R Muraleedharan

One can say very little that is positive about the current state of the public health care system in India, despite the fact that an enormous amount of investment has been made by the central and state governments over the last 50 years. The contribution of the Primary Health Centres (PHCs) to public health has been dismal. For example, a 1998 World Bank study has shown that there is no correlation between the availability of sub-centres and PHCs and child survival among either the poor or the non-poor [1]. This lack of impact of PHCs on child survival was largely attributed to the fact that services are not oriented to the type of care needed and/or that these services are not functioning as they should be. Overall, the World Bank study has this to say: "India is not getting the returns it should from its spending on public health. And more importantly, the poor are not benefiting much from that spending." Indeed this would not be surprising to those who have some familiarity with what goes on at the ground level.

It does not follow, however, that the private health sector's contribution to peoples' health is much greater, or even that it is better than that of the public health care system. The sad part of the story of the health care system in India is that no one has any clue, in empirical terms, about the health of the country's people over the last five decades. And the saddest part of the story is that there has hardly even been an attempt to find out. This speaks volumes for the state of health policy planning in this country.



Farzana

Health policy outlook: a dismal reality

The health care sector has the dubious distinction of not having any overall policy guidelines to direct its growth and development. That job, it has been assumed, is the responsibility of the World Bank. The Bank in the recent past has come out with a few reports on various aspects of health care financing and provision and how the system should be (re)organized in order to be efficient, equitable, etc. [2] Periodically (almost yearly, in fact) governments make policy pronouncements on a variety of subjects such as tiny, small, medium- and large-scale industries, agriculture, insurance, financial institutions, tourism, sports, transportation, import of gold, telecommunications — the list can go on to include at least a dozen other items. But for the health sector, there was just the infamous, forgotten and forsaken 1983 National Health Policy document produced by the Government of India [3]. That was the only policy direction on health care services from the central government to the state governments, and that was more than 15 years ago.

In keeping with our tradition of declaring "sound policy statements", the NHP 1983 also contained several well-articulated visions, goals and possible strategies that various state governments should adopt to achieve these goals. But the NHP is one of the most forgotten and ignored documents in the history of health care policy in independent India. Amazingly, even the most responsible persons sitting in the government's administrative hierarchy do not know of the NHP's existence, much less its contents. I have experienced this personally with some senior personnel in the government. Isn't that a great tribute to our parliamentarians who had debated and formulated the 1983 NHP?

Why has this happened? Why has this document been thus ignored? What does it contain, or what does it not contain, to warrant such scant attention from academics, bureaucrats, activists and others in the past? One reading could be that it had literally nothing to guide the actions of planners and executives. Another reading could be that its recommendations were good but they were not implementable for various reasons. Did the NHP contain anything worth recalling? Let's find out.

A sample of pipedreams:

The NHP was broadly committed to attaining the goal of "Health for all by the Year 2000" through the universal provision of comprehensive primary health care services. The document clearly recognized that such a goal can be attained only through "a thorough

From Muraleedharan → TN/CMF/VB/ARS/DPJ/RD/SDR For information

DPJ 7/9/99

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overhaul of the existing approaches to the education, training of medical and health personnel and the reorganization of the health services infrastructure". Furthermore, it said, "considering the large variety of inputs into health, it is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process...." Needless to say, the rhetoric included the right dosage of expressions such as, "(health care services) should be relevant to the needs and priorities of the community", "should be at a cost which the people can afford", "should be delivered through the organized involvement and participation of the community". It contained many more eloquent and impressive expressions.

Thus, with a view to putting "an end to the existing all-round unsatisfactory situation", the NHP proposed a set of approaches to bring about the "urgently necessary" restructuring in the health services. What were they? We shall cite only a few of them here [4].

a) To ensure that the proposed set of approaches do not merely form an assemblage of "disparate health interventions" the NHP emphasized the formation of "a nation-wide chain of sanitary-cum-epidemiological stations. The location and functioning of these stations may be between the primary and secondary levels of the hierarchical structure, depending upon the local situations and other relevant considerations. Each such station would require suitably trained staff equipped to identify, plan and provide preventive, promotive and mental health care services. It would be beneficial, depending upon the local situations, to establish such stations at Primary Health Centres. The district health organisation should have, as an integral part of its set-up, a well-organised epidemiological unit to coordinate and superintend the functioning of the field stations...." (NHP, p 42)

The question is: Where are all these sanitary-cum-epidemiological stations? Why were they not established anywhere at all? If they were, what was their experience? The fact remains that this approach has not taken any shape as visualized by the NHP.

b) Take another example: The NHP proposed that to "reduce governmental expenditure and fully utilise resources, planned programmes may be devised, related to the local requirements and potentials to encourage the establishment of practice by private medical professionals, increased investment by non-governmental agencies in establishing curative centres..." (NHP, p 43)

This was another pipedream. Nothing to date has happened in terms of actively encouraging the establishment of private health institutions/facilities. The state has happily slept over this proposal of the NHP. Over the last couple of years, some initiatives have been made by a few state governments in getting to know how the private sector is organized and working. Much less effort is being made to witness its healthy growth and development. It is common knowledge that the state has no control whatsoever on the private health sector and no clue as to how it should go about building a healthy relationship with the private health sector. It should also be noted that over the years both private and public health care systems have lost credibility in the eyes of the public. No doubt, they have lost credibility mutually as well.

c) Consider just one more pipedream, which relates to medical research. The NHP said the ultimate test of medical research "would involve the translation of available know-how into simple, low-cost, easily applicable, appropriate technologies, devices and interventions suiting local conditions, thus placing the latest technological achievements within the reach of health personnel and front-line workers in the remotest corners of the country. Therefore, besides devotion to basic, fundamental research, high priority would be accorded to applied, operational research including research for continuously improving cost-effective delivery of health services. Priorities would require to be identified and laid down in collaboration with social scientists, planners, decision-makers and the public" (NHP, p.51)

Has any effort been made in the past to involve people in the setting of priorities? Has any effort ever been made to involve social scientists in the formulation of state-level planning in health care services? Has any operational research study ever even been conceived to improve the cost-effectiveness of health programmes? You can stick your neck out and say, 'No'.

It would require tremendous dedication and effort on the part of the state to instill confidence in the minds of the people who are expected to identify priorities and participate in decision-making. But has any effort been made in the past to involve people in the setting of priorities? Has any effort ever been made to involve social scientists in the formulation of state-level planning in health care services? Has any operational research study ever even been conceived to improve the cost-effectiveness of health programmes? You can stick your neck out and say, "NO".

The proof of the pudding...

More than 65 per cent of children under five suffer from malnutrition. Not more than 30 per cent of the population has access to sanitation facilities. The under-five mortality rate per 1000 is still above 85. The infant mortality rate is around 65. The public health care system continues to suffer from an inadequate number of physicians and nurses despite a high annual production of these personnel. A substantial part of per capita health expenditure (even for primary care) is borne by individuals. A large proportion of India's population continues to seek care from the private sector even for diseases (malaria and tuberculosis, for example) for which national programmes have been in operation for several years. The medical education system continues to lean heavily towards curative care. The public health care system continues to suffer from lack of intersectoral cooperation — often one directorate of the health and family welfare department does not know what another directorate of the same department is doing! Very few would try to deny such facts. We are far removed from considering health insurance schemes (one of the pipedreams of the NHP 1983) for rural areas. In fact, there has been no attempt so far in this direction, let alone the feasibility of sustaining such schemes.

But we have tottered along, despite poorly executed (and

often unexecuted) intentions over the years and (not surprisingly) have even shown some impressive improvements. For example, life expectancy has gone up substantially over the last 40 years. Crude birth and death rates have gone down significantly. But as said earlier, we shall never be able to prove adequately how many of these improvements have occurred due to specific policies, although scholars have a knack of making models out of nothing! For example, quite an amount of scholarly work has been produced on the remarkable fall in the total fertility rate (TFR) in the state of Tamil Nadu to 2.1. There is no definitive explanation as yet (and possibly can never be), but attention to this question has already started waning. In the absence of any concrete evidence, one can safely attribute it to the "invisible hand" of god, although there are competing interest groups — the bureaucrats, for example — who appropriate all the credit for themselves!

One concluding thought:

Since independence, we have produced several policy documents, one of which we commented upon briefly in this essay. There is plenty of food for thought and action in these reports, and it would be worthwhile for policy-makers to pore over these policy documents and reflect carefully as to where and why we have gone wrong and re-establish our goals and approaches.

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NOTES

1 World Bank (1998), chapter 3.

2 The three noteworthy reports are: World Bank (1995), World Bank (1997) and World Bank (1998)

3 The National Health Policy was endorsed by parliament in December 1983. We shall hence call this the 1983 NHP.

4 For want of space, we have not gone into the details of other approaches. The reader is advised to go through the original document of the 1983 NHP.

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POVERTY, DISEASE AND NATIONAL AND INTERNATIONAL POWER STRUCTURE

THE CASE OF INDIA

Debabar Banerji*

SOME CONCEPTUAL ISSUES

It is necessary to understand at least the key quantitative and qualitative issues involved in the phenomena of poverty and health in a population, and in their interrelation. Both these areas of study are very complex and multi-dimensional. There have been numerous instances of distortion of the concepts concerning these areas because many writers have fallen to the temptation of adopting what amounts to a rather simple and fragmentary approach to very complex issues. This has automatically distorted their analysis of the interrelation between the two. Matters have been worse confounded when they set out to use such flawed ideas to make international comparisons. It is contended that despite all the efforts at the improvement of what the United Nations Development Programme (UNDP) has called Human Development Index (HDI), it still suffers from some major infirmities for comparing relative levels of 'development' in different countries of the world.

POVERTY

It is not intended to go into the highly controversial area of measurement of poverty. Even some carefully chosen statistical indices (which are not necessarily exhaustive enough in capturing the key variables), that are used to draw up profiles of poverty stricken people in a population, give only a part of the picture; sometimes it can even be a deceptive picture. Poverty, in whatever way it is defined, has a number of deep human dimensions in the form of the way it affects individuals and groups; it has deep cultural, social and human ecological implications. Over and above, it has roots in the history, international politics and trade, geography, economy and power relations which determine the political setting. These obviously cover too wide an area. It is, nevertheless, contended that at the very least these dimensions are kept in mind while making judgements and conclusions about individual countries and populations. Very often this is not done.

Gunnar Myrdal was among the early scholars to draw attention to the complex nature of poverty of a community and the social, cultural, economic and political implications that flow from that condition. He had articulated his thinking in 1944 in the famous book, American Dilemma, the Negro Problem and Modern Democracy to analyse the causes of

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American Dilemma, the Negro Problem and Modern Democracy to analyse the causes of backwardness of the American Negro, as he was then called. He had contended that the 'Negro' was caught in a vicious circle of poverty, apathy, ill-health, crime, illiteracy, family instability and many other such negative attributes, which form a vicious circle. Here, one attribute gets accentuated by the influence of many others.

Myrdal had based his findings on the plight of the American Negro to propound his theory of Cumulative Causation in his book, Economic Theory and Underdeveloped Regions: the negative attributes feed on one another to form a vicious cycle, making the community more backward. He suggested that this vicious cycle can be reversed by what he termed as 'purposive intervention' in carefully chosen 'key variables' in the process of cumulative causation and thus turn it into a 'virtuous cycle'. He had identified intervention for improvement of health status as one of the key variables.

Persistence of poverty and ill-health and other social and economic maladies is due to the failure of those who command authority to translate this concept of purposive intervention into action. This is essentially a political question.

HEALTH

Focusing on issues concerning community health, the great German medical scholar and political activist, Rudolf Virchow, had asserted as early as in 1848 that 'health is nothing but practice of politics on a larger scale'. Thomas McKeown has provided ample historical and epidemiological evidence to conclude that socio-economic factors have more to do with the decline in the death rates in Europe, than the public health measures undertaken during that period. Walshe McDermott has marshalled convincing evidence to show that the sharp fall in the infant mortality rates in New York City in the 1920s can be explained essentially by the socio-economic changes that had taken place at that time.

As will be discussed in detail at a later stage, this does not imply that no action need be taken to protect, promote and alleviate health problems of people through integrated public health services. As with many other socio-economic variables, interventions through health services has a positive role in contributing to converting the vicious cycle into a virtuous one. As has been pointed out earlier by many scholars, properly designed health services to alleviate the sufferings of the poor due to health problems have a positive role in preventing people from going below the 'poverty line', in increasing their capacity to fight for their causes, increasing their capacity to earn more and in acting as entry points or a 'lever' to stimulate development in other poverty related areas of action.

WHO'S APPROACH TO POVERTY AND HEALTH

The oft quoted WHO's definition of health as a state of complete physical, social and mental wellbeing, and not mere absence of disease' (the word 'spiritual' was added later) also commits that organization to a wider scope of activities in the field of health. For all its efforts of the past half a century and the catchy slogan of Health For All by AD 2000, using the approach of Primary Health Care (HFA-2000/PHC), WHO has a great deal of

catching up to do in assisting its member states to reach even the goal of ensuring `mere absence of preventable diseases'. It is worthwhile to recall that WHO had taken some major inititiatives to grapple with twin and interrelated problem of poverty and health.

The first among them was in 1975-76, when WHO joined the World Bank in launching a proposal to concurrently deal with the problems of poverty and health. That this initiative was to aborted within a short time ought to have served as a warning signal to them about the challenge of undertaking such ventures.

Undaunted, WHO launched its famous programme of HFA 2000/PHC in 1977. This was followed in 1978 by the Alma-Ata Declaration of 1978, signed by all the countries of the world. The Declaration marked a watershed in public health practice, both at the national and international levels - health as a fundamental human right of all the peoples of the world, people as the prime movers for giving shape to their health services, intersectoral action in health, social control over the health services, are some of the principal elements of the Declaration. For reasons that need not be gone into here, HFA-2000/PHC never took off; a feeble gesture was made by WHO to have a World Conference at Riga, Latvia, in 1988 to mark the tenth anniversary of the Declaration; it was almost totally forgotten by the time the twentieth anniversary came in 1998. The recent declaration by thepresent director-general of WHO, in the World Health Report of 1999 as well as in her address to the South-East Asian Regional Committee meeting at Dhaka in September, 1999, about the primacy of linking health with poverty removal, while insisting on the vertical programmes concerning tobacco, AIDS, tuberculosis and malaria, provides a good instance of ambivalent approach of WHO towards the problem. Significantly, as will be discussed below, Amartya Sen's Keynote Address to the 52nd World Health Assembly, entitled `Health in Development', which is also published in the WHO Bulletin, also reflected a similar ambivalent line of thinking.

AMARTYA SEN ON`HEALTH IN DEVELOPMENT'

Sen makes the usual correct remarks about curtailing military expenditure, skilful social allocation of resources to support to a `support-led' process to provide basic health and education and other relevant social arrangements, informed public discussion in the form of participatory politics, `development as freedom', liberation from `misery and unfreedom', and so on. He also refers to a `variety of historical reasons' for the spectacular economic growth in the East and South East Asian countries and devotes an entire section to `the economics and politics of health care'. It is ironical that having made all these lofty pronouncements, he did not think it worthwhile to make a deeper analysis of the historical, political and socio-cultural forces and the forces generated by international politics, trade and military pacts, which led to the neglect of the `social support systems'in many poor countries.

His approving references to South Korea, for instance, do not take into account the impact of the Korean War, economic benefits of locating a huge US military base in that country, propping up of dictators like Syngmen Rhee, huge foreign direct investment for politically and socially correct behaviour of the Syngman Rhee's government and

formation of an export-led economy. Similar is the history of Chiang-ki-Seik's Formosa/Taiwan, or Lee Kwan Yew's Singapore and the Crown colony of Hong Kong. Unleashing of the Viet Nam War led to yet another bout of economic `prosperity' of the countries of this region, including the not so famous rest and recreation industry of Thailand and the dictatorial regime of Suharto in Indonesia. These features did not seem to come in the way Sen's praise for economic development of such countries.

How could Sen shower praise for achievements of `pre-reform' China when he is well aware of the `misery and unfreedom' of a totalitarian approach to the economy, politics, judiciary, access to information and administration, and the disastrous failures of the movements of `let hundred flowers bloom', `the great leap forward', the great Chinese famine, the cultural revolution and the Tianenman Square incident of 1989?

He greatly emphasises the importance of `informed public debate', but which `public' has he in mind in the vast majority of the poor countries of the world where a minuscule elite has a vicious grip over the levers of power to make public policy decisions? Another major problem with Sen's presentation is his idea of measuring `health'. While at the start of his address he mentions the idea of capability of `living really long and to have a good life while alive', he ends up in measuring health in terms of mortality rates and life expectancy. How do his data capture his idea of good life while alive and liberation from misery and unfreedom? How do these apply to South Korea, Taiwan, China, Indonesia and other Asian Tigers? Do even the peoples of the oft quoted Kerala State of India, Sri Lanka, Jamaica (which incidentally has one of the highest homicidal rates in the world) and Costa Rica enjoy `a good life while alive'?

Talking to a global audience, Sen made no mention of the devastating impact on the poor peoples of the world of the World Bank/IMF inspired programmes of globalisation, structural adjustment programmes and cost recovery for social services from the people and encouragement of the private sector in health; the World Trade Organisation has added to the predicament of the poor by imposing many trade regimes which affect their lives. For instance, in the Indian Union budget for 1992-93, the well known welfare economist and the then finance minister, Manmohan Singh, had imposed a drastic cut of 20 percent on the health budget as a whole (without taking into account the inflation of 1991-92); the cut was still more severe on the communicable disease control programmes which are of particular relevance to the hapless poor. There were also cuts in other social services; but the defence budget was virtually left untouched. Sen has described elsewhere Manmohan Singh as a `dear friend' and he would like to have him as a future Prime Minister of India!

QUANTITATIVE DATA USED BY UNDP AND OTHER INTERNATIONAL ORGANIZATIONS

The foregoing analyses reveal serious infirmities in the use of quantitative indices for measuring development by UNDP and other international organizations. Besides, there is the very serious question of reliability of the data that are made available to these organizations by the national governments. Finally, there is the key question of

comparability of data from one country with others and wide differences in the endowments of different countries. Sen, for instance, has pouted out the incongruity of comparing a country like India with, say, Maldives.

Taking just one example among the poor countries of the world, one can ask: how many countries have even the quantitative data which can be comparable to the almost half a century series of the National Sample Surveys on a wide range of socio-economic problems? Very few, if any of them have the time series data on vital events through Inida's Sample Registration Systems. Yet information from the NSS and SRS in India is compared on equal terms of reliability and validity with countries with very poor and, not infrequently, doctored quantitative data.

One can also point to the other problem of bias, unintended or otherwise, which tend to package some data in alarmistic terms. For instance, with many highly populated countries of the located in the South-Eastern region of WHO, intellectual fairness demands that disturbing situations are depicted as population ratios, rather than in hyperbolic terms as `containing the largest number of the poor of the world'. They conviently overlook that they have no access to corresponding data from China. There is a strong undercurrent of cheap public relations exercises in presenting various conditions in many international organisations. This ought to be curbed.

The recent commissioned report, Poverty and Health - Regional Issues: South-East Asia, brought out by the South-East Regional Office of the WHO, reflects most of the flaws referred to in the previous paragraph; that is, reliability, validity and comparability of the information base. On the other side, WHO/SEARO does not make any mention of the reasons why it had not been able to implement HFA-2000/PHC and other anti-poverty initiatives taken by WHO, both before and after Alma-Ata. That is a more important issue than playing with quantitative data of limited value.

There is, however, one set of quantitative data from the Human Development Report 1998 of UNDP which reasonably captures the real situation. It says that the countries which account for 20 percent of the population of the world consume as much as 86 percent of the world resources. Of the remaining 80 percent of the population, it can easily be surmised from numerous sources of information that the upper crust forming barely the 5-10 percent of them consume seven percent of the resources, thus leaving a mere seven percent for anywhere between 90-95 percent of the population of the residual 80 percent of the world population. This set of data is being presented to underline the awe-inspiring nature of distribution of resources between and within different countries in this world. Is this the vision of the global village of the rulers of the rich countries? The horrendous maldistribution indicates the very dangerous trend of how a small fraction of the population of the rapidly polarising world is so thoroughly brainwashed so as to wallow in the in the mindless consumption of such utterly frivolous and aggressively marketed `products' as designer merchandise, brand name values, prize fights and other big money sports events, fashions and cosmetics and a powerful industry built on most outlandish noises that go in the name of pop and reggae music, on the one side, and a huge mass of the population living under most degrading conditions of

poverty, ill-health and destitution, on the other. Inadequate recognition of this alarming situation explains why the authorities concerned have repeatedly failed to come to grips with problems of poverty and health. The approach has to be different. The forces engaged in the frenzied creation of markets have to be tamed. For this purpose, the affected people themselves will have to get together to wrest theirrights from their rulers. A tiger can not be expected to become a vegetarian!

POVERTY AND HEALTH IN INDIA HISTORICAL BACKGROUND, HUMAN ECOLOGICAL CONDITIONS AND DEVELOPMENT

Considering the global and the national economic order, India, with a population of one billion, has a very large number of those who are poor. This problem of poverty and its relation to health is being analysed here very briefly in the perspective that has been developed at the beginning of this presentation.

When the country gained independence in 1947 after two centuries of British colonial rule, the nature and extent of poverty was much more severe and extensive than what exists today. The health services too were in a very rudimentary form, leaving an overwhelming proportion of the poor to their fate. There were frequent outbreaks of epidemic diseases which were mostly left unchecked. Twenty mothers lost their lives for every 1000 childbirths. Only half of the children born, after such colossal sacrifice of lives by the mothers, were alive ten years after their birth. Expectancy of life at birth as measured in 1941-1951 national census was 32.1 years.

Since then, despite assigning overwhelming priority to family planning in resource allocation, the size of the population has shot up from 351 million in 1951 to the present figure of a billion. This addition of an extra 650 million people in a country which was already overpopulated in 1951 has been a very significant feature of human ecology in the country. It is indeed a remarkable achievement that the already overpopulated and poverty stricken country managed to absorb an additional 650 million people over a period of half a century, thus belying the grim Malthusian forebodings; the country also managed not only to retain, but actually deepen the democratic system of government; infant and other mortality rates have shown significant decline all over the country; despite increase in population, the proportion of the poor has been reduced from around half to about a third of the population; there has been a sustained growth in the per capita income in fixed prices; the latest NSS figures show that the literacy rate have gone up to 74 percent in 1998 from 62 percent in 1991; the life expectancy was 57.7 in the 1971-80 census and it has now risen to 63 years; and so on.

UNEQUAL STRUGGLE FOR DEVELOPMENT OF HEALTH SERVICES

A mention is made here of some positive achievements to underline the fact that the poor have been able to wrest some of their rights from the minuscule elite who control the levers of power of the country. Looking at the opposite side, if one goes beyond the criteria of defining a poor as one who gets two square meal a day all round the year to

one getting some proteins in his diet, has access to protected water supply, basic conditions of housing, including toilet facilities and environmental sanitation and access to basic education and health services, as reflected in the UNDP assessment of distribution of the global resources, some three-fourths or more of the present population will be branded as poor.

The task of alleviating poverty-disease syndrome is thus an uphill one. The deprived have to struggle hard to impel the ruling elite and their abroad to make what Sen has called judicious social allocations for this purpose. Manmohan Singh did not do so. This has been a difficult task because of the distribution of political power in the population. It has been compounded because of severe cuts in the budgetary allocation for health and other social services, increasing inefficiency in the use of whatever is allocated and gross inadequacies in finding more cost-effective programmes for social interventions to break the vicious cycle of poverty and ill-health.

In the health services sector, for instance, there has been severe erosion even of some modest gains that were made during the first two decades after Independence. Giving over-riding priority to resource allocation for implementation of the very defectively designed and extremely expensive and wasteful family planning programme for more than three decades has grievously damaged almost all the components of the health service system. As if that was not enough, international agencies then came in with their own prefabricated technocentric global agenda against some specified diseases and managed to get the politician/bureaucrat diad to accord these unsuitable programmes priority over the basic health activities.

HERITAGE OF ENDOGENOUS HEALTH SERVICE DEVELOPMENT

The net result was a virtual decimation of the philosophy of health service development, which was so painstakingly built up during the first two decades. This 'philosophy' was evolved as a part of an overall philosophy for development in consonance with the socio-cultural and economic conditions. Very briefly, developing people-oriented technology, providing promotive, preventive (including family planning) and curative services in an integrated form, training of manpower in consonance with the tasks to be performed and undertake research to make the system cost-effective (optimisation), and later on, entrusting "people's health in people's hands", were some of the major elements of the public health philosophy that was endogenously developed in India. It may be noted in passing that this philosophy has had strong resonance in the postulates of Primary Health Care contained in the Alma Ata Declaration. One possible reason for this could be that the moving spirit behind the Declaration, Halfdan Mahler, had his public health baptism in India at that time.

In fact, moving a step forward, the public health workers in India questioned the then conventional wisdom of economists in the Planning Commission to consider health services as a 'consumption item' for national planning. It was argued by public health workers that alleviation of suffering due to health problems strengthens the people to fight for their democratic rights and increase their productivity in the bargain; it was also considered as levers or 'entry points' for workers from other fields of social development

to more effectively bring about developments in their respective areas, such as education and cooperative movements. Sen has added yet another economic argument by stating that investment in health services for the poor is labour intensive and very cost-effective.

COUNTERPRODUCTIVE ROLE OF FAMILY PLANNING AND OTHER GLOBAL INITIATIVES

The 'fear' of population explosion was invoked by some foreign consultants, with enthusiastic concurrence of the elite class subservient political leadership, to vivisect the composite ministry of health into department of family planning and that of health. This was done in 1967. To enforce the population control programme, the political leadership brought in bureaucrats to make people accept sterilisation for population control. They were considered by the politicians and their advisors from outside agencies more suitable to 'get the job done'.

