Book
14

PUBLIC HEALTH RESOURCE NETWORK

PHRN

Issues of Governance and Health Sector Reform

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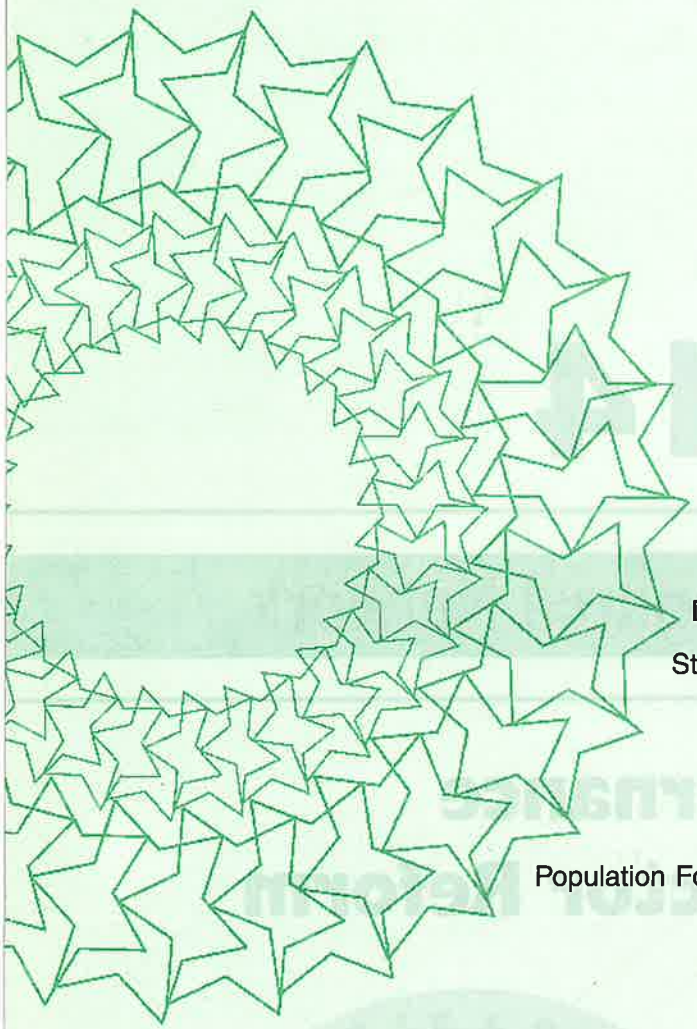

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Partners

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Contents

Public Health Resource Network

Preface

Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantees of increased employment or career options. It is meant to support individuals and organizations both within and outside the health department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out with information, tools and a diversity of programme options and perspectives.

The Health Mission needs a combination of dedication and professionalism, where being a professional is not one more form of privilege - but a competence that anyone willing to put in the time and effort — and a little expense— can acquire!! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change. The immediate context is the National Rural Health Mission. But hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralized planning and decentralized governance and to all societal efforts towards an equitable and just society.

This book, the fourteenth book in the PHRN series, relates perhaps to the most difficult aspect of health

sector reforms; that of achieving better governance of health systems in our country. This is even more so since many issues discussed in this book are poorly documented or researched though every single person involved in health sector encounters them on a daily basis. Many blocks to good governance are not easily dealt with at district level and seem to need interventions form 'above'. Yet these areas demand the greatest priority if we are to succeed in our collective mission. Thus 'managing change' in the context of the health sector is the basic challenge of this book, but for doing so, one has to be equipped with the skills to recognise and analyse the bottlenecks to this positive change. This book takes us through some of the perspectives, attitudes, beliefs and practices that prevent positive change or promote corruption, apathy and lack of initiative. It also similarly examines how knowledge itself is subject to perspectives, attitudes and beliefs, and how, therefore, it can be manipulated to maintain the status quo. Case studies, such as the one on the pharmaceutical industry, are used to demonstrate how 'power' functions for its own advantage and the various ways in which it may corrupt. However, at the end, we hope this book enables you not just with the analysis, but with clear and practical directions on how to create change in favour of a better health system, despite resistance. We also hope that it reinforces the conviction that health governance can be improved significantly through our own endeavours even at levels such as the district.

Lesson ONE

Constraints on Change: Between theory and practice

In this lesson we shall discuss:

- The systemic constraints on the district health system for which action within the district alone is not possible
- The gaps between the theory and practice of public health and why is it that many simple and essential steps that need to be taken for health sector reform, turn out to be so difficult, and almost impossible to take
- Ways in which learning in this series be translated into practice

INTRODUCTION

The first 13 books dealt with various aspects of pubic health management. They talked of the possibilities of reform and change. All the suggestions they made for strengthening public health systems were addressed to the district health officers and district health teams.
However, as experienced district health officers would point out, not everything can be carried out by the district health officers or even by state health officers. There are many systemic constraints or barriers to change. This book is about understanding these systemic constraints and how to address them.
The major systemic constraints that limit efforts at change arise from the following:

a. The Economic Policy Framework and its influence on the health sector.
b. The Institutions of Governance and their functioning.
c. The Pharmaceutical and Health Industry- as encountered at the district level.
d. The Professional Institutions and the commercialization of health care:
e. Mindsets of service providers and the community.

Each of these above influences will be examined in some detail in the subsequent chapters. What is important to note is the nature of relationship that would exist between the district team working for a change and these overarching influences. The district team cannot live and function in denial of these influences. It cannot cause change if it surrenders to the constraints imposed by these institutional structures. It cannot mandate that change would occur only if these constraints are removed- which would be a form of surrender- for these constraints are not likely to go away. It cannot even set itself the task of changing these constraints- for these institutions occupy a higher position in the relationships of power to what a district team would command. But if the district team accepts these constraints as unalterable, that would neither be fair, nor useful to reach the health objectives set out. This feeling that "there is no alternative" and therefore we have to accept the existing situation is in itself one of the most important barriers to change. In that sense change is also a step that we take within our own mind.

Let us examine a few situations :

Situation 1

A district team makes a district plan with considerable effort and sincerity and the plan is approved with modifications and resources come in for its implementation. At this point there is a change of leadership and the new leadership does not own the earlier plan. Worse, the new leadership seeks changes in the plan which is arbitrary, and which largely are shifting financial resources from essential human resource development components to procurement of goods, much of which is not immediately utilizable due to

lack of human resources, but whose eventual need cannot be denied. The new leadership expects the district team to implement his vision of what is needed and sees their role as providing intelligent justifications for such changes as he wants to make. The district team is divided on their response:

Some feel that theirs is not to reason why. If the leadership wants it – their function is to deliver and they must make the changes required. Others agree with having to comply with the leadership, but have no heart or stomach for these changes and think that the best thing to do is to walk away. To them, this is not part of the problem of district planning and management. It is by definition outside it, and it is for the system to resolve it, not them. Yet others in the team feel that they would continue to work on that part of the plan which was agreed on and somehow ignore the arbitrary changes being introduced and let those who would work on this – continue to do so.

How does one look at such a situation? Where would you find yourself?

(General issue: weak motivation in leadership, weaknesses in governance)

Situation 2

The district plan calls for employing three nurses per PHC. However, very few qualified nurses respond to the advertisement of the posts and those who apply are not willing to go beyond the district headquarters. The problem seems to be the lack of nurses available for recruitment. Policies of recruitment and compensation are also rigid. There is an ANM school in the district, but it has few trainees and that too from a centralized selection process. Many of them may not be willing to work in this district. The district has no powers or influence over policies of opening or managing nursing schools, over nurse recruitment, over nurse compensation packages, or over work force practices that could attract and retain nurses to work in rural areas. The district officer feels his task is over, once he has advertised the post. The rest should be accepted as an objective limitation.

How does one address such a set of issues- without which of course it is going to be impossible to reach this most fundamental of goals – a functional 24*7 PHC.

(General Issue: Policy change at a higher level needed. But such policy change is not happening due to some constraints)

Situation 3

While the district plan is being made there is one small but very vocal NGO which demands that the plan

includes resources for urban homeless. And it has convinced you. There is little sympathy for this view amongst the professionals and even within the district team. The district leadership does not have a hold over the issue. Indeed most persons feel that these homeless are "losers". Nothing can be done about them and it is best to ignore them.

As the person writing the plan, one could insert the item in and put some funds for it- as there is a high chance that it would get through. Then take up advocacy once the plan is sanctioned. Is that an appropriate course of action? Or would it lead to arbitrary plans full of individual whims and fancies?

How does one look at such a situation. Go along with the majority? Slip in the correct position?

(General Issue: New problem area – not within the priorities of planners and decision makers but which the district feels is important).

Situation 4

A considerable part of the district budget is for drugs and consumables. With drug prices rising, one is getting lesser and lesser drugs for the same percentage share of the budget. There are also pressures from the pharmaceutical agents to place higher orders on certain drugs as the commissions are better- and it is being justified on the basis of perceived needs- since there is no data anyway. Both these causes taken together mean that almost 75% of patients receive a prescription to buy drugs from private pharmacies, because the essential drugs are not there in the facility. This leads to higher out of pocket costs on the poor when they visit a public hospital and it reduces access and utilization of the public hospitals by the poor. But the doctors are happy to write outside prescriptions because the sales agents encourage and plead with them to do so.

How does one respond to such a situation? Accept it. Change it? If the latter- how does one begin?

(General Issue: There is a general provider behaviour linked to promotion of such behaviour by vested interests that forms the barrier to change).

Situation 5

Two doctors return from a course in emergency obstetrics and in anaesthesia for emergency obstetrics and though a bit shaky in confidence, they are keen to start the services in their CHC. They however find their chief medical officer, a senior peer approaching retirement, but a man known for integrity, being very

hesitant to let them start off. He recalls how even in the private clinic providing these services at the district headquarters the doctors face so many complications and wonder how they would manage in their remote CHC. Whenever they have a case that could merit surgery, he arranges to transport the case at once to the district hospital, and if the services are not there on that day, the case is sent to the private clinic. The private clinic of course profits, but there is no nexus or kickback. It is just that the chief medical officer feels that it is a safer option for all concerned. And at the monthly review meeting all other CHC doctors endorse his view. In the monthly Indian Medical Association meeting they are asked repeatedly if they feel confident. If they say no- everyone is warmly supportive. If however they say, yes, the atmosphere turns a little bit colder. Though there is no official criticism of the multi-skilling policy a lot of professional seniors come to the two young doctors, and tell them in a friendly fashion, not to be foolhardy and take this sort of professional risk.

Net result is that despite 'successful' multi-skilling programme, there is no expansion of emergency obstetric service.

How does one respond to such a situation?

(General Issue: professional value structures- or any existing value structures and peer pressures acting as constraints on change)

Situation 6

The district RCH officer, a young woman, has recently taken charge and has led the district planning effort. Confronted with all the situations listed above, she is reminded of her personal priority, which is to get posted back in the state capital where the rest of her family is. The lack of any significant improvement has been a source of frustration to her. Recently her district has been noticed by the national HMIS as an outlier district--one of the poor performers- poor institutional deliveries, low outpatient attendance, no emergency obstetric care, low immunization etc. This is less than last year's achievement and less than other district achievements. It takes her some time to realize that others have inflated their figures by about 10 to 20% leaving her district at the lower level, and her earlier officer had also done the same. For three months, she spiritedly tries to explain the districts problems at the monthly review meeting- but at the last meeting she is pointedly told- "no more excuses- I do not know how you do it, but your figures better improve. It has been noticed even at the national level." She needs the good will of her senior officer, for a transfer back to the headquarters and the problems mentioned seem intractable. A small mark up of ten to 20% it turns can be produced for each data element by a few well chosen data entry errors- for example adding ANM reports on institutional deliveries to the institution reports on the same or by adding cumulative totals for outpatient attendance. After all, her colleagues' reason with her, "you still

will know the truth and can continue to work at improving it- why do you become a reformer trying to convince the state officials. Just give them the numbers they want."

How does one respond to such a situation?

(General Issue: Leadership's consciousness in change trails behind the awareness level of the district. Is change always led from below? How does anyone in a district influence the process of change).

This book will grapple with these questions. While doing so, its basic principle would be that to understand the problem is half the solution. Many of the above situations arise because of circumstances which extend far beyond a district, or even a state or nation. It is important to understand the framework within which a district plan operates if one has to effect changes in the district. Also, there is much confidence gained from knowing the possibilities of action.

This chapter's central question is – **Do such questions have a place in public health management – or are they outside the domain? Should these be seen as within the syllabus or are they extra-curricular?**

For many traditional schools of public health, these situations and questions are outside the domain. They relate to problems of implementation and have little to do with theory or teaching. Typical of this approach is the statement- "We make very good plans- but they are very poorly implemented." Or to state- "What is the purpose of so much training and learning, when the will to implement it is not there?" The counterpart of this public health expert opinion is seen with the district officer or programme manager who would tell us – "all that is academic and in practice this is not the way it works."

Thus planning and implementation are seen as existing in two compartments – one theoretical and the other practical- and these themselves are seen as two water-tight categories.

An alternate and activist view of public health would not only acknowledge these questions but would also see them as the central questions of the day. In such a view, practice and theory has to be a unity. Theory is sterile where it does not relate to practice. Theory has to be actively used and in the course of its use subject to constant modification by practice. Conversely, experience alone is a limitation on progress, unless it is informed by, and challenged with theory. Knowledge of health management is valid knowledge only to the extent it is able to address real problems- and the above situations are real problems because they are most resistant to change. They could be seen as the most important of the problems.

Thus "managing change" taking into account the existing institutional structures and mindsets is a central skills area for course participants. In subsequent chapters we discuss a number of institutional structures

and influences on the health sector, and see what their strengths and limitations are and what their influences are on both the design and implementation of health programmes. Then in the last chapter we come back to these situations and discuss how one could "Manage Change" in such circumstances.

This book hopes to empower each trainee to understand and maximize the contribution they can make to strengthening public health systems- whichever position they find themselves in- whether they are a medical officer in a PHC, or a block programme manager or a district programme officer.

Also we hope that this book will prevent frustration and the development of cynicism in those working for change. This is because managing change is not easy and one requires patience and persistence and for that one needs to understand what one is up against. Change what you can, cope with what you can't and have the wisdom and understanding to know the difference between the two.

Review Questions:

1. What are the factors outside the control of the district team which would act as barrier to change?
2. "We make very good plans- but they are very poorly implemented." Discuss the implications of these for the planning process.
3. "This is academic, too theoretical- but not practical." What is the understanding of academics and theory in this line? Why does one need good theoretical grasp of principles for the planning and management at the district level?

Application Questions:

1. Could you list any more barriers to change – other than those listed above and other than capacity building needs?

Project Assignment :

1. Write a case study of some small meaningful effort at change that did not succeed and list the constraints that were encountered and the attempts to overcome these constraints..
2. Write a case study of some small meaningful effort at change that did succeed and list how these constraints were overcome..

Lesson TWO

Economic theory and Health Sector Reform

In this lesson we shall discuss:

- How economic theories and their policy influences have determined health systems: in particular - Keynesian economics, Socialist economic theory, Neo-liberal economics, Development economics positions
- How to read economic theory influence in the present context: the many meanings of health sector reform at present
- How to understand the relationships between political influence on planning and economic theory
- How to be able to use such information to influence health planning at different levels

INTRODUCTION

We are used to thinking and talking of health planning and district health planning as if only what district programme managers decide matter. On the other hand, the accepted economic theory and the economic policy of the day, the political party in power and its own preferences in economic theory, do make a huge difference to health policy and health strategies. There may be little a district planner can do about this, but understanding the influences of such policy factors is important to understand both the boundaries under which district planning can be conducted as well as the points where such a boundary could be negotiated. Such an understanding prevents frustration and promotes dialogue between different stakeholders.

Also many of the changes we have been seeing in state health systems are driven by a process called "health sector reform". Many of these health sector reforms took place with support from international funding agencies like the World Bank and bilateral health sector aid programmes of the US, Britain and the European Union. Under NRHM a similar process of addressing systemic design issues is referred to as "architectural correction" of the health system. Since almost all such processes calls for decentralization and strengthening district level planning and management, it is important for a text on district planning and management to understand health sector reform and its relationship to economic theory.

WHAT IS KEYNISIAN ECONOMICS?

Keynesian economics is important because it was the dominant economic theory in the post world war-II years- all the way from 1945 to almost the end of the seventies. This was the major influence on the development of health systems in all of Western Europe and most of the industrialized world (Canada, Australia, Japan etc.) save the United States. Though Keynesianism was the dominant economic theory in the United States in this period its influence on the development of its health systems in the US was less so than in other western economies. As the third world became decolonized, the political systems of these countries were to choose between the solutions offered by socialist countries, solutions offered by the social democratic countries in the West, or the US economic model. A large number of them, especially those third world countries who had some democratic process in place and were not led by communist parties were influenced by a Keynesian understanding, But due to severe resource constraints and the continued influence of colonial relationships, few could build health systems as robust as Western Europe had been able to build.

So how do we understand Keynesian economic theory? First we need to have a basic understanding, of what is called, classical economic theory - the economic theory prevalent before Keynes.

The economic and political system that was dominant at the turn of the century was called capitalism. This system then held that governments had little role to play in the economy except to maintain law and order – in social life and in economic matters. For the rest the market was the best decision maker. Thus, people can buy from the market whatever goods they want and this could include services like education and health. Manufacturers and service providers would for their part provide whatever they are able to manufacture or deliver at whatever prices they decide. If the prices are too high, or the quality is too low for the consumer's satisfaction, they would take their custom elsewhere, forcing these manufacturers to lower their prices. If manufacturers are not efficient enough to sustain production at lower prices this would force them to close down. Competition between manufacturers and service providers offers a much larger choice to the customer and ensures the best possible price for the consumer and the most efficient way of making the product or delivering the service. In this understanding the market was supposed to be fair to workers. Unlike earlier, workers were not bonded. They could work under whomsoever they chose. If their salary was too low they could go elsewhere. This was also called laissez-faire economics. Laissez-faire meaning "let us alone" which was the then cry of the manufacturer and trader to the government.

Critics of laissez-faire were many. The main criticism was that this notion of free competition was something of a myth. At best competition acted in a very limited way. For example, since the number of workers was always large and many were always unemployed, no labour market could act to raise wages. Indeed the market acted only to lower wages and collective action like strikes and protests could increase wages. Another related criticism was that this situation of unemployment and excess workforce was also created and maintained by displacing people from the land and property they owned and destroying all artisanal production through laws that worked against the poor.

One of the most powerful criticisms was that this system was not sustainable because as the labour market depressed wages further and further and technologies improved productivity of labourers more and more, a situation would arise when there would be no one to buy what was being manufactured. This would lead to a recession, leading to shut down of factories which in turn would lead to more unemployment and even further decrease in markets. Such a vicious depression brought the system to its knees in the mid- thirties in what is known as the Great Depression.

Son asking mother: Mother, it is so cold. Why has the fire in our fire place not been lit?

Mother: How can we light the fire, son. We have no coal left.

Son: Why do you not get more coal? You could buy it in the shop.

Mother: But we do not have money to buy coal. As you know your father is out of a job for the last three months.

Son: But why is father out of a job?

Mother: Your father worked in the coal mines. And the mines have been shut down.

Son: Why have the mines been shut?

Mother: Because son, too much coal was being produced and no one was buying it.

Could we not write a story about this for the whole of the garment industry which is facing a crisis? Or even the food produced by farmers, or about the dairy industry? It was obvious that even if we had no ethical problem with high degrees of inequality, after a point, inequality led to an unsustainable system. "Leave us alone" no longer worked and government intervention was needed – to save the wealthy- industry and trade- and as part of this the poor too had to be saved.

Keynesian economics became prominent at the Great Depression. Though Keynes believed that markets were the most efficient means of resource allocation he felt that there were some problems inherent in the capitalist system. The role of the government was to address these problems. Thus, there was a need for government to play an active role in economic activity. Governments, he wrote, must intervene to create employment and bring back purchasing power. Governments must also undertake to provide services like education and health care and ensure that people do not starve.

Keynesian economics also became necessary to save capitalism, for the danger was seen from two alternatives- fascism and communism.

Fascism of the sort that Hitler and Mussolini created saw one solution to the crisis- war. War helped to create a huge market that could overcome the depression. The winning countries could acquire the colonies and the wealth of the losers. Anyway in the prevalent system there were losers – those who starved to death. So why not, a fascist would opine, whole countries become losers and slaves. Internally within the country, fascism wins support by mobilizing people actively to support the rule of the wealthy by making a scapegoat of one section of society and making the people believe that this minority section is the cause of all problems. In this case it was the Jews who were made a scapegoat. Even though fascist solutions appear to work (for certain objectives) for short periods of time, it was at a huge cost, both in terms of lives lost and the costs of war and certainly not sustainable. Also it went against all the central tenets of liberal philosophy that goes back to the enlightenment. Saving the western world was then the

central challenge and even an alliance with communism was possible for that purpose.

Not surprisingly, it was at the height of the World War II when bombs were being showered on London and fascist aggression was its peak that the British government announced its commitment to a National Health Service and to welfare measures that would guarantee every last citizen from the cradle to the grave and later from the womb to the tomb, a cast-iron welfare –security guarantee. If the entire people had to be mobilised behind a beleaguered government, if all of liberal enlightened civilization was threatened by the advancing fascist armies, then this much was necessary. Yes the market could operate and be the main force for the industry, but from now on the government would have the responsibility for the ensuring the minimum provisions needed for a human life with dignity. That would not be left to the market.

"These values of liberalism were a distrust of dictatorship and absolute rule; a commitment to constitutional government with or under freely elected governments and representative assemblies, which guaranteed the rule of law; and an accepted set of citizens' rights and liberties, including freedom of speech , publication and assembly. State and society should be informed by the values of reason, public debate, education, science and the improvability (though not necessarily the perfectibility) of the human condition."[1]

If even today, public health expenditure accounts for over 75% of total health expenditure in these countries and in many countries it accounts for 90 to 95%, the reasons for this are to be found in this bitter history. Two devastating world wars and in between a huge depression that challenged its entire economic system leading to Keynesian economics and social democratic politics. Almost all these countries have either a completely government managed health system, or a comprehensive social health insurance programme. The United States has a similar path, but followed in a much more limited manner, with the creation of Medicare and Medicaid and some health insurance provisions.

Another reason for this break-away from the doctrines of market economy in the health sector was the challenge of the socialist economy. To a war torn society, to a depression hit society, to a society facing starvation and mass migration, with little wealth, against all these odds, the victories of the Soviet Union and later China were able to guarantee access to equitable health and education to its people. This was a powerful beacon to the world and the West had to respond to it. Laissez-faire could no longer be the answer.

Let us turn to look at health care under socialist economies:

[1] Hobsbawm, Eric, "The Age of Extremes : The short twentieth century, 1914-1991", pg.109-110.

WHAT IS THE SOCIALIST UNDERSTANDING OF ECONOMICS AND HEALTH SYSTEMS

At about the same time that Keynesian economics had modified and given a human face to capitalism, there was another rival theory which was gaining ground in many parts of the world- this was socialist economic theory. It came into prominence with the October revolution and the creation of the Soviet Union. During the depression years, it offered an economic philosophy that could be an alternative to capitalist theories. After the Second World War, all of East Europe, and most of China, three countries of Indo-Chine and the Korean peninsula and a number of countries in Latin America came under this system. Moreover, even in the third world, many countries getting decolonized were inspired by the socialist promise, even if they were not socialist per se.

