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On
India's Health System: Role of Health Sector Reforms

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INAUGURAL SESSION

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Smt P Jyoti Rao

Secretary Family Welfare Shri Hota, Dr Habayeb, Shri Chowdhury, Dr. Agarwal, Director General of Health Services, Dr. Ramachandran, Adviser Health, Planning Commission, Ladies and Gentlemen. It gives me great pleasure to welcome you to this workshop on India's Health System: Role of Health Sector Reforms. While reforms have been on the anvil in our country, its effects have not been clearly visible. We have not as yet, been able to crystallize our thoughts on 'health sector reforms in the Indian context'. The customized set of reforms for our country must be unique and should flow from our system itself.

We need to give a very serious thought to what actually constitutes reforms in the overall global perspective, in the Indian perspective and also in the regional perspective. I think this conference which we are holding today perhaps should have been held ten years earlier, when this whole talk of reforms was on. But somehow, I think we missed that opportunity and we are doing it now. But it's better late than never. Of course, it has its advantages, because we have the free rider advantage, where we can make use of the experiences of the other sectors in the implementation of the process of reform. This therefore is one of the main objectives of this one and a half day workshop. We are very happy to find that there is a galaxy of State government secretaries who are going to make presentations on this subject and we hope to learn a lot from them because despite the fact that we really don't have a well defined strategy for reforms, some of the States have taken initiatives and moved forward despite severe resource constraints. We all know the constrained resource scenario in the States. Despite that there has been some commitment in some of these areas which impinge on economic reforms. The first thing we need to do today, is to have a brain storming session to look at what could be a workable definition of health sector reforms, what would be our priorities, what would be the first generation, the second generation and the third generation reforms.

Health is such a vast subject covering so many areas. Many new issues are emerging. Now we have telemedicine coming in, computerization which is changing the entire way of looking at things including medicine, we also have the other very critical issues on social side of delivery of health systems to the poor, to the below poverty line (BPL) people. While there is some sensitivity in the system of delivery to below poverty line persons, we really have not been able to crystallize a mechanism for the same. Even the government delivery system unfortunately is elitist, the access is elitist and the poor really do not get much out of it despite the fact that it is a system which is supposed to reach out for them. So that's one very important area which I thought I should mention first because in this whole process of commercialization of the health sector, the concepts at one time would be an anathema to anybody in health. Health tourism which is a very commercial face of health, you know these kinds of concepts, I think we should not forget the safety nets, because in any civilized reforms package, safety net for the poor has to be a very important consideration and it has to be built into the package. Some of these reforms are driven by the multilateral and bilateral collaborations that we have.

Some very interesting concepts have come in; we need to thank the World Bank for this whole concept of user charges. This user charges is something which didn't exist in our lexicon, not so long ago, but today it is there, we are all very sensitive to the need of user charges, for building a stake for the people who use the system. So these are driven by compulsions, we have in our collaboration with multilateral and bilateral agencies. This is one set of reforms and many good things have come out of it and they will continue to come out of it, in so far as the concept of user charges is concerned. Of course as we stand today, user charges as they exist in most hospitals do not go beyond the domain of tokenism, I am sorry to be so forthright but we need to look at user charges in a much more serious way because while we need to insulate the poor from these very high charges, at the same time we have to see that the people who can pay are charged rationally and are charged as per the costs actually involved in providing them that kind of health services.

I am sure that this august gathering here today will decide what should be our priorities, what should be the first thing that we should undertake and the timeframe that we would set for ourselves in achieving some of these reforms. The other pre-occupation of this workshop is documentation. We hardly have any documentation on health sector reforms. There have been very good stories coming out from across the globe and we need to take a closer look at such initiatives This cell which has been set up now in the Bureau of Planning, which is looking very intensively at this subject will access all the pertinent information on what have been the global initiatives and where and how they could apply to our situation. The other thing is that we would also like to document the various initiatives that have been taken by the various State governments. At the end of this, we would also like to bring out an annotated bibliography on whatever literature that exists on this subject so that it can be accessed by academics, health professionals and all other stakeholders. So, these are the two primary concerns. Of course as I said, we have no choice but to go ahead with the process of reforms. The State government and the Government of India would for quite some time to come continue to play a dominant role on issues of access, investments, etc. There is no way that we can wish away the role of the State. But we envisage the role of the State with a very vibrant public private partnership. We have to make some more efforts, to reach out to the non-governmental organizations (NGOs), to reach out to the private sector and evolve a working mechanism where their involvement in our health initiatives is of a very high and sensitive order.

And alongside with all of this, we will have to carry on our crusade for more share of the investment pie in the health sector. In fact, I am sorry to share this piece of information with you, that in the current year, the budgetary support for the Department of Health is pegged at a level of Rs. 1550 crore. It is I would say, a tribute to the resilience of our system that these 1550 crore are looking after hundreds of institutions, they are looking at a myriad of disease programmes, it's something. Sometimes, it really puzzles me as to how we are able to stretch the rupee value so much that it can cater to so many things at the same time. So we need to have higher investments in the health whether they flow from the budgetary resources, or from the private sector and I think all of us in health, need to generate a lobby for getting more funds. A Ministry like Rural Development, where I have had the privilege to work earlier, has a budgetary allocation of Rs. 14,000

crore against the Department of Health getting just Rs. 1550 crore. So without investments in health, our reforms would remain hollow. This is something, which we would not be able to implement.

I think I have in my own way introduced the subject. We have present here today a galaxy of knowledgeable persons in this field. I would once again, welcome you on behalf of the Ministry and thank you for sparing your precious time, for being with us today and we look forward to very intensive and meaningful deliberations and excellent documentation coming out of what we discuss over the next one and a half days.

Thank you very much.

Dr Prema Ramachandran

Thank you very much for giving me this opportunity to share with you an area of intense interest to all health professionals and an area in which 13 working groups of the Planning Commission for the Tenth Plan slaved. In fact, it was far easier for them to review their programmes, talk about the future but we insisted that in every one of them there has to be health sector reforms and what is it that has happened and how they have fared. In a similar fashion, we had also requested all the States to keep on telling us about what reforms they had done, what the impact, why did they do it was and how things progressed. I must place on record, the fact that they were all extremely co-operative and did this hard work. Very often, saying that you know we didn't really plan out the way we planned out, and that honest admission is in the basic of all good reform processes.

I would try to give some background on what was done in the Ninth Plan and in the Tenth Plan Steering Committee, chaired by Secretary Health (at that time), who also did quite a lot of heart searching and frank discussions on what is going right and what is going wrong. Some of this has already entered into the Tenth Plan document. Lot of it is yet to be implemented. First I would like to take on why we embarked on health system reforms. Over the last five decades, we have built up a huge infrastructure with a large manpower. There is always going to be resource constraint, competing claims on what is right and what is priority, but all of us must admit that to some extent health did get its due share. As a result, primary, secondary and tertiary care institutions were built, not only in the government sector but also in the voluntary and private sector. This country has no dearth of health manpower. In fact we now face a question of under employment and unemployment, not only in the nursing profession but even among the doctors today. We have produced people, their commitment and competence is not in question, by anybody. In fact we have a significant place in many of the health systems of Middle East, not to talk about the United Kingdom and the United States of America, where we form a significant proportion of health care professionals. In the initial 20 years when this hard work was going on, we were all buoyed up by the fact that mortality rates are crumbling down; small pox has been eliminated and so on. Everybody felt good. The problems arose in the 1990s when mortality rates started plateauing and we started facing the dual disease burden. Along with the dual disease burden, we also had the problem of escalating awareness about things that could be done, by the health system and the fact that many of them are beyond what the individual or the institution at the country could afford and this conflict was at the base of most of our mandate to look at reforms which would ensure that health system provides the kind of care that it ought to.

We have a health system which consists of four major subsystems; one is the primary, secondary and tertiary care institutions, manned by medical and paramedical personnel who provide health services. Services are provided in the private, voluntary and public sector. Additionally, we have medical colleges and paraprofessional training institutions to train the needed manpower, again in private, public and voluntary sector. There are also programme managers in the governmental sector who manage the ongoing programmes at central, state and district levels. Theoretically, we have a two way Health Management Information System (HMIS) system of data collection, collation, analysis

and response. Data collection, collation and analysis pose a problem and responses, if we are honest, in most cases are non-existent. The major catastrophy we face is that none of these four are linked with one another and they just do not function as a part of cohesive single system. If an eye says I will see sometime and an ear says, I will hear sometime, how will human being function? It is that which is creating the major problem in the health system. As I said earlier, the initial enthusiasm that if one really improves access by creating primary health care there will be tremendous improvement in access to essential services, was sustained by the government investing in sub-centres (SCs), primary health centres (PHCs), community health centres (CHCs), between 1980s and mid 1990s. By mid 1990s, we had more or less achieved the requirements for sub-centres and primary health centres and if we really integrate the community health centres with the sub-divisional hospitals and taluka hospitals, we also have achieved theoretically the numbers that were required to cover the entire country. However, if you have a look at the National Facility Survey done by the Department of Family Welfare, you can see that barring Maharashtra, where about almost all the primary health centres (PHCs) had more than 60 percent of essential basic requirement for providing minimum health services, none of the States have those essential things without which primary health care delivery is impossible and in this we must pay tribute to people who did this kind of survey and came out with the reality, however much it might have displeased the people who have been contributing to this kind of infrastructural development. Because of this survey and its data, for the Tenth Plan we were able to say, not to have any more construction. Whatever money, is available should be invested in ensuring that the primary health system that exists, becomes fully functional and that is our highest priority.

The private sector also provided some inputs and over the time period, there has been an increase in the number of hospitals in the private sector. Contrary to the popular belief, majority of the increase in hospitals in the private sector has also been what we would consider as primary or secondary sector. Corporate and super-specialty hospitals still form only about 3 percent of the whole private sector hospitals. But we do have a major paradox. Plethora of hospitals exists but very few are located in areas with high morbidity. There is huge health manpower, there is considerable underemployment and unemployment but still in slums of Delhi quacks practice. That is the reality. Vast sums are spent on drugs and diagnostics, not only by the government sector but also by the private sector. On the one side we see unused piles of drugs in some places but in many places lack of appropriate diagnostics and drugs is the reason why many people are not able to access good quality health care. Above all, there is still today, lack of defined norms of care at each level and appropriate referral services. Finally, one critical thing, we have to respect the primary health care worker. We have to assign them a unique role. Do we give them the responsibility of acting as a gatekeeper to people accessing secondary and tertiary care? No and on their recommendation when they do refer, are we always honoring them? No and these are hard realities which come in the way of building up a good referral system. As a result of this, we have a system where some hospitals are grossly overcrowded and many are grossly underutilized.

We also have a problem of gap /mismatch between manpower and infrastructure and availability and utilization of services are poorest in the neediest rural areas. This access

and utilization differences, account for the massive interstate/ inter district and urban rural differences in health care performance. I am stressing this because investments have been essentially similar, then why is there such great disparity in performance? That is due to access, awareness and utilization.

So if we summarize, we have health care institutions that are reasonably staffed with skilled staff and here I include private and voluntary sector, it is not the government sector alone. All of them face difficulty in running their institution because there is a change in health care needs. Further in the last ten years, the momentum of change has been rather great and that really puts the system at a severe disadvantage for we are facing a change not only in the health care needs but also in the technology leading to faster obsolescence of equipment. How can one afford to buy new equipment in a span of five years? In the private and voluntary sector, there is a tremendous, rapid turnover of staff, who is seeking better opportunities. All the institutions also face the conflicting imperatives of containing costs and becoming self-sustaining. Can one shoulder social responsibility? Is health a fundamental right and should one really be subsidizing it? Whom would one subsidize? How will one target and how does one marry self sustainability with social responsibility? I think these are questions that are to be honestly addressed and some via-media answers have to be found. Last but not the least, major medical institutions face labour and consumer litigation which is increasingly becoming an agony for them because the system people are not trained in tackling this, they are not managers, they are not legal experts and when they find things are going wrong they feel demotivated and disheartened.

The health personnel are highly skilled, but I believe and I know, all of us have tribal feelings and we tend to say, that we are the nicest and the best. But I still believe that educationists and health professionals are usually slightly more committed to social cause then many others. I am not saying its universal but proportions perhaps are titled towards commitment in these sectors. They require periodic updating and that is absolutely lacking. What I know about most things, is what I learnt 30 years ago, and the world has turned absolutely upside down in the meanwhile. They also have a problem in having a system for screening and referral, access to institutions with adequate staff to whom they can farm off their patients when complications arise. Quality control systems do not exist, and because of that how can anyone ensure that the patients get appropriate care, cost of care is not prohibitive and physicians get protection against litigation. In many private institutions today, Indian doctors pay about 15 percent of their packet for health insurance, for malpractice insurance protection and that is not a very healthy trend at all, because it will escalate the cost of care still further.

The findings of a National Sample Survey (NSS), which was later analyzed by the National Council for Applied Economic Research (NCAER), shows that people above poverty line (APL) and below poverty line always go to the government hospitals for immunization services. The same government hospitals, the same queues, the same two-hour wait but they know that fresh vaccines of good quality are made available and that system does not fail. It has not failed in the last 15-20 years and therefore they access it. And look at the other end, for out-patient care for cough, cold, fever, diahorrea; they

never go to government hospitals, as they feel it is a waste of time and energy. All they want is symptomatic relief, that they feel can be got anywhere. They are very discerning and this is something that we have to accept and understand.

When it comes to in-patient care, there has definitely been a growth in in-patient care and out-patient care in the private sector. But for inpatient care, majority of people still use government hospitals, the reason is shown in the next slide. It is because the cost of care in government hospitals even after institutionalizing all the user charges, are a fraction of the cost for the same in private institutions. It is logical, it has to be like that because there is so much of subsidy in the government system and therefore people are aware of it and are using it.

People are willing and trying to invest both in public and private facilities for accessing health care. It cuts across all, the richest to the poorest. All use government facilities, all use private facilities. The proportion which they use is not very radically different. They are willing to, irrespective of their income status, use their savings sell their assets and borrow for health care. Health is definitely, therefore a valued commodity by all segments of population. So can we not conclude from these that the people here, are responsible, rational and increasingly aware; they might have been slow to respond initially but once they have responded, their response is sustained and they are willing to invest in health. But what are their concerns? Their concerns are very clearly articulated. Diagnosis and management of illnesses are becoming increasingly complex and costly; the trusted family physicians have vanished and the greatest of their concern is the commercialization of health care, they fear potential for poor quality care, problem of overuse, abuse and misuse of technology for treatment as well as diagnosis and the exploitation of vulnerable patients because of information asymmetry. And information asymmetry in health sector is enormous.

The health sector as a whole, faces this problem of dual disease burden of communicable and non-communicable diseases, technological advances which widen the spectrum of possible interventions and escalating cost of care and therefore the Ninth Plan, emphasized that there is a need to review the response of the public, voluntary and private sector health care providers as well as population to the changing health scenario. The Department of Health & Family Welfare and the National Sample Survey Organisation (NSSO) conducted many of the surveys in response to this first mandate that was given. The second was to reorganize and restructure health services so that they function as an integral component of an efficient and effective multi-professional health system. Third was to introduce health system reforms to enable the population to obtain optimum care at affordable cost. Words, at least the words came into being and very often words are the beginning of action.

Who are all the stakeholders? The States are the major stakeholders because health is a state subject. The Centre depends upon effective state infrastructure for implementation of the Centrally Sponsored Schemes and therefore is also an important stakeholder in this. Health care institutions are also involved because they can function much better if there is a defined norm. Healthcare providers, as they will get the essential requirements

to provide care are also stakeholders. And the people themselves have stakes, as they need access to good quality health care at an affordable cost. So in a situation where everybody has a stake, we need to propagate this whenever temporary difficulties are encountered in the implementation of health systems reforms.

The health system reforms broadly fall into three categories: Structural and functional aimed at improving efficiency, Financial aimed at improving the resources available and governance related aimed at improving transparency. We envisage that the public sector would play the lead role in health systems reform.

The structural reforms are essentially re- organizing and restructuring of existing health care infrastructure including the infrastructure for delivering Indian System of Medicine & Homeopathy (ISM&H) services at primary, secondary and tertiary care levels. They should have the responsibility of serving the population residing in a well defined area and have appropriate referral linkages with each other. The second major thought in this is, mainstreaming of the ISM&H manpower and infrastructure, especially at primary and secondary care level because they have a major role to play not only in improving access to health care but also in counseling and life style modification, which are going to be critical if we have to combat non-communicable diseases in this country.

Regarding human resource development, we have numbers there is no doubt about it, but we have some worry not about the skills but about the attitudes and that is partly because they are also getting torn between two streams. Do we go for super-specialty and high end of technology or do we provide primary health care and when they are torn, their attitudes obviously are going to be somewhat ambivalent for both. We urgently require skill up-gradation and knowledge up-gradation through Continuing Medical Education (CME) programme, so that the existing manpower can take care of emerging health problems.

The functional reforms are horizontal integration of current vertical programmes. This is one of the thorniest issues. All of us know that when there is a line function, it functions well. It is good for me, I get a good response but line functions are terribly expensive and after a time they also will go through a fatigue phenomenon. Ultimately you have to have an integrated infrastructure delivering all health care. There is only healthy population or people who are ill. People needing services, don't come saying, 'I have tuberculosis', and therefore that integration is terribly important. Going along with it, there has to be district based planning, implementation, monitoring, and Information, Education and Communication (IEC). This is very difficult and we are taking stumbling steps in this. Building up efficient and effective logistic system for supply of drugs, vaccines and consumables based on the need and utilization is critical as it will cut health care cost by reducing massive wastage that does occur at all places.

The reporting systems today are in disarray. There are multiple reporting systems, for e.g. one for tuberculosis, one for family welfare. People fill many registers. Unless we get the system to report reliably, accurately and tell people that it is worth it, it is going to be a time consuming exercise to keep on motivating, evaluating and telling people that they

did not report well. It is a very disheartening situation for people in the field and therefore, we need to get this system going in a much more integrated and authentic fashion. An initiative of building up a system of disease surveillance and response at district level was taken in the Ninth Plan. Some hundred districts were picked up and some systems were built up. They are functioning though not very optimally. But it is a difficult task. We have to however, slowly continue doing this.

Last, but not the least is governance related reforms. We have to introduce a range of comprehensive regulations prescribing minimum requirements of qualified staff, conditions for carrying out specialized interventions and a set of established procedures for quality assurance. A beginning has been made in some. Typical example is what we did for blood banks as a part of the AIDS Control Programme. We re-organized the system, made it subservient to a few norms and the results are today for all to see. It may not have served the AIDS Control Programme but it did serve a very vital function of making safe blood available in this country and therefore, one need not look immediately for benefits for a vertical programme, one needs to look at it, in slightly broader terms. The major thing that we need in this country now is the standard protocols for care for various illnesses at primary, secondary and tertiary care, the impetus for this should come from medical colleges, professional associations. The testing ground should be public sector hospitals at primary, secondary and tertiary care. They should come out openly with what works and what does not. And based on that we should evolve these norms and make them available to all. Along with that, once the standard protocol is worked out, we should embark on working out the cost of diagnostics and therapeutic procedures for major/ minor ailments in different levels of care and setting cost of care norms.

Very often it is stated that quality of care will escalate the cost enormously. This is a very untrue statement. And second is the question of how to assess quality. It is a subjective belief and you can not really document it. That is a very wrong notion too. Quality of care can be assessed, once a norm exists, through quantifiable determinants and ingredients of quality, which include access, infrastructure, manpower, processes for diagnosis and treatment, safety and timeliness, a cost of care at each level, outcomes in terms of case fatality and disability. Each one of these are numbers from which we can draw absolutely dependable conclusions. And I think we are mature enough on this extremely difficult exercise and if we do it right, we will set the tone for the entire developing countries health care system. It is worthwhile doing it.

What will the quality control in India do? If we are to sweat it out so much, we should tell the people what are the benefits. Everyone there has a rampant suspicion of overuse, underuse, abuse, misuse of facilities, diagnostics and overcharging. Health profession, which was once upon a time respected enormously, is losing out on this count. Quality control system will help re-establish the same. It will of course improve effectiveness and efficiency, help to make positive outcomes more likely, it will help us utilize the available resources effectively and responsibly. We have to live in a globalised world, if your systems are equivalent of International Standards Organization (ISO) certification, it will open the floodgates of tourism, health tourism. It will cross subsidize, institutions will survive and do well. Instead of exporting medical professionals, there is nothing

wrong in having health institutions, which provide good quality care at an affordable cost in an ambience, which is familiar to people in neighbouring countries. And in that we can do similar things as Information Technology is doing, perhaps in a more sustained fashion for the next 30-40 years. At the primary health care level, we should increasingly use the Panchayati Raj Institutions (PRIs) in bringing out local accountability, planning and monitoring of ongoing programmes and also providing better access to information on what types of service are available where and at what cost.

Financial reforms are the last and we have just started. First and foremost, thanks to the number of people who did support it through various times. The Tenth Plan reiterated the continued commitment to provide essential primary health care, emergency life saving services, services under the National Disease Control Programmes and the National Family Welfare Programme totally free of cost to individuals based on their needs and not on ability to pay. In fact, National Disease Control Programmes and Family Welfare services are accessible to all of us, in the highest income group, free of cost; because there can be a gender bias, there can be problems and therefore, those services are protected for public health cost. And that cost has been protected by people, many of whom are sitting around this table. Further, there is a need to evolve, test and implement suitable strategies for levying user charges for health care services from people above poverty line, while providing free perhaps subsidized service to people below poverty line; utilize the collected funds locally to improve quality of care. Many health administrators, have really worked months to get these things passed through their State legislatures because otherwise whatever user charges that are collected in any government institution reverts back to the State's consolidated fund and if that is done, the incentive for them to generate adequate user charges gets killed and therefore, many of the States now have legislations which enables these institutions to retain their funds. Finally, evolve and implement a mechanism to ensure sustainability of ongoing government funded health and family welfare programmes even after the currently substantial external assistance tapers off. These were some initiatives proposed in the Tenth Plan.

I would like to end by saying that as seen in our recent annual review, both within the Centre and the States; there is not a single State which has not implemented reforms. Every single centrally sponsored programme has implemented some reform. The problem currently that we face and why we are not seeing the immense benefit that would accrue is reforms implementation is fragmented. No body has carried out one set of reforms fully so that at least you can say that system is functioning well. And no state has carried out across the board horizontal reforms. But every struggle that has been undergone by either the Centre or the State has paid some dividends, and there is no need to get disheartened, the initial steps are usually the hardest. Having embarked on it, persist. We will hold hands and there is nothing but improvement ahead, please persist.

Thank you very much.

Shri P. Hota

Friends, after Dr. Ramachandran's very detailed and comprehensive coverage of the subject of health sector reforms; I really do not feel the urge to take up your time in stating the obvious. I would like to supplement a few points which I think could be added to her presentation or maybe she is a seasoned practitioner, so looks at 'do-ables' and leaves aside 'un-doables'. I will try to flag a few un-doables but which must be done. We seem to talk of reforms that somebody else would reform. That the district level, primary health care level, private sector, even non-governmental organisations (NGOs) we have tried to streamline, they must reform. We have seldom subjected the main health policy formulators to any scrutiny. So talk of reform must start with looking at State Health Department, even Family Welfare Departments. Health is a generic term for me, doesn't mean only the Health Department. Family Welfare and Indian System of Medicine & Homeopathy, Directorates are all included. Similarly, the Central Governments, their various departments and institutions must also subject themselves to scrutiny. That process, I do not see anywhere and if you permit me to say, the international and bilateral agencies involved in India must also subject themselves to scrutiny. I am a new entrant to this sector, though I was a Health Secretary earlier and did interact at the Central level. The number of people trying to reform you is immense, you hardly have any time to really work out a programme for reforms and you have this perception that the multilateral and bilateral agencies are to start the ball rolling by having a common agenda. There must be convergence in their programme. You could be having a situation where the World Health Organization (WHO) would be carrying on a workshop on reforms and somebody else is carrying on a workshop on reforms and it does not go into operational issues. We do not share work in a rational manner. We talk of rational drug use; we should also talk of rational use of our management's attention. The Central government as I said, must also subject itself to scrutiny. Budget is not available in some sense, but budget which is available is not properly spent. Some money is surrendered each year, the disbursements are jerky, and the two way flow of funds and accounts do not happen. Finance as a base of Management Information System (MIS) does not happen. These are some of the major concerns. Our traditional issues of reforms are already there. What Jyotiji said that ten years back such a meeting should have taken place. These sorts of meetings did take place in various State Headquarters. There are quite a few initiatives in State and district headquarters. These user charges, are now no more a buzz word, they are practical words in many States. I also would submit that Dr. Ramachandran reflected on the imbalance of personnel in this sector. Whether we need reform of that? We initially started with health personnel, and then we have gone to the stage of health managers. Earlier when I was Health Secretary, they were seen at the Central level. These health managers are now seen, percolating down to the State level but they are yet to percolate down to the district headquarter level, in at least what we call the Empowered Action Group (EAG) States.

The health managers apart, there are some efficiency issues, which cannot be attended through the personnel, that are engaged in this sector. But that is a generic problem in the whole Indian administration. We have finance personnel everywhere who are not really finance persons. They do not have the professional financial qualifications but they do

dominate the Indian financial administration. The health sector would benefit with the introduction of Chartered Accountants, Cost Accountants and such people at district level. The traditional financial personnel, who are at the State level or below at district level, are accounts clerks who have come up through the system and who are hard boiled ones and people like Shri Goel can make some attempt at a difference. We are engaging and taking help of some multilateral agency to look at these issues very deeply. I would invite attention of my colleagues from the States that this is a key factor. If funds do not flow, accounts do not come back, no buzz word of reform will carry the system anywhere. I see that programme related expenditure; hardly 20- 40 percent expenditure takes place. There are a lot of failures in those specific programme related expenditures. Then some States have carried out reforms in personnel policy. If they have had a good effect, this should be codified and should be circulated and the Central Government should also take note of it. And as it was said, an integrated package of reforms must start with an emphasis on personnel. Karnataka apparently has attempted some reforms. It would be worthwhile to listen to them, because issues of tenure, issues of compulsory rural health service are important issues for my sector, as also for the primary health care sector. There are statisticians galore, in this sector. But they are again in Central Government; to some extent they are present in State headquarters. There is also a need to look at the reforms in this area because every time you need to launch a programme, you start with a new survey. Can we reform the process and give them a due identity, empowerment, recognition so that statistics is generated on a continuous basis and goes away from the survey mode which is highly expensive, dubious, time consuming. Then I have this perception that Centre says, States should own programmes. States say that district level should develop its own programmes. Up to the district level, the capacity building is slightly visible. It is time to strengthen that, because ultimately we will have to go to the Panchayat system. But in many States we are hesitant to go to that level, because Panchayats are still seen as immature, non-functional, and non-transparent. But how do you implement a vast health care programme, the public health content of it, if the local self government institutions do not participate. So any agenda for reform must address resources and attention to involving the Panchayati Raj Institutions (PRIs).

Dr. Ramachandran has more effectively dwelt upon other points, so I will not take time of this august gathering. I have come here to learn. I would be watching out for the documents that this workshop generates.

Dr. S. J. Habayeb

Secretary Hota, Dr Rao, Dr. Agarwal, Dr. Ramachandran, Ladies and Gentlemen. I am pleased to be here and I am pleased that the World Health Organisation (WHO) is working with you on this important topic. The goals of health sector reform in a formal sense would be the achievement of efficiency, improving quality, preserving and promoting equity and generating new resources for health care.

Health system reforms falls in three broad categories, structural and functional, aimed at improving efficiency, financial aimed at improving the resources available and governance related reforms aimed at improving transparency and accountability. Health sector reforms have been the subject of debate over a long time in many political circles. In a nutshell, the success of reforms depends on how the process is applied and by whom, and not only on the contents within that reform. Unfortunately, the reform frequently tends to ignore issues relating to the process of reforms, its feasibility, implementation and the political realities. Mr. Secretary, like you I am only going to give the bullets. We are running out of time. The WHO has been supporting countries in health sector reform processes. In the South East Asian Region (SEAR), in 1997 at meeting of the Ministers, there was a declaration highlighting the challenges in the region and the first recommendation was initiating health sector reforms to reduce the inequities in health. As you know the region suffers from very massive inequities and creating conditions to promote health and self reliance. This was followed by the Regional Committee which underlined the Health Ministers Declaration, and also called for more consultation, documentation and dissemination. As you rightly said, the language of health reforms has changed over the years. The first generation of reforms was overwhelmingly supply driven and focus was within the sector only. Historically, this was less successful and worldwide we notice that success came when there was more global move towards reforms and not only mono-sectoral effort within the health sector alone. The second generation of reforms shifted more to the demand side and broadened to poverty alleviation and to a broader spectrum, including more partnerships with various stakeholders. I don't know where we are Mr. Secretary; I think we are in between them.