In the course of time the bureacrats spread their tentacles more extensively. The situation now is that these bureaucrats have acquired dominant positions in decision making processes in complex fields of both health and population for which they have no competence; they are certainly not equipped for making what Sen has termed sound social allocations on the basis of cost-effective studies. They can not even be held accountable for their actions because they are frequently transferred to other departments. Reference has also been made earlier to the devastating impact on the health services of implementation of the plans for structural adjustment, globalisation and encouragement of private sector and cost recovery from the people for public financed health services. There is also the impact of WTO. There appears to be a deterministic streak all these decisions which adversely affect the poor.

The net result of all these acts of omission and commission was that desperately poor people were literally 'thrown to the wolves' in the garb of unregulated, greedy, private sector. The predicament of the poor was dramatically demonstrated by similar findings from two nationwide surveys on utilisation of medical services in India in the late 1980s - one by the NSS and the other by the National Council of Applied Economic Research (NCAER): 90 percent of them had lost their indigenous mechanisms for coping with their medical problems and depend on Western medicine; only around 3 per cent sought help from primary health centres; and most ominous of all, among the poor, meeting the cost of 'buying' services from hospitals was the second most important cause of rural indebtedness. The last item shows how important is access to public funded health services for countering the problem of poverty in the country.

At long last, the World Bank has conceded in The World Development Report, 1999 that the anti-poverty programmes that had been implemented for half a century by the Bank have not been very effective. If the Bank and other organisations are keen on following up on these conclusions, then they must look inwards for the causes. There is a crying need for fundamental 'structural change' in the Bank and other international organisations.

As early as in the early 1970s, warnings were sounded loud and clear about the infirmities in design of the Bank's India Population Project-I. These warnings were simply ignored. Taking the more recent example of the global programme of tuberculosis, it has been repeatedly pointed out to the Bank and other 'authorities' concerned, on the basis of sound scientific data, that the programme is ill-conceived, ill-planned, ill-designed and extremely wasteful. For instance, there had been no evidence which made WHO declare tuberculosis as a global emergency in 1993. How can a once respected organisation make such a sweeping declaration without a sound data base? What has happened to that emergency? Similarly, while the AIDS epidemic in Sub-Saharan Africa has precipitated a human tragedy unprecedented dimensions, affecting tens of million of people, UNAIDS was conferring to India the dubious and totally unsubstantiated distinction of being 'the AIDS capital of the world'. There seems to be some deep seated malady in the working of international agencies in the poor countries of the world. The Bank, the WHO and other agencies must find out why scientific data questioning their programmes were suppressed and why those who dared to produce scientific evidence to raise doubts were systematically ostracised as 'untouchables'? There appears to be a whiff of totalitarianism in their actions.

CONCLUSIONS: AGENDA FOR ACTION FOR INDIA

Perhaps the most urgent task in the field of poverty and health will be to provide relief to the poor for their medical problems. This, as has been repeatedly pointed out earlier, is essentially a political question; the democratic forces in the country must impel the political leaders to reverse the trends of the past three decades. This, as has been shown by the NSS and NCAER data, will make significant contribution to alleviating poverty and destitution. Specifically, this might include the following steps:

1. Many health activities can be decentralised to village/slum levels, depending on the level of community organisation and political action for devolving power to the people. Local communities can be encouraged to: (a) set up reasonably clean living space for conduct of normal childbirths; (b) have locally trained girls for giving immunization, keeping stores and overseeing the administration of anti-tuberculosis drugs to diagnosed patients, providing family planning services and advice and implementing child feeding and other programmes under the Intergrated Child Development Projects; (c) keeping records of births and deaths; (d) checking the visits of village/slum-level health workers and obtaining their assistance for more complicated problems; (e) maintaining reasonably good village/slum sanitation levels, including working of tube wells and providing drainage; (f) imparting education and information on health and development matters to the population; (g) arranging for transport of needy patients to the nearest health facility and ensuring that the personnel in those facilities adequately respond to the people's needs. The list can go on, depending more on the capacity of the community organisation, than on funds.

2. Concurrently, urgent steps can be taken to rectify the anomalies that have crept into the health services, from the very top to the bottom. Some of the priority areas for action could be:

a. Strengthening education, training and research capabilities of health administrators by rejuvenating
the existing public health institutes, so that they can occupy key positions in the health administration.

b. rolling back generalist administrators from positions for which they do not have the needed competence.

c. integrate the family planning department with the health department.

d. Integrate the vertical programmes with general health services.

e. Initiate health system research to improve the efficiency of the system.

The list is obviously incomplete. Many other actions can be added on the basis of deeper studies and analyses. It must be made explicit that these programmes will be integrated with other programmes directed towards dealing with the problem of rural poverty.

October 30 1999

Dr Ravi Narayan, CHC.

HEALTH POLICY AND PLANNING; 10(4): 333–349

Review article

The role of private medical practitioners and their interactions with public health services in Asian countries

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This paper aims to review the role of private practitioners and their interactions with public health services in developing countries, focusing largely on the Asian region. Evidence on the distribution of health facilities, manpower, health expenditures and utilization rates shows that private practitioners are significant health care providers in many Asian countries. Limited information has been published on interactions between public and private providers despite their co-existence. Issues related to enforcement of regulations, human resources, patient referrals and disease notifications, are examined.

Introduction

This paper examines evidence on the role of private practitioners and their interactions with public sector providers in developing countries focusing primarily on Asia, though information on other countries is included when helpful. The private sector is defined as all those organizations and individuals working outside the direct control of the state, that is both for-profit companies and individuals, and not-for-profit private organizations (Bennett 1991). In health care, this is a heterogeneous group consisting of a wide range of providers with different motives. Claquin (1981) defined private practitioners as 'individuals who were perceived by the community to provide resources and assistance in illness but were not employed by the government health service'. This definition makes a clear distinction between public and private practitioners in relation to their employer. Following this, he grouped private practitioners in Bangladesh into 7 categories: allopathic practitioners with MBBS qualification or Medical Board license, unqualified allopathic practitioners, homeopathic practitioners, ayurvedic or unani practitioners, spiritual healers, traditional midwives and others that do not fall into any of the earlier categories such as bone setters.

The private practitioners or providers that form the object of this paper are those who are allopathic practitioners with MBBS qualifications or equivalent. Within this group, the providers may have either a profit or non-profit motive. The former usually have financial gain as their dominant objective in contrast to the latter who provide health care for humanitarian, religious, charitable or other non-specified reasons. For-profit private practitioners include general practitioners in group or solo practice and doctors working in private clinics and hospitals. Church and mission hospitals and clinics are examples of non-profit providers. To add to the complexity, some non-profit providers may identify their organizations as such only for tax purposes, since in many countries non-profit organizations are given tax relief and subsidies (Green 1987).

Significance of private health care in Asian countries

There is limited information published on private practitioners in Asian countries. A brief review, however, shows that private practitioners are heavily used, although sometimes for particular

complaints. An example of information available is the Malaysian National Morbidity Survey conducted by the Ministry of Health in 1986–87. This nationwide household survey used a two-week recall period, and showed that private clinics were most commonly utilized for out-patient care. During the two-week period, for every 100 ill persons, 5.2 visits were made to the private clinics as compared to 2.1 visits to health centres, 1.4 visits to government hospitals and 0.4 visits to traditional practitioners (MOH 1988a). One obvious limitation of this study was the use of health workers as the interviewers, which might have affected the way respondents reported. An example of this problem is shown in a study in rural Kenya by Schulpen and Swinkels (1980), where they found gross under-reporting of the use of traditional healers when health personnel were employed as interviewers.

Another study, conducted in two rural villages in the state of Selangor in Malaysia, found that 32.5% of adults above 18 years of age utilized the public services, 22.2% sought treatment at private clinics, 33.6% used self-medication and 11.7% visited traditional healers (Aljunid and Norhassim 1992). The study was limited by the use of a six-month recall period which would lead to under-reporting, especially of visits for trivial conditions.

In Indonesia, most of the doctors and a large number of nurses and other paramedical staff working at private hospitals are public sector employees either seconded or working part-time in the private sector. Only 15% of the country's health workers are directly employed full-time in private institutions (Gish et al. 1988). Berman et al. (1987) showed that in Western Java, among the 3322 treatment contacts, 12.8% were made with private providers (doctors and paramedics), 16.8% with public providers and the rest with traditional healers or self-treatment. In 1986, the private sector accounted for 63.2% of the total health expenditure of Indonesia (Brotowasisto et al. 1988).

Among 132 physicians in the Northern Thailand Provinces, more than two-thirds of the public sector doctors reported having after hours private practice (Smith 1982). In 1985 it was estimated that there were more than 12 000 private clinics in the country compared to 7800 public health centres (Griffin 1989). Private health care expenditure in Thailand increased from 66.7% of the total health expenditure in 1978 to 73.2% in 1987 (Wibulpolpraset 1991a).

In 1974, 69% of primary care facilities in the rural areas of the Philippines were owned and run by private practitioners (Griffin and Paqueo 1993). A study among 399 households in the Bicol region, a poor rural region of the Philippines, showed that 31% of the adults visited private practitioners compared to 18% using government clinics; the remainder visited traditional healers or did not seek any medical help (Akin et al. 1986). In 1980, the per capita expenditure on health for the country was US$18.23; US$13.39 was spent in the private sector and only US$4.84 in the public sector (World Bank 1987). Roemer (1991) reported that in 1981, 59% of physicians in the Philippines were engaged entirely in private practice. Among the 41% public doctors, nearly all did some private practice part of the time.

In India, 56% of hospitals and 49% of dispensaries in the country were owned by private organizations in 1988. Furthermore, it was thought that the figures for private ownership were even greater as information on clinics and nursing homes which exhibited strong private ownership were not available (Bhat 1991). It was estimated that about 73% of qualified physicians in the allopathic system were in private practice and only 27% worked in public services (Bhat 1993). In a household survey in a rural district of Maharastra, Duggal and Amin (1989) found that 77% of the illness episodes were presented to private practitioners and hospitals compared to only 13% to government facilities. In another study (Visvanathan and Rohde 1990) it was shown that 65% of diarrhoeal cases sought medical treatment, 80% of these cases went to private practitioners and only 10% to government health facilities. In terms of health expenditures, Nichter (1980) found that 82 poor families in South Kanara district of Karnataka spent 7% of their family expenses on health, 60% of which was spent for private consultations and drugs.

In Papua New Guinea, Kolehmainen-Aitken et al. (1990) reported that the percentage of doctors

in full-time private practice increased from 13% to 18% between 1984 and 1990. In 1974 only 15% of the patients of all expatriate private practitioners were nationals; 10 years later this had increased to 50%.

Hillier and Zheng (1990) reported that China has 160 000 private doctors (including paramedics). Seventy per cent of them worked in rural areas and 45% of villages had at least one private doctor.

These studies show that private practitioners in Asia are important health care providers besides the government and indigenous healers. In some of these studies, private practitioners were utilized more frequently than the government services.

Factors influencing utilization of health services

This section reviews evidence of factors which influence the utilization of private and public services. Identifying such factors assists in understanding the barriers faced by users of the services. These barriers which limit accessibility to services need to be considered by policy-makers when promoting private or public sector services.

The classification of Kroeger (1983) was used to assess factors influencing utilization of health services: characteristics of the subjects, the disorder and the service.

Characteristics of the subjects

Socioeconomic status

Socioeconomic status is commonly mentioned as an important factor affecting the choice of provider in rural communities. More importantly it also affects the decision of whether or not to seek treatment (Fiedler 1981).

Cortinovis et al. (1993) argued that developed country socioeconomic classifications based on income, occupation and literacy are inappropriate in developing countries because of structural and economic heterogeneity between the countries. However, many studies in developing countries do use income or occupation as socioeconomic indicators but tailor them according to the local situation (Benyoussef and Wessen 1974; Heller et al. 1981; Berman et al. 1987). Others use a combination of more than one variable, such as occupation, ownership of land, and educational level, to classify socioeconomic status (Cortinovis et al. 1993; Ramachandran and Shastri 1983; Amin et al. 1989). Recently, Dye and Lee (1994) reported using only ownership of cows and sheep as an adequate indicator of the socioeconomic status of households in rural Kashmir.

Heller (1982) found that households with higher income levels shifted their demand from public to private clinics in Malaysia. The National Morbidity Survey by the MOH showed that lower income groups (monthly income of RM 500 and below) had lower utilization rates and higher tendency to use public services than higher income groups (MOH 1988a). However, private clinics were utilized by 35% of those in the lowest income groups (less than RM 300 per month) while 25% of those in upper income groups (RM 2000 and above per month) used the subsidized public facilities. These two studies did not disaggregate urban and rural areas.

A community-based study in a rural village in Malaysia showed that utilization of private clinics by adults aged 18 years and above increased significantly as income increased (Aljunid and Norhassim 1992). The percentage of respondents who utilized private clinics increased from 7% for those with monthly per capita income of less than RM 50.00 to 36.5% for the group with income of RM 150.00 and above. The percentage of respondents who visited traditional practitioners decreased as income increased.

Berman et al. (1987) showed that in Indonesia, at all levels of severity of illness, higher income groups were more likely to seek treatment; he pointed out that the use of private physicians was primarily restricted to the upper income group. Heller et al. (1981) found that in Mexico, those in lower socioeconomic classes were less likely to have a stable source of medical care and more likely to use public rather than private facilities.

Ethnicity

Different ethnic groups have different patterns of utilization. In Malaysia, Heller (1982) found that Chinese people used out-patient services more frequently than Malays and Indians even

after controlling for socioeconomic status. No explanation was offered for these findings. The National Morbidity Survey in Malaysia also showed that the Chinese were more likely to use private care facilities than Malays and Indians (MOH 1988a). These findings are likely to be confounded by income, not controlled in the analysis. The explanation offered for the ethnic differentials in this study was the distance to services: the Chinese population is more urbanized than the other two population groups. Kroeger (1983) suggested that differences in symptom sensitivity in different ethnic groups may be one explanation for inter-ethnic variations in utilization. The patients' desire to choose doctors from the same ethnic group who speak the same language might be another reason for the observed ethnic pattern of utilization.

Senior and Bhopal (1994) recently suggested four problems in using ethnicity as a variable in research: difficulty of measurement, heterogeneity of populations being studied, lack of clarity about the research purpose, and ethnocentricity affecting the interpretation and use of data. Among other things, they suggested that ethnicity should be perceived as different from race, that researchers should appreciate the complex and fluid nature of ethnicity, and that higher priority be given to research on methods for ethnic classifications. Such issues are as relevant in industrialized as in less developed countries.

Age

Health needs at different ages influence utilization patterns. A study by Benyoussef and Wessen (1974) in Tunisia found a 'U' shape utilization rate with peaks at both extremes of age; this was explained by the high morbidity rates in the very young and the elderly.

Heller (1982) found that the schoolchildren and household members in the working age group in Malaysia were more likely to consume out-patient services (public or private services) despite their relatively lower morbidity rate. He showed that the high morbidity group in the age groups 0–4 years and more than 45 years consumed the smallest amount of out-patient care. He postulated that this unusual finding might be due to household choices to treat a significant fraction of minor illnesses of these dependent age groups within the home. Another interesting finding was that those aged 5–15 and those over 45 were more likely to use traditional medical care rather than modern treatment. The latter finding might be due to the confidence of older age groups in traditional practitioners but the former finding could not be explained by Heller.

In Singapore, Fong and Phua (1985) found that at all age groups, private general practitioners were more frequently utilized than government out-patient services. For both services, their utilization rate peaked at the age groups 5–9 and over 50. There was another peak in the utilization rate of private general practitioners at the 20–30 age group. The researcher suggested that this peak might be due to employees who require a medical certificate for absences from work.

Gender

Studies from various countries have shown different utilization patterns between males and females. In Tunisia, for instance, it was found that females had higher rates of utilization than men in both rural and urban areas in almost all age groups (Benyoussef and Wessen 1974).

Akin et al. (1986), in their study on the demand for adult out-patient services in the Philippines, reported a statistically significant increase in the probability of a private versus a public sector visit if the sick person was male. They suggested that such findings may be indicative of a diversion of resources towards males to improve the quality of their care.

The priority of men over women in receiving health care was also found by Feldman (1983) in his study in Bangladesh. He found that men are more likely to use allopathic treatment than women. He suggested that allopathic medicine, which has a quicker effect and is more powerful, may be reserved for the males since male labour is assumed to be of greater value than women's labour. This is particularly true for poor families where males seek quick cures in order to be available for employment opportunities. It is also possible that when men control the family finances, they might give priority to their own health needs.

In contrast, Fong and Phua (1985) in Singapore found that females visited private general practi-

tioners 1.7 times more often than males. Women also visited government out-patient services 1.6 times more often than men.

Sources of finance

Source of finance is one barrier to use of private health care providers in developing countries. Third party payment mechanisms, such as health insurance coverage, are poorly developed though developing rapidly in some richer developing countries. Coverage of such schemes tends to be limited to certain sections of the population, usually those employed in the formal sector. Services covered tend to be mostly hospital admissions rather than out-patient services. Ron et al. (1991) reviewed health insurance schemes in 14 developing countries and reported that in most countries public services were utilized to deliver services under the scheme, except in South Korea, the Philippines and Thailand where private practitioners were selected through an accreditation process. Bennett and Tangcharoensathien (1993) noted that in Thailand, formal sector employees covered by national health insurance demanded access to the private sector in return for their contribution.

In Malaysia, only 6.5% of users of government facilities paid through third parties, 70% had free services and the remainder paid out-of-pocket. Among the users of private facilities, 20.9% paid through third parties and the majority paid out-of-pocket. Most with third party coverage in the private sector received this privilege as an employee benefit (MOH 1988a).

In Indonesia, 13% of the population, almost all of them government employees and their families, were covered by some form of health insurance (Brotowasisto et al. 1988). Direct out-of-pocket payment comprised by far the greatest part of all household payments to public and private sector facilities.

Characteristics of the disorder

In a study in a Malay rural village in Malaysia, Colson (1971) found that acute and fatal disease were presented more frequently to modern practitioners, whereas chronic non-fatal illnesses were presented to traditional healers. In another study among villagers attending a rural clinic in Malaysia, Heggenhougen (1979) found that most people used the public clinic for minor problems and presented their more serious health problems directly to a private physician.

Lim (1991) reviewed 3164 patients attending 8 private clinics in two rural districts of Pahang, an east coast state in Malaysia, and found that 87% of patients came for medical treatment and only 13% for preventive care. Minor conditions, mostly acute illnesses, represented 82% of the cases; major disorders (mainly chronic illnesses such as hypertension, asthma and diabetes mellitus) accounted for 18% of cases. Upper respiratory tract infections were the commonest minor conditions while hypertension was the most common major condition. He suggested that chronic illnesses were not commonly treated in the private sector because of the expense of obtaining long-term treatment which was provided free of charge in the public sector.

In Kenya, Mwabu (1986) reported that different illnesses gave rise to different consultation patterns. He found that although government clinics were more frequently visited on first consultation, villagers visited private mission clinics for diseases like diarrhoea, malaria, leprosy and tuberculosis.

A disease-specific utilization pattern emerged in a study by Sarder and Chen (1981) in Bangladesh. They found that although some problems like diarrhoea and fever were treated by all practitioners, others such as respiratory infections and parasitic diseases were treated by allopaths and homeopaths while jaundice, snake bites and headache were treated by traditional healers. They stated that client selection of practitioners was influenced by availability, cost and the perceived effectiveness of technology in relation to a particular disease.

Yesudian (1994), in his study in Bombay, India, showed for all socioeconomic strata that patients with minor and chronic illnesses more commonly used private sector providers than other sources. However, for acute illnesses, the level of utilization of private health care increased with socioeconomic status. Criteria for grouping the diseases into minor, acute or chronic were not stated.

Characteristics of the service

Geographical accessibility

In rural areas of developing countries, a low degree of geographical accessibility to modern health services is a major reason for use of other services such as traditional care. In a study in rural Nigeria, Stock (1983) found that rural populations living further from health facilities tend to delay using these services and preferred alternatives such as self-treatment with traditional or patent medicines. He also noted that various factors affect utilization in relation to distance, including perceived effectiveness of Western-type treatment and perceived quality of service. Males travelled further than females to obtain treatment. This was attributed to the religion of the Hausa people in which married women must obtain permission from their husbands before leaving their homes. Adults were found to travel further for treatment than children.

In the West Indies, a study by Poland et al. (1990) showed that distance to permanent health care services was a significant predictor of utilization. This was supported by a study in Southern Iraq which noted a decline in utilization rates at modern health care centres (both public and private) with increasing distance travelled. The authors concluded that the single most important factor related to variation in utilization was distance travelled by people to reach the service, once variation due to sickness or need was taken into account (Habib and Vaughan 1986).

Mode of transport also affects utilization. In Ethiopia, patients in the cities use private or government cars to get to private clinics; those in the periphery make the trip on foot, by overcrowded buses or taxi and use a mix of government facilities and traditional remedies (Kloos et al. 1987).

In Malaysia, it was found that utilization rates of both government and private clinics decreased with increasing travel time and travel cost (MOH 1988a). Earlier, in 1982, Heller reported that among households using both government and private clinics, an increase in travel time lowered the utilization rate of government clinics but not of private facilities.

Studies in developed countries, such as Joseph and Bantock (1982) in Canada, Dutton (1986) in the USA, and Haynes and Bentham (1982) in the UK, have also found that distance is a barrier to utilization or affects the poor more.

Quality of care

Patient satisfaction, a component of quality of care, has been given high priority in developed countries. Fitzpatrick (1991) cited three reasons for the importance of patient satisfaction: it determines compliance with recommended treatment and influences patient choice of provider; it is a measure of patient involvement in decisions about care; and it can be used to choose alternative methods of organizing and providing health care.

Research in developed countries has focused attention on the theoretical and methodological issues in assessing patient satisfaction. Pascoe (1983) suggested that research on patient satisfaction has not been guided by a well-supported definition or psychological model of satisfaction. Williams (1994) supported Pascoe's views on the theoretical weaknesses and identified the impact of different methodological approaches on the results of patient satisfaction research. He showed that in quantitative studies, satisfaction tended to be high while greater levels of disquiet were revealed through qualitative methods.

A few studies on patient satisfaction in developing countries have exposed the weakness of public services and higher patient preference for private health care. Gilson et al. (1994), using both quantitative and qualitative methods, studied community satisfaction with primary care facilities in Tanzania and found that services provided by church dispensaries were appreciated much more than government facilities. Drugs were more consistently available and health workers in these services exhibited more positive attitudes towards their patients.

Long waiting times, shortage of drugs, and poor attitudes of nurses and physicians were among the complaints about public facilities gathered in group discussions in a study in Mali (Ainsworth 1983). The respondents indicated that personal connections were important in skipping registration queues and that the only way to obtain ade-

quate care was to arrange for private care after office hours.

Kloos et al. (1987), in a household study in a suburb of Addis Ababa and four rural villages, showed that patients preferred services from private physicians rather than government clinics because of their personalized services and shorter waiting times. He found that 60% of wealthy traders and 13% of people from other socioeconomic groups used private services, even though the charge was 10 to 15 times higher than in government facilities.

In Malaysia, 90% of the patients bypassed the community clinics manned by community nurses to seek treatment at health centres, district hospitals and private clinics where doctors were available (MOH 1988a). Patient perceptions on the quality of services provided by doctors might be one reason for this finding. On average, patients have to spend longer in government health centres compared to private clinics (MOH 1988a).

Annis (1981) reported poor utilization of government health posts due to understaffing, badly underequipped services and poor quality of services in rural Guatemala. In rural Mexico, people preferred private physicians over the more accessible health centres which were staffed by young and inexperienced doctors (Walt 1977).

In most of the studies mentioned above, patients perceived the quality of care given by private providers to be higher than in public services. However, some studies using professionally defined criteria for quality of care have found contrary results. Uplekar and Shepard (1991) studied the prescribing patterns of 143 private allopathic and non-allopathic doctors in the treatment of tuberculosis in a slum area of Bombay. They found that the doctors prescribed three times more expensive drugs than the national standard and also used unnecessary drugs. Eighty different regimes were used by the doctors, although only four of these conformed with the regimes used by the National Tuberculosis Programme. They suggested that poor participation of private doctors in continuing medical education and the lack of integration with the national health system were the reasons for the poor quality. In another study on management of leprosy by 106 private practitioners from the same area, Uplekar and Cash (1991) found that none of them followed the WHO recommended regime for treating leprosy.

Recently, Hooi (1994) reported that of 100 tuberculosis cases treated in a public hospital in Malaysia, 48 of them had consulted private practitioners and 67% of these had had delays in diagnosis and treatment compared to only 15% of those in the government facilities. Furthermore he showed that only 14.6% of those who had first consulted private practitioners had undergone chest X-rays and only 2.1% had undergone sputum analysis on their first visit. He suggested that private practitioners may be unaware of proper diagnostic and management regimes for tuberculosis. This study suffered from selection biases as only those cases eventually treated in public hospitals were studied.

A study in India showed that private doctors prescribed a greater number of drugs and injections than public doctors and that the most commonly prescribed drugs were vitamins and tonics. Among the patients who visited private practitioners, 55% were given an antibiotic; of these, 23% received two or more types. In contrast, only 18% of patients who attended government primary health care centres were prescribed antibiotics; of these only 6% received more than one drug (Greenhalgh 1987). This study did not indicate whether the type and severity of illness suffered by both groups of patients were comparable. In the same study, the management of diarrhoeal cases differed, with private doctors being less likely to recommend oral rehydration therapy and more likely to prescribe an inhibitor of gut motility or a binding agent than the doctors in government primary health care centres and teaching hospitals.