Socialist economic theory is derived from the economic theories of Marx. According to this theory, the best way to manage an economy is by planned economic activity which ensures basic human rights and an equitable and sustainable growth. It is not the market, but democratic decision making that should be at the heart of economic activity. The fact that some countries are very rich, and within countries some families are very rich has nothing to do with merit or hard work. On the contrary such wealth was gained by exploitation and by the unequal distribution of assets and privileges. Thus by this theory, the difference between the developed world and the developing world lies in the fact that the latter are all colonies and the former were all colonisers. Thus all the European countries were colonisers and all of Africa and Asia was colonised. Japan is an exception in Asian countries. Japan was never a colony, but it had colonies. Having colonies gave them a source of wealth and assets which they could then use for a privileged position in trade and manufacture. Similarly within countries, those who owned land and later factories and wealth, got this advantage by using power and depriving others and having got this advantage were able to accumulate more wealth. Inequality is thus not only unsustainable and undesirable; it is also inherently unjust and has to be contested by those who are poor and marginalised.

The primary role of government is to redress this inequality. Leaving it to the market would only increase inequality as only those who have more power and wealth benefit from it. Government has to play the lead role in both the economy and the provision of social services. Thus, all of health care and education should be provided by the government in such a way that everyone could access it. The tremendous success of socialist countries in providing health care and education to all, even for a relatively modest economic growth was seen as proof of this model. In the sixties and seventies, all the way up to the Alma Ata declaration of 1978 this model of a nationalized health service, fully public funded, was at its peak as the desirable model to be aimed for. Now only Cuba is held up as an example of this model.

Because of the large overlap between social democracy and socialism, between Keynesian and

Marxism, as far as the implications for the role of governments in health sector went, a declaration like Alma Ata was possible. Equally important, because of this consensus on the role of governments, the relatively democratically structured UN bodies and institutions, like WHO, led the move for universal, participatory and equitable health systems in this period between 1945 and 1980.

CRITICISMS OF SOCIALIST MODEL

The main criticism is that though its intentions are laudable, it does not work. Critics of socialism portray inequality as natural and as a necessary stimulus for growth. Though there are practical and ethical reasons for ensuring some rights for the poorest, there is no need to ensure equity, especially in the economic sphere where accumulation of assets in the hands of a few is also desirable and deserved. Also democratic government-planned economic growth is difficult to achieve, and there would never be a system that gives as clear indications and regulations for directing growth as the market. Government planning inherently becomes inefficient, becomes dominated by the corrupt, and would fail to ensure growth. The failure of a large number of socialist countries was seen as evidence of this.

It has, however, been argued, that the failure of the economic model of socialism should not be seen as a failure of socialist health systems. Indeed when these countries shifted out of socialist models back to capitalist models of growth, all of them underwent a severe worsening of the health status. There is nothing inherent in poor government planning and corruption. These are manageable problems and credible public systems and economic planning can be achieved.

WHAT IS THE NEO-LIBERAL MODEL OF ECONOMIC GROWTH

In the eighties another trend started up which reached its peak in the nineties. During the Gulf crisis and the recession in the world economy it was felt that Keynesian economics did not provide the solutions. Thus the economic theory of monetarism gained influence with Milton Friedman as its most famous economic spokesperson. With this grew the neo-liberal policies which are politically most associated with the names of US president Ronald Reagan and British Prime Minister, Margaret Thatcher.

In this economic philosophy, there was rejection of much of Keynesian teaching and a drive to privatising many spheres of government action like public transport, infrastructure development and health care and education which were the heart of Keynesian governance. There was an all round emphasis on keeping the government small and limited. There was also a pressure to retreat the government even from roles usually associated with national sovereignty like trade policies, import/export policies and even the role of foreign capital in domestic economy. Globalisation became the catch-word. Globalisation in this context meant the free movement of capital and goods across national boundaries without restrictions.

Globalization as defined by the West did not allow for free movement of people or skills. In the period of growth leading up to the eighties huge amounts of capital had accumulated in the West. The areas so far under public provisioning needed to be privatised and capital flows across the countries needed to be liberalised so that all this accumulated capital could find new avenues for investment. Institutions like the World Bank and International Monetary Fund (IMF) could also take this accumulated capital and invest it as loans to third world governments and guarantee returns on this investment.

In the world arena the three international financing institutions- the World Bank, the IMF and the World Trade Organization (WTO) became the lead organisations which negotiated and led theory and practice, not only in economic policy, but also in health and education. They took it on themselves to propagate this neo-liberal understanding of the world onto every third world country. The changes in economic and political practice that they brought about were called structural adjustment. Third world countries facing a fiscal crisis were obliged to undergo structural adjustment to qualify for getting World Bank or IMF assistance. Without this their access to funds from other countries was also limited. The WTO for its part insisted on countries abiding by a number of trade related laws that promoted free trade, which in effect benefited those developed countries who were better placed in the market to export their manufactures at the cost of domestic manufacture in third world countries. However, though the third world exports to the first world increased, it did not increase as much due to a number of laws and loopholes in the agreements.

ECONOMIC THEORY AND ITS RELATIONSHIP TO HEALTH SECTOR REFORM

In the health sector, the philosophy of changes that these institutions sought to bring about in the third world is best brought out in the World Development Report of 1990 and 1993[2] published by the World Bank. This new philosophy of public health could be summarised as follows:

a) Governments need to play a role in health care for the following reasons

   i. Structural adjustment is going to have huge human costs by causing loss of jobs and poverty at least transiently. In such a situation a strong health system would act as a safety net to limit deaths and the discredit that health reversals would bring to the process of structural adjustment. By providing health care, the government gets good media and legitimisation. (Even the World Bank image changed for the better due to its entry into health care).

   ii. Governments need to stay out of interfering in the economy. But one of the areas where it can intervene with least distortion to market forces is the health sector. Investment in health is thus one of the few areas of permissible transfer of resources to the poor under structural adjustment.

[2] World Bank (1993), World Development Report: Investing in Health, OUP, New York.

iii. The market mechanisms are imperfect. Health interventions have high externalities i.e. when one family purchases and consumes a particular service, then many others who have not paid for it also benefit, even though they have not paid for it. For example, if I pay for a person to come and rid my street of mosquitoes so that my family has less bites and a better sleep, there is no way I can do it without everyone in my street benefiting. Such a service can, therefore, not be marketed and needs to be purchased /delivered by the entire street or by the government. This could even be said about treatment for tuberculosis. If a person is treated on time, ten persons are saved from getting tuberculosis. Therefore, there are some areas where market forces will not work and will not be able to provide services and governments would of have to play the role of being the sole or the main service provider.

b) When government decides to play a role in health care, which seems inevitable, it should not try to provide everything for everybody. It should limit its interventions to a small package of services which are the most cost effective. For everything else, the market would take care.

c) What technical interventions should make it into this package is best decided by estimating the number of dollars spent per Disability Adjusted Life Years (DALY)[3] saved. DALY is a notional value given to every disease for scoring the extent of disability it causes. At one stroke it reduces very different diseases with very different types of suffering into a common measure. Then by another equally fuzzy process it estimates how many dollars are spent to each disease condition. From these two figures it arrives at a third figure, the numbers of dollars spent per DALY saved to rank interventions. By this process it arrived at a package of a very few number of interventions which would make the most difference and concluded that if by some way these few were delivered the rest was not such a priority. In fact the 1993 World Development Report suggested a short list of four - six that would be applicable for most countries.

d) For all other interventions, it was said that it is best to allow private parties to provide the services. For those who are too poor to access these services, they could be allowed to access some accredited providers free of costs, and these providers could be reimbursed at an agreed upon rate.

e) The existing public health care services should be brought into the logic of the market by charging user fees. This would encourage people to choose between government services and private services and to value government services more if they purchased it. The poor could be exempted. Indeed many states had to sign agreements where they agreed to 'conditionalities' which specified what part of costs would be recovered by charge of user fees.

f) Decentralisation would be encouraged. This would make the public sector more effective and efficient (in practice this was done with so little delegation of resources and of powers that it was accused of becoming a way of shifting the accountability to the panchayats, rather than of solving the problems).

[3] Refer to http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/index.html for definition and how to calculate

In 1997 many countries seemed to be facing setbacks with these policies. Many of the policies instead of helping the countries get out of their crisis had a depressing effect on their economies. Hence, a need for reversal in the emphasis on some of these reform features was found essential. For example, there was less insistence on user fees or the package of services was made much larger. However, the mindset had been created and since it matched the opinions of the elite who are involved in decision making and in the top management positions, most of these views have persisted though the World Bank has now reversed most of them.

In India the nineties saw an abrupt cessation of almost all public sector expansion and massive but passive privatisation of the health sector. By active privatisation we mean government facilities being sold to private sector or even government transferring investments to the private sector.[4] This did not happen in a very big way. What happened was that the government investment in public health sector fell sharply- there were no new facilities created, not only were no new posts created, even existing and new vacancies were never created for over 15 years and many government-run nursing schools and hospitals closed down. Meanwhile, driven by the rising health awareness and left with no option, the private sector grew rapidly. This was seen as a vindication of the position of neo-liberalism which all along had predicted and advocated that the private sector be the main provider of services.

CRITIQUE OF NEO-LIBERAL ECONOMIC PHILOSOPHY

The neo-liberal period is recognized as a period that stimulated growth in the economy but that growth was not equitable. To a person to whom equity is an important value this is very upsetting. To those who do not see equity as a basic value, and believe in the philosophy of trickle down growth this is not as upsetting and could be seen as a period of India shining. There are arguments about this but many scholars believe that this period led to greater poverty and starvation, in not only India, but much of Africa and East Europe and even to some extent in Latin America.

The main criticism in the health sector also is that there was a sharp rise in inequity in health care provision and access and a virtual loss of social protection of the poor. Health care costs became a major cause of poverty. Also there was a slow down in many health gains- including those as basic as IMR and MMR. Even simple measures like immunisation levels failed to rise through the nineties.

Essentially neo-liberal philosophy is accused of being a philosophy where economic growth in itself is taken as a shining success with little care about what happens to the poor.

During the eighties and nineties with the spectacular collapse of the socialist countries, a triumphant West could afford to ignore this section. But since then growing security concerns and their links to inequity ,

[4] Muschell, J. (1996), "Privatisation – A Balancing Act" in World Health Forum, Vol. 17.

growing disenchantment with the promises of this growth, increasing voices representing the poor and the muted voices of liberal enlightenment aghast at growing levels of inequity and starvation in the midst of plenty have challenged this complacency. Above all, a looming environmental crisis including threats of climate change have brought into focus a new set of problems regarding the neo-liberal paradigm. This model of unlimited iniquitous growth with a trickle down is increasingly recognised as neither desirable nor sustainable and a role for governments is back on the agenda. Of all of these, the most dramatic comeback of government involvement agenda occurred with the financial meltdown in the United States which brought Obama into power. If government action and government mega funding was needed to help out the largest of banks and manufacturing industries, all the arguments for keeping government out of providing services the poor seem preposterous. Predictably the health sector was in the centre of the debate- and the debate was about bringing back the government as a health care provider and putting reins on the private health industry.

WHAT IS DEVELOPMENT ECONOMICS AND THE NEW SYNTHESIS

This growing need to give importance to the demands of the poor is leading to a new trend. Whether like the Keynesian social democratic consensus or the socialist model it would last 35 years or whether it would last 15 to 20 years like the neo-liberal model or whether it is just a passing aberration on some other existing or emerging trend is yet to be seen. This we term, for the purposes of our discussion, as development economics.

In India, the major influence in policy of this trend begins with the year 2004 and what was known as the Common Minimum Programme. In political theory one of the theorists who most represents this trend is undoubtedly Nobel laureate Amartya Sen. The key characteristic of this trend is to link economic growth to its ability to provide universal access to a basket of entitlements which are considered as the basics of all development and growth. Such an access to the basic provisions of life is seen not merely as an outcome of economic growth, but even as a pre-condition for sustained growth. The ability or capacity of every individual to access these basic necessities is included in the very notion of economic growth itself. Whereas globalisation on trade and capital flows are not seen as a problem and the market economy remains central, development economics sees a strong role for government in poverty reduction strategies, and in ensuring that every family has – through public action, enough access to food, clothing, shelter, education and health.

Working in parallel the Jeffrey Sachs chaired international Commission on Macro-economics and health had argued for increased investment in public health as a fundamental pre-requisite for economic growth and as one of the most effective ways of poverty reduction. This commission presented its report in 2001. Two of its members were the economist and former finance minister, Dr. Manmohan Singh and Ms Isher

Ahluwalia. The message of this commission has been repeated in the Indian version of this report the National Commission on Macroeconomics and Health that was chaired by Prof. Ranjit Roy Choudhury with Ms Sujata Rao, the current secretary of health as its member-secretary. The main contention of this report was to call for a considerable increase in public health expenditure and to ensure that such expenditure at one level addressed key health issues, but was also engaged with a more comprehensive provision of health care that could provide social protection for the poor and reduce the out-of-pocket costs of care.

The philosophy underlying the government since 2004 was that while economic liberalisation was to lead to a 10% growth and such growth was a central purpose of economic planning, this increase in revenues was to be ploughed by government action into employment generation and poverty reduction, and into education and health care, for these were seen as engines of sustainable growth.

Internationally, in the year 2000, the WHO was almost silent on the progress on the Alma Ata conference and so was every major publication on public health policy. An effort by civil society representatives to strengthen a rather weak and ineffective resolution on primary health care in the 2001 World Health Assembly met with such resistance than it had to be hurriedly passed in its original weak formulation. Yet by 2008, the World Health Report was a special issue on primary health care and a series of international regional meetings had been held in 2006 to 2008 on revitalizing primary health care and the spirit of the Alma Ata declaration. Lancet held a special international symposium to celebrate 30 years of Alma Ata and in the special issues brought out a critique of selective health care and health sector reforms as having undermined the drive to universal health care.[5]

As part of this process, every national and international forum suddenly discovered a crisis in human resources for health care and action for enhancing human resources became central to health sector. This was conveniently forgetting the fact that in the nineties it has been the policy of health sector reform to close down nursing schools and stop all recruitments and declare many categories of health workers as dying cadres. Similarly the policy of promoting user fees were reversed rather dramatically in Andhra Pradesh and then much more apologetically as part of the revised guidelines on hospital development societies.

CRITIQUE ON DEVELOPMENT ECONOMICS

This has been criticised by adherents to social economic theory as much as neo-liberalism with some apologetic and token steps towards provision for a government role in some public services. In this view the danger is that the government may never be able to generate the resources it needs for living up to its promises on public services unless it alters its economic policies and its revenue mobilisation policies in a

[5] Lawn E. J., J. Rohde, S. Rifkin et al (2008) "Alma-Ata: rebirth and revision I: Alma-Ata 30 years on: revolutionary, relevant, and time to revitalize" in The Lancet. Vol. 372, No. 9642, p. 917-927

pro-poor direction. As proof they point to the failure of the public health expenditure to rise above Rs. 19,000 crore whereas it was expected to reach almost Rs. 50,000 crore by 2012. They also point to many areas where public health strengthening has been weakly implemented whereas insurance mechanisms and private provision has been given a fillip.

Development economics has also been criticised by neo-liberals as nothing more than the coming back of Keynesian economics and socialist rhetoric that does not work. According to their criticism, there should be a greater persistence on privatising services and the government must shift from being a provider of services to a purchaser of services. Thus, those who cannot access private care services can be provided services by the provider and reimbursed by the government. The poor could be given vouchers and they could use this like money to choose their provider, thus not interfering with the market. The number of persons provided should decrease while private insurance providers should be encouraged to cover all the others. The government's role should only ensure that insurance companies do not cheat i.e. reduced to that of a regulatory agency. They point out especially to the NRHM and say that it is not working because all the investment is going into public provision of health care – which because of governance and motivation issues would never work.

WHAT IS RELEVANCE OF ABOVE DEBATES TO INDIAN HEALTH SECTOR PLANNING

We can see all these four stages in Indian Health Planning.

The first phase was represented by the vision of the Bhore committee. Before Independence the provision of health care was offered as a justification for its ruling this nation. It was part of their civilising mission, of their bringing modern science and knowledge to the colonies. However, in practice the public health systems they built were limited to the main cities and ignored both the systems and the health needs of the majority. The Independence movement seized on this duplicity and exposed it and laid out the plans for a complete comprehensive health care movement. The Bhore committee was set up by the British as part of their rule, but it also became the charter for Independent India's health system. At independence only 8% of modern medical care was provided by the private sector. The rest was by the public sector. The Bhore committee proposed a road map to making this public sector universal and effective.

In the period between the 1950 and 1980 the nation saw some advances in the public health system. There was a major expansion of the medical colleges and of research institutions in the 50s and 60s. There was some increase in public health facilities also – the basic framework of health facilities being laid down at that time. However due to reasons rather peculiar to Indian development, the whole health

programme became fixated around the family planning programme and to some extent malaria control. It could be said that the family planning programme was seen as such an urgent and priority issue that it altogether displaced all elements of primary health care – both the sub-centre and the primary health centre being seen as extension centres of just one or two of these programmes. By 1980 it was being conceded that the family planning programme fixation had not only displaced primary health care but even failed to delivery family planning in all the states which had not strengthened the health systems as a whole.

In early eighties, inspired by the Alma Ata declaration, and learning from the bitter experience of the past three decades, there was some attempt to re-cast the health system. One saw the adoption of the National Health Policy document of 1983 – a major progressive document and an increased investment in health care in some states, mostly in the south and west that brought in some rich dividends. At the national level this trend lasted very few years.

By the mid-eighties the international mood had changed from stressing on comprehensive to a few select cost effective interventions- a change led by UN agencies and funding agencies operating in India. By nineties, the States and the Centre were in a fiscal crisis- very crunched for resources. The whole of health planning came under the influence of both neo-liberal thought and the direct influence of World Bank planners. Central government support was more or less continued at same levels with funds flowing to a slightly larger basket of activities, for example, to Reproductive and Child Health instead of merely family planning, and a number of disease control programmes instead of only malaria. However, the centre did not yet provide any funds for state health systems. The Centre could retain its level of funding because it could mobilize aid from international agencies.[6,7]

The state governments reacted to the fiscal crisis by cutting back on all public health expenditure. Their level of funds was more or less enough to pay salaries of existing staff, leaving no money for programmes or even for fresh staff. Soon even implementation of public health programmes became difficult. Given this crisis the States sought funds and over 14 States got permission for different forms of funding from international aid agencies – mainly the World Bank, the USAID, DFID and much later the European Union. Most of these were called health sector reform programmes and they brought into the states the same features of neo-liberal thinking on health care systems that we described earlier. There were considerable variations between the state programmes, but the main thrust was the same. None of these programmes were reported to have done very well in effecting any significant health sector reform, though all had some outputs to show for it. However, for States hard pressed to manage their budgets the

[6] Katherine S. Mohindra (2008), "Maps and Health Sector Reforms: Surveying the Literature" in S. Haddad, N.S. Baris, D. Narayana (eds.) Safeguarding the health sector – in times of macro-economic instability, IDRC-CDRI, Africa World Press, 2008

[7] D. Narayana (2008), "Adjustment and Health Sector Reform in India" in S. Haddad, N.S. Baris, D. Narayana (eds.) Safeguarding the health sector – in times of macro-economic instability, IDRC-CDRI, Africa World Press, 2008.

funds that came in were very helpful. International agencies were also, in tune with international thinking on these issues, active votaries of what was called 'developing health markets.' This could mean increasing the space for private players in public health programmes, it could mean more international procurements of drugs and vaccines and equipment, it could mean international consultancies etc. This was a major influence on technical choices as well.

In the year 2002 - 2004, the international funding agencies had come together to form a pool or donor consortium which would as a pool contribute a billion dollars to shaping and supporting the RCH- II programmes. A similar one billion dollar support was worked out for the National AIDS Control Programme. A third large part of international support was towards the TB, vector borne and disease control programmes. Support from international agencies directly to States had reduced. By this time government funds were buoyant and the amount of international funds coming in were modest. There was a re-positioning of international aid assistance to operate only in the area of technical assistance – which really meant the management of knowledge and programme design.

In the year 2005, with the launch of the NRHM programme and increased funds available for State Health Systems from the NRHM, international aid flow became a very small part- less than 2% of funds to any state. The NRHM also had a strong political and civil society articulation of its own positions, which was independent of technical-donor prescriptions on many areas. Many key strategies of the NRHM – like ASHA, the second ANM, the three nurses in the PHC, the use of untied funds to name a few were never part of any technical discourse set up by the international agencies. None of these strategies were to do with developing health markets - they merely increased the size and space of the government.

ECONOMIC PERSPECTIVES AND THEIR INFLUENCE ON DECISION MAKING

Though we have described the economic philosophies as four distinct categories, each having a separate set of stakeholders supporting it and each occupying a different space in time- that is only for the ease of discussion. In practice there are lot of overlaps- and it is more a question of what is the dominant philosophy or influence at a given point of time, than seeing it as only a single influence.

The main influence of economic thinking is in the choice between public and private. Those who favour private provisioning of services with a very minimalist role of public financing limited to the poorest would probably be from the neo-liberal stream of thinking. Those who favour a large scale, almost universal public financing of health care but with private provisioning playing a major or even dominant role would be social democratic thinking or development economics thought. Most public-private partnerships conform to this stream. Those who favour the public provisioning and public financing of services would

be of the socialist stream of thinking or of development economics thinking in specific national contexts. However, these are not hard categories, only trends. There are many who would be a neo-liberal in general economic theory but believe in a completely government run health system. (The reverse view with demanding a private health system with the rest of the economy being state commanded would be very rare indeed).