In India, since the early 1990s, considerable work has been done in health sector reforms, which involved government and other agencies. It is necessary to review, to evaluate the impact and outcome of these efforts, as many colleagues have rightly said. The review would aid developing future strategies and future options that the government and the State governments may consider. We need viable and feasible medium term options for enhancing service coverage for poor and vulnerable groups, while promoting efficiency and equality. The Ministry of Health & Family Welfare and the Indian System of Medicine and Homeopathy would play a vital role in the documentation of reforms and provide a platform for learning from each other's experiences. Success in reform obviously depends on State governments, as health is largely a state subject. Unfortunately, many reforms were propelled within a vacuum and with decentralization; there was a vacuum at the periphery. Reforms should be linked with capacity building at the periphery, e.g. the panchayats to be able to cope with such reforms.

At the end again, I would like to stress the need to document the experiences and best practices, which are adapted to social local conditions, and not a blueprint imported from somewhere or from an agency. We shall try to promote debates and consensus to the extent possible and we need to jointly monitor and review health systems developments and research to provide valid and scientific evidence for strengthening processes and mechanisms for health sector reform. The related analysis if performed with adequate scientific rigour would be useful in suggesting the preferred options under sector reforms that the governments may consider.

We at the WHO, along with the other multilateral and bilateral agencies and sister agencies are keen to work closely with you and with stakeholders in India in your efforts. I take this opportunity to congratulate the officers of the Bureau of Planning for undertaking this initiative and wish them all success and on behalf of the WHO, I would like to assure you of our total and continued support.

Thank you very much

Dr. S.P. Agarwal

Shri Hota, Secretary Family Welfare, Shri Javid Chowdhury former Secretary Health, distinguished participants, ladies & gentlemen. Fortunately all the things that the Director General Health Services still in government service is supposed to say, the good things which I too had written up, have already been stated. So I would then like to use this opportunity to raise a few issues. The health sector reforms basically refer to improvements in the health systems and the improvements in the health systems in turn refers to good health. Unlike the common perception, good health has very little to do with the Ministries of Health. I will tell you why. I am a practicing surgeon for about three decades now. Good health as I have learnt, depends on environment, genetics, social index that would mean your nutrition, your level of education, lifestyle – i.e. the type of food intake, type of exercise and this lifestyle depends a lot on the physical body, the emotional and mental being, intellectual level and so on. So, if we take good lifestyle, good environment, good social index, then 90 percent of the diseases will not affect you.

So in fact, Ministries of Health, who in reality are more like Ministries looking after diseases, in actuality, should be Ministries of Health Promotion and Disease Prevention with some departments of disease control. So, if that is the concept of health, then for that 10 percent we need to have the advice of professionals and health reformers that Shri Hota referred to.

Some of us tend to believe that these reforms are dependent on a number of factors, which will vary from one place to another, one country to another, one state to another. It depends on the beliefs of the people, it depends on the local governance, it depends on a number of other factors which all of you know.

Let me mention a few points, which were said here. One is of course the greater autonomy to the health institutions. Well, we need to learn lessons, as to what will sell. We have various examples, which I would like to share. The Delhi State gave some concessions to private hospitals but this did not work. We have another very major non profit hospital where the management is in the hands of very eminent doctors, with the Trustees playing a very little role. The situation works in that case as it is not merely profit driven which is normally the case in the private sector.

Another very familiar term in the health sector reforms is 'outsourcing'. Well, it is good to have the laundry, kitchen and other things outsourced. But at the same time we are facing problems. For example, recently you might have heard that there was a robbery, bank robbery or something in the World Trade Centre, a couple of days ago, where security, etc was just ceremonial. These people when you outsource, they are put on duty, made to sign somewhere else but are paid very little. So you need to have outsourcing with strict regulatory mechanism. This area really needs to be looked at again.

The problem that we talk about is mainstreaming. Mainstreaming of what? We are talking about mainstreaming of practitioners from ISM&H. Are we talking about integration of these services? The issue is that unless we really want to demolish

Ayurveda from this country, we need to look at availability of facilities under the same roof. People have a choice. We know for certain, I am not holding a brief for modern medicine, but the fact is that we know that 80-90percent of these doctors use modern system of medicine, whether they are 'A', 'B' or 'C' drugs. Facilities of different systems of medicine should be available under the same roof with greater interaction between experts of different types. A small experiment has been started in the Central government hospitals, we have an Ayurveda clinic in Ram Manohar Lohia hospital and we have a Homeopathy and Ayurveda clinic in Safdarjung Hospital. That is the type of integration which is required; otherwise we will land up with a system which may not be right for us.

Who is doing the health sector reforms in this country? I will tell you, let us not feel shy and say, it is the judiciary that is doing the health sector reforms for us. They said that the safety belts should be compulsory for the cars and next day you see it all over. They only said that helmets should be compulsory. Head injury is a public health problem today. We as neurologists have been crying hoarse over years, that if you don't have helmet and you drive, you may get a serious brain injury. They said that clean environment is important; if you have this type of fuel then there would be pollution. The environment in this city as everyone knows has changed. I think they continue in this vein. These are some of the major reforms in the health sector, to my mind.

Now the question was of greater investments in health. Yes, sure. The main architect of the National Health Policy, Shri Javid Chowdhury is here. I had the fortune of assisting him. Yes, you have to increase the public health investment from 1 percent to 2 percent of the Gross Domestic Product, but what we learnt from Shri Chowdhury simultaneously was that you have to have the greater capacity to utilize those funds and prior to his joining, if you see the record it is not very happy. Different types of funds were getting lapsed year after year, not only here but at many places.

Then, the issue is that of utilization of existing infrastructure. Dr. Prema Ramachandran showed us a huge infrastructure that has come up, especially in the government sector. Now the issue is that our monitoring mechanism needs to be put in place. You might have a working Magnetic Resonance Imaging (MRI) system which probably does 2-3 scans a day, while the one across the road with the private sector, might do 40-50. So the question is of proper utilization of the existing infrastructure by way of public private partnership. One could evolve a mechanism wherein expensive equipment like MRIs, computerized tomographic scan (CT scan), catheterisation (Cath) laboratories and other things, are provided by the private sector while the government provides the place, electricity and other facilities for the private sector to install its equipment. The private sector would have the responsibility to make the set up operational with a stipulation that these services would be available to the poor patients on a priority basis.

Another very important area that was referred to was the lack of proper health care planning and management of human resource. How many surgeons, orthopaedics, gynaecologists are required? It is nobody's business. If some one wants to become a gynaecologist and he has role model, he gets into that system. So there is an urgent need for a system to be put in place to look at this; that 5-10 years down the line, we require so

many surgeons, so we need to increase a few seats and we will have to decrease some seats in some other speciality. I again quote Shri Chowdhury. We debated this intensely during the weekend meetings that he used to hold on health policy. There is a system, where we said that 25 percent of the new post graduate seats will be progressively earmarked for the public health professionals and for the family physicians.

Before I close, I would like to say that these health system reforms have to be very flexible. Small pox went away; we thought that nothing more will happen. More than 20 virulent viruses struck us; the latest was Severe Acute Respiratory Syndrome (SARS). You know when the Surat plague took place, the country became poorer. Apart from the shame, flights were stopped; a loss of US $ 1.4 billion took place. So, you have to have flexibility. You can not be straight jacketed, importing a type of system, expecting that everything will fall into place, if this is followed. It has be flexible depending upon the situation. The latest of course was Severe Acute Respiratory Syndrome (SARS), where effective steps were taken, although we had 30 lab positive cases and 3 definite or probable cases, which could be controlled.

I would now close by finally saying a few words about the system of posting of doctors in the rural areas. This is our favourite subject. Time and again, since the last five decades, we have been saying that there should be compulsory posting of doctors. Doctors, who do not go to the rural areas, should be given compulsory posting and they should not be allowed to do their post-graduation unless they do this. I think this colonial mindset has to go. If you have to really serve the people, let me be very candid about it, because the primary health care business does not involve any foreign travel, is not as glamorous as AIDS probably is, it is to do with poor man so nobody is really bothered and unless this base becomes strong, unless our primary health structure becomes strong, nothing will happen. I have a small, brief suggestion to make. We have the practice of young men and women getting into medical services. By the time they are 22 or 23 yrs old, these boys and girls become doctors. We train them that once there is a headache, do a CT scan or MRI, whether it is due to sinusitis, brain tumour or tension headache. These doctors, even if one is able to force them to go to a primary health centre, what will happen? He or she is in competition with a village quack who is a punditji or some school teacher, who is working there for 30-40 years, who works on superstitions and beliefs. I know of a young doctor who was trying to resuscitate a person by cardiac massage that we teach them and the villagers gave him a beating, because they felt that the young doctor had killed the patient or broken his ribs by pressing his chest too hard. The issue is that according to the villages, this young doctor was not competent to treat the patients there. The doctor is trained to work in a group, under guidance and then it takes the best out of him. We feel there is a model. Why is it that doctors do not go to rural areas? It is because there are no places to stay, no security, no electricity, no water, there is no education for their children, there is nothing and to say that the ISM doctors will go there, please understand that it is a myth. We had a system 20- 30 years ago, of licentiate doctors, they had been trained for 2-3 years. None of them stayed, all of them at the first opportunity got into M.B.B.S and then they completed their MS or MD, who so ever could get, they migrated to cities. That is the natural tendency. Instead of pushing it under the carpet, we must accept this reality. Our people need to make the primary health

centres vibrant by people who can really manage. There are middle level doctors and all of them belong to some villages or towns. We all have home town advantages. We say that we belong to that village or to that town. Depending on that, it should be possible to post them for tenure of 1-2 years, where their children and families will continue to stay in cities and towns and get education. This man or lady goes to that village in the primary health centre on a tenure posting, he knows that he is not going to be dumped there for ever. He has over 15 years of some training. He can treat patients with his experience, he can relate to those people. People consider him as a son of soil. He speaks the same language; he is accepted there and that gives him some autonomy to function. Chances are that some of them would actually settle there. Nobody wants to stay in small flats in towns, in the polluted areas that we live. So if we have a plan to post middle level doctors to the places to which they belong in a rotational manner, nothing compulsory, say during the age of 40 – 45 years, he is given the flexibility to choose a year when he would be willing to go and work in the village at the primary health centres, chances are that many of them would settle there, probably they would be able to do good service and all the national health programmes that we have will actually function. I must say that I have failed to sell this idea to many of the people who matter but I thought that it is a very great opportunity in such an august gathering, I have again tried to put this forward.

I know that this country is of continental proportion, the type of terrain we have, the type of people we have, and what succeeds in one country will not succeed here, what succeeds in one state may not succeed elsewhere, what succeeds in Karnataka may not succeed in Bihar, so it is an extremely important workshop where the States tell their experience and we tend to emulate and learn from them and in that regard I would congratulate the Bureau of Planning and thank them, especially Smt. Sadhwani who organized this workshop and gave me this opportunity to be here with you this morning. Thank you for your attention.

TECHNICAL SESSION

Technical Sessions

Dr. Rama Baru

Dr. Baru provided an overview of health sector reforms (HSR) and spoke of national and international experiences in this area. She located HSR in the larger political and economic context, examined the elements included in HSR, the role of donor funding and national as well as international experiences with HSR.

Dr Baru began by emphasizing the need to relate the debate on HSR with the world recession on the late 1970s and early 1980s, which mainly occurred in the developed world and where concerns had been raised about escalating costs of care and not having enough to spend on public sector. The supporting ideology was a lesser role for the government and an increased role for the market. This was the context in which health sector reforms emerged. A formulation which is commonly used is that public provisioning was seen as inefficient as compared to markets, markets were characterized to be more efficient in terms of costs, and also in terms of being responsive to patients needs. Since the emphasis was to reduce state involvement or to rationalize costs, number of methodologies were developed, both for assessing and prioritizing investments in health. Cost effectiveness was the basic underlying objective. The strategies employed included amongst others introduction of user charges in public facilities, provision of incentives and subsidies to the private sector.

Another key issue raised by Dr. Baru pertained to defining 'health sector reforms.' She posed the question, 'what is a commonly accepted definition of HSR?' and what are its varied elements? She proposed that an accepted definition of HSR includes improving the civil service, decentralization of power and resources, improving function of health ministries, broadening health financing (including finding alternate sources of financing) and increasing role of private sector in the financing of provisioning of health care. The elements included in HSR, are privatization of health services specially at secondary and tertiary levels of care, introduction of cost recovery mechanisms that were seen to enhance cost effectiveness and also improve quality of services, including inter-alia introduction of user fees; contracting out of ancillary services in public sector, implementation of "essential services "for specified target groups at the primary level and decentralization of services, both financial and administrative.

Drawing the link to developing countries, Dr. Baru felt that it is pertinent to examine the relationship between HSR, its global understanding and how HSR was actually opertionalized in developing countries. The larger context of resource constraints in developing countries (as was also the case with developed countries) also needed to be kept in mind. Health sector reform was clearly driven by an ideological position which placed better faith in markets than the State and this was borne by differential experiences of effectiveness of public sector health provisioning across the world. Debates occurred in Great Britain, China and a range of developed and developing countries. The important things that need to be factored in were elements of HSR which were globalized by bilateral and multilateral agencies. The HSR process received an impetus by the bilateral

and multilateral agencies (though they were not the only ones who pushed health sector reforms). But these ideas had influenced health system provision already.

Dr Baru stated that one of the motivations for donor involvement in health sector, (as is also stated in some of the writings of the World Bank) was to cushion the impact of globalization. She said that the importance of the need to invest in health comes out in terms of the inequities that arose especially from the experiences of the African and Latin American countries where blanket privatization led to enormous inequities and collapse of the public systems. The desire to rebuild them at a later point became a difficult task as there was no public money. So through loan financing from the Bank there was an effort to rebuild or save through safety nets some sort of a public system once again. And it was also seen clearly as a way of rationalizing costs in the health sector.

Drawing from international experiences, she stated that across the world till the 1980s, the bilateral agencies had a fairly dominant position as far as funding was concerned. A shift occurred in the 1990s. Clearly, the World Bank had a role in sector wide programmes like nutrition, population, but they emerged as the single largest funding agency and started setting the trends and priorities in terms of policy interventions globally while various other bilateral agencies dove-tailed to the World Bank programmes. Across the world, the loans to the health sector were tied with conditionalities in terms of defining programme content, choice of technology, programme priorities etc. This has been documented across the world in the Bank's own literature as well as other work undertaken.

Coming to the Indian context, Dr. Baru said that what is significant about the health sector reform agenda is that there is funding from multilateral and bilateral for specific projects. She spoke of her past work of trying to obtain perception of donors and main actors in the Ministry about health sector reforms in India. A common response to the question, what is health sector reforms, was that it is 'a grouping of projects which includes disease control, preventive and child health, primary health care and restructuring of secondary and tertiary health care.'

In terms of assessing the impact of health sector reforms, experience largely from African, Asian and some Latin American countries through various studies has shown that the option of user charges has reduced access, especially for the poor and the middle classes. It is being seen that indebtedness due to especially high costs of medical care is pushing families from the 'middle class' to lower level. This is especially the case for countries of South Africa, Brazil and Chile. This set of evidence has set the World Bank itself thinking, with the Bank documents of the 1980s and the 1990s indicating a perceptible shift and recognition for putting equity or at least reduced inequity at the centre of the reform agenda. The other issues brought up by Dr Baru pertained to privatization and corporatization of health services which has led to increased costs as depicted in India as well as the United States. The issue of regulation is critical in this context and she felt this should be an important part of the health sector reform debate. In terms of health sector reforms in India, she drew attention to the fact that few elements of HSR predate the Structural Adjustment Programme and the World Bank. Privatization in

India has occurred since the mid 1970s but at an accelerated pace in the 1980s and 1990s. In 1991, India opted for the Structural Adjustment Programme and the loans from the World Bank with support from the bilateral agencies. These loans were sought to deal with the fiscal crisis in the health sector, especially at the state level. These loans were given to specific projects that included disease control programmes, Reproductive and Child Health programmes, primary level care and the state health systems projects that dealt with restructuring of the public sector. Each of the projects had a specific conditionality to the loans. To illustrate, in case of the Disease Control Programme, priority was accorded to certain diseases like tuberculosis, malaria and HIV/AIDS. Debate also occurred over the kind of technology that should be used, in terms of the drugs, regimens. Negotiation did occur amongst different players and conditionalities played a part in influencing policy. Similarly, a review of the health systems projects outlines a clear break up of budgets in terms of civil works, drugs, purchase of equipment and also use of contracting out of services and user fees.

Pertaining to information availability for HSR in the Indian context, there is paucity of information; some studies are available from the early reforming state of Andhra Pradesh on completion of the first referral health systems project. A review of the secondary health system projects show that a large percentage was spent on civil works, equipment and drugs. She illustrated her point by stating the case of Andhra Pradesh. In Andhra Pradesh, investments were made in the health sector, infrastructure from the level of community health centres (CHCs) to the district level hospitals was well developed but there is worry in some of the studies conducted after the initiation of reforms. The reforms were initiated with the view that it would attract patients back to the public sector. Unfortunately, the Andhra Pradesh experience has shown that the paying sections, viz. the middle classes did not move back to the public sector in significant numbers. The National Sample Survey (NSS) rounds in the mid 1980s showed that the middle class in Andhra Pradesh had already moved to the private sector as far as consumer care was concerned, with Andhra Pradesh being a State with high private sector growth. There was worry in the Andhra Pradesh government as to how they would financially sustain these reforms, how they would obtain the finances to proceed with what had been created. A small study was conducted by the Administrative Staff College of India (ASCI) using data from the community health centres and Andhra Pradesh Health Systems data. The study showed that this worrying trend had already set in.

In relation to the issue of user fees, Dr. Baru stated that even the international experience of user fees has not been a very happy one. The proportion recovered from user fees to the total revenue in the health sector was very small. The exercise in an African country undertaken by Creese shows that recovery rate ranges from 0.2 to 12.5 at the maximum. She stated that the World Bank itself has gone easy on user fees. While they were vocal about it, user fees as a concept has been a non-starter in terms of the extent to which it would be able to generate a great deal of revenue. Dr. Baru pointed out that the concept of user fees has a political dimension in the Indian context. Citing an example of Andhra Pradesh, she said that when the user fees were introduced there was tremendous protest, and the fees were withdrawn, but now there are plans for its re-introduction. She gave instances of how the Uttar Pradesh government had passed a law for user fees, which has

been reversed by the new Chief Minister. While user fees are seen to be a way forward, the political context determines how it works and the state experiences have been varied in this area.

To summarize, she said that essentially there is some data available from international experiences. In the Indian context, we have some notions of what HSR are, some elements of HSR have been incorporated by States but one does not know what has happened, and what the experiences have been what has been the impact of such reforms. She stressed the importance of being able to document and track reforms, because only then impacts can be studied. This is crucial when States begin initiating reforms. She said that the government is still committed to some notions of equity and universality. If one wants to adhere to that, it is also necessary to define impacts. And we need to as part of this workshop deliberate as to where and how we are going to do this. There is a need to document and share the process and experience of HSR across states and felt that the present workshop is an important contribution to this area.

Thank you.

State Presentations

1. Punjab

Dr. Anjali Bhawra, shared health sector reform initiatives undertaken in the state of Punjab. In her presentation, Dr. Bhawra focused on why a need was felt for health sector reforms and how it is linked to the aid received from the World Bank. She also focused on programmes put in place to improve the health delivery system, but may not be known as health sector reforms.

Punjab started implementing health sector strengthening programmes with the support of the World Bank since 1995-96. 154 secondary level organizations were selected in the state. The assistance received was to the tune of Rs. 470 crore and included a civil component, equipment component and drug packaging. Health sector reform was engaged with a view to improve the quality of health care delivery system. Given the limitations of the costs of health care delivery, increasing health expenditure especially for below poverty line families is a long sought goal. Resource allocation dilemma always exist and the perception of performance in the health system gets compounded due to lack of patient satisfaction, heterogeneity of patients seeking care from the public health system and intangible outputs. In the state of Punjab, the process of reform was initiated with re-evaluation of the health needs of the community, assessment of the deployable resources in health sector, and analysis and reprioritization of the needs and resources.

Initiatives taken by the Government of Punjab:
After receiving funds under the Secondary Health system project, Punjab began implementing user charges, linking additional resources to improve health care delivery, retaining and utilizing user charges at the point of collection, vesting higher financial powers to bring more autonomy to CSO level. Other initiatives included, democratic decentralization (i.e. handing over of primary care systems to Panchayati Raj Institutions (PRIs) and outsourcing of services in secondary hospitals. Some of the schemes which are in pipeline include medical insurance scheme, public – private mix, revamping of primary health care services, health care delivery through better mobility and emphasis on maintenance of assets & optimum utilization. Dr. Bhawra then detailed out the experiences in select areas. These are:

A. <u>Implementation of user charges</u>
Initially user charges were implemented category wise. Subsequently, slabs were removed and user charges are now being imposed uniformly. 2.5 percent of charges collected are ear marked to be spent at the institution level for poor categories. This is being done at the discretion of the SMO. Dr. Bhawra opined that the current user charges need to be revised but these she felt were harsh decisions in the political context. This proposal is under consideration. The collection procedures have been made more rigorous. Also, these have been computerized in 40 hospitals and centralized. In terms of rationalization of user charges, limits have been laid down on how that money can be spent – e.g. regular maintenance, outsourcing of the activity and on drugs. Institutional

level officers have been authorized for purchase of drugs. The indexing of user charges has been done in order to cover operational expenses excluding manpower cost and capital cost. The major policy change has been allowing for retention of user charges at the institutional level and setting out priorities on its utilization. In order to bring about more autonomy and accountability various activities are being tried out. This includes, delegation of higher financial powers to doctors at various levels, introduction of systems to monitor breakdown of diagnostic equipment, inculcating a sense of belongingness and ensuring management of emergencies.

B. **Health Insurance**

The Punjab government is in the process of finalizing a health insurance scheme. The terms of reference have been approved by the World Bank, who has indicated an interest in funding the same. This scheme proposes to address the unmet need of government employees, pensioners, and people below poverty line.

C. Democratic Decentralization

In the area of democratic decentralization, i.e. decentralization of primary care institutions to PRIs, the deadline for implementation is October 2nd, 2003. The immediate powers which would be transferred are the supervisory powers. The government has prepared a schedule of the financial powers and the administrative powers to be transferred to PRIs along with the time frame. The schedule has been communicated to the Directorate of Rural Development and Panchayats (DRDP) for confirmation. All services would be delegated to PRIs in a phased manner.

D. Outsourcing of services

The Punjab government has begun outsourcing of services in secondary level hospitals. The services relating to security, dental services, sanitation and ambulance services have already been contracted out. It is proposed that diagnostic services, medical waste disposable services, cash collection services, computerization services and maintenance services would also be gradually outsourced.

E. Public private mix

Pertaining to the area of public private mix, the government has identified one hospital and is in the process of leasing out operation and maintenance (O&M) to the private sector. Certain conditions would be laid down, which would ensure that poor patients are taken care of. This proposal is presently in the pipeline.

F. Others

Since, clinical level services at the secondary level have been strengthened, the state would like to fill the gaps in the health care system at primary health care as well as strengthen the linkages between primary and secondary system, so as to ensure that clinical services are available to maximum number of people. Hence, there is a proposal for revamping of primary health care services. The state would be trying out schemes like introduction of mobile health clinics, benchmarking in hospitals, etc. Attempts at ensuring a waste disposal system are underway, training and re-training in this area is being done. Other measures adopted include reviewing the performance of all hospitals

on a monthly basis. Nodal officers (Deputy Medical Commissioners) have been appointed in every district. Through the Health Management Information System (HMIS) system, reports relating to number of surgeries performed, bed occupancy rates, etc are obtained and hospitals are graded and hospital performance is commented upon based on the set norms. Training is seen as an important component, especially for para-medics.

To conclude, Dr. Bhawra emphasized that these efforts are being made to improve the health delivery system in order to ensure that the facilities are accessible to all, especially the poor in the state of Punjab.

2. Rajasthan

Rajasthan Health Sector Reform: A Perspective, was presented by Dr. B Sekhar wherein he focused on three main areas. He began by giving a brief introduction to Rajasthan, examined the past efforts at health sector reforms and outlined the unfinished challenges for the state.

Dr. Sekhar presented a broad profile of Rajasthan relating to various social development parameters like population, literacy rates, health status indicators, health care infrastructure, and distribution of human resources amongst others. He then presented a brief analysis of public health expenditure. The diversity of Rajasthan, the decadal growth rate and use of public sector by different sections of the population was also presented. Thereafter, Dr. Sekhar went on to share the past efforts undertaken in the area of health sector reforms by Rajasthan. These broadly covered the areas of financing methods, changes in health system organization, regulation of private sector, re-organization and re-structuring of existing government health care system, reforms related to human resources, drug policy and procurement, policy reforms, private/ non-governmental organisation / voluntary and public partnerships and equity enablers. The details are as under.

A) <u>Financing Methods</u>

Medicare Relief Society (MRS) is one of the significant reforms in Rajasthan. MRS was created in 1995 in all hospitals with 100 or more beds under the Rajasthan Societies Act. The societies are registered at hospital level, district level and sub district level and have now been expanded up-to community health centre (CHC) level. The first attempt at establishing pay clinics and auto finance scheme such as user fees was made in 1980, but these attempts were unsuccessful. The probable reasons for that include, lack of any incentives to generate revenue, and the fact that the revenue generated was deposited in the State Treasury. Learning from this experience, the MRS sought to compliment and supplement the health facility thorough generation of additional revenue, to retain and use the resources generated in the hospital through decentralized decision-making. The MRS includes various components of health sector reforms such as decentralization as it has capacity to decide the user fees and to determine how the user fees would be utilized. No guidelines have been established how the user fees are to be utilized, the same would be determined by the people and the local officials. It also provides low cost diagnostic and treatment services, free medical services to poor and disadvantaged, obtains donations from financial institutions, conserves resources through adopting wards and opening of life line fluid stores and contracting out of facilities such as Sulabh complex and the maintenance of buildings and equipment. The management structure of MRS consists of an autonomous management committee comprising of official and non-official members at State, Regional and District levels. The Executive Committee takes day to day decisions. The source of funds for the Society includes seed money by State Government, transfer of operational control of diagnostic machines to the societies. The societies are authorized to levy user charges, to retain income from auction of other support services and to accept grants and donations and loans. The Society functions outside the purview of the State and the Government Financial Rules (GFR) do not apply

and they can purchase equipment according to its own requirements. The people exempted from payment of any charges include the families living below the poverty line, widows, freedom fighters, destitute, citizens over 70 years and retired government servants. The money collected is utilized for maintenance and renovation of buildings, maintenance and repair of equipment, purchase of new equipment, improving sanitation and cleanliness, improving other facilities for patients and attendants, computerization of various systems, provision of free medicines for below poverty line (BPL) families. Past studies have shown that the funds are used appropriately, though some cases of misappropriation might also have come to fore.

Dr. Sekhar then shared the experience of establishing Life Line Fluid Stores (LLFS), which function in all hospitals with 100 or more beds. As part of this initiative, I.V. fluids, surgical items and injectable antibiotics are provided to patients at marginal profit. These services are available 24 hours and there is no financial involvement by the department or M.R.S. This initiative has been widely appreciated. The Society continues to grapple with challenges pertaining to rationale use of surplus funds, how to ensure free services to exempted categories, ensure 25 percent of surplus funds for below poverty line (BPL) families, use of funds in same financial year, developing systems for setting user fee, expanding the scope for levying user fee and ensuring proper systems for perspective planning and accounting.

B. Changes in Health System Organization

The changes in health system organization include decentralization, granting autonomy of hospitals/ CHCs / PHCs, contracting-out which in turn encompasses, appointments being made on contract-basis, and the Information, Education and Communication (IEC) Bureau. Dr. Sekhar briefly specified the kind of changes being undertaken in each of these areas.

In the area of decentralization, district health societies have been formed headed by the Pramukh of Zilla Parishad. Under this society, the various societies of the National Programmes have been merged. There has been a relocation of Dy. CMHO offices. Studies have shown positive impact arising out of this change. Powers have been delegated / devolved to the Panchayati Raj Institutions. Autonomy has been granted to institutions like the Medicare Relief Society as discussed earlier. Contracting out has been done in various ways. This comprises the cleaning services in hospitals, appointment of computer operators and computerization on Built-Operate-Transfer basis. Appointments on a contract-basis are being given to Auxiliary Nurse Midwives (ANMs), Laboratory technicians, Staff nurses and medical officers at the district level. Changes are also being made in the functioning of the IEC Bureau, which established in 1990. Attempts are underway at comprehensive reorganization of fragmented efforts in IEC, planning, monitoring of these techniques, research and experimentation and production of material and providing technical support services.

C. Regulation of the private sector

This is another area where reforms are underway. The enactment of the Rajasthan Clinical Establishment Regulation Bill, 2001/ 2002 is in process. This Act would soon be

sent to the Assembly. Dr. Sekhar, also briefly shared about the Rajasthan governments unsuccessful initiative in formulating an Anti-Quakery Bill.