Wyatt (1992) suggested that injections were very popular in developing countries because these may epitomize Western medicine, reinforce traditional beliefs about healing and disease, and may be the most profitable part of doctors' work, especially in the private sector. She cautioned against the excessive use of injections because of the danger of provocation of paralysis in poliomyelitis cases and transmission of hepatitis B and HIV virus if unsterile needles and syringes were used.

Ahmad and Bhutta (1990) studied the prescription of four types of non-essential drugs (anti-diarrheals, appetite stimulants, multivitamins and brain tonics) promoted by the pharmaceutical industry among 100 private physicians in Karachi. Most of these drugs were ineffective and some may be hazardous: 55% of all drugs prescribed by the doctors were in this category. He suggested that poor prescribing resulted from the dependence of doctors on salesmen and promotional materials from drug companies, the lack of involvement in continuing medical education among private practitioners, and the absence of a national drug policy in the country. No comparison was made with doctors in public services and the information was gathered by questioning the practitioners rather than studying their actual prescribing habits.

Gilson et al. (1993), using retrospective data from patient registers, compared drug prescriptions from four church dispensaries and 16 government facilities in Tanzania. Church dispensaries prescribed 24% more drugs per visit than government units. Antibiotics, chloroquine and injections were given in higher proportions by church dispensaries compared to government units. Most of the non-essential drugs were given in church dispensaries. It was suggested that the prescribing pattern observed was due to the success of the Tanzanian Essential Drugs Programme (EDP) in the government services. Church dispensaries, which were outside the EDP system, charged fees for treatment and may prescribe more drugs to gain revenue and to satisfy patient demand resulting from payment of fees.

Price of care

In most developing countries, public services are usually highly subsidized and private health care is often expensive. The high utilization rate in private sector facilities, despite the high charges, has been used as evidence that demand for services was not primarily determined by the price of care. For example, Akin et al. (1986), in the rural Bicol region of the Philippines, showed that private clinics and hospital charges were over 28 times higher than charges at government clinics and hospitals. Despite this, private facilities were still utilized more frequently than public facilities.

In Malaysia, almost all out-patient visits to government health centres are free, and in 60% of visits to government hospitals the charge is only RM 1.00 for both consultation and medication. The average payment in a private clinic was RM 12, with 32% paying RM 5 to RM 9 and a further 30% paying RM 10 to RM 14. Despite the great differences in the fees, private clinics were utilized twice as frequently as public clinics (MOH 1988a). Heller (1982) showed that demand for out-patient and in-patient care among Malaysian users was highly inelastic to cash price (price elasticity of demand measures the responsiveness of demand to changes in price). He concluded that the demand for out-patient and in-patient care in Malaysia was not responsive to changes in the price of care. A 10% increase in the price of public out-patient care would reduce demand by only 1.5%. Nevertheless, consumers were responsive to the relative cash prices of private and public out-patient clinics. Heller showed that the cross price elasticity of demand for public care due to changes in private out-patient prices was approximately +0.15. Cross price elasticity of demand measures the response in quantity demanded of a certain good or service which arises from a change in the price of other goods or services. In this study, a 10% increase in the price of private out-patient care increased the demand for public out-patient services by 1.5%.

Gilson (1988) and McPake (1993) criticized studies by both Akin et al. (1986) and Heller (1982) for their failure to estimate the impact of price on demand for different income levels. The impact on utilization resulting from price changes would probably be greater in lower than upper income groups. Akin et al. (1986) attributed their findings of low price elasticity partly to the differences in quality of care between the public and private sector and severity of illness. These two factors were not controlled in their demand model: it is possible that patients are willing to pay more for higher quality care and when their disease is severe.

Yoder (1989) showed that in Swaziland the increase of fees in government services led to a 32.4% decline in the attendance at government facilities and an increase of 10% in attendance at mission facilities. There were also declines in patient visits to both government and mission

facilities for BCG, DPT immunizations, and for treatment of dehydration in children, each showing substantial declines in average attendances of 16, 19 and 24% respectively. The negative impact of user fees on utilization of public facilities has also been shown in Kenya (Moses et al. 1992), Zimbabwe (Hongoro and Chandiwana 1994) and Zaire (Bethune et al. 1989; Haddad and Fournier 1995).

Types of services available

The types of service available also affect the choice of facility. In developing countries the types of services of private providers have rarely been documented. This is basic information, needed before a greater role of private providers can be considered in developing countries. Tsui and Donaldson (1987) suggested that lack of systematic and careful record-keeping by private practitioners was one reason for poor documentation of services provided by private providers.

It is generally assumed that curative services are the main focus of private practitioners' activities, although the actual nature and extent of services has been little documented. In a survey in the state of Perak, Malaysia, 17 private practitioners were asked to list their services (Diong 1988). The practitioners indicated curative and preventive services, including procedures and diagnostic investigations. The list has limited value since it did not really reflect what was actually provided by the private doctors. Some of the procedures listed (e.g. deep lymph node biopsy and removal of breast lump) can only be carried out by trained specialists. The profile of the providers was not given in this study.

Leopando (1988) reported that 74% of family physicians (mostly private practitioners) in the Philippines provided immunization services in addition to other curative care.

Family planning services are widely provided by private practitioners in developing countries. A study in Kenya among 592 private physicians using mailed questionnaires showed that family planning services were being dispensed on patient demand, the pill was the method largely prescribed, and sterilizations were being done for older female clients (Mugo-Gachuhi 1977). Surveys carried out in 25 countries in Africa, Asia, Latin America and the Middle East between 1979 and 1984 showed that an average of 13% of rural and 18% of urban family planning users reported using private clinics (London et al. 1985).

Antenatal services have also been reported to be provided by private practitioners. In Egypt 71% of the households in a rural area received antenatal services from government facilities as compared to 21% from private clinics (Abu-Zeid and Dann 1985). The extent and comprehensiveness of this service by private practitioners were not reported. Among the urban poor in Kuala Lumpur, 13% of pregnant mothers received antenatal care in private clinics and hospitals, and 11.5% of children were delivered in these facilities (Gan and Yusof 1993).

Private practitioners were also found to provide services not provided by government facilities. House calls by doctors are common among private practitioners in Indonesia (Berman et al. 1987). In the Philippines, private clinics generally operate longer hours than public clinics. According to Griffin and Paqueo (1993), almost all private clinics (96%) opened on holidays compared to only 10% of the public clinics, and nearly three-quarters of the private clinics provided services after office hours compared to only 6% of the public clinics.

Interactions between public and private providers

Interactions between health workers in the public and private sector have been poorly documented, particularly in developing countries, yet it could be argued that interactions between the two providers are inevitable and it is surprising that so little information exists (EPU 1985). Given that many health programmes affect both private and public providers, understanding the kinds of interactions and problems faced by them provides valuable feedback to health planners seeking to improve the effectiveness and efficiency of such programmes.

Due to limited evidence in the literature, the interactions between the two sectors on enforcement of regulations, human resources, patient referrals and diseases notification only will be discussed.

Enforcement of regulations

Perhaps the commonest form of interaction between the public and private health sector is through the regulation of private health care. Extreme proponents of the market approach are not in favour of regulation, even in the presence of market failure, as state intervention is not seen as providing any better solution than that reached by market adjustment (Bennett 1991). They blame excessive government regulation as the cause of many of the current problems in health care. Regulation of health services has been argued to cause greater administrative costs, greater inequality in attendance access, greater chance of unnecessary or iatrogenic interventions, and unjustified development of inadequately evaluated, complex technology (Belmartino 1994).

Roemer and Roemer (1982) believe that the existence of a free market in health care provision may lead to monopoly or oligopoly, turbulent competitive disequilibrium in favour of providers, and long-term contractual arrangements between consumers and providers. They further suggest that these outcomes might be very deleterious to consumers unless regulated. It has been argued that the government is responsible for regulating the private health sector because it has obligations to protect its citizens and to ensure that resources are not wasted (Garner and Thaver 1993).

Regulation of the private health sector in many developing countries is weak because of lack of resources, poorly decentralized government services, lack of information on activities of private providers and professional self-interests of the regulatory agency (Bennett et al. 1994). The World Bank, while suggesting a greater role for the private health sector, recognizes the need for governments to strengthen their capacity to regulate the private sector in order to ensure quality of care (World Bank 1993).

Registration of doctors and other health workers is usual in most countries. In Malaysia, under the Medical Act (1971), the Malaysian Medical Council (MMC) was established to register the practitioners and take care of ethical issues. The MMC is a quasi-governmental body with government maintaining control through the nomination of 13 of 24 members. The nominated members are government officers in the MOH and the remaining members are elected by the profession. Reports of the activities of the MMC showed that, despite many complaints of medical negligence in the media, very few cases were reported and investigated. Between 1989 and 1991, 72 cases were reported to the MMC, only 35 were investigated and disciplinary action was taken against only 7 doctors (*New Sunday Times*, 1993).

In India, Yesudian (1994) reported that people's confidence in the Maharasta Medical Council had decreased because it tended to protect the doctors rather than the public in cases of medical negligence. He cited a case of medical malpractice where the Council had to be forced to take action through court orders.

In 1990 in Malaysia there were 79 health laws and regulations and 36 health-related laws: it is commonly held that these are poorly enforced. The Private Hospital Act (1971) is the main act regulating the private hospitals in the country. It has provision for annual inspections and registration of private hospitals. This is enforced by the Ministry of Health. This Act is now being amended to extend its coverage to private clinics. It was envisaged that under the amended act the minimum standards for private clinics and their distribution in the country would be spelled out (MMA 1993). The existence of similar regulations have been reported in Thailand (Bennett and Tangcharoensathein 1994), Singapore (MMA 1993) and Malawi (Ngalande-Banda and Walt 1995).

Regulation regarding location of practice is applied in developed countries but has rarely been reported in developing countries. In Tanzania, regulations to control the location of clinics and types of personnel to be employed were present but not properly enforced (Mujinja et al. 1993). Under the Medical Practitioners and Dental Act, 1987, paramedicals in Malawi were allowed to open private clinics but only in rural areas. This regulation was not strictly enforced as most paramedicals opened their clinics in peri-urban areas (Ngalande-Banda and Walt 1995).

Government control over new investments has been applied in many countries through certificates of need. This is aimed at controlling cost

escalation due to excessive use, particularly of expensive medical equipment. In developed countries such as France and Canada, investments in expensive medical technology are controlled by the government. Yang (1993) reported that Magnetic Resonance Imaging (MRI) in Korea had not been regulated by the state and the service was more accessible to the rich than the poor. He further suggested the formation of a corporate body responsible for assessing new technologies before adoption. Foote (1986) assessed the Medical Device Amendments of 1976 which authorized the Food and Drug Administration in the USA to regulate medical equipment for safety, but concluded that it was not effective and failed to stop the entry of unsafe medical devices into markets.

Bhat (1991) raised the issue of uncontrolled use of high technology equipment in private clinics to attract customers. He argued that this would lead to unnecessary waste of resources and exposure of patients to unnecessary risks. In the USA, Hillman et al. (1990) found that patients were at least four times as likely to have diagnostic imaging (ultrasonography and radiography) done if they sought care from a physician who had the facilities in his office rather than from one who referred patients to a radiologist. This suggests the presence of supplier-induced demand.

In Thailand, where there is no legislation to control the purchase of sophisticated medical equipment, 35 out of 57 CAT scanners in the country were in private hospitals. Six out of the total of 8 MRI scanners in the country were owned by private hospitals (Wibulpolpraset 1991b). Where populations are less vigilant and knowledgeable, unscrupulous practitioners may take advantage of the situation for their own gain.

Human resources

Roemer (1984) expressed concern about how the private health sector competes with public services to attract trained workers in developing countries. He stated that most developing countries spent only 2–4% of the GNP on the public health sector, leading to low salaries for public health workers. Health workers such as physicians and nurses are normally trained by government to serve the public health sector. The private health sector attracts these trained and sometimes experienced workers by offering high incentives which cannot be offered by the government services.

One way of retaining health workers is through regulation, where health workers are required to serve in the public sector for a certain period of time before being allowed to leave for the private sector. In Malaysia, the Medical Act (1971) requires all doctors to serve three years in government services. This was extended to five years in 1992. Those sponsored by government for their training are bonded for between 7 to 10 years to serve in government services. Nevertheless, many doctors leave the public services after the compulsory service period and some pay their bond to be released to work in the private sector (MOH 1988b).

Incentives to retain doctors in the public services by allowing them to work in private clinics after office hours were reported in Jamaica, Egypt, Sri Lanka, Thailand, Indonesia and Malawi (Roemer 1984; Ngalande-Banda and Walt 1995). However this is not favoured in some countries for fear of abuse or neglect of government facilities. In Nigeria, government doctors reportedly referred patients they see in government facilities to their own private clinics (Attah 1986). In Egypt, even though newly graduated doctors are required to work for at least two years in government health units in rural areas, they only saw public patients in a few hours in the morning and spent the afternoon in private clinics where they could earn more than their government salaries (Roemer 1984).

To solve shortages of manpower, private doctors are sometimes employed to work in public facilities. In India, for example, private specialists were employed as honorary consultants in public facilities. However, these honorary consultants abused their position by admitting their private patients to government facilities and charging them (Yesudian 1994).

The Malaysian Medical Association has been urging the government to allow government doctors to work part-time in private clinics to reduce the influx into the private sector (MMA 1991). This suggestion was turned down by the MOH on the grounds that public services would be neglected (*The Star*, 1992).

In India and the Philippines government doctors were not allowed to open private practice (Roemer 1984). Nepal, Pakistan and Thailand had similar regulations and paid non-private practice allowance incentives to public doctors. However, this financial incentive failed to stop government doctors engaging in private practice (Bennett et al. 1994).

Patient referrals

The referral system is the most important link between different health providers and is the system through which medical practitioners communicate with one another. Private practitioners refer two groups of patients to public providers: those who cannot afford to be treated by private practitioners and those who cannot be treated or investigated due to lack of facilities and expertise (Lachman and Stander 1991).

In rural areas of Malaysia, private practitioners do not normally have in-patient services. Since most private hospitals are located in urban areas, private patients needing secondary care and in-patient services will be referred to public hospitals (Ming 1982).

Interaction between providers has been studied through analysis of referral letters in many studies in developed countries. For example, studies in the UK and Netherlands have focused mostly on interactions between general practitioners and their colleagues in hospitals. The complaints of general practitioners include the failure of hospital doctors to return the patient to their care and the failure of hospital doctors to read the referral letters (Doeleman 1987). General practitioners have also accused hospital doctors of not understanding the problems of the patient outside the hospital (Grace and Armstrong 1987) and considered the replies to referral letters by specialists to be irritating, discourteous and belittling (Western et al. 1990). Grace and Armstrong (1986) studied 213 referrals in the UK and found that in only 48.4% of the cases was there agreement between hospital consultants and general practitioners on the reasons for the referrals. The hospital consultants criticized the general practitioner's management of patients before the referral and felt that most of the referrals were unnecessary (Grace and Armstrong 1986).

The quality of referral letters by general practitioners has also been studied. Creed et al. (1990) found that doctors who write detailed referral letters refer the least patients. Westerman et al. (1990) showed that 60% of referral letters sent by general practitioners to specialists in the Netherlands were of poor quality.

A standard referral letter has been introduced in some settings to improve the quality of communication between providers. Jones et al. (1990) showed that despite the introduction of a standard ophthalmic referral form, 19.2% of the general practitioners did not use it when referring patients to an eye hospital in Manchester, UK.

The studies reviewed so far have been carried out in developed countries. In developing countries, assessment of referrals between public and private practitioners has rarely been reported. In South Africa, of 1143 referral letters received in a children's hospital, only 4.8% were considered to be complete in terms of patient history, examination, diagnosis, appropriate investigations and treatment at primary level (Lachman and Stander 1991). It was suggested that the varying quality of referral letters found in this study was due to the workload of referring doctors, lack of understanding of the need for comprehensive details about patients and lack of contact between the hospital and referring doctors. Yesudian (1994) reported medical malpractice in referral in India where money was paid to general practitioners to encourage referrals to certain consultants.

Disease notification

Disease notification is one component of communicable disease surveillance programmes in many countries. Since disease surveillance programmes are normally carried out by the public sector, public and private providers may interact through this programme. Disease notification is useful in advising appropriate medical therapy, detecting outbreaks, and for planning and evaluation of prevention and control programmes (Chorba et al. 1989).

Despite the importance of reporting, underreporting of notifiable diseases has been identified in many developing countries. Studies in 7 East Mediterranean countries (Pakistan, Sudan, Somalia, Syria, Yemen Arab Republic,

Democratic Yemen and Egypt) and five Asian countries (Bangladesh, Bhutan, India, Indonesia and Thailand) showed that only 2–5% of neonatal tetanus cases in 1980–81 were notified (WHO 1982). This estimate was based on the number of deaths from neonatal tetanus in the various countries and the total number of reported cases. The low percentage of notifications may also be due to people not seeking medical treatment at all because of poor accessibility to health services. However, a study in the Philippines in 1980–81 found that 85% of polio cases were seen by medical practitioners during the acute phase, but only 12% of cases were notified (WHO 1981a). Whether a correct diagnosis was made by the medical practitioners during the initial consultation was not reported.

Under-reporting of notifiable diseases is also faced by health authorities in developed countries. In the USA, for example, a study of discharge records in 11 hospitals in Washington DC revealed that only 35% of selected notifiable diseases were officially reported (WHO 1982). In the Netherlands, it was estimated that only 3% of measles cases were reported by general practitioners (WHO 1981b). Clarkson and Fine (1985) estimated that 40–60% of measles cases and only 5–25% of pertussis infections were notified in England and Wales in the period 1957–1980.

Although the various studies reviewed here demonstrated under-reporting of notifiable diseases, none has shown concrete evidence that medical practitioners are wholly responsible for this, even though they are required to notify once they are suspicious or have diagnosed a notifiable disease (Galbraith 1990). Several events must occur before correct notification by a medical practitioner is made: 1) the infected individual must suffer some clinical disease; 2) the patient must be seen by a medical practitioner; 3) the practitioner must make a correct diagnosis and then notify the case (Clarkson and Fine, 1985). The first two steps are beyond the control of medical practitioners. However, Konowitz et al. (1984) found that medical practitioners in the USA failed to report notifiable diseases despite making the diagnosis. They found that some practitioners did not know which diseases should be reported, others assumed that the laboratory workers would notify the case. Practitioners may also fear that notification will affect their patient's confidentiality and may violate the doctor-patient relationship (Rothenberg et al. 1980; Clere et al. 1967).

Lack of uniformity in case definition also leads to confusion among medical practitioners as to whether or not to notify. For example, in some states in the USA, Salmonellosis infections are required to be notified if culture results are positive; in other states, notifications are required only when culture results are positive *and* the individual is symptomatic (Chorba et al. 1989).

Kirsch and Harvey (1994) suggested that private physicians failed to notify cases because it was time consuming, and because of lack of reward, feedback and supervision. Nevertheless, as with all the literature reviewed earlier, there was no evidence that private practitioners were any worse than those in the public sector in disease notification.

Various ways to improve notification rates have been reported, such as sending stamped reporting forms to practitioners (Hall and Douglas 1976), actively telephoning practitioners (Rothenberg et al. 1980; Weiss et al. 1988; Vogt et al. 1983), sending them feedback (Spenser and Warren 1979) and paying them (McCormick 1987). Except for actively telephoning practitioners, all the other methods failed to increase the notification rates significantly. In developing countries, efforts to encourage notification and problems facing medical practitioners in disease notification have not been reported.

Conclusion

Medically qualified for-profit private practitioners have been the main focus of this paper. There is evidence to show that private practitioners are important health care providers in many Asian countries, even in rural areas. Existing literature shows that patient characteristics (socioeconomic status, ethnicity, age, gender, source of finance), types of illnesses and characteristics of the service (geographical accessibility, quality of care, price and types of services offered) influence the relative utilization of public and private health care.

Very little information is available on interactions between public and private providers. In

most developing countries, regulations on the private health sector are either absent or poorly enforced. An influx of human resources trained at the public expense into the private sector is common in developing countries. Mandatory public service, payment of non-private practice allowances, a requirement to seek permission to work in the private sector, are among the means governments have used to seek to retain health personnel in the public sector. When private practitioners are primary care providers, they may interact with public providers through the referral system. In communicable disease surveillance, public and private providers may interact through disease notification.

In all these areas, research is required to document and analyze existing interactions if policies are to be developed which identify the appropriate role of private practitioners and encourage good quality, cost-effective care in the private sector.

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Acknowledgements

The author would like to thank Anthony Zwi and Gill Walt for their valuable comments on earlier drafts of this paper. This review is based on a study of the role of private practitioners in rural districts of Malaysia and their interactions with public health services, funded by Universiti Kebangsaan Malaysia and the Health Economics and Financing Programme, London School of Hygiene & Tropical Medicine. The Health Economics and Financing Programme is supported by the Overseas Development Administration (UK).

Biography

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BMJ 1994;309:1168 (29 October)

Views and reviews

Autumn books: The Fight for Public Health: Principles and Practice of Media Advocacy

Simon Chapman, Deborah Lupton BMJ Publishing Group, pounds sterling 19.95, pp 270 ISBN 0-7279-0849-9

How do you translate the findings of epidemiological studies into policies that actually improve population health? Chapman and Lupton's ambitious efforts to "examine both the why and how of the ways that particular public health issues become prominent and politically actionable in an issue-rich political and news environment" should greatly help. Their strategy is "**media** advocacy" - the use of mass **media** to **influence** public, health policy. Through many case studies, mostly concerning smoking, the prevention of accidents, and gun control in Australia, they show how creative use of the **media** can play an important part in public health campaigns.

There are, of course, powerful forces opposing the potentially positive effects of **media** coverage of health issues. Not least of these is the economic clout of the manufacturers of health damaging products. Threats by tobacco companies to pull advertising from magazines will **influence** the decision to publish articles about the damaging consequences of smoking.

Rich corporations can simply buy plenty of **media** space for their efforts to confuse what are essentially straightforward facts, such as that smoking shortens average life expectancy by several years and (more obviously still) guns are used to kill people. Even more cheaply, a rather sad list of "experts" can be found who will cloud these issues on television or in print. The fact that the central social dynamic of capital is that it is required to make more capital, whatever the consequences, aids the process.

The intrinsic processes of producing news can also act against the goals of public health. It is newsworthy when a few children have apparently been harmed by vaccinations, while the prevention of epidemic childhood diseases, in part by immunisation programmes, receives no coverage at all. Uncommon diseases, of low public health importance, receive an inordinate amount of **media** attention, while the toll from common conditions is, by definition, simply not news. High technology medical breakthroughs, applicable to relatively few people, will produce a better story than the workaday activities of disease prevention.

The ways in which it is possible to win against vested interests within the constraints of how the **media** operate are illustrated extensively in the book's main section, "The A-Z of public health advocacy." BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions) simply changed the messages of posters paid for by the tobacco companies. Thus "Have a Winfield" was changed to "Have a Wank - it's healthier," the Benson and Hedges slogan "Gold is the perfect mixer" to "Cancer is the perfect fixer," and "Marlboro" to "It's a bore." Strategic research can also be used, as was recently shown in Britain by the killing of the "Reg" campaign for Regal cigarettes through a study showing how this appealed particularly to children, against the voluntary code governing tobacco advertising.

As well as these high profile activities, more routine methods of optimising **media** coverage are given. Good interview technique, the use of press releases, the incorporation of props to grab attention, and the involvement of celebrities are discussed.

The only disappointing aspects of the book relate to issues that may be considered outside its intended scope but that should at least be acknowledged. Firstly, there is no discussion of evaluating whether campaigns are successful in the final aim of improving public health. Indeed, John Snow's removal of the handle from the Broad Street pump and hence his stemming of London's cholera epidemic is yet again given as an example of successful public health practice. The epidemic was, however, disappearing, and Snow's action probably had little if any **influence** even though it would have provided a wonderful photo opportunity. The same may be the case today, and some campaigns could be successful at getting television coverage but have no **influence** on health outcomes. Secondly, little attention is paid to the views of the public. A detailed analysis of the often complex ways in which health and disease are popularly conceptualised should be at least as important an aspect of public health advocacy as knowing the fax numbers of a pack of journalists.

The limited impact of conventional health education is shown by the high regard in which it is held by the tobacco companies. A Rothman's spokesperson wrote of "fully supporting sensible and effective public education," and others wrote that "the industry wholeheartedly supported any sensible campaign to discourage school children from smoking." Teaching of health promotion often emphasises that simple educational activities have little effect, without offering any real alternatives. The Fight for Public Health shows that feasible alternatives exist and can even be fun.

G D Smith

HEALTH POLICY AND PLANNING; 12(4): 296–311

Reform follows failure: I. Unregulated private care in Lebanon

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This first of two papers on the health sector in Lebanon describes how unregulated development of private care quickly led to a crisis situation. Following the civil war the health care sector in Lebanon is characterized by (i) ambulatory care provided by private practitioners working as individual entrepreneurs, and, to a small extent, by NGO health centres; and (ii) by a fast increase in hi-tech private hospitals. The latter is fuelled by unregulated purchase of hospital care by the Ministry of Health and public insurance schemes. Health expenditure and financing patterns are described. The position of the public sector in this context is analyzed. In Lebanon unregulated private care has resulted in major inefficiencies, distortion of the health care system, the creation of a culture that is oriented to secondary care and technology, and a non-sustainable cost explosion. Between 1991 and 1995 this led to a financing and organizational crisis that is the background for growing pressure for reform.