Though this is the main area where economic theory influences, there is some form of influence on a much wider range of decision making - though at most times, the discussants may not be conscious of the history or inter-connections or the implications of the views he has. Let us give below a few examples:

a. A lot of administrators and managers when asked about what the poorest could do if they are unable to access user fees may just shrug their shoulders (this is a special problem where many of the poorest have no formal BPL cards). This notion that it is the responsibility of the government to ensure universal access, even for the poor and the homeless and the illegal migrant, is not something that is well understood. Though social democratic, and socialist and development economist and even neo-liberal positions concede the role of the government in this regard, there is the original view of laissez- faire capitalism that the poor are only losers who need to be punished rather than pampered could persist. More so where the thinking is still feudal or zamindari - where the rich think that the poor have to pay them regular gifts and tributes. To allow a dalit to sleep in beds with clean sheets and actually be nursed and tended and attended to by people whose caste and class status is of a higher order is unthinkable.

b. The idea that poor people breed because they are irrational and only coercive methods can curb them has been long given up in government policy. It is well recognised that provision of a good quality of health care, especially maternal and child health care that provides the confidence that the child will survive could act in a big way to lower fertility rates. It is also known that today in fertility control it is no longer a demand side problem- but a supply side problem. Yet there is considerable opposition to the Janini Suraksha Yojana programmes on the grounds that it would encourage larger families. This is a persistence of the mind set of the years when primary health care was displaced by family planning. What we need now is to re-position availability of contraceptive services, including sterilization services, as part of a comprehensive primary health care package, instead of as a stand alone programme.

c. District planners accept a number of constraints as inevitable and do not think of strategies to overcome these. Look at these two examples:

    i. One evaluator of NRHM finds that no doctors are willing to stay in rural areas, even after incentives. He concludes that public health systems as inherently inefficient and as NRHM

has failed to deliver he does not come up with possibilities of what to do next. He suggests looking for public private partnerships. Is his economic philosophy the boundary of his thought? Does he believe that public health systems are inherently inefficient? Another evaluator sees the same problems and decides to propose a different set of strategies to find doctors to work there, for example, to train nurses with clinical skills and place them instead.

ii. One evaluator looks at a public-private partnership where many service providers were either charging double or not providing the services. They were contracted-in and evaluator concludes that better contract management would solve the problem. Another evaluator looks at the same problem and concludes that public-private partnerships do not work. How have economic philosophies, in particular their perception of the public and the private sectors, bound their thought?

d. How do we look at resource constraints and priorities? Does it not reflect the economic philosophy of the government? Does economic philosophy influence how much the government spends on health and what it spends on within the health sector?

e. In the nineties when we proposed to fill up vacancies and create more posts there was huge opposition. The male health worker was given up and declared a dying cadre. Today not only is there pressure to fill up vacancies, more posts have been created and the MPW has been brought back? What were the changes? Could there be a relationship between prevailing economic theory of these two periods to the perception of investment in health worker?

f. How do we explain why ANM training schools in all the northern states went into decay and closed down with no new batches between 1993 and 2003?

g. When were user fees introduced in your district? What was the advantage it was supposed to provide? What is the current perception of the usefulness of user fees? How do you think this perception has changed?

h. There is choice of strategies involved to improve the management of childhood diarrhoea?

We could for example:

- promote home based ORS
- insist on commercially prepared ORS
- ensure that inclusion of zinc tablets as a major feature
- propose to introduce a second community health worker for just child health
- introduce vouchers with which children very sick with diarrhea could be seen in private clinics which could be reimbursed for the same
- or we could strengthen public health facilities by training a nurse in each to manage diarrhoea effectively

This decision would go by technical merits and by district circumstances – but would economic philosophy also influence choice? If funds were limited what would be the top three strategies prioritized by

- UNICEF
- the district magistrate who is chair person of the district health society (assume he has a degree from IIT before he joined the IAS - so he is a non-medical professional as well)
- the chief medical officer who also has a busy private practice
- the pharmaceutical supplier who has the rate contract for the drugs for this districts
- the management consultancy firm hired by a development partner on the districts' behalf to help the district make its district plan
- the NGO which has been working for health rights in this district
- the Indian academy of paediatricians

Do note that it is not only their economic theories that would influence the choices, but their professional value structure, their evaluation of technical options and their own sectional interests. **Could there be a methodology by which the different stakeholders could talk to each other and ensure that these concerns are taken care of ?**

Review Questions:

1. How is the Keynesian understanding different from the Socialist understanding of economic theory?

2. Discuss the neo-liberal economic theory and the dominant framework within which it works.

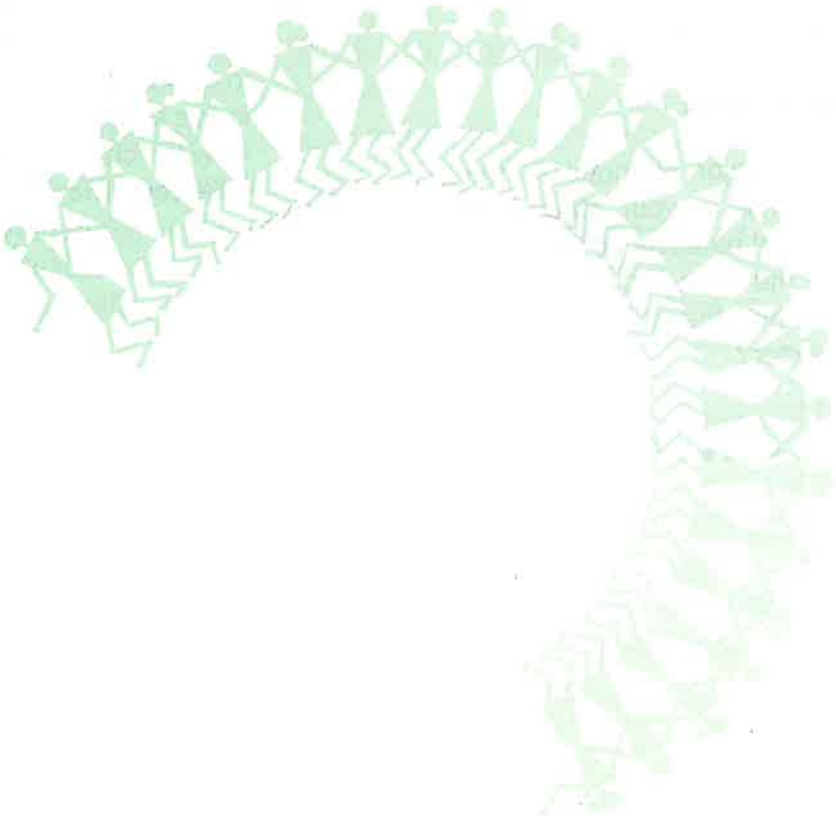
Application Questions:

1. Track the major changes in the health sector in your state post 1990s. What parallels do you draw between the changing ideology of the state and the changes in the health sector?

Project Assignment:

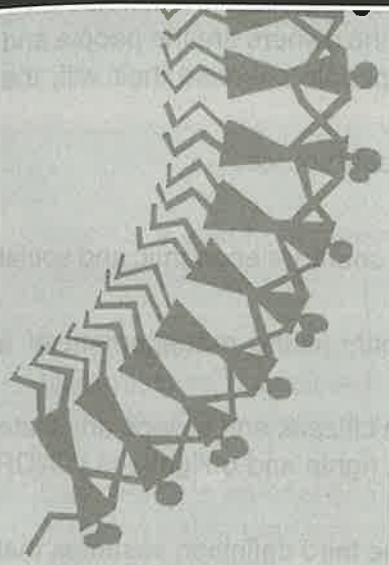
1. Interview key officials in the health sector and try and understand the dominant view point regarding introduction of user fees or initiatives in public-private partnerships in health in your state. Also interview some retired officials in the health sector who have been in this sector for long. How do they view the changes? Do you see any difference in ideologies?

NOTES



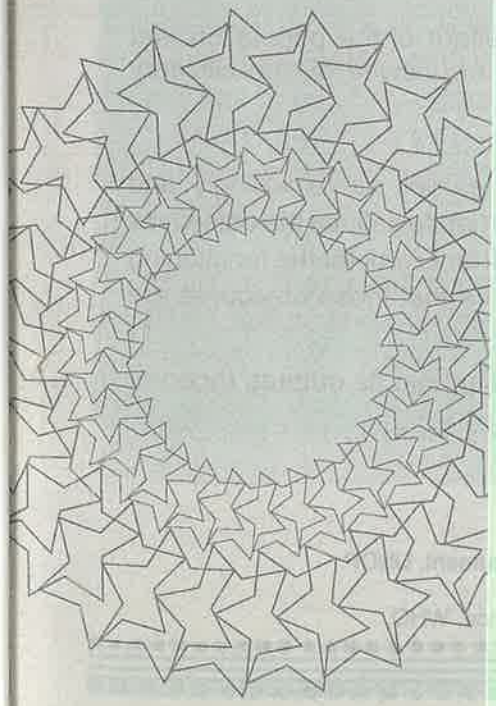
Lesson THREE

Issues of Governance as barriers to change



In this lesson we shall discuss:

- What governance is and how it differs from management
- The principles of good governance
- The governance mechanisms in place for ensuring participation, accountability, performance, and fairness of health systems and how effective these mechanisms are
- The relationship of governance and equity
- Corruption and how it acts as a constraint on health sector effectiveness. What the institutional mechanisms of limiting corruption could be
- How governance relates to politics and to institutional structures
- Why reforming governance is such a challenge and such a necessity



GOVERNANCE

Governance refers to the processes by which the owners of an institution/organization exercise their authority and control over the system. In the context of a public institution the owners are the people and their representative organizations. Of the agencies through which the people exercise their will, the government is the most important.

Let us examine three definitions of governance, each made by an international source.

Governance is:

1) "The manner in which power is exercised in the management of a country's economic and social resources for development" (World Bank 1994)[8].
2) "The exercise of political, economic and administrative authority in the management of a country's affairs at all levels. (UNDP 1997)[9]"
3) Complex mechanisms, processes and institutions through which citizens and groups articulate their interests, mediate their differences and exercise their legal rights and obligations (UNDP 1997).

The first two definitions have a central place for power and authority. The third definition assumes that power is with citizens and groups. Management is the object of action of power. But what is the subject- who wields the power?

Governance comprises complex mechanisms, processes and institutions through which citizens and groups articulate their interests, mediate their differences and exercise their legal rights and obligations (UNDP 1997).[10]

Stewardship is the function of a government responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry (WHR 2000).[11]

Leadership is the art or process of influencing people so that they will strive willingly and enthusiastically towards the achievement of the group's mission. Governance defines the objectives for which institutions are established, creates a policy and institutional framework for the functioning of these institutions, and monitors and guides the institutions to ensure that these objectives are achieved.

Management is a process applied to convert inputs of the organization into its outputs (good or

[8] World Bank (1994) Governance: The World Bank's Experience Washington D.C
[9] UNDP (1997), Governance for Sustainable Human Development: A UNDP Policy Document, UNDP.
[10] Ibid. (1997)
[11] WHO (2000), The World Health Report 2000 – Health Systems: Improving Performance, WHO.

service) or in other words the process of optimizing mix of resources in order to achieve organizational objectives most efficiently. There is an overlap between the two- but essentially they are distinct and express two different relationships and different set of processes.

THE BEING OF LEADERSHIP

There is a shift from power over people (management) to shared power, commitment and vision (leadership).

Management is associated with efficiency, planning, procedures, control and consistency while leadership is associated with vision, creativity, dynamism, change and risk-taking, obviously indicating that leadership and management are not identical though complementary.

Leadership is an enabling art, it is empowerment of others more than the exercise of power, it is inspiring rather than commanding, it is motivating rather than manipulating and it is for service and not for subjugation.

Doing and Being are two integral aspects of leadership that are not mutually exclusive like the two sides of a coin. The 'doing' side of leadership is the ability to manage and get things done in the right way and in a consistent manner. The 'being' side of leadership on the other hand points to the character and personal charisma which add value to the 'doing'. If the 'doing' is the body of leadership, the 'being' may be considered the soul of leadership.

The quality of BEING is what distinguishes a great person from an average person. Applied to leadership we can say that what makes a leader great is not what he DOES but what he IS. Before one can emerge as a great leader in public, one has to go through a process of inner leadership, reflection and mastery over self which will result in enhanced emotional intelligence, increased capacity for self management, improved mental focus and deeper sense of one's own vision and purpose.

BEING refers to certain intrinsic qualities and attributes of a person. Applied to leadership, these qualities include authenticity, credibility, honesty, openness and integrity. Authenticity is being true to oneself.

Credibility – which is not just looking good, but being good- is an offshoot of authenticity. Integrity is

the unquestionable quality of a greater leader. A person of integrity is truthful and speaks truth: he is just and acts justly. Honesty and integrity are cultivated by choosing what is morally right all the time. One can bend actions and conform to principles or bend principles to conform actions. The choice will make the difference. But the fact remains absolute integrity brings absolute trust.

Authentic leaders with qualities of integrity, honesty and credibility become inspirational leaders. The being of leadership has a number of overlapping features which are perceptible in the form of inner calm, resilience, judgment, realism about self, moral courage and compassion.

The challenge of leadership today is to inspire people to be fully involved in generating new and better ways of working. To stay ahead of the competition, an approach that unleashes innovation, creativity and trust is essential. If you cannot gain the trust of your people, you can't ever become a great leader. Authentic self is then our best answer to leadership.

Source: Fr. V M Thomas SDB, The Brahmaputra, Rhythm of the promises, Vol: I issue 2 December 2009, Managing Change

In a democracy, and more so in a republic, the owners of the public health system are the public, the people.

In an ideal democracy, the people who are most affected by the institution, who need it most, should have maximum ownership over it. This is not possible for many reasons as individuals have each their own tasks and priorities and neither can all of them give the same amount of time, nor would they have the same views. Also to manage an institution requires capabilities, which would vary widely in people. On some aspects the professionals who manage the institutions would always know more than the people who 'own' it.

Therefore mechanisms are put in place by which people could exercise their control. We will study these mechanisms of governance further. But first let us look at the purpose of governance further. Why is public control over public health systems needed? Or in other words what must be the principles of good governance:

Given below is one definition of the principles of good governance:

UNDP's Five Principles of Good Governance

Principles	Thematic areas
Legitimacy and voice	• *Participation*
	• *Consensus orientation*
Direction	• *Strategic vision*
Performance	• *Responsiveness*
	• *Effectiveness and efficiency*
Accountability	• *Accountability*
	• *Transparency*
Fairness	• *Equity and inclusiveness*
	• *Rule of law*

Source: UNDP (1997)

A brief set of definitions of these principles are given below:

a. **Legitimacy, voice and direction:** The objectives and direction of development are set by the people and their representatives, and people own these objectives as theirs. The voice of different sections, even non dominant sections, in the making of policy is reflected, and decisions are seen to have been made by participation and consensus.

b. **Performance:**

   i. Responsiveness: needs and priorities vary. To ensure that the institution can flex itself to respond to varying needs and fix priorities appropriately. Not that people have to make do with whatever it is delivering.

   ii. Effectiveness & Efficiency Effectiveness: to ensure that the programme or facility attains the objectives envisaged and set for it by the community. Efficiency: To ensure that the objectives of the health facility/health system are achieved making optimal use of resources. This is public money and there is a necessity to ensure that it is well spent.

c. **Accountability:** The staff and the management of the facility feels the obligation to achieve the purposes set for which the institutions are built and for which they are employed. For a health facility it would mean delivering the package of services it is meant for , with quality. For a public health facility the staff needs to feel accountable to the public. Accountability implies transparency. What the institution achieves and what it achieves must be visible and open to examination by the public and its representatives.

d. **Fairness:** To ensure constitutional obligations on equity and inclusiveness are maintained and that the rule of law and principles of natural justice prevail. Corruption is the most endemic and widespread problem of governance with respect to the rule of law.

Let us look at each of these in some greater detail.

Legitimacy: Participation and Consensus

The role of the legislature: In a democratic system, health is always placed under an elected minister of health which was one of the first and most important recommendations of the Bhore committee report.

The health minister assisted by his officers finalizes the annual plan and budget for the health department and this is approved by the legislature. Before it goes to the legislature it would need the clearance of the finance ministry and the cabinet. And it would need to be consistent with the long term plans for the ministry as made by the ministry and approved by the planning commission.

The above process occurs at both the national level and the state level. Since health is a state subject, and over 70% of the expenditure is from the state budget the process at the state is very important in the health sector. The central plan is limited to a few national programmes of disease control and reproductive and child health and some areas of medical education and research.

It is expected that because it is made by an elected representative of the people and because it is debated by, discussed and modified by elected members of the assembly and parliament before it is passed, such a plan has legitimacy. The political mechanisms reflected in the acts, policies, vision statements and in the five year plans and annual plans lays down the direction and the objectives and provides it with the necessary legitimacy.

Decentralization: the role of local elected bodies of governance : The national centre and even the state center is too far removed, and the situation in the districts and villages far too variable for all plans to be made and implemented from a distance. Few get to participate in a national or state process, while many more can participate in local processes. Decentralisation also makes for greater efficiency and effectiveness. For these reasons decentralisation has always been central to health sector reform.

In practice since local self-government institutions are dependent on grants from the state government or center, and they have limited technical capacity to plan on their own, they tend to conform to the objectives for which the grants are given. Kerala and Karnataka are exceptions where about 40 to 50 % of all state health departments' funds for the health sector are transferred to the panchayats. Most states do not make such transfers. Even in these states, local planning is very dependent on the design of the schemes that bring in the resources. The process of handing more powers to panchayats is a political decision and most states are reluctant to go very far, even where panchayats and municipalities are effective bodies. There are reasons stated both for and against more power to panchayats in the health sector and the debate is far from over.

In this context, the NRHM has explored a number of parallel institutional spaces which allows far greater flexibility and spaces for local planning and participation than hitherto. These institutions provide room for the participation of panchayats, but do not mandate it, so that states are able to allow as much play for the elected local body as they want to. These institutional spaces expand the scope for participation, but since they parallel existing structures have to constantly contend with their legitimacy being questioned.

These are:

i. The State Health Society and State Health Mission
ii. The District Health Society and District Health Mission.
iii. The Rogi Kalyan Samiti for PHCs, CHCs, SDHs and district hospitals and the sub-center committee.
iv. The Village Health and Sanitation Committee.

In each of these structures, except for the last, the participation of government officials is the majority. Public participation is small- but important for it makes the process transparent and more responsive and accountable.

These structures allow for local planning efforts which involve different concerned sections. Thus the district health society becomes the owner and the governance of the district health plan. The

Rogi Kalyan Samiti could become the owner of the facility level plan. The village health committee becomes the architect and the owner of the village health plan. Though bound by the legal framework and the strategy choice and the resource allocation of higher structures, within these boundaries there is a potential for the system to be more participatory and consensus based.

The governing boards of the state health society and district health society and the Rogi Kalyan Samities are meant to be participatory governance structures. The executive committees of these societies and their secretariats - the programme management units - are management structures and need not have the same broad based representation. The public representation in each of these governing boards should maximize the participation of user groups. But often, representation is given to those with conflict of interests or who attract political patronage. The greatest problem is that often the capacity to participate is weak and the space provided for participation is limited and each acts as a justification for the other.

Performance: Responsiveness, Effectiveness and Efficiency

Good governance demands that the health system is effective and efficient. In a context of a state owned and run public health system, it is the role of governance to ensure that enough financial resources are provided to the public health sector and that there are policies in place that ensure attraction and retention of enough human resources to run such a system. It is also the role of governance to ensure that a suitable leadership is provided to the sector and the institutional framework for management is built such that it can deliver the results.

Responsiveness, effectiveness and efficiency can also said to be the role of management. The difference is that it is the primary role of governance to put in place an appropriate management that could achieve this and monitor the management and hold the senior management accountable to deliver the health services. Governance would also set the priorities and the policy framework within which a management would operate.

For example take a state where the principal secretary, the mission director and the director of health services all have served three year terms. The health minister conducts a quarterly review and the chief minister conducts a six monthly review of the department with all senior officials present. In the review the plan objectives and time table is the basis and where there are delays either the explanation given must be acceptable to the minister or responsibility must be affixed and action taken. This would be well governed.

In another state, we find that none of the key state officers complete more than 12 months to 18 months.

There is always a key officer who says, "I have recently joined. I am not responsible for this action – it was done by the earlier officer." The reviews are conducted- but that is not linked to the plan- only to some immediate work allocation. Most districts are managed by an acting ad hoc appointment of a doctor to hold the post of chief medical officer and even a regular appointment is of one person from many persons of equal rank. Merit, is not the basis of selection and there is a lot of lobbying with the minister for this particular appointment.

Obviously in the latter state the health sector effectiveness would be much lower than in the former one. But this is not for reasons of poor management but of poor governance.

It is not only through choice of management that governance affects effectiveness. It is also by the choice of strategy. Though again choice of strategy is largely a management decision, overall strategy and key decisions on strategy are influenced or directly made by the mechanisms of governance. Thus for example, whether the new medical colleges would be government owned, or built under public private partnerships, whether particular health facilities and services would be public provided, or private provided with public financing is a decision of governance. Even a choice for introduction of a new vaccine or the decision to address a specific health problem with a scheme-design is a government decision. However, management has a major role in preparing the case for such interventions- other than its role in eventually implementing them.

Since institutional structures of governance and management remain stable cutting across political changes- they bring about a continuity which is sometimes welcome and sometimes is a major limitation and barrier to change.

Sometimes we find a political leadership or party which has received a political mandate for change. But because of the unchanging nature of the institutions of governance and management and of other supportive structures of knowledge and technology, it would find resistance to change and a loss of efficiency. That would still be a case of failure of governance.

Unless decision makers have access to information and experiences beyond the knowledge and perceptions of the immediate structures of governance and management within which they operate, it would be difficult to find a way out. Sources of creativity for designing innovative and effective situations could be institutions like think tanks built for this purpose, non governmental institutions, the academic community or even the people themselves.

Mechanisms of Accountability

A medical officer in charge of a primary health center is accountable to the people in the villages he serves. How could this accountability be enforced? It could be

a) To the block medical officer who in turn is answerable to the chief medical officer of the district, who is appointed by the state director at the behest of the minister.
b) To the gram panchayat or block panchayat.
c) It could be to the Rogi Kalian Samiti of the PHC or to other institution providing representation for the community.

Accountability of a chief medical officer of a district, similarly could be to:

a) The state director of health services , who in turn is accountable to the minister, who through the elected government is accountable to the electorate
b) It could be to the district panchayat or municipal corporation head who is accountable to the electorate
c) It could be to a district health society where there are other officers and the panchayat is also represented in it.

The legislative- administrative mechanisms of accountability:

a) The minister of health reports to the chief minister who is chosen by the majority of the elected members. In addition the health minister has to face questions raised by members of the legislature on the floor of the assembly thrice a year. If he still does not perform, the government could be voted out by people. It, therefore, is in the interest of the health minister that he ensures the accountability of the medical officers. Areas of non performance are expected to be highlighted in the assembly and parliament.

b) There is a disease outbreak in a remote village- and five children have died. The state level newspapers have highlighted and even sensationalized this incident. In the assembly a call attention motion is filed. During the debates the minister presents what has happened in the village and the actions his department has taken. But the opposition is not satisfied since the minister did not make a personal visit and was instead seen at some inaugural function. Minister promises to visit the area himself and punish those who caused a delay in the response. As a submission made on the floor of the house, his commitment is binding and he would have to take action and that would be monitored.

c) The auditor of the health system is another major arm of legislative accountability. The accountant general of the state has completed audit of the account for the year 2005 -06. This has been tabled during the assembly session held in March 2008. Now there is a meeting to public accounts committee to review and take action on the basis of the report. Both the members of the opposition and of the ruling party are in the committee. Officers are called in and asked to respond to the audit observations and comments. On many issues the committee calls the replies inadequate and seeks further action. On a few issues, the opposition decides to take it up in the assembly as a charge against the minister and demand his removal.

The Legislature-Administrative institution (ministry- department) is one of the most important mechanisms of accountability that the system has. However it may be difficult for many persons and organizations to ensure accountability by these means alone. One reason is that because there could be many problems, only very few get attended to. Even if it attended to, it could be delayed so much that it is of little use. Lack of information and transparency is also a reason why public cannot use these official spaces adequately. The right to information has helped, but even then it could be quite difficult to attain redressal. The main problem is that the flow of accountability is upwards to centers of power, and not downwards to the community. The priorities of those in power may not match the priorities of the community.