D. **Re-organization and Re-structuring of the existing Govt. Health Care System** This has included initiatives like the relocation of the office of the Dy. CMHO.

E. **Reforms Related to Human Resources:** Reforms in this area comprise of initiating a three month training to address the shortfall of Anesthetists. It aims at rational allocation of resources and certification.

F. Drug Policy and Procurement reforms consist of formulation of an essential drug list and directions for implementation.

G. Policy Reforms: In the arena of policy reforms, the following policies have been framed. These are Population Policy & RG Population Mission, training policy, essential drug policy, policy to promote private sector and transfer policy amongst others. Health Vision 2025 is being worked upon. The other policies under consideration are formulation of a State Health Policy, Anti Quackery Bill, Clinical Establishment Act, Regulatory Authority for Health Care and Medical Education.

H. In the realm of the Private/ NGO/ Voluntary Sector, the existing schemes are Jan Mangal Scheme, Swasthya Mitra – village level worker based on the Madhya Pradesh experience, encouraging private medical colleges, nursing colleges and schools.

I. Equity Enablers: The equity enablers include the BPL Medicare Card Scheme being implemented by the MRS wherein cards have been distributed to these households and 25 percent of funds raised under the Society are used for purchase of drugs for them.

J. Others: Dr. Sekhar opined that the experience of the MRS should be studied extensively. It has done a great deal for health sector reforms. There is a need to examine the innovations, the gaps that require to be filled up and to examine the multiplier effect of user fees. He also stressed the need for an enabling environment for policy. There exists only one Secretary for Health & Medical Education. Given the scale of work, it is suggested that there should be three Secretaries, each looking after Health, Medical Education and Family Welfare. Several experiments were tried in this area. There is a need to re-examine the existing administrative set up, especially in the light of the burgeoning number of mega hospitals and lack of appropriate manpower to manage them. He posed the question that we might want to examine whether restructuring the departments as urban health and rural health might be more appropriate. The other issue is of enhancing management capabilities, addressing geographical, social, gender inequities, encouraging and regulating private sector, improving quality and protection from impoverishment. He also emphasized the need to examine the equity element in relation to establishment of medical colleges, the need to enhance the role of paramedics, given the size of the private sector and the increased need to have discussions about the private sector and it's functioning. There is a need to ensure some mechanism for ensuring accountability of the private sector, wherein initiatives need to come from the

Centre as well as the States. Dr Sekhar also posed critical questions, relating to insurance, as to whether we had the management capacities as well as resources to implement such schemes.

3. Gujarat

Shri S. K. Nanda, traced structural, functional and systemic initiatives undertaken in Gujarat. He was of the view that reforms should be placed in the context of Alma Ata, the objectives of which include inter-alia community participation, health promotion, equity, appropriate technology and multi-sectoral collaboration. To this, he felt we need to add health mapping and prevention of morbidity. Shri Nanda emphasized the need to invert the triangle, wherein primary health care has become the tip with curative care forming the basis. Pertaining to health sector reforms, he mentioned that small steps have been taken in Gujarat to correct the inadequacies in the system.

A. **Grouping the Community Health Centres (CHCs)**

In terms of health delivery, the CHCs are emerging as a crucial first referral unit, and are important centre of activities. Many specialists are getting spread out in the districts and it was anticipated that many things would be done by these persons. Hence, a practical initiative was taken by grouping the CHCs in an attempt to enhance resources. There would be 1-2 mother CHCs, and at least 4 specialists who are available in the 50 km area would be brought to the selected potential CHCs by rearranging their posts. He voiced the opinion that one of the reasons that people spend more on private sector is due to quality of care, including the waiting time, the promptness of service, the behaviour of the service provider, the clinical outcomes and post care concerns. Issues relating to the availability of doctor, his / her accessibility, the transport facilities, facilities inside the hospital amongst others detract the patients from approaching public sector institutions. Hence, it was decided that attempts would be made at regrouping of CHCs and identification of mother CHC, a first referral unit of excellence.

B. Decentralization – Creation of Block Health Office

Shri Nanda shared that in Gujarat, gaps have been identified in terms of lack of personnel at the Taluka / Block level. A person at this level can help in optimization of time by attending meetings or attending to non-officials who begin delving in matters of public health. Personnel at the block level would function as an 'insulating rod'. S/he would interact and intermediate with all the multi-sectoral agencies and programmes. This has led to creation of Block Health Office, to assist District Health Organisation in planning, implementation and review of activities related to PHCs, to facilitate supplies of medicines, vaccines and other supplies related to implementation of relevant National Health Programmes, to facilitate health-related data flow from the primary health centres, to analyze, communicate and give feedback to the concerned officials thereby improving quality of delivery of primary health care, as well as enabling effective supervision at the Taluka level.

C. Establishment of Emergency Obstetric Care:

The third area of reforms has been the establishment of Emergency Obstetric Care (EOC) centres in tribal and inaccessible areas, aiming to address the high maternal mortality rates. With the use of wireless technology, communication and transport of patients to facility in time is being achieved. The use of technology has made it possible to reach previously unreachable areas. This project is being piloted in one taluka with training and

net working for early referrals. It is proposed that very high frequency voice communication through wireless would be provided in 32 sub-centers, 8 PHCs, district hospital and mobile vans. Upgraded ambulances having facilities for emergency critical care and newborn care would be available at the district hospital. The staff of district hospital and primary health centres would be trained in emergency obstetric care and newborn care and district hospital facilities will be upgraded. Rs.50 lacs have been sanctioned under planned activities of the state budget for this initiative.

D. **Application of Geographical Information System (GIS) in Malaria**

The other model being tried out is that of application of GIS in planning of activities related to malaria control. Mapping of all 18000 villages has been done for the last four years for micro planning of control activities by district and sub district officials. The village wise data for four important malaria indices has been categorized them in to four levels. "Remote Sensing and Communication" [RESECO] a governmental organization is working for institutional capacity building by combining the use of GIS and pictures/ images received through satellite.

E. **Granting of powers to Medical Officers**

Another area where reforms are being carried out, is granting powers to medical officers to spend Rs. 10,000 – 15,000 for minor structural repair work in primary health centres or sub-centre buildings with a limit of Rs. 25,000 per year. These powers are limited for the grant received from donor agencies. Similarly powers for civil works are delegated to District Reproductive and Child Health (RCH) societies up to Rs.10 lacs for a single item.

F. Contracting out

Services like IEC are being contracted out. The intention is to pool together the best information through a system of contracting. One of the players is the pharmaceutical companies, who have their own IEC budgets. The money is pooled together on a common basis and the agencies hired by the private sector are allocated the money through a special sanction. Hence, attempts are being made to build partnerships to ensure wider coverage.

G. Reorganization of the entire cadre of Para Medical Ophthalmic Assistant (PMOA) The cadre of Para Medical Ophthalmic Assistant (PMOA) is being reorganized according to community needs. This is being done by relocating PMOA posts in Primary Health Centres to the community health centres to facilitate use of the primary eye care service like refraction, treatment of primary eye care, etc.

H. **Urban Health Care**

'Urban Health Care' Project is proposed for providing primary health care to urban slum population under public private partnership by community based health volunteers in urban areas. Given the lack of infrastructure in urban areas, towns with less then one lakh population would be covered under this scheme. The community based health volunteers would be selected from local areas and they will act as link between service providers and community. The towns either have community health centre / primary health centre/

post partum unit / urban family welfare centre or trust hospital, which would monitor the activities. They will be paid monthly honorarium as per the approved scheme. This scheme would be tried out on a pilot basis.

I. **Appointment of honoraries and part-time specialists to encourage private practitioners under "Samaydan scheme"**

This scheme aims to ease the problem of vacancies of specialists in health and medical services. The government of Gujarat is appointing honorary and part-time specialists. So far, about 125 such specialists have been appointed. The government has encouraged private practitioners to give the services in public sector under "Samaydan scheme". As a part of this, govt. is actively considering the removal of age-eligibility criteria for appointment of doctors in govt. services.

J. Extending partnership spirit with NGOs

The management of primary health centres and community health centre has been taken by non-governmental organisations under a partnership programme. So far one primary health centre and three community health centres have been handed over to non-governmental organizations for running the same, while nine proposals are under consideration

K. Link Couple Scheme

The Sector Reform Cell committee has approved scheme of link couples in rural areas. Under this scheme, 10 Couples married during last five years and having aptitude for social work will be selected from villages where the post of Auxiliary Nurse Midwives (ANMs) post is vacant or not staying at the Head Office. They will act as link between service provider and community. Good couples will be rewarded in cash every quarter. Budget is Rs.10, 000 per primary health centre per year.

L. Establishment of Quality Control Circles to improve quality of health care services by means of capacity building

Primary health care is provided through a network of community health centres or primary health centres and sub-centres. So far the emphasis has been on quantity. To improve coverage and patient satisfaction, quality of services requires to be improved. It was planned to implement quality control circle in one Taluka of Rajkot district under the European Commission supported Sector Investment Programme. The base line study has been completed. As a part of this initiative, medical officers and primary health centre staff of Sabarkantha and Dahod districts have been trained. This project was taken up under the United Nations Population Fund (UNFPA) assisted integrated population and development project with the aim of creating awareness about quality among staff

M. Establishment of Blood Transfusion Grid/Network

Most of the blood banks exist in the urban areas and are operated privately. It has been felt that networking of blood banks is most urgently required to deal with the issue of maternal deaths. Hence, first referral units would be identified in the state to establish a network. Under this scheme, it is proposed that blood collection and storage facilities are developed as per government guidelines at district hospitals and first referral units (FRUs). A networking of blood banks operated by government, trust hospitals and by private owners would be done.

N. Capacity Building

Health training is being planned through involvement of peripheral training institutes of relevant expertise (management, administration etc) available with private/ non-governmental organization (NGO) sector. Mapping of the expertise available for training in private and non-governmental organizational sectors and involving them in training and in sharing of the information (e.g. IDS).It is proposed that these programmes would be run on shared work schedule.

O. Others

The other reforms include involving community in health service delivery and provision; arranging for sharing of information for surveillance from the private clinics. This would include training community volunteers and National Social Service (NSS) students, specifically girls and women groups, about primary health care, reproductive health care, essential trauma care and essential obstetric care, amongst others.

4. Himachal Pradesh

Dr. R. N. Mahanta presented on health system reforms in Himachal Pradesh. He traced the process of reforms along with their content. Dr. Mahanta shared that the genesis of health sector reforms can be traced to a combination of factors. Besides the keenness of the State Government to reform the Health Sector in Himachal Pradesh, two Organizations – GTZ (German Project) and European Commission Programme through the Government of India are supporting reforms in the health programmes and activities in Himachal Pradesh. Dr. Mahanta spoke of reforms that have occurred in the area of financing methods, health system organization, delivery and management, role of panchayati raj institutions (PRIs) in health, contracting out of services, promulgation of the Himachal Pradesh Paramedical Council Bill, reorganization and restructuring of existing government health care system, human resources and drug use amongst others.

A. Changes in financing

Changes in financing have been enacted through the establishment of Aspatal Kalyan Samiti, under the Registration of Societies Act, at Zonal and District Hospitals. The Government issued a letter on August 5, 2000 followed by a Government Order on July 8, 2001. These Samitis were set with an objective to improve system efficiency, service quality; patient satisfaction; enhance local decisions and initiative of the officers; ensure accountability at hospital level; enhance resource utilization and generate resources through community financing and user charges. In terms of process, he shared that this work which began in 2001 was attacked from all quarters. There was opposition as is always there for any reforms measure. However, the results started showing in 2002-03 and people, now, appreciate the steps taken.

The Aspatal Kalyan Samiti has been extended to Sub-Divisional level Hospitals in 2002. There exists provision for giving seed money to improve such facilities so that they add to resource generation in the hospitals. Dr. Mahanta shared that encouraging results have been seen. In terms of services, primary health care, emergency services, National Disease Control Programmes as also entire treatment of families living below poverty line is absolutely free. The criteria for families BPL are that they carry an Integrated Rural Development Progamme (IRDP) card/certificate with them; or the treating doctor is satisfied that the patient actually belongs to the BPL category. The major stakeholders include the community and various non-governmental organizations (NGOs). In some of the hospitals, the NGOs have adopted wards; they provide food to the indoor patients; are involved in improving the infrastructure of the hospitals. The other stakeholders are the Panchyati Raj Institutions (PRIs), district administration, patients and health providers. In terms of the monitoring and evaluation system, monitoring is a regular process. One of the members of the Samiti is a representative of the Audit and Accounts Wing of the Finance Department. The evaluation of the working of these Samities upto the hospitals at Zonal and District level were done by Himachal Pradesh Voluntary Health Association (HPVHA). The recommendations of the report are being implemented in order to improve the functioning of the hospitals.

Dr Mahanta also outlined the successes and failures, constraints faced and lessons learnt. He said that it is clearly visible that where there are creative and dedicated in-charges of hospitals, there the improvement in the hospitals is remarkable. However, the improvement is State wide because it is for the first time that the doctors in the hospitals have started developing a Vision for the hospital. The greatest hurdle in bringing about changes is the employees of the Government, who vehemently opposed the formation the Societies. They could come to terms after long deliberation with them. Another lesson is that before jumping into a change or reform, all the stakeholders should be taken into confidence after a series of discussions with them.

B. **Health system organization, delivery and management**

Another change attempted is in the area of health system organization, delivery and management. These include granting of autonomy to hospitals, decentralization of administrative and financial powers upto the primary health centre (PHC) level. The Block Medical Officers (BMOs) have been given an imprest of Rs. 5000/- while the Medical Officer In-charge (MO/Ic) of the primary health centres has been given an imprest of Rs. 1000. However, in practice due to financial crunch the MO/Ic are not enjoying this power as the funds are not placed at their disposal by the Block Medical Officer. Dr. Mahanta stated that while delineating the role, one major step was the functional integration of the Department of Indian System of Medicine and Homeopathy and the Department of Health and Family Welfare to follow standard protocols in the National Health Programmes. The same has been notified. The process was streamlined in 2002-03 by putting into practice a defined methodology wherein District Ayurveda Officers attend monthly meetings of the Chief Medical Officers (CMOs); the CMOs allocate targets to the District Ayurveda Officers in preventive and National Health Programmes. Meetings of sub-divisional Ayurveda Officers and Block Medical Officers are held for determining targets for CHCs and PHCs; Officers have been appointed in both the Directorates to solve the problems, if any. The training of Ayurveda officers in National Health Programmes and other reforms is likely to be undertaken in Health and Family Welfare Department, subject to availability of funds.

C. **Role of Panchayati Raj Institutions (PRIs)**

Another development is that the Panchayati Raj Institutions are being given adequate powers to play a vital role in health related activities. Parivar Kalyan Salahkar Samiti (PARIKAS) have been formed at all the three levels of Panchayati Raj System. The Panchayat PARIKAS has Pradhan of Gram Panchayat as the President and, preferably, the female health worker as the Secretary. The Khand PARIKAS has Chairperson of the Panchayat Samiti as the President and the Block Medical Officer as the Secretary; and the Zila PARIKAS has the Chairperson of the Zila as the President and the Chief Medical Officer as the Secretary. Also sensitization workshops have been completed in 10 districts for the representatives of PRIs towards health related programmes. Workshops for the representatives of the PRIs or 2 blocks are being held in Kangra District by Centre for Research in Rural and Industrial Development (CRRID). A booklet giving details about PARIKAS and health institutions plus health programmes has been published in Hindi and it has been distributed to all the representatives of the PRIs. Funds for family health awareness camps under HIV/AIDS and those for Mahila Swasthya Sangh

activities are being given to PARIKAS now instead of the Block medical Officers to ensure more involvement of PRIs in health related activities.

D. **Contracting out of services**

Select support services in health institutions have been contracted out. Three support services; viz., scavenging, laundry and diet are being transferred to the private sector, wherever possible. The private sector is being involved in the service delivery only as far as the National Health Programmes are concerned. There are some hospitals in the State and four Hospitals outside the State where the employees of the State Government can get their treatment done and the expenses reimbursed to them. Himachal Pradesh is also attempting to appoint health care personnel on contractual appointment. As a part of this process, the first step was to appoint institution-specific doctors. It was successfully done and a three-day pre-placement training was given to these newly appointed Medical Officers. The second step would be to fill 100 posts of doctors and 181 posts of nurses in institutions where there is paucity of staff.

E. **Promulgation of the Himachal Pradesh Paramedical Council Bill**

Another change being attempted is the promulgation of the Himachal Pradesh Paramedical Council Bill 2003. The objective is to maintain the State Register of Paramedical practitioners and to prescribe a code of ethics for them; also to register para-clinical establishments etc. Efforts are also underway at promulgation of H.P. Medical Council Bill 2003. A significant step in terms of policy has been the adoption of the Himachal Health Vision 2020 by the government as a policy document, wherein it commits to being the dominant provider of total health care services.

F. Reorganization and restructuring of existing government health care system

Another area of reforms pertains to reorganization and restructuring of existing government health care system. Steps have been taken towards rationalization of health institutions with staff being mentioned for each category of institutions. A revised nomenclature of the health institutions in the State has been developed. Service Norms for various health institutions have been notified and this would pave the way for "care of a patient and the level at which he would be looked after". Attempts are underway at re-structuring the cadre of Medical Officers in the service of the Directorate of Health and Family Welfare.

G. **Reforms related to human resources**

In the area of human resources, state-wise cadre of laboratory technicians; pharmacists; female and male health workers; dais (Birth Attendants) and staff nurses has been converted into district cadre (Workforce Management). Secondly, all Health and Family Welfare societies have been merged into one at the state and the district levels. Thirdly, managerial skill up-gradation of senior level Officers has been done so that they prove equal to the posts that they are likely to hold. Capacity building of Medical Officers in proper utilization of the powers is being done along with the Reproductive and Child Health programme refresher courses.

H. **Drugs**

In the area of rationalization of drug use, Essential Drug List, Drug Formulary and Standard Treatment Guidelines have been prepared after the formulation of Essential Drug Policy. Capacity building of Medical Officers in the use of generic drugs is underway.

I. **Other**

Other improvements which have been attempted include, ensuring interconnectivity for Management Information System for collecting data for National Health Programmes, disease surveillance and manpower planning, which is currently being implemented on pilot basis in select areas; improving information, education, communication (IEC) and advocacy, streamlining the writing of annual confidential reports (ACRs), conducting a survey on burden of disease, registration of vital events and its computerization. The unfinished agenda has been documented in the Himachal Pradesh Health Vision.

5. Uttaranchal

Dr. I.S. Pal began his presentation by giving a profile of the State of Uttaranchal, relating to its population, administrative and health care delivery structure. He outlined the issues of accessibility of health care due to the physical terrain, geographical locale of the state and lack of infrastructure and human power. Thereafter, he described the reforms being attempted in the health sector at the primary and secondary levels of care.

A. Reform initiatives at the primary level

The reform initiatives for primary health service delivery consist of contractual appointments of medical officers and Auxiliary Nurse Midwives (ANMs), especially in the remote areas to combat the problem of access to health services, development of a transfer policy for medical officers again aiming to ensure availability of service providers in remote areas. The medical officers posted in remote areas are given preference for post graduate admissions during service, specialists are appointed in the community health centres / Tehsil and district hospitals. The other areas are training of birth attendants, provision of incentives like a special non practicing allowance to service providers in difficult areas. Amalgamation with the Integrated Child Development Scheme (ICDS) by training Anganwadi workers (AWWs), holding joint meeting with medical department at district, block and sector levels are some other measures being adopted. Similar kind of integration with the Indian System of Medicine and Homeopathy (ISM&H) by involving them in implementation of National Health Programme and establishing linkages between this department and the health department at sector, block and district levels is also underway. To ensure better management of human resources, a fixed day schedule for health service delivery has been drawn up. Also, the powers and responsibilities of medical officers at additional primary health centres have been fixed. Community participation in health service delivery is being attempted through a pilot project planned with the support of the Sector Investment Programme. In the realm of public private partnerships, mobile van is being provided for diagnostic and curative services in collaboration with the department of Science & Technology and the Birla Institute of Scientific Research.

B. Reform initiatives for secondary health service delivery

Reform initiatives for secondary health service delivery include privatization of sanitation, laundry & diet services. A government order to hand over laundry and diet services in nine hospitals to private agencies was passed in December 2001. The agencies were selected based on competitive bidding. Disease specific diet is being served in these hospitals. The services in the Doon hospital were handed over to the private agencies in February 2003. Another area of partnerships with the private sector has been establishment of public calling offices (PCOs) in government hospitals. The other initiative includes formulation of a drug procurement policy. A state comprehensive policy is to be formulated by the Uttaranchal Health System Development Project (UAHSDP). With a view to bring about decentralization and ensure community participation, Chikitsa Prabandhan Samitees have been established in select hospitals. These committees have been registered for 30 district level hospitals under the

chairmanship of the District Magistrate. Elected members are represented in the samitees. 100 percent of the user fees collected is retained by the Samitees for utilization.
Initiatives have been taken to establish integrated umbrella society at state and district level. At the state level, apex society for National Programme has been established under the Chairmanship of Chief Secretary to ensure implementation of National Health Programmes. Furthermore, six sub-committees have been set up under the chairmanship of secretary medical for various national programmes with the Director General as vice president. The funds flow from the Government of India through the state level society to district empowered committees for implementation of National Programmes. A secretariat is proposed to be setup in the campus of Director General with support for manpower and equipment. At the District level, district empowered societies have been registered. The committee is headed by the District Magistrate with the Chief Medical Officer as Vice President. Similarly, to the state level, even at the district level, a secretariat is proposed to be set up.

At the policy level, an integrated health and population policy was formulated in December 2002, outlining specific health and population stabilization objectives, policy directions and interventions to achieve the mission and policy objectives. Lastly, Dr Pal spoke of the proposed delegation of powers under the 73rd Amendment wherein the Gram Panchayat would have administrative control of male and female workers at village level. In the future, recruitment would be made through the gram panchayat. The block panchayat would have administrative control of all health delivery personnel at block level. Again, future recruitments except for medical officers would be through the block panchayat. The Chairman of the Zila Parishad would have administrative control at district level with the Chief Medical Officer functioning as the Additional Executive Officer.

6. From First Phase to Second Phase of RCH

Ms. Nandita Chatterjee shared the initiatives being planned under the second phase of the Reproductive and Child Health (RCH) programme, which is presently being designed.

The first phase of RCH programme would close by March 2004 and presently efforts are underway for designing the second phase of the RCH programme. Based on past experiences, some of the lessons learnt include, criticality of state ownership of the programme, need for flexibility based on state needs and capacities, for adequate institutional arrangements to be put in place, for upfront agreement on process and output indicators, insistence on regularity and quality of monitoring systems, linking of performance to financing, establishing linkage between the reproductive and child health programme and family planning services, strengthening of management capacity in the areas of planning, supervision, budgeting and fund flow, strengthening of program management capacity at district levels especially in the Empowered Action Group (EAG) states, need for introduction of human resource planning, forecasting requirements of human resources, their training, posting and promotional policies. The other lessons include, need to establish client sensitive behavior in service providers, developing state specific behavioral change strategies, enhancing client responsiveness to the reproductive and child health services so as to introduce a demand driven service delivery system, improving outreach services, particularly regarding routine care and in retaining clients for completing the cycle of care, involving communities and local elected bodies in planning, management and monitoring of program performance, inclusion and emphasis on neonatal health & adolescent health, involvement of private sector to enhance availability of services and to build bridges with other critical sectors.

Ms. Chatterjee also outlined the need for the second phase of the RCH programme in view of the high level of Infant Mortality Rate (IMR) and contribution of neonatal mortality, the need to focus on states with high total fertility rate (TFR), to address inequities in the use of service delivery systems related to child health, maternal health and essential obstetric care in the weak states, to improve functional linkages of primary care services with facilities providing emergency obstetric care (EOC) and better understanding of contributory factors through maternal death audits and the need to improve birth spacing, skilled attendance during pregnancy, care and service during child birth and post natal periods.

The vision of the Second Phase of the RCH programme is to bring about outcomes as envisioned in the National Population Policy 2000(NPP 2000), The Tenth Plan Document, National Health Policy 2002 (NHP 2002) and Vision 2020 India, minimizing regional variations in the areas of Reproductive and Child Health and Population Stabilization through an integrated, focused, participatory program meeting the unmet demands of the target population, and provision of assured, equitable, responsive quality services, by adopting a mission mode. Further, the programme, also aims to educate and empower through behaviour change communication and community mobilization in improving the health seeking behaviour, to increase quality/responsive/sensitive/reliable service availability and improve the accessibility in order to improve the attendance at the

public health system, to set in motion sector reform initiatives in order that the service availability in the public health delivery system achieve a better perceived image among the population, to put in place strategic initiatives to bring about a wider role for the private sector providers to enable achievement of wider reach of services and to initiate policy changes to ensure assured services at all levels in a equitable manner to all those who seek services as well as enable initiatives hither to not possible due to the policy environment.

The proposed strategies for the same include provision of dedicated structural arrangements to improve program management, improved ownership among states, decentralized planning and implementation through involvement of the Panchayati Raj Institutions (PRIs) and Urban local bodies (ULBs), strengthened system of planning, monitoring and supervision, adopting a differential approach, integrating referral networks, strengthening quality aspects of service delivery, enhancing coverage of antenatal care, new born care, institutional deliveries, bringing comprehensive integration of family planning into safe motherhood and child health, inter-sectoral collaboration and convergence, empowering structure and enabling environment and increasing the involvement of the private sector.

The various components of the programme would include maternal health, reproductive tract infections / sexually transmitted infection, new born and child health, adolescent health, population stabilization, urban health, tribal health, involvement of non-governmental organisations, infrastructure mapping & strengthening, behavioral change communication and training.

The process of designing this programme for a state would include the formation of a design team with a nodal official to lead the process, drawing experts from the state itself, looking at outputs upfront, interpolating process indicators and working out annual plans and budgetary requirements, conducting a sector analysis, monitoring on the basis of performance benchmarks as agreed upon mutually by the state and the Ministry of Health & Family Welfare (MOH&FW), drawing on good practices and attempting decentralization through the PRIs or ULBs.

Remarks by Resource Persons

1. Shri Javid Chowdhury, Former Secretary Health, Ministry of Health & Family Welfare

At the outset, Shri Chowdhury expressed unease at the use of the term, 'health system reforms.' He was of the view that the health scenario keeps changing from time to time. It may improve or deteriorate due to various reasons like interventions by the state or private practitioners. To cope with this changing scenario, various initiatives have to be modified from time to time and these initiatives may be called reforms. In his remarks, he spoke of the significant features of the health scenario in India today, which would have a bearing on the reforms or initiatives to be undertaken.

Shri Chowdhury began by addressing the issue of accessibility of health services. He opined that the services available to the citizens of this country are highly inadequate. He based his views on the findings of the National Sample Survey (NSS), 1995-96 study which indicates that as many as 16.4 percent of people who fall ill, do not have any access to health services, mainly due to want of financial resources and for want of access to a health delivery centre nearby. The fact that this occurs in a country where at least 26 percent of the population lives below the poverty line; he felt is a matter of serious concern.

The second issue that Shri Chowdhury spoke of related to public and private health expenditure incurred in the health sector. The public expenditure of Rs. 200 per capita (US $4) per year is miniscule. This expenditure as percentage to GDP is 1 percent, which is amongst the lowest in the globe. On the other hand, the private expenditure is about Rs. 800 per capita per year. This expenditure though not very low, is very sporadically spread. Hence in times of availability of funds, an individual may seek good treatment at fairly high cost while non-availability of the same may lead to serious ailments being untreated. This composition of low public health expenditure and sporadic private expenditure provides no health security in India.

Shri Chowdhury laid emphasis on the need to examine the responsibilities assigned to public administrators and the increased reliance placed on private practitioners, institutions and private service providers. The National Sample Survey Organisation (NSSO) data has shown that though public health expenditure is very low, the public health services are largely utilized and accessed by those below the poverty line or those marginally above it. The high proportion of private expenditure on health and utilization of private sector is partly due to the limited availability of public health services. He disagreed with the general perception that if given a choice, people would avoid public health services and opined that people avoid these services, as no service exists. Therefore, he said that the expenditure being made in public health services is not a dead loss; it is a mode of service delivery which cannot be ruled out.

Further, he added that the fact that private services cost more than those provided in publicly funded institutions is an aspect which cannot be forgotten in the process of

formulating a policy and discussing how to develop a mix between public and private sector to achieve the goal of ensuring reasonable health services to the population.

Shri Chowdhury then raised the issue of lack of monitoring of quality of health services and the lack of any professional standards or ethics. This in light of the dominant role of the private health sector was seen by him as an area of concern. While issues of lack of quality crop up in the public sector too, there exist mechanisms for ensuring some standards in the public institutions thereby making it unlikely that the situation would become as exploitative as it might in an unmonitored private health delivery system.