Introduction

Many European countries have been or are presently going through a process of reform of the health care sector. The impetus for such reform comes from the inability to control costs, criticism of bureaucratic rigidity, and the impression of getting poor value for money (Dekker 1994). Most attention goes to the supply side, and the reform debate is dominated by a focus on administrative/financial and organizational issues (Oevretveit 1994). There is a characteristic shift towards market-derived incentives in pursuit of micro-economic efficiency (Saltman 1994) and control of expenditure.

Developing countries are increasingly interested in following similar approaches in order to control costs, but also, and this is much more a central issue than in Europe, in order to correct obvious government failures in financing and provision of health care (World Bank 1993). As in Europe, reliance on the private sector and managed markets is supposed to enhance provider efficiency through competition and the substitution of direct management with contractual relationships.

A growing number of developing countries are now embarking on reforms in which contracting out clinical services – and specifically hospital care – is a key element. The speed with which these approaches have been endorsed in development circles is in sharp contrast with the lack of actual experience and empirical evidence for success (Carr-Hill 1994). The do's and don'ts, the approaches that work and those that do not, have not been clearly identified in the industrialized world (Petchey 1995; Saltman 1994), let alone in developing countries. What little evidence there is to date indicates that in developing countries the conditions for successful introduction of such reforms are often not in place (Broomberg 1994). Appropriate regulation technologies and capacities need to be developed. Reforming the health care sector in developing countries is indeed subject to specific constraints that centre around the government's regulatory capacity and the strength of its

bargaining position (McPake and Hongoro 1995). If ultimately reform has to be evidence-based, documentation of present pragmatic efforts is essential.

In most developing countries the original impetus for health care reform comes from a reaction to the government's failure to deliver health care, combined with a crisis in the financing of the health sector. Scaling down public delivery of services and the introduction of private sector competition in the provision of health care with retention of public financing is usually seen as the way to address public sector inefficiencies whilst retaining a tool for ensuring equity (Birdsall and James 1992). Privatization is further to be seen in an ideological context of shift from welfarism to monetarist macro-economics (Price 1989) but, as in the industrialized world, the debate is now moving from ideological positioning to operational questions (Belmartino 1994). In practice, reform mainly addresses urban health care systems where it focuses on introducing purchaser–provider splits so as to induce supply-side efficiency through competition, whilst keeping the State in a monopsonistic power position.

In Lebanon the impetus for health care reform also starts from the recognition of an unchecked growth of expenses for medical care. In contrast with many developing countries, however, it is not a reaction against the government's inefficiency in delivering services. In Lebanon, indeed, the State has only a marginal role in delivering health care, and a purchaser–provider split exists *de facto*. Both ambulatory and hospital care are almost exclusively private. Ambulatory care is essentially provided through private clinics financed through out-of-pocket payments. Hospital care is provided through (small) private (for-profit and not-for-profit) hospitals. For about half of the population, hospital care is covered by private or public insurance schemes. For the rest of the population, it is purchased by the State. Private hospitals are thus heavily dependent on public funding. This arrangement has proven highly inefficient, the absence of self-regulation of the private system being compounded by the absence of adequate public sector regulatory mechanisms and capacities.

This first paper documents how, in a very short time-span, unregulated privatization has created an inefficient and distorted health care system, and a non-sustainable cost explosion. The Lebanese case illustrates the strategic importance of the regulation, planning and policy setting functions of the public sector. It shows that public financing per se, without the institutional capacity and proper attention for the mechanics of regulation, does not provide sufficient leverage to avoid predictable market failures. Although the starting point for the Lebanese health care reform is different from most other developing countries engaging in reform (down-scaling public care provision is not an issue), the question of the regulation of a partly publicly financed private sector is of wider relevance.

Lacking regulatory authority – and essential reliable information – the Ministry of Health (MOH) was forced to adopt a reform strategy wherein the problems of financing of the health sector are not dealt with head-on. Tackling the organizational problems of health care delivery first provided an opportunity for building up alliances and pressure that should allow it to tackle finance at a later stage. A second paper documents the way pressure for reform has built up, and identifies the key elements on the reform agenda (Van Lerberghe et al. 1997).

Health care delivery and the civil war

Once a prosperous, upper-middle-income country, Lebanon declined during the war of 1975–1990. About one-quarter of the population emigrated during these 15 years. A 1992 study, two years after the end of the war, classified 450 000 individuals as displaced (Feghali 1992). This is a very large number considering the relatively small population of the country–approximately 3 million. Reliable demographic figures are politically sensitive and hard to come by: the last population census in Lebanon dates back to 1932. Furthermore there are some 900 000–1 200 000 unregistered foreign workers (mainly from Syria), and some 400 000 Palestinian refugees. Economic activity is picking up fast again following the cessation of internal fighting, and GDP increased from around US$ 1500 in 1992 to around US$2300 in 1994 (different sources mention different figures). In real terms, however, the per capita income is still below the pre-war level.

The war was a period of an accelerated urbanization: 85% of the population now lives in towns. It was also a period of demographic and epidemiological transition. Only 9.6% of the population is younger than five years, as opposed to the 12–13% that is common in the region. Infant mortality increased from 48 per 1000 in 1975 to 57 in the middle of the war, but then dropped to 44 in 1990. By 1992 it was down

to 34, concentrated in a limited number of areas. Preliminary results of the 1996 PAP-Child survey show an infant mortality rate (IMR) of 28 per 1000. Infectious and parasitic diseases are on the decline. The pattern of demand for care is now dominated by chronic diseases and problems related to the urban environment. For example, the most consistent finding in an analysis of the reasons for encounter in health centres in Lebanon was the high frequency of diagnosis and treatment of hypertension and diabetes (Adib 1994).

With a culture of trade and commerce, and delicate religious and denominational balancing acts that determine politics and administration, Lebanon has a strong tradition of individualism, self-reliance and private initiative. The private sector – with private-for-profit (PFP) and community-linked not-for-profit non-governmental organizations (NFP-NGO) – dominates in most fields, including health and education. Although traditionally considered reasonably competent, effective and even an attractive career possibility, public administration in Lebanon has never played a dominant role in the health sector.

Public services in Lebanon were severely affected and weakened by the war (Kronfol and Bashshur 1989). Buildings and equipment were destroyed, looted or damaged. Trained and capable people left the country (Kronfol et al. 1992), whilst those who stayed had to struggle to survive on inadequate salaries. There has been little opportunity for modernization of ideas, skills or style of work. For all practical purposes, the MOH disintegrated during the war. There was no clear policy, no means to implement it, no information to work on. The public health programmes that were active during the war period were donor driven – with major roles for WHO and UNICEF – and channelled through NGOs of various denominations. Considering the circumstances, this proved highly effective; NGOs proved to be highly flexible and able to deliver results – 89% vaccination coverage with an ongoing civil war. The MOH, however, had only a marginal role in all this.

The MOH activities were limited to contracting with private hospitals in order to deal with emergencies. This was in fact a continuation of the policy of contracting-out that already existed before the war, when the government paid the bill for some 40 000 acute care hospitalizations per year in the private sector. During the war, direct involvement of the MOH in direct provision of hospital care became marginal. By the mid-1980s, seven of the public sector hospitals had been destroyed. At some point the public sector could avail of only 200 beds in Beirut. The share of the public sector in national hospital bed capacity thus fell to less than 10% by 1984 (Anonymous 1987). By the end of the war public hospitals had only 700 partly operational beds left of the 1870 they had in the early 1970s.

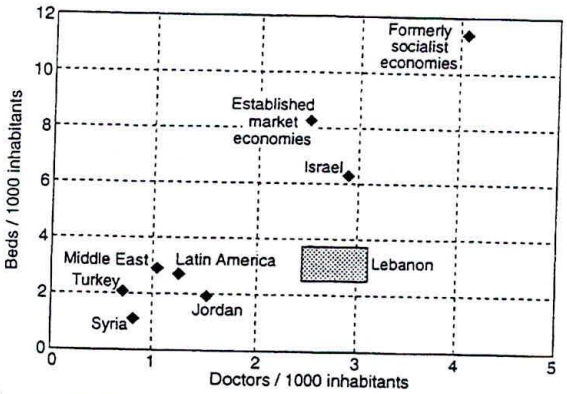
In contrast, the private sector remained very dynamic throughout the war. For example, 56% of the present private hospital capacity was created during the war years. Most of this represented development of business opportunities by private entrepreneurs for whom the war provided fresh investment capital.

But the war was also a period of major expansion for NFP-NGOs. These set up a network of health centres and dispensaries, and carried out public health programmes. Lebanese and international NGOs undertook emergency programmes with the support of donors through financial grants designated for short-term emergency aid. International NGOs expanded from 28 to 171 services. There was also an exponential growth of national NFP-NGOs. These were mainly small-scale organizations, working in underserved rural and urban poverty pockets, with emphasis on Beirut and Mount Lebanon. They focused on emergency relief and humanitarian assistance, rarely on community development work. For example, in the mid-1980s, 43% of their clients were health service and 47% relief assistance beneficiaries (Ministry of Labour and Social Affairs and Norwegian People's Aid 1985). Most NFP-NGOs depended on donations from foreign NGOs and support from political parties and factions. During the war these NGOs gained high visibility and credibility, although many were mere propaganda machines or even fronts for commercial organizations. After the war, however, this credibility was not translated into involvement in planning or policy discussions.

In summary, over the last 20 years the Lebanese health care system has developed in a largely unregulated way, following private initiative and investment. The public sector has been absent, but the country has a NFP-NGO health care delivery network with a public sector logic that has been developed on the basis of the relief operations during the war.

Ambulatory care in private clinics

Private practice has been the main source for ambulatory medical care for the Lebanese. Roughly



*Lebanon ratios are given as a range to take into account uncertainties in the data

Figure 1. Doctor and hospital bed per population ratios in Lebanon and selected other countries*

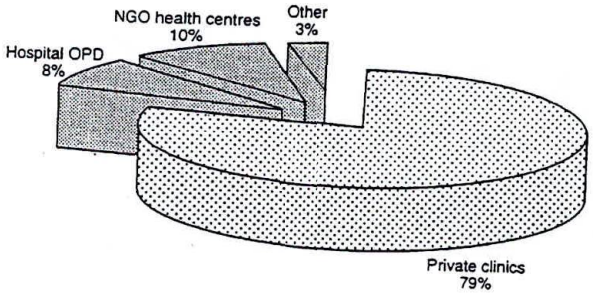


Figure 2. Sources of ambulatory care

one out of five households identifies with one medical practitioner as its 'family physician', very much in a West-European fashion though with less reliance on house calls – less than 5% of contacts are house calls (Abyad 1994; Kronfol et al. 1985).

There is an ample supply of physicians: some 8–9000, i.e. a ratio that comes close to three doctors per 1000 inhabitants. This is higher than most of the rest of the world outside the formerly socialist economies of Europe (Figure 1). The doctor/bed ratio of 0.88 is also among the highest in the world, almost three times that of OECD countries. This relative over-supply of doctors makes ambulatory care a natural career perspective.

Most ambulatory care is provided in private clinics (Figure 2). Hospital outpatient departments capture 8% and health centres, whose number increased spectacularly during the war, have expanded their share to 10%. Most of these health centres are run by NFP-NGOs; the few public health centres and dispensaries offer services of poor quality and are barely used. Health care delivery by NFP-NGOs is strategically important since in many cases their health centres are the only accessible option for the poor. Also, they

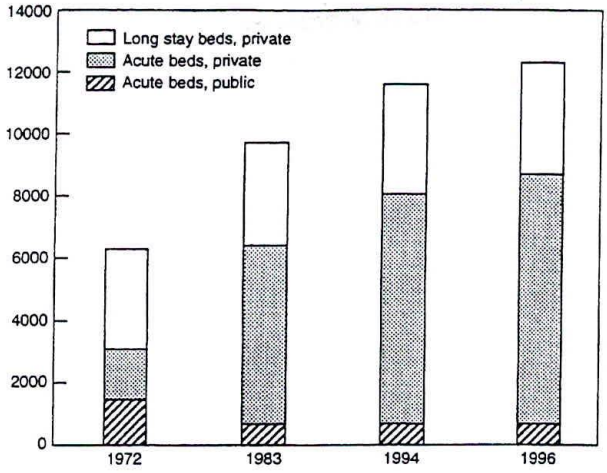


Figure 3. The expansion of hospital bed capacity in Lebanon

remain a key vehicle for programme activities such as vaccination. The set-up of these health centres is very varied and flexible. There are major institutions with lots of staff, various specialities and extensive equipment; others operate out of a rented apartment and offer only essential amenities. Some of these health centres function poorly; others offer services of a better quality level than the average private practitioner – at a lower price to the patient.

On the whole, however, the profile of care offered by NFP-NGO health centres increasingly looks like that of private clinics. This is a consequence of the changes in the environment in which the NFP-NGOs operate. Since the end of the war they have been experiencing growing difficulties in securing funds. Inputs from foreign donors to Lebanon have diminished and the trend has been to redirect funds towards the government. Furthermore, political funding related to the various factions in the war dwindled. Consequently, the importance of ensuring cost recovery became paramount. Since there is an amply supply of physicians, the NFP-NGO health centres can afford to rely more and more on non-salaried part-time physicians: an average of 8.4 per centre. Proceeds of fee-for-service payments are split between the physician and the NGO, for example on a 50/50 or 75/25 basis. The NFP-NGO health centres are thus progressively transforming into an infrastructure that is rented out to private practitioners who carry out the NFP-NGO's mission, but at the same time use the infrastructure to build up a private clientele. This phenomenon has now become so extensive – also in the government health centres – that some of the NGOs are looking for ways to limit the fragmentation of care that is the result of the multiplication of doctors who use the health centres as a recruitment basis.

When not working in a NFP-NGO setting, private practitioners function essentially as individual private entrepreneurs, most often with some specialist label, but without accreditation, control or regulations. There is thus a continuum between health centres and private practice that affects the way both function: practice in most NFP-NGO health centres becomes more 'commercial', while the PFP sector cannot ignore the *de facto* quality standards some of these NFP-NGO health centres are setting.

Hospital care in subsidized private hospitals

There are at present approximately 3.4 beds per 1000 inhabitants in Lebanon (Figure 1), more than in the rest of the region but less than in other countries with similar doctor/population ratios. The number of beds increased both during and after the war (Figure 3).

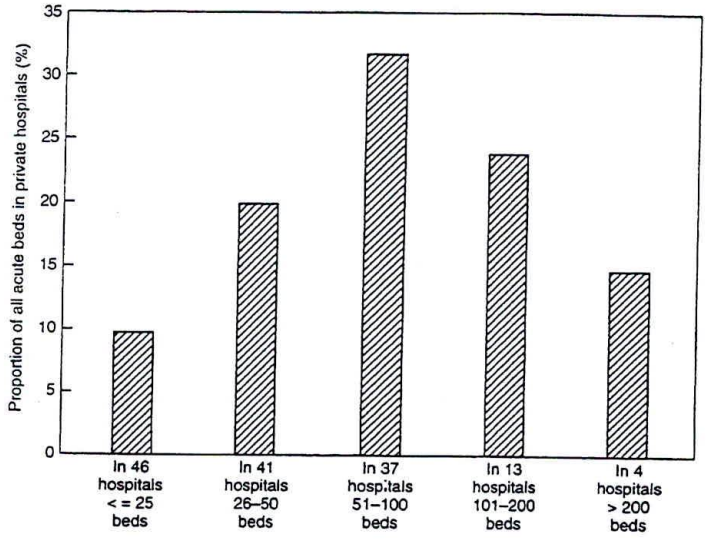


Figure 4. Most acute care beds are in small hospitals: bed share of hospitals of various sizes

More than half of the private hospitals became operational during this period. At the same time the number of public beds shrunk, both in absolute and in relative terms.

The long stay hospitals belong to the NFP-NGO sector. The short stay hospitals belong either to the public sector (6% of the total number of beds), NFP-NGOs (22%) or for-profit (FP) private organizations: individual doctors or groups of businessmen that include doctors. Most of the expansion over the last 15 years took place in the form of small-scale private acute care hospitals: 87 out of 140 have less than 50 beds. Almost one-third of all acute beds are in hospitals of 50 beds or less (Figure 4). On the average, FP-NGO hospitals are smaller than those owned by NFP-NGOs or universities.

In the 1980s, 61% of patients were admitted to voluntary and teaching NFP private hospitals, 37% to other private hospitals and less than 2% to public hospitals (Kronfol et al. 1985). The latter have now become even more marginal; since 1992 the numbers of hospitalizations, outpatient consultations, x-rays, laboratory examinations, etc. have declined by 10–20% each year. Many of these public hospitals now have bed-occupation ratios of less than 5–10%. In the meantime, the smaller PFP hospitals seem to increase their market share. This evolution is linked to the way health care is financed in Lebanon.

Health expenditures in the 1990s

It is extremely difficult to know who spends how much on health care in Lebanon. Data are incomplete and contradictory. The 1992 estimate is of US$ 301 million, i.e. about US$ 100 per person per year (Posarac 1994). Triangulation of information from various sources on 1995 yields a range of between US$ 600–862 million (Table 1): US$ 200–300 per person. Around 60% of expenditures is private money in the strict sense of the word (out-of-pocket and private insurance), while one-third is paid for from public sources (MOH and public insurance schemes, i.e. the National Social Security Fund (NSSF), the army and the Civil Services Cooperative (CSC)).

Obviously the situation is changing very fast, not only in absolute terms (doubling in less than three years), but also as a percentage of GDP. Table 2 shows that in 1992 private health expenditures were at the same level, in terms of GDP, as in established market

Table 1. Who pays the health bill?*

	1992	1993	1994	1995
Public insurance schemes	49.0 (16%)	71.0	-	130.8 (15–22%)
Public funding: MOH	45.1 (15%)	62.8	72.1	98.2 (11–16%)
Lebanese NGOs and international donors	29.0 (10%)	-	-	41.6 (5–7%)
Private insurance	41.6 (14%)	-	-	151–207 (24–25%)
Out-of-pocket	136.4 (45%)	-	-	179–381 (30–44%)
Total	301			601–859

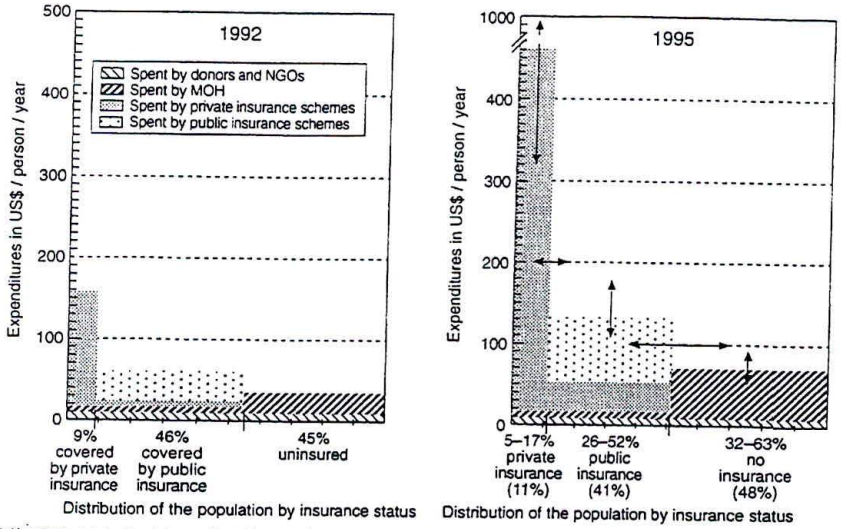
* US$ million; estimates adapted from Posarac 1994 and other sources

Table 2. Public and private expenditures for health (excluding donor assistance), as percentage of GDP

Area	Total (% of GDP)	Public (% of GDP)	Private (% of GDP)
Lebanon (1992 estimate)	4.8	1.6	3.2
Lebanon (1995 estimated range)	6.4–9.1	2.4	3.9–6.6
Syrian Arab Republic	2.0	0.4	1.6
Jordan	3.8	1.8	2.0
Turkey	4.0	1.5	2.5
China	3.5	2.1	1.4
Middle East Crescent (weighted)	4.1	2.4	1.7
Latin America (weighted)	4.0	2.4	1.6
Sub-Saharan Africa (weighted)	4.5	2.5	2.0
Asia (weighted)	4.5	1.8	2.7
India	6.0	1.3	4.7
Established market economies (weighted)	9.1	5.6	3.5

economies, and higher than in most of the rest of the world. Public expenditures, on the other hand, were among the lowest. By 1995, overall health expenditure in GDP terms in Lebanon appears to close the gap with the established market economies; mainly through an increase in private expenditures but also by catching up in public.

Not all these resources are uniformly distributed. Figure 5 shows who paid for whom in 1992 and 1995. NFP-NGO and donor expenditures were assigned to the whole population. MOH expenditures were allotted to the uninsured population, except for the disbursements for cardiac surgery, kidney dialysis and cancer treatment, which benefit the entire population (see below). Expenditures of the various public insurance systems were allotted to the beneficiaries of these systems and their dependants. The same goes for the expenditures of private insurance schemes. No account is taken of the possibility that some may benefit from a number of insurance schemes at the same time. Nevertheless, in Figure 5, 25% of private insurance expenditures are arbitrarily distributed over both privately and publicly insured, to take account of the increasingly common practice of subscribing to complementary insurance. Both expenditure and coverage data are rough estimations, with a considerable amount of uncertainty, indicated by the arrows in Figure 5. This makes a precise interpretation of expenditure levels difficult. With this caveat, the figure nevertheless illustrates present trends in financing.



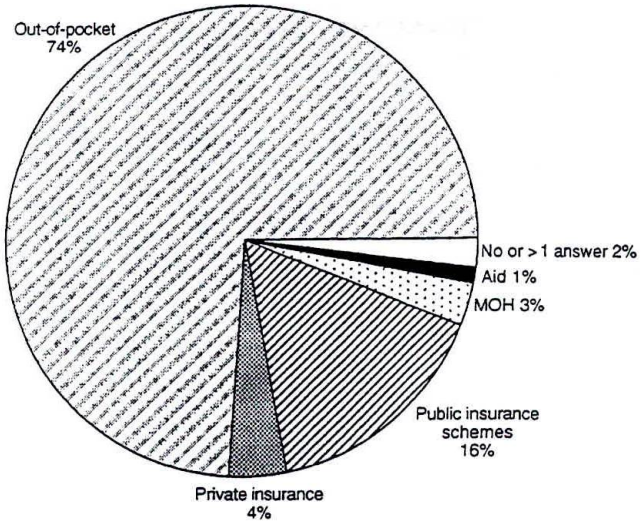
* Abscissa: proportional to number of population covered; ordinate: US$ per inhabitant per year within the coverage group
NB: The arrows indicate the range of uncertainty on expenditures and proportion of population covered. Where relevant, the average of various estimates of expenditure or population coverage has been used.

Figure 5. Non-out-of-pocket expenditures on health per person in Lebanon in 1992 and 1995, according to type of coverage*

Between 5% and 17% of the Lebanese population have private insurance coverage – estimates range widely but there is a consensus that the sector is expanding. If one assumes that private insurance coverage has gone up from 8% in 1992 to 11% in 1995, average non-out-of-pocket expenditure for this part of the population in 1995 was around US$ 460 per person (but may be as high as US$ 950 according to some estimations). Of this, US$ 13.8 was donor money or NFP-NGO expenditure, and the MOH paid between US$ 10–14 (a conservative estimate: the real figure may be significantly higher) in hospitalization costs for cardiac surgery, kidney dialysis and a number of other specific conditions. The rest, over US$ 430 per person in 1995, nearly three times as much as in 1992, was accounted for by private insurance. The latter mainly covers hospitalization, but not exclusively.

Nearly half of the population is covered by one of the three public insurance systems: army, public service (CSC), and employees (NSSF). These insurance systems were created in the 1960s following European models (Kronfol and Bashshur 1989). They more than doubled their expenditures between 1992 and 1995 (Table 1), and now reach around US$ 74 per person per year. About 40% of their expenditures are for inpatient care. People in a public insurance scheme also may carry a complementary (private) insurance (estimated here, rather arbitrarily, to contribute US$ 29 per person), and benefit from MOH (low-end estimate between US$ 10–14) and donor-NGO inputs (US$ 13.8). Total expenditure would then be around US$ 129 per person (with a range of US$ 112–168).

The rest of the population is uninsured. The MOH spent around US$ 55 per person in reimbursements to private hospitals for inpatient care for the uninsured. It does not reimburse them for outpatient care. The only other non-out-of-pocket contribution to financing health care for this part of the population is that of donors and NGOs. Overall non-out-of-pocket expenditures for the uninsured were around US$ 69 (range US$ 58–89) in 1995: more than double the figure for 1992. Setting aside the *de facto*, but



Adapted from Firkh et al. 1996

Figure 6. How people pay for ambulatory care

limited, subsidies by NFP-NGOs, the uninsured have to pay out-of-pocket for all of their ambulatory care.

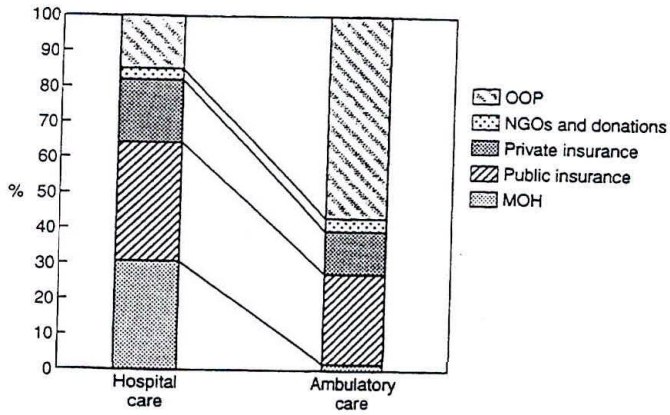
The overall impression is one of an explosion of expenditures that is most marked for the population with private insurance, but touches the rest of the population as well. If coverage for ambulatory care was eliminated, very similar expenditure levels would be expected for both the uninsured and those with public insurance, roughly between US$ 50–70 per person per year; for the privately insured, non-out-of-pocket expenditures are probably well above US$ 300.

