

## Delivery of health services in the public sector

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RE HEALTH SYSTEMS AN END IN THEMSELVES OR A MEANS TO ACHIEVING certain ends? Worldwide, there seems to be a consensus on measuring health systems in terms of improving the health status, enhancing patient satisfaction and providing financial risk protection. In 2000, the World Health Organization (WHO) further expanded the definition to include a reduction in disparities for improving health status; being mindful of the patient's need for privacy and confidentiality and providing services promptly and with courtesy as characteristics of a responsive system; and sharing the financial burden in accordance with the ability to pay as being a fair form of health financing (World Health Report, WHO, 2000). There is, however, little consensus on what constitutes an ideal health system in universally acceptable terminology to enable better intercountry comparisons. This is because, unlike any other sector, health systems are highly contextualized and influenced by various exogenous factors such as societal values, epidemiology and disease burden, availability of financial resources, technical capacity, individual preferences and the nature of demand.

Technological innovation in the health sector has improved the quality of life but has also increased costs. In countries that have no social insurance and where the role of the state is limited, people spend a substantial proportion of their incomes on seeking medical treatment, and in the process, get impoverished, thus widening disparities in the health status. To contain spiraling prices and distortions created by market failures such as moral hazard, asymmetry in information, induced demand etc., countries resort to multiple policy instruments.

Health systems have five aspects or knobs that interact with each other and influence its basic nature and direction: (i) financial (tax, user fees, out-of-pocket expenditure, insurance), (ii) payment systems (how providers are paid: salary, per service rendered, capitation), (iii) organizational (manner in which the delivery systems are organized/structured), (iv) legal (regulatory frameworks) and (v) social (access to health information, advertising) (Hsiao 2000). The effectiveness with which these instruments of state policy are designed and used determines the extent to which the health system is equitable, appropriate or fair.

The health system in India consists of a public sector, a private sector and an informal network of providers of care operating within an unregulated environment, with no controls on what services can be provided by whom, in what manner, and at what cost, and no standardized protocols to help measure the quality of care. There are wide disparities in access, further worsened by the poor functioning of the public health system.

In this chapter, we diagnose the nature of the health system in India, in the public sector, analyse the problems that constrain it from achieving the stated goals, and identify issues that require to be addressed for overhauling the system of health care for meeting future challenges.

### Part I An overview of the evolution of the health system in India

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

- Phase I (1947-83)-when the health policy was based on two principles: (i) that none should be denied care for want of ability to pay, and (ii) that it was the state's

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responsibility to provide health care to the people.

- Phase II (1983–2000)–when the first National Health Policy of 1983 articulated the need to encourage private initiative in health care service delivery, while at the same time expanding access to publicly funded comprehensive primary health care.
- Phase III (post-2000)–which is witnessing a further shift that has the potential to profoundly affect the health sector in three important ways: (i) the desire to utilize private sector resources for addressing public health goals; (ii) liberalization of the insurance sector to provide new avenues for health financing; and (iii) redefining the role of the state from being only a provider to a financier of health services as well.

### Phase I (1947–83)

At the time of Independence, malaria affected almost a quarter of India's population; virulent diseases such as smallpox, plague and cholera were rampant, maternal mortality was over 2000 per 100,000 live-births and longevity of life was less than 32 years (Bhore 1946). While the public sector consisted of a few city hospitals, the private sector consisted largely of individual practitioners of Indian systems of medicine and licentiates practicing in villages, as family doctors. With meagre resources, this period saw the effective containment of malaria, bringing down the incidence from an estimated 750 lakh to less than 20 lakh, eradication of smallpox and plague, halving of the maternal mortality rate (MMR), reduction of the infant mortality rate (IMR) from 160 per 1000 live-births to about 105, containing cholera and increasing longevity of life to almost 54 years. Institutes of excellence such as the All India Institute of Medical Sciences (AIIMS) were set up for research and quality training, making India an exporter of highly trained medical doctors. These gains were in no small measure due to the strong foundation of public health on which the health system was grounded and the highly professionalized cadre of public health specialists who provided leadership from the front, camping in villages in hostile environmental conditions, whether to eradicate smallpox or supervise the malaria worker.