He clearly stated that he was not assuming any confrontationist role between the public and private sector but merely trying to identify the characteristics of the two modes of delivery so as to assess the extent to which they could be enhanced. He was of the view that the unmet need for medical services in the country is so great that even if both these sectors stretch themselves out fully, there would still be a substantial unmet need. In this context, he offered some suggestions as to what would possibly be a reform direction that one could adopt to mitigate the current situation.

The initiative taken to delegate powers and resource raising authority to local self government institutions under the 73rd and 74th Amendment have a significant bearing and need to be strengthened. The second initiative is the greater association of private practitioners and private service providers in public health programmes. To illustrate, the vertical programmes for control of tuberculosis and malaria can be implemented through private practitioners and private service delivery centres. Therefore, partnership in such activities Shri Chowdhury felt would be very fruitful and should be adopted at the earliest. He proposed that other programmes like immunization, prenatal and post natal supervision of the mother and children, also be implemented through the channel of the private practitioners and private service delivery centres. These would increase the outlets enormously, particularly in the urban areas. The partnership with the private sector as an outlet for health services funded by the state could also be adopted.

Moving to the area of insurance, Shri Chowdhury opined that it is currently estimated that 107 million people are covered by way of voluntary social health insurance, mandatory insurance or private insurance. It is felt that in the medium range this is not likely to grow to more than 165 – 170 million. So out of one billion population, 170 million would be serviced by some type of health security. Given this position, the question that needs to be addressed is where would the rest of the people go? This in turn necessitates a larger role for the state, in spite of the prevailing constraints. He also brought out the lack of any operational research and base data relating to health insurance and the information gap pertaining to what types of modes of service delivery would be effective in different situations and in different parts of the country.

Thereafter, Shri Chowdhury drew attention to the fact that the non-governmental organisations (NGOs) operating voluntary social insurance schemes are doing an admirable job but within a limited span of operation. It would then be unrealistic to expect this mode of service provision to lead to complete coverage. He suggested that

one needed to take up small blocks, provide funds and a package of primary health care services of say Rs. 150 per capita, per year. This could be entrusted to the PHCs, so that one is able to ascertain, based on field experiences, as to what is 'doable'. He also spoke of alternative financing. Shri Choudhury's view was that the scope for alternative financing is relatively low in India. He questioned that if 83 percent of health expenditure is privately funded then what more can one expect from the private sector? He was of the view that there existed a possibility of obtaining better value for it and one of the mechanisms would be risk-pooling. The private insurance which exists is applicable only for a limited section. Therefore, he suggested it would be useful to carry out experiments for implementing social health insurance in compact blocks, which could be funded by the state in say 50 PHCs on a pilot basis. A minimum health package would need to be defined; operations would need to be reviewed to see if these are viable. The modules can be of different parameters to ensure that we strive towards an optimal solution.

He felt that any talk of health sector reforms, should also include budgetary reforms. There cannot be any talk of improving organizations without having the basic inputs. Given the low levels of allocation of resources, he felt that the public health system has not been optimally tried out. He hoped that the policy prescription contained in the National Health Policy 2002 of increasing public health expenditure to 2 percent of the Gross Domestic Product (GDP) by 2010 would lead to improvements in the performance of the public health providers. Lastly, he stated that while the concept of health sector reforms is being pushed by developed countries, they are also realizing that providing advice without any support is not likely to be expected.

2. Dr. Tej Walia, Adviser, HSD, WHO-SEARO

Dr Walia traced the process of health sector reforms and highlighted some critical issues of concern. He opined that health sector reforms is an ongoing process in the South Asian region, and its beginnings can be traced to the Alma Ata Declaration and the call for Health for All (HFA), using primary health care as mechanism for delivering 'Health for All'. Health sector reforms have been taking place in a piecemeal manner not only across different states in India but also globally and some of these experiences have been recorded. There have been some successes from the health sector reform process, with an improvement in health indices over the last 30 years but an unfinished agenda still exists.

Prior to the reform process, in the 1960s, most governments were more focused on economic development and hoped that it would lead to a trickle down effect. Later, it was realized that this was not necessarily the case, so focus in the second stage turned to the reaching those who were not being reached such as the poor, the underprivileged and the focus also shifted to the rural areas. Currently, the emphasis is on health and poverty, wherein publication of reports like the Commission on Macroeconomics and Health, have provided a new impetus to this process. However, the call for health sector reforms has been voiced not from within the health sector but from the outside. The bilateral and multilateral agencies have been calling for reforms as many of the basic elements of primary health care have not been addressed at the peripheral level. Also, from the government side, economic pressures, dwindling resources and need for rationalization of

health care delivery, financing of public sector are some of the other issues which have given an impetus to the process of reform.

Dr. Walia stressed the fact that the government is no longer in a position to provide free health care to the entire populous of this country, with increasing population, lack of resources, increased provision and financing by the private sector, which is primarily involved only in curative care. This calls for a public-private mix. The various problems associated with the private sector, its burgeoning growth outside the scrutiny of the public sector necessitates that the government plays a stewardship role and brings the private sector into provisioning of health care along with the public sector. Dr Walia also brought out the fact that we tend to focus our discussion of health sector reforms on the public sector alone, thereby leaving out opportunities for capacity building of non-governmental organisations (NGOs) and the private sector. Also, as health goes beyond health sector reforms, we need to foster new partnerships with other sectors like environment, water, transport. We also need to strengthen existing partnerships while simultaneously maintaining the leadership role. The other issue, he addressed pertained to how best to provide services to the under-privileged and the poor. The need for community based health care has emerged clearly. While it is crucial, to go down to the community level, certain pre-requisites need to be met. Measures need to be taken to develop local leadership; there is a need to look at decentralization process, locate appropriate technology at that level and to look at sustained mechanisms for partnership. He also brought out the fact that health sector reform demands links between policy makers and decision makers, has to involve the planners, the economists and the researchers. There is need to ensure optimal use of research findings on guiding health sector reforms.

3. Sunil Nandraj, NPO, EIP, WHO-India Office

At outset, Shri Nandraj remarked that it was an eye-opener to listen to the experiences of the States and the various initiatives taken by them in a proactive manner. He stated that the need to change felt by the states (which itself may be due to several reasons) is a positive development. He raised the question, whether health sector reforms is the latest 'buzz' word and emphasized the need to define health sector reforms in the Indian context, as each person has assigned different meanings to this term. Shri Nandraj, illustrated that the usage of the term, public-private partnership, is another oft-used word in the health sector today, defined differently by each State. In one State, it may take the form of handing over a public hospital to the private sector while in another, services may be contracted out to the private sector under the realm of partnership or primary health centres (PHCs) may be handed over to non-governmental organisations (NGOs). He opined that the term 'partnership' implies similarity in objectives and raised the question, where the public and private sector had similar objectives and whether we have attempted to match the two. He was of the view that right now, it appears as if the private sector is bestowing favours on the public sector by involving itself in health care delivery.

He also brought out the fact that many states tend to classify routine matters as health sector reforms and remarked that much of the presentations of state experiences have focused on the content rather process of reforms. There is need to undertake process

documentation of these reforms in the Indian context. This is significant, as it would enable States to share and learn from each other's experiences and mistakes. The other issue that we need to gain clarity on is what to reform. Moreover, given, the dominant role of the private sector, health sector reform should include the private sector. He shared experiences of different states in regulation of private sector through enactment of a law, some successful while others facing stiff opposition by different lobbies and hence continuing as draft bills, awaiting clearance from the Legislature. There is also lack of adequate data on the private sector, in terms of number of hospitals, etc. He felt that there is a need to examine the health sector as a whole with the government clearly defining its role either as a financer or provider or administrator or all three. These issues he felt are important in the light of emphasis being laid on public private partnerships. Given the past experiences at enacting legislation for the private sector, there is a need to examine new mechanisms such as accreditation to improve the quality of health services. These mechanisms could be linked to insurance and the new incentives such as those announced by the Ministry of Finance. Partnerships can be entered into with accredited providers, which in turn would ensure minimum standard of care to the patient.

Another issue raised was the role of various stakeholders in the process of health sector reforms. Terms like user charges, contracting out, and decentralization are increasingly being used. But who is initiating these changes. There is lack of evidence as to whether these initiatives are having the desired impact. It is pertinent that one reviews these initiatives and assesses its impact.

He concluded by stating that the present workshop was a good beginning for us to document, and learn from each other and hoped that the Ministry would ensure wide scale dissemination of the documentation.

4. Dr. Indrani Gupta, Associate Prof. Institute of Economic Growth

Dr Gupta presented her views as a researcher and economist. She began by raising the question, whether states were really engaged in health sector reforms or were essentially carrying on innovations, which we may want to term as reforms. She expressed discomfort at the repeated use of the word 'reform' as it essentially means revamping, undertaking of major changes. She also brought up the fact that we might feel that if we are not undertaking these changes, then we are failing. The term health sector reforms, has been around for several years, and unfortunately tends to largely conjure up images of the World Bank and user fees. This, she felt was unfortunate as health sector reforms encompasses many other things. She expressed the view that a series of innovations are occurring at the state level on a continuous basis and these could occur in any sector.

The second issue raised by her was that some of the bilateral and multilateral donors had stepped in and seem to have influenced the agenda in the health sector. Dr. Gupta opined that they have probably filled an existing vacuum. This is especially so, in light of the divide which exists between the Centre and the States. In her opinion, although the Centre has not played a proactive role in terms of dialogue during the reform process, the dialogues have occurred essentially between the World Bank and the Centre, in spite of

health being a state subject. The states have been left behind in this process and understandably various agencies have filled a vacuum which should not have existed in the first place.

Dr. Gupta was of the view that we need to utilize whatever option may work, whether it is public private partnership, decentralization, user fees in a state or district as long as it is consistent with the principles of health sector equity and efficiency. In the area of resource allocation, on one hand, we need to allocate more to the health sector, and the initiative for the same needs to the come from the Centre as well as the States. Simultaneously, we need to ensure that the existing resources are being spent efficiently and equitably.

She pointed out the fact that the states had not focused on evaluation and brought out the need to monitor and assess whether a reform is working – administratively, financially and outcome-wise. This would necessitate having a system in place for data collection, in a format which can be utilized at a later point to assess whether the 'innovation' has worked. Based on her experience, she emphasized the need to bring about management and administrative changes in the health sector.

Lastly, she concluded by saying that this was the first time , she had an opportunity to be present at a workshop where experiences from the state were being shared and this she felt was a very encouraging sign. So also was the fact that at the state level, there are efforts underway to re-evaluate its own health needs and priorities. Each state would then formulate its own innovations and reforms. If the Centre helped the States on prioritizing their innovations, then in her opinion it would be a great step forward.

5. Dr Rama Baru, Associate Professor, Jawaharlal Nehru University

Dr Baru felt that it was a very heartening experience to listen to the presentations made by the various states and to learn about the various initiatives undertaken. She too, expressed the view, that it might be more appropriate to use the word, 'innovations' rather than 'reforms'. While the presentations of the states, clearly brought out that there are elements of reform, it appears that states are attempting various innovations, which in itself is a heartening process. Based on the presentations of the various states, she felt that elements of reforms are common across states, while the emphasis differs with some focusing more on financing while others on infrastructure. She lauded the fact that emphasis is slowly being given to other areas which support the heath services and not on provisioning alone. The other issue raised by her, related to the need to create evidence and the importance of this workshop in that direction. She felt that it is very important to have evidence if one would like to study the innovations and scientifically evaluate them.

6. Shri J. P. Misra, EC Health & Family Welfare Sector Programme in India

Shri Misra mentioned that the reforms in the public sector essentially began in the 1990s. He shared the experience of the EC Health & Family Welfare Sector Programme in

conducting two workshops on this issue, in Delhi and Kufri with the State Health Secretaries. He brought up the need to further examine the reform initiatives in depth, as they may appear to be very significant on the surface and reiterated the need to back up the initiatives by building capacities to undertake these activities. The basket of reform initiatives more or less, include elements of decentralization, user fees, etc. There is a need to examine whether these intentions have actually been implemented and what may be the possible factors which may hinder effective implementation. He based his observations, on his experience of working in the state of Uttaranchal, amongst others. The other issue raised by him pertained to the capacity of the system to absorb all the existing resources and the need to strengthen the same. He also shared information about the initiative of the Sector programme in bringing out a Policy Reforms Options Database (PROD), which aims to enable exchange of information.

Other remarks, suggestions and issues raised

- It was felt that any talk of health sector reforms should favour the poor. They should be at the centre of any reform process and the key question that we need to address is how to make the health services more equitable.
- One of the suggestions to enable sharing of information across states was to evolve a web based forum / web site. Apart from a website where information about reform initiatives would be available, a framework or template for the same needs to be developed, such that it allows individual experiences to also emerge.
- There appears to be lack of sharing amongst the various government departments and programmes, both at the centre and state level and there is a need to evolve a mechanism to enable the same, to avoid duplication and to contribute to mutual efforts.
- Capacities need to be built at the State level, to analyze data and emerging trends rather than encourage reliance on external experts.
- There is a need for content as well as process documentation of health sector reform initiatives underway in India.
- It was brought out that prior to talking about health sector reforms, there is a need to ensure health improvement in communities and efficiency, equity, quality, sustainability and client responsiveness. Health sector reforms would entail a fundamental change. There is a need to look at both technological and managerial improvements in the health sector.
- The need to examine the role of various medical colleges, universities, research institutions in the health sector reform process, especially prior to the initiation of reforms was brought out. They can be involved in conducting feasibility studies and initial assessments. The feasibility of initiatives like user charges, decentralization, should be assessed, particularly from the perspective of the community.

Synopsis of Day 1

Ms. Anagha Khot, WHO National Consultant, Ministry of Health & Family Welfare, presented a synopsis of the proceedings of the first day of the workshop. She outlined the main points made by the various speakers. The points made by the various speakers clearly brought out the following issues.

There is a need to define health sector reforms in the Indian context. The questions raised were, 'are we really engaged in health sector reforms? Or are innovations being undertaken in terms of health planning and provisioning of services?' There is a need to distinguish normal incremental changes from reforms and define the parameters which would be used to distinguish between the two. Secondly, emphasis should be laid on the process of reforms along with the content. Lack of adequate process documentation of health sector reforms in India was identified as one of the gaps. Further studies would be required across various components of health sector reforms to assess their impact and to emulate the 'success' stories and learn from failures. Furthermore, monitoring and evaluation mechanisms need to be incorporated right from the point of initiation of reforms. Adequate mechanisms for collecting data for review and documentation need to be built into the process of reforms. The state presentations clearly brought out the plurality of experiences among the states as far as health sector reforms are concerned. There is a need to learn from these experiences as to what works as a reform and the possible obstacles that one may face and to ensure participation of all stakeholders in the reform process from its conception. Capacity building of stakeholders at different levels is another critical area of concern. The discussion clearly brought out the need for the Centre to play a more pro-active role in the area of health sector reforms and for all present to define the way forward.

Group Work

The participants were divided into two pre-determined groups. The issues for group work were:

Group 1: Definition of health sector reforms & the next steps
Group 2: The content of reforms & the next steps

Definition of health sector reforms

The group began by examining the definitions of health sector reforms *(Refer to Background Paper: India's Health System: Role of Health Sector Reforms)*. The definitions given by Berman, 1995 & Cassels, 1995 were examined in depth. It was felt that these definitions were too generic in nature and could be applied to reforms in any sector and was not necessarily confined to health sector reforms. Also, being generic in nature, these definitions could not be operationalized.

During the course of discussion, the perceptions of the various group members about health sector reforms were discussed. The group felt that the definition and content of health sector reforms are interlinked. The group discussed what should be the different elements of health sector reforms, its guiding principles and how the same could be operationalized. Based on the deliberations and the experiences of various States, the following matrix to examine health sector reforms in India was suggested. It was felt that the same matrix could also be used to evaluate the reforms at a further point.

Matrix to define health sector reforms in India

Issues	**Guiding Principles**				
	Equity	Efficiency	Quality	Sustainability	Accountability
Regulation of private sector					
User charges					
Institutional reform for financing					
Statutory control of quality & minimum infrastructure norms for service provision					
Evidence based policy and programme					
Strategies to enhance quality public sector					
Strengthening of primary health care					
Financing of consumables (E.g. drugs at PHC)					
Hospital Autonomy					
Even distribution of manpower					

Content of health sector reforms

The group felt that prior to looking at the content of reforms, there is need to define the same. Based on the presentations made by the various states, it was felt broadly, health sector reforms would include elements of administration / governance, financing, provisioning. The group was of the view that it should not outline the specific elements

within each of these, as it would restrict the states and that the same should be defined by the States.

Suggested next steps

Group 1

- Need to clearly state at the policy level, as to what would constitute reforms and guiding principles for the same. A need for a state health policy was expressed by representatives of various states.
- Need for process documentation of the initiatives taken. This in turn would provide a methodological framework which could be used to evaluate health sector reforms against some agreed set of principles.
- Sharing of experiences and information across states. Apart from the web, maybe states need to visit each other. A related issue was that while there is agreement that such sharing needs to take place, need to address who would fund such an initiative. A question asked was whether consolidated donor funding with donors from each state can contribute to such an endeavour.
- Need for an institutional mechanism to enable sharing between states as well as the state and the centre
- It was suggested that an institution be identified as a nodal point for undertaking such review and documentation. The other view was that the Ministry itself can serve as a nodal point, network and co-ordinate with the states.
- Donor agencies working in the States should be involved in the health sector reform process and they should engage in capacity building at the state and regional level.

Group 2

The group tried to define roles for the centre and the state.

Role of the Centre:

- In house dissemination of information relating to health sector reforms.
- Provision of experience sharing platform for the States
- Informing states of experiences that have worked through: (a) Research studies, (b) Documentation, (c) Creation of a specific unit in the Ministry of Health, which would collect information on various ongoing reform experiences and to ensure its sharing.
- Providing guidelines for health sector reforms, for each of its components and to facilitate technical guidance, capacity building, facilitating and funding interstate visits.
- Involving other Ministries like Ministry of Finance while addressing reform issues like health financing.

Role of the State:

- Identification of a nodal officer in each State to coordinate activities of health sector reforms and to liaise with the unit at the centre
- Organization of a state level workshop for all categories of State level officers
- Inclusion of health sector reforms in Annual Plan and Five Year Plans

Open Discussion

Based on the group presentations the following issues were raised.

- One of the questions posed was, given the plurality of experiences, priorities and norms prevailing in different states, how can comparison of experiences be ensured, using a standard procedure or system? In response, it was felt that establishing certain benchmarks and common guiding principles would assist in such a comparison, though the content of reforms may vary across States.
- Need to empirically examine whether a programme or initiative has done well and this information then needs to be widely disseminated. The issue itself may be amenable to quantitative or qualitative examination.
- While there is a need to talk of macro level policies, there is simultaneously a need for policies at micro level
- The funding obtained from donor agencies should be treated as an additionality to the budget and not form a part of the consolidated fund.
- Need to define a role for the civil society in the reform process.
- The ideological overloading or abstractness while defining health sector reform has to remain.
- There is a need to examine possibility of composite funding rather than programme specific funding.
- In terms of any evaluation, need to be clear about its purpose. The aim should be constructive and to draw lessons. The evaluation process needs to be institutionalized as a learning process. Furthermore, need to ensure that the institution / individual undertaking the evaluations have appropriate experience and capacity to undertake such work. Instead of conducting evaluation through external organizations, there is a need to encourage development of internal systems for a constant stream of data collection and analysis for correction purposes as well as to ascertain whether the reforms have trickled down to the lowest level. If one does not have internal evaluation system to support reform initiative, it carries the risk of being termed as a failure while the cause ultimately lies in poor management
- Need to document and share positive experiences with each other.
- States should be assisted to evaluate their priorities before launching any reforms and the centre can play a crucial role in this.
- Need for the centre to co-ordinate the involvement of different donor agencies and to define the priorities rather than each donor deciding which states they want to work in.
- Need to take this process forward by setting up a nodal officer at state level, and centre.
- Need for better co-ordination between the centre and the state.
- Much of the documentation pertaining to health sector reforms is being done by multi-lateral and bi-lateral agencies and this is not easily available. There is a need to demand some transparency in this process.

To summarize, the discussions clearly brought out the need for ensuring ongoing sharing of reform initiatives between the Centre and the State as well as amongst the States. It was felt that the Centre needs to act as a nodal agency and play a critical and proactive

role in this regard. A beginning could be made by having in-house sharing of views and experiences in the Central Ministry itself. While providing a platform for sharing of experiences, the Centre also needs to engage in capacity building initiatives. At the State level, suggestions relating to assigning a nodal officer to co-ordinate health sector reform initiatives, holding workshops with officers, inclusion of health sector reforms as part of the Five Year Plans were made. The need for co-ordinated donor assistance was a common issue raised by the groups. The group also stressed upon the urgent need for documenting and evolving a framework / methodology to ensure comparison of reform initiatives across States.

CONCLUDING REMARKS

Concluding Remarks by Shri Javid Chowdhury & Smt. P. Jyoti Rao

As part of the concluding remarks, Shri Javid Chowdhury shared his thoughts on the proceedings of the one and half day workshop. He felt that the workshop was educative and provided a forum to learn about the various initiatives taken by the states. The states are reacting based on their own priorities; some more pro-actively while others less so. But essentially they are reforming and are bringing out changes in a sequence which their system and political environment can accept. He was of the view that such a workshop sensitizes and shows that certain things are possible with significant impact.

Secondly, Shri Chowdhury brought out the necessity of evidence based evaluation. He saw the lack of in-house database / expertise as a hindering factor. He stated that there have been instances when the project evaluations conducted by various agencies have not been upto the mark. At the same time he stressed that one should not wait to build a corpus of research database, but begin with what is available and further develop the same. Even in terms of reforms, he felt that without getting over-awed by lack of understanding or by the fact that one has not thought out the reform to the last detail conceptually, all states and practitioners would be well advised in their areas to launch reforms.

Given the fact that implementation of reforms leading to change is a long process, he encouraged all policy makers and other stakeholders not to loose heart and to persist in the achievement of reform goals and objectives. He stressed the importance of achieving various milestones along this process, to enable sustenance interest, enthusiasm and morale of the group. Based on his experience wherein good schemes were planned elaborately over ages but also steam by the time they were implemented, he urged that any reform idea be pushed ahead with small changes or innovations as long as it was coherent with the larger picture envisaged for the health sector in India.

Thereafter, Smt. P Jyoti Rao thanked the participants. She voiced the view that while one had not worked out definitions of health sector reforms, the broad parameters had been defined in the due course of discussions. She emphasized the need for each one present to introspect within their own spheres of activity to assess whether there was any scope for structural change within the system as well as implementation of reform initiatives. In her view, health sector reforms should be concerned with larger paradigm shifts and structural issues. She regarded the present workshop as an opportunity to contemplate on how little changes can be brought about and how few innovative practices could make the system perform better within the given constraints. She welcomed the suggestion made about the need for having a small cell or unit at the ministry which would essentially function as a networking outfit as well as engage in collection and dissemination of information pertaining to health sector reforms. She mentioned that the deliberations of this workshop would be documented intensively and assured of such interaction at regular periods to ensure continuity in the process. Given, the complicated nature of the health sector no one intervention by itself would make a difference as there are a range of issues and multiple steps would be needed. On behalf of the Centre, she committed, within the given constraints to complete the required documentation, do the networking

and be on look out for success stories and failures and ensure its wide scale dissemination. She felt that the purpose of this workshop has been served as one had got more sensitized to this area, and assured of such interactions to take place at shorter periodicity.

ANNEXURE

Agenda

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA
NEW DELHI

Workshop on
India's Health System: Role of Health Sector Reforms
September 4-5, 2003

Tentative Time Schedule & Agenda

Time	***Theme***	
	Date / Day: September 4, 2003 Thursday	
9.15-9.30	Registration	
9.30-9.40	Address	Smt P Jyoti Rao Additional Secretary, Health
9.40-10.00	Address	Dr. Prema Ramachandran Planning Commission
10.00-10.10	Address	Shri P. Hota Secretary, Family Welfare
10.10 - 10.20	Address	Smt. Malati Sinha Secretary, ISM&H
10.20-10.30	Address	Dr. S.J.Habayeb WHO-WR India
10.30-10.40	Address	Dr. S. P Agarwal Director General Health Services
10.40-11.00	Coffee/Tea	

Working Session I

11.00 - 11.20	Overview of health sector reforms: International & national experiences	Dr. Rama Baru
11.20 - 11.40	Remarks	Shri Javid Chowdhury

Health Sector Reform initiatives across States

11.40 - 12.00	Punjab	Dr. Anjali Bhawra
12.00 - 12.20	Rajasthan	Dr. B. Sekhar
12.20 - 12.40	Observations & Analysis	Dr. Tej Walia
12.40 - 1.00	Observations & Analysis	Shri Sunil Nandraj
1.00 - 1.20	Discussion	
1.20 - 2.00	Lunch	

Working Session II: HSR initiatives across States continues

2.00 - 2.20	Gujarat	Shri S.K. Nanda
2.20 - 2.40	Himachal Pradesh	Dr. R.N. Mahanta
2.40 - 3.00	Observations & Analysis	Dr. Indrani Gupta
3.00 - 3.20	Observations & Analysis	Dr. Rama Baru
3.20 - 3.40	Discussion	
3.40 - 4.00	Coffee/Tea	

Working Session III: HSR initiatives across States continues

4.00 - 4.20	Uttaranchal	Dr. I.S. Pal
4.20 - 4.40	From First Phase to Second Phase of RCH	Ms. Nandita Chatterjee
4.40 - 5.00	Observations & Analysis	Shri J. P. Mishra
5.00 - 5.30	Discussion	

Date / Day: September 5, 2003 Friday

9.30 – 9.40	Synopsis of proceedings of Day 1	Ms. Anagha Khot
Working Session IV:	**Group Discussion**	
9.40– 11.15	Group Work (Working definition for health sector reforms in the Indian context, Content and process of reforms, Next steps)	
11.15-11.30	Coffee / Tea	
Working Session V:	**Next Steps**	
11.30 -12.15	Presentation of group discussion	
12.15 -12.30	Discussion	
12.30 – 1.00	Concluding remarks Next Steps	Shri Javid Chowdhury Smt. P. Jyoti Rao
	Lunch	

Background Paper

Health Sector Reforms: The Indian Scenario

Background Paper

Workshop
On

India's Health System: Role of Health Sector Reforms

September 4-5, 2003
India International Centre
New Delhi

Bureau of Planning
Ministry of Health & Family Welfare
Government of India, New Delhi

In collaboration with
World Health Organization
New Delhi

HEALTH SECTOR REFORMS: THE INDIAN SCENARIO

Objective of the paper: This paper endeavors to define health sector reform, list its content and forms. Further it attempts to identify the rationale and goals of health reform and to ascertain key issues / challenges for future planning and implementation of health reforms in the Indian context.

Introduction

'Health sector reform' has been the subject of increasing attention and is an often-used word in the health parlance today. The last two decades have seen health sector reforms emerge as a major issue on the policy agenda. Despite different levels of income, institutional structures, and historical experiences, many countries in recent years, have embarked on health sector reform in varying degrees. A wide range of contextual factors including the macroeconomic situation, the political environment, the societal values and external influences affect the development of health sector reform in a particular country.

The genesis of health sector reforms can be traced to the early 1980s. Prior to the 1980s, health care provision was mainly publicly funded and organized through public health care services with the aim of improving equity in access to care. However, the 1980s saw a smaller role emerge for the State and a shift to a neo-classical paradigm. In face of world recession, the oil shock of the late 1970s, the socio political changes that occurred globally especially after the collapse of the Soviet Union, a fiscal crunch was felt by both developed and developing countries. As a consequence of the economic crisis of the early 1980s, there was a change in the economic policies of several developing countries. This situation was coupled with governments struggling to develop financing mechanisms in the context of severe income inequalities, low access and utilization of health services by the poor, overburdening of existing services due to diseases such as AIDS and rising communicable as well as non communicable diseases. During this period, social sectors like education and health were increasingly squeezed financially and cutbacks were made in the state intervention in the health sector. The fiscal constraints coupled with pressure on health systems due to rising health needs led to many countries availing of loans from the "Bretton Woods" institutions namely the World Bank and the International Monetary Fund, under the Structural Adjustment Programme.

Thus, during the period of 1980s to mid 1990s, health sector reforms were an attempt to respond to the serious challenges posed by the collapsing health service delivery systems in many poor countries and reforms were particularly concerned with re-defining the relationships between the state, service providers, users and other health related organizations *(Standing H, 2002)*. One of the foremost documents highlighting the change in role for the government and the enforcement of a new paradigm was

'Financing Health Services in Developing Countries' brought out by the World Bank in 1987. This document led to the Bank placing health financing at the centre of its policy dialogue with borrowers. This paper proposed four reforms: implementation of user charges at government health facilities; introduction of insurance or other risk coverage; usage of nongovernmental resources in a more effective manner, and introduction of decentralized planning, budgeting, and purchasing for government health services.