Financing

Only one-fifth of the population relies mainly on third party payment for its ambulatory care: 16% through public insurance and 4% through private insurance (Figure 6) (Firkh et al. 1996). Ambulatory care is essentially paid out-of-pocket by 77% of the users. Ten per cent of the population rely on NFP-NGO run health centres where financial barriers can easily be overcome (low fees, possibility of free care); the rest of the population uses the services of (expensive) private practitioners. Out-of-pocket payment is the source of 74% of expenditures on laboratory services, 79% of those on drugs and 92% of those on dentistry.

Ambulatory care (slightly over half of total non-donor funded expenditure in 1992–93) is therefore fairly independent from public funding. Public insurance schemes contributed around US$ 40 million to non-hospital care in 1993. The rest was made up by private insurance, NGOs (whose contribution was estimated at US$ 6 million, probably targeting mainly the uninsured) and out-of-pocket payments. The latter have increased with the expansion of the supply of doctors, whereas the MOH was nearly completely absent (Figure 7).

The situation was very different for hospital care. The share of the public sector in directly providing hospital care is marginal. The State, however, makes use of non-public hospitals through three mechanisms. The first is the various public insurance schemes. These have arrangements to reimburse



*Estimations based on aggregate 1993 data; OOP: out-of-pocket; NGO: private non-for-profit only

Figure 7. How hospital and ambulatory care are paid for*

itemized expenses made at outpatient consultations and for hospitalizations in private hospitals. They are independent from the MOH.

Secondly, the MOH pays, through its budget, for particular categories of treatment (cardiac surgery, kidney dialysis and cancer treatment). A political decision in 1990 led the MOH to pay for such interventions in the private sector for all Lebanese citizens. This now mobilizes between one-third and half of MOH expenditure for reimbursement of inpatient care: low-end estimates range between US$ 10–14 for 1995, up from US$ 8.5 in 1992. It is not known whether beneficiaries of this MOH financing are concentrated among a particular class, or equally distributed.

The final mechanism is contracting with private hospitals that provide for reimbursement of hospitalization costs of the uninsured population. Such treatment in the private sector, paid for by the government, concerned around 40 000 patients per year during the war, and rapidly increased afterwards: 64 200 patients in 1990, 65 800 in 1991, 80 000 in 1992, 90 000 in 1995. The MOH earmarks a number of beds for subsidized patients. Each hospital is graded, and a room rate and tariffs of charges for tests, drugs, use of the operating theatre, etc. are agreed. The MOH has to give authorization for admission – based on a very cursory referral note. After hospitalization of an authorized patient, the MOH will receive an extremely detailed bill, which it has to pay without being able to exercise any control (up to 1993–95) over the justification of the cost items. There are probably no or very few countries in the world that have a billing system that is both as complicated and as uncontrollable as the Lebanese system. Misuse is rife, but although public insurance has in two instances cancelled contract arrangements with hospitals, the MOH has never been in a position to do so.

Almost half of non-donor-funded expenditure is for hospital care. The public sector provides some US$ 12 per person per year for the (affluent) privately insured through reimbursement of heart surgery, kidney dialysis and cancer treatment. It spends US$ 50–60 per person per year for the publicly insured (employees and military with their dependants), and around US$ 55 per person per year for the uninsured. All in all, public insurance and the MOH paid about US$ 80 million for hospital care provided in private hospitals in 1992, and almost twice as much in 1995. The rest came from private insurance and from the users through out-of-pocket payments. In 1992–93, 65% of private hospitals' income came from MOH and public insurance, 18% from four private health insurance schemes and only 15% from

Table 3. Sources of income of four hospitals in 1995

	MOH and public insurance schemes	Private insurance	Out-of-pocket payments
82 hospitals in 1994	67.1%	17.6%	15.3%
Hospital 1, 1995	88.4%	6.1%	5.5%
Hospital 2, 1995	76.1%	16.9%	6.9%
Hospital 3, 1995	46.0%	25.0%	20.0%
Hospital 4, 1995	51.0%	30.8%	18.2%

out-of-pocket payments. Donations account for 3% of their income (Figure 7) (Posarac 1994). A study of 82 hospitals in 1994 (Jurjus 1994) and detailed data on four hospitals in 1995 (Ramaddan 1996) confirm this pattern (Table 3).

Health care delivery, both hospital based and ambulatory, is thus essentially private and unregulated. Ambulatory care has developed outside public financing considerations. Hospitals, on the other hand, depend very much on public financing. Reimbursement of hospitalization expenses by public and private insurance schemes, and by the MOH, has been the motor of the expansion of the private hospitals. Without it, the survival of the smaller hospitals would probably be immediately endangered.

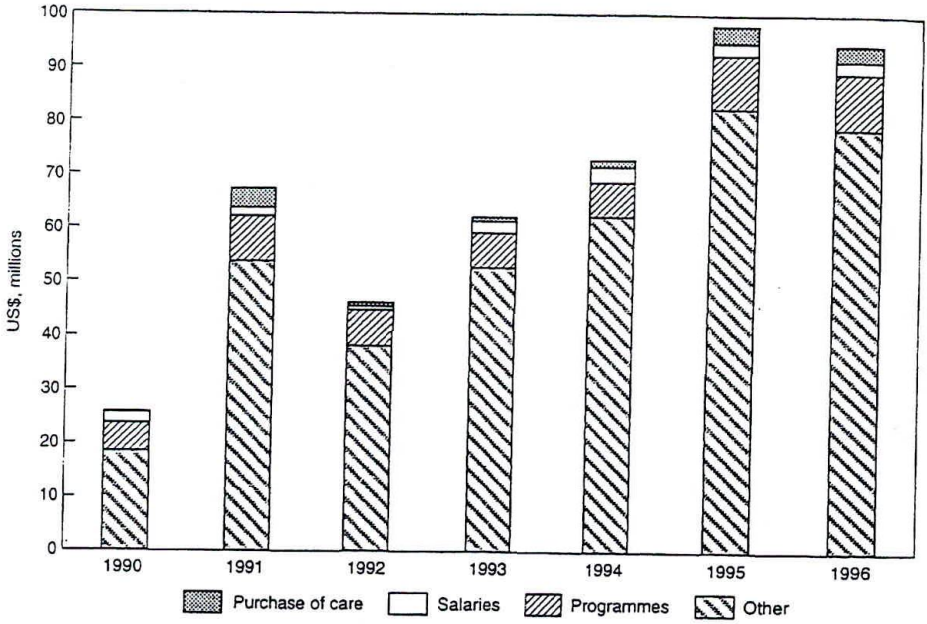
Institutional bargaining capacity

The dependency of private hospitals, and especially of the smaller ones, on public funding should put the MOH in a strong bargaining position. Nevertheless, the MOH has been unable to restrain the growth of the cost of the hospital care it contracts for in the private sector. Hospital care is putting an increasing strain on its budget, as it does on public insurance (Abyad 1994). Before the war, payment of hospital care accounted for roughly one-third of the MOH budget. This then increased considerably, and since the end of the war hospital care has consistently mobilized more than three-quarters of the budget, including salaries. That is considerably higher than the OECD mean share for hospitals, excluding ambulatory care, in total public recurrent health expenditure (54% in the 1980s). Out of 60 low, middle and high income countries (Barnum and Kutzin 1993), only Malawi allocates as high a proportion of recurrent public spending to hospitals. The MOH's reimbursement to hospitals has tended to grow over the years, both in absolute and relative terms (Figure 8). In the 1970s this made up one-third of the MOH budget. Since 1991 hospitals have absorbed over 80% of the budget, peaking at 86% in 1994 – rising from US$ 18.6 million in 1990 to US$ 62.5 million in 1994 and US$ 82.4 in million in 1995. The scope for developing the other activities of the MOH within this budget frame is limited and shrinking.

The MOH is having increasing problems in obtaining the budgets to keep up with the growing requests for reimbursement of private hospital care. Public insurance schemes are also experiencing problems in securing the required government contributions. On the other hand, the MOH is unable to exert the necessary pressure to control the amounts paid to private hospitals, neither through rationing nor through the pricing mechanisms.

In theory Lebanon's MOH could have leverage over what happens in the field of hospital care, through its crucial role in the financing of hospital income (Figure 7). This leverage is, however, limited by the fact that the MOH has no authority over public insurance. It can only use its own inputs and technical authority as a basis for influencing hospital care in the private sector. In practice it has very little effective influence, for technical, administrative and political reasons, and coordination in this matter only started timidly in 1996.

Technically, the asymmetry of information available to the purchaser (MOH and public insurance) and the provider (the private hospitals) makes it difficult for competition, in the form of preferred contracting, to occur. Lebanon's MOH has no inside knowledge on the functioning of the hospital sector. The complexity of the payment mechanism and the absence of adequate technology and trained personnel make it



*1991 expenditures include catch-up expenditures for under-budgeting in 1990; figures for 1996 are budgeted expenditures

Figure 8. Ministry of Health expenditure, in US$ millions, for reimbursement of hospital care in private hospitals, as part of overall MOH budget*

impossible even to identify blatant misuse or inappropriate billing (Kronfol and Bashshur 1989), let alone issue guidelines for standard treatment protocols or costing norms. This deprives the MOH of control over the pricing mechanism, which, as European experience shows, is a critical tool for balancing supply and demand in regulated markets (von Otter and Saltman 1992).

The MOH thus has little information on which to base a regulation or control function. This is compounded by the fact that the MOH budget offers little scope for a personnel policy that would increase its capacity. In terms of purchasing power, the 1994 personnel budget is only 67.5% of the 1990 level. This also represents a shrinkage in relative terms: from 15.3% of the budget down to only 8.9%. With such a budget (an overall average of about US$ 3600 per employee for 1994), it is obviously difficult to retain, and near impossible to attract new, qualified staff, let alone maintain any illusion of setting up a health care provision system based on public sector employed staff. As such, the budget for personnel would be sufficient to hire staff to fulfil a regulatory role. However, this would require the MOH to rid itself of excess staff presently assigned to health care delivery, which is politically difficult. A 50% increase (in US$ terms) in the budget for salaries in 1995 brought purchasing power back to 1990 levels. This, however, does not fundamentally alter the situation, given the administrative constraints on hiring personnel in the public service.

Politically, the MOH is being urged to further promote expansion of hospital capacity rather than regulate it, and to refrain from showing preferences between potential provider-hospitals. The choice of hospitals to be contracted is basically a question of denominational and political considerations. The MOH thus cannot restrict market entry on technical

grounds. When a new small hospital starts activity, it is near impossible for the MOH to impede this, especially since it cannot provide alternative public hospital care possibilities.

Furthermore, non-market pressures and concerns with continuity of care and accessibility prevent hospital closure or stopping of reimbursement arrangements, even when market conditions suggest otherwise. Only once has the NSSF, over which the MOH has no control, had the political clout to stop purchasing care in a hospital for reasons of persistent false billings. In the Lebanese context, where denominational and political balances are all-important, the MOH itself has never been in a position to do this. Even a hospital that constantly overcharges by 60% or more remains contracted by the MOH. Theoretically the MOH has the administrative authority to intervene, but it does not have the technical means or information to make a case. The lack of technical prestige and credibility of a public service that has been absent from health care delivery and policy making for the last decade or more, further weakens its capacity to resist pressure on technical grounds. Both participation in and exclusion from the health care market are thus politically constrained. In such circumstances, it is unavoidable that there is little control over the size of costs, over their justification and over quality of care (Maynard 1991).

Without financial leverage, Lebanon's MOH has even less control over what happens in the field of ambulatory care. Even though there has been a slight improvement over the last five years, the MOH still spends less than 4% of its budget for technical activities and programmes. Primary health care accounted for only US$ 21 000 in 1991. Their share of the budget has since increased to US$ 1 500 000 in 1995, but this remains a marginal amount compared to the bill for hospital treatment. As is the case in the field of hospital care, the MOH does not have technical authority since it has not been a significant actor in health care delivery over the last decades. And its administrative authority is extremely limited and almost impossible to carry through in a context of political interference and delicate denominational balances.

The MOH is thus left with (i) a budget that does not provide enough funds to ensure its own activities, including competitive payment of its personnel; (ii) a growing demand for reimbursement of care provided by private hospitals; and (iii) limited scope for increasing the total budget, or for further cuts in budget lines other than those for reimbursement of private hospital care. In the meantime, the economic and cultural effects of the unregulated expansion of the private sector are becoming apparent.

Incentives for inefficiency and distortion

In the aftermath of the war, the switch from emergency relief to health care delivery was to be based on a self-regulated system of private care providers, fuelled by public funds, where competition would ensure quality of care and affordability. Within five years the assumption that the sector would self-regulate (provide good quality care in an affordable and efficient way) proved false. There is ample anecdotal evidence that technical quality of care is wanting, especially in many of the smaller hospitals. There is no real evidence of growing consumer dissatisfaction as yet, but this can be expected as soon as problems with sustainability become more evident. Indeed, the mechanisms for regulation of the health sector (or rather their absence) act as incentives towards inefficiency and distort rational organization of health care delivery. They promote, and are reinforced by, a specialist-centred and secondary care oriented culture among both professionals and the public.

There are no incentives to expand the private provider's or health centre's responsibility for care beyond that of responding to immediate demand. Continuity of care is absent; for example, less than 2% of the contracts with private practitioners are revisits. Many health centres offer specialist consultations, but, in contrast, leave prenatal care to hospitals. This implies a tendency to medicalize, irrational use of drugs, and reliance on technology at the expense of communication. Hospital pharmacies have an average of 514 different items, up to 8000 in one hospital. Public funds pay for half of the 1.5 million x-ray acts made in Lebanon every year (Jurjus 1994). There are more health centres or private clinics with ECG services than with family planning activities. Little or no work is done in the field of health promotion, such as prevention of smoking. The priority given to kidney dialysis is in contrast with the absence of diabetes programmes (diabetes being the underlying aetiology for over one-quarter of kidney failure patients); the priority given to open heart surgery contrasts with the lack of primary preventions.

NFP-NGOs are presently offering an alternative of reasonably cheap and, in cases of need, free access to care for the poor. They, rather than government services, make up the social safety net for the poor in Lebanon. Their way of operating has led them to accept comprehensive responsibility for the care of certain population groups. This situation is now changing. Since their traditional sources of funding are withering, NGOs increasingly copy the work-style of private practice: exclusive focus on those activities that have immediate income generating potential. The financial predicament of NGOs, combined with a *de facto* restriction of their mission, results in erosion of the social safety net as well as in gradual elimination of examples and models of better practice at primary care level.

These changes are clearly dependent on the absence of public funding to sustain structures accessible to the poor, and on the inability of government to influence or rationalise the way the private practitioners operate. The lack of guidelines and regulation is fuelling prescription patterns that merely respond to demand, without elements of rationalization or constraints other than the patient's ability to pay. This is preoccupying, for example, in the field of treatment of hypertension and diabetes, which was donor-sponsored for the last few years. The government is now contributing US$ 1.5 million per year to this programme, but still without treatment policy guidelines that would make it possible to control rising costs.

The lack of tools or levers for rationalizing ambulatory care is compounded by the type of political and financial incentives for hospital care. Hospitals and first level care in Lebanon are completely unrelated subsystems, both operationally and in the way they are financed. Since quality or cost-effectiveness are not determinants for purchase of hospital care, there is no real competition among hospitals. On the other hand, public subsidy for hospitalization, but not for ambulatory care, results in a *de facto* competition for patients between hospitals and first line services. This distortion carries an opportunity cost in terms of missed possibilities for efficiency gains through a division of labour between complementary first, second and tertiary care levels.

The expansion of the hospital network has taken place in an inefficient way, sacrificing overall sustainability for short-term return on singular investments. The creation of a large number of small private hospitals has resulted in an excess bed capacity in relation to the level of demand, as evidenced by a low bed occupancy (56%, compared to an OECD average of 81%), a short average length hospitalization stay of 4.8 days (less than half of that of OECD countries) (Jurjus 1994) and a hospitalization rate of 13.9 that approaches the OECD median of 16.1. A large proportion of hospitalizations in the small hospitals have no medical justification.

Lebanon now has three times more physicians per inhabitant than the average for the other countries in the Middle East. This can be expected to further fuel the growth of expenditure and the increase in hospital beds: new hospitals are already under construction. Most are so small that economies of scale are difficult. This results, for example, in under-utilization of equipment: CT scans in the smaller hospitals perform only between three and eight (often unnecessary) examinations per day. Kidney dialysis facilities could handle double the present patient load (Jurjus 1994), though the 400 dialysis patients per million inhabitants is already above the OECD median of 360.

Although manpower imbalances (e.g. only 2000 qualified nurses compared to 8–9000 doctors) will make it difficult to sustain proper functioning, hospitals aim for a level of technology that is way above that of many developed countries. The financing structure provides an incentive for the private hospitals to invest in heavy technology, since its operation will be preferentially subsidized by public funds. This has led to very rapid expansion, with little technical or economic justification. There are now five MRI in Lebanon, all located within a few kilometres from each other. At 240 cases per week the total cost can be estimated at US$ 4 400 000 per year: the equivalent of 5% of the MOH budget. There are 27 CT scans, six centres for in-vitro fertilization, and ten centres for litotripsy (Jurjus 1994). The fastest expansion is in cardiac surgery and cardiac catheterization, techniques that are automatically reimbursed by the MOH. Heavy medical technology is now more available in Lebanon than in many industrialized countries (Figure 9). Apart from the expected iatrogenic effects, this expansion of technology will further reinforce a culture of hospitalocentrism and fuel the cost explosion.

These considerable investments gamble on a continued growth of the health care market to ensure returns. Even compared to established market

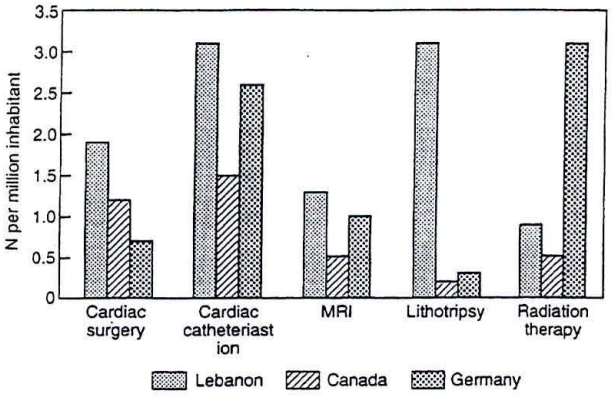


Figure 9. Selected medical technology: availablity in Lebanon as compared to Canada and Germany

economies, however, private expenditures are already high in terms of GDP (Table 2), and public expenditure is growing too fast for the government to sustain. The present predicament is that without proper regulating mechanisms, an unbearable strain will be put on the MOH and social security schemes, whereas rationing or regulating mechanisms would endanger returns on private investment.

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Acknowledgement

Part of this research was supported by a grant of the European Union, General Directorate XII (Avicenne Project), contract ERBAVI* CT93-0012.

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668

HEALTH POLICY AND PLANNING; 12(4): 312–319

Reform follows failure: II. Pressure for change in the Lebanese health sector

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This paper describes how, against a background of growing financial crisis, pressure for reform is building up in the Lebanese health care system. It describes the various agendas and influences that played a role. The Ministry of Health, backed by some international organizations, has started taking the lead in a reform that addresses both the way care is delivered and the way it is financed. The paper describes the interventions made to prepare reform. The experience in Lebanon shows that this preparation is a process of muddling through, experimentation and alliance building, rather than the marketing of an overall coherent blueprint.

Introduction

In the aftermath of the civil war in Lebanon, the health care system was characterized by a very rapid expansion of private health care provision. In the absence of any regulation, this has led to a crisis situation. Private expenditures on health care are already high in terms of GDP (Van Lerberghe et al. 1997), and public expenditure is growing too fast for the government to sustain. Rationing or regulating mechanisms would endanger returns on private investment, and generate strong opposition from interest groups. On the other hand, the strain on the Ministry of Health (MOH) and social security schemes is rapidly becoming unbearable. The MOH is faced with (i) a budget that does not leave enough funds to ensure its own activities, including competitive payment of its personnel; (ii) a growing demand for reimbursement of care provided by private hospitals; and (iii) limited scope for increasing the total budget, or for further cuts in budget lines other than those for reimbursement of private hospital care. In the meantime, the economic and cultural effects of the unregulated expansion of the private sector are becoming apparent.

A first paper (Van Lerberghe et al. 1997) has described how this crisis developed between 1991 and 1995. This second paper documents how pressure for reform built up between 1994 and 1996, and identifies the key issues that, for better or worse, are on the reform agenda today. It is a reconstruction of events and positions in a rapidly changing environment, based on a reconstruction of the sequence of events, document analysis and their (often contradictory) interpretation in discussions with key players. It suffers from the biases of participant observation.

Putting reform on the policy agenda

Recognition of the need for reform usually emerges gradually among various actors with different and often contradictory agendas. It is the work of coalitions, by no means always led by the same groups. The MOH in Lebanon, which initially had a marginal role, has come to have a central position in the health reforms, using an alliance with some of the international organizations present in Lebanon. This is unusual since reform is usually put on the agenda by politicians (Hunter and Stockford 1996), professionals (von Otter and Saltman 1991) or, in developing countries, by the international development agencies, often in the wake of structural adjustment programmes (Okuonzi and Macrae 1995).

This central role for the MOH was possible because the ministry filled a policy vacuum. There is no easily

identifiable leadership in the sector. The actors are extremely diverse and fragmented, and none emerges with recognized authority. Whereas NGOs had prestige and authority during the war, both operationally and in the eyes of the public, this diminished afterwards. Professional organizations play only a limited role, and each private hospital looks after its own immediate interests. Lay politicians in Lebanon are rather indifferent to the organizational structure of health care delivery, or to proposals for change. They look at the health care system basically as one of the tools to help ensure political equilibrium. Ideologically biased in favour of hospitals, technology and private enterprise, they seem unaware of the financial predicament of the health care sector – considered a marginal problem compared to the political and economical challenges of reconstruction. Dissatisfaction with health care delivery is interpreted as an expression of the need for expansion of health care supply (physicians and hospitals), rather than as a need for rationalization and a change in policy and the health care provision model.

The ideological climate in Lebanon clearly favours private sector development, making it difficult to restrain expansion of the private sector hospital capacity or equipment. At the same time, the strategy for economic reconstruction is to be driven by public works. In the case of the health sector this means that the major focus is on hospital construction. Saudi, Kuwaiti and OPEC grant and soft-loan money is presently being used for the construction of seven, and possibly more, new public hospitals. This is clearly done more with a view to creating opportunities for public works than with a health sector development rationale.

Managers within the MOH view the prospect of having to operate these hospitals as a future budgetary and manpower nightmare. They find it difficult to envisage how they will recruit the necessary staff and liberate the operating funds, given (i) the MOH's track record in the operation of existing public hospitals; (ii) the restricted margin for reallocation of funds in a budget tied up by the present system of care purchasing in private hospitals; (iii) the scarcity of nursing staff; and (iv) the already existing hospital over-capacity in the private sector. On the other hand, they see the political necessity to (i) maintain some negotiation power by offering an alternative to the private sector; (ii) be able to deal with emergencies in case of armed conflict; and (iii) be able to refer patients that need secondary level care.

Conflicting agendas within the MOH

The current predicament of the health care sector within the MOH is by no means universally agreed. The main lines of thinking and the influences are schematized in Figure 1.

A first agenda is that of transforming Lebanon into a 'hospital for the Middle East'. In line with the private sector ideology that fuels the reconstruction policies in Lebanon today, this is an agenda that those in the MOH with a political constituency share with lay politicians. It receives support from different groups: political parties, the majority of the private sector medical establishment, interest groups within the MOH and, given the prevailing specialist and secondary care oriented ideology, the public as well. This agenda results in policy options favouring expansion of hospitals and a status quo in matters of regulation and financing mechanisms. It is made possible by the easy availability of both Lebanese and donor capital for heavy investments, and is fuelled by the high short-term returns on investment. A major advantage is that it responds to the political constraints typical for Lebanon. Decisions on hospitals and financing can be used as ways to obtain short-term political goals of maintaining or shifting equilibria within an extremely heterogeneous 'house of many mansions' (Salibi 1993).

The same group also has an agenda of reorientation towards PHC in response to pressure from their constituencies, e.g. for care for chronic patients. On this agenda they are in concordance with those within the MOH who have a more technocratic and managerial outlook. This agenda is supported by part of the medical establishment and academia: family medicine concepts are not dominant but do exist (Abyad et al. 1992). Reorientation towards PHC is also advocated by the NFP-NGOs (not-for-profit non-governmental organizations), and those within the MOH who promote it found allies in agencies like the World Health Organization (WHO) and, at a later stage, the World Bank.

The third agenda is that of control of the financing crisis. For the managers within the MOH the main impetus for reform has come from the budgetary predicament. As of 1992 the consequences of the political decision of unlimited reimbursement of certain types of care had become apparent.