However, under the overarching influence of modernization that characterized the post-colonial phase of global development, the urge to be on par with the western norms of modern medicine proved to be too strong to resist. India, unlike China, missed the opportunity to launch public health campaigns to promote, at the community and individual household levels, healthy lifestyles alongside expanding public investment to assure universal access to water, sanitation, nutrition and education. Instead, and more particularly during the 1960s and 1970s, public health campaigns were focused only on promotion of the small family norm and family planning. India also failed to utilize the strengths of the traditionally used and accepted modes of medical treatment and gave undue emphasis to allopathy, gradually laying the base for an expanded market for western style curative services, which are urban-based as well as costly.

### Phase II (1983–2000)

#### *The National Health Policy of 1983*

Despite the remarkable achievements in disease control, the failure to control the population, the lack of access to basic health facilities in rural areas, and the international commitment to focus on providing comprehensive primary care as envisioned by the Alma Ata Declaration in 1978, led to the formulation of the National Health Policy of 1983. Limited resources to meet the growing demand for health services led to the articulation for private sector to shoulder some part of the burden. An estimated Rs 6500 crore worth of subsidy in terms of exemptions in customs duty for import of equipment, subsidized inputs such as land, etc. were extended to stimulate private investment in health. Alongside, the focus of state policy shifted to primary health care to reduce the iniquitous urban-rural divide and expand access to the rural populations, particularly the poor. Lack of resources resulted in segmenting health into independent silos of disease control programmes rather than visualizing health care as a continuum of service. Such segmentation led to simplistic formulations of the role of state being confined to primary health care and a selected list of diseases and health interventions, rather than being responsible for the well-being and health of the people. This phase witnessed an expansion of health facilities for providing primary health care in rural areas and the implementation of national health programmes (NHPs) for disease control under vertically designed and centrally monitored structures.

The adoption of this twin strategy had its advantages. With less than Rs 200 per capita investment (2000), prioritization of interventions that benefit the poor and entail wide externalities, provided a moral and technical justification. Besides the establishment of health facilities in accordance with a population norm, guinea worm was eradicated and the disease load due to infectious diseases reduced and deaths averted. During the 1990s, with assistance from the World Bank, NHPs were upscaled with impressive outcomes: the cure rate of tuberculosis (TB) under the Directly Observed Treatment, Short-course (DOTS) programme doubled and averted an estimated 50 lakh deaths, leprosy was eliminated except in 70 districts, the incidence of cataract as a cause of blindness reduced from 80% to less than 50% and the number of polio cases decreased drastically from 29,709 to about 100 (Table 1).

Fiscal stress gave rise to innovation; various States attempted to improve the overall performance of public health facilities by a combination of policies–improved availability of inputs, greater flexibility in spending; defining responsibilities and rationalizing performance outputs; widening the scope for involvement of local bodies, non-governmental organizations (NGOs), etc. Table 2 gives a broad idea of the policy areas, the direction and nature of such innovation and names of the pioneer states.

The initiatives taken and the outcomes are impressive when analysed in reference to wide disparities in income and socio cultural behaviour, a fast-changing economic scenario,

**Table 1****Evaluation of World Bank-funded projects in four States under the State Health Systems Project**

Programme	Indicator before the project	Current status
TB control (cure rate)	25% (1997)	86% (2003)
Control of cataract blindness/number of surgeries	21 lakh (1995)	42 lakh (2003)
Control of Leprosy (prevalence per 10,000)	24 (1992)	2.44 (2003)
Control of HIV - per 1,000,000	3.5 (1998)	5.1 (2005)
Control of malaria in 8 project districts API	13.8 API (1999)	9.5 API (2002) In 32 out of 100 districts API fell below 2.
Reduction in Polio cases	29,709	< 100

SOURCE: Ministry of Health and Family Welfare (MOHFW)

comparatively unstable political environment in several States and a near stagnant average per capita investment in primary health care of Rs 105. Despite the reduced health spending as a result of fiscal pressures that States faced during this period, most of them took advantage of available opportunities to achieve whatever they could, underscoring the fact that a limited level of investment can only give a commensurate level of outcome.

