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Health Sector Governance and Reforms in India

Abstract

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

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Once again, a selective approach to health care became the focus when a strong lobby, questioning the financial repercussions of the primary health care approach came up. Verticality was reintroduced as an 'interim' arrangement and interventions of immunization, oral rehydration, breastfeeding and anti-malarial drugs were suggested[2]. This was seen as a technical solution even before comprehensive primary health care could be realized. UNICEF too came out with its report on the state of the world's children's health and suggested immunization as the spearhead in the selective GOBI-FF (growth monitoring, oral rehydration, breastfeeding, immunization, food supplements for pregnant women and children, and family planning) approach (Rifkin and Gill 1986).

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

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

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

Delivery of Health Services in the Public Sector

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

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

Evolution of the Health System in India: An Overview

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

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