Panchayat (local elected government) based accountability: One additional mechanism of accountability could be that the medical officer /health staff report to the village health committee or the gram panchayat of these villages. If it is a large gram panchayat with about 30,000 population as occurs in states like Kerala or Haryana, this would be possible. But if the PHC serves five or six gram panchayats of about 5000 population each, then such a reporting relationship could be difficult in which case the medical officer could be asked to report to the block panchayat. The elected members of the panchayat are accountable directly to their electorates.

In Kerala for example all sub-centers are placed under the gram panchayat and all PHCs under the block panchayat. Even salaries are paid through the panchayat- and in effect they are panchayat employees. This form of governance is also seen in many urban corporations.

This makes for better accountability in the Kerala context. But is it possible to replicate it, in other states. Why has it not been possible to do so?

Non-governmental or quasi governmental accountability structures: Yet another form of ensuring accountability is to create institutional structures where the local community directly or through its local representatives can participate. The Rogi Kalyan Samiti was meant to be such a body. In this body the officers have the main role, but the elected panchayat leader is also a member or even office bearer. Some representatives of the public are also nominated by the district officer. These could be from non-governmental organizations or could be chosen on the basis of the fact that they made some donations to the hospitals or just as known eminent persons. As compared to the earlier arrangement this is not true decentralisation, but in most states this is the option that has been chosen, even before the NRHM came into being? Why is this so? Is this also the guidelines under NRHM?

In addition under NRHM in about 200 GPs a few select NGOs have tried an approach where they have mobilised the community, especially through ASHAs and village health committees to understand health services as their entitlements and to demand that services be properly provided to them. This is known as the community monitoring programme.

Most systems try for a mix of all three mechanisms of accountability. Accountability mechanisms which are directed upwards are essential in a democracy- but they are never sufficient. Panchayats are nearer the people and are therefore able to enforce more accountability, but in areas of weak political awareness local elite could dominate the process. Participatory accountability mechanisms are therefore also needed- but for them to be functional the system needs to be transparent in all its transactions. The media also plays a major role in strengthening the mechanisms of accountability at all three levels, by highlighting issues and problems.

Fairness: Equity and Governance

One of the central tasks of governance is to ensure that all it citizens have equal access to what are known as basic entitlements- food, drinking water, clothing, shelter, education, health care etc. The concept of entitlements is linked to the concept of basic human rights. The government has a responsibility to guarantee these rights to all.

Unequal access may occur to due to active barriers to some sections seeking care. Or it may be due to the fact that access to care is mediated through the market mechanisms- those who are able to pay get care and those who cannot pay do not get care. Or it may occur even when 'free care" is provided, when some sections are so disadvantaged that without some further support they cannot access care. One principle of equity is that unequals must not be treated equally, they must be treated unequally. There must be affirmative action to ensure that those who start at a lower baseline are provided additional assistance.

Thus, if a hospital charges user fees of Rs 5 for everyone this could be called equal access. But no, there are some persons who are below the poverty line, meaning they do not have even enough money for food. To be equitable these poor would need to be exempted from these five rupees.

But is exemption of Rs 5 enough? Take those families who live over 100 km away from this hospital and who have no other hospital nearby. Exempting these people of the Rs 5 makes little difference because they have to spend over Rs 200 to come to the hospital. They would either need an insurance payment or a cashless referral transport system that could bring them to the hospital. The local hospital authorities could contend- that it is not their responsibility- they only treat those who come to the hospital- but the government could not be so sanguine about it. The district authorities could also claim that they have not been asked to do so- but an elected member who gets votes from such an area would have to respond more meaningfully to the suffering of the people there and make some arrangement for them. Nevertheless, even the health authority would realize in time that its own health goals cannot be met without in some manner responding to situations which seem outside its ambit / responsibility at first sight.

But there are others in the village, for example, those who are homeless, or migrants who do not even have votes. Even if they are transported to the hospital they are too poor or have no family and friend support to provide an attendant to the hospitalized sick. Here the hospital or the social welfare department may have to provide a voluntary assistant to these homeless when they are hospitalized. The local government authority may protest that these persons are 'illegal' they should not even be staying there and now to ask not only to provide free transport and treatment, but also provide an attendant to stay with them- is just asking too much. Even the elected representatives who have little votes to gain and much resentment from the other poor to face- would back off. Only a very enlightened democracy would have governance which would own responsibility for these sections of society.

So how do mechanisms of governance safeguard the concerns of equity?

Governments are expected to adopt a legal framework and a health plan that together are meant to ensure that the poor and the disadvantaged are able to access health care services in proportion to their need. These laws and policies and plans have to be administered by the administrative system- the directorate of health services- or other alternative administrative structures created – like the state health societies – to ensure that there is equity of care.

However we know from statistics that the goal of equity is not being achieved. There are inequities by gender, by caste and community and by economic category.

Can giving it to panchayats and local self governments improve the situation in equity? Because panchayats are less complex and less distant structures than state governments, there is the potential that weaker sections can assert their rights better. On the other hand, many organizations that represent weaker sections are wary. They would contend that nearness of the government makes it more difficult to contend with oppressive dominant local elite- not easier. Thus the dalits/scheduled caste of an area would find it difficult to oppose the upper caste rich farmer in the decision making process in the gram panchayat meeting, because they are landless agricultural labourers and the rich farmer is also their employer and money lender. Indeed he is used to demanding all sort of gifts and services from them for free and it is unthinkable that he would actually suggest that they be given free treatment in the hospital while his family has to pay for it. Of course in the assembly if such a policy is passed, he would be happy to come to a function and announce this exemption from fees and take credit for this change as if, it was something that he got done for the poor.

It is not only the local elite who are reluctant to provide space for equitous affirmative action. Sometimes resistance to equity could be much sharper from sections of the poor and middle class. These are not the poorest, but are engaged in a grim struggle to earn enough and live in terror of the problems like unemployment and rising prices or risks like disasters that could wash away their hard earned income and assets. They are struggling to use their vote-share to get more out of the government for themselves, and may be reluctant to share this with anyone who in some way or other has an identity which can defined by them as "the other"- not part of them. Thus the health worker may dismiss the migrant worker as not part of the village and the village may also not own them. The poor farmer from a backward caste may be resentful of the privileges that a scheduled caste status brings. Though most scheduled caste families would be poorer than him, his eyes would fall upon that boy from a scheduled caste family who had less marks than his own child, but still could access a better educational opportunity. One area where this contestation for the privileges of poverty becomes most acute is in the identification and distribution of the BPL card. One would find many families who are not the poorest, have been able to leverage influence to get this BPL status, whereas many families which are the poorest are excluded on one grounds or the other- since they had no such access to power.

Leaving equity concerns to local power relationships is seldom a solution.

When a redistribution of power happens in favour of one marginalized section, often the section immediately above may that get adversely affected. For example, when NREGS offers a living wage to the very poor, the small farmers feel the pinch of shortage of agricultural labourers the most. When a

woman is empowered to fight for her rights, it is her immediate family that resists and resents the change the most. There is the risk that these small but important changes could get reversed or crushed by local opposition unless there is support from larger and more distant structures and systems.

The local institutional structures – District health society, Block health committees, Village health committees and the Rogi Kalyan Samitis have all the potential to address equity concerns. But in practice they seldom do so. For example: RKS should ensure that the poor are exempted from user fees. IN practice the common review mission found that exemption is poor. If 30% of the people are below poverty line, one expects at least 50% of those using the public hospital to be exempted as poor would preferentially go these hospitals. In practice, exemption is often less than 10%. And when it comes to high value services like CT scans and even X-rays, exemption could be even less.

The local officer would have the concern that if he exempted one of them, then all would demand exemption and the only way out is to be strict. Justifications- like see how much they spend on drink – why cannot they afford a few rupees for the treatment also back them.

But it is not only the local officer. A very common belief is that people do not value things provided free. "Unless they are charged they would not value the service" - is a view that officers hold at all levels.

Also this was part of the mindset of the nineties where states were stressed financially due to a fiscal crisis. Indeed user feeds were forcibly introduced as conditionality for availing of World Bank loans or development partner grants. There was often a goal set that 10% to 25% of the costs should be recovered from user fees. In many states such cost recovery is still being paid to the state treasury. Though World Bank had reversed its recommendation on this by the end of the decade, this was picked up by the administrators as their own idea. The fact that this collection provided an untied fund source, that was very useful for local activities – was one reason why this was welcomed.

The push for user fees has diminished since 2004. The first state to withdraw it was Andhra Pradesh in 2004. User fees had become an important election issue. So as soon as the chief minister was sworn in, to dramatise his priority to the abolition of user fees which was a major part of his electoral platform he signed an order abolishing user fee from the stage itself.[12] Under NRHM, user fees was declared a state government decision with no national guideline on this, except to state that if such fees were collected, it should be retained and spent in the institution- not taken to the state center or treasury. The NRHM also provided an untied fund to every Rogi Kalyan Samiti, underlining the position that the RKS was no longer a vehicle of cost recovery, but part of the framework for providing accountability for funds provided locally.

At the national level there is an effort to divide the national pool of available resources such that there is a

[12] Health System in India: Crises and Alternatives, JSA, 2006

greater proportion provided to the poor performing northern states and to the special category of hilly and tribal states. Thus the fund is divided on a fixed per capita basis, but the poor performing states would get 1.5 times per capita what the other states would get. Special category states would get two to three times what other states would get.

There is no corresponding allocation of NRHM funds between poor performing and high performing districts in the village level, or between villages and facilities at the district level. Doing this, would be an important operational challenge for the NRM. Similarly there are few schemes that are operational for tribal areas or urban slums as yet- though these are proposed.

Fairness: Rule of Law

One of the key issues of governance is corruption. Corruption has many forms. But the common characteristic is that someone who has power, and owns an asset or position of influence, demands an illegal payment, merely because he owns it or because of his position. This has also been called rent seeking behavior. A poor woman pays an ANM an illegal payment of Rs 400 to conduct a normal delivery when she should be providing it free- because the ANM is in a position of power vis a vis the user. A doctor pays a bribe of Rs 50,000 to get a job, or a choice posting, merely because the person he paid to has the power to give him or her job. A senior medical officer pays a bribe of many lakhs to get his appointment to senior administrative posts and retain that position. A drug company pays a huge bribe to ensure that its products are purchased. Or a large company pays a huge bribe to secure a public private partnership in the form of a favorable contract. Though all are similar illegalities, the guilt of each person in the above transactions varies. The pregnant woman paying the ANM has little choice, and the ANM is also offering a service. The doctor paying the bribe for the posting has much more choice but may be feeling compelled or taking a short cut. On the other hand the person receiving the bribe has no value addition to contribute- and is on the other hand doing great damage and is earning illegally merely because of the position occupied. Rent seeking at its worst. In the drug company paying of the public health system or for that matter a payment made by a private partner to a public authority in return for a contract- both sides are powerful. This is thus a cartel or a conspiracy made at the cost of the public, and on public money. Of all the forms of corruption, these could be the most difficult to address and most distorting to the priorities and needs of the public health system.

Corruption occurs in a context of low accountability and is at the same time one of the most important causes for decreasing accountability within the system. It also undermines responsiveness, effectiveness and efficiency of the system.

Corruption at the local service provider level can be checked by public awareness and community

monitoring mechanisms. But the much more damaging corruption at governance and management levels requires re-examination and re-engineering of the processes of governance and management. For rent seeking also requires specific institutional processes and can be limited if these processes are made transparent or checked. But that is easier said than done. For many of the lack of suitable processes of management and governance are not due to lack of capacity but due to rent seeking goals interfering with health care goals.

Avoiding conflict of interests is also an important part of fairness and the rule of law. A doctor prescribing a CT scan, and having a kick back arrangement with the radiological institution for every case referred is a clear conflict of interest situation. Public sector doctors, referring patients to their private clinics or prescribing drugs in return for gifts from companies are also conflicts of interest. An expert on a public committee deciding on a vaccine who is paid by the manufacturing firm to promote the vaccine –directly or indirectly is another damaging form of conflict of interests. All conflicts of interest are not illegal- but ethics requires that they are always declared to the concerned parties.

Observing a number of laws of the land in the implementation of health programmes is also an important aspect of governance. Thus whether it is compliance with PNDT Act, or observing the Supreme Court guidelines on safety and quality in sterilization operations, one of the key functions of governance is to ensure that the law of the land is observed. Failure to observe the rule of law is a failure of governance.

WHY DO GOVERNANCE PROBLEMS PERSIST? TO WHAT EXTENT CAN THEY BE ADDRESSED AND HOW?

Why-- is always a difficult question.

There are many possible explanations that flow from different theoretical perspectives. Let us examine first the relationship between governance and politics- for as we have seen much of governance is centered around the political-administrative structures.

Governance and Politics:

Politics is about power as power brings authority and control. There are different forms of power. Peoples voting rights is one form of power. Economic power of the wealthy is another source of power. The command that individuals and associations have over different institutions, and organizations and communities is another source of power. A party in power is in power precisely because it has managed to do the best possible negotiation between these different sources of power to gain resources and influence and been able to convince people that its agenda is in their best interests.

Those voted to power in the government therefore do not have only the interests of their electorate in mind. They come to power because they command the support of many powerful factors and votes of people is only one of them. Even for the people who vote for them, health care is only one of the reasons why they vote for them- one amongst many possible reasons, from which people have to choose. A political party presents a range of things for which it stands, and a number of things it opposes and it also seeks to create an identity by which different sections of the people identify that party with their own interests.

Many parties have the support from organised big industry. The pharmaceutical industry or the health care industry is one of the biggest industrial sectors and have a lot of stakes in ensuring that the government has a health policy that looks after their interests. The professional organizations and associations are also politically influential. Political parties may have won the support of leaders of specific communities who could transfer their community votes to them in return for the party addressing some of their sectional priorities. The politicians may have their own considerable personal wealth or industrial interests and build on these. Once they are in power they would have to fulfill the expectations of all these sections – and health rights may be only a small part of this.

Some political theorists would argue that most political parties are really representative of the wealthy and privileged sections of society and not only voting, but indeed all of governance is only a process of manufacturing the consent of those who are poor and underprivileged to be ruled at such terms. They would evidence this argument by pointing out to the fact that a few families and sections benefit disproportionately over time, and most of them are those who already owned enormous wealth and assets.

Others would argue that such inequality is not wrong or shameful. It is indeed essential – or even natural- as some persons are more capable or lucky. And by keeping government role to only that of a policeman to ensure everyone plays by the rules, and allowing all economic decisions to be decided by the market the most efficient win out. People seldom are convinced of a government that projects working for the wealthy as a virtue, but there could be other reasons like that of "identity" by which people could nevertheless be persuaded to vote for them.

Many others would go along with the market based approach as far as the organization of economic activity goes, would however argue that there are such things as basic rights and entitlements and it is the role of the government to guarantee a minimum level of these to every citizen. Society has reached the capacity to provide for the food clothing shelter and education and health care for all its citizens and no citizen should be denied basic provisions necessary for a life with dignity. Wealth can be according to the market, but the baseline in minimum provisions should be set by the government. The reasons for this are not only rights but also the practical necessity that one cannot secure the votes of the people if a minimum

life with dignity and some constant increase in their standard of living is not provided for. The government's role in areas like food security and health and education, legitimizes it as a government working for all peoples interests and not only for the rich.

It follows that a minister of health and a government of the day has a number of goals that it has to attend to and that the health of the people especially of the poor is only one amongst them. However the only sustainable and long term way to good governance is to increase voter awareness to make health care an important part of the political agenda- so that it is not diverted or diluted by other parts of the political agenda. Also for the people to be able to articulate the nature of changes they need and to hold the rulers accountable in the next elections and in different platforms like the media, whenever they fail to deliver on their promises.

Governance and Institutions:

There would always be some states where a political party is elected with a deep commitment to improve health outcomes or where a minister of health shows a high level of dedication to achieve the main objectives of the public health sector. However, even in such a situation, the leadership would have to act through the existing institutions of governance and management. The shaping of these institutions has taken place over centuries. The relationships of power that we discussed have shaped these institutions and are embedded in them- in the way they are organised and function and in their values, mindsets, conventions and rules. The main instruments of action or institutional structures through which a political leadership would have to act are:

a) The general administration- which is the central effector mechanism of governance.
b) The technical administration – which has a combination of governance and professional influences and is also the main management arrangement for the public health sector.
c) The health care industry and its numerous links with both the institutions of administration and the institutions of knowledge
d) The professional associations, the medical education institutions and research and technical assistance institutions and all the influences that shape medical and public health knowledge.
e) The workforce in the public health sector and their own sectional priorities and influences.

Even if the political leadership were to change abruptly, the organizational processes and mindsets that have been shaped over time would not change. Indeed they could work to frustrate or convert the political leadership to its bias rather than the other way around. This could be discussed with many examples.

Thus there is a resistance to change that gets built into institutional structures due to problems of governance. However all these institutions are also charged with increasing the effectiveness and

efficiency of health care delivery- and to that extent they also have a positive potential. The challenge is that when one works for improving governance one has to examine the rules framework, the organizational processes and the mindsets within each of these institutions and work on them simultaneously.

Addressing Issues of Governance: Political and Stakeholder Analysis.

The fact that multiple stakeholders shape policy and that these multiple interests, often of a conflicting nature, have to be negotiated keeping the main interest in mind, is a fact known to almost all politicians. Politics has been defined as the art of the possible. The politician's role is to make this negotiation. How much weight the political process gives to each stakeholder interest and how much they are willing to compromise depends both on objective circumstances as well as on the subjective politics of the leadership and the main interests that its represent.

To those sections who want to consciously create a change that leads to better health outcomes and empowerment (empowerment being defined as the increased ability of people to make informed choices about their own health care needs and services), the starting point is to look at each change from the lens of a political analysis – or what is called a stakeholder analysis. This means understanding how change affects each stakeholder and institutional structure and how they would respond to it.

Many health sector strategies and outcomes can be viewed and understood as arising from such a process of negotiating between many stakeholder positions pulling in different directions.

This could be discussed with a few examples. The nature of plans for decentralization under NRHM. Or the design of the ASHA programme. Understanding governance and decisions using political/stakeholder analysis is essential for managing change.

STRENGTHENING GOVERNANCE IN THE DISTRICT AND STATE HEALTH PLANS

The following are a list of possible measures each of which would contribute to strengthening governance:

a. Participation and Consensus:

   i. Ensure the spaces provided for public participation- have representatives of the public-user groups, organizations working on behalf of weaker sections of society etc.
   ii. Ensure that the platforms created for public participation meet regularly and function

seriously. Particularly applies to state and district health societies, and facility based committees and district health societies. Report on their performance in the annual review and give it a budget line and activity timeline as well.

iii. Ensure that decisions taken by these committees and the district and state plans themselves are public documents- available on the websites and as publications.

iv. Build up the capacity of public representatives to play their role in governance.

v. Provide and keep active platforms for direct community participation – like VHSCs.

b. Performance: Responsiveness, Effectiveness and Efficiency:

i. Define objectives clearly and fix accountability mechanisms

ii. Ensure that management structures are appropriate and held accountable to reach their objectives. Individually and as a group assess performance against objectives and performance criteria with some rewards or recognition for good performance and punishment in case of negligence are essential features of good governance.

iii. Build capacity of management personnel to be able to provide effective and efficient services.

c. Accountability and Transparency:

i. Separate governance structures from management structures- allowing for as little overlap as possible. The district health society governing board from its executive committee and district programme management unit, the governing board of the RKS from its management or executive committee and so on.

ii. Maximize participation in governance structures. Develop a culture of the management making itself accountable to the board- presentation of an annual report, and submitting itself to review and policy and institutional frameworks laid down by the governance body.

iii. Clarify accountability down the line. Every single employee and participant should have clarity on what function or output they are individually and as a group accountable for.

iv. Ensure transparency of processes. Especially key processes that are the sources of mis - governance that act to distort the entire chain of accountability. In particular transparency in procurement of goods and services, transparency in processes of appointments to key management positions especially the post of chief district health officer, transparency in postings and transfers, and transparency in technical choice and programme design and transparency in annual plans with budgets and flow of funds and expenditure patterns and transparency in public private partnerships.

d. Fairness: Equity in Governance:

i. Identify and remove barriers to inclusion of the poor and of marginalized groups.

ii. Identify groups who are marginalized and unable to participate and plan affirmative action that could bring them in.

iii. Measure health outputs and outcomes in sub-groups through special surveys (and not routine monthly HMIS reporting) and set objectives that aim to reduce differentials across sub-groups.(this could form an indicator of good governance).

iv. Provide platforms for participation of weaker sections, so that their voices can be heard, and build in functional grievance redressal mechanisms and assistance protocols to enable feedbacks from hitherto excluded sections.

e. Fairness: Rule of Law:

Identify areas of rent seeking behavior and construct institutional safeguards that limit this. In particular we need to craft transparent and non discriminatory institutional mechanisms for

i. Procurement of goods and services. The TNMSC is the gold standard in institutional arrangements for this. Rent seeking behavior in this area is easily identified if we look at three indicators: cost of drugs purchased as compared to the TNMSC benchmark, stock out of drugs in the peripheral facilities and with field staff, and transparency of the tendering and quality control process- where every bid can be seen and every rule is known before hand.

ii. Appointment of persons to key management positions, especially the posts of chief of the district health system. Again Tamil Nadu is an example in this, though many states have similar processes in place. The mechanism of the Department Promotion Committee (DPC) is usually adequate. Though it does limit merit based selection, it also prevents arbitrary processes which puts a limit on how many inappropriate persons can be chosen. This DPC is usually subverted by having key posts held in ad hoc capacities for long periods of time or by having the key post and the same seniority level as many other posts, from which the decision maker can arbitrarily appoint one person as the chief officer in charge. Lack of capacity building is another factor in this. Lack of adequate tenure for persons in key management positions is also reflective of governance. These are useful as indicators of good governance too.

iii. Transfers and postings: Again Tamil Nadu is an example in this, though many states like Karnataka and Kerala have also robust systems. No one is transferred as a routine unless they ask for it. The only exception being to staff difficult postings, which are to be filled on

rotation. When there is a transfer request, the person goes on queue and has a choice of the available vacant postings in order of his or her position on the queue- a process that has come to be called counseling- though in fact no counseling takes place.

iv. Technical choice: Example, which vaccine is chosen for the national programme, how programme design is finalized etc. There are no robust mechanisms in India which could serve as a benchmark. Most mechanisms depend on attributed technical authority and are seriously inadequate. NICE (National Institute of Clinical Excellence - refer to case study lesson 5) in United Kingdom is the benchmark in this and is worth emulating. It would not only save the country crores of rupees, it would make for much better governance at every level.

v. Contract Management: When entering into public private partnerships, systems need to be in place, for appropriate, fair and transparent choice of partner or contracted agency and transparency of the contract itself in the form of a publicly declared agreement or MOU document. Further adherence to the terms of the contract, especially quality and cost and equity parameters, needs to be independently monitored by a contract management unit under the government and having no conflict of interests with the service providing agency.

f. Conflict of Interests: All conflict of interest situations are to be avoided or at least publicly declared.

g. Existing laws and rulings of the courts should be observed. An active legal wing, that promotes the understanding of the legal obligations of the public health system is necessary.