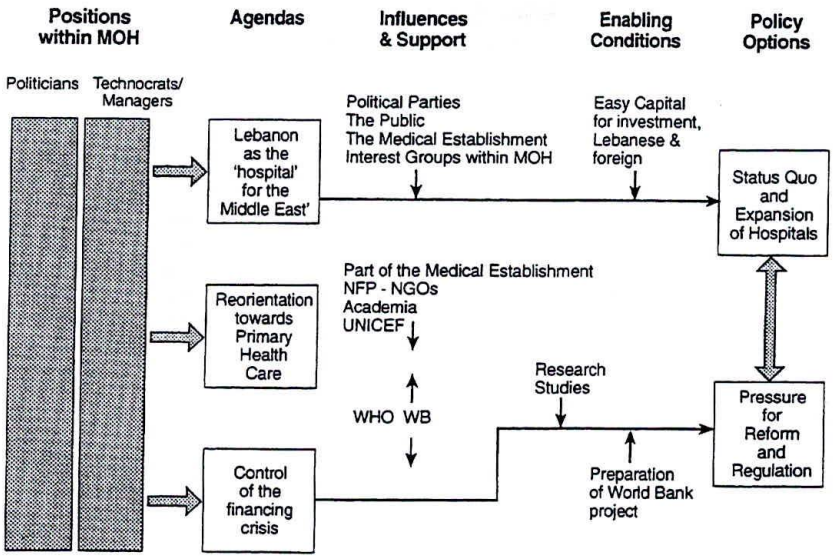

Figure 1. Agendas and conflicting policy directions with the Ministry of Health

This was not, however, the only element. The MOH also wanted to find a new and more rational equilibrium between primary, secondary and tertiary care, and to address the challenges of the epidemiological transition. Furthermore, some of these managers have a strong ideological tradition of public service, reinforced through their links with the NFP-NGOs during the war period. This makes the MOH one of the only organized groups concerned with equity and access, a concern reinforced through its links with WHO and academia.

The fusion of the second and third agenda items, reorientation towards PHC and control of the financing crisis, led to increasing pressure for reform and regulation. The challenge is to do this in a political environment with little awareness of the need and the stakes of reform, and with powerful interests pushing towards the status quo. Part of the private sector, for example, would like to get managerial control of the public insurance funds, as a way of streamlining bureaucracy and guaranteeing subsidies to hospitals.

The major constraint was the MOH's lack of recognized leadership, institutional capacity and authority to put the need for reform on the political agenda and to shape the orientation of the reform (Kronfol and Bashshur 1989). The MOH itself had little technical authority, limited political weight and few qualified professionals. Only a handful had an overview of the problems of the sector and a vision of possible ways out. Much of this had to do with the absence of information on what went on. It is revealing that even senior public insurance management staff are unable to provide a clear image of money-flows, and that the MOH has no updated inventory of health centres or hospitals in the country.

Despite its political and institutional fragility, the MOH has been taking the lead, being the body most immediately confronted with the financial consequences of the evolution of the last five years. For the MOH, both the way health care is delivered (with issues such as the equilibrium between hospital and community care, quality of care, access and equity) and the administrative-financial aspects of regulation, cost-containment and efficiency, were at stake. Very early on its priority option was one of regulation, rather than direct involvement in health care provision. This evolution was made possible by the fact

that the MOH had a better insight into the problems of the sector, which accelerated during the preparation of a World Bank loan for the reform of the health sector.

The need for information and alliances

In the first phase of putting health care reform on the agenda, research and information gathering have played a crucial role. This consisted essentially of documenting the extent of the cost explosion; the efficiencies and contradictions the health care system was heading for; and the extent of the problem of chronic diseases and ill health related to the urban environment. A flurry of research activities, funded through WHO, were contracted out to academic circles, but in close collaboration with the MOH. Besides providing information and evidence for the double agenda of organizational and financial reform, this research phase has had several important spin-offs.

First, knowledge provided the MOH with new leverage. It allowed the MOH administration to make the case for reform and, by the mere fact of knowing the sector, to progressively gain the authority to take a leadership position. Second, it fostered alliances outside the MOH and, within the ministry, a new sense of purpose. Third, this phase – with all the discussions with academia, NGOs and the international scene – allowed the MOH to make a basic strategic choice: it would aim to strengthen its policy-making and regulation functions rather than try to build a public sector delivery system.

This phase of awareness creation went on into 1994 and beyond. From 1994 onwards the MOH used the preparation of a World Bank loan as an opportunity to launch the process of reform. The aim was twofold: reorient the way health care is provided and rectify the financing structure. In order to do that the MOH had to improve its bargaining position and its policy leadership.

In current health sector reforms in industrialized countries the focus is on the pursuit of microeconomic efficiency on the production side, and on the allocation mechanisms that link finance to production (Saltman 1994). Most attempts start by concentrating on economic incentives and the financial operation of the health care system (Oevretveit 1994) in order to respond to fiscal pressure (Beaglehole and Davis 1992). Characteristic of the reform agenda in Lebanon is the sequencing of health care organization and health financing reform. Both are obviously interrelated, but the accent was put on health care reform first (with actual interventions), whilst in the field of financing, actions were limited to the preparation of future macro-level reform proposals.

Hospitals and the way they are financed are clearly at the heart of the problems of cost explosion and distortion of the Lebanese health system. This does not mean, however, that these problems can be tackled head on. The strategic role of public funding provides the MOH, *a priori*, with a good bargaining position towards the hospitals, and should allow it to eliminate major inefficiencies, control costs, and provide incentives for quality assurance. In particular, the smaller, inefficient private hospitals would be very vulnerable to financial incentives and disincentives. But the MOH controls only its own inputs, not those of public insurance, and moreover, although potential and willingness are there, it is too weak technically and politically to enforce changes in the financing structure on its own. There is some margin for controlling costs, and some steps have been taken in 1994–96, but a thorough restructuring requires stronger pressure and alliances.

Such pressure does not come from ambulatory private practice as it functions now. Lebanon has some tradition of family medicine (Abyad et al. 1992) that has been built up in academic circles, but over the last year hospitalocentrism, reduction of ambulatory care and technology consumption have become dominant. Public sector health centres are not a credible alternative, and few or no officials believe that they have the potential to become so rapidly, even with major resource inputs. One of the major impediments to improving quality of care at first contact level, and to using first contact level care as a lever to rationalizing hospital care, is the absence of an organizational model as an alternative to the present situation. For family doctors or general practitioners to put pressure on hospitals, they need first to start working in a different way themselves.

Currently, it appears that influencing the private sector will not be possible through mere financial mechanisms, certainly not in the short term. This would require massive state intervention, which is unrealistic given the budgetary situation and the weakness and lack of authority of the MOH. It will therefore be possible only to work through forms of pressure that are not exclusively dependent on MOH

Table 1. Interventions to prepare reform

Problem area	Interventions	Expected short-term results	Expected medium results
Hospital care: cost and quality	1994 onwards: Control billing and change price structure 1995: Autonomous public hospitals 1995: Feasibility study HMO	→Cost containment	Negotiated contracting conditions: gains in quality and efficiency
		→Regain credibility for public hospitals →Get more options	Ability to negotiate with private sector
First contact level care: quality and access	1993: WHO PHC Report 1995 onwards: Formulate programmes for control of chronic diseases 1995–6 onwards: Contracting NFP-NGO health centres: support in exchange for registration, minimum package and quality care	→Create demand for quality care	Pressure on private practitioners to improve quality
		→Accessible quality care →Capacity to manage responsibility for a defined population	Social safety net Fundholding type pressure in negotiations with hospitals
Regulation capacity	1992 onwards: Studies and research 1994 onwards: Control billing and change price structure 1995 onwards: Institutional strengthening 1996 onwards: Infrastructure coverage planning	→Alliances (especially with with social security system) and expertise	Ability to lead financing reform
		→Tools for regulation →Recognition of leadership and authority	Better control over system Ability to negotiate with private sector
Preparation of financial reform	1996 onwards: focus of studies and research on problems of financing	→Recognition of leadership and authority	Ability to market reform proposals
		→Knowledge on the functioning of the system	Ability to formulate a reform proposal
Pressure for sector reform	Capacity building (human resources documentation, information)	Favourable environment and increased control	Ability to formulate, to lead and to negotiate

administrative mechanisms: pressure from the medical community and pressure from user demand for accessible quality care.

Interventions to build pressure for reform

Pressure for reform in Lebanon built up through a series of parallel and phased interventions rather than through the marketing of an overall plan. A number of interventions were put in place in order to build a capacity, in terms of personnel and knowledge of the system, that would make it possible to create a favourable environment and gain some degree of control over the system. The aim is to provide the MOH with the ability to formulate, lead and negotiate overall proposals for reform. These different interventions are presented in Table 1.

In the field of hospital care, public hospitals became autonomous, and attempts are being made to improve their management. A major stumbling block is the absence of any links with the health centres. A feasibility study on establishing an HMO (health maintenance organization) in a Beirut suburb (Firkh

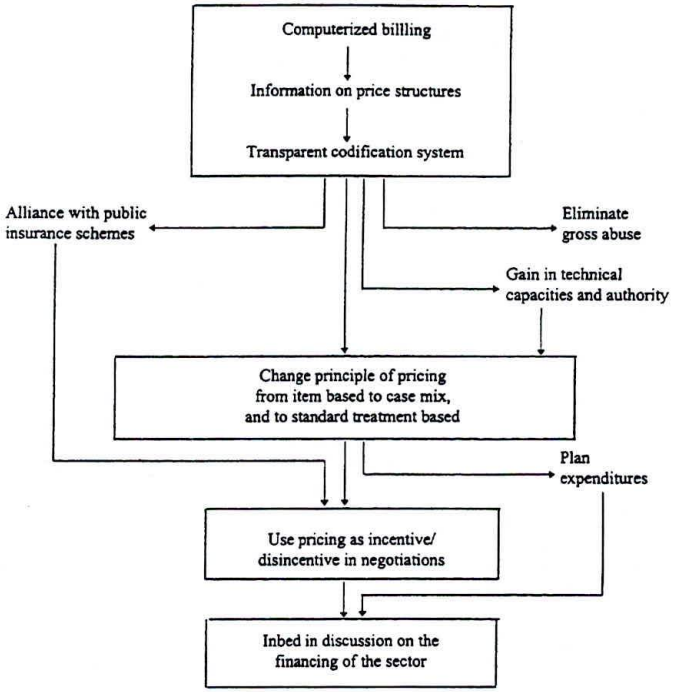

Figure 2. The strategy followed to control billing and pricing of purchased hospital care

et al. 1996) contributed in broadening the range of options that can be considered.

The key intervention, however, was the attempt at controlling the billing and pricing structure of purchased hospital care (Figure 2). Initially, this was a technical response to the budgetary emergency caused by increasing costs of purchasing care in private hospitals. A computerized system was created to allow identification of abuse and misappropriation, to get a thorough knowledge of the cost structure of hospital expenditure, and to transform the principles of reimbursement from an item-by-item to a case-mix basis. This, in turn, must make it possible to introduce elements of rationalization into hospital care (e.g. introduction of day-care) and to improve micro-level efficiency.

Transforming the pricing system requires technologies and capacities that were not available in Lebanon a few years ago but that are now being introduced gradually. It also requires the authority to follow-up on decisions made possible through this regulation technology, and to re-negotiate conditions of purchase of care in rational treatment norms – and despite its lack of authority, the MOH was able to negotiate a 13% rebate on the bills submitted for 1995. This new strategy has been crucial in creating an alliance with the NSSF, over which the MOH has no formal control, for a common position in the negotiation of prices with private hospitals.

A second area of intervention concerns ambulatory health care. The beginning of the 1990s saw the first studies on the health sector and initial attempts to formulate disease control programmes. A further, more radical step was taken in 1995–96, when the MOH negotiated contracts with NFP-NGO health centres. In exchange for logistic support (drugs, training,

equipment etc.) NFP-NGOs are supposed to provide an agreed package of care for their population (Bobadilla et al. 1994), and to introduce quality assurance in a planned way.

With these contractual arrangements the MOH hopes for a triple effect. First, accessible quality care would be assured for the health centre's population. This answers the MOH's preoccupation with maintaining a social safety net for the poorest. Second, providing quality care is expected to enhance demand for quality care, putting consumer pressure on private care providers. A climate of changed consumer-provider expectations would be the best bet for rationalizing health care provided by individual private practitioners. Third, gradual introduction of registration combined with support on a capitation basis would give the possibility of enabling health centres to make contractual arrangements for hospital care for their registered population. These health centres would then have a role similar to that of general practitioner fundholders in the UK or primary care gatekeepers as used by some health maintenance organizations in the USA (Enthoven 1991). Pressure for a rationalization of hospital care would then come not only from the MOH, but also from part of the health care community in the capacity of patient advocates.

With this strategy towards NFP-NGOs, the MOH has a first entry point in the ambulatory care market. An overall strategy towards regulating and rationalizing private ambulatory care is still missing. At this stage it is very much an approach of seizing opportunities and creating a favourable environment. As a strategy, however, starting with the NFP-NGO health centres offers only limited perspectives. NFP-NGO health centres only cater for some 10% of the first level contacts. Fundholding in the UK, however, only covered 3% of practices three years after its introduction, and major expansion was decided when only 15% of practices were enrolled (Petchey 1995). Thus, going by this example, even with a small section of the market it should be possible to wield significant influence.

LL17.6Registration of the population and capitation payment are likely to meet with considerable resistance (Blecher et al. 1995). The technical aspects of the contractual arrangements are crucial to the success of the strategy, and still need to be tested. Politically it will probably be difficult to introduce and enforce performance-linked incentives. Nevertheless, the plethora of doctors is a favourable factor. With the high doctor-population ratio (close to 3:1000; Van Lerberghe et al. 1997), a certain degree of proletarization, or possibly even pauperization, of doctors is likely. This would create a pool of doctors among which the MOH could find candidates for collaboration in a support-in-exchange-for-quality scheme.

The major bottleneck in creating a regulatory capacity and preparing the reform of health sector financing is the lack of institutional capacity and system intelligence. Drastic change is unlikely in a fragmented society such as in Lebanon, where everything is linked; incremental change, on the other hand, would not produce results without a strong sense of direction. The MOH has had to develop and provide that sense of direction.

The interventions concerning hospital and ambulatory care have provided the MOH with a first set of instruments to initiate sector regulation. In order to capitalize on the first successes, the MOH has had to recruit new, technically qualified staff, mainly with an NGO or academic background. These new recruits have brought technical expertise and a new managerial culture. There has been visible progress in streamlining MOH administration and in its performance in monitoring, evaluation and planning. Combined with the alliances the MOH has created during the research and documentation efforts of the first half of the 1990s, this accelerated modernization is starting to pay off. The MOH now has the best, if still very inadequate, knowledge of the situation. It is now technically capable of commissioning and leading studies that give an insight into the national health accounts, health expenditure and provider patterns. This increased system intelligence does not mean that the MOH has the capacity to plan and implement a comprehensive reform, but it is now in a position to mobilize pressure for reform and to push its own public sector agenda.

Seizing opportunities to prepare for reform

The strategy of the MOH is not merely one of muddling through (Bennet and Holland 1977; Lindblom 1959), but rather of seizing opportunities to make headway where progress or experimentation is possible. The major weaknesses of this approach are that there is as yet no clear view on the future of health sector financing and no vision of how to restructure ambulatory care. Delay in tackling the financing issues is also the major criticism made by the international community. This weakness, however, may

be the strength of the MOH strategy: the groundwork is being done, and there is time for experimentation and analysis. There will thus be less risk of importing ready-made solutions which are not adapted to the Lebanese situation. This is turn will increase chances that reforming health sector financing will not merely aim at cost containment, but will actually improve health care delivery. More important still, especially in Lebanon's fragmented society, there is time for creating the necessary alliances. By the time there is an overall vision of reform, not only of health care but also of the sector's financing, the balance of power will have changed.

The key issue in the Lebanese health crisis is that of the role of the public sector. Before the war this was limited to purchase of hospital care and lip-service to providing universal access (Hayek 1980). With the war, there has been the implosion of the MOH and the expansion of the private sector, presenting a situation which is becoming untenable: the extent of the problem in financing the present system is now such that it is increasingly difficult to justify further expansion for mere reasons of political equilibrium. It seems clear now that the public sector in Lebanon will remain a marginal health care provider but that there is some scope to redefine its role in financing and regulating the sector. There is thus hope that elements of public sector rationality will be injected into what is now, still, essentially a seller's market.

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Acknowledgement

Part of this research was supported by a grant of the European Union, General Directorate XII (Avicenne Project), contract ERBAVI*CT93-0012.

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SECTION – A : RESULTS OF THE FIRST ROUND

Total Questionnaire sent : 130

Total responses received: 64 (49 %)

Total responses analysed as on 26th December - 59
(The rest of the responses were received after the analysis was done They would be included in the final Analysis. A quick look at them suggests that their inclusion is not likely to change the results)

Age Distribution : (Range 28 yrs to 72 yrs)

< 35 yrs	6
35-44 yrs	16
45-54 yrs	23
54+ yrs	14
	59

Gender: 7 females and 52 males

Job profile:		**Sector**	
Academic	30	Government	32
Administrative	21	Private	7
Others	8	NGO	10
		Others	10
	59		**59**

Level:		**Zone**	
Community	12	North	18
State	15	South	23
District or below	3	East	3
Centre	10	West	9
Medical College	14	Central	3
International	5	International	- 3
	59		59

Health Priorities:

The **top three priorities** identified based on the proportion of people identifying it as one of the priorities were

1. Improving the quality of services under the primary health care - 75%
2. Improving medical education to suit country's requirement - 36%
3. Setting up a disease surveillance system - 28%

The issues that were accorded least priority were

1. De-linking public health and hospital services at all level and
2. Creation of separate public health cadre in the health ministry. – 55%
3. Creation of regulatory mechanism for private sector – 33%
4. Instituting cost recovery mechanism in health sector – 33%

Now, let us look at the section wise comments. In all ten sections were there. Each section has two subsections. First sub-section gives the actual results and the second has our comments. These comments are based on the above data and the perusal of the open ended comments given by you)

I. Medical Education : While 71% of the respondents opined that Government should not open new medical colleges, 56% of them were of the opinion that medical colleges should not be opened even in Private sector. Regarding the subsidy in medical education, the group was almost vertically split with 42% in favour of and 49% against the subsidy. Almost 60% opined that medical education should be subsidized only for those who opt to work in government sector or in rural areas. 85% of respondents were dissatisfied with the undergraduate medical curriculum

Comments:

1. Opinion seems to be against opening any medical college, both in private and public sector.
2. While the group was divided on the issue of subsidy in medical education, the opinion seems to be that the subsidy has to be recovered by making the graduates work in the government sector or rural areas, if necessary, by a bond.

3. Medical education system came under severe criticism. Some people appreciated the recent initiatives of MCI, but felt more needed to be done. The issues identified in the open section mainly pertained to

3.1Selection criteria – caste based reservations/ need for merit/ assessment of aptitude
3.2 Upgrading the PSM/ Community medicine/public health content in the curriculum, coupled with a better "status" for the subject.
3.3 More skill based teaching and assessment rather than theoretical foundations.

II. Public Health Administration : Only 36% believed that Water supply should be a part of Health ministry. Majority (75%) opined that there is no need for a separate division of Family Welfare. An overwhelming 81% of the respondents felt that , it should be made mandatory for government doctors to serve in rural areas for a fixed period of service. However, 90% also felt that these people should be given major incentives in terms of better pay scale (even 20% higher basic pay) and preference for higher education. 58% of the respondents did not believe that curative and public health services should be separated at all levels. However 60% believed that within the Ministry, there should be a separate public health cadre and DGHS should be selected from them.

Comments:
1. Need for Integration between Family Welfare and Health Division in the Ministry was strongly felt.
2. Most people believed that government doctors should be made to work in the rural are and major incentives should be given for the same.
3. There was a strong opinion that all people in ministry or in posts that deal with public health (rather than hospital) should have formal training in Public Health.

III. Health Care Delivery System: The opinion on the performance of the current health care delivery system was almost equally divided. Majority (64%) agreed that campaign approach affects the heath services, its need was not doubted by 72% of the respondents. The house was divided with roughly 45% vote on either side for the need for vertical health programs in the country.. 78% believed that Health workers should carry out domiciliary visits.

Comments:
1. Most people seem convinced that theoretically, horizontal programs and routine health care delivery systems are needed. However, their confidence in the system to actually deliver seems to be not that great. Thus, they feel that campaign approach as well as vertical programs do have place. These measures should be restricted to major public health problems so that some immediate impact of control measures is seen,

IV.Investing in Health and role of Subsidy : About three fourths of the respondents believed that the government should focus only on the primary and secondary level health care and 51% believed that Government should invest in tertiary level hospitals

while 44% did not agree with this. Most of them (82%) were of opinion that health services should not be provided free of cost. About 70% felt that partial cost recovery mechanism could be instituted at primary level, 72% for full cost recovery at secondary level and 55% at tertiary level with the caveat that really poor patients should be exempt.

Comment:

1.There seems to be consensus that health services should not be provided free, even at primary level, some cost recovery mechanism can be instituted – like fee for registration. The level of cost recovery from primary to tertiary could be graded one.

2.The need for cost recovery was justified on two grounds:

i. Payment of certain amount would result in better valuation of the government services by the public.

ii. The resources recovered by this procedure should be used for improving the quality of services.

3.However, it was also felt that some objective criteria for "really poor" should be made and strictly enforced – free of unwanted influences.

V. Health Insurance : Two thirds of the respondents believed that introduction of insurance would increase in health care costs. Only 53% believed that poor would protected from the higher costs. 60% opined that introduction of insurance would reduce the burden on the public sector, the role of private insurance companies was not looked upon favourably by 65% of them.

Comment:

1. The need for insurance as a protective measure was accepted by most. However, the major fear was that the insurance would not really help the " actual poor " , as they may not be able to pay the premium as well. The insurance would probably protect the middle class only. What would probably be a better way out was the need for community based insurance which is locally managed.

VI. Role of Multipurpose Workers: Two thirds of the respondents believed that MPWs should be given a curative role, while 76% believed that we have no other choice, as the reach of other health personnel is very poor. Almost 50% agreed that the quality of curative services by the workers was better than the "quacks" who are practising in the rural areas. The need for better training of the MPWs with an upgradation of their status was very strongly felt (88%). 56% of the respondents also believed that we should have a three year medical course. 74% believed that the Male MPWs should be retained.

Comment:

1. It is quite clear that we have no choice but the MPWs , for the delivery of health care in rural areas and to some extent in urban slums. Therefore, we need to greatly improve their training and skills..

2. There appears to be schism in the role of MPWs in the system. Traditionally, a predominantly promotive and preventive role was envisaged for MPWs. To this subsequently curative role has been added, mainly due to lack of any alternatives. While for the first they require mainly communication skills, for the later they require more technical skills. The scheme seems to have fallen between the two stools. Currently, they neither have sufficient communication skills, nor adequate technical skills.
3. It was also felt that their adequate supervision was the weakest link in the chain with Medical Officers of the PHCs failing in this aspect.
4. There is a clear need for a complete overhaul of the system from training needs to their status in the health system hierarchy

VII. Community Participation: Three fifths of the respondents believed that it was a good idea to have PHCs under Local Self Governments (LSGs). 83% believed that we should involve LSGs in PHC/CHC management. However, the respondents were divided (43% on each side) over doctors being accountable to them. It was felt by 60% of the respondents that the community volunteer scheme has failed. 51% agreed that we should focus on other developmental issues like education.

Comments:

1. The consensus seems to be that community participation should be welcome and it is time that the health sector made them equal partners. Without their involvement, it is difficult to make much headway.
2. However, it was also felt that the Panchayats and other LSGs are not yet ready to take upon this role. There is still too much unwanted influence on them and therefore, doctors should not be made accountable to them.
3. There is a need to carry out training activities for the local leaders on health related issues so that, they appreciate the issues involved in decision making.
4. It was also felt that the failure of the Community Health Volunteer scheme was more because of poor implementation rather than a failure of the concept.

VIII. Private Sector: 70% of the respondents felt that NGOs and Private sector should be allowed to adopt communities on a large scale. An overwhelming majority believed that there should be a formal interaction between a Government Hospital and private practitioners working in that area. 90% believed that Government should take tough steps to ban the practice of unqualified practitioners of medicine. 50% believed that we should carry out training of unqualified practitioners. The need for an accreditation system for both private and public sector was thought to be equally important by an overwhelming majority of the respondents.

Comments:

1. An important role of private sector was envisaged by most. However, it should be restricted to qualified people only. But knowing the realities of India, they also felt that this may not be possible to implement. Therefore, we should train the existing practitioners, irrespective of qualifications.

2. The need for government hospitals to regularly interact with the private practitioners was very strongly felt. This way it could serve both the training and the monitoring needs of the private sector.

IX. Modern Technology : 78% agreed that increasing use of modern technology is a welcome step. However, 93% believed the inappropriate use of this technology has increased the health care costs. 72% felt that, as a step towards making this technology available to all, Government should invest in modern technology. Half of the respondents believed that doctors of Indian System of Medicine should be posted at PHCs.

Comment:

1. The need for investing and using modern technology in health care was strongly felt by majority of the respondents. However, they felt very strongly that there should be some control over the use of technology. Most of them suggested an independent body at central and local levels for deciding on policy of allowing the use of newer medical technologies based on some objective assessment.
2. Included in this was issue, related to Indian System of Medicines. Majority felt that they should be encouraged. Though as a trial such facilities should be provided at CHC level rather than at PHC level.

X.Others: 69% of the respondents disagreed that we should close the national level institutions. 61% felt that the priorities identified by the international agencies were not the real needs of the country. 85% felt that a Disease Surveillance system should receive top priority. 67% felt that even Government Institutions should be brought under Consumer Protection Act (COPRA). Only 36% agreed that our health services have focused on MCH services at the cost of others.