In terms of the overall macro environment, by mid- 1990s, shifts began to occur in the pattern of international aid, bilateral aid budgets continued to decline as a total proportion of international transfers to the poor countries. There was however, an increase in the proportion of loans from multilateral agencies, particularly for social expenditures such as health. This was in part due to the concern being expressed over the impact of structural adjustment programmes on the social sectors. This period saw a move away from donor specific project funding to sector investment programmes and approaches (SWAPs). There was a more broad based thinking not only on the technical aspects of reforms but also on needs and concerns of users and the importance of involving a wide range of stakeholders. Trends towards decentralization, continued growth and use of private provision of health services persisted, leading to an emphasis on governance, accountability and regulatory issues. *(Standing H, 2002).*

A path breaking document the *World Development Report (WDR), 1993* titled, 'Investing in Health', provided the blueprint for health sector reform for developing countries. This paradigm included changes in the conceptualization, planning, and delivery of health services, apart from new ways of health financing. The WDR 1993 proposed a three pronged approach to government policies for improving health. These include: (A) Fostering an environment that enables households to improve health (B) Improving government spending on health (C) Promoting diversity and competition. The overall role envisaged for the government was that of promoting economic growth. The report visualized that the government would pursue economic growth policies that benefit the poor, expand investment in schooling, particularly for girls, promoting the rights and status of women through political and economic empowerment. It also recommended improvement in government spending on health in a manner that benefits the poor. The methods suggested included reduction of government expenditures on tertiary facilities, specialist training; implementation of user fees to affluent patients using the government hospitals and services, financing and implementing a package of public health interventions and essential clinical services and improving the management of government health services through measures such as decentralization of administrative and budgetary authority and contracting out of services. It suggested adoption of policies which encouraged social or private insurance for clinical services outside the purview of essential services being provided by the government, encouragement of suppliers, both in private and public sector to compete both to deliver clinical services and to provide inputs to publicly and privately financed health services. Generation and dissemination of information of provider performance was also seen as a crucial role

which needed to be performed by the government. With the publication of this document, the mid-1990s saw an increasing emphasis on assessment of priority health, with the global burden of disease analysis and associated priority setting methodologies becoming the recommended basis for planning and allocating health expenditure. This led to the development of basic packages and interventions based on assessments of greatest health needs and on maximum gain per unit of expenditure. Acknowledging the fact that the private sector was emerging as one of the main players in the health sector, attention was accorded to ways of regulating and harnessing the private sector in health delivery, thereby leading to experiments in contracting out of services amongst others.

The late 1990s to 2000s has seen the re-emergence of poverty as a global concern in the macro economic fora. Health has again come to occupy an important place in the international aid agenda, in view of the close linkages between poverty and health. This period has seen the emergence of initiatives like the Commission on Macro Economics and Health, development of poverty reduction strategy papers (PRSPs) and the Millennium Development Goals (MDGs) as well as the emergence of new international financing mechanisms like the Global Fund to fight AIDS, Tuberculosis and Malaria, the Gates Foundation amongst others. While financial and institutional reforms, regulation have continued to be important issues in the health reform process, increasing stress is being laid on governance and accountability issues. The underlying conditions necessary for economic and social development and the role of governments as regulator and in the context of multiple players and interests is assuming increasing significance. This has meant a greater role for the civil society in developing mechanisms to hold the governments as well as service providers accountable. *(Standing H, 2002)*

Hence, it can be seen that there have been different generation of reforms, which differ subtly in its emphasis and premises. For example, while the first generation of adjustment policies ascribed importance to the stabilization measures, the second-generation of reforms focused on structural and institutional issues. The current third-generation adjustment policies are placing a special emphasis on poverty reduction, transparency, accountability and democracy.

Prior to delving into the content of health sector reforms, it is pertinent to address key questions like, 'What do we mean by reform?', 'What are the essential components of reforms?' 'How do reforms differ from normal evolutionary and incremental system changes?'

Definition of health sector reforms

The term 'reform' has become increasingly popular during the last few years, yet there is no consistent and universally accepted definition of what constitutes health sector reform thereby leading to varied meanings and connotations. Reform essentially

involves change that affects goals, strategies, institutions, services and human behaviour. Some of the definitions put forth are stated below:

- The current wave of interest in changing the policies, practices and management systems within the health sector is often referred to as health sector reform. Berman describes health sector reform as 'sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector' *(Berman, 1995)*

- Cassels defines health sector reform as activities concerned with changing health policies and the institutions through which these are implemented. Redefining policy objectives alone is not enough. To deal with health sector constraints, there is a need for institutional reform with changes to existing institutions, organizational structures and management systems. Thus, health care reform is concerned with "defining priorities, refining policies and reforming the institutions through which those policies are implemented." *(Cassels, 1995 cited in Figueras J et al, 1997)*

- Health sector reform is a sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government. The process lays down a set of policy measures covering the four main core functions of the health system, viz. governance, provision, financing and resource generation. It is designed to improve the functioning and performance of the health sector and ultimately the health status of the people. Health sector reform deals with equity, efficiency, quality, and financing and also defines the priorities, refining the polices and reforming the institutions through which policies are implemented *(WHO, 1997)*

- A reform is defined as a process that involves sustained and profound institutional and structural change led by government and seeking to attain a series of explicit policy objectives *(Figueras J et al, 1997)*

- Health sector reform can be defined as 'a process that seeks changes in health sector policies, financing, and organization of services, as well as in the role of government, to reach national health objectives.' Reform is a process and not a one-time event or decision and involves changes intended for the long term, not ad hoc or emergency solutions to address crises. "Sector reform" is by definition sector-wide in that it affects more than one service, supply, or clinical policy, and more than one facility, provider, institution, or geographic location. In the course of this long-term process, reforms require midterm assessments and corrections. *(Change & Population Council, 1998)*

- Health sector reform in the Region of the Americas has been defined as a process aimed at introducing substantive changes into different health sector entities and

functions with a view to increasing the equity of their benefits, the efficiency of their management, and the effectiveness of their actions and, thereby, meeting the health needs of the population. It involves intensive transformation of the health systems, carried out during a given period of time and justified by circumstances that make it a viable undertaking. *(PAHO)*

- Health sector reform is the systematic redesign of the role of the public sector in the organization, provision and financing of health services and the design and implementation of the structures and financing strategies needed to effect these changes *(Rosenthal as cited in Johnson S, 2000)*

Thus, health sector reforms are "sustained purposeful processes of fundamental change in the policy and institutional arrangements in the health sector".

Firstly, it is essential to specify what is meant by "fundamental" change. Fundamental change means that it must make a real or significant different in the way things work over time. William Hsiao (*as cited in Berman & Bossert, 2000*) specifies a set of "control knobs" that determine the major processes and outcomes of health care systems. Hsiao's framework implies that the major focus of health sector reform efforts is to establish, set, or adjust these control knobs of financing, payment, organization, regulation, and consumer behavior. It may be useful to distinguish more strategic and fundamental programs of system change from those that are more limited, partial, or incremental. The former might be called "big R" reforms and the latter "little R" reforms. The "big R" reforms are those that involve at least two or more of Hsiao's control knobs in programs that affect a substantial part of the health care system. "Little R" reforms are those that address only one control knob with a more limited scope of change. For example, establishing a new or greatly expanded system of national health insurance should properly involve substantial changes in financing, regulation, and delivery. Depending on how these are structured, they would significantly affect the organization of health care delivery as well. This would qualify as a "big R" reform. In contrast, "small R" reforms would include the introduction of user charges in public clinics or granting of autonomy to the national teaching hospital. Such efforts can have important benefits, to be sure, but in isolation they are not of the same scope or degree of difficulty as the "big R" changes. While a "big R" reform may involve the implementation of many "small R" activities, it is the broad systemic package that makes a "big R" implementation more that the sum of its "small R" parts. Secondly, it is stated that the reform should be "purposeful." Purposeful effort implies that there are clearly defined objectives, strategies for achieving those objectives and efforts to monitor change and modify strategies as needed. The elements and components of the reform need to have been developed in a rational manner: identifying clearly the problems of the health systems—evidence-based—and linking the mechanisms of system change to solving those problems. A clearly articulated policy of health reform is required so that major actors responsible for implementing the change can specify goals and objectives, acknowledge

the relationship of their activities to achieving the goals of reform, and the purposeful linkage among different components of system change. Third, is that the reform should be "sustainable." Most fundamental changes will be sustained because they involve significant transformation of systems and the creation of actors who will defend their new interests in the political process. However, reforms that are passed by legislation and not implemented would not qualify; nor would failed reform efforts that are later reversed. For instance, the ambitious "managed competition" reforms of the Netherlands were not sustainable—they were never fully implemented and the reform laws were amended to remove most of the anticipated system changes. The respective governments usually guide the reform processes on a technical and political basis. They are designed to improve the functioning and performance of the health sector and, ultimately, the health status of the population.

While it is unlikely that one definition would be able to capture all the nuances of the different types of change strategies in the health sector, it is essential to identify the key elements that could be used to characterize health sector reform. Figueras J et al, (1997) have described the following framework.

Key elements of a framework for health sector reform

Process
• Structural rather than incremental or evolutionary change
• Change in policy objectives followed by institutional change, rather than redefinition of objectives alone
• Purposive rather than haphazard change
• Sustained and long term rather than one off change
• Political top down process led by national, regional or local governments

Content
• Diversity in measures adopted
• Determination by country specific characteristics of health systems

To sum, health sector reform is deliberate, planned and intended to make long term, permanent changes, rather than ad hoc or emergency action. It is about seeking solutions to major problems in a country's health care system and involves many actors, institutions and stakeholders. While most of the health sector problems that reformers identify tend to be relatively 'technical', solutions require much more than developing or applying the 'right' technical answer. Designing and implementing health sector reform is a preeminently political process. Hence, health sector reform deals with equity, efficiency, quality, financing and sustainability in the provision of health care and also in defining the priorities, refining the policies, and reforming the institutions through which policies are implemented. It is a process of change involving the what, who and

how of health sector action, and generally forms part of a bigger reform taking place in the public sector *(WHO, 2002)*

Manifestations / forms of health sector reforms

The content of reforms is a complex process. There is no universal 'package' of measures, which would constitute health sector reforms, and reforms have tended to assume varied forms across various countries. But review of literature indicates that reforms often tend to be initiated by the Ministries of Health with the aim of deliberately effecting a change in the health policy of the government with a view towards improving its performance. The reforms attempt to ensure the strengthening of the health policy and planning functions, introduction of organizational changes, new management policies and practices, defining national, regional and local-level disease priorities, setting standards for provision of health care, developing appropriate systems for monitoring performance (including quality assurance initiatives) and introducing effective health interventions. *(WHO, 1997)* Hence, it can be said that reforms tend to cover four core functions of the health system viz. governance, provision, financing and resource generation. Some of the approaches adopted for classification of reforms are given below.

Changes in financing methods

- User charges;
- Community financing schemes;
- Insurance (social, private, compulsory insurance, community risk sharing schemes);
- Stimulating private sector growth; and
- Increased resources to health sector.

Changes in health system organization and management

- Decentralization
- Contracting out of services; and
- Reviewing the public-private mix.

Public Sector Reform

- Downsizing the public sector;
- Productivity improvement;
- Introduction of competition;
- Improving geographic coverage;
- Increasing role of local government; and
- Targeting role of public sector through packages of essential services.

.....*Thomason (1997)*

> Reforms in Policy and Organization, including health care financing: Health policy changes, allocative efficiency, changes in health financing mechanisms, management and organizational changes, privatization in health care
>
> Reforms for improving health care delivery: Changes in development and / or deployment of human resources for health, strengthening district health systems, essential health care package(s), selective v/s integrated health care.
>
> Reforms beyond the health sector: Decentralization, intra- and inter-sectoral actions, community action, health care market promotion and international investment.
>
> .....*(WHO, 1997)*

Frenk *(as cited in Berman, 1995)* identifies four policy levels for reform action: the systemic, programmatic, organizational and instrumental. The systemic level of policy action addresses organizing and managing the linkages between the major actors in the system including the institutional arrangements. The programmatic level addresses what the health service actors do while organizational level focuses on the how of health care provision, addresses issues related to quality of care and productivity. The instrumental level refers to policies for collection and use of health systems information, for research and technology, development and for the development of human resources and other inputs for health care.

Hence, the most widespread elements of health sector reform include *(Mills, 2001)*:

- Restructuring of public sector organizations (including decentralization and bureaucratic commercialization whereby publicly owned facilities are restructured so that they run more along the lines of privately owned establishments, in the health sector this is usually termed hospital autonomy or 'corporatisation').
- Changing the way in which resources are allocated and paid to both organizations and individuals, generally with the aim of creating a clearer link between performance and reward
- Encouraging greater plurality and competition in the provision of health care services through policy measures such as liberalizing the private health sector and contracting with or subsidizing private health providers
- Seeking increased financing for health care from non tax revenue sources such as user fees, social health insurance and private health insurance
- Increasing the role of the consumer in the health system through enhancing the power and scope of consumer choice and making health providers more accountable to community based organizations such as hospital boards.

While the earlier section has outlined the content of health sector reforms, it is crucial to outline what are the goals and principles of health sector reform.

Goals & Principles of health sector reform

The various approaches to reform process are underlined by different goals. Improved planning and management by making decision making more responsive to local needs, improved service organization by reducing duplication of service provision, increased accountability by introducing clearer lines of accountability at all levels and promoting participation are common objectives of reform process *(Gilson L & Mills A, 1995)* The goals of health sector reform, in a formal sense, remain the achievement of efficiency, improving quality, preserving or promoting equity, and generating new resources for health care, sustainability of the health sector and the organizations and institutions that comprise it. Hence, most reform measures are meant to ensure that an appropriate share of public funds (overall government expenditure) is spent on health care, or there is an equitable distribution of public health expenditure across all levels of care or there is an appropriate mix of public and private spending in health development (i.e. allocative efficiency). The users have to be satisfied with both the form and content of health services offered (i.e. improved health status and client satisfaction) and the benefits of publicly funded health care (including preventive health interventions) are also equitably distributed (i.e. improved equity of access to care)*(WHO, Nov. 1997)*

Preconditions for successful reforms

Ensuring the success of the various reforms and the reform process, would necessitate the fulfillment of certain pre-conditions. The national capacity to plan and manage the process of change would be the first requisite. This would include training and development of human resources, improving the capability of individuals and institutions to carry out the expected tasks, capacity building of government as well as non-governmental structures, establishment of and / or linkages with autonomous institutions for strategic studies and policy analysis amongst others. Continuous monitoring and review of the content as well as process would increase the likelihood of 'successful' reforms, thereby meeting the goals behind the initiation of reforms.

Health sector reform in India

Economic liberalization in India can be traced to late 1970s. However, it was only in 1991 that reforms began in earnest. Dwindling foreign reserves, negative growth of exports, soaring inflation, culmination of fiscal profligacy during the 1980s, high cost import substitution policies coupled with a balance of payments crisis set off by the Gulf War opened the way for an International Monetary Fund (IMF) program that led to the acceptance of a major reform package. The situation was compounded by a quick succession of changing governments. This was coupled with a realization which had been gaining ground in policy making circles that a major change of economic system was needed and led to the initiation of a wide ranging programme of reform. The program which consisted of stabilization-cum structural adjustment measures was put in place with a view to attain macroeconomic stability and higher rates of economic growth *(Bajpai 2002).* This occurred in a larger deteriorating public health scenario, wherein on hand, communicable diseases persisted and some of them like malaria

developed insecticide resistant vectors while others like Tuberculosis were increasingly becoming drug resistant, HIV / AIDS was assuming extremely virulent proportion. On the other hand, non-communicable diseases were arising as a result of life style changes and increase in life expectancy.

Hence, in the Indian context, reforms per se were necessitated as it was felt that in spite of some gains, the earlier regulatory model of development, had not delivered the expected results. These reforms sought to achieve rapid economic development, to improve the living standards of the people and ensure their development, to eliminate poverty, to protect human rights and to ensure people's participation, especially that of excluded groups. These reforms aimed at closing the gap between India's potential and actual performance. The essence of the reforms has been to increase the productivity of all sections of the society by making competition free and access to markets easier. *(Economic Advisory Council, GOI).* Though India's reforms have been piecemeal and incremental, the reforms of the last decade have gone a long way towards freeing up the domestic economy from state control. State monopoly has been abolished in virtually all sectors, which have been opened to the private sector. The impact of policy trends towards greater deregulation, liberalization and integration with the global economy has been felt in the health sector too.

Content of health sector reforms in India

In India, there has been a gradual shift in the organization, structure and delivery of health care services. Some of the important policy shifts as enumerated in the Eighth, Ninth and Tenth Five Year plans are described below (*Eighth, Ninth& Tenth Five Year Plan Documents, Govt. of India)*

The **Eighth Five Year Plan (1992-1997)** was the first plan document wherein the need for re-structuring of economic management systems, following the macro developments of the 1990s was stated. In terms of health reforms, during this period, the concept of free medical care was revoked and people were required to pay, even if partially, for the health services, thereby leading to the levying of user charges from people above the poverty line for the diagnostic and curative services offered in health institutions. The scheme was so designed as to ensure free access or highly subsidized access to the needy. Furthermore, other initiatives with the private sector were encouraged.

The **Ninth Five Year Plan (1997-2002)**: The Ninth Plan emphasized the need to review the response of the public, voluntary and private sector health care providers as well as the population themselves to the changing health scenario, to reorganize health services so that they become efficient and effective and to introduce health system reforms to enable the population to obtain optimum care at affordable cost. The suggested health system reforms broadly fall into three categories: structural, functional and governance related. It was envisaged that the public sector would play a lead role in health system reforms. **The Tenth Five Year Plan (2002-2007)** touches upon reforms at primary,

secondary and tertiary level. The suggested reforms are similar to those mentioned in the Ninth Five Year Plan.

In terms of structural reforms, the Plans envisaged reorganization and restructuring of all the elements of health care so that they function as integral components of a multiprofessional health system. In terms of functional reforms, it envisaged that efforts be made to improve efficiency by creating a health system with well defined hierarchy and functional referral linkages. The suggested categories of reforms: structural & functional, financial or resource related and governance related are detailed below.

Structural & Functional Reforms:

- Reorganization and restructuring of existing health care infrastructure including the infrastructure for delivering ISM&H services at primary, secondary and tertiary care levels , so that they have the responsibility of serving population residing in a well defined area and have appropriate referral linkages with each other.
- Human resource development to meet growing health care needs – adequate in number, with appropriate skills and attitudes.
- Skill up gradation of health care providers through CME and redeployment of the existing health manpower so that they can take care of the existing and emerging health problems at primary, secondary and tertiary care levels.
- Horizontal integration of current vertical programmes including supplies, monitoring, IEC, training and administrative arrangements; formation of a single health and family welfare society at state and district levels.
- Fully functional accurate reporting system which provides data on births, deaths, diseases and data pertaining to ongoing programme through service channels, within existing infrastructure; monitoring and evaluation of these reports and appropriate midcourse correction to be done at district level;
- Building up an effective system of disease surveillance and response at district, state and national level within and as a part of existing health services;
- Building up efficient and effective logistic system for supply of drug, vaccines and consumables based on the need and utilization.

Financial Reforms / Resource related reforms:

- Continued commitment to provide essential primary health care, emergency life saving services, services under the National disease control programmes and the National Family Welfare programme totally free of cost to individuals based on their needs and not on their ability to pay
- Evolve, test and implement suitable strategies for levying user charges for health care services from people above poverty line while providing free service to people below poverty line; utilize the collected funds locally to improve quality of care.
- Evolve and implement a mechanism to ensure sustainability of ongoing govt. funded health and family welfare programme especially those with substantial external assistance.

- Working out cost of diagnosis and therapeutic procedures for major and minor ailment in different levels of care and setting cost of care norms.

The Ninth Plan envisaged that major public health priorities such as essential primary health care, emergency life saving services, services under the disease control and family welfare programmes would be provided free of cost for all. Further, it advocated that the Centre and the state governments work out appropriate norms for levying user charges on people above the poverty line for other services and hospitalization and evolve mechanisms for collection and utilization of funds. It is recognized that health sector reforms during the Tenth Plan address the issues of equity and need and devise a targeting mechanism by which people below poverty line have ready access to subsidized health services to meet their essential health care needs; simultaneously efforts be made to build up an appropriate mechanism of payment for health care by other segments of population. Simultaneously, there is a need to explore mechanisms for providing near-universal coverage of the population for meeting the cost of hospitalization and continuous care for chronic disease. Health finance options may include health insurance for individuals, institutions, industries and social insurance for below poverty line (BPL) families.

Governance related

- Introduce a range of comprehensive regulations prescribing minimum requirements of qualified staff, conditions for carrying out specialized interventions and a set of established procedures for quality assurance.
- Evolving standard protocols for care for various illnesses at primary, secondary and tertiary care settings – public sector hospitals, medical colleges, professional associations to play a major role in this exercise.
- Quality assurance and redressal mechanism such as Consumer Protection Act and Citizens' Charter for hospitals are to be set up.
- Appropriate delegation of powers to Panchayati Raj Institutions (PRIs) so that the problems of absenteeism and poor performance can be sorted out locally and primary health care personnel function as an effective team.
- Involvement of the Panchayati Raj Institutions in the planning and monitoring of ongoing programmes and making timely corrections for optimal utilization of services.

Efforts are under way to bring about quality assurance and accountability in health care services. Many states are setting norms for posting of medical personnel in rural areas, and ensuring transparency in these so as to bring about accountability regarding presence and performance of health care providers (*Planning Commission, Annual Report 2002-03).* To illustrate, ***West Bengal*** has demarcated the state into three zones, and has provided for posting of medical officers in these zones for a fixed period. The state has 'District Health and Family Welfare Samiti', so that various committees and societies do not act at cross purposes. All public health functions are controlled by the CMOH. A

system performance has been developed to identify the performance of different categories of employees and all the donor partners supporting the state health department are brought under a donor partner's coordination committee headed by the chief secretary to improve coordination. In ***Uttaranchal*** special incentives are being given to doctors posted in remote areas with difficult terrain. Tour programmes of the ANMs are fixed in advance and MCH clinics are conducted on fixed days, and immunization days are also fixed. Sectoral and block level meetings are held every month. The deputy CMO pays surprise visits to these meetings whenever he can. In ***Nagaland*** the medical officer of every PHC is directed to visit every sub-centre once a month. The ANM is required to live there, and her tour is fixed in advance. She has a list of hospitals where different specialists are available, so that she can direct the people appropriately in an emergency. A booklet listing all the villages under each PHC/sub centre is available with the Village Health Committee. In case the service providers are absent from their duties, their salaries are deducted and used for up gradation of health care services there. ***Uttar Pradesh*** is planning to give special incentives to doctors willing to work in rural areas e.g. giving urban houses for their families, creation of a specialists' cadre etc. MBBS doctors will have to serve in the rural areas for a specified period before being eligible for an urban posting.

Another area where reforms have been underway pertains to ***public – private participation in health care.*** A wide variety of public-private collaborative efforts have been reported by different States.

- Ongoing experiments involving private sector practitioners in the National Programmes (E.g. Mahavir Hospital, Hyderabad in DOTS programme in Andhra Pradesh, involvement of private practitioners/ institutions in blindness control programme, utilization of NGOs and not- for- profit institutions in leprosy and HIV/AIDS programme)
- In states where private practices for Govt. doctor is allowed, 80% of the doctors in government services, practice either in their own private clinic or work in a private clinic as a consultant.
- In some states the private practitioners either in modern medicine or ISM&H are given the responsibility of manning a primary health care centre where government doctor is not available; these contract physicians need orientation training so that they can fulfill the role expected of PHC physicians in preventive, promotive and curative care as well as implementation of national programmes.
- Private practitioners especially specialists are hired on contract to provide specialist care in primary health centre/community health centre under RCH Programme, to improve access to RCH services for "at risk" women and children. Districts engage services of private doctors for performing MTPs
- Private sector individuals/institutions e.g. Tata Iron & Steel Company (TISCO) provide health care to the population living in a defined area.

- ∂ Private sector institutions e.g. companies contribute to meet health care needs of a population living in the vicinity of their factory.
- ∂ Private superspeciality, tertiary/secondary care hospitals were given permission to import equipment without duty with the understanding that they will provide in-patient/out-patient services to poor patients free of charge.
- ∂ Private super-speciality, tertiary/secondary care hospitals were given land, water and electricity etc. at a concessional rate with the understanding that they will provide in-patient/out-patient services free of charge to BPL patients.
- ∂ Private practitioners provide information for disease surveillance in some districts in *Kerala.*
- ∂ Part time hiring of general practitioners and specialists to visit and provide health care in PHCs/CHCs in under-served areas e. g., *Madhya Pradesh;*
- ∂ Private agencies have been engaged for support services like kitchen, laundry, cleaning and security (E.g. *West Bengal, Maharashtra, Uttranchal, Gujarat),*
- ∂ States are inviting private sector to set-up medical colleges (E.g. *West Bengal).*

The impact of all these on improving access to health care at affordable cost and improving control of communicable diseases have not yet been evaluated. However, available information suggests that these schemes had succeeded in places where there was a well defined committed group to ensure that the MOUs were implemented fully. It is important that public/private participation should be area specific taking into account the health care needs of the population, presence of each of these sectors, their strength and weaknesses. Monitoring of implementation with participation of the PRI and local leaders will go a long way in ensuring accountability. The Ninth Plan period also saw the initiation of various collaborations between the private and public sector institutions. The Tenth Plan aims to build on the recommendations of the Ninth Plan and take up on a priority basis, documentation of such collaborations between private sector and public sector institutions and the role each of them play in outpatient/ inpatient health care in different districts/states. Attempts would also be made to improve area-specific public-private collaborations, taking into account the health care needs of the population, the presence of each of these sectors, their strengths and weaknesses. Feasibility of GIS mapping to identify under-served areas and providing suitable incentives to encourage private sector to set up health facilities in such areas will be explored. During the Tenth Plan appropriate policy initiatives would be taken to define the role of government, private and voluntary sectors in meeting the growing health care needs of the population at an affordable cost

Reforms initiatives in the Department of Family Welfare

The Department of Family Welfare has also made efforts to enhance the quality and coverage of family welfare services through increased participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of ISM&H. Panchayati Raj Institutions (PRIs) have been involved with a view to ensure inter-sectoral coordination and community participation in planning,

monitoring and management of the RCH programme. The PRIs would assist the states in supervising the functioning of health care related infrastructure and manpower and ensure coordination of activities of workers of different departments such as Health, Family Welfare, ICDS, Social Welfare and Education and functioning at village, block and district levels.

Under the RCH programme, several initiatives were taken to improve collaboration between the public and private sectors in providing family welfare services to the poor, especially in the under-served areas. Efforts were made to increase the involvement of private medical practitioners in RCH care by providing them orientation training and ensuring that they have ready access to contraceptives, drugs and vaccines free of cost. Various NGOs are being encouraged to participate in RCH programme. The Department on project basis involves NGOs in programmes such as introducing Baby Friendly Practices in hospitals, for advocacy of RCH and family welfare practices and for counselling. The Department of Family Welfare funds mother NGOs (larger NGOs looking after smaller ones) covering 412 districts and over 800 NGOs. These NGOs cover all districts in ten states. The state governments have also been trying to involve NGOs in providing services, or adopting a PHC. The results have been mixed; these experiments need to be carefully monitored. The Department of Family Welfare has also proposed that the NGOs who have adequate expertise and experience may participate in RCH service delivery. The Tenth Plan calls for undertaking policy initiatives which increase public-private-voluntary sector collaborations to meet the health care needs of the poor and vulnerable segments of population and monitor and enforce regulations and contractual obligations amongst others.