A state or a national body could promote these measures of good governance by making funds flow conditional on achieving these different process parameters described above. It would certainly contribute to a much better health sector performance. That it has not done so already is because of "politics", where politics is understood as a negotiation between contending forces, as the art of the possible. However governance requires legitimacy. And poor governance undermines legitimacy. Making mechanisms of mis governance visible and building support for alternative good governance mechanisms is essential in the process of governance reform. The question is what each one of us, working from the positions we occupy, could do to make it possible!!

Review Questions:

1. What is governance? How does it differ from management?
2. Good governance has been stated as essential for making the health systems participatory, responsive, effective, efficient, accountable, equity sensitive and fair. What do we understand by each of these terms?
3. What are the mechanisms of participation and consensus in place? How could they be enhanced? What role does decentralization have?
4. What are the mechanisms of accountability within the system?
5. What measures can be proposed to strengthen good governance?

Application Questions:

1. Selecting the chief medical officer - Do a stakeholder analysis to find out what has led to the current mechanisms in place and to suggest alterations for the future that have a hope of getting accepted.
2. Propose some indicators of good governance.

Project Assignment:

1. Take the issue of user fees. Do a set of interviews to get the views of different stakeholders. How do we chart a position that could take along everyone's legitimate concerns in a decision to abolish user fees?
2. Measure the state of good governance in the district on a set of parameters and consider what areas could be improved upon in an annual plan?

Lesson FOUR

Pharmaceutical Industry, Pharmaceutical Policies and Public Health

In this lesson we shall discuss:

- Out of pocket expenditure and public sector expenditure on pharmaceuticals
- The structure of the pharmaceutical industry: its size, its product composition and its concentration.
- The drug policy and drug price control orders and their impact
- The role for promoting essential drugs and limiting inessential ones
- Pharmaceuticals in the public sector
- Pharmaceutical industry and its impact on public health planning

EXPENDITURE ON PHARMACEUTICALS

Estimates from the 55th consumption expenditure National Sample Survey reveal that three-fourths of the total out-of-pocket (OOP) health expenditure is spent on drugs, in rural and urban areas. Estimates further show that out of per capital expenditure of households amounting to Rs 577 spent annually on health in urban India, Rs 400 goes into buying drugs, accounting for around 70%. In rural India, however, the share was 77%, where the spending pattern has been Rs 380, out of which Rs 295, has been on drugs. Kerala, Haryana and Goa, all small States, appear to be spending over Rs 600 per annum per capita in urban areas while households in poor States such as Bihar and Orissa spend relatively less.

Of this drug spending spent on drugs in urban India, a substantial part of it is by way of outpatient payments totalling around Rs 325 and the remainder (about Rs 75) is on account of inpatient payments. A similar pattern can be observed in rural India. Out of the total of Rs 295 spent on drugs annually, inpatient expenses accounted for Rs 45, and outpatient expenses were about Rs 250.

In rural India, the share of drugs in outpatient care is observed to be the highest, accounting for nearly 83%, while in urban India, this worked out to 77%. In fact, in a few states, the share of drugs is more than 90% (Bihar, Himachal Pradesh, Jammu and Kashmir, Orissa and Rajasthan in rural areas and Haryana and Orissa in urban areas). On the other hand, the share of drugs in inpatient treatment is not as high as in the outpatient category. The respective share of drugs (inpatient) in rural and urban India was roughly 56% and 47%. It is interesting to note that in rural India, if both inpatient and outpatient expenses are taken together, the share of drugs to total household expenditure accounts for roughly around 5% while in urban India, it is around 3.5%. Overall, as indicated earlier, it appears little over 4% of the total household spending."[13]

The situation in public expenditure on drugs is quite the contrary. To quote: "The component of drugs and medicines in the overall budget of both the Central and State Governments is only a minor share, as salaries account for the bulk of the health sector expenditure in India. The analysis involves 16 major Indian States, which accounts for roughly 85% of the total health budget in the country. The expenditure pattern on drugs of the State Government shows that there are wide-ranging differences across States, from as little as less than 2% in Punjab to as much as 17% in Kerala during 2001-02. The southern States such as Kerala and Tamil Nadu spend over 15% of their health budget on drugs. Many backward States, both in economic and health indicator terms, incurred the lowest expenditure on drugs. States such as Assam, Bihar, U.P. and Orissa spent about 5% or less of their health budget on drugs and medicines.

[13]S. Sakthivel (2005), Access to Essential Drugs and Medicine, National Commission on Macro-Economics and Health. Background Papers- Health Systems in India- Delivery and Financing of Services. pg. 158

It appears from the analysis that approximately Rs 2000 crore was spent in India by the State and Central Governments together on procuring drugs and medicines during 2001-02. The Central Government's share of drugs in its total health budget is around 12%. In all, roughly 10% of the health budget goes into procuring drugs in India."[14]

THE INDIAN PHARMACEUTICAL INDUSTRY

Most health expenditure is private and anywhere from 70 to 90% of private health expenditure is on drugs. No wonder then, that the nation has a booming pharmaceutical industry.

The size of the Indian pharmaceutical industry, both bulk drugs and formulations is estimated at Rs 35,471 crore in 2003-04 (IDMA 2004). At present, there are about 6,000 units operating in this sector (if only bulk drugs, formulations and large parenterals are taken into account) (Mashelkar Committee 2003)[15]. Investment in the industry has steadily grown over the years from a mere Rs 23.64 crore in 1950 to a moderate Rs 500 crore in 1980 and went up considerably to reach around Rs 4000 crore in 2003.

Although drug consumption and pharmaceutical industry boomed, not all of it was necessary. Indeed it can be shown, that the drug consumption patterns were largely determined by the priorities of industrial growth, rather than the other way around. Thus drug production mainly catered to maximise the market amongst those who have purchasing power, rather than going by the burden of diseases and the need for drugs. Irrational, unnecessary formulations flooded the market. Of the top twenty five formulations sold in the Indian market in 1999, ten were irrational formulation (four vitamin pills, one cough syrup, one liver preparation, one nutrient, one tonic, one analgesic and one antacid) and accounted for almost a Rs. 500 crore turnover.

It is worth studying which segment of the industry is more prone to irrational products. Thus of the top 50 companies multinational companies account for 54% of the total turnover and 87% of the irrational drugs turnover, and 29% of the essential drug turnover and only 25% of the antibiotics and none of the anti-tubercular drugs(in 1999). Anti-tubercular drugs, anti parasitic drugs, antibiotics etc, were primarily of domestic manufacture. Irrational drug promotion requires brand image building and high marketing and allows greater margins and MNCs prefer to focus on such high value low volume market segments. These lead to greater returns per dollar invested- and that is what drives industry the rate of profits. Another reason for this preponderance of inessential drugs and the reluctance to essential drugs is because the drug price control orders are applicable only to essential drugs. This is not a reason for relaxing the price control. It is an argument for banning the production and marketing of inessential drugs.

A further feature of pharmaceutical industry is the high levels of concentration or controls in a few giants

[14]S. Sakthivel (2005), Access to Essential Drugs and Medicine, National Commission on Macro-Economics and Health. Background Papers- Health Systems in India- Delivery and Financing of Services. pg. 158

[15] GoI (2003), Report of the Expert Committee on a Comprehensive Examination of Drug Regulatory Issues, Including the problem of Spurious Drugs, MoHFW, Delhi.

who can then make a number of mutually helpful price and production agreements amongst themselves- based almost exclusively on considerations of profitability. The top ten companies of which 7 were Indian command about 30% of the entire market. Further within each sub-category of drugs there are only three or four companies who command over 30 to 90 % of the market share.

As a result the retail of prices of drugs can be astronomically high as compared to what they actually costs. The table below gives a sense of the difference.

Drug price difference between retail market and tender purchase

Disease conditions	Therapeutic drug	Formulation	Strength and No.	Retail Price (Rs.)	TNMSC price (Rs.)	Price difference (%)
Cancer	Cyclophsphamide	Endoxan-N	50mg;10	36.35	13.218	275
Cancer	Fluorouracil	Fluracil	5ml	11.67	1.001	1166
Child and infectious disease	Chloramphenicol	Chloromycetin	250mg;10	30.76	4.4	699
Child health	Phenytoin Sodium	Dilantin	100mg;10	131.55	9.75	1349
COPD and Asthma	Betamethasone	Walacort	0.5mg; 10	3.55	1.043	340
COPD and asthma	Salbutamol	Asthalin	4mg;10	5.21	0.522	998
CVD	Verapamil	Veramil	40mg;10	5.02	4.392	114
CVD	Atenolol	Aten	50mg;14	25.75	1.2	2146
Diabetics	Insulin NPH	Actrapid	10ml	129.28	86.85	149
Diabetics	Glibenclamide	Daonil	5mg;10	6.60	0.454	1454
Injuries	Bupivaccine HCl	Sensorcaine	0.5%;20ml	34.34	15.5	222
Injuries	Ketamine	Ketalar	50mg;10ml vial	89.50	15.15	591
Japanese encephalitis	Ceftriaxone	Lyceft	1g;vial	90.00	16.11	559
Lymphatic Filariasis	Diethylcarbamazine	Banocide	50mg;10	3.88	0.707	549
Malaria	Chloroquine	Melubrin	250mg;10	4.36	2.233	195
Maternal health	Carboprost	Prostodin	1amp	80.13	68.5	117
Maternal health	Ferros Sulphate	Ferrochelate-Z	150mg;10	19.94	0.495	4028
Mental health	Chlorpromazine	Chlorpromazine-NP	25mg;10	5.95	1.81	329
Mental health	Alprazolam	Alprocontin	0.5mg;10	22.55	0.442	5102
Tuberculosis	Rifampicin	Rifacilin	150mg;100	99.68	66.6	150
Tuberculosis	Pyrazinamide	PZA-Ciba	500mg;10	42.46	5.188	818
Others	Ranitidine	Consec	150mg; 10	7.51	2.205	341
Others	Dopamine	Dopinga	5ml	25.00	6.05	413
Others	Ciprofloxacin	Ciplox	200mg;100ml	27.00	6.41	421
Others	Paracetamol	Calpol	500mg;10	8.78	1.24	708
Others	Diclofenac Sodium	Diclonac	50mg;10	11.03	0.686	1608
Others	Diazepam	Calmpose	5mg;10	13.70	0.4	3425
Others	Dexamethosone Sodium Phosphate	Decdan	2ml	10.36	0.222	4667
Others	Cetrizine	Alerid	10mg;10	31.50	0.561	5615

Source: For Retail Price—Monthly Index of Medical Specialities, India, August, 2004
For TNMSC Price—Tamil Nadu Medical Services Corporation (TNMSC). Available from URL: http://www.tnmsc.com/system.html

Source: S. Sakthivel (2005), Access to Essential Drugs and Medicine, National Commission on Macro-Economics and Health. Background Papers- Health Systems in India- Delivery and Financing of Services. pg. 158

DRUG PRICE CONTROL

Developed countries have much more extensive price controls. However, the need for exercising price controls is much more urgent in a country like India. The first reason for this is that out-of –pocket expenses on purchase of medicines is much higher in India, and this affects the poor disproportionately. Moreover, India is special in another way. Retail sales account for approximately 85% of drug consumption. In all developed countries, and many developing countries, retail sales constitute a small fraction of drug consumption. In these countries more indirect forms of price control measures , like better public procurement and dispensing policies, are possible to safeguard interests of patients. In India, such an option is not available, and the only remedy available is to have a larger cover of price controls over the retail market through direct price controls.

Our analysis has shown that Price Controls, when exercised, do work. It also shows that in the absence of price controls, markets do not stabilise prices. This points to the urgent need to control the prices of medicines that are of primary importance.

The First Drug Price control order in India was introduced in 1970. Subsequently in 1978 a national drug policy was announced and in 1979 a revised drug control policy. Some of the key objectives of the Drug Policy were:

- to ensure adequate availability of drugs
- to provide drugs at affordable prices
- to ensure the quality of drugs and check medicines from being adulterated
- to achieve self-sufficiency in production and self-reliance in drug technology.

The drug price control order covered 347 essential drugs, and categorised all drugs into four categories. Three of these categories were drugs that were permitted a different mark-up as maximum retail price, over and above its manufacturing cost- 40%, 55% and 100% respectively with the rest being placed in category IV and outside control.

This policy was based on the Hathi Committee Report of 1975 (Committee on the Drugs and Pharameuticals Industry chaired by Jaisukhlal Hathi), which was one of the most far reaching and influential studies on this issue. The patent regime was changed to a process patent regime in 1970s and this also helped the growth of Indian industry. Some drugs were reserved for public sector production, others for the domestic industry and the rest were open to foreign competition. Under these protectionist policies the national companies who commanded less than 20% of the market in 1970s rose to 65% by 1995.

In a subsequent modification of the drug price control order in 1987, the number of drugs under control came down from 347 to only 142 drugs under price control. Further the controls to ensure production of essential drugs and to limit import of drugs were all removed.

In 1995 drug price control was further reduced to only 76 drugs. Moreover the 1995 policy changed the methodology for selecting drugs to be placed under control. No longer was the criterion for inclusion on the list based on public health, only market based criteria were seen as appropriate. A drug had to have a total turnover of 4 crores and show that manufacture was less than 5 bulk drug producers or 10 formulators and that one or more formulators had more than 10% market share to qualify for being brought under control. Further all drugs were allowed a maximum of 100% manufacturing costs and post manufacturing expenses which included the costs of marketing and distribution. The percentage of the drugs in the market that were now under control was less than 25 to 30%.

As the cost of drugs escalated under de-control, the growing drug companies were fighting for a greater share of only a small part of the paying population – hardly about 20%. To find a way out of this, India majorly started to look at exports seriously and in this period of the nineties, exports rose dramatically. Globalisation was now convenient for the leading industries for they needed international markets.

A new policy draft in the year 2002, intended to take this even further. But it was challenged in the Supreme Court, and was therefore never implemented. In practice it is the 1994 policy and the 1996 DPCO that is still operational.

" The Drug Policy 1994 envisaged setting up of an independent body of experts to be called the National Pharmaceutical Pricing Authority (NPPA) to do the work of price fixation and monitoring of prices of decontrolled drugs and formulations and to oversee the implementation of the provisions of DPCO. The government constituted the NPPA vide its resolution dated the 29th August 1997 as an attached office of the Department of Chemicals and Petrochemicals. The Authority is entrusted with the task of price fixation, revision and other related issues as per the provisions of para 3 of the Drugs (Prices Control) Order 1995. The authority also has power to regulate its own procedure for performing the functions entrusted to it and it is free to call for notes, memoranda, results of studies, data and other material relevant to its work from official and non-official bodies and hold discussion with them. NPPA fixes/revises the prices of the scheduled bulk drugs and formulations in accordance with the provisions of DPCO 1995. The State Drugs Controllers help NPPA in monitoring the prices and enforcing the provisions of DPCO.

NPPA is empowered to regulate the price of not only the scheduled bulk drugs and formulations but also non-scheduled bulk drugs and formulations if required to protect the public interest. Para 10 (b&c) of DPCO 1995 states "the Government may, if it considers necessary so to do in public interest, after calling for such information by order fix or revise the retail price of any formulation including a non-Scheduled formulation.

The Government may, if it considers necessary so to do in public interest, by order include any bulk drug in the First Schedule and fix or revise the prices of such a bulk drug and formulations containing such a bulk drug in accordance with the provisions of paragraphs 3, 7, 8 and 9, as the case may be".[16] (Sengupta, 2008)

[16]Sengupta, Amit; Reji Joseph,Shilpa Modi, Nirmalya Syam (2008), Economic Constraints to Access to Medicine:CTD-CESS,WHO.

The latest guidelines for monitoring the prices of non-scheduled formulations are issued on 16th March 2007. According to these guidelines, companies will be short listed and will have to provide reasonable explanation if the prices of its non-scheduled formulation increased by more than 10% (earlier the limit was 20%) during a period of 12 months and the annual turnover of the formulation pack exceeded Rs.1 crore. Further, NPPA will initiate action against non-compliance of internal guidelines/directions and direct the manufacturers to reduce prices and then maintain the price-levels in absence of any reasonable explanation regarding the price hike. The monitoring of prices of non-scheduled formulations is done on the basis of regular data from ORG-IMS. Entry prices of new products are also sought to be monitored and regulated- but this has not yet happened. There is no control of the prices of medicines in the alternative systems of medicines such as Ayurveda, Yunani, Sidha and Homeopath. Section 2 of the DPCO 1995 specifies that the Order shall not cover "any medicine included in any bona fide Ayurvedic (including Sidha) or Unani (Tibb) systems of medicines, any medicine included in the Homeopathic system of medicine and any substance to which the provisions of the Drugs and Cosmetics Act, 1940 (23 of 1940)".

Analysis of price rise between 1996 and 2006 to study the impact of NPPA done in Amit Sengupta's study showed that " Rise in prices of all medicines in the basket of drugs chosen was 39.93%, between 1996 and 2006. Change in Prices of Medicines in the Price Controlled Category in the same ten year period was nominal - 0.02%. Rise in prices of medicines in the EDL in the period was 15%, largely because most of them are in the drug controlled category and the rise in prices of medicines for drugs not in EDL and not price controlled was 137%." Prices are still much higher than what is obtained in Sri Lanka or what is obtained within India by generic manufacturers.

ENSURING MANUFACTURE OF ESSENTIAL DRUGS AND BANNING NON ESSENTIAL ONES

Given the huge price increases and profits that are available in the marketing of non essential drugs, the industry prioritises their promotion and sales. The use of brand names provides an irrational promotional advantage for selling inessential drugs. Since patients do not decide on what drugs they consume and since prescribers are easily influenced to prescribing inessentials, the only way forward to curtail such huge out of pocket expenditure is to curtail the production and promotion of inessential drugs.

Whereas the Hathi Committee was clear on moving all prescription to generic names, ensuring adequate production of essential drugs and phasing out irrational and unnecessary drugs, no government has had the ability to question the power of the industry on this score.

Perhaps the only step forward that some state governments have been able to do in this regard, is to ensure that at least state public health systems procure and distribute only essential drugs. Towards this

end many states have published and are using essential drug lists, drug formularies and standard treatment guidelines. However, given the huge investment that private sector makes in promoting the irrational, government adoption of these guidelines needs to be accompanied by active promotion of the rational drug and diagnostic use concepts and regulation on the promotion of the irrational drugs. Otherwise even public service providers end up writing "outside prescriptions" for promoting the irrational.

DRUG QUALITY CONTROL

One of the functions of government is to police the markets to ensure that all drugs brought to the market are safe and of adequate quality. However, drug regulatory mechanisms have been very weak. There are roughly 935 drug inspectors – about one per 320 wholesale and retail units as against the norm of one per 200. Further another 120 inspectors are needed to monitor closely 5877 priority manufacturing units and another 100 inspectors to monitor the rest of the 20,000 manufacturing units in the country. The units prioritised for inspection are 1333 bulk drug units, 4354 drug formulation units, 134 large volume parenterals and vaccine manufacturing units.

Diagnostic devices and equipment also need monitoring and so do a vast variety of health foods.

Clinical research, prior to the introduction of new drugs into the market also needs to be monitored. Certifying new drugs for introduction and modifying regulations on existing drugs in parallel with technical advances is yet another function. Drug regulatory authority of India thus is one of the most important vehicles of drug industry regulation. Because of these gaps in monitoring and an overall weak implementation of drug safety laws, we have a large number of spurious and sub-standard drugs on the market, which are a threat to the health of the people.

DRUG PROCUREMENT FOR THE PUBLIC HEALTH SYSTEM

Given the huge retail costs of drugs, one of the most important services that the public health system performs is to procure drugs at reasonable rates, and supply it to the poor free of costs.

However to maximise this benefit to the poor, drugs have to be procured through a fair and competitive process that brings down the purchase price without any compromise in quality and distributes the drugs to the service providers through excellent logistics management. The Tamil Nadu Medical Service Corporation is a role model of such management. This model has been discussed earlier.

Some states, notably Tamil Nadu provide these drugs free. Others notionally supply it free but drugs in the hospital pharmacy are so limited that the bulk of prescriptions need to be purchased by patients from commercial pharmacies. Yet other states allow free supply of drugs only to the poor, or not at all. These

lead to different levels of out of pocket expenditures in the public hospital. Thus the whole social protection function of the public facility is lost, and many patients are excluded or lost to treatment because of their inability to face these costs.

Average medical expenditure (Rs.) for treatment under different heads of treatment during stay at Public Hospitals as inpatient during last 365 days per hospitalisation case receiving treatment - 60th round (Rural)

States	Doctor's fee	Diag. test	Other services, bed	Medicine	Blood etc.	Food	Total
Andhra Pradesh	76	72	23	702	30	104	1007
Arunachal Pradesh	0	158	68	805	36	228	1295
Assam	233	280	119	1363	256	142	2393
Bihar	86	871	71	1578	130	342	3078
Chattisgarh	237	43	0	338	0	9	627
Goa	0	19	0	938	0	111	1068
Gujrat	11	179	12	1113	182	186	1683
Haryana	114	327	136	3268	14	123	3982
Himachal Pradesh	8	277	37	2166	95	97	2680
Jammu & Kashmir	36	263	40	1579	61	144	2123
Jharkhand	60	110	60	974	2	214	1420
Karnataka	116	110	20	566	6	91	909
Kerala	36	182	41	497	15	111	882
Madhya Pradesh	34	54	22	933	25	125	1193
Maharashtra	38	23	30	457	73	146	767
Manipur	137	402	6	1756	18	301	2620
Meghalaya	0	19	0	102	0	143	264
Mizoram	0	30	509	26	35		600
Nagaland	10	173	0	2832	0	13	3028
Orissa	107	151	47	1496	40	220	2061
Punjab	176	37	223	1624	45	344	2449
Rajsthan	77	697	59	3187	109	253	4382
Sikkim	2	293	2	1547	76	262	2182
Tamil Nadu	15	20	27	102	1	90	255
Tripura	17	135	61	927	32	148	1320
Uttrakhand	637	282	303	1821	25	499	3567
Uttar Pradesh	411	439	341	1730	117	166	3204
West Bengal	21	180	131	1098	91	87	1608
ALL INDIA	61	175	64	976	55	137	1468

Source: NSSO 60th round (2004)

The other issue is sufficient government expenditure to ensure availability of medicines and staff. Public expenditure on drugs has generally remained low– much less than the recommended US $ 1 per capita. Overall public expenditure on health is at 1.2% of the GDP which is well below the average of 2.8% for low and middle income countries and the global average of 5.5% of the GDP(ICRIER 2001). Of the total value of health sector in India, 18 to 22 % by different estimates is public financed and insurance coverage is minimal. What is needed is a strengthening of the public health facilities such that it achieves the Indian public health standards in terms of density of facilities, density of public health workforce and in terms of service guarantees for each facility level. This along with increase public expenditure on the health sector to 3% of the GDP and on drugs to at least 1% of the GDP along with the implementation of a rational drug policy would be mandatory to achieve the goals of universal access to essential drugs. This is also a pre-condition on being able to curb the super-profits made by the pharmaceutical industry and shape it in a more ethical and responsive direction.

THE POWER OF INDUSTRY AND THE DISTRICT HEALTH PLAN

Pharma power and health industry power in general influences district health systems in various ways.