Notwithstanding the above, five serious omissions occurred in the public health policy: (i) the private sector was encouraged without provisions for regulations, standards and accreditation processes; (ii) there was an absence of surveillance and

epidemiological surveys to get a more accurate understanding of the changing profile of disease prevalence and incidence, which is necessary for measuring risk factors, designing interventions and launching information campaigns to reduce risky behaviour; (iii) advantage was not taken of the 73rd and 74th Constitutional Amendments for decentralizing programme implementation to the local bodies/community for increasing accountability in the system; (iv) neglected of research and development to promote technological innovation; and (v) provided inadequate investment in developing the critical mass of required skills and human resources. In other words, the governments ran public health programmes that would have been more cost-effective for the communities and local bodies and in the process

neglected their more fundamental responsibility of governance-of laying down a framework, defining the rules of the game and monitoring systems to see that no player takes undue advantage in the health sector.

**Phase III (post 2000)****National Health Policy II, 2002**

By 2000, India had not achieved 13 out of the 17 goals laid down in the first National Health Policy of 1983 (see Annexure IV). Analysis of the 52nd Round National Sample Survey (NSS) on the utilization of health services showed that dur-

**Table 2****Innovation in the health sector by States 1995-2000**

Area of Innovation	Broad Direction of the innovation and innovators
Public-private partnerships	Handing over the management of public facilities to NGOs (Gujarat, Karnataka); Contracting private specialist services and outsourcing other services, such as diet, distribution of IEC materials, etc. (most States)
Decentralization	Transfer of budgets to and involvement of local bodies (Kerala, Karnataka, Himachal Pradesh, Orissa); Management Boards of Health Facilities (Rajasthan, Madhya Pradesh, Andhra Pradesh)
Human resources	Contracting professionals for service delivery-ANMs, doctors, surveillance, auditing, etc. (all States); Multiskilling, pre-internship training, Mandatory pre-post graduate rural service (Orissa)
Financing	User fees and financial autonomy to hospitals (Madhya Pradesh, Rajasthan, Andhra Pradesh, Karnataka, Punjab, West Bengal, Maharashtra); Health insurance (Andhra Pradesh, Karnataka, West Bengal); Direct transfer of funds from GOI to districts under NHPs; Financial delegation of powers to PHCs, CHCs and district CMO (Tamil Nadu, Gujarat)
Accountability	Delegation of powers to district-level officials (Gujarat, Tamil Nadu, rationalizing responsibilities for better accountability, performance-based monitoring (Andhra Pradesh, Gujarat)
Community mobilization	Link couple schemes (Gujarat, Rajasthan); Village Planning and Community Health Worker (Madhya Pradesh, Uttar Pradesh)
Regulation/standard setting	Quality control circles (Gujarat); Blood transfusion standards (NACO); ISO certification (Karnataka, Himachal Pradesh) Ensuring the availability of essential drugs at health facilities under the Panch Byadhi Chikitsa scheme (Orissa); Centralized drug procurement (Tamil Nadu, Orissa, Andhra Pradesh, Rajasthan)

IEC: information, education and communication; GOI: Government of India; NHP: National Health Policy; PHC: primary health centre; CHC: community health centre; CMD: chief medical officer; NACO: National AIDS Control Organization.  
SOURCE: Initiatives from Nine States, MOHFW, GOI 2004

ing 1986–96, there was a decrease in the utilization of public facilities for outpatient care from 26% to 19%; a decrease in access to free care from 19% to 10% and an increase in the number of persons not seeking care due to financial incapacity (Table 3) see also Annexure 1.