Health Sector Reform initiatives across select States

In face of problems like suboptimal functional status and difficulties in providing adequate investments for improving health care facilities in the public sector, almost all the state governments have introduced health system reforms. There are substantial differences in the content and extent of the reform. Several States have obtained external assistance to augment their own resources for initiation of health sector reforms in their State. All States utilize funds from BMS, ACA for PMGY and EAP to fill critical gaps in manpower and facilities. One of the major reform initiatives is the Secondary Health System Strengthening Project funded by the World Bank in seven states (Andhra Pradesh, Karnataka, Punjab, West Bengal, Maharashtra, Orissa and Uttar Pradesh). The focus in this project is on strengthening FRUs/CHCs and district hospitals to improve availability of emergency care services to patients near their residence and reduce overcrowding at district and tertiary care hospitals. The States have reported progress in construction works, procurement of equipment, increased availability of ambulances, drugs; improvement in quality of services following skill upgradation training in clinical management, changes in attitudes and behaviour of health care providers; reduction in mismatches in health personnel / infrastructure; improvement in hospital waste management, disease surveillance and response system. All the States have also

attempted introduction of user charges for diagnostic and therapeutic services from people above poverty line with varying degree of success. (Planning Commission, Annual Report, 2002-03)

Health sector reform initiatives undertaken or underway across the States of Andhra Pradesh, Delhi, Kerala, Madhya Pradesh, Orissa, Rajasthan, TamilNadu, Gujarat, Himachal Pradesh and Tripura are described below. *(Planning Commission, Annual Report 2001-02& 2002-03; response to Questionnaire on Health Sector Reforms)*

Andhra Pradesh: Some of the major initiatives include:

- **Strengthening of the Primary Health care infrastructure** under the Andhra Pradesh Economic Rehabilitation Project, which includes the provision of buildings, additional staff training and recurring expenditure.
- **A system of community health care workers** has been set up to improve access to health care for tribal population.
- **Volunteers covering 20 families** act as link between community and health care providers.
- **Filling critical manpower gaps** in medical officers and certain para medical staff on contract basis for a period of one year through district-based recruitment.
- **Setting up of Advisory Committees** to improve community participation, and monitor quality of services in Sub Centre, PHCs, CHCs, Civil Hospital and district hospitals.
- **A system of Hospital Advisory Committees** to provide for greater autonomy and accountability at hospital level has been formed.
- **Hospital Development Societies** have been formed in all tertiary level hospitals in the State which are under the control of Director of Medical Education.
- **Strengthening and upgradation of 150 first referral units** under World Bank assisted Secondary Health systems project, which also includes strengthening of civil infrastructure, equipment, additional staff and has a provision for meeting recurring expenditure.
- **Centralized system of procurement of drugs for all government institutions** has been put in place.
- **Privatization of non medical services** (E.g. security, cleaning in all hospitals).
- **Pilot project of handing over one Primary Health Centre (PHC)** each in the tribal areas to NGOs
- **Private sector** is encouraged to set up medical and dental colleges and paraprofessional training institutions.
- A transparent policy for posting of personnel based on merit and on grading given through the performance monitoring system has been finalized. Medical and Paramedical personnel serving in remote rural and tribal areas are given special incentives.
- District population stabilization societies are formed, and authority and funds were devolved to local levels.

Gujarat : Reforms underway in the State of Gujarat are

- Project undertaken for **creation of Block Health Office** to assist District Health Organization
- Scheme proposed for **creation of Community based health volunteers in urban areas.**
- To ease the problem of vacancies of specialists in health and medical services, honorary and part time specialists are being appointed. **Private practitioners are encouraged to provide services in public sector under the 'Samaydan scheme'.**
- **Management of PHCs and CHCs has been undertaken in partnership with NGOs.** Primary health care services have been handed over to SEWA-Rural.
- **Link Couple Scheme** has been approved for the rural areas. Under this scheme, ten couples married during last five years and having aptitude for social work would be sleeved from villages where the post of ANM is vacant or ANM is not staying in the HO. They would act as a link between the service provider and the community.
- **Grouping of CHCs** has been done, so as to ensure that at least 4 specialists are available in these CHCs. This has necessitated rearranging posts of specialists from low performing CHCs, PP Units, etc.
- Emergency obstetric care services have been established in tribal and inaccessible areas. A pilot project would be implemented in one Taluka.
- Application of GIS in planning of activities related to malaria control.
- Proposal to implement Quality Control Circles to improve quality of health care services by means of capacity building in one Taluka.
- Services have been **contracted out for developing strategies and implementing key IEC project in malaria control.**
- In RCH training, the **training is being imparted by inviting faculty on task related contact system**. Similar system is followed for training and research for HIV control programme.
- **Re-organization of entire cadre** of para medical ophthalmic assistant (PMOA)
- **Powers have been delegated to medical officers** to undertake minor repair work in PHC/SC buildings. These powers are limited to grants received from donor agencies. Similar powers delegated for civil works to District RH societies.
- Networking of blood banks operated by government, trust hospitals and by private owners would be done.
- Urban health care project is proposed under the 12th Finance Commission for providing primary health care to urban slum population under public private partnership.
- **Mapping of expertise available for training in private and NGO sector and involving them in training and sharing of information.** (e.g. Integrated Disease Surveillance)

Himachal Pradesh: Himachal Pradesh has initiated reforms in the following areas

- **User fees** introduced in hospitals from the zonal to sub-divisional levels.

- **Administrative and financial powers right up to PHC level have been decentralized.** PARIKAS (Parivar Kalyan Salahkar Samiti) has been formed at all three levels of Panchayati Raj System.
- **Autonomy** has been granted to hospitals / health institutions
- **Select services** such as scavenging, laundry and diet have been **contracted out**. The responsibility of security of hospitals has been entrusted to the Home guards.
- **Partnership with private sector** has been engaged in. There exists provision for reimbursement of expenditure on medical treatment to government employees if they undergo treatment in prescribed private hospitals in and outside the State. Also, provision exists for engaging services of private specialists on fixed fee per case basis, if specialist for that discipline is not available.
- **Functional integration of ISM&H practitioners** with an aim to improve coverage and utilization of national disease control programme and family welfare programme. A methodology for the same has been worked out.
- **Limited public health functions have been entrusted to nurses, paramedics** and others after due training.
- Institution specific **sub-cadre of doctors has been created** for institutions located in remote areas
- **Staff norms** for health institutions have been notified
- **Managerial skill upgradation** of senior level officers and training of other health personnel is underway
- **Service norms** for health institutions have been prepared.
- Civil dispensaries in rural areas **re-designated** as PHC1
- Staff fixed according to the number of patients attending the PHCs and CHCs
- Suggestions received to **re-structure the cadre of Medical officers** in the services of the Directorate of Family Welfare.
- **Community financing** introduced in hospitals through AKS
- Health and family **advisory committees formed** at three levels of Panchayati Raj Systems
- Studies on burden of diseases by PGI Chandigarh completed

Kerala: Health sector reforms in the State focused on decentralized planning, strengthening disease surveillance and increasing the autonomy of institutions.

- The State has initiated **decentralized planning** right from the inception of Ninth Plan.
- Kerala has **handed over all the health care institutions up to the district level along with the funds to the Panchayati Raj Institutions.**
- The state is implementing a **district hospital project with Additional Central Assistance from Planning Commission.**
- It is proposed to provide inpatient services in General ward, pay ward and pay rooms. A system of cross subsidy for inpatients has been proposed.
- Attempts are being made to work out the **cost of care for common ailments** so that the norms for cost of care are available.

- For effective vector control, the Kerala Government has initiated a **"monitoring and management of mosquitoes programme"** with community participation.
- Kerala is implementing a **model of disease surveillance using data generated from government and private sector health care providers.**
- Kerala is proposing creation of a **cadre system of specialists to fill the existing vacancies.**

Madhya Pradesh: Madhya Pradesh has embarked on health system reforms to achieve structural and functional improvement in government health care institutions.

- **The devolution of powers** both financial and administrative to the Panchayats has been completed.
- **Rogi Kalyan Samitis in all districts and a Medical Facilities Development Board at State Level** has been established
- Efforts are being made to fully operationally **decentralized area specific micro planning.**
- The state is implementing **Swasthya Jeevan Sewa Guarantee Yojana** wherein a core set of services are guaranteed by the State Government within a specified time frame at the village level.

NCT of Delhi: Delhi has taken several steps to improve health status of under-served urban slum population through improved access to health care facilities.

- Specific efforts have been made to provide linked primary, secondary and tertiary health care in under-served East Delhi areas through **healthy city initiative.**
- The Delhi government has brought out a **directory of all public funded hospitals/ dispensaries** in each of its constituencies as the first step of area specific rationalization.
- In newer hospitals **privatization of non medical services** e.g. security, cleaning etc. has been undertaken.
- Initiative to improve **availability of essential drugs** at affordable cost and rational use of drugs has been taken up.
- **Registration of all physicians in Delhi** under Delhi Medical Council has been completed.
- **Hospital infection control and waste management** is taken up as a major thrust area in all tertiary, secondary and primary care institutions.
- **Child friendly city action plan** for 1998-2002 has been formulated and is being implemented.

Orissa: In order to rapidly improve health care services, the State has obtained substantial funds through externally assisted projects for strengthening primary, secondary care infrastructure and implementation of disease control programmes. Some of the major reforms initiated by the state are:

- **Improvement in Drug Procurement and distribution** in all public health institutions through establishment of a centralized Drug Procurement and distribution system.

- **User Charges** were introduced to raise resources for all tertiary, and district level government hospitals in the State for three categories of service, viz. diagnostics, special accommodation (pay wards) and transportation.
- **A pilot project initiated where the cleaning work** of the State's Capital Hospital Bhubaneswar was contracted out to Sulabh International at a negotiated price.
- **Petty maintenance of health buildings:** 100 CHCs/Block PHCs were identified in the first year and each Medical Officer in charge was given Rs. 10000 to take up petty repairs and to maintain simple accounts.
- **Mandatory pre-PG rural service** was introduced to improve the presence of doctors in remote and difficult areas and provide better rural orientation to young doctors.
- **Pancha Byadhi Chikitsa (5 Diseases Treatment Scheme)** The scheme created health entitlement and risk protection guarantee for the poor free of cost.
- **State Health and Family Welfare Society** was established to create a simple, problem free method for making funds available under the centrally sponsored schemes, as and when required.
- **Amalgamation of District Health Societies** was done to ensure better co-ordination of all health and family welfare programmes and to avoid duplication.
- **Formation of District Cadres for Paramedics**
- **To utilize existing health personnel for different activities** the state is implementing a scheme of multi-skilling of health personnel; under this scheme
- **A pilot programme of providing a 3 month training in Anaesthesia** administration to CHC doctors to enable them to administer anaesthesia in emergency obstetric care was taken
- **Pilot project of handing over PHCs to NGOs** was tried in 2 districts.

Rajasthan: In an attempt to improve access to health care the state has been investing over 50% of the plan funds for primary health care for the last decade. In order to ensure sufficient funds for development of secondary and tertiary levels of care, the State Government has attempted the following:

- **Increased Public/Private participation**
- In 1995-96, the State Govt. created autonomous **Medicare Relief Societies, one in each tertiary and secondary level hospital;**
- Medicare societies have promoted the **adoption of wards through institutions like Lions club, Rotary club, charitable trusts and individuals.**
- **Life Line Fluid Stores** have been established which sell drugs and other consumables on cost basis with a margin levied as service charges.
- **Privatization of non clinical services like cleaning, laundry, security,** transportation services has been attempted in some hospitals.
- The State has allowed **private sector to provide medical education and training.**
- The State has **attempted sharing of public sector facilities by private sector.**

Tamil Nadu: Tamil Nadu embarked on health system reforms aimed at improving antenatal care and institutional deliveries. To tackle the increasing disease burden due to

non communicable diseases attempts were made to improve access to services aimed at early detection and treatment of non-communicable diseases.

- **Strengthening and reorganization of primary health care services** was taken up under the DANIDA assisted Area Health Care Project. PHCs were strengthened so that facilities for emergency care and delivery are available round the clock.
- Contracting out of services in area of diet and catering, laundry, security and IEC
- **Loans to purchase mopeds were provided to the ANMs** to improve their mobility so that they could visit all the villages on schedule and undertake screening of all pregnant women and children.
- In order to improve access to facilities for **early diagnosis and effective treatment of non-communicable diseases** the state had initiated a system in which a team of specialists visit villages on a fixed schedule; after initial screening, persons detected to have problems were referred to appropriate facilities for treatment.
- Tamil Nadu Government set up a **Medical Supplies Corporation** in 1994.
- Involving the industry in improving the performance of PHCs by adopting a local PHC, health sub-centre or district hospital.

Tripura: Health reforms underway in Tripura include:

- Levying of **charges in hospitals**
- Establishment of pay clinics or pay cabins.
- Granting of **autonomy to hospitals**
- **Hospital development committee** has been formed.
- Services relating to **maintenance of hospital has been contracted out** to Sulabh International
- Issues relating to merger, restructuring and relocation of hospitals, dispensaries and block level PHCs is under consideration
- Limited public health functions have been entrusted to the MPWs
- **Panchayati Raj Institutions** have been involved in **implementing health programmes** (E.g. ICDS, immunization, spraying of DDT). A three tier system of PRI, TTAADC, Municipal Council, NGOs is involved in implementing programme and conducting IEC activities.
- Super-speciality services at a hospital have been entrusted to a society formed with representatives of Care Foundation Hyderabad and officials of the State Government.
- Upgradation and expansion of select institutions / hospitals, construction of new facilities is underway project basis, with financial assistance of different donor agencies and the Central Government.
- A committee has been constituted to determine manpower requirements in health institutions.

To sum, it is obvious that the Centre and the States have made every effort to implement the recommendations of the Ninth Plan regarding health system reforms. The progress, however, has been uneven. None of the states have implemented a comprehensive

package of structural and functional reforms. Most have taken up essential components of reforms such as logistics of drug supply, hospital infection control and waste management. The coverage as well as progress varies between states. Some States have moved far ahead in some aspects, e.g. Kerala in decentralized planning and devolution of funds and responsibilities to PRIs while others have encountered difficulties in implementing similar reforms. It is essential to assess progress and problems in implementation of the reforms in each state and appropriately modify the content and pace of implementation. In some states in the initial phases there may be greater enthusiasm in implementation of the reforms with the centre, state and the externally assisted programme providing financial assistance; the progress in such states should be carefully monitored so that there is no faltering after the initial phase. Others who may have encountered problems in the implementation of the reforms in the initial phases have to be encouraged to persist.

Health Sector Reform: Emerging Issues

The health sector in India is at cross-roads today. On one hand, India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care in government, voluntary and private sectors. The population has become aware of the benefits of health related technologies for prevention, early diagnosis and effective treatment for a wide variety of diseases and accessed available services. Technological advances and improvement in access to health care technologies, has resulted in substantial improvement in health indices of the population and a steep decline in mortality. Yet at the same time, we continue to grapple with newer challenges with the country now being in the midst of a dual disease burden of communicable and non-communicable diseases. It is acknowledged that the existing public health infrastructure is far from satisfactory and that the public health system suffers from paucity of funds, lack of adequate manpower, non-availability of consumables, obsolete equipment and dilapidated infrastructure. In spite of this, the Government has taken several steps for improving the public health care institutions and strengthening the primary health care infrastructure. However, the situation is compounded by severe resource constraints – financial, technical and human power related, which has led to policy makers as well as programme managers at differing levels being faced with difficult choices. In such a situation, attempts are being made through various reform initiatives to ensure meet the health needs of the people. Health sector reforms are underway or are being proposed in different States across India. In fact innovative experiments are also being done across the States with varying degrees of success. While various bi-lateral and multi-lateral agencies (like World Bank, DFID, Health & Family Welfare Programme of EC, CIDA amongst others) are supporting various reform initiatives or have undertaken evaluations and / or reviews of health sector reform in India, there is insufficient and inadequate systematic documentation and analysis of the various aspects of reform. Such an overview and analysis of all related issues is necessary to provide evidence to policy makers and other stakeholders in terms of the various dimensions and impact of health sector reform. Such an analysis would be useful in suggesting the preferred

further activities under health sector reform in India. Recognizing the need for evidence based information about and assessment of various initiatives undertaken as part of the health sector reform process in India, the Ministry of Health & Family Welfare, Government of India has undertaken a review and documentation of health sector reform initiatives in India.

In spite of being engaged in the reform process for over a decade, certain concerns and challenges face the Indian health sector and the stakeholders especially the policy makers. An attempt is being made to enumerate some of the areas of concerns. At the outset there is a need to operationalize the concept of health sector reforms in the Indian context and formulate a working definition, a broad conceptual framework that would guide further actions. It is important to distinguish purposeful health reform from changes in the health sector that are imposed by reforms from outside the sector as well as from normal evolutionary and incremental system changes in the health sector. This in turn may necessitate re-examining what has been the nature of 'health sector reform' so far.

The nature and direction of health sector reforms are specific to each State, with each one being situated at a different juncture in the reform process. Inspite of such divergence, common themes and approaches, objectives and issues can be identified across states. There is a need for policy makers at the State and Central level to exchange experiences and information on health systems reform, sound warnings, disseminate successes and failures, to draw lessons from and draw on best practices from experiences of States and for all of us to gain a better understanding of the concept of health sector reforms in India and determine the next steps to be taken. This assumes particular significance in light of the changing role for the government in the health sector today. The present workshop is a first step in this direction and aims to develop a working concept of health sector reforms in India and to enable experience sharing amongst the different stakeholders involved in the health sector reform process.

There is also a need to identify the content and process of health sector reforms including best and doable initiatives, understand the key stakeholders involved in the reform process and their interests in reforming the health systems, and identify areas where gaps exist in knowledge and / or implementation of reforms, mechanisms for continued monitoring and evaluation during implementation. Ensuring successful implementation of reforms would require building capacities of individuals as well as institutions within the health system at each stage in the health sector reform process. A related issue that would require to be addressed is that of promoting research on health sector reform. Researchable areas need to be identified and mechanisms need to build to ensure effective linkages between research and policy making. Health policy and systems research should be an integral art of reform agenda. Currently, there exists no systematic mechanism at the policy level to track the impact or consequences of health sector reform. With more information being available about the dynamics and impacts

of specific reforms, policymakers and programme managers can make appropriate corrections or move forward in successful directions. This in turn would require developing an integrated system of surveillance, National Health Accounts, health statistics and assessing health system performance. One would need to develop relevant and accurate indicators or pointers that can be used for evaluation, for setting priorities and for guiding programmes at national, regional and local levels. This is a collective activity involving the key stakeholders in the health sector reform process. The information available needs to be widely disseminated and discussed by establishing mechanisms for shared learning and exchange of experiences and trainings. Sustained information and education on health sector reforms is needed to generate wider political and public understanding and support for the reform process. Towards this end, regional resource institutions and persons need to be identified and / or inter-sectoral groups involving the key stakeholders need to be established to support health sector reform.

There is no one answer as to what would be the best health sector reform option. If equity in access to basic health care must remain the goal, then the State cannot abdicate its responsibility in the social sectors. India would have to continue with a mixed model of government and private health care and evolve an optimal balance; the need to strengthen the state-sector would continue and at the same time it would be necessary to plan for a regulated growth and involvement of the private health sector as well. At the present juncture it is pertinent that we review the impact of current options and thereafter assess whether they could be could be implemented differently from the past as well as if required consider introducing substantive changes in different health sector entities and functions. Any options we agree upon need to build in flexibility to deal with the differing realities across States. The way ahead should be based on consultations, debates and by forging a consensus amongst policy makers at Centre and State and other stakeholders and should aim towards increasing equity, efficiency effectiveness and thereby, meeting the health needs of the population.

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Power Point Presentations

List of Power Point Presentations

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8. From First Phase to Second Phase of RCH	Ms. Nandita Chatterjee
9. Synopsis of Day 1	Ms. Anagha Khot

INDIA'S HEALTH SYSTEM – ROLE OF HEALTH SYSTEMS REFORMS

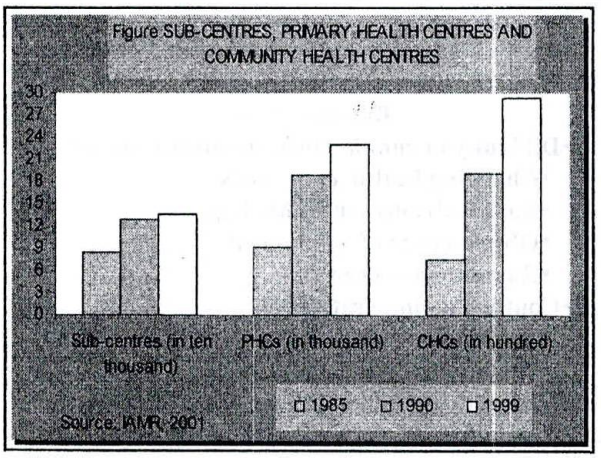
Prema Ramachandran

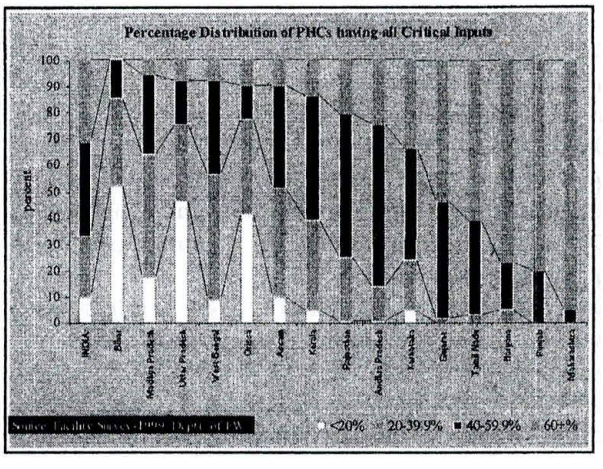
Adviser(Health) Planning Commission

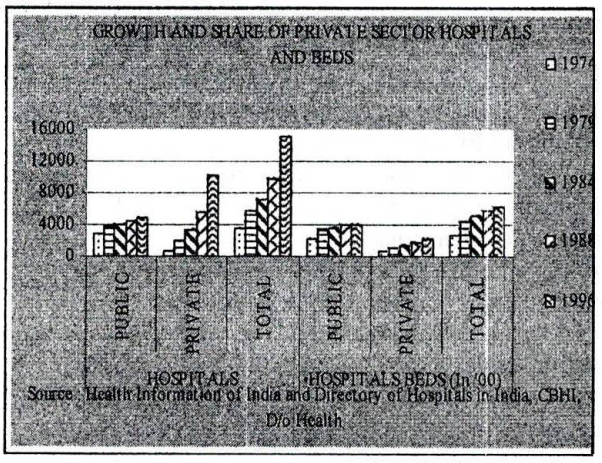
Health system Consists of

- Primary, secondary and tertiary care institutions, manned by medical and paramedical personnel to provide health services
- Medical colleges and paraprofessional training institutions to train the needed manpower and give the required academic input
- Programme managers managing ongoing programmes at central, state and district levels
- HMIS - two way system of data collection, collation, analysis and response.

They are not linked appropriately and do not function as cohesive parts of the system







Paradoxes in health sector

- Plethora of hospitals but few located in areas with high morbidity .
- Huge health manpower – many underemployed some unemployed - still unqualified persons practice
- Vast sums spent on drugs and diagnostics- unused piles of drugs in some places & lack of appropriate diagnostics and drugs in others
- Lack of defined norms for of care at each level & referral
- Primary care workers not given the responsibility of gate keepers; their referrals are not honoured.
- Some hospitals overcrowded; many underutilised

Current problems in providing health care

- **Persistent gaps/ mismatch in manpower & infrastructure especially in primary health care in areas where health care needs are greatest,**
- **Plethora of hospitals in Govt., voluntary and private sector not having appropriate manpower, diagnostic and therapeutic services and drugs,**
- **Sub-optimal functioning of the infrastructure; poor referral services,**
- **Availability and utilisation of services are poorest in the most needy remote rural areas in states/districts.**
- **Massive interstate/ inter district / urban rural differences in performance**

HEALTH CARE INSTITUTIONS

- **Good facilities with skilled staff;**

But they face

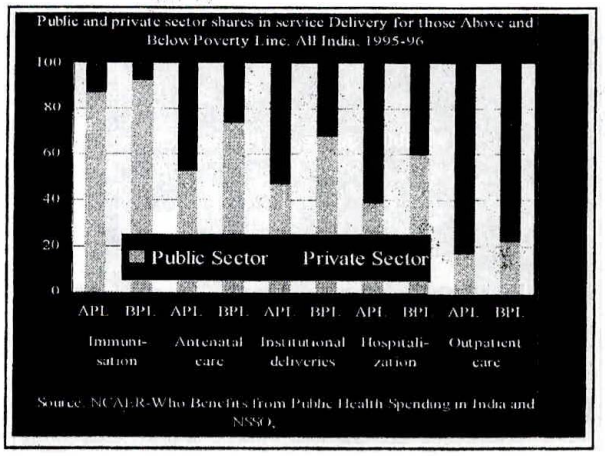
- **Difficulty in running institutions because of**
  - **Changing health care needs**
  - **Rapid advances in technology**
  - **Obsolescence of equipment**
  - **Rapid turn over of staff**
- **Conflicting imperatives of**
  - **Having to contain costs & be self sustaining**
  - **Shouldering social responsibility**
  - **Dealing with labour & consumer litigations**

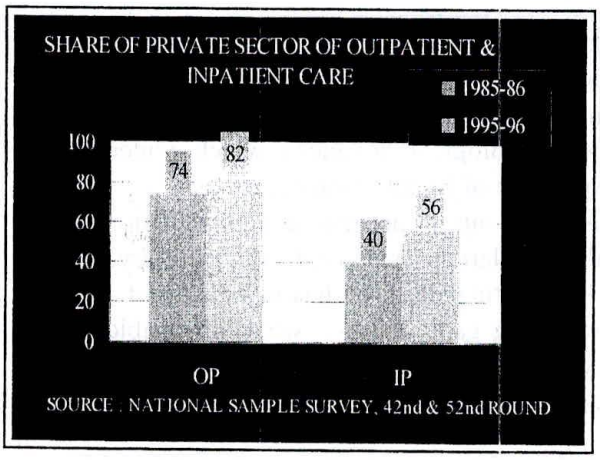
HEALTH PERSONNEL

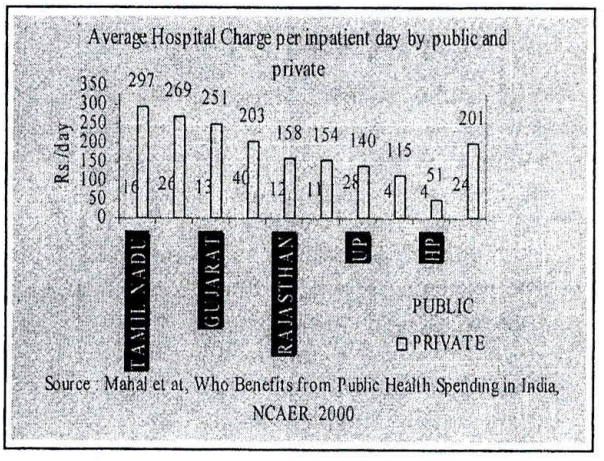
- Highly skilled, competent and committed

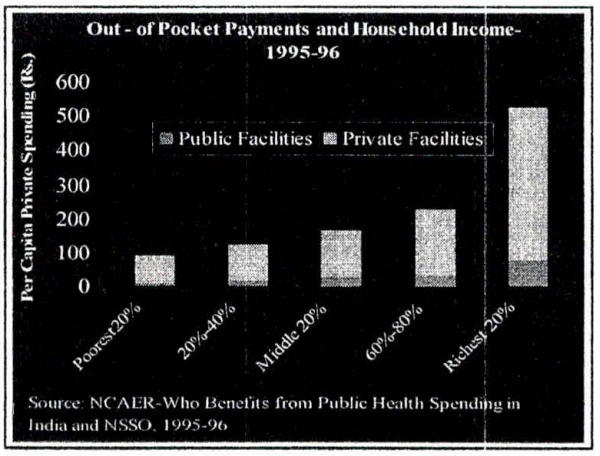
But Require

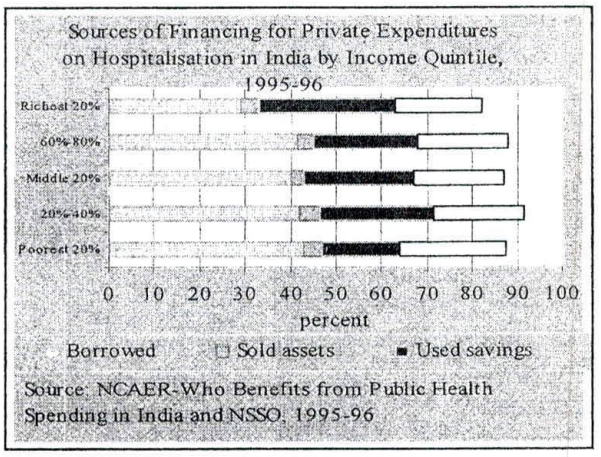
- CME providing up dated information on
  - rational use of drugs and
  - protocols for management of illnesses
- System of screening and referral
- Access to institutions with adequate staff
- Quality control systems which ensure that
  - patients get appropriate care
  - Cost of care is not prohibitive
  - physicians get protection against litigation











THE PEOPLE

- Responsible, rational, increasingly aware
- Slow to respond but response is sustained
- Willing to invest for and in health But
- Diagnosis and management of illnesses are becoming increasingly complex and costly ;
- Trusted family physicians have vanished
- With commercialisation of health care fear
  - Potential for poor quality care
  - Problems due for overuse, abuse and misuse of technology &
  - Exploitation of vulnerable patients

Health sector -Emerging problems

- Dual disease burden of communicable and non-communicable diseases
- Technological advances which widen the spectrum of possible interventions,
- Increasing awareness and expectations of the population regarding health care services,
- Escalating costs of health care and ever widening gaps between what is possible and what the individual, institution or the country can afford.