Just look at the mushrooming pharmacies around a functional public health facility. Further as many district hospitals get revitalised and there are sharp increases in turn over we also find closely following a rapid increase in private pharmacies first, and then clinics and then finally even private nursing homes. Private industry tries to skim off the cream of the increasing health load in the public facilities by drawing the paying patients from the public sector into the private sector. Not only those who can afford it, but those who can be frightened or persuaded into paying even if they cannot afford it. Or skim of those who are dissatisfied or impatient with the care given in the public sector. Much of this is by unfair means. Doctors are persuaded to write outside prescriptions for drugs and diagnostics in the private clinic or make unnecessary referrals and surgeries due to kick backs arrangements and gifts and other inducements.

Pharma companies and their agents also take over all continuing medical education functions, including those by professional bodies in a context where government- organised consciously unbiased CMEs are rare or nonexistent.

At another level pharma agents seeking out of turn contracts and orders interfere and intervene in the governance of the health system to favour pliant officials in key positions.

Since the private sector gives them a much higher and much more irrational turnover, pharma agents are known to discredit rational prescribers and the government systems and favour and support the setting up of private clinics and hospitals.

Pharmaceutical industry also contributes to a major escalation of out of pocket expenditure both in private sector provisioning of health care and in public sector provided health care. Rising costs of drugs also skew health planning and priorities.

There is little that a district plan can do about it, except for appealing to the genuine professional instinct to promote rational drug use and patient welfare. Also to promote public awareness on rational pharmaceutical use so that pressures on doctors to mis-prescribe are also less.

Review Questions:

1. What is the proportion of expenditure on drugs as a percentage of private health expenditure and as a proportion of public health expenditure? Why this difference?
2. What are the special features of the pharmaceutical industry and the source of its enormous profitability?
3. What were the main changes between the 1978 drug price control industry and 1995 drug price control order. How effective is the NPPA at curbing drug prices?

Application Questions:

1. How can public health system ameliorate the adverse effects of the power pharmaceutical industry on costs of care and access to drugs?
2. How does the power of the pharmaceutical markets affect the governance and management of public health sector?

Project Assignment:

1. Review 10 prescriptions randomly to look at costs of drug treatment in each. Compare with what the cost would be had generic drugs (or the cheapest brands) been prescribed.
2. Review the prescriptions of 5 patients from a government facility to see what drugs were given free from the facility and which had to be bought from a private chemist. Do a brief tabular description of illness (diagnosis), drugs prescribed, purchased from outside, duration of treatment, cost of drugs to patient.

Lesson FIVE

Knowledge, Power and Privilege: Relevance to Public Health Management

In this lesson we shall discuss:

- The health professional and his sources of knowledge and privilege
- The mystification of medicine, what it means and its implications
- The health professional as facilitator and as constraint in the process of change
- The choice of technology and generation of knowledge in public health and its relationship to power

Part I

THE NATURE OF MEDICAL KNOWLEDGE AND MEDICAL PROFESSION

When medical students pass out of college, they are often made to take the Hippocratic Oath. This is the oath that promises to use medical practice only for the good of the people but it also privileges "medical knowledge".

We give below the Oath:

THE HIPPOCRATIC OATH
(ORIGINAL VERSION)

"I SWEAR by Apollo the physician, Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgement, I will keep this Oath and this stipulation.

TO RESPECT him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look up his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according the law of medicine, but to none others.

I WILL FOLLOW that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give a woman a pessary to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my Art. *I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work.* Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves.

WHATEVER, IN CONNECTION with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!"

Note that line—, *I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according the law of medicine, but to none others.* Ever wonder what it meant?

This oath's origins are at a time when the knowledge of medical practice was a privilege given to you by birth or which you could acquire by working with a master of that craft provided you agreed to retain the privileged nature of this knowledge.

This was the way it was till the late eighteenth century.

There were different categories of medical practice: many were herbalists and folk medicine practitioners for whom it was a family tradition and this survives even today. Others called apothecaries were like the compounders we used to have who made and gave medicines written out by the doctor for there was no pharmaceutical industry in those days. Another major sub-group in the West were surgeons, who also learnt their job like learning a trade-craft. Note that line above- "I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work."

Since there was no anesthesia or blood transfusions before the late nineteenth century, there was little major surgery that could be performed. The surgeons were most needed in the battle-field for treating wounds. In most civilizations across the world this category was undifferentiated from barbers. Indeed the first association of these surgeons was known as the Royal society of barber-surgeons and it was only in the mid eighteenth century that they petitioned the king and got their names changed to the royal society of surgeons!![17]

In India it is worth noting that to this day, in many places barbers belong to a caste which is also known by a local name that translated to "medicine men." The men folk of this caste practice as barbers and their women as traditional birth attendants. These were not high in caste or status but their services were essential and acknowledged. Even now in many places their services continue unchanged.[18]

[17] Porter, R. (2006), Cambridge History of Medicine: Cambridge illustrated history, Cambridge University Press.

[18] Ghosh, Amitav, In an Antique Land, Ravi Dayal Publisher and Permanent Black.

Then there were the court and university associated physicians, who were more associated with royalty and nobility. They played a role in the development of medical science. Their services were available to very few. They would come to the homes and attend on the sick- and only the rich could afford them.

MEDICAL KNOWLEDGE AS PRIVILEGE IN THE 19TH CENTURY

In the late eighteenth century and throughout the nineteenth century, feudal societies were replaced by modern industrial societies. In feudal societies power and privilege and wealth related to birth. There was the king and then the nobles and then the landowning classes. Below these were various people working in different occupations who had little chance of moving away from their family occupation or status. In India there was an additional dimension of caste.

From the fifteenth century onwards manufacturers or factory owners, merchants, traders and certain categories or artisans became wealthy, but because of feudal society were denied the status and privileges that they wanted. That led to the overthrow or feudal society and with it rule by monarchy and privilege by birth. The political feature of the industrial society that arose in its place was that status and economic wealth was based on those who could make the most wealth in the free market, and the market was a device where everyone could compete equally and that rewarded those with merit. In practice it was ownership of property and investments that decided who would succeed. The laws were often designed to protect such private property and its owners and initially even the right to vote was their monopoly. However, the right to vote gradually became a universal right and those who commanded political power did so legally, by virtue of commanding votes, on behalf of the people. A republic is a state where the people are sovereign.

When France became a republic by overthrowing its monarchy, the question that seized the constituent assembly set up by the French Revolution to draft the constitution was- what to do with the medical profession and its birth-based privileges. Initially and in its most radical phase they toyed with abolishing all medical schools declaring it free for anyone to learn under any teacher and then the public would decide by merit whose services they could access. But in the very next war, such self-declared and self-taught doctors turned out to be a disaster that as one general then declared "these doctors caused as many deaths as the enemy." The solution that the assembly decided at was to establish medical schools and let those who want to become doctors compete in an entrance examination and the most meritorious would get admitted. The assembly also proposed another cadre with a three year training- who would have "practical' skills – but not be a qualified doctor, since he would not have 'clinical' training and skills. It is curious to read about all these debates in the assembly of 1890s in France in the midst of a revolution –for all these discussions are very much live today also.

One key question that society of those times had to grapple with is that if medical knowledge was to be based on science and not on privileged information, why could not every doctor's assistant become a doctor. One could let the doctor certify that his assistant has learnt, or even hold an examination but why was there a need for merit or property based entry into medical schools?

By definition scientific knowledge is different from faith in that it is possible to communicate it to all, and to be acquired by all. How could the privileges of being in the medical profession possibly be restricted to a few, if the basis of that knowledge was science? This was a big problem because many persons were setting up practice like this, and the government was trying, rather unsuccessfully to restrict them. Even today we have persons who work as compounders under doctors and after some time they have their set ups as doctors. How could a process be defined by which only a few could become practitioners and medical knowledge could be held as a privilege of these few?

MEDICINE MYSTIFIED

Medical knowledge had to become a privileged knowledge which meant that it had to be perceived as a form of knowledge that cannot be communicated or appreciated by those who have not been through the processes of a medical school and that it would confer special privileges and powers on those who have it. In a medical school, the student is first taught anatomy and for this he was to be ready to do dissection of corpses. In the entire discussion on medical education right up to the end of the 20th century, going through "dissection of dead bodies" was seen as a very important stage in the making of a doctor. Another critical step was the 'clinicals.' This refers to the bed-side teaching of medical practice, where each case becomes an example to teach the entire area of clinical management. Clinical teaching imparted special skills some of it was technical- palpation, percussion, auscultation – by which only those who had been specially trained could feel, and hear as a doctor should. Other skills were related to disease understanding and theory. One famous line that every doctor has heard during is teaching is "the eye does not see what the mind does not know."

This clinical teaching was differentiated from the practical training of internship, which was much like the old apprenticeship of the craftsmen. Thus by undergoing the processes such as dissection and clinical training the doctor acquired skills which were at the same time empirical as well as privileged. Medical science could thus be scientific knowledge yet restricted to a few, what is often referred to as the problem of the mystification of medicine. When a doctor examines a patient he could tell him what disease he had and, therefore, what treatment to take without ever explaining how he came to that conclusion. The doctor has somehow divined the aberration in the tissue or cell or process which he gives a name. The patient has to take the information on trust or on faith. Even today if a less educated patient questions a prescription he could meet with a curt- "Are you the doctor or am I the doctor? Just follow my prescription".

This would not be so much of a problem but for the fact that a) very often the doctor cannot quite make out the cause and is treating only symptomatically and b) many common problems do not admit of any treatment and heal by themselves. However at all times most doctors feel it necessary to make it appear that they "are in control", that they always know "what is happening" and their mediation is necessary to cause the cure.

A lawyer when faced with a difficult case starts consulting books before the client – and this is taken as the sign of a serious lawyer. But if a doctor sees a case and starts opening the book before the patient he may be taken for an incompetent doctor. If a doctor tells the patient that there is no treatment for a simple case of jaundice, the patient would feel that the doctor does not know much. The doctor would feel obliged to prescribe some medicines even if irrational to maintain his image.

This is what is meant by the phrase "the mystification of medical science". Increasingly educated persons are becoming more aware of this problem of mystification and ask more questions about their disease and eventually this attitude may change. But by far and large this trend continues.

This is also what is meant by the problem of information asymmetry. If a consumer goes to buy any commodity, he knows much of his requirements and the price range at which he can get the commodity. If he makes a wrong buy the consumer could figure out what was the defect and not buy the same again. Consumers daily buy cars, they buy pens. They purchase services of electricians, or mechanics and so on and in all these cases the consumer can make a choice. However, when the consumer goes as a patient to a doctor, he does not know which is the best doctor to consult, whether he could get the same care for cheaper prices or get an equally effective prescription with cheaper and lesser number of drugs, and whether if there is no improvement it is because of the disease or the poor quality of medical advice. In all these areas it has to be trust. Given the fact that the doctor is generally more powerful than the patient, especially when the patient is sick, the chances of the patient getting the information or exploring alternatives is even less. Thus, the doctor controls expenditure, risks to be taken (for example in undertaking a procedure like angiograms or spinal taps) and physical comfort and discomfort (for example in determining how many times a child must be subjected to blood tests). Money, pain or relief from it ,well being and life itself seem to lie in the doctor's hands, giving him a god like status, often expressed in colloquial phrases addressing the doctor as 'mai baap' (mother and father) and 'bhagwan samaan'. This "information asymmetry" leads to "market failure", which in this context refers to the inability of the market forces to regulate the prices and quality of this service. To address this problem of "market failure," developed countries have tried making the payment to the doctor through an insurance company or the government, or some other third party who would look at whether the treatment was correct and payment was fair or not. However, even this solution does not work. Either the third party becomes closer to the provider or to the patient and adjusts the deal such that they both make a better

return at the cost of the other. There is no way of knowing and verifying whether indeed a given patient treatment was excessive or inadequate.

How do doctors explain this mystification to themselves? Do they see it as mystification or do they perceive it in some other way? There is no clear answer to this. Some doctors in some situations would see many patients as having only self limiting or non serious problems that they are unnecessarily getting worried about – and getting them to pay reassures and therefore, cures them. In other situations they would rationalise that faith in them is itself curative and patients must hold their faith and confidence in them and that would in itself be curative- even if they as doctors are not sure about what is happening. The point is that medicine in reality an imperfect and infant science and there is much the doctor does not know. There are many situations where the diagnosis and treatment is clear and it can be explained very well and the doctor can and does make a huge difference. And there are many other situations where the doctor does not know or is not sure and is only making an informed guess or trying the best out of a limited number of options. And yet they would have to hold the confidence of their client, for they cannot help them otherwise.

MEDICAL PROFESSIONAL MINDSETS

It is worth remembering that this perception of medical science becomes a mind-set within the medical profession, a culture in itself. The medical professional sees its central power and purpose in diagnosis in the clinic of the individual case. Medical Professionals perceive this objective as being detached from all other emotional and social influences - the focus is on identifying the lesion (disease) and its management. Often doctors are insensitive to costs of different drugs they prescribe, or the different social situations of their patients. Public health thus becomes of low importance and of low status/desirability for a true medical professional to be dabbling in even though they intellectually concede its importance. Administration is a function which cannot be avoided, since to do so would mean loss of seniority and status- but administrative work would still be perceived as secondary to the act of clinical care and not requiring much more than common sense.

To perceive professionalism only as a problem would however be wrong. Professionalism is also a culture which brings along with it value structures that could be a very positive source for change. The doctor–patient interaction does indeed have a central role in medical care and failure to enable this through appropriate health planning would be perceived with greater passion and sincerity by health professionals than any other section. Their sense of responsibility for the health of the people is another value that could be built upon. In an enabling environment professional values are a major source of motivation for public service and to provide quality care. It could be tapped to encourage continued education and skill up-gradation leading to excellence in their area of work.

Good professionals in any field are demarcated by the fact that they have a better appreciation of the limitations of their own profession. In that sense, the medical professional too must be made aware of both their strengths and weaknesses as a profession.

WHAT ARE THE IMPLICATIONS OF MEDICAL PROFESSIONAL MINDSETS FOR PUBLIC HEALTH PROGRAMMES

Certain attitudes and mind sets which are typical of professionals may act as constraints for public health programmes. It is not necessary that these act as constraints; nor is it fair to think that all professionals behave in the same way. However, these are three common problem-sets raised with some professionals and it is useful to consider strategies to counter such mind-sets.

a. Public Health and Public Health Management has a low priority:

i. Public health is taught in medical colleges as a subject but gets little priority. It is not the preferred option for post graduation. Often it is a second or third choice for those who get admission to these courses. The teachers of public health are not practitioners of public health – unlike in the clinical subjects which makes for weak role models and poor links between theory and practice. All of this leads to such a weak understanding of public health that on the job training is almost mandatory.

ii. Little interest is shown in public health tasks. Supervision and training of paramedical staff is weak. Areas like food and drug control, vector control do not receive adequate interest.

iii. Weak skills in administration. Poor recognition of administration as being an area which has its own skill requirements. However, unlike public health, because it confers powers and authority it cannot be passed up.

iv. Public health skills are weak. Little appreciation of collection and use of epidemiological inputs, and how to evaluate technology choices or design and evaluate health programmes. Tend to prefer bio-medical approaches and solutions which is the inappropriate extension of clinical knowledge into public health domains. Areas like health financing and health informatics are not appreciated and they are unable to relate technical interventions to social situations. Weak appreciation of sociological, economic, cultural and political dimensions of decision making.

b. Trend to retain Medical Knowledge as Professional Privilege and Mystify it

i. Resistance to non-medical professionals learning skills which are generally associated with medical professionals or even to general practitioners learning specialist skills. For example,

medical professionals would be reluctant to allow health workers to prescribe co-trimoxazole or any antibiotic, or nurses to be trained as nurse practitioners or even to carry a stethoscope, though they need it for taking blood pressure or the resistance to MBBS doctors being trained to provide anaesthesia in emergency situations. Part of the opposition is well founded. There should be no trivialization of the level of skills needed. But even if it is shown that the skills are well and truly acquired and this is certified, there is resistance. For example, a community health worker nurse need not know all of medicine to understand when to use an antibiotic or how to give an injection and what side effects this could have. However, even when a nurse is shown to have the competency, there could be a refusal to let her practice it, because she is a community health worker and not a doctor. This is partly due to a fear of competition, but mainly it is due to treating some skills as the "doctor's privilege".

ii. Resistance to any measure that is seen to reduce the doctor's autonomy in the doctor patient interaction is also a problem. Thus essential drug lists, standard treatment protocols, specific recommendations on drug combinations for specific diseases could all be seen as interference in the doctors choice, more so by higher levels of the profession. This resistance is maximal for prescription audit.

iii. Reluctance to provide feedback on referrals to health workers, nurses and even junior doctors. Referrals tend to be one way process even where follow up is needed by primary care physicians and health workers.

c. Internalized power relationship with patients

i. Doctors do not see themselves relate to their clients as most service providers do even in the private sector where they are charging huge fees. This could contribute to poor communication and even rude behavior, lack of sensitivity to patient concerns like the amenities in the waiting room or wards etc. The focus is only on the doctor –patient interaction with the doctor placed at a much higher pedestal. All other aspects of the interaction get underplayed.

ii. In health communication/health education there is tendency to be prescriptive. Also to believe that minimum information to patients/public is adequate. Full details and access to case records are seldom provided.

iii. There is a tendency to underplay social and cultural of behaviour and blame individuals for their illness(victim-blaming)

ADDRESSING THE CONSTRAINTS

a. Giving Public Health its due:

i. One thrust of reform needs to be towards developing a higher profile and competence for departments and schools of public health as a priority. Expose students to good role models for public health role. Try to encourage faculty of public health to also be role models in the practice of public health and to also make public health more multi-disciplinary.

ii. Allow doctors who are already within the public health sector and are interested in public health to emerge as public health professionals with specific qualifications and create a specific cadre structure for them.

iii. Sensitise all health professionals to the social dimensions of public health and develop basic public health skills as needed for their job, through in-service programmes.

b. Sensitise professionals to the following:

i. The right of persons to access skills needed to save lives and suffering should over-ride other considerations especially considerations of privilege or unfair monopoly over certain skills. All health care knowledge and skills can be taught and learnt by almost anyone. Time is a variable but the level of skills must be kept as a constant and if a well defined set of skills is imparted, tested and independently certified, than the benefits of having these skills in the field would far outweigh the risks. The definition of the doctor and specialist needs to be linked to skills possessed rather than seen as a privilege area.

ii. Need to respect autonomy and the doctor's right to over-ride the general advice on treatment protocols in specific situations where the reasons for the same are documented. Need to mobilize authority of senior members of the profession behind any clinical protocol recommendation. Need to be able to explain reasons for choice and provide evidence support as well as explain limitations of individual perceptions on clinical issues. Need carefully planned advocacy campaigns and dialogue to be able to take through measures related to professional choice and not administratively rush through measures. Need to highlight that these measures ultimately provide much needed support to the clinician, especially in an atmosphere of increasing litigations and 'consumer' action against medical professionals.

c. Need to understand that technical choices are also largely social and political choices and therefore in a democratic polity, other sections have a right and duty to be involved in these choices. The role of the professional is in assisting them making informed choices , rather than in making choices for them

which the rest have to accept on trust. Institutionalise processes and build institutions that can handle this task of technology choice and programme design on such a basis.

d. Much more focus in medical education and in in-service training on social and human aspects of illness and the doctor patient relationship. Literature is a good source of promotion of this dimension. Need to see the doctors role as the teacher(docteure= to teach)- a person who empowers his patient to decide as much as possible for themselves and become a counsellor instead of being a "baiga"- a magician curing illness by potions and magic remedies.

PROFESSIONALISATION AS A POSITIVE FORCE

Many would contend that these are not problems specific to health professionals. It is a feature of many professionals. This is true. Some of the problems like the problems of power in doctor-patient relationships may also flow from differences in economic and social background and need not be attributed to professional mindsets.

Others would argue that if this group has this set of problems – which sections of the people do not have their own prejudices and biases. Does not the general administrator have their own sharp limitations? Are they also not organized around power and privilege? In a context of mistrust these weaknesses of the medical profession could be raised only to deprive the doctor of his position and help the general administrator and others seize the positions of authority that medical professionals had hitherto held. These weaknesses therefore should not be posed as reasons to disqualify professionals from health management roles.

The depth of knowledge and motivation of the true professional is one of the most important sources of strength for health systems. Power is not only a constraining source; power is a term that is used to describe relationships and the setting of terms of interaction in relationships. The power of the professional is also a positive force that has played a major role in the development of medical science, public health knowledge and health care systems. Though it has serious negative aspects to guard against, in essence it is a positive force that can and must be built upon.

Part –II

TECHNOLOGY CHOICE AND GENERATION OF KNOWLEDGE IN PUBLIC HEALTH:

Technology choices in public health that planners and practitioners are commonly called could be categorized as those relating to choice of technical interventions, those relating to health programme designs and the third to health systems improvements. These are overlapping categories.

Examples of technical intervention choice:

- Is a vaccine safe and efficacious for introduction?
- Should chloroquine be the drug of choice for presumptive treatment of malaria or should we switch over to an artemether combination?
- Do Zinc tablets make a difference in treatment of diarrhoea?

Examples of health programme design:

- Should every child below five years be given a tablet of albendazole for de-worming every six monthly?
- Should we keep to measles immunization as part of the routine immunization or should we adopt a pulse measles strategy?
- What is the strategy chosen for addressing child mortality? Which technical interventions are included, which are excluded? What health messages are to be included in the health communication effort? How much human resource is deployed? How much financial resources are deployed? How much improvement in child survival is expected?

Examples of health systems improvements:

- Infrastructure development: What are the materials to be used and design of the facility? How doe we get the job done on time and with quality? Drafting a tender document so as to procure the services of a construction company which is able to complete the task on time and with quality and at the most competitive rates etc.
- Improving procurement and logistics of drugs and other consumables,
- In a given area, should we contract in a service provider and reimburse the costs of service provision on agreed upon rates or should government build and operate its own facility?

Health systems development includes policy development, capacity and system building for planning, for

human resource development, for financing strategies, for quality improvement, for community level processes, legal frameworks, health monitoring and information strategies and so on.

The choice of technology is officially made by the officer vested with the authority to act on behalf of the government. This choice cannot, however, be arbitrary and the officer would have to justify his or her choice. To advise the government therefore, a technical body or expert committee is constituted or commissioned to give its opinion. The composition of the expert committee becomes very important. Usually the government nominates its members, taking care to see that its composition is such that it would carry credibility with different stakeholders. After two or more meetings the committee reaches its decision. The chairperson and member secretary usually have a major say in the final outcomes.

The main problems noted with this process of decision making are:

a. Many members have conflict of interests. Most government require that such conflict of interests be declared in writing and those with a high degree of conflict not be placed on the committee. However, this is often not insisted upon.

b. No rules or guidelines dictate how the draft is prepared, or how the majority is arrived at, or on what basis each expert opines. Somewhat analogous to the doctor giving his opinion to the patient, the expert pronounces his opinion and a number of "independent" experts agreeing on a given position are taken as enough proof of the correctness of the positions.

c. Generation of evidence and knowledge itself becomes shaped by commercial and professional pressures. Thus, funds become available for funding some types of research questions and not for funding others. Research and knowledge that would create a huge market for a product or service that the private sector provides would obviously be seen as a profitable investment for industry and funds would flow for this. However, research that would alter life styles or habits or advocate options that reduce the market for products and services would not attract such investment and it may be much more difficult to get public funding. Professionals also have their own bias in selecting research questions. Choice of research methodology could also influence outcomes.