**Table 3**

### Utilization of primary and community health centres for outpatient care in rural areas

State	Utilization of PHC/CHC for OP care (out of total OP) (%)	Utilization of PHC/CHC for OP by the poorest 2 quintiles (out of total PHC/CHC OP) (%)	Untreated ailments out of total number of ailments (%)	Untreated ailments due to financial reasons (out of total number of ailments) (%)	Average total household expenditure for treatment per ailment (OP) (in Rs)
	1	2	3	4	5
<b>Well performing States</b>					
Kerala	5.4	49	11.7	1.5	119
Tamil Nadu	7.2	41.5	22.4	-	79
Andhra Pradesh	5.7	52.1	25.5	5.2	116
Maharashtra	6.4	47.7	11.4	2.9	144
Karnataka	11.0	55.1	22.3	2.6	91
<b>Moderate performing States</b>					
Gujarat	9.9	29.3	8		144
West Bengal	4.3	49.1	19.9	4	105
Punjab	1.8	41.2	1	0.5	173
Haryana	5.1	23.5	3	-	183
<b>Poor performing States</b>					
Rajasthan	10.2	44.1	10.2	6.2	172
Orissa	18.4	30.2	32.3	14.6	99
Madhya Pradesh	8.9	27.6	16.3	1.7	129
Uttar Pradesh	1.5	38.6	9.4	-	202
Assam and NEast	27.13	-	44	9.02	83
Bihar	2.0	19.6	21.9	5.5	220
All India	6.4	37.9	17.3	3.5	144

PHC: primary health centre; CHC: community health centre; OP: outpatient  
**NOTE:** The total OP for a reference period of 15 days is 375.3 lakh.. The total number of ailments (rural) is 408 lakh yearly. The average total expenditure for OP care is for the reference period of 15 days. Total expenditure includes medical expenditure and all expenses other than medical expense incurred by the household for availing the treatment.  
**SOURCE:** Mahal et al. 2002

State-wise comparisons show that the poorest in the poorer States of UP and Bihar had to pay substantial amounts for outpatient treatment and a low utilization of public facilities, which indicates a virtual breakdown of the public health system. On the other hand, in Assam and Orissa, a large proportion of persons did not avail of treatment at all. Read along with the number of untreated ailments due to financial reasons, the picture is dismal, as it further emphasizes the failure of the public health system in providing risk protection, since the average cost of outpatient treatment for every episode of illness is equivalent to three to five days' wage of one earning member of the family.

To reduce the disease burden affecting the poor and alarmed by the falling levels in the utilization of public facilities, the

government brought forth the National Population Policy (2000), the National Health Policy (2002), and the AYUSH Policy (2000), reiterating its resolve and commitment to achieve a set of goals by 2010. The goals envisaged are to increase public investment in health from the current level of 0.9% to

2%–3%; to increase the utilization of primary care facilities from less than 19% to over 75%; to reduce the MMR by three-quarters from the current level of over 540 per 1000; to reduce the IMR from 62 per 1000 live-births to less than 30, eradicate polio, eliminate leprosy, reduce deaths on account of TB and malaria by over 50%, etc. Many of these objectives are in consonance with the Millennium Development Goals (MDGs) for 2015. The following section highlights the systemic issues that may constrain us from achieving these goals within the given time-frame unless addressed on priority.

## Part II Organizational Structure of the Public Sector Delivery System

There has been a clear absence of any deliberate strategy to use the organizational tool for achieving public health goals, except family planning, until the Sixth Five-year Plan when, under the Minimum Needs Programme, concerted efforts were made to focus on expanding access to primary care in rural areas. Thus, built over the years, the public health delivery system consists of a large number of dispensaries, primary health care institutions, small hospitals providing some specialist services, large hospitals providing tertiary care, medical colleges, paramedical training institutions, laboratories, etc. (Table 4).

The failure to improve the health status, be accountable and responsive to people's

needs or protect them from financial risk has brought into focus the functioning of the public health system, underscoring its failure in fulfilling such legitimate expectations. The focus of this section is to understand the causal factors that have led to such a failure. These causal factors can be divided into three broad groups:

1. Poor goal setting and lack of formulation of strategic interventions;
2. Management Failures;
3. Limited role of the State.