Comment:

1. The consensus seems to be that the national Institutions have not really performed well. Though, this does not mean that they do not have a role but that they should be strengthened.
2. The Disease Surveillance system should receive top priority was also reflected in the list of priorities.

Areas of Consensus: (defined as ≥ 75% responses)

1. Improving the quality of Primary health care services
2. Reassessing the role and the training needs of MPW
3. Increasing community participation at local level
4. Revamping the medical education for the country's needs
5. Making rural posting compulsory for government doctors with a concomitant incentive in remuneration
6. Instituting Cost recovery systems in Government sector
7. Formal channel of Interaction between Government hospitals and private doctors in that area
8. Practice by "Unqualified " practitioners to be banned
9. Setting up an Independent body for assessment of introduction of technology at various levels.
10. An accreditation system for both Government and private hospitals
11. COPRA to cover both private and government hospitals
12. Setting up an disease surveillance system

Areas of Clear Discord (defined as both sides having > 35% responses)

1. Subsidy in Medical Education – Whether it should continue or not
2. Role of vertical versus horizontal programs
3. Training of Unqualified practitioners
5. Water supply to be part of Health Ministry
6. Health Insurance's role in protecting the poor from the medical costs
7. Doctors being accountable to Sarpanches/ Zila Parishad Chairman etc.
8. Too much focus on MCH services

Name:

Section – B – Your Response needed

1. You have read the report. You may have had your own priorities, Now that the group has identified the priorities, we want that you should respond to the list. Whether you agree or not, we are interested in receiving your comments. If you agree, please write very briefly why you agree and if you do not, then why not? Please restrict your comments to the box provided

1.Improving quality of services under the primary health care
2. Improving medical education to suit country's requirement
3. Setting up a disease surveillance system

2. We would now like you to please give three most important steps that needs to be taken in order to achieve these objectives.

1.Improving quality of services under the primary health care
2. Improving medical education to suit country's requirement
3. Setting up a disease surveillance system

THANKS FOR RESPONDING AGAIN.

Com H-49.

CENTRE FOR COMMUNITY MEDICINE
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI

20TH January 20001

Dear Colleagues,

We take this opportunity to wish you all a **HAPPY NEW YEAR 2001.**

It gives us great pleasure to share with you the results of our first round of Delphi Survey on "Health priorities for India". This was possible entirely due to the response from all of you. We received responses from a wide range of people from academicians to grassroots workers, from local NGOs to International agencies.

We are aware that you would be very keen to go through the report. It would be obvious from the report that we need to go further than what we did in the first round. Some areas have been identified where we would like to probe more deeply and request you to respond again. We would be eagerly awaiting your responses as you so wonderfully did in the first round.

We hope to share the results of the full survey including the second survey during the Indian Public Health Congress to be held in Delhi in mid April 2001. We have written to them in this regard. We therefore, request you to kindly respond at the earliest so as to give us time to analyze the data for presentation. We look forward to receive your responses by 28th February. As always, your contribution will be duly acknowledged.

Thanking you in anticipation,
With Warm Regards.

Dr. K. Anand Dr. S.K. Kapoor Dr. C.S. Pandav

Enclosure : Section – A : Results of the first round
Section – B : Questions for the second round

TO: SKK

(790) 30/01/01

DES NO. 42/1990

GOVERNMENT OF KARNATAKA

STATISTICAL ABSTRACT
OF
KARNATAKA
1983-84

DIRECTORATE OF ECONOMICS AND STATISTICS

BANGALORE

XXVIII - PUBLIC HEALTH

Table No. 28.1 HOSPITALS AND DISPENSARIES BY MANAGEMENT, 1979 - 84. (contd..)

(in No.)

Year/ Division/ District	State Government				Central Government		E.S.I.	
	Hospitals	Primary Health Centres	Subsidiary Health Centres +	Primary Health Units	Hospitals	Dispensaries	Hospitals	Dispensaries
1	2	3	4	5	6	7	8	9
1979-80	140	269	-	1152	11	13	2	106
1980-81	137 @	300	-	1215	11	13	2	106
1981-82	136 @	305	-	1274	11	13	2	106
1982-83	137	315	50 +	1244	11	13	2	106
1983-84	137	328	50	1303	11	13	2	106
1983-84 :								
I. BANGALORE DIVISION:	32	92	9	446	7	4	1	62
1. Bangalore	12	24	2	113	5	2	1	50
2. Chitradurga	4	16	2	82	-	1	-	5
3. Kolar	9	18	4	79	2	-	-	4
4. Shimoga	5	14	-	87	-	1	-	2
5. Tumkur	2	20	1	85	-	-	-	1
II. BELGAUM DIVISION:	27	87	13	257	1	-	1	15
6. Belgaum	4	25	2	78	-	-	-	7
7. Bijapur	6	23	3	66	-	-	-	1
8. Dharwad	11	26	6	72	1	-	-	6
9. Uttara Kannada	6	13	2	41	-	-	1	1
III. GULBARGA DIVISION:	21	64	13	181	1	-	-	11
10. Bellary	11	13	2	42	1	-	-	3
11. Bidar	3	11	3	32	-	-	-	-
12. Gulbarga	4	22	7	56	-	1	-	5
13. Raichur	3	18	1	51	-	1	-	3
IV. MYSORE DIVISION:	57	85	15	419	2	3	-	18
14. Chikmagalur	5	11	4	62	-	-	-	-
15. Dakshina Kannada	12	19	3	93	-	1	-	9
16. Hassan	4	13	4	78	-	2	-	1
17. Kodagu	22	6	-	11	-	-	-	-
18. M	2	13	2	70	-	-	-	1
19.	12	23	2	105	2	-	-	7

Note : @ Decrease
and 1981-
+ 50 PHUs.
strenght
* One Hospit

Source: Directorate
Karnataka,

Table No. 28.1 HOSPITALS AND DISPENSARIES BY MANAGEMENT, 1979 - 84. (concld..)

(in No.)

Year/ Division/ District	Other Departments		Private Organisations		Total	
	Hospitals	Dispensaries	Hospitals	Dispensaries	Hospitals	Dispensaries
1	10	11	12	13	14	15
1979-80	37	85	13	11	233	1636
1980-81	40	85	13	11	233	1730
1981-82	41	85	13	11	233	1794
1982-83	40 *	65 *	13	11	233	1804
1983-84	40	65	13	11	233	1876
1983-84 :						
I. BANGALORE DIVISION:	33	25	13	4	86	642
1. Bangalore	32	13	8	2	58	206
2. Chitradurga	-	1	-	-	4	107
3. Kolar	-	1	4	2	15	108
4. Shimoga	1	10	1	-	7	111
5. Tumkur	-	-	-	-	2	107
II. BELGAUM DIVISION:	2	21	13	-	44	373
6. Belgaum	-	6	5	-	9	118
7. Bijapur	1	2	1	-	8	93
8. Dharwad	1	3	5	-	18	113
9. Uttara Kannada	-	10	2	-	9	67
III. GULBARGA DIVISION:	2	5	2	3	26	283
10. Bellary	1	3	-	-	13	67
11. Bidar	-	1	1	1	4	48
12. Gulbarga	1	-	1	1	6	92
13. Raichur	-	1	-	1	3	76
IV. MYSORE DIVISION:	3	14	15	4	77	558
14. Chikmagalur	-	2	-	-	5	79
15. Dakshina Kannada	-	1	6	3	18	129
16. Hassan	-	-	3	-	7	98
17. Kodagu	-	8	4	-	26	25
18. Mandya	2	2	-	-	4	88
19. Mysore	1	1	2	1	17	139

Note : @ Decrease in No. of State Government Hospitals During 1980-81 and 1981-82 is due to the fact that they were taken over by other depts + 50 PHUs. Were upgraded as subsidiary health centre (Along with the bed strenght) during 1982-83.

* One Hospital & 20 Dispensaries were taken over by the State Government.

Source: Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.2 MEDICAL INSTITUTIONS IN RURAL AND URBAN AREAS, 1979 - 84. (contd..)

(in No.)

Year/ Division/ District	Hospitals				Dispensaries			
	Government		Private		Government		Private	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
1	2	3	4	5	6	7	8	9
1979-80	33	157	14	29	49	155	7	4
1980-81	33	157	14	29	49	155	7	4
1981-82	33	157	14	29	49	155	7	4
1982-83	33	157	14	29	49	135 +	7	4
1983-84	33	157	14	29	49	135	7	4
1983-84 :								
I. BANGALORE DIVISION:	1	72	-	13	15	76	1	3
1. Bangalore	-	50	-	8	7	58	1	1
2. Chitradurga	-	4	-	-	-	7	-	-
3. Kolar	1	10	-	4	2	3	-	2
4. Shimoga	-	6	-	1	6	7	-	-
5. Tumkur	-	2	-	-	-	1	-	-
II. BELGAUM DIVISION:	5	26	3	10	18	18	-	-
6. Belgaum	-	4	3	2	7	6	-	-
7. Bijapur	-	7	-	1	2	1	-	-
8. Dharwad	4	9	-	5	-	9	-	-
9. Uttara Kannada	1	6	-	2	9	2	-	-
III. GULBARGA DIVISION:	1	20	1	1	3	19	3	-
10. Bellary	1	9	-	-	3	7	-	-
11. Bidar	-	3	-	1	-	1	1	-
12. Gulbarga	-	5	1	-	-	6	1	-
13. Raichur	-	3	-	-	-	5	1	-
IV. MYSORE DIVISION:	23	39	10	5	13	22	3	1
14. Chikmagalur	-	5	-	-	2	-	-	-
15. Dakshina Kannada	1	8	4	2	2	9	2	1
16. Hassan	-	4	2	1	-	3	-	-
17. Kodagu	11	8	3	1	5	3	-	-
18. Mandya	2	2	-	-	3	-	-	-
19. Mysore	3	12	1	1	1	7	1	-

Table No. 25.2 MEDICAL INSTITUTIONS IN RURAL AND URBAN AREAS, 1979 - 84. (concld..)

(in No.)

Year / Division / District	Primary Health Centres Subsidiary Health Centres and Primary Health Units	
	Government	
	Rural	Urban
1	10	11
1979-80	1255	166
1980-81	1348	167
1981-82	1409	170
1982-83	1419	170
1983-84	1491	169
1983-84 :		
I. BANGALORE DIVISION:	474	73
1. Bangalore	103	36
2. Chitradurga	89	11
3. Kolar	90	11
4. Shimoga	94	7
5. Tumkur	98	8
II. BELGAUM DIVISION:	317	49
6. Belgaum	93	10
7. Bijapur	80	12
8. Dharwad	90	14
9. Uttara Kanpada	52	4
III. GULBARGA DIVISION:	233	23
10. Bellary	47	10
11. Bidar	44	2
12. Gulbarga	79	6
13. Raichur	63	7
IV. MYSORE DIVISION:	467	52
14. Chikmagalur	70	7
15. Dakshina Kannada	113	2
16. Hassan	90	5
17. Kodagu	13	4
18. Mandya	75	10
19. Mysore	106	24

Note : + Reduction as a Consequence of taking over of 20 Dispensaries run by 'Other Departments' by State Government.

Source: Directorate of Health & Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.3 BED STRENGTH IN HOSPITALS ETC., 1979 - 84. (contd..)

(in No.)

Year/ Division/ District	State Government				Central Govt. E.S.I.		Other Dept.	
	Hospitals	Primary Health Centres	Subsidiary Health Centres	Primary Health Units	Hospitals	Dispensaries	Hospitals	Dispensaries
1	2	3	4	5	6	7	8	9
1979-80	20068	2552	-	2023	1730	438	1031	328
1980-81	19830	2744	-	2023	1730	138	1269	328
1981-82	19099	3003	-	2436	1730	138	2154	328
1982-83	19490	3226	107	2531	1730	438	2109	126
1983-84	19607	3342	123	2798	1730	438	2109	126
1983-84 :								
I. BANGALORE DIVISION:	7325	1275	2	837	1472	414	1975	16
1. Bangalore	4015	325	-	244	1170	414	1825	-
2. Chitradurga	1420	306	-	94	-	-	-	-
3. Kolar	878	281	2	103	302	-	-	-
4. Shimoga	625	136	-	205	-	-	150	16
5. Tumkur	387	227	-	191	-	-	-	-
II. BELGAUM DIVISION:	3413	644	28	687	137	24	56	96
6. Belgaum	830	174	-	192	-	-	-	27
7. Bijapur	601	212	-	176	-	-	32	-
8. Dharwad	1655	180	28	169	137	-	24	32
9. Uttara Kannada	327	78	-	150	-	24	-	37
III. GULBARGA DIVISION:	2591	416	18	534	25	-	46	-
10. Bellary	1294	108	-	41	25	-	26	-
11. Bidar	308	66	6	89	-	-	-	-
12. Gulbarga	774	132	-	294	-	-	20	-
13. Raichur	215	110	12	110	-	-	-	-
IV. MYSORE DIVISION:	6278	1007	75	740	96	-	32	14
14. Chikmagalur	428	134	18	74	-	-	-	-
15. Dakshina Kannada	1569	162	39	68	-	-	-	12
16. Hassan	582	98	10	243	-	-	-	-
17. Kodagu	1142	104	-	-	-	-	-	-
18. Mandya	350	171	8	234	-	-	26	8
19. Mysore	2207	338	-	121	96	-	6	-

Source: Dire
Kar.

Table No. 28.3 BED STRENGTH IN HOSPITALS ETC., 1979 - 84. (concld..)

(in No.)

Year/ Division/ District	Private		Total		Of Which	
	Hospi-tals	Dispen-saries	Hospi-tals	Dispen-saries	Rural	Urban.
1	10	11	12	13	14	15
1979-80	6408	4	29237	5345	5220	25368
1980-81	6408	4	29237	5537	5406	29368
1981-82	6408	4	29391	6209	5622	29978
1982-83	6584	4	29913	6432	5864	30481
1983-84	6584	4	30030	6831	6134	30727
1983-84 :						
I. BANGALORE DIVISION:	2630	4	13402	2548	982	14968
1. Bangalore	2224	4	9234	987	292	9929
2. Chitradurga	-	-	1420	400	126	1694
3. Kolar	356	-	1536	386	170	1752
4. Shimoga	50	-	825	357	202	980
5. Tumkur	-	-	387	418	192	613
II. BELGAUM DIVISION:	1268	-	4874	1479	1643	4710
6. Belgaum	719	-	1549	393	921	1021
7. Bijapur	53	-	686	388	152	922
8. Dharwad	446	-	2262	409	338	2333
9. Uttara Kannada	50	-	377	289	232	434
III. GULBARGA DIVISION:	142	-	2804	968	723	3049
10. Bellary	-	-	1345	149	176	1318
11. Bidar	50	-	358	161	101	418
12. Gulbarga	92	-	886	426	298	1014
13. Raichur	-	-	215	232	148	299
IV. MYSORE DIVISION:	2544	-	8950	1836	2786	8000
14. Chikmagalur	-	-	428	226	112	542
15. Dakshina Kannada	1995	-	3564	281	1557	2288
16. Hassan	150	-	732	351	261	822
17. Kodagu	89	-	1231	104	359	976
18. Mandya	-	-	376	415	229	562
19. Mysore	310	-	2619	459	268	2810

Source: Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.4 MEDICAL INSTITUTIONS, FOR SPECIALISED TREATMENT, 1979 - 84.

(in No.)

Year/ Division/ District	T.B.		Leprosy		Mental Health		Cancer	
	Hospi-tals	Bed Strength	Hospitals	Bed Strength	Hospi-tals	Bed Strength	Hospi-tals	Bed Strength
1	2	3	4	5	6	7	8	9
1979-80	13	2644	1	260	2	1260	1	200
1980-81	13	2644	1	260	2	1260	1	200
1981-82	13	2674	1	260	2	1260	2	275
1982-83	13	2676	1	260	2	1260	2	310
1983-84	13	2676	1	260	2	1260	2	310
1983-84 :								
I. BANGALORE DIVISION:	5	1143	1	260	1	885	1	200
1. Bangalore	3	779	1	260	1	885	1	200
2. Chitradurga	1	80	-	-	-	-	-	-
3. Kolar	1	264	-	-	-	-	-	-
4. Shimoga	-	-	-	-	-	-	-	-
5. Tumkur	-	-	-	-	-	-	-	-
II. BELGAUM DIVISION:	3	525	-	-	1	375	1	110
6. Belgaum	1	363	-	-	-	-	-	-
7. Bijapur	1	100	-	-	-	-	-	-
8. Dharwad	1	62	-	-	1	375	1	110
9. Uttara Kannada	-	-	-	-	-	-	-	-
III. GULBARGA DIVISION:	1	288	-	-	-	-	-	-
10. Bellary	1	288	-	-	-	-	-	-
11. Bidar	-	-	-	-	-	-	-	-
12. Gulbarga	-	-	-	-	-	-	-	-
13. Raichur	-	-	-	-	-	-	-	-
IV. MYSORE DIVISION:	4	720	-	-	-	-	-	-
14. Chikmagalur	-	-	-	-	-	-	-	-
15. Dakshina Kannada	2	150	-	-	-	-	-	-
16. Hassan	-	-	-	-	-	-	-	-
17. Kodagu	-	-	-	-	-	-	-	-
18. Mandya	1	100	-	-	-	-	-	-
19. Mysore	1	470	-	-	-	-	-	-

Source : Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.5 PATIENTS TREATED IN HOSPITALS AND DISPENSARIES BY CAUSES 1979-83.

(In no.)

Causes	1979	1980	1981	1982	1983	Total
1	2	3	4	5	6	7
1. Infective and parasite Diseases	1664029	1104912	1243632	1012292	741126	5765991
2. Neoplasms	44391	72633	83480	30347	46281	277282
3. Endocrine nutritional and metabolic Diseases	281711	176461	243717	198531	111519	1012171
4. Diseases of Blood and Blood forming organs	660292	449673	516436	475977	575205	2677783
5. Mental Disorder	28848	56914	27376	8992	528748	650878
6. Diseases of nervous system and sense organs	712389	401118	470670	313327	245367	2142871
7. Diseases of circulatory system	207038	149885	150153	134034	128118	811338
8. Diseases of Respiratory system	2144931	1185562	1369492	1030979	659528	6387542
9. Diseases of Digestive System	2278146	351219	410167	302630	226231	3568413
10. Diseases of Genito Urinary system	158302	91085	108830	71707	82114	512040
11. Complication of pregnancy child birth and the puerperium	162038	25052	191[illegible]	86815	101581	567087
12. Diseases of skin and subcultaneous tissue	415604	410301	508369	235580	195[illegible]	1815243
13. Diseases of the musculoskletal system and connective tissue	255133	130942	133491	93129	38073	650078
14. Congential Anomalies	5386	5111	6941	2376	12879	32943
15. Certain causes of perinatal morbidity and mortality	18965	11114	22657	77651	47568	177955
16. Symptoms of ill Defined conditions	117539	96242	143996	731357	573841	1662975
17. Accidents poisionings and violence (External only)	1022290	1157219	1337056	522820	515301	4554687
TOTAL 1 to 17 --->	10209302	5877863	6967903	5378084	4899267	33333419

Source: Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.6 FAMILY WELFARE PROGRAMME AND USERS OF CONTRACEPTIVES, 1979 - 84. (contd..)

(in No.)

Year/ Division / District	Family Welfare Centres	Sterlisations			
		Target	Achievement		
			Vasec-tomy	Tubec-tomy	Total
1	2	3	4	5	6
1979-80	400	166000	5584	111583	117167
1980-81	428	190400	4785	138111	142896
1981-82	428	190400	2498	186322	188820
1982-83	503	305000	2332	230682	233014
1983-84	516	417000	5060	234829	239889
1983-84:					
I. BANGALORE DIVISION:	169	137700	1173	80225	81398
1. Bangalore	70	55400	431	30106	30537
2. Chitradurga	24	20000	79	11581	11660
3. Kolar	28	21400	554	13967	14521
4. Shimoga	22	18650	42	10664	10706
5. Tumkur	25	22250	67	13807	13874
II. BELGAUM DIVISION:	132	105650	1770	60710	62480
6. Belgaum	39	33500	190	19587	19777
7. Bijapur	32	27000	1005	13726	14732
8. Dharwad	43	33100	441	21417	21858
9. Uttara Kannada	18	12050	133	6178	6311
III.GULBARGA DIVISION:	89	71350	823	27348	28171
10. Bellary	21	16750	138	7352	7490
11. Bidar	15	11200	200	5276	5476
12. Gulbarga	30	23350	167	7176	7343
13. Raichur	23	20050	98	7724	7822
IV. MYSORE DIVISION:	126	102300	1494	66146	67640
14. Chikmagalur	13	10200	145	8427	8572
15. Dakshina Kannada	31	26700	585	11337	11922
16. Hassan	18	15200	293	12324	12617
17. Kodagu	9	5200	23	3165	3188
18. Mandya	17	15900	109	13351	13460
19. Mysore	38	29100	339	17542	17881

Source:

Table No. 28.6 FAMILY WELFARE PROGRAMME AND USERS OF CONTRACEPTIVES, (concld..)

(in No.)

Year/ Division / District	IUD		C.C.Users (Target)	Estimated C.C.Users (Achievement)
	Target	Achievement		
1	7	8	9	10
1979-80	67000	50776	79400	83285
1980-81	55000	54657	123600	88293
1981-82	55000	55448	123600	89236
1982-83	102000	68877	136000	94165
1983-84	170000	97097	170000	108865
1983-84:				
I. BANGALORE DIVISION:	56800	39715	56100	28072
1. Bangalore	22850	17050	22600	8171
2. Chitradurga	8250	4192	8150	2643
3. Kolar	8800	7324	8700	5648
4. Shimoga	7700	3214	7600	4375
5. Tumkur	9200	6135	9050	6915
II. BELGAUM DIVISION:	43600	18446	43050	25423
6. Belgaum	13800	6857	13650	7011
7. Bijapur	11150	4013	11000	7626
8. Dharwad	13650	4490	13500	6623
9. Uttara Kannada	5000	3086	4900	4158
III.GULBARGA DIVISION:	27400	9155	29100	19915
10. Bellary	6900	3446	6800	5271
11. Bidar	4600	1193	4550	2015
12. Gulbarga	7650	1925	9550	5211
13. Raichur	8250	2591	8200	7418
IV. MYSORE DIVISION:	42200	29581	41750	35455
14. Chikmagalur	4200	3248	4200	4536
15. Dakshina Kannada	11000	4420	10980	6358
16. Hassan	6300	4183	6200	4615
17. Kodagu	2150	1525	2100	2585
18. Mandya	6550	7109	6500	7303
19. Mysore	12000	9096	11850	10058

Source: Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.7 STERILISATIONS CONDUCTED, 1979 - 84.

(in No.)

Category	1979-80	1980-81	1981-82	1982-83	1983-84
1	2	3	4	5	6
STERILIZATION CONDUCTED					
I. By Religion:	117142	142896	189820	233014	239889
a. Hindus	103831	126924	168878	179279	213645
b. Muslims	6247	8408	12572	13879	18083
c. Chirisians	2024	2693	3260	3502	6437
d. Sikhs	28	18	25	70	42
e. Others	278	148	306	563	374
f. Not Known	4734	4705	4779	35721	1308
II. By Educational Status:	117167	142896	188820	233014	239889
a. Illiterate	62089	72784	133714	140053	121552
b. Primary	22217	41151	23171	26287	74333 *
c. Middle	13907	12356	14894	16880	24307
d. Secondary	10430	9262	9712	10329	14881
f. College & Above	2601	1778	2662	2589	2782
g. Not Known	5923	5565	4667	36876	2034 **
III. By living children:	117167	142896	188820	233014	239889
a. 0	82	19	29	144	20
b. 1	2228	1538	1986	3796	4917
c. 2	21638	23843	35403	40814	54519
d. 3	40223	51072	67692	69971	85062
e. 4	29727	37966	45848	47183	55573
f. 5 and above	17841	23339	33649	35006	37468
g. Not Known	5428	5119	4213	36080	1530

Note : * Includes Literates but not completed primary level.
** Includes persons Whose Education Status has not been stated.

Source: Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.8 PUBLIC HEALTH COVERAGE UNDER MAJOR PROGRAMMES, 1979 - 1983.

Item	1979	1980	1981	1982	1983
1	2	3	4	5	6
A. Malaria (in thousand):					
1 No. of Units in Different Phase:					
A. Total	19.13	19.13	19.13	19.13	19.13
B. Attack Phase	-	-	-	-	-
C. Consolidation Phase	3.57	3.57	3.57	3.57	3.57
D. Manitenance Phase	15.56	15.56	15.56	15.56	15.56
2 No. of Blood Smears (in '000):					
A. Collected	4283	4722	5268	5198	5485
B. Examined	4109	4491	5162	5198	5485
C. Positive Cases	277	225	158	102	62
D. Treated	258	205	144	96	59
E. Deaths	Nil	Nil	Nil	Nil	Nil
3 (a) No. of Structure Targeted for spraying (in '000)					
i. DDT	4460	4543	4973	5624	15025
ii. BHC	4665	2822	2210	5407	12875
iii. Malthion	679	662	742	894	1522
(b) NO. OF STRUCTURE SPRAYED (IN '000) :					
i. DDT	3525	3146	3131	3917	8975
ii. BHC	3539	1957	1511	3911	7306
iii. Malthion	510	404	494	570	697
II School Health Progamme:					
a. No. of PHCs Selected	105	300	90	90	90
b. No. of Schools Selected	1461	22577	8270	9075	9094
c. No. of Trageted Children	84000	781140	306065	312750	323800
d. No. Examined	30988	80427	63453	22283	34633
e. No. Found Defective	7119	8741	13421	3408	2689
f. No.of Children Immunised Against:					
i. Diptheria & Tetanus	24260	283348	113668	93655	73011
ii. First Doze					
iii. Second Doze	20827	246036	102746	74288	71736
iv. Third Doze (Booster Doze)	7622	23324	10177	7237	8723
2 Tuberculusis	3997	117232	37192	71295	33426

Note: 1. Since state was delcared free from 'Small Pox' during May 1974 due item has not been included.