Thus the process of choice of technology in public health becomes yet another area where power and privilege shape knowledge to suit their own needs- and these choices would impede the ability of districts to be able to make and implement effective health plans.

Now in more respected international committees and in countries with high levels of public

accountability, there is a process laid down to examine and evaluate the evidence and document this process and to welcome and encourage public scrutiny of the choices proposed and made. The reasoning behind the final choices and reasons for over-riding contrary evidence should be documented and publicly known. One model institution and process for such technology choice is the National Institute of Clinical Excellence (NICE) in the United Kingdom.

National Institute for Health and Clinical Excellence (NICE): An Innovative Institution for providing National Guidelines for effective health services

By late 1990s it was realized that the National Health Services (NHS) in UK lacked quality standards, there was lack of guidance for professionals, unaffordable and new technologies and other unexplained variation. It was decided by the British government that a new National Institute for Clinical Excellence (NICE) would be established to give new coherence and prominence to information about clinical and cost-effectiveness. It was decided that membership would be drawn from the health professions, the NHS, academics, health economists and patients and there was a felt need to have access to an appropriate range of skills, including economic and managerial expertise as well as specialist input on specific issues.

NICE, established in 1999, is now an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health to the NHS. NICE guidance is developed by a number of independent advisory groups made up of health professionals, those working in the NHS, patients, their carers and the public. One essential function is the effective use of available resources in the health service by using evidence to inform healthcare policy and practice.

NICE produces guidance in three areas of health:

- Public health - guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector – Centre for Public Health Excellence;
- Health technologies - guidance on the use of new and existing medicines, treatments and procedures within the NHS and institutionalising technological selection for the NHS. Guidance is provided about when and under what circumstances drugs and other technology should be prescribed - Centre for Health Technology Evaluation and;
- Clinical practice - guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS- Centre for Clinical Practices.

NICE, inter alia, evaluates new treatments to decide whether or not these should be covered in NHS. It advices on optimal use of new medical technologies like drugs, and medical devices, surgical procedures. It also maintains a negative list of cost-ineffective drugs and devices.

NICE also sets quality standards for treating diseases. Hosting the largest clinical guidelines programme in the world, it has developed several clinical guidelines and while doing so it covers whole diseases and conditions and not just individual drugs and interventions. In addition, NICE reviews new interventional surgical procedures and tells NHS about their usefulness and safety. The decisions of NICE have comprehensive evidence back-up, including those obtained from external output. It also holds consultations and provides support for implementation. A system of regular review is also present. NICE regularly collects national data, carries out patient surveys, holds national audit and publishes its research.

Although assessing cost-effectiveness is one of the main functions of NICE, it promotes values that have positive bearing on equity and distributive justice. The innovative nature of technology and value added (therapeutic improvements) are compared to existing alternatives. New technologies are evaluated to get best value for money (clinical and cost effectiveness are compared to next best alternative). Technologies already in use are also evaluated for cost-effectiveness and safety. There is evaluation of individual high cost technology, assessment for introduction or exclusion from basic medical care package and it gives precedence to value for money but not cost containment.

NICE manages pressures from interest groups/industry, among other things, by adopting an evidence-based approach. NICE uses select universities to generate research-based information/evidence on any technology under scrutiny. The same is further discussed with stakeholders. The Standing Advisory Committee of NICE, which has around 30 members, only a couple of them are representatives of the industry (generally pharmaceutical association representatives). If such a representative happens to be directly related with any company whose product is under scrutiny, s/he is asked to be replaced by another person from the industry association.

NICE has established guidelines for the management of most clinical diseases and these have been used by many countries to determine how to allocate resources. The challenge is to adapt the NICE guidelines to the situation and medical practice in the country.

HOW DOES THE DISTRICT HEALTH TEAM CONTEND WITH THIS BOUNDARY TO HIS DECISION MAKING?

One way forward is always to seek to understand the basis on which a decision was reached. Examine the context in which evidence was generated and reviewed and re-evaluate it in the context of its implementation. Today with internet, much of the background on such decisions can be accessed. Networks of serious public health practitioners could help in such understanding.

The district programme manager has to implement the technology choice that has been made centrally irrespective of his opinions and judgement because the district is part of a public structure and there would be chaos if each district manager made his own technical choice. Even in areas of uncertainty someone has to take the call and the district practitioner needs to respect it. But for that he need not have to accept it as an article of faith. By developing a better understanding of technology choice, the programme manager could now treat the knowledge critically, understanding the contents of the black box and its rationale. This makes him or her much more open to seeing problems in implementation as and when they arise and helps him or her to handle it better locally while providing feedbacks to the structures above.

There are also many areas in health programmes and in health systems improvement where the design is not fixed rigidly. A district health planner could still find places to show the potential for skilled and informed use of evidence to make district specific plans. And in the next step should use learning from the experience of implementing district level innovations to generate new knowledge by theorising their experience. The district thus emerges not merely as a recipient of knowledge and technical assistance, but also as a source of knowledge and theory. Admittedly it would be difficult for a district to play this role for access and inter-change with centres of knowledge and resource centres would be limited but networking as a strategy could help reduce this limitation.

Review Questions:

1. How was medical knowledge privileged knowledge before the nineteenth century?
2. Medical knowledge is scientific, and science is by definition possible to communicate and acquire by everyone. Then how is modern medical knowledge mystified?
3. What are positive energies that medical professionalization brings to the public health sector?
4. What are the barriers and constraints created by professionalization and its mindset.
5. How is technology choice made in public health and what are the limitations in current mechanisms of technology choice?

Application Questions:

1. Choose one of the following as a case study:
   - Decision in RCH-II that training of dais should be excluded and focus should be on institutionalising deliveries; or
   - the decision on the Pulse Polio Campaign; or
   - the decision of inclusion of Hepatitis B in the routine immunization protocol.

In the case study you choose, discuss how power and politics could have influenced the policy and the process of decision making.

Project Assignment:

1. Take a National programme and interview key policy makers. What are the differing views on these policies? Discuss how this decision was arrived at and made part of the national programme?

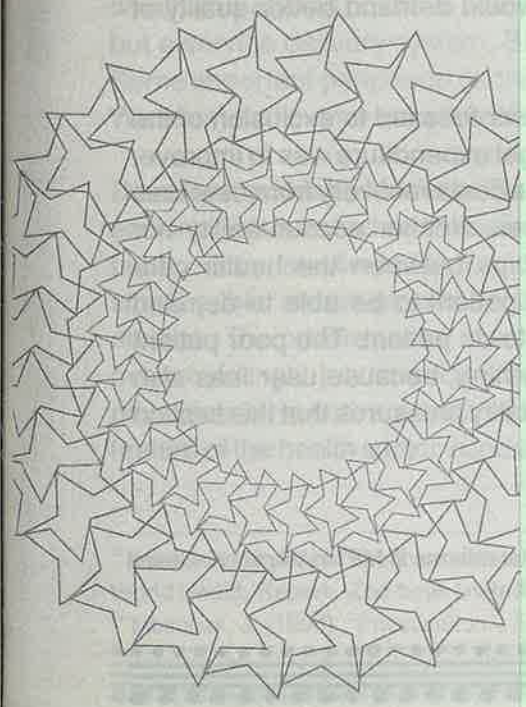
NOTES

Lesson SIX

Managing Change

In this lesson we shall discuss:

- What architectural correction means under NRHM and the relationship between health sector reform and architectural correction
- How does one work to understand the constraints to such architectural correction at the level of a district
- How a few persons charged with leading the process of change, or who are self motivated to lead change but have no formal authority, work to generate change
- How change is sustained and built on



INTRODUCTION

For at least the last 20 years, the need to change the way the public health system works has been clearly articulated in all policy statements. For most of the nineties and the first four years of the first decade of the 21st century, the term used to describe this was health sector reform. Since 2005 and the NRHM the preferred term has been the architectural correction of the public health system.

Let us quickly examine these two terms and the overlap and divergence between them.

HEALTH SECTOR REFORMS

What was meant by health sector reforms differed between different states and in different countries. However, there was a common thread between them.

The common threads were three features- a) Reforms in financing of health care b) decentralization and c) integrating competition within the public health sector.

User Fees:[19] In financing related reforms the most important measure introduced was to push for user fees, partly for cost recovery, and partly to limit and rationalize consumption of services. It was also believed that user fees would increase the perception of the value of services and make it more accountable.

A common value statement made is "people do not value the services they get free. "

Another belief was: "If people are asked to pay for the services, they would demand better quality of services. This would improve the health system."

It is now accepted that many of these aims were not achieved. In fact, user fees led to exclusion of the poor from services. Though as part of the same financing reforms the budget expenditure was to improve, this did not happen. Instead, budgets were cut back or failed to rise, and the costs recovery from user fees was too low to close the gap, leading to the collapse of many services. Neither accountability nor responsiveness of services showed any improvement. The relationships between the health care professional and the patient, any patient, are too asymmetrical for the patient to be able to demand accountability. Even in private practice and even with an educated well-to-do patient. The poor patient has even less ability to enforce accountability or responsiveness. If anything, because user fees also drove away the middle class to the private sector, that meant the accountability pressures that this section brings to provide quality care could actually have decreased.

[19]Sadanandan, R. and N. Shiv Kumar (2006)," Rogi Kalyan Samitis: Case study of hospital reforms in MP" in Vikram K. Chand (ed.) Reinventing Public Service Delivery in India: Selected Case Studies, Sage, New Delhi.

Selective Care: Another key element of health sector reform was to argue that public health systems should not try to "provide everything for everybody." That was the idiom with which the message of comprehensive universal health care of Alma Ata declaration was undermined. Instead the reforms aimed to make the public health system focus on a few priorities, and leave the rest to market forces. These few health sector priorities would be decided on the basis of cost effectiveness studies to see which interventions would have maximum benefits- these benefits being measured by a newly proposed unit of measurement called disability adjusted life years (DALYs). The list selected was very small and related only to maternal health and some aspects of infant health and a few disease control programmes. Also important was the shift to the understanding that these local priorities would be chosen, not by communities or by decentralized planning, but by health economists and other technocrats based on techniques which were inaccessible to the community or the usual medical or public health professional. Since states were facing a severe financial crisis in this period, this call to leave all the rest to the market forces was later modified to emphasize public private partnerships where such services could be purchased by the government from private providers through insurance mechanisms for the poor.

Decentralisation: In decentralization, the main objectives were to improve planning and management of services, to create a more effective and efficient management of services , to increase accountability and to encourage community participation in decision making. Many of these objectives were never achieved. Indeed so poor was the achievement on these fronts that the charge was that decentralization was only a strategy to shift the responsibility to lower levels without either providing the funds or the technical capacity or powers for them to do so.

Downsizing the Workforce: There was also, in the Indian context, a stated thrust to improve the productivity of the workforce. Also part of the overall thrust of economic reforms was to keep governments small. This should not have been applied to the health system which is not an administrative mechanism, but a service delivery system. But it was. This meant reducing the workforce and cutting down its size. Some important peripheral cadre were declared or perceived as dying cadre (such as Male Multipurpose Workers) and even vacancies of sanctioned posts were not filled in many states.[20]

Developing Health Markets: The other major reform strategy was of introducing competition into the health sector which is based on the belief that the market is a more efficient producer of goods and services. Since public sector was limited to four or five sharply limited goals, and government employment was to be kept small, public sector growth became constrained and few new hospitals or facilities were added in the nineties. The private sector in contrast grew rapidly and this was the period that the health sector became overwhelmingly private sector driven – more so than almost any nation in the world. This is known as passive privatization. In active privatization one transfers ownership of public units to private hands – not a major feature of the health sector in India.[21] In the late nineties, there was greater recognition of the increasing cost

[20] International people health movement, The Global Health Worker Crises , Global health watch 2005-2006, An Alternative World Health Report, Zed book limited 2005

[21] Muschell, J. (1996), "Privatisation – A Balancing Act" in World Health Forum, Vol. 17.

of health care and its adverse effect on poverty, leading to some rethinking. But since the dominant ideology believed that public health systems were inherently inefficient, and since they also believed in what was called "the magic of the marketplace," the direction of rethinking was mainly to try to re-invent the public sector role as a purchaser of health services on behalf of the poor from the private sector. This was what led to a thrust on public private partnerships. This too had limited success.

ARCHITECTURAL CORRECTIONS

Architectural correction is a term introduced by the National Rural Health Mission. The popular electoral mandate was interpreted to mean that economic growth and markets had left the common man behind in many areas. He or she was not a part of India shining (this was the electoral slogan of the party that lost). One area where markets had left the common man out was identified as health sector and a political decision was taken to strengthen public health delivery. Many public health experts, mainly educated in a few famous public health schools of the West in the nineties and who had imbibed the belief that innovation should be only in the direction of developing health markets, were reluctant for this change. Yet the political mandate was insistent, and it was in this context that the National Rural Health Mission was born. However all stakeholders, whether it was the pro-market public health expert, or the politician wanting a stronger public health delivery or whether it was civil society and pro-public sector experts- all were agreed that more money could not be pumped into the current public health system, without in a major way changing how it is structured and how it functions. For one, the money would not even be absorbed. And secondly even if absorbed, outcomes would not be the desired ones. There would, therefore, have to be design changes in the public health system. This was what was referred to as architectural correction. Since these changes were not in the same direction as earlier health sector reforms, this term became associated with the attempted changes under NRHM, though these too were health sector reforms.

There are many areas in common, both in language and content, between earlier health sector reforms and the current ones. For example, decentralization is a major canon of both reforms. However there were now some specific plans on how to take decentralization forward. One major step was in the use of untied funds to facilities at every level. Another was an effort to have specific district plans and resource envelopes for each district. There is also an effort to build technical and management capacity in the district level. Transfer of powers and involvement of elected bodies at the district level still remains incomplete, and without this there cannot be effective decentralisation – but still these are well defined steps forward, whereas the earlier period such steps were not present.

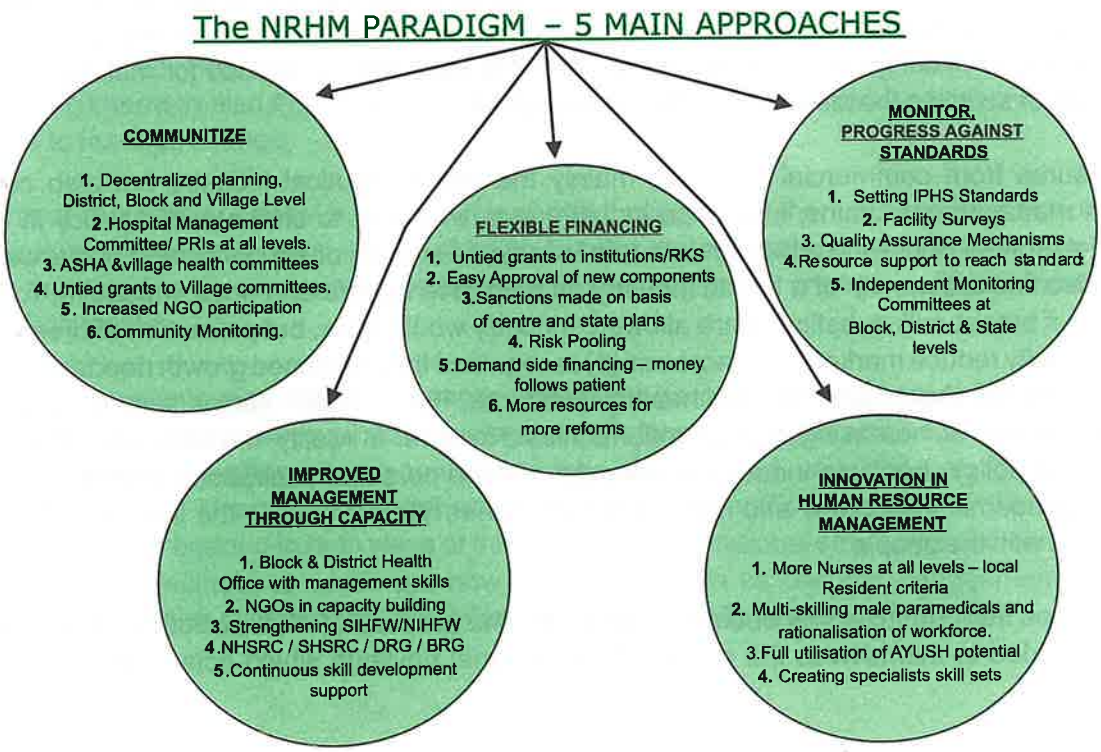
On financing with respect to user fees also there is a change of direction from earlier health sector reform. Though the official position is that the decision on user fees is a state government decision, the direction of central advice is to emphasize equity and not cost recovery and even where the user fees are in place,

keep its attention on adequate exemptions rather than on cost recovery. The Rogi Kalyan Samiti had always had both the aspects of decentralization and public participation on one hand and of user fees and cost recovery on the other. Whereas in the earlier period, the RKS came to be identified with the latter, now the effort is to make it synonymous with the former.

Pressures to increase budgetary expenditure on public health sector to 3% of the GDP are much more clearly stated and are more monitored.

The main platform of NRHM is to craft credible public health systems and to strengthen and make the functioning of public health systems effective and efficient. Though the policy of engaging with private sector provisioning with public purchase of services is welcomed, it is not generally presented as the central thrust of change or as an alternative to strengthening public health systems in the NRHM document.

The main features of change that constitute this architectural correction are given in the cabinet approved central document of the National Rural Health Mission called the Framework for Implementation, 2005 to 2012. The spirit of this is summarized in the now famous diagram given below. When we talk of managing change we are essentially talking of all that it takes to achieve these changes.



CONSTRAINTS TO ARCHITECTURAL CORRECTION

The constraints to change or architectural correction at the district level flow from

a. Mindsets and ways of thinking created over time regarding the inherent inefficiency of the public health system which flows from the dominant economic philosophies that have influenced our society in recent years. Also because the public health system needs to have a value system where service to the sick and the poor in the spirit of social service needs to be at its core. However in an overall society governed by private profit and even where the health sector itself is dominated by private practice it is difficult to create such values within the public health system alone.

b. Weakness in the institutions of management and governance, and in the leadership which have over time created a work culture, inimical to the goals of public health. Thus the instruments of the state/government have historically evolved for control and establishing conformity in the populations they govern. There is considerable resistance and active distortions within the same structures when one tries to reform it to become an instrument of empowerment of people which would hold these very institutions accountable. Even where the structure is ready to allow change, the mindset is so top-down that those below refuse to use their space. For example, we find that in many states, the manager of a facility provided with untied funds would keep asking for a statement of what specific items the untied funds should be spent for and are uncomfortable with the autonomy and responsibility of making their own decisions. And this becomes an excuse for making centralized purchases or scuttling the idea of united funds altogether.

c. Pressures from commercial interests, mainly the pharmaceutical industry but also corporate hospital management chains, insurance industry etc., which try to shape public policy in favor of industrial profits. Achieving a high growth rate in India as a driver of economic and social well being would also find the growth of a health industry as a positive feature and not as negative. To give an example, if breast-milk substitutes are allowed, industry would grow, but promotion of breastfeeding would actually reduce markets. It is increasingly recognized that sustained growth needs a productive workforce which, this in turn, needs a healthy workforce. Hence health sector is not to be seen only through the lens of increasing market opportunities. However in reality, the latter goal also persists and distorts policy- because industry is powerful and the personal aspirations and identification of many in academic institutions and managerial positions relates more to the interests of industry, rather than with the people.

d. Pressures from professional bodies which during the process of their evolution have developed and embedded in themselves the notion of professional privilege which acts to shape the health

sector in such a way that its interests are prioritized over all other interests. However the professional commitment and pride of this section in its ability to address all health problems, is also a strength that can be leveraged to improve the systems.

e. Lack of capacity within the district health systems and its support structures to make adequate use of the space and flexibility available for it to change, even where it is to its own interests and empowerment.

The first 13 books of the PHRN series has largely focused on the building capacities for decentralized health planning and management. This book however has dealt largely with discussing the constraints to change. Now this closing lesson tries to draw the broad contours of what would be the process by which a district team now empowered by the capacity building of this 18 month process, but still very much limited by the structural constraints outlined in this book above would be able to act as a driver of change, as a force to lead the architectural correction that this section so clearly needs. For the sake of communication we describe this process of securing change in the form of ten simple steps given below.

MANAGING CHANGE

Step into any book-shop and one finds it full of books for self improvement and for improved management techniques. Industries in a competitive market always need to be able to manage the changing situation due to so many developments always taking place outside them. But they know that unless they are restructuring internally also it is not possible to survive. And sometimes even the best of managers are not quite able to manage change.

This term of 'managing change' as used in this context, implies that there is need for a senior level policy and management decision to go in for a change, but the system has many constraints or resistances to change that need to be overcome. The process of securing policy change is different and outside the scope of this series.

Public health systems also have to change. Changes occur because of new technologies. Changes occur because of new disease and epidemiological transitions. Changes also occur because of changing political priorities. Very often when a new programme is introduced, very little thought is given to how to manage the change. The political will is necessary, but it is not sufficient to lead to change. Old ways of doing things are embedded in both ways of thinking and in institutional structures and one needs to learn the management techniques which are now popularly known as change management. Without this, architectural correction to craft a credible, effective, efficient public health system is just not possible.

There is no formula of how this is done. But for an ease of understanding and communication and partly with some humour, to make it interesting- we codify it as ten steps. Don't take this number ten too seriously. In some places, it is only one step, and in some places it is a hundred. It is the spirit of what is being discussed below, that is important.

Step 1: Defining the subjects of Change

First issue: Who are 'we'? What is the position of the change agent vis a vis the rest of system. It could be a community health fellow doing a two year programme in the district. Or a block medical officer who would like to take a risk and make a few changes happen. Ideally though it should be the district health team- and to the extent we can build a team capable of leading this change we have succeeded in taking the first step.

"Give me a place to stand" said Archimedes talking about levers "and I can move the world."[22]

This is true about the change we are talking about also. There must be a place to stand from which one can act on the system. It could be inside – but it can't be so far inside that it is merged with it. It has to have a more advanced and distinct awareness – in that sense a detachment – a sense of being from the outside and acting on it, without being so far outside that one has no purchase, or no point of locking onto the main system. A training plan for district health management or for facilitators for ASHA for example could be constructed so as to build such awareness. It could build individuals within the system into agents of change. Alternatively one could recruit persons willing to work for change from outside and introduce them in. It is best if one does both with good understanding between those who work for change from the outside and from within.

Example: Consider how these persons helped to bring about change. Where and how should they be positioned so that they can contribute to architectural correction?

- The Contractual District Programme Manager
- The State Facilitator of NHSRC or NE-RRC or a consultant in SHSRC.
- The development partners and their consultants.
- A civil society organization involved in public health- like a community health fellow, or NGO activist.
- A civil society member in an RKS

However- do remember- anyone can contribute to change- if only they make up their mind to do so.