### Goal-setting and Strategic Interventions

The public health system is inaccessible, disconnected to

Table 4

## Public health infrastructure In India, 1951-2001

		1951	1961	1971	1981	1991	1998	2000
Hospitals	Total	2,694	3,054	3,862	6,805	11,174	NA	15,888
	% Rural	39	34	32	27			22
	% Private				43	57		71.2
Hospital/dispensary beds	Total	117,000	229,634	348,655	504,538	664,135	NA	719,861
	% Rural	23	22	21	17			11.06
	% Private				28	32		38.2
Dispensaries	Total	6,600	9,406	12,180	16,745	27,431	NA	23,065
	% Rural	79	80	78	69			53
	% Private				13	60		57
PHCs		725	2,695	5,131	9,115	18,671	22,149	22,842
Subcentres				27,929	84,736	130,165	136,258	137,311
CHCs					761	1910	2,633	3,043

PHC: primary health centre; CHC: community health centre  
 SOURCE: Health Statistics/Information of India, CBHI, GOI, various years; Rural Health Bulletin, GOI 2002; National Health Policy, MOHFW, GOI, 2002

public health goals and inadequately equipped to address people's expectations. For the majority of citizens, the public health system is out of their reach due to distance, lack of money, lack of confidence in the system or the availability of a cheaper alternative. The organizational structure requires a villager to travel an average distance of 2.2 km to reach the first health post for getting a paracetamol; over 6 km for a blood test and nearly 20 km for hospital care. Given the poor road connectivity, the unreliability of finding the provider at the health centre, the indirect costs for transport and wages foregone, the marginal cost of availing a public service outweighs that of getting some treatment from the local quack. Further, even when accessed, there is no continuity of care guaranteed. In other words, the segmentation of the health system into primary, secondary and tertiary, administered and monitored by different bodies, with none working in coordination, has resulted in the dilution of the concept of the integral nature of health where curative services are a continuum of the preventive and promotive health care.

In 8 States, substantial investments were mobilized from the World Bank to upgrade, strengthen and establish hospitals at the district, sub-district and block levels. Under these projects, the comprehensive definition of the primary health infrastructure (Health for All Report of 1980) got a further distortion with the community health centres (CHCs) rechristened as first referral centres (FRUs), divorcing them from their contextual framework. In Andhra Pradesh, Karnataka, Punjab, etc. the World Bank-funded CHCs were brought under the administrative control of autonomous Directorates dealing with secondary level hospitals while those CHCs not covered under the project are continued to be administered by the Director of Health Services. An evaluation report of West Bengal, AP, Karnataka and Punjab showed that while these projects were successful in improving the quality of care in urban and semi-urban areas (Table 5), an expected outcome, such as, for example, an increase in institutional deliveries was

not realized. Had the focus been on establishing the referral system and linkages with the other World Bank-assisted disease control and Reproductive and Child Health (RCH) projects, investments made for strengthening the health systems would have had a measurable impact on reducing maternal, neonatal and infant deaths, or deaths due to malaria, TB which require hospitalization. This experience clearly demonstrates that mere increase in investments in infrastructure does not automatically translate into better public health outcomes. It also underscores the urgent need for conceptual clarity on the expectations of the organizational structures that have been established and the urgent need for standardization of facilities across the country.

Shortage of funds has been primarily responsible for the non-availability of facilities in accordance with the norms set by the government; and inadequate provisioning of critical inputs such as drugs, equipment, facilities such as operation theatre, etc.

Due to lack of budgets and the pressure to achieve targets, several States upgraded the two-roomed subcentres to PHCs. With no place for laboratory, examination, pharmacy, etc. most are non-functional. There are PHCs with over 33 subcentres and there are subcentres which cover over 200 habitations. It is estimated that 25% of people in Madhya Pradesh and Orissa, and 11% in Uttar Pradesh could not access medical care due to locational reasons (NSS-India Health Report, 2003). The question that then arises is to what extent is infrastructure an important determinant in health outcomes? Is there any association? Box 1 symbolizes the mockery we have made of the health care service delivery system by having subcentres function in non-standardized places denying dignity and privacy to women who visit the ANM for treatment and care. Annexure I gives the levels of utilization of the PHC facilities.