Ninth Plan emphasized the need to :

- Review the response of the public, voluntary and private sector health care providers as well as the population themselves to the changing health scenario
- Reorganise and restructure health services so that they they function as integral components of an efficeint and effective multiprofessional health system
- Introduce health system reforms to enable the population to obtain optimum care at affordable cost.

Who are the stakeholders

States - as Health is a state subject

Centre –as effective implementation of the CSS requires an efficient state health care infrastructure.

Health care Institutions – as they can function better according to defined norms

Health care providers- as they will get essential requirements to provide care

People – because they need access to good quality care health at affordable cost

Health system reforms broadly fall into three categories:

- ⇔**structural and functional aimed at improving efficiency,**
- ⇔**financial aimed at improving the resources available and**
- ⇔**governance related aimed at improving transparency/ accountability.**

It was envisaged that the public sector would play the lead role in health systems reform

Structural Reforms

Reorganisation and restructuring of existing health care infrastructure including the infrastructure for delivering ISM&H services at primary, secondary and tertiary care levels, so that they have the responsibility of serving population residing in a well defined area and have appropriate referral linkages with each other.

Mainstreaming of the ISM&H manpower and infrastructure to improve access to health care and performance under the national disease control programmes and Family Welfare programme

Human resource development

- **Human resource development to meet growing/changing health care needs – adequate in number, with appropriate skills & attitudes.**
- **Skill up gradation of health care providers through CME; redeployment of the existing health manpower so that they can take care of the existing and emerging health problems at primary, secondary and tertiary care levels.**

Functional reforms

- **Horizontal integration of current vertical programmes and ongoing state sector programmes at& below district level;**
- **Integrated system for district based administration, planning, implementation, monitoring, IEC, training, supplies**
- **Building up efficient and effective logistic system for supply of drug, vaccines and, consumables based on the need and utilisation**

Functional reforms

- **Fully functional accurate reporting system which provides data on births, deaths, diseases and data pertaining to ongoing programme through service channels, within existing infrastructure; monitoring and evaluation of these reports and appropriate midcourse corrections to be done at district level;**
- **Building up an effective system of disease surveillance and response at district, state and national level within and as a part of existing health services**

Governance Related

- **Introduce a range of comprehensive regulations prescribing minimum requirements of qualified staff, conditions for carrying out specialized interventions and a set of established procedures for quality assurance.**
- **Evolving standard protocols for care for various illnesses at primary, secondary & tertiary care with the help from public sector hospitals, medical colleges, professional associations**
- **Working out cost of diagnostics and therapeutic procedures for major/ minor ailments in different levels of care and setting cost of care norms.**

Quality of Care

✓Assessment of quality of care is not a value judgement.

✓Quantifiable determinants & ingredients of quality include:

- Infrastructure/manpower
- Processes for diagnosis and treatment,
- Intervention – Safety & timeliness
- Outcome – case fatality, disability
- Cost of care

Quality Control system in India will:

- Prevent over use, under use, abuse, misuse facilities
- Improve effectiveness and efficiency
- Help to make positive outcomes more likely
- Help to use of resources effectively an responsibly
- Minimise barriers to appropriate care different levels by matching levels of care to lev of need;bring in accountability in the healt system
- Open the gates for Health tourism

Governance Related

- Appropriate delegation of powers to Panchayati Raj Institutions (PRIs) so that the problems of absenteeism and poor performance can be sorted out locally and primary health care personnel function as an effective team.
- Involvement of the Panchayati Raj Institutions in the planning and monitoring ongoing programmes and taking timely corrections for optimal utilisation of services.
- Better access to information what types of services are available where and at what cost

Financial Reforms

- Continued commitment to provide essential primary health care, emergency life saving services, services under the National Disease Control Programmes and the National Family Welfare Programme totally free of cost to individuals based on their needs & not on ability to pay
- Evolve, test and implement suitable strategies for levying user charges for health care services from people above poverty line, while providing free service to people below poverty line; utilise the collected funds locally to improve quality of care.
- Evolve and implement a mechanism to ensure sustainability of ongoing govt. funded health and family welfare programmes especially those with substantial external assistance.

AN OVERVIEW OF HEALTH SECTOR REFORMS

- This presentation provides an overview of the following:
- The Political and Economic context of health sector reforms (HSR)
- The elements included under HSR
- Donor Funding and HSR
- International experience with HSR
- HSR in India

Context of HSR

- The world recession of the late seventies and early eighties is the context within which HSRs emerged
- The motivation for HSRs was to reduce government spending and increase the role for markets
- Public provisioning was seen as inefficient as compared to markets that were characterised as efficient and more responsive to the needs of 'consumers'
- As a result there was a shift away from the welfare state to greater reliance on markets

Context of HSRs -2

- Since the emphasis was to reduce state involvement, methodologies were developed for both assessing and prioritising investments in health were driven by the objective of cost effectiveness.
- Many of these strategies included contracting out, introduction of user charges in public facilities, incentives and subsidies for private sector etc

Definition and Elements of HSR

- An accepted definition of HSR includes:
- improving the civil service
- decentralisation of power and resources
- improving function of health ministries
- broadening health financing
- increasing the role of private sector in the financing of provisioning of health care

Elements of HSR

- Elements that have been included as a part of HSR are:
- Privatisation of health services specially at secondary and tertiary levels of care
- Introduction of cost recovery mechanisms that were seen to enhance cost effectiveness and also improve quality of services. These include introduction of user fees; contracting out of ancillary services in public sector
- Implemention of "essential services "for specified target groups at the primary level.
- Decentralisation of services- financial and administrative

Donor Funding and HSRs

- HSRs were seen as a response to fiscal constraints that were being faced in both developed countries
- They were driven by an ideological position that placed greater faith in the market than the state
- The elements of HSR were globalised through both multilateral and bilateral agencies

Donors and HSR

- One of the motivations for donor funding for HSRs was to 'cushion the impact of globalisation'
- It was also seen as a way of 'rationalising costs' in the health sector
- Uptil the 1980s the donor funding for the health sector was dominated by bilaterals
- The 1990s witnessed the emergence of the World Bank as the single largest agency to fund the health sector in the developing world.
- Loans were given by the World Bank to the health sector as a part of the Structural Adjustment Programme

Donors and HSR

- The loans to the health sector were tied with conditionalities in terms of defining the programme content, choice of technology, programme priorties
- The loans were earmarked for specific programmes like disease control, Reproductive and Child Health, primary health care and restructuring of secondary and tertiary levels of services

Experience of HSR

- Much of the evidence pertains to the African and Asian countries with respect to HSR
- The various studies show that elements like privatisation, user charges have reduced access, especially for the poor and sections of the middle classes.
- Privatisation and corporatisation of health services has increased costs.
- It has also affected the quality of public provisioning;
- User charges in the public sector are not an important source of revenue, as was believed.
- A recent review of experiences with contracting out shows that the administrative costs to manage it has proven to be not cost effective.
- The market failures in health services is now well accepted

HSR in India

- A few elements of HSR like privatisation started during the late 1970's and early '80s
- 1991-India opts for SAPs in the economic domain
- Loans from the World Bank with support from bilateral agencies to the health sector begin by the mid 1990s. The Indian government opts for these loans to deal with the fiscal crisis in the health sector specially at the state level
- These loans were given to specific projects that included disease control programmes, Reproductive and Child Health programmes, primary level care and the state health systems projects- that dealt with secondary and tertiary levels of provisioning

HSRs in India-2

- Each of these projects had specific conditionalities regarding the use of loans
- For example- the disease control programmes gave priority to a few diseases and also specified the kind of technology to be used. In the case of the health systems projects the items for which the loans were to be used were specified. It also called for introduction of user fees and contracting out in public hospitals
- Although these loans were negotiated between the Bank and the respective states. The spaces for negotiation were small given the unequal relationship that exists between the lender and the borrower
- The spaces for negotiation were small given the unequal relationship that exists between the lender and the borrower

HSR in India-3

- A few studies on the reform of secondary and tertiary levels as a part of the health systems project in states like Andhra Pradesh raise a number of important questions.
- The health systems project was initiated during the mid 1990s across several states and a major percentage of the loans was spent on civil works, equipment and drugs.
- Investments in these areas was seen as necessary to enhance patient supply. Through the introduction of user fees it was assumed that additional revenues could be generated.

HSRs in India-4

- Studies from Andhra Pradesh show that even after these investments the out patient and inpatient numbers did not increase significantly. The middle classes who had moved out of public sector to the private sector during the mid eighties did not start utilising the public sector.
- User fees that were introduced met with resistance and met with protests in Andhra Pradesh. However they have been reintroduced despite the protests.
- Since the fiscal crisis continues the financial sustainability of these projects is of concern
- There is a need to document and share the process and experience of HSRs across states and this workshop is an important contribution to this area.

WORKSHOP

ON

INDIA'S HEALTH SYSTEM : ROLE OF HEALTH SECTOR REFORMS

SEPTEMBER 4-5, 2003

MS. ANJALI BHAWRA,IAS
MANAGING DIRECTOR-PHSC
& SPECIAL SECRETARY HEALTH, PUNJAB

NEED FOR HEALTH SECTOR REFORMS

- QUALITY OF HEALTH CARE DELIVERY.
- COST OF ITS DELIVERY.
- INCREASING HEALTH EXPENDITURE.
- RESOURCES ALLOCATION DILEMMA.
- THE PROBLEM IS COMPOUNDED DUE TO
  - LACK OF PATIENT SATISFACTION
  - HETEROGENITY
  - INTANGIBLE OUTPUT

PROCESS INITIATION

- RE-EVALUATION OF THE HEALTH NEEDS OF THE COMMUNITY.
- ASSESSEMENT OF THE DEPLOYABLE RESOURCES IN HEALTH SECTOR.
- ANALYSIS AND REPRIORITIZATION OF THE NEEDS AND RESOURCES.

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

- IMPLEMENTATION OF USER CHARGES
- LINKING ADDITIONAL RESOURCES TO IMPROVE HEALTH CARE DELIVERY
- RETENTION & UTILIZATION OF USER CHARGES AT THE POINT OF COLLECTION
- HIGHER FINANCIAL POWERS TO BRING MORE AUTONOMY
- MEDICAL INSURANCE SCHEME.
- DEMOCRATIC DECENTRALIZATION
- OUTSOURCING OF SERVICES

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

- PUBLIC – PRIVATE MIX
- REVAMPING OF PRIMARY HEALTH CARE SERVICES
- HEALTH CARE DELIVERY THROUGH BETTER MOBILITY
- EMPHASIS ON MAINTENANCE OF ASSETS & OPTIMUM UTILIZATION

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

A. IMPLEMENTATION OF USER CHARGES

- IMPLEMENTATION OF USER CHARGES POLICY SPECIFICALLY IN THE SECONDARY LEVEL HEALTH CARE SERVICES.
- COLLECTIONS PROCEDURES MADE MORE RIGOROUS.
- RATIONALIZATION OF USER CHARGES.
- INDEXING USER CHARGES IN ORDER TO COVER OPERATIONAL EXPENSES EXCLUDING MANPOWER COST AND CAPITAL COST.

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

LINKING ADDITIONAL RESOURCES TO IMPROVE HEALTH CARE DELIVERY

- ADOPTING THE POLICY FOR RETENTION & UTILIZATION OF USER CHARGES
- SETTING OUT PRIORITIES FOR UTILIZATION:
  - DRUGS 45%
  - IMPROVING FACILITY FO THE PATIENTS (25%)
  - MAINTENANCE OF BUILDING (15%)
  - MAINTENANCE OF EQUIPMENT (15%)

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

HIGHER FINANCIAL POWERS TO BRING MORE AUTONOMY:

- MEETING DAY-TO-DAY EMERGENY REQUIREMENTS FOR DRUGS, REPAIR OF HOSPITAL EQUIPMENT & OTHER CONTINGENCIES.
- CUTTING DOWN / BREAK DOWN TIME OF DIAGNOSTIC / EQUIPMENT.
- SENSE OF BELONGINGNESS.
- MANAGEMENT OF EMERGENCIES.
- DELEGATION WILL BRING MORE ACCOUNTABILITY.

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

IMPLEMENTATION OF MEDICAL INSURANCE SCHEME:

- GOVERNMENT IS IN PROCESS OF HIRING A CONSULTANCY FOR DEVELOPING A SCHEME TO ADDRESS THE UNMET NEED OF GOVERNMENT EMPLOYEES, PENSIONERS, AND PEOPLE BELOW POVERTY LINE.

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

DEMOCRATIC DECENTRALIZATION:

- GOVERNMENT HAS PREPARED A SCHEDULE OF THE FINANCIAL POWERS AND THE ADMINISTRATIVE POWERS TO BE TRANSFERRED TO P.R.Is. ALONG WITH THE TIME FRAME.
- THE SCHEDULE HAS BEEN COMMUNICATED TO D.R.D.P. FOR CONFIRMATION.

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

OUTSOURCING OF SERVICES:

COMPLETED

- SELECTED CLINICAL SERVICES.
- SECURITY SERVICES
- SANITATION SERVICES.
- AMBULANCE SERVICES.

PIPELINE

- DIAGNOSTIC SERVICES.
- MEDICAL WASTE DISPOSABLE SERVICES.
- CASH COLLECTION SERVICES.
- COMPUTERIZATION SERVICES.
- MAINTENANCE SERVICES.

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

PUBLIC - PRIVATE MIX:

- STATE GOVERNMENT IS INITIATING A PROJECT WITH THE HELP OF PUNJAB INFRASTRUCTURE DEVELOPMENT BOARD FOR HANDING OVER O&M OF SELECTED HOSPITALS IN THE STATE.
- ONE PROPOSAL FOR 150 BEDDED HOSPITAL AT AMRITSAR IS AT ADVANCED STAGE.

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

REVAMPINIG OF PRIMARY HEALTH CARE SERVICES:

- **PROCESS INITIATED FOR HIRING A CONSULTANT.**
- **ASSESS & EVALUATE THE CURRENT STRUCTURE OF PRIMARY HEALTH CARE SYSTEM.**
- **UNDERLINE THE AREAS REQUIRING STRENGTHENING AND RESTRUCTURING.**
- **IDENTIFICATION OF CRITICAL NEEDS & GAPS.**
- **EVOLVING AN INTEGRATED DISEASE SURVEILLANCE SYSTEM.**

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

HEALTH CARE DELIVERY THROUGH BETTER MOBILITY:

- **INTRODUCTION OF MOBILE HEALTH CLINICS.**
- **STRENGTHENING OF PRIMARY & SECONDARY HEALTH INSTITUTIONS.**
- **PROPOSAL FOR INTEGRATION OF OTHER SYTEM OF MEDICINE AND BRINGING THEM UNDER ONE ROOF FOR COST EFFECTIVE PURPOSES.**

INITIATIVES TAKEN BY THE GOVERNMENT OF PUNJAB

EMPHASIZE ON MAINTENANCE OF ASSETS:

- **PRIORITIZING MAINTENANCE RATHER THAN CREATION OF ASSETS.**
- **HIGHER ALLOCATION FOR MAITENANCE BUDGET.**
- **INTEGRATION OF HEALTH MAINTENANCE INFRASTRUCTURE INVOLVING D.R.M.E., P.H.S.C., D.O.H.F.W., E.S.I. DISPENSARIES, AYURVEDA, AND HOMOEOPATHY.**

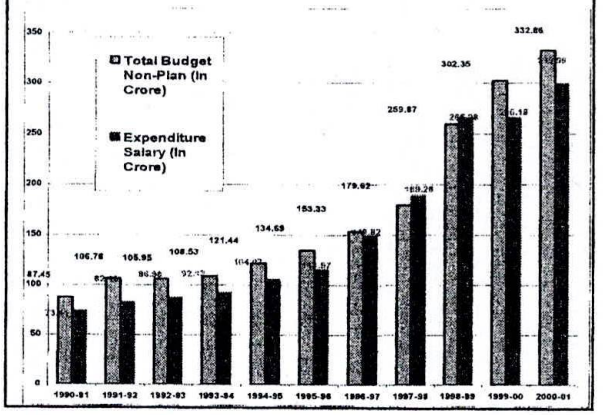
INITIATIVES TAKEN BY PHSC

- BENCH MARKING
- WASTE DISPOSAL SYSTEM
- GRADING OF THE HOSPITALS
- REGULAR MONITORING
- TRAINING

HEALTH INFRASTRUCTURE IN PUNJAB

HEALTH INSTITUTIONS			
DIRECTORATE OF HEALTH (DHS)		PUNJAB HEALTH SYSTEMS CORPORATION (PHSC)	
Name of Health institution	No.	Name of Health institution	No.
Hospitals / Community Health Centre (CHC)	160	District Hospital (DH)	16
Primary Health Centre (PHC)	484	Sub Divisional Hospital (SDH)	45
Subsidiary Health Centre (SHC) / Dispensary (Rural&Urban)	1,465	Community Health Centre	96
Sub Centre	2,852		

BUDGET ALLOCATIONS



THANK YOU

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Rajasthan
Health Sector Reform
A Perspective

Dr B Sekhar IAS
Special Secretary, Medical and Health, Govt. of Rajasthan

***

Workshop on Health Sector Reforms, Sept. 4-5, 2003
Ministry of Health & FW
New Delhi

Framework of Presentation

I. Brief introduction to Rajasthan
II. Health sector reforms- Past efforts
III. Unfinished challenges

I. Brief Background of Rajasthan

Indicators	Rajasthan	India
Population (2001) in million	56.5	1027
Decadal population growth rate, 1991-01	28.33	21.34
Sex ratio (females per thousand male)	922	933
Population density (persons per sq km)	165	324
Per cent urban	23.4	27.8
Percent 0-6 yr.	18.5	15.4
Literacy rate total	61.03	65.37
Literacy rate male	76.46	75.85
Literacy rate female	44.34	54.16
Per cent Scheduled Cast (1991)	17.29	16.7
Per cent Scheduled Tribe (1991)	12.44	8
Total fertility rate (1997)	4.2	3.3
Crude birth rate (1999)	31.1	26.1
Crude death rate (1999)	8.4	8.7
Infant mortality rate (1999)	81	70

Items	Number
Divisions	6
Districts	32
Sub Divisions	188
Tehsils	241
Municipalities	183
Panchayat Samities	237
Village *Panchayat*	9188
Total Villages	39810
Inhabited Villages	37889
Cities/ Towns	222

I.Brief Background of Rajasthan

Particulars	1997-98	1998-99	1999-00	2000-01	2001-02
Hospitals (CHC)	219 (72)	219 (72)	219 (72)	219 (72)	219 (72)
Dispensary	268	268	268	268	268
MCW Center	118	118	118	118	118
PHC (Upgraded PHC)	1646 (190)	1662 (190)	1674 (191)	1674 (191)	1674 (191)
PHC (Urban)	20	24	29	29	29
Sub Center	9650	9851	9926	9926	9926
F.W. Centre	293	293	293	293	293
Beds	37486	37766	37918	37918	37918
Doctors	6107	6143	6184	6106	6252
Population (2001)	440.06	440.06	440.06	440.06	564.73
Budget (Lakh)	69346.5	86132	106871	100616	102231
Budget per person (Rs.)	157.58	195.73	242.85	228.64	181.02
Population per bed	1174	1165	1161	1161	1489
Population per doctor	7206	7164	7116	7207	9033
Population per institution	3691	3624	3593	3593	4611

Background…

Distribution and trend of Human resources at primary and secondary level

Personnel Category	Strength (in Number)								
	91/92	*92/93*	*93/94*	*94/95*	*95-96*	*96/97*	*97/98*	*2000-01*	*2001-02*
Senior Specialists	232	231	243	239	234	234	234	222	224
Junior Specialists	1076	1116	1187	1203	1284	1299	1325	1438	1486
Senior Med. Officer	917	947	960	345	897	897	891	892	783
CAS+Dentist	2939	3044	3178	3229	3518	3558	3657	3554	3527
Nursing Staff	9610	9784	10009	10149	10656	10760	10942	1891	12029
Lady Health Visitor	1298	1303	1308	1308	1308	1308	1358	1358	1358
ANM	10148	10298	10442	10571	11271	11991	12291	2271	12271
Sr. LT/LT	1912	2008	2065	2138	2246	2271	2326	2262	2355
Sr. Rad/Radio/AR	462	482	510	519	534	539	545	527	527
Food Inspectors	34	34	34	34	34	34	34	34	34

Background…

Analysis of Public Health Expenditure by Major Heads of Expenditure

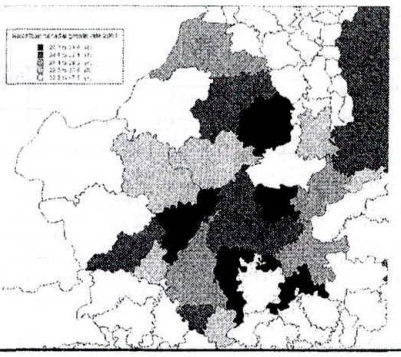
Major Heads	1998/99	1999/00	2000/01	2001/02
Total Government Expenditure on Health Of which	4323.55	39603.8	41084.1	42382
Salaries (amount)	3474.59	32258.6	34006.2	34920.7
Salaries (share of total expenditure)	80.3	81.45	82.77	82.39
Drugs (amount)	186.75	1543.46	1698.8	1609.35
Drugs (share of total)	4.3	3.89	4.13	3.79
Maintenance of equipment amount)	26.05	78.49	111.43	62.36
Maintenance of equipment (share)	0.6	0.2	0.27	0.14
Maintenance of Vehicles (amount)	10.42	72.02	63.44	65.14
Maintenance of vehicles (share)	0.24	0.18	0.15	0.15

Background…

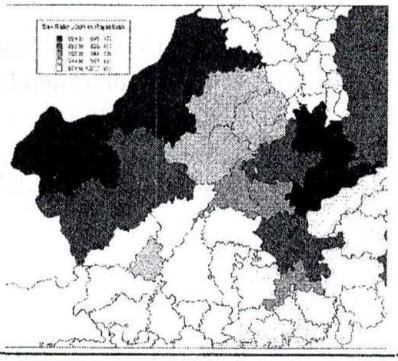
Percentage Allocation of Public Expenditure by Levels

Expenditure Level	94/5	95/6	96/7	97/8	98/99	99/00
Expenditure at Primary Level (including FW)	52.6	53.8	55.7	55.7	54.16	53.73
Expenditure at Secondary Level	23.7	23.2	22.7	22.6	21.97	21.83
Expenditure at Tertiary Level medical colleges)	23.7	23	21.6	21.7	23.87	24.44

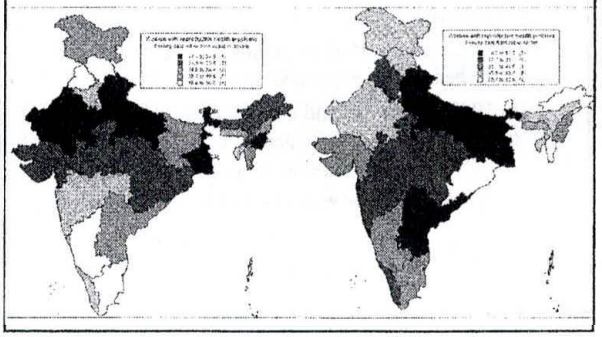
Rajasthan-Diversity: Decadal Growth Rate



Rajasthan-Diversity: Sex Ratio



Public Sector Use in Rajasthan



II. Health Sector Reforms Past Efforts

1. Financing methods
2. Changes in health system organization
3. Regulation of private sector
4. Re-organization and re-structuring of existing government health care system
5. Reforms related to human resources
6. Drug policy and procurement

II. Health Sector Reforms- Past Efforts (Cont.)

7. Policy Reforms
8. Private/ NGO/ Voluntary and Public Partnerships
9. Equity Enablers

1. HSR-Financing Methods Medicare Relief Society (MRS)

Background

- MRS created in 1995 in all hospitals with 100 or more beds; Now expanded up-to CHC level
- In 1980 pay clinics and auto finance scheme were tried but they were not successful
  - Did not offer any incentives to generate revenue
  - Revenue generated were deposited in State Treasury

MRS-Objectives

- To compliment and supplement the health facility thorough generation of additional revenue
- To retain and use the resources generated in the hospital through decentralized decision-making

MRS-Functions

- Provide low cost diagnostic and treatment services
- Provide free medical services to poor and disadvantaged
- Obtain donations from financial institutions
- Conserve resources through adopting wards and opening of life line fluid stores
- Arranging facilities - Sulabh complex, maintenance of buildings, equipment, contracting out services

MRS-Management Structure

- Autonomous management committee comprised of official and non-official members at State, Regional and District level
- Executive Committee to take day to day decisions

MRS-Source of Funds

- Seed money by State Government
- Transfer of operational control of diagnostic machines to the societies
- Societies authorized to levy user charges
- Authorized to retain income from auction of other support services
- Authorized to accept grants and donations and loans

MRS-Exempted Category

- Families living below the poverty line
- Widows
- Freedom fighters
- Destitute
- Citizens over 70 years
- Retired Govt. Servant

MRS-Use of Funds

- Maintenance and renovation of building
- Maintenance and repair of equipments
- Purchase of new equipments
- Improving sanitation and cleanliness
- Improving other facilities for patients and attendents
- Computrisation of various system
- Free medicines for BPL

MRS-Challenges

- Rationale Use of surplus funds
- Ensuring free services to exempted categories
- Ensuring 25 % of surplus funds for BPL
- Use of funds in same financial year
- Developing systems for setting user fee
- Expanding the scope for levying user fee
- Ensure proper systems for perspective planning and accounting

B. Life Line Fluid Stores (LLFS)

- LLFS started all hospitals with 100 or more beds
- I.V. fluids, Surgicals items and injectable Antibiotics are provided to patients to 40 to 50 market cost
- The services are available 24 hours
- No financial involvement of the department or M.R.S.

2. Changes in Health System Organization

A. Decentralization
B. Granting autonomy of hospitals/ CHCs/ PHCs
C. Contracting-out
D. Appointments on contract-basis
E. IEC Bureau

A. Decentralization

- District health societies
- Relocation of Dy. CMHO offices
- Delegation/ devolution to Panchayati Raj

B. Granting Autonomy to Institutions

- Medicare Relief Societies

C. Contracting-out

- Cleaning services in hospitals
- Computer operators- Rs 6,000 machine + operator
- Computerization on BOT basis

D. Appointments on Contract-basis

- ANMs
- Lab technicians
- Staff nurses
- Medical officers

E. Information, Education and Communication Bureau

- Established in 1990
- Comprehensive reorganization of fragmented efforts in IEC
- Planning, monitoring of IEC techniques
- Research and experimentation
- Production of material and providing technical support services

3. Regulation of Private Sector

- The Rajasthan Clinical Establishment Regulation Bill, 2001/ 2002 – in process

4. Re-organization and Re-structuring of Existing Govt. Health Care System

- Dy. CMHO office relocation

5. Reforms Related to Human Resources

- Anesthetists short-fall: 3 months training
- Rational allocation of resources
- Certification

6. Drug Policy and Procurement

- Essential drug list and directions

7. Policy Reforms

- Population policy & RG Population Mission
- Training policy
- Essential drug policy
- Private sector in Health policy
- Transfer policy
- Health Vision 2025

Population Policy & RG Mission

- Second State in India to formulate State Population Policy
- Launched in January 2000
- Rajiv Gandhi Population Mission in July 2001 established for effective implementation of the Policy and Population Programme

Essential Drug Policy

- Rational use of drugs
- Essential Drug List
- Quality, Access and Availability

Policy to Promote Private Sector

- Permitting Private Sector in Medical, Dental, Nursing and Para-clinical Education
- Allotment of land

Policies Under Consideration

- State Health Policy
- Anti Quackery Bill
- Clinical Establishment Act
- Regulatory Authority for Health Care and Medical Education

8. Private/ NGO/ Voluntary Sector

- Jan Mangal Scheme
- Swasthya Mitra – village level worker
- Private- Medical Colleges, Nursing Colleges and Schools

9. Equity Enablers

- BPL Medicare Card Scheme – Medicare Relief Society

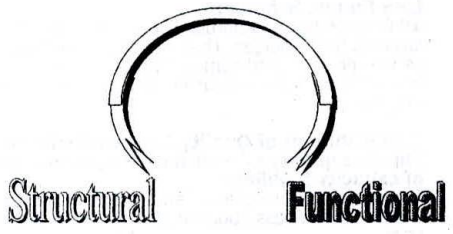
III. Unfinished Challenges

1. Organizational restructuring
2. Enhancing management capabilities
3. Addressing geographical, social, gender inequities
4. Encouraging and regulating private sector
5. Improving quality
6. Protection from impoverishment

Thanks !!