[22] John Tzetzes (12th century AD), Book of Histories (Chiliades) 2, 129-130,Translated by Francis R. Walton

Also note there are many persons already doing this. Like for example UNICEF, technical support agencies of development partners, corporate social responsibility organisations etc. They have funds specifically earmarked for what is called advocacy.

Step 2: Deciding on the directions of change

Second Issue: What is the change we want? Who decides the agenda?

Since we have decided to work through the system, the agenda has to be consistent with the official stated agenda, or official policy. The process of creating new agenda or of changing the policy is a different process - a political process. It would be chaotic if each group or individual thought that their idea of change- however sincerely it has been proposed, or however backed by " expert opinion" it is, could be the aimed for unilaterally. There is the freedom to promote the concept, and the freedom to demand and work for including It in the official agenda- but till that happens it cannot be taken up for implementation. However, if we look at something like the NRHM agenda- one would find many dimensions of it which are not taken up and implemented in the spirit with which it is intended. Thus, there is a great deal of space within the official agenda to create a pro-people change. Recall the six examples we gave in the first chapter:

a. Situation of a district plan being arbitrarily altered from a high priority area to a low priority potentially vested interest area- and that too being done by the highest authority in the district.
b. A sub-critical and mechanical effort into recruiting nurses for 24*7 PHCs in a context where the nurse training system is in disarray and there are few available in the open market for recruitment.
c. The district plan excluding special health needs of the homeless, an example of a highly marginalized group.
d. Getting medical officers to change prescription practices, so as to stick to essential drugs and keep out of pocket costs of care for the poor at a low level.
e. Resistance from different sections to multi-skilled doctors starting to use such skills in emergency obstetrics.
f. Grappling with pressures to fabricate the HMIS data.

All of the above are examples of different constraints on implementing the official agenda. A process of managing change has to address these constraints if the official policy has to be realised. So this is all about taking the official agenda seriously – in the spirit in which it is meant. Not about replacing it with "our' own- whatever "our" is taken to mean. The process of shaping and even, where needed, changing the officiai agenda must proceed in parallel and indeed only when very wide sections become involved in the process would there be a better understanding of the constraints at the policy level. But changing official policy is largely to be done in forums meant for this.

Step 3 - Understanding the Objective: The stakeholder analysis

Every policy, every strategy and every objective must be understood from the lens of each major stakeholder/sectional interest group. Indeed every policy and strategy is best understood as a result of a negotiation between different stakeholder groups. Another way of saying this is that every policy and strategy can be deconstructed into being seen as the resultant vector of a number of different stakeholder's perceptions and plans pushing in different, but overlapping directions. And each stakeholder must be seen as having some level of power and as using this power to shape the discourse in a direction of their choice. Many of the concerns of each stakeholder are genuine and would affect all groups adversely but some of the concerns are only with regard to that section's interests. When we use the term vested interests, we refer to sectional interests that are illegitimate or unfair or unethical. Most sectional interests are not vested interests – but some could be. Even where it is not an unfair advantage, it could be more for retaining their power relationship or control and may come in the way of reaching the main objective. Whether it is fair or unfair, whether the concern affects all groups and the rights of the poor or whether it does not, the perception and attitude of that group is a real problem, and hence one must address it.

Step 4 - Posing the alternative

One skill that is critical is to be able to advocate and describe why the change is needed; to create a picture in the imagination of how things ought to be. A clearly articulated proposal for what the alternative should be and how it can be achieved has to be firstly created and then posed before the various sections. This picture of the alternative should address the concerns of different stakeholder groups to the extent it can. This is one of the most difficult steps. Necessarily it is a tentative solution- and there is no way of being 100% certain whether it would work. But it should be made participatory, combining whatever wisdom from experience and knowledge of theory could be mobilized. A bright idea of conviction of a single individual is seldom the solution though administrators have a tendency to believe limitlessly in their own powers to divine the answers to problems. For more ordinary mortals it takes a process of study, discussion, and repeated drafts and re-drafts, of a combination of theory and experience to arrive at a possible alternative. Creation and demonstration of model programmes or areas of excellence in some programmes is also needed to pose the alternative.

Step 5 - Defining the processes

For converting the imagined alternative into process steps there are number of tools needed. These are the guidelines, budgets, instructions, note sheets, brochures, posters, slogans etc. The imagined alternative differs from wishful thinking, in that it has to be followed through with defining the road map and

the processes to reach the alternative and expressing it in the form of the tools of management and governance needed to reach it. Thus one would need to make draft guidelines, write out model instructions, perhaps a draft file note-sheet and also bring out theses in the form of booklets, brochures, posters and slogans so that it could be disseminated. Usually only those with considerable experience in such work can do this well and those who are quite competent in theory may be incapable of doing this part of the work. However, if one demystifies these processes and recognizes these steps as part of administrative skills, it can be quickly learnt by anyone.

Step 6 - Building confidence and optimism

This could be done by tours to visit alternative sites to show similar programmes at work. Or it could be done by the written word. An oral presentation in a seminar or meeting could be inspiring if it could conjure up the picture of what it would be to have such a programme in place. One of the most important ways of building confidence and optimism is providing positive feedback. Thus highlighting a block or district or even a village where the processes are taking place as envisaged and the benefits that flow from this to others who are starting up or struggling for outcomes, builds confidence and optimism.

Step 7 - Providing an enabling environment

Peer values and peer recognition and recognition by superiors are major enablers. Creating an enabling order from superiors creates an enabling policy environment. Meetings of the peer group where a superior officers or a person with moral and intellectual authority in that group supports the change also acts as an enabler. At the village level use of cultural media and village meetings enables change. Emphasis on these changes by programme leaders – ministers, secretaries etc also creates an enabling atmosphere for larger more difficult structural changes. A tight review taken by a superior officer to follow up a process of change with rewards for those who lead the change and disincentives for those who refuse to comply could work in some circumstances- but for many changes this would either be unnecessary or insufficient.

Step 8 - Networking

It is important to increase the numbers of those who are working actively for change. As each of the above steps take place, some persons emerge who are clearly interested in this change and willing to take initiative. Networking them, and giving them also things to do for supporting or facilitating the change is one of the important steps in working for change.

Step 9 - Persisting and Negotiating

One of the most important factors that contribute to generating change, is the ability to persist. Often whichever side of the controversy outlasts the opposition wins. Just keep at it, saying what one has been saying till the idea catches up. And as one persists, one negotiates and re-negotiates. For now, since one has demonstrated the concept as working, built up confidence and built up networks, and other stakeholders reassured about some of their central concern, the pro-change side of the negotiation is much strengthened one could get a better final position than earlier. One important element of persisting for change and networking is the role of building up champions ***for change***. Champions are not just supporters. They are supporters in positions of power and influence, who's taking sides brings along significant moral support or resources or influence to promote the change. These persons could help also in protecting advances made and in gaining new ground.

Step 10 - Recognizing game changers[23]

Taking advantage of potentially significant opportunities and problems that arise: From time to time new developments take place that could dramatically alter the nature of the negotiation or even the objectives. Such a factor could be a change in governance or in management which is much more supportive, even proactive, to lead this change. (It could be a game changers in the opposite direction is the new leadership is hostile to this change.)Or the game changer could be the introduction of some new technology. Or is could be a change in the policy environment. Sometimes the change is in itself small- but it would force a change in the configuration and alignment of forces. An institution would wait and respond to a game changer- but even be able to anticipate that some very ordinary looking change in the rules or programme design could actually become major game changers and plan ahead for it.

Take the example of the following story - we need to start up a monitoring system for ASHAs in the district. This would have to define indicators, it would have to define a schedule of meetings, it would have to put in place facilitators, and it would have to develop a discipline of regularly compiling the data, analysing it and acting back on it. How does one manage this change? Let us consider an example of the community health fellow's work from a district in an EAG state (the name of the district is kept confidential for the district authorities feel that they did this themselves and would not be amused if the credit was given to this very young girl who was the community health fellow there).

a. This monitoring structure is clearly part of the ASHA guidelines issued by the MOHFW and further there is an order issued for this. The fellow first obtains copies of these guidelines, to be able to explain that the change being sought is part of official policy.

b. The stakeholder analysis shows that different sections respond to the suggestion differently. The

[23] Nandan Nilekani (2009),, Imagining India: The Idea of a Renewed Nation, Penguin Press

administrative leadership is worried that it would be very difficult to make a fair selection and then to monitor and get work out of these facilitators. It would rather make the existing staff do this work. The other workers are worried that a new cadre may be competitive with them. The local NGOs would like this work to be given to them but since there are pressures to select only the weakest amongst them the administration hesitates to choose this route. The ASHAs themselves would possibly welcome this if they got the support- but a few of them point out that if their supervisors should be paid, why could they not be paid.

c. The community health fellow prepares a note to the decision makers where she points out the following:

i. That all successful community health worker programmes have needed a on-the-job support mechanism.

ii. That this is indeed the official policy and the policy makers had good reason to provide funds for this- and therefore what-ever the problems are, we have to find ways to overcome it rather than throw the idea out.

iii. How the concerns of each stakeholder would be addressed or answered. E.g. that the process of problems of recruitment can be greatly reduced by observing a few simple rules which can be justified easily- only women, only one person from each cluster of ASHAs, and preference to educated ASHAs or else to an NGO field worker or to an SHG organizer. Also while recruitment needs to await a state level change of policy to begin by designating one health dept employee per sector as the nodal officer cum facilitator for the programme. This could continue even after recruitment is done. E.g. the ASHA supervisor has to work full time and cannot do any other job and has to work mostly outside the village. Whereas the ASHAs work has to be without compromising her livelihood- a couple of hours per day in the evenings.

iv. That Chhattisgarh, Assam and Orissa have put such a system in place and benefited greatly from it.

d. Without waiting for the approval of the monitoring plan, the community health fellow develops a guideline to be issued to programme managers and facilitators that details the schedule of meetings, the indicators to be used and the roles and responsibilities of the facilitator and nodal officers at each level. The guideline is written such that if need be it can be just signed and issued. She also develops a one page note sheet draft that the junior officer could put up on file for approving the plan. For both of these drafts she consults the state health resource center and some friends on the PHRN e-group. She also asks for editing corrections improvements on the draft from the assistant chief medical officers and the block medical officers and local NGOs etc. She gets some useful suggestions, but

more important in the process all of them come to learn the contents of the notes and some of them start implementing some of the suggestions in their authority area.

e. A trip is organized to a block where some of these suggestions are working well. Small studies of the outputs in the 7 blocks show the advantages of the monitoring system. This study report along with the monitoring report is presented in the next monthly review meeting at the district level.

f. Once the order is issued a lot of copies of this are made and along with the guidelines almost everyone who matters is given a copy of the same.

g. A number of persons, both from government and from non government organizations, who helped her plan for this change meet informally one evening and discuss what further steps are needed to implement this order as well as what new initiatives are needed to further strengthen the ASHA programmes. They remain in touch with each other and whenever the fellow or many of them write about the programme they mark copies to the others also – so that everyone in this group keeps involved.

h. It takes months of follow up before ASHA meetings are being held regularly at the sector level in every block and even more months before the quality of the meetings and the monitoring data is adequate. All this time, the group keeps at improving the quality of the process. For example only in the third month is an order issued that the facilitators or nodal officers who attend the meeting of ASHAs at the sector level monthly would themselves have a meeting once a month. In the six month it is made into a meeting every 15 days for the facilitators. Their training for this role takes place in the fourth month. Only at the eighth month is the order issued for them to also facilitate the village health and sanitation committees. Payments to them become more regular though still delayed only after 12 months are over. Each step forward needed effort, needed negotiation, needed support. But it made a different and the programme is doing much better now.

i. At the 18th month, the state government suddenly announced, on the combined persuasion of politicians and enlightened NGOs, that it was going to pay Rs 700 per ASHA- Sahiyya. This was a game changer. Suddenly the local elite who had never bothered much about this sahiyya started questioning her functioning and there were many complaints received. In many villages they did not even complain – they simply declared her non functional and changed her and of course the poor Sahiyya could not even protest. In the department the nodal officers who were so far not very functional became very actively and wanted to be in charge of making the payments – to the VHSC and through the VHSC. The district officer in charge was changed- the public health nurse tutor who was so far in charge being replaced by the district immunization officer. In the meetings the discussion regarding payments threatened to become the most important or only the only issue discussed. MPWs and ANMs started regularly ordering them around the way they were used to being ordered around. A few sahiyyas even left because of the rudeness with which officers were talking to them and

the change of the programme spirit. These problems were, however, minimal in this district compared to the others, because the network of those who were driving pro communitisation change in the district had anticipated the effects of such a fixed salary and planned such that it could be used to further strengthen the programme rather than to destroy it. What was that plan? Well in practice this has not yet been announced. We are only in the twelfth month of this case study and this paragraph was written in anticipation. The fellow requests that her plan not be revealed at this time!!

Now let us take up each of the six case studies given in the opening chapter. Each one of them represents a systemic constraint- a framework constraint that prevents us from reaching the goal. In contrast in the above example there were no such framework constraints. It was therefore, relatively easier to handle, at least till the game changer at the end.

Let us recall each of these situations and construct some imaginary alternatives for each of these situations. After all as we have discussed in this chapter, visualising the alternative is perhaps the most difficult part of the above steps.

Situation 1

A district team makes a district plan with considerable effort and sincerity and the plan is approved with modifications and resources come in for its implementation. At this point there is a change of leadership and the new leadership does not own the earlier plan. Worse the new leadership seeks changes in the plan which is arbitrary, and which largely are shifting financial resources from essential human resource development components to procurement of goods, much of which is not immediately utilizable due to lack of human resources, but whose eventual need cannot be denied. The new leadership expects the district team to implement his vision of what is needed and sees their role as providing intelligent justifications for such changes as he wants to make. The district team is divided on their response. The consensus arrived at is as follows:

a. To ensure to the extent possible that the training programme proceeds as scheduled and brings to the notice of those concerned with training at state and national level that the training schedule is being altered.

b. Also to bring pressure, to the extent possible, that procurement occurs as per rules and is transparently possible. But also recognizing that the powers of the authority to make such changes and the difficulty of proving any malpractice are great. Even if at great risk we do prove something, but since we would only get a one time correction with the arbitrary functioning continuing, we decide not to push such direct action too far, but rather to push for a systemic solution against this problem. One of the best ways is to put the district plan up on the website

and make it a public document and build in a system of public awareness around it.

This was what the Bihar state health society did, assisted by the NHSRC and by PHRN. On the Bihar state health society website we can see not only every district plan but also the final amount sanctioned to the district item-wise against this plan. Thus any change of expenditure is potentially under the public gaze, and one can with little effort make it a matter of proactive public gaze if there non transparent or vested alterations of the plan. A practice of annual social audit of the implementation of this plan would make all the difference to curb such arbitrariness.

The story of how such change was managed is interesting. The common review mission and other sources had pointed out to the problem of the district implementation not corresponding to the district plan. Also the problem was legitimized by the fact that national sanction of the state plan came later and with changes which made the district plan become outdated, even before it was implemented. Obviously a process was needed to re-align the old district plan with the final sanctions. Identifying this process as the critical next step a stipulation was introduced into the central sanction of the state plans that within 45 days the states would issue a similar integrated sanction to the districts of the funds that would be made available to each district for the coming year. This created the enabling environment within which the change team in Bihar was able to secure the rest.

Situation 2

The district plan calls for employing three nurses per PHC. However advertising the posts leads to very few qualifying nurses applying, and those applying are not willing to go beyond the district headquarters. The problem seems to be a lack of nurses available for recruitment. Policies of recruitment and compensation are also rigid. There is an ANM school in the district, but it has few trainees and that too from a centralized selection process. Many of these will not be willing to work in this district. The district has no powers or influence over policies of opening or managing nursing schools, over nurse recruitment, over nurse compensation packages, or over work force practices that could attract and retain nurses to work in rural areas. The district officer feels his task his over once he has advertised the post. The rest should be accepted as an objective limitation.

How does one address such a set of issues- without which of course it is going to be impossible to reach this most fundamental of goals – a functional 24*7 PHC.

The district group suggested the following measures in a note to the chief medical officer and the district magistrate. Firstly they would announce a walk in interview of any nurses who wanted to join. Any letter received with a filled in application would be considered as attending the interview. Then it hired a HR

agency and said that it was ready to pay it one month's nurse wages for every nurse it was able to secure for employment. The HR agency was only to identify the nurse and get a filled in application form from them and when they joined the payment would be made. The HR agency could advertise and seek the nurses out and negotiate and persuade them to join and even agree on their place of posting. Once they came to join a special welcome would be organized for the joining nurses.

But beyond this was also the plan to open a nursing school in the district using both the district hospital and the beds of a private ward. The candidates for the course, preference would be to that district and other regional districts' needs for the first five years. The same agency would find the faculty and make the payments to them till within two years a full time trained faculty became available. Some nurses were identified to be sent for training as nursing school faculty meanwhile.

Situation 3

While the district plan is being made there is one small but very vocal NGO which demands that the plan includes resources for urban homeless. And it has convinced you. There is little sympathy for this view amongst the professionals and even within the district team. The district leadership is not seized of the issue. Indeed most persons feel that these homeless are "losers" . Nothing can be done about them and is best to ignore them.

As the person writing the plan, a line on the needs of the homeless were inserted with some funds to write the plan and do a pilot with the statement that once the plan is made funds for the full plan would be asked for. Once the plan was sanctioned, advocacy was taken up in the form a task force which was assigned the task of preparing a plan for this most marginalized section. This task force not only worked on the plan but also used an extensive process of consultation that itself acted as advocacy and sensitized everyone to the issues and possibilities. In this process a number of activists and experts who had worked on these issues were invited. So were some senior administrators and intellectuals who made an impassioned plea for including this issue. By the time the plan was made and finalized a small network of interested persons had been created.

Then as described above the guidelines were drafted and issued, confidence was built up to go ahead and the process of implanting the plan was begun.

Consider on your own the next three situations: These three problems described below are being faced in almost all districts. We suggest that the trainees refer to the chapters that deal with these topics, discuss the issues in the state and district level and then draft a plan of how they would over come the constraints. In the first two cases the constraints are the mindsets of the professional institutions while the third is the

problem of HMIS being seen as a form of accountability – and of disciplining and punishing the poor performer rather than as a tool of management.

Situation 4

A considerable part of the district budget is for drugs and consumables. With drug prices rising, one is getting fewer and fewer drugs for the same percentage share of the budget. There are also pressures from the pharmaceutical agents to place higher orders on certain drugs as the commissions are better- but it is being justified on the basis of perceived needs since there is no data. Both these causes taken together means that almost 75% of patients receive a prescription to buy drugs from private pharmacies, because the essential drugs are not there in the facility. This leads to higher out of pocket costs on the poor when they visit a public hospital and it reduces access and utilization of the public hospitals by the poor. But the doctors are happy to write outside prescriptions because the sales agents encourage and plead with them to do so.

How does one respond to such a situation?

Situation 5

Two doctors return from a course in emergency obstetrics and in anesthesia for emergency obstetrics and though a bit shaky in confidence are keen to start the services in their CHC. They however find their chief medical officer, a senior peer approaching retirement, but a man known for integrity, being very hesitant to let them start off. He recalls how even in the private clinic providing these services at the district headquarters the doctors face so many complications and wonder how they would manage in their remote CHC. Whenever they have a case that could merit surgery, he arranges to transport it at once to the district hospital, and if the services are not there on that day, to the private clinic. The private clinic of course profits, but there is no nexus or kickback. It is just that the chief medical officer feels that it is a safer option for all concerned. And at the monthly review meeting all other CHC doctors endorse his view. And in the monthly Indian medical association meeting repeatedly they are asked if they feel confident. If they say no- everyone is warmly supportive. If however they say, yes, the atmosphere turns a little bit colder. Though there is no official criticism of the multi-skilling policy a lot of professional seniors come to the two young doctors, and tell them in a friendly fashion, not to be foolhardy and take this sort of professional risk.

Net result is that despite 'successful' multi-skilling programme, there is no expansion of emergency obstetric service.

How does one respond to such a situation?

Situation 6

The district RCH officer, a young woman recently taken charge had led the district planning effort. Confronted with all the situations listed above, she is reminded of her personal priority, which is to get posted back in the state capital where the rest of her family is. The lack of any significant improvement has been a source of frustration to her. Recently her district has been noticed by the national HMIS as an outlier district--one of the poor performers- poor institutional deliveries, low outpatient attendance, no emergency obstetric care, low immunization etc. This is less than last year's achievement and less than other district achievements. It takes her some time to realize that others have inflated their figures by about 10 to 20% leaving her district at the lower level, and her earlier officer had also done the same. For three months, she spiritedly tries to explain the districts problems at the monthly review meeting- but at the last meeting she is pointedly told- "no more excuses- I do not know how you do it, but your figures better improve. It has been noticed even at the national level." She needs the good will of her senior officer, for a transfer back to the headquarters and the problems below seem intractable. A small mark up of 10% to 20% it turns can be produced for each data element by a few well chosen data entry errors- for example adding ANM reports on institutional deliveries to the institution reports on the same, or adding cumulative totals for outpatient attendance. After all, her colleagues reason with her," you still will know the truth and can continue to work at improving it- why do you become a reformer trying to convince the state officials. Just give them the numbers they want."

How does one respond to such a situation?

Review Questions:

1. What are the main features of the change desired under health sector reform?
2. How do the changes sought under architectural correction differ from health sector reform? To what extent are they the same?
3. What are the changes sought in the name of architectural correction and what are the key constraints acting to limit these changes?
4. What are the key steps in managing change?
5. What is referred to as game changers?

Application Questions:

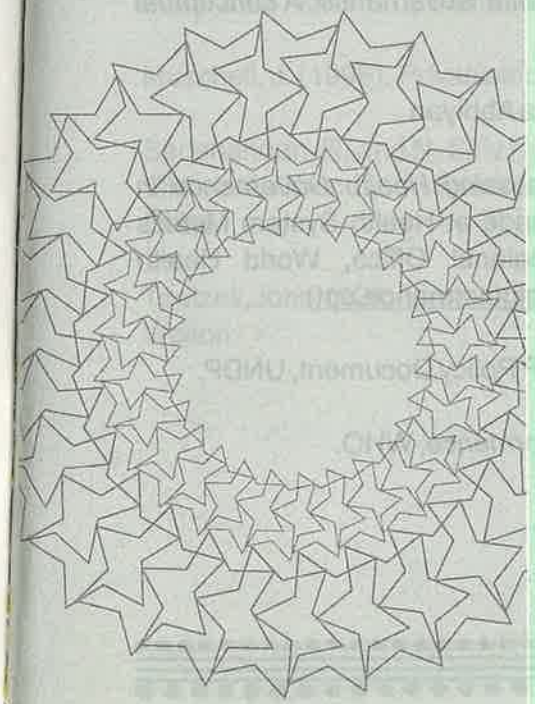
1. What are the various components of the ASHA and VHSC programme and how are they functioning today. What can be done to change them and make them functional as intended?

Project Assignment:

1. Given in the text are six situations. Three of them have not been discussed. Discuss the process of change in these situations if one is working as a district programme manager and deputy chief medical officer.
2. Describe one situation within the last three years where a major improvement was brought about due to a change in the workplace or organization of work.

Lesson SEVEN

References, Technical Resources and Further Readings



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