Source: Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.9 MEDICAL AND PARA MEDICAL PERSONNEL, 1979 - 84. (contd..)

(in No.)

Particualrs	1979-80		1980-81	
	Sanctioned	Position	Sanctioned	Position
1	2	3	4	5
1 Doctors	2910	2696	2960	2730
2 Dentists	91	90	91	78
3 Staff Nurses	2839	2777	2839	2777
4 Compounders / Pharmacists	1985	1626	1985	1495
5 Midwives /A.N.M.s	5690	5600	5786	5435
6 Lady Health Visitors	920	860	920	860
7 Health Inspecti..	1170 +	1170 +	1170 +	1147 +
8 School Health Assistants $	105	105	-	-
9 Laboratory Technician	882	835	882	835
10 B.C.G.Technicians	137	131	137	130
11 Heath Visitors (TB)	50	50	59	58
12 X-Ray Technicians	140	120	145	117
13 Other Para-Technical Personnel	N.A	N.A	N.A.	N.A

Table No. 28.9 MEDICAL AND PARA MEDICAL PERSONNEL, 1979 - 84. (contld..)

(in No.)

Particualrs	1981-82		1982-83		1983-84	
	Sanctioned	Position	Sanctioned	Position	Sanctioned	Position
1	6	7	8	9	10	11
1 Doctors	2960	2730 @	4384	3299	4725	4157
2 Dentists	91	73	130	51	131	91
3 Staff Nurses	2862	2797	3074	3065	3204	3114
4 Compounders / Pharmacists	2077	1587	2043	1749	2169	1795
5 Midwives /A.N.M.s	7624	7074	7924	7574	8380	7458
6 Lady Health Visitors	1030	890	1115	890	1215	916
7 Health Inspectors	975 *	905 *	981 *	984 *	984 *	964 *
8 School Health Assistants $	-	-	-	-	-	-
9 Laboratory Technician	882	835	969	835	1026	830
10 B.C.G.Technicians	135 #	130	135	130	135	130
11 Heath Visitors (TB)	59	59	59	59	59	59
12 X-Ray Technicians	147	127	185	127	185	185
13 Other Para-Technical Personnel	7514 +	6507	7514	6507	7514	6507

Note: * Pertains to only Senior Health Inspectors.

+ Includes Health Inspectors (TB), SR. Health Inspectors, SR & JR Non-Medial Supervisors, BCG technical Leaders (Broadly classifed under one head Viz., Health Assistants (Male). Hence the difference in No. sanctioned and in position.

Fall in Sanctioned Strenght During 1981-82 is Due to Abolition of 2 Posts in Lady Willington TBIDTC, Bangalore during 1981.

$ The post was Abolished Since 1.4.1980 and was merged under Multipurpose workers Scheme as Health Workers (Females).

N.A. Not Available.

Source: Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.10 EXPENDITURE ON MEDICAL & HEALTH SERVICES, 1979 - 84.

(Rs in lakhs)

Particulars	1979-80	1980-81	1981-82	1982-83	1983-84
1	2	3	4	5	6
I. Medical Services					
1 Medical Relief	2329.49	2605.12	3527.45	4060.31	4190.07
2 Medical Education, Training & Research	485.75	566.73	579.52	774.35	765.34
3 E.S.I. Scheme	385.68	435.40	605.06	888.91	759.06
4 Ayurvedic	117.82	129.60	152.23	229.84	236.40
5 Homoepathy	2.92	2.36	2.79	3.80	5.19
6 Unani	3.40	4.67	8.49	11.18	13.70
7 Sidda & Other Systems	0.56	0.47	0.50	1.56	0.67
8 Stores	278.08	267.32	187.04	364.48	185.85
9 Others	38.38	157.50	45.41	51.91	62.38
Total - I	3642.08	4169.17	5108.49	6386.34	6218.66
II. Health Services					
1 Public Health Sanitation and Water Supply :	-	-	-	-	-
a. Pevention and Control of Diseases	525.64	737.38	1148.95	1203.99	1058.23
b. Rural Water Supply Scheme	451.55	709.23	658.33	1093.32	1125.34
c. Others	765.45	602.12	837.45	970.36	1035.92
2 Family Welfare	803.22	825.05	964.17	1277.95	1651.10
Total - II	2545.86	2873.78	3608.90	4545.62	[illegible]
GRAND TOTAL I + II	6187.94	7042.95	8717.37	10931.96	[illegible]

Source: A Picture of Karnataka Budget.

Table No. 28.11 IN-PATIENTS TREATED AT THE MENTAL HOSPITAL, BANGALORE, 1979 - 82.

(in No.)

Particulars	1979-80		1980-81		1981-82	
	Males	Females	Males	Females	Males	Females
1	2	3	4	5	6	7
I. Age Group :						
1 Below 15 Years	80	70	123	74	171	89
2 15 - 19	1218	662	294	170	231	206
3 20 - 29			874	510	906	460
4 30 - 39	646	393	610	351	599	279
5 40 - 49	393	194	362	203	343	198
6 50 - 59	163	101	91	82	127	65
7 Above 60	89	41	133	52	66	35
8 Age not Known	-	-	-	-	3	2
Total - I	2589	1461	2487	1442	2446	1334
II. Religion :						
1 Hindus	3441 *	-	2080	1203	2099	1144
2 Muslims	283 *	-	234	149	208	113
3 Others	324 *	-	173	90	139	77
Total - II	4018 *	-	2487	1442	2446	1334
III. Treatment Conditions:						
1 Cured	20	9	152	136	170	98
2 Improved	2520	1422	1767	1035	1621	934
3 Slightly Improved	-	-	-	-	414	206
4 Non-Improved	@	@	481	222	172	72
5 Left Hospital Against Medical Advice	@	@	26	18	29	15
6 Otherwise Discharged	36	20	20	5	-	-
7 Transferred	-	-	-	-	8	3
8 Died	11	10	7	6	10	5
9 Not Known	-	-	34	20	2	1
Total - III	2587	1461	2487	1442	2446	1334

Note : * Sex-Wise Breakups are not Available.
@ The Figures are included in item No. 2. of III Since the Breakups are not available.

Source : Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

Table No. 28.12 INDIAN RED CROSS SOCIETY, BANGALORE, 1979 - 83.

(in No.)

Particulars	1979	1980	1981	1982	1983
1	2	3	4	5	6
I. Sub Branches					
1 District Branches	16	16	16	16	18
2 Taluk Branches	26	26	26	26	26
II. Memberships					
1 Vice-President	1	1	1	11 @	11 @
2 Patrons	7	6	6	6	6
3 Vice Patrons	8	8	8	13	14
4 Life Members	707	710	757	1242	1410
5 Life Associates	1620	1648	1765	2351	2508
6 Annual Members *	58	79	22	755	63
7 Annual Associates *	1016	233	109	2886	3220
8 Institutional Members	205	254	228	342	325
9 JR. Red Cross Groups	36	84	75	70	16
III. Income (in Rs.)	266438	281811	325836	3999999	242027
IV. Expenditure (in Rs.)	223333	244859	317478	358457	328562

Note: @ Includes Non-Vice President (i.e. those who have paid Rs 10,000/- or more to the society).
* Refers to During each Year.

Source: Indian Red Cross Society, Karnataka Branch, Bangalore.

Table No. 28.13 REGISTERED NUMBER OF BIRTHS, DEATHS, STILL BIRTHS, ETC., 1979 - 1983.

(In No.)

Year/ Division/ District	Live Births	Still Births	Birth rate	Deaths	Death Rate	Infant Death	Infant mortality rate	Maternal	Maternal Mortality rate
1	2	3	4	5	6	7	8	9	10
1979	455668	7714	12.08	163296	4.06	-	39.05	774	1.70
1980	460295	7673	12.68	87566	2.41	9075	19.71	577	1.25
1981	466387	7036	12.56	150526	4.06	14714	31.54	583	1.25
1982	480337	4420	12.66	150008	3.96	15251	31.75	528	1.09
1983	406812	5921	10.51	124115	3.21	10190	25.05	356	0.88
1983:									
I. BANGALORE DIVISION	122946	2705	9.55	35364	2.75	4706	38.27	93	0.76
1. Bangalore	75614	1989	14.36	22464	4.27	3860	51.04	33	0.44
2. Chitradurga	12207	40	6.58	4370	2.36	378	30.96	27	2.21
3. Kolar	14235	65	7.18	3577	1.80	183	12.85	7	0.49
4. Shimoga	18331	607	10.61	4119	2.38	226	12.33	8	0.44
5. Tumkur	2557	4	1.25	834	0.41	59	23.07	18	7.04
II. BELGAUM DIVISION	167263	1599	17.14	50488	5.17	3252	19.44	160	0.96
6. Belgaum	47389	304	15.33	16377	5.30	761	16.06	53	1.12
7. Bijapur	33816	371	16.03	12032	4.84	931	23.36	41	1.10
8. Dharwad	48380	750	20.41	17697	5.77	1406	22.46	56	0.87
9. Uttara Kannada	17418	174	15.62	4382	3.92	154	8.83	7	0.40
III. GULBARGA DIVISION	39763	204	6.02	14000	2.12	799	20.09	51	1.28
10. Belllary	10610	88	6.79	4120	2.83	294	27.70	18	1.69
11. Bidar	10136	74	10.13	3110	3.02	177	16.96	11	1.05
12. Gulbarga	11877	27	5.53	4340	2.02	227	19.11	11	0.93
13. Raichur	6810	15	3.68	2130	1.18	101	14.76	11	1.61
IV. MYSORE DIVISION	76340	1413	8.12	24263	2.56	1433	18.65	52	0.68
14. Chikmagalur	2535	16	2.68	1131	1.19	103	40.63	3	1.18
15. Dakshina Kannada	34382	344	13.95	8405	3.41	610	17.74	15	0.44
16. Hassan	10080	717	7.16	3905	2.77	171	16.96	9	0.89
17. Kodagu	3815	52	8.03	1180	2.46	39	10.14	-	-
18. Mandya	5310	121	3.61	1939	1.32	48	9.04	1	0.19
19. Mysore	20688	163	7.66	7703	2.85	462	22.33	24	1.16

Source: Directorate of Economics and Statistics, Government of Karnataka, Bangalore.

Table No. 28.14 ESTIMATED LIVE BIRTH RATE, DEATH RATE ETC., 1979 - 1983.

(per thousand)

Year/ Residence	Birth Rate	Death Rate	Natural Growth Rate col.2-col.3)	General Fertility Rate	Gross Reproduction Rate	Total Fertility Rate	Infant Morata-lity Rate
1	2	3	4	5	6	7	8
1979							
Rural	29.0	11.8	+17.2	119.8	1.9	3.9	94.3
Urban	25.9	6.4	+19.5	100.3	1.4	3.0	50.9
Combined	28.1	10.4	+17.7	114.2	1.8	3.6	83.4
1980							
Rural	28.9	10.7	+18.2	118.5	1.8	3.8	79.1
Urban	24.1	6.6	+17.5	95.9	1.4	2.8	45.0
Combine	27.6	9.6	+18.0	112.2	1.7	3.5	70.9
1981							
Rural	29.2	10.2	+19.0	119.0	1.8	3.8	77.1
Urban	25.7	6.3	+19.4	100.9	1.5	3.0	45.0
Combined	28.3	9.1	+19.2	113.9	1.7	3.6	69.1
1982							
Rural	28.8	10.2	+18.6	118.2	1.8	3.8	71.1
Urban	25.7	6.4	+19.3	101.0	1.5	3.0	46.6
Combined	27.9	9.2	+18.7	111.3	1.7	3.6	65.0
1983							
Rural	30.2	10.6	+19.6	126.9	1.9	4.0	80.4
Urban	26.0	6.0	+20.0	102.8	1.4	3.0	41.4
Combined	29.1	9.3	+19.8	120.1	1.8	3.7	71.0

Source: Office of the Census Operations in Karnataka,
Sample Registration System Report.

Table No. 28.15 AGE SPECIFIC FERTILITY RATES, 1979 - 1983.

(Per thousands)

Age Group of Mothers (in years)	1979		1980		1981		1982		1983	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
1	2	3	4	5	6	7	8	9	10	11
15 - 19	76.1	62.5	79.4	67.6	73.2	75.5	72.9	59.7	83.6	60.5
20 - 24	210.6	185.5	208.3	172.9	213.3	174.2	198.0	181.1	227.8	196.9
25 - 29	211.5	165.1	201.2	148.7	203.0	164.1	201.0	177.8	204.4	160.4
30 - 34	142.2	96.1	138.0	97.8	142.8	114.0	140.1	104.6	138.8	101.2
35 - 39	85.9	54.7	83.8	51.6	83.5	61.4	90.9	55.3	83.1	47.0
40 - 44	32.8	25.9	34.6	24.2	30.9	26.0	39.3	18.5	35.1	26.0
45 - 49	17.6	15.4	14.8	5.0	14.7	6.4	15.1	8.7	19.0	8.9

Source: Office of the Census Operations in Karnataka,
Sample Registration System Report.

Table No. 28.16 AGE SPECIFICED DEATH RATES, 1979 - 1980.

(per thousand)

Age group (in years)	1979			1980		
	Males @	Females @	Combined	Males @	Females @	Combined
1	2	3	4	5	6	7
0-4	29.3	32.7	31.0	25.4	27.5	26.4
5-9	3.5	4.3	3.9	3.6	3.2	3.4
10-14	1.6	1.4	1.6	1.6	1.5	1.6
15-19	1.6	2.1	1.8	1.5	1.7	1.6
20-24	1.8	2.9	2.4	2.4	3.3	2.8
25-29	2.4	3.9	3.1	1.9	2.6	2.2
30-34	3.9	4.5	4.2	3.7	3.4	3.5
35-39	4.7	4.3	4.6	4.8	4.0	4.5
40-44	6.4	4.8	5.6	5.9	3.2	4.5
45-49	9.0	6.6	7.8	9.8	5.5	7.7
50-54	15.5	7.7	11.7	13.1	12.4	12.7
55-59	23.7	22.4	23.1	20.4	13.8	17.1
60-64	35.9	36.0	36.5	37.5	28.4	33.9
65-69	47.6	31.7	39.5	42.8	36.9	39.8
70+	102.1	85.5	95.1	45.1	79.9	82.2
All ages	10.6	10.6	10.6	9.2	9.5	9.3

Note : 1. @ Sample value derived from MTP of Bureau of Economics and Statistics.
Source: Report on Sample Registration System 1971-80, (Published by the Director of Census Operations, Karnataka.)

Table No. 28.17 PERCENTAGE OF LIVE BIRTHS BY ORDER OF BIRTH 1981 - 1983.

Birth order	1981		1982		1983	
	Rural	Urban	Rural	Urban	Rural	Urban
1	2	3	4	5	6	7
1.	27.23	22.28	25.98	33.70	25.90	33.78
2.	22.94	20.04	23.72	20.45	23.90	25.92
3.	18.43	16.38	18.94	17.90	19.07	18.15
4.	13.99	13.61	12.81	14.00	12.58	9.85
5.	6.94	10.47	7.19	4.16	6.94	4.83
6.	3.67	7.72	4.26	2.08	4.05	2.41
7.	2.38	3.32	2.08	1.13	2.03	1.10
8.	1.27	1.98	1.39	1.93	1.30	0.67
9.	0.62	0.47	0.65	0.50	0.63	0.35
10.	0.31	0.30	0.32	0.30	0.31	0.16
Above 10.	0.14	0.21	0.23	0.13	0.21	0.09
Not stated	2.08	3.22	2.43	0.72	3.08	2.69

Source: Directorate of Economics & Statistics, Government of Karnataka, Bangalore.

Table No. 28.18 PROJECTED VALUES OF EXPECTATION OF LIFE AT BIRTH, 1961-90.

Year	Males	Females
1	2	3
1961-70	47.1	45.9
1971-75	50.9	50.0
1976-80	53.4	52.8
1981-85	55.9	55.6
1986-90	58.4	58.3

Source: Census of India 1971
India Series - I, Paper -I of 1979.
Report of the Expert Committee on polulation projections.

COMH-49.

Dear Sir,

Kindly find attached a Note on the proposed restructuring of the Group A medical posts in the Health and Family Welfare Department. The Note is in line with the broad recommendations of the Task Force on Health and Family Welfare and seeks to address concerns expressed at various fora by elected legislators.

The Note is a follow up of the discussion at my level with DHS, Mr. Ramnath, former Joint Secretary DPAR, and CAO –I. It is suggested that you may kindly agree to chair a meeting where the following is discussed:

1) Appointment and terms of reference of Shri Ramnath as Consultant to draft the C&R rules for Group A as well as other posts to form the proposed District cadre along with time frame and estimated amount for the consultancy; and,
2) The proposed structure of the reorganized Group A medical cadre.

It would be useful to have the DPAR (Service Rules) involved in the discussion at this stage itself. In view of this, the following could be invited:

1) DHS, 2) Shri Ramnath, 3) Shri A. Kadeer, JS DPAR, 4) CAO –1, 5) Shri Padmanabha, Member, Task Force, 6) PD 1PP-IX, 7) PA, KHSDP and 8) DS (H).

In view of the complex nature of the subject to be discussed a minimum of two hours may kindly be earmarked for the discussion. A date and time may kindly be indicated to enable me to the circulate the note in advance of the meeting.

With kind regards,

Yours sincerely,

(Sanjay Kaul)

Shri A.K.M. Nayak,
Principal Secretary, HFW,
MS Buildings, Bangalore.

RESTRUCTURING OF THE GROUP "A" MEDICAL AND PUBLIC HEALTH POSTS IN THE DEPARTMENT OF HEALTH AND FAMILY WELFARE

Need and justification for Organizational Reform

There is an unequivocal feeling that the present organizational structure of the department of health and family welfare needs urgent restructuring, particularly in respect of the Group A posts. The need for restructuring has arisen on account of the following:

(a) The **public health** element in the department has become devalued and needs to be reinstituted.
(b) There is reluctance on the part of doctors to opt for non-clinical posts.
(c) There is lack of management expertise in the cadre.
(d) There is a reluctance of doctors to work in backward districts and remote places.
(e) There is need to recognise talent and specialization outside the department and attract such persons into the cadre.
(f) There is need to induct professionalism in both the medical and public health spheres.
(g) There is need to make changes to suit the Zilla Panchayat system.

Elected legislators as well as the Task Force on Health and Family Welfare have also voiced the above concerns. The restructuring proposed is in keeping with the broad suggestions made by the Task Force.

Proposed wings in the Medical and Public Health cadres

All posts of doctors and specialists will be reclassified into the following three services.

1. Karnataka District health service.
2. Karnataka Health service (public health).
3. Karnataka Health service (medical)

The Karnataka District Health Service (KDHS)

The KDMPHS will have the following categories and numbers of posts. These posts will be constituted into separate district cadres. The district cadres will have the following two categories of posts:

1. All posts of GDMOs – approx. number 2400.
2. All posts of specialists in CHCs and Taluka hospitals – approx. number 1400.

The method of recruitement will be as below:

1. <u>GDMOs:</u> All vacancies of GDMOs in each district will be notified by the respective DHOs. Selections will be made based on the qualifying percentage of marks secured by the candidates in the MBBS examination. Reservation would be provided to SC/ST/BCs as per the prevailing Government Orders. 30% of posts in

each category would be reserved for women. There would be no written exam or interview.

Time bound promotions: GDMOs would be eligible to two time-bound promotions, one at the end of 6 years and the second on completion of 13 years.

2. Specialists: 50% of posts of specialists in CHCs and Taluka hospitals will be reserved for such GDMOs who complete their PG in the specified disciplines. The balance 50% posts will be Direct Recruitment posts, selected based on 50% weightage each for the marks secured in MBBS and in the PG degree/diploma examination as the case may be. All vacancies of Specialists earmarked for Direct recruitment, speciality-wise, will be notified by the respective DHOs. If there are no qualified candidates in a particular year in any of the specialities available from among GDMOs for filling up 50% of the seats, the posts would be filled by direct recruitment. Similarly, if DR does not get adequate number of specialists in any speciality, the same would be made available for filling by promotion.

Promotion and Pay: Direct recruit specialists will start on a salary scale equal to a GDMO who has completed 6 years of service. A GDMO promoted as a specialist would also be given the same specialist pay scale irrespective of the number of years of service rendered by him/her as a GDMO.

Time bound promotions: Specialists will be entitled to the next scale on completion of 6 years of service. Those specialists who have been promoted from GDMOs will also get their next scale after rendering six years of service as a Specialist, provided that he will be entitled to time bound promotion irrespective of his years of service on completion of 13 years of service.

Transition period: All GDMOs/specialists who have less than 13 years of service and/or those not inducted into the KHS(PH) or KHS(M) will be automatically inducted into the KDHS in the districts where there are presently working as soon as the final notification of the revised C&R rules are issued. Those desirous of seeking a change to another district will make an application to the Commissioner who shall consider the change or reject the application keeping in view the availability of existing GDMOs/specialists in the districts concerned and the seniority of the Doctor.

Karnataka Health Service (public health) [KHS(PH)]

The KHS(PH) will be comprise the following posts:

1. Taluka Health Officers;
2. Programme Officers;
3. Principal DTCs;
4. District surveillance officers;
5. DHOs;
6. Deputy Directors and other equivalent posts;
7. Joint Directors;
8. Additional Directors;
9. Director, Public Health Services.

Method of recruitment: The posts at Sl Nos. 1-4 will be equivalent posts carrying an identical pay scale. 80% of the posts will be filled by promotion on the basis of seniority-cum-merit from among GDMOs belonging to the KDHS and who have completed their Post graduation in Public Health or possess a DPH/PESM degree. However, if there are no suitable qualified persons, then these posts will be filled by promotion on the basis of seniority-cum-merit from among GDMOs who opt for the KHS(PH). This option would be irrevocable, and no member of KHS(PH) will be eligible to change to KHS(Medical) in his subsequent career. 20% of the of the posts at Sl. Nos. 1-4 will be filled by direct recruitment based on 50% weightage for MBBS marks and 50% weightage for a written examination to be conducted by the Rajiv Gandhi University of Health Sciences. Commissioner Health & Family Welfare will be the recruiting authority. GDMOs would also be eligible to apply for the DR posts and would also be eligible for age relaxation of upto 5 years.

In respect of Doctors who have completed 13 years in service, all Doctors not possessing a PG degree and all Doctors having a DPH/PESM degree will be automatically inducted into the KHS(PH), except for such Doctors who decline to opt for the Service, subject to the availability of vacancies. Doctors not possessing a DPH/PESM degree will be give suitable training in Public Health A seniority list of such members of the service will be published soon after the final notification of the revised C&R rules.

Inter-se seniority among GDMOs serving in various districts:

The inter-se seniority among GDMOs for their promotion into the KHS(PH) will be decided in the following manner:

1. A list of GDMOs serving in various districts in the KDHS will be compiled based on their year of recruitment. They will be asked to give their irrevocable option with regard to joining the KHS(PH). A common seniority list will be compiled. Those possessing a DPH/PESM degree will be placed on top and the remaining on the basis of their existing seniority position. In respect of fresh recruitments made after the revised C&R rules are notiied, the list of all doctors recruited in the various districts will be clubbed year-wise and seniority determined according to their marks in the MBBS examination. In respect of those possessing a DPH/PESM degree, such persons will be placed on top while others will be placed according to their year of recruitment and their MBBS marks.

2. Promotions from the KDHS into the KHS(PH) will be done on the basis of seniority-cum merit according to the seniority list generated as above.

KHS(PH) Probationers

Candidates selected through Direct recruitment into the KHS(PH) will be on probation for two years. During this period they will be undergo a one year's DPH programme at the State Institute of H&FW and will receive a DPH certificate recognized by the Rajiv Gandhi University of Health Sciences. Selected Candidates already possessing a DPH/PESM degree will also undergo this Course. The University in consultation with the State Institute, will conduct the examination, and will also decide

the curriculum. Other institutions apart from the State Institute recognized by yhe University can also conduct the DPH programme. Candidates successfully passing the DPH examination and other prescribed examinations shall undergo training as a GDMO for one year before being given regular charge as Taluka Health Officer/Programme Officer.

Karnataka Health Service (Medical)

The Karnataka Health Service (Medical) will comprise the following posts:

1. Senior specialists;
2. District surgeons or equivalent posts;
3. Chief Surgeons;
4. Joint Directors;
5. Additional directors;
6. Director, Medical Services.

Method of Recruitment

All specialists on completion of 13 years of service or direct recruit specialists on completing 7 years of service in the KDHS will enter the KHS(Medical) on giving a bond that they are willing to serve anywhere in the State, subject to available vacancies. There will be no Direct recruitment into the KHS(M). Promotions to the different cadres will be on the basis of seniority-cum-merit. Chief Surgeons are upgraded posts equivalent in rank and pay to that of Joint Director created to ensure a reasonable balance of promotional opportunities between the two services. District Surgeons or equivalent officers in this higher grade will be designated as Chief Surgeons, though they will continue discharging their earlier responsibilities, in addition to new responsibilities given to them. Some senior specialist positions will be made available at Taluka hospitals/CHCs also.

Promotions in the KHS(PH) and KHS(M)

All promotions into the various posts in the KHS(PH) and KHS(M) will be based on seniority-cum-merit.