Reforms in Health Services provided by Gujarat State

A fundamental, sustainable, purposeful and positive process
towards health services provision made in
two different directions



Structural Reforms

- **RESOURCE ALLOCATION**
  - **Grouping of the CHCs:**
    At least 4 specialists are available in selected potential CHCs by rearranging posts of specialists
- **DECENTRALIZATION with RESOURCE ALLOCATION & MANAGEMENT:**
  - **"Creation of Block Health Office":**
    To assist District Health Organisation in planning, implementation and review of activities related to Primary Health Centres (PHC), to facilitate supplies of medicines and vaccines and to data flow
  - **Establishment of Emergency Obstetric Care services in tribal and inaccessible area:**
    Piloted in a taluka with training and net working for early referrals
  - **Application of GIS in planning of activities related to malaria control:**
    Mapping of all 18000 villages for last four years for micro planning of control activities by district and sub district officials
  - **Minor repair work in PHC/SC buildings**

- **CONTRACTING OUT**
- **For developing strategies and creative under IEC to bring professionalism**
- **RE-ORGANIZATION OF INFRASTRUCTURE**
- **Cadre of Para Medical Ophthalmic Assistant according to community needs**
- **'Urban Health Care' Project proposed for providing primary health care to urban slum population under public private partnership by Community Based Health Volunteers in Urban areas**
- **Easing up the problem of vacancies of specialists in health and medical services:**
  Appointment of honoraries and part-time specialists to encouraged private practitioners under "Samaydan scheme". As a part of this, govt. is actively considering the removal of age-eligibility criteria for appointment of doctors in govt. services.

Functional Reforms

- **Extending partnership spirit with NGOs :**
  PHCs' and CHCs' management taken under partnership programme with sustainable NGO for running consideration
- **Link Couple Scheme:**
  10 Couples having aptitude for social work will be selected from villages. They will act as link between service provider and community. Good couples will be reward in cash every quarter.. Budget is Rs.10, 000 per PHC per year.
- **Establishment of Quality Control Circles to improve quality of health care services by means of capacity building:**
  To improve coverage and patient satisfaction by means of creating awareness about quality and involvement of staff.
- **Capacity Building:**
  The health training is being planned through involvement of peripheral training institutes of relevant expertise
- **Establishment of Blood Transfusion Grid/Network:**
  Most of the blood banks are in urban areas and operated privately. 88 First referral units are identified in the state to establish Networking. Blood collection and storage facilities as per GOI guidelines will be developed at district hospitals and FRUs. A networking of blood banks operated by government, trust hospitals and by private owners will be done. Facilities will be provided to these blood banks.

HEALTH SYSTEM REFORMS IN HIMACHAL PRADESH

Besides the keenness of the State Government to reform the Health Sector in Himachal Pradesh, two Organizations – GTZ (German Project) and European Commission Programme through the Government of India – are supporting reforms in the health programmes and activities here.

CHANGES IN FINANCING METHODS

1. Establishment of Society under the Registration of Societies Act called ASPATAL KALYAN SAMITI at Zonal and District Hospitals: Government letter issued on August 5, 2000 followed by Government Order issued on July 8, 2001. These Samitis would improve:
   - System efficiency;
   - Service quality;
   - Patient satisfaction;
   - Local decisions and so initiative of the Officers;
   - Accountability at Hospital level;
   - Resource utilization;
   - The Hospital itself;
   - Resource generation through Community Financing and User's Charges.
   - The good work that was started in 2001 was attacked from all quarters. There was opposition as is always there for any Reforms measure. However, the results **started pouring in in 2002-03 and people, now, appreciate the steps taken.**

2. ASPATAL KALYAN SAMITI extended to Sub-Divisional level Hospitals in 2002:

a. Provision of Seed Money to improve such facilities that add to resource generation in the Hospitals exists;

b. Encouraging results are pouring in.

3. Primary Health Care, Emergency Services, National Disease Control Programmes as also entire treatment of families living below poverty line is absolutely free. The following is the criteria for families below BPL:

a. They carry an IRDP card/certificate with them;

b. The treating doctor is satisfied that the patient actually belongs to BPL category.

4. Major stakeholders involved and their role

a. Community and various NGOs. In some of the hospitals the NGOs

-have adopted wards;
-provide food to the indoor patients;
-improve the infrastructure of the hospitals;

b. Panchyati Raj Institutions

c. District Administration

d. Patients and Health Providers

5. Monitoring and Evaluation System

a. Monitoring is a regular process. One of the members of the Samiti is a representative of the Audit and Accounts Wing of the Finance Department;

b. Evaluation of the working of these Samities upto the hospitals at Zonal and District level was got done by HPVHA.The recommendations of the Report are being implemented in order to improve the functioning of the hospitals.

6. Successes and Failures, constraints faced and lessons learnt

a. It is clearly visible that the Man behind the Machine makes the Machine workable. Where there are creative and dedicated In-charges of hospitals, there the improvement in the hospitals is remarkable. However the improvement is State wide because it is for the first time that the doctors in the hospitals have started developing a Vision for the hospital.

b. The greatest hurdle in bringing about a change is always the employees of the Government. They raised hullabaloo at the time of forming the Societies.They could come to terms after long deliberation with them.

6.c. **The lesson learnt is that before jumping into a change or Reform, all the stakeholders should be taken into confidence after a series of discussions with them.**

7. **A few other changes in financing methods are included in the Decentralization of Powers to Medical Officers in PHCs. These will be discussed there.**

CHANGES IN HEALTH SYSTEM ORGANIZATION, DELIVERY AND MANAGEMENT

1. **Granting Autonomy to hospitals has been discussed above**
2. **a. Decentralization of Administrative and Financial Powers right upto the PHC level has been done.**
   -the BMOs have been given an imprest of Rs. 5000/-
   -the MO/Ic of PHCs have been given an imprest of Rs. 1000/-

   Due to Financial crunch the MO/Ic are not enjoying this

2.b. While delineating the role, one major step was Functional Integration of the Department of Indian System of Medicine and Homeopathy and the Department of Health and Family Welfare to follow standard protocol in National Health Programmes was notified. The process was streamlined in 2002-03 by putting into practice a defined methodology:

- **District Ayurveda Officers attend monthly meetings of the CMOs;**
- **CMOs allocate targets to the District Ayurveda Officers in preventive and National Health Programmes;**
- **Meetings of Sub-Divisional Ayurveda Officers and BMOs are held for determining targets for AHCs and PHCs;**
- **Officers, by name, appointed in both the Directorates to solve the problems, if any crop up, in the fields.**
- **Training of Ayurveda Officers in National Health Programmes and other Reforms is likely to be undertaken in HFW Department provided the funds are available.**

2.c. Panchayati Raj Institutions are being given adequate powers to play a vital role in health related Activities:

- PARIKAS (short of Parivar Kalyan Salahkar Samiti) have been formed at all the three levels of Panchayati Raj System:
- Panchayat PARIKAS has Pradhan of Gram Panchayat as the President and, preferably, Female Health Worker as the Secretary:
- Khand PARIKAS has Chairperson of the Panchayat Samiti as the President and the Block Medical Officer as the Secretary;
- Zila PARIKAS has the Chairperson of the Zila as the President and the Chief Medical Officer as the Secretary

- Sensitisation Wrokshops for the representatives of PRIs towards Health Related Programmes stand completed in 10 Districts. Workshops for PRI's representatives for 2 Blocks is going on at DADH in Kangra Distt. by CRRID.
- A booklet written in Hindi giving details about PARIKAS and Health Institutions plus Health Programmes was got published and distributed to all the representatives of the PRIs.
- Funds for Family Health Awareness Camps under HIV/AIDS and those for Mahila Swasthya Sangh activities are being given to PARIKAS now instead of the Block medical Officers to ensure more involvement of PRIs in health related activities.

3.Contracting out of Select Support Services in Health Institutions:

-Three support services; viz., scavenging, laundry, and diet are being transferred to Private Sector, wherever possible.

4.The Private Sector is being involved in the service delivery only as far as the National Health Programmes are concerned. There are a couple of hospitals in the State and four Hospitals outside the State where the employees of the State Government can get their treatment done and the expenses reimbursed to them.

5.Contractual Appointment of the Health Care Personnel.

a. The first step was to appoint Institution-specific doctors. It was successfully done and a three-day pre-placement training to these newly appointed Medical Officers was given:

-It was a much appreciated step that filled vacancies in Health Institutions in the interior;

-Course for their pre-placement training was designed;

-Trainers identified;

-Training given to 73 Medical Officers.

- b. The second step is to fill 100 posts of doctors and 181 posts of nurses in institutions where there is paucity of staff.

6. **Promulgation of The H.P. Paramedical Council Bill 2003. The objective is to maintain the State Register of Paramedical practitioners and to prescribe a code of ethics for them; also to register para-clinical establishments etc.**

7. **Promulgation of H.P. Medical Council Bill 2003.**

8. **Himachal Health Vision 2020 adopted by the Govt. as Policy Document**

"All Residents in the State will be enabled to be healthy, both in mind and body Himachal will be the Dominant Provider of total Health Care Services, including physical, mental and spiritual Health care will be the major powerhouse of growth and economic development in the State"

9. Interconnectivity for MIS for collecting data for NHP/Disease Surveillance and Manpower Planning:

- **The Computers are installed in all the District Headquarters**
- **Software developed during 2002-03 (Forms 6,7 and 8) and is currently being implemented in District Hamirpur, Bilaspur and 4 Blocks of Kangra District on pilot basis**

10. Improving IEC and Advocacy:

- Strengthened the IEC Wing by giving long due promotion to certain categories of Officers.
- Month-wise Plan for IEC activity drawn reflecting the responsibilities of various Departments and the personnel to carry out the activities.

11. Writing of ACRs was streamlined.

12. Burden of disease survey has been conducted by the PGI, Chandigarh. The Report has been received. The results of the survey will help in developing proper policy and governance.

13. Registration of vital events:

- During the year 2002-03, the level of Registration of vital events has gone up to 98%
- The vital rates are being worked out up to Panchayat level
- The information about District Una, Lahaul-Spiti, Shimla, Mandi and Solan is computerised

Health Sector Reforms

September 4th & 5th 2003.

Dr. I.S. Pal
Director General Medical Health & Family Welfare, Uttaranchal

Background

Born on 9th November 2000 .

- Comprises 13 Districts, 49 Tehsils , 95 Blocks & 16414 Villages
- Small scattered rural settlements.
- 50% of villages have population less then 200 & 84% less then 500

- Each sub-center serves 5-8 villages & distance of village to sub- center varies from 5 - 8 Kms
- Poor road connectivity , difficult hilly terrain (93% of area in hills), small scattered settlements lack of infrastructure & man power contribute to problems of access to health service delivery & a felt need for reforms in health sector.

A. Reform Initiatives for Primary Health Service Delivery

Contractual Appointments
Transfer policy
Training of TBAs
Special Salary for Doctors in remote areas.
Integration with ICDS.

Integration with ISM&H
Fixed Day schedule for health service delivery.
Fixation of roles & responsibilities of MO at Add. PHC.
Proposed health service delivery through community sponsored candidates.
Mobile Van for curative services.

B. Reform initiatives for secondary health service delivery

Privatization of sanitation, laundry & diet services.
Drug procurement policy.
Chikitsa Prabandhan Samittee in select hospitals.
Establishment of PCOs in Govt. Hospitals

C. Other Initiatives

Integrated umbrella society at state level.
Integrated umbrella society at district level.
Formulation of Integrated Health & Population Policy.
Delegation of powers under 73rd Amendment tc PRIs.

Reform Initiatives Taken

Appointment of 154 Medical Officers & 269 ANMs on contract

- **Reform taken to combat problem of access**
- **Service providers have been serving for more than one year .**
- **Positions in mostly remote areas.**
- **Improved access to health services in these areas.**

- At present only 56 male medical officers, 11 lady medical officers & 4 dental surgeons continuing.
- Difficult to retain services of service provider due to lack of accommodation & low salary.
- Preferable to take up local service providers in future.

Transfer Policy for Medical Officers

- Reform taken to combat problem of access
- Service providers serving in remote areas to be given soft postings & vice a versa.
- Reform ensures availability of service provider in remote areas.

- Medical Officers posted in remote areas given preference for PG admissions during service.
- Specialists to be appointed in CHCs / Tehsil Hospitals / District Hospitals.
- Fresh recruitment of specialists by Public Service Commission.
- Reform has improved access to health services in the State.

Dai-Training

- Reform taken to combat problem of access .
- 900 untrained dais imparted 10 day training in 2001-02 & 2002-03, & distributed DDK.
- 800 dais to be imparted training in 2003-04
- To reduce maternal & infant mortality.
- To increase safe delivery & institutional delivery.
- Dai training has improved access to health services.

	2001-02	2002-03	Apr-Jul 03
Deliveries by TBA	40250	46201	12641

Incentives for Service Provider in difficult areas

- **Reform to combat problem of access.**
- **Special non-practicing allowance for doctors posted in remote & difficult areas.**

S.N.	Basic salary	Special NPA	
		Very difficult area	Difficult area
1-	Less than 10,000	3000	2000
2-	10,000-12000	3500	2500
3-	More than 12000	4000	3000

Integration with ICDS Department.

- **Reform taken to combat problem of access & bring convergence.**
- **AWWs given orientation training to register ANCs & refer high risk cases.**
- **AWWs act as depot holders & provide information on births & deaths .**

- **AWWs responsible for providing communicable disease information .**
- **Conduct joint meeting with medical department at District, Block & sector levels.**
- **Convergence with ICDS has improved access to health services.**

Integration of Medical Department with ISM&H

- **Reform taken to combat access to health services & bring convergences.**
- **Service providers of ISM&H to participate in implementation of National Health Programme.**
- **Two day district level workshop planned for Doctors of ISM&H.**

- ISM&H service providers to provide monthly reports to the directorate through Chief Medical Officers.
- Linkages between ISM&H and Health Department established at sector block and district levels.

Fixed Day Schedule for Services

- Reform for better management of human resources
- Days fixed for providing services and meetings all over the State.
- Ensures availability of health service delivery to clients.
- Ensures ease of monitoring.

Tuesday - Sterilization days at district level hospitals

Wednesday – Sub-center days. A.N.M. to provide services at sub-centers.

Thursday – R.C.H. camps at block level PHCs.

Third Friday - Sector meetings at PHC. Coordination with ICDS&ISM&H

Fourth Friday - Meeting at Block. Coordination with ICDS&ISM&H

Saturday - R.C.H. out reach session days.

Monday - R.C.H. out reach session days for left over sites.

First Monday - Meeting at district head quarter. Coordination with ICDS and ISM&H

Powers and responsibilities of Medical Officers at Add. PHCs & SADs

- Reform taken to tackle managements issues.
- MO incharge of Add. PHCs will be controlling officer of all service provider at sub-centers and health supervisors working in their territory .
- Integration of ICDS with Medical Department at level of Add. PHCs.
- MO incharge of SADs to coordinate with MO incharge of Add. PHCs in discharging their duties.

Health Service Delivery through Community Participation

- Pilot Project planned with SIP support.
- Project planned in two blocks-Jaspur in U.S. Nagar & Prtapgragh in Tehri districts.
- HIHT to act as mother NGO
- Project to follow LIP initiative of HIHT which is already operational in Tehri & Uttarkashi Districts.
- Primary health care delivery through volunteers at village level.

Mobile Van for curative services

- Reform initiatives for health service delivery with public private partnership.
- Mobile van for diagnostic & curative services in Kumaon division.
- Support of TIFAC (technology information forecasting &assessment council) under Department of science & technology, GOI.

- Diagnostic & curative services provided at fixed sites mostly in Kumaon division & some sites in Garhwal division.
- 50% of operational cost bourne by GOU.
- Mobile van operated by Birla institute of scientific research Bhimtal.

Privatization of Sanitation, Laundry and diet services

- Reform taken to improve health service delivery.
- GOU order to hand over laundry and diet services in 9 big hospitals to private agencies in December 2001
- Agencies selected on competitive bidding.
- Disease specific diet served in these hospitals
- Services handed over to private agencies in Doon Hospital in Feb 2003.

Statistics for Doon Hospital after privatization

Year	OPD patients	Indoor patients	Average Diet Distributed per day
2002	2,19,541	11,006	45
Up to July 2003	1,61,146	7,341	150

Statistics for Doon Hospital after privatization

Month	OPD		IPD	
	2002	2003	2002	2003
March	15565	21147	828	988
April	18491	22938	908	1151
May	19510	24638	1182	1320
June	17778	22098	1043	1114
July	25080	22437	1112	1107

Establishment of PCOs in Govt. Hospital

- Reform taken for client convenience & improve health service delivery .
- GOU Order for Telephone facility in Govt. Hospitals with support of private PCOs.
- PCOs selected on competitive bidding for three years.
- Rent to be paid to hospitals by PCO.
- Space provided by hospitals and users to pay for calls at DOT rates.

Drug procurement policy

- Reform to improve quality of service.
- Company to have minimum turn over of 15 crores in past three years.
- WHO-GMP certification an essential pre-requisite.
- Drug to be supplied by company should have been in manufacture for minimum three years.
- State comprehensive drug policy to be formulated by UAHSDP.

Chikitsa Prabandhan Samitee in Select Hospitals

- Reform taken to bring about decentralization & community participation.
- Reform to also improve health service delivery.
- Chikitsa Prabandhan Samitees to be registered for 30 district level hospitals under the chairmanship of district magistrate.
- Representation of elected representatives in the samitees.
- 100% retention of user charges for utilization by Chikitsa Prabandhan Samitee.

Integrated society at State Level

- Reform initiative taken to tackle management issues.
- Apex Society for National Programme under the Chairmanship of Chief Secretary for implementation of National Health Programmes with DG as member secretary.
- Six sub-committees under the chairmanship of secretary medical for various national programmes with DG as vice president.

- Funds flow from GOI through State Level Society to District Empowered Committees for implementation of National Programmes.
- Secretariat to be setup in the campus of Director General with support for man power and equipment.

Integrated society at District Level

- Reform initiative to tackle managements issues.
- District Empowered Society registered in each district.
- Committee headed by the DM with CMO as Vice President.
- Fund flow from GOI through State Level Society to District Empowered Committees for implementation of National Programmes.
- Secretariat to be setup in each district with support in man power and equipment.

Formulation of Integrated Health & Population Policy.

- Integrated policy released in Dec'2002
- Specific Health & Population Stabilization objectives .
- Specific policy directions to achieve the mission & policy objectives.
- Specific policy interventions also identified in the policy.

Proposed delegation of powers under the 73rd Amendment .

- Gram panchayat to have administrative control of male & female workers at village level.
- Future recruitments through Gram panchayat .
- Block panchayat to have administrative control of all health delivery personnel at block level .
- Future recruitments through block panchayat except for medical officers.
- Chairman zila parishad to have administrative control at district level with CMO as Add.Exec. Officer.

From First Phase to Second Phase of RCH

Major Lessons Learnt from first phase of RCH

- State ownership critical
- Flexibility based on state needs and capacities
- Adequate institutional arrangements need to be in place

Major Lessons learnt

- Process and output indicators to be agreed upfront
- Insist on monitoring systems –regularity and quality

Major Lessons learnt

- Link performance to financing
- Establish linkage between RCH and FP services
- Management capacity to be strengthened in the areas of planning, supervision, budgeting, fund flow

Major Lessons Learnt

- Program management capacity at district levels to be strengthened especially in the EAG states.
- Need to introduce Human resource planning forecasting requirements of human resources, training, posting and promotional policies.
- Establish client sensitive behavior in service providers.

Major Lessons learnt

- Clearly developed state specific Behavioral change strategies
- Enhance client responsiveness to RCH services so as to introduce a demand driven service delivery system.
- Improve outreach services particularly regarding routine care and in retaining clients for completing the cycle of care.

Major Lessons Learnt

- Involve communities and local elected bodies in planning, management and monitoring of program performance
- Include and provide emphasis on neonatal health & adolescent health.
- Involvement of private sector to enhance availability of services

Major Lessons Learnt

- Building bridges with other critical sectors such as Rural development, Urban development, sanitation, public health, nutrition, Women & Child development sectors.

Why we need the Second Phase?

- High Level of IMR and contribution of neonatal mortality
- Need to focus on states with high TFR.
- Address inequities in the use of service delivery systems related to child Health, maternal Health and essential obstetric care in the weak states

Why we need the Second Phase?

- High MMR indicates the need to improve functional linkages of primary care services with facilities providing EOC/Emergency Obstetric Care and better understanding of contributory factors through maternal death audits
- Need to improve birth spacing, skilled attendance during pregnancy, care and service during child birth and post natal periods.

RCH SECOND PHASE

VISION

The vision is to bring about outcomes as envisioned in the National Population Policy 2000(NPP 2000), The Tenth Plan Document, National Health Policy 2002 and Vision 2020 India, minimizing regional variations in the areas of Reproductive and Child Health and Population Stabilization through an integrated, focused, participatory program meeting the unmet demands of the target population, and provision of assured, equitable, responsive quality services, by adopting a mission mode.

OBJECTIVES

- **To educate and empower through behaviour change communication and community mobilization in improving the health seeking behaviour.**
- **To increase quality/responsive/sensitive/reliable service availability and improve the accessibility in order to improve the attendance at the public health system.**

OBJECTIVES

- Set in motion sector reform initiatives in order that the service availability in the public health delivery system achieve a better perceived image among the population
- To put in place strategic initiatives to bring about a wider role for the private sector providers to enable achievement of wider reach of services.

OBJECTIVES

- To initiate policy changes to ensure assured services at all levels in a equitable manner to all those who seek services as well as enable initiatives hither to not possible due to the policy environment.

PROPOSED STRATEGIES UNDER RCH SECOND PHASE

- Dedicated structural arrangements to improve program management
- Improved ownership among states
- Decentralized planning and implementation through involvement of PRIs and ULBs
- Strengthened system of planning, monitoring and supervision
- Differential approach

PROPOSED STRATEGIES UNDER RCH SECOND PHASE

- Integrating referral networks
- Strengthening quality aspects of service delivery
- Enhancing coverage of ANC, New Born care, Institutional deliveries
- Bring about a comprehensive integration of FP into safe motherhood and child health
- Inter-sectoral collaboration and convergence
- Empowering structure and enabling environment
- Increasing the involvement of the Private Sector

RCH SECOND PHASE COMPONENTS

- MATERNAL HEALTH
- RTI/STI
- NEW BORN AND CHILD HEALTH
- ADOLESCENT HEALTH
- POPULATION STABILIZATION
- URBAN HEALTH
- TRIBAL HEALTH
- NGO INVOLVEMENT
- INFRASTRUCTURE MAPPING & STRENGTHENING
- BEHAVIORAL CHANGE COMMUNICATION
- TRAINING

Design process for the state

- Formation of a design team with a nodal official to lead the process.
- Drawing experts from the state itself
- Looking at outputs upfront
- Interpolating process indicators and working out annual plans and budgetary requirements
- Conducting a sector analysis
- Monitoring on the basis of performance benchmarks as agreed upon mutually by the state and the MoH&FW
- Drawing on good practices
- Attempting decentralization through PRIs/ ULBs

Thank you

India's Health System: Role of Health Sector Reforms

Proceedings of September 4, 2003
A Synopsis

Ms. Anagha Khot
WHO National Consultant (HSR), MOH&FW

- Structural reforms include restructuring & re organization of existing health care infrastructure, mainstreaming of ISM&H practitioners. Functional reforms would include horizontal integration of programmes, integrated system for district based administration, effective logistics system for supply of drugs amongst others
- Financial reforms include levying of user charges, developing alternative financing mechanisms, evolving and implementing mechanism to ensure sustainability of ongoing govt. funded health programmes especially those with substantial external assistance.
- Governance related reforms would include initiatives aimed increasing the accountability of health care providers and of the health systems such as evolving standard protocols for care, setting norms for cost of care, delegation of powers to PRIs.

- Definition of HSR includes
  - improving the civil service
  - decentralization of power and resources
  - improving function of health ministries
  - broadening health financing
  - increasing the role of private sector in the financing of provisioning of health care
- Elements included under HSR:
  - Privatization of health services specially at secondary & tertiary levels
  - Introduction of cost recovery mechanisms (E.g. introduction of user fees; contracting out of ancillary services in public sector)
  - Implementation of "essential services "for specified target groups at the primary level.
  - Decentralization of services financial and administrative

Punjab

- Resource mobilization through user charges including its retention & utilization at point of collection & Medical insurance
- Decentralization (viz. handing over of subsidiary health centres and sub-centres to PRIs)
- Outsourcing of services such as clinical, security, sanitation and ambulance; maintenance of services and engagement of health personnel
- Public – private partnership
- Re-vamping of primary health care services
- Health care delivery through better mobility
- Maintenance of assets and its optimum utilization

Rajasthan

- **Financing methods – Medicare Relief Society (MRS), Life Line Fluid Stores**
- **Changes in health system organization**
  - **Decentralization – District health societies**
  - **Granting of autonomy of hospitals / CHCs / PHCs - MRS**
  - **Contracting out – Cleaning services in hospitals**
  - **Appointments on contract basis – ANMs /Lab Technicians, Staff nurses, Medical officers**
  - **Establishment of IEC Bureau**
- **Regulation of private sector- Rajasthan Clinical Establishment Act**
- **Re-organization & re-structuring of existing govt health care system**
- **Reforms related to human resources**
- **Drug policy and procurement**
- **Policy reforms (E.g. Population Policy, Essential Drug Policy, Health Vision 2025, Transfer policy)**
- **Private / NGO/ Voluntary & Public Partnerships (E.g. Jan Mangal Scheme)**
- **Equity enablers (BPL Medicare card scheme)**

Gujarat

Structural Reforms

- Resource Allocation
- Decentralization with resource allocation & management
  - Creation of Block Health Office
  - Establishment of Emergency Obstetric care services in tribal & inaccessible areas
  - Application of GIS in planning activities related to malaria control
  - Minor repair work in PHC/SC buildings

Functional Reforms

- Public private partnership
  - Extending partnership spirit with NGOs
  - Community based health volunteers in urban areas
  - Link Couple Scheme
- Establishment of Quality Control Circles to improve quality of health care services by means of capacity building
- Contracting out of services for IEC
- Re-organization of infrastructure Establishment of blood transfusion grid/network

Himachal Pradesh

- Establishment of Aspatal Kalyan Samiti (AKS)
- Decentralization of administrative and financial powers upto PHC level
- Involvement of PRIs (viz. PARIKAS) at all 3 levels of Panchayati Raj System
- Contracting out of select support services in health institutions
- Contractual appointment of health care personnel
- Promulgation of HP Paramedical Council Bill 2003
- Interconnectivity for MIS for collecting data
- Improving IEC and advocacy
- Registration of vital events
- Re-organization and re-structuring of existing government system
- Reforms related to human resources
  - Merging of all Health & Family Welfare Societies
  - Managerial skill up-gradation of senior officers
  - Capacity building of MOs in proper utilization of power

Uttaranchal

- Reforms at primary health service delivery
  - Contractual appointments
  - Transfer policy
  - Training of TBAs
  - Special salary for doctors in rural areas
  - Integration with ICDS, ISM&H
  - Fixed day schedule for provision of services
- Reforms at secondary health service delivery
  - Privatization of sanitation, laundry & diet services
  - Drug procurement policy
  - Establishment of Chikitsa Prabandhan Samiti
  - Establishment of PCOs in government hospitals
- Integrated society at State and district level
- Delegation of powers under the 73rd Amendment

Issues and challenges .....

- State has to continue as a provider of services. The basic goal of providing a reasonable standard of health to all citizens with the underlying principles of equality, equity and comprehensive care should lead the reform process.

- A clear picture of the current scenario in the health sector & a situational analysis at national & regional level relating to content and process of HSR would be one of the pre-requisites for ensuring successful implementation of HSR. The linkages between the various components of health system, logistics of availability and accessibility to services, manpower, drugs have to be ensured. Accountability of public and private providers is essential to enhance efficient delivery of services.

- Emphasis should be laid on the process of reforms along with the content. Lack of adequate process documentation of HSR in India was identified as one of the gaps. Further studies would be required across various components of HSR to assess their impact and to emulate the 'success' stories and learn from failures.

- Monitoring and evaluation mechanisms need to be incorporated right from the point of initiation of reforms.

- Adequate mechanisms for collecting data for review and documentation need to be built in.

- There is a plurality of experiences among the states as far as HSR are concerned. We can learn from the experiences as to what works as a reform and the possible obstacles that may be there in the process. A suggestion was received on ongoing sharing of experiences across states in a web enabled format.
- Ensure participation of all stakeholders in the reform process from its conception.
- Capacity building of stakeholders at different levels would be critical
- Need exists for the Centre to play a more pro-active role in the area of HSR
- Need to identify the next steps

List of Participants

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE

Workshop on
INDIA'S HEALTH SYSTEM: ROLE OF HEALTH SECTOR REFORMS

SEPTEMBER 4 & 5th, 2003

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