Annexure II links outcomes with the infrastructure to examine if there is any such association. What emerges from the

**Table 5****Evaluation of World Bank-assisted projects for State health systems**

State/year of project	Increase in the utilization of outpatient care (%)	Increase in the utilization inpatient care (%)	Increase in laboratory tests (%)	Additional beds (% increase)	Increase in bed occupancy (%)	Reduction in institutional deliveries 1999-2003
Karnataka (1996-2001)	72.2	83.3	290	29.3	10.8	From 55% to 33%
West Bengal (1996-2004)	44.6	29.3	54.4	12.9	71.6	From 77% to 74%
Punjab (1996-2003)	115.9	65	456.6	45.6	14.4	From 97% to 26%
Andhra Pradesh (1995-2002)	102.2	100		67.3		From 35% to 33%

SOURCE: Implementation Completion Report, World Bank 2004

data is that while in the poorer performing States, the ratio of facilities to 100,000 population are on par with the rest of the States, and even better than that in Andhra Pradesh and West Bengal, the health outcomes are poor. This shows that it is not the mere establishment of a physical facility but a combination of factors such as distance, availability and quality of skills, adequacy of infrastructure and access to alternative sources of care that seem to influence health-seeking behaviour and determine outcomes which have been captured by a set of indicators such as complete immunization, percentage of those severely malnourished, full antenatal coverage, safe and institutional deliveries and finally, the IMR and the under 5 mortality rate (U5MR).

While it is clear that infrastructure development had little linkage to goal setting, it is also seen that policy interventions per se often lacked focus, were not based on hard evidence, and had weak institutional capacity to translate policy into action.

**Lack of Focus, Evidence and capacity****Lack of focus: Vertical versus horizontal programmes**

The NHP 1983 made a strong policy commitment to establish a comprehensive primary health care, based on the active

**Box 1****The state of India's health delivery system**

In one district, where the NCMH took up a facility survey, officials stated that 90% of the 369 ANMs did not reside in the area of their jurisdiction—a situation referred to in Rajasthan and Gujarat as 'up-down'—and that with just Rs 75 per month as rental most subcentres were functioning in verandahs. Now the rent has increased to Rs. 250 but the 'verandahs cannot be left as dues have to be paid! Due to lack of any facility and privacy, the ANM does not provide any maternal services.

involvement of the community and inter-sectorally linked to non-health determinants such as water, sanitation, etc. Such an approach if implemented would have helped avert an additional 15 lakh infant and 800,000 maternal deaths. Gains could have been impressive. However, as can be seen from Annexure III and Annexure IV the NHP was hardly implemented. Instead, due largely to resource constraints, strategies contrary to what was stated in the policy, were adopted (such as the selective primary health care approach).

The adoption of the strategy of selective primary health care, running counter to the vision of a comprehensive primary health care laid down in the NHP of 1983 was on account of resource constraints.

Compulsions to prioritize resulted in selecting interventions based on the criteria of the extent to which the disease/condition affected the poor disproportionately more, was technically feasible to implement and could be made available at comparatively low cost, and to be implemented vertically from the centre. Evidence from community-based experiments and surveys however tell another story. They conclusively show that people have other health needs and expectations from their health system which make integrated approaches more effective, efficient and, in the long run, more sustainable. The experiments also show that vertical programmes fail to integrate with the provisioning of general health services, weaken the health system as a whole and, over a period of time, get disconnected from local health problems, priorities and the community itself.

These observations find resonance in the experience gained so far. A range of health needs such as treatment for debilitating fever that incur wage losses for the labourer, treatment for epilepsy, uterine prolapse, infertility or menstrual problems affecting women's ability to work are concerns that are ignored as public health systems narrowly focus on achieving programme targets: sterilization, immunization, collection of blood smears in case of fever, providing drugs to sputum-positive persons etc. In fact, even under a programme such as the RCH, which is expected to be gender-sensitive, due to its vertical, target-oriented nature, the number of women receiving postpartum care was very low (NFHS II). Given the large number of domiciliary deliveries, the health workers visited an average of 5.1% mothers within one week of delivery and 16.5% mothers within 2 months of delivery. In Madhya Pradesh, these figures were 1.8% and 10% and in Uttar Pradesh 2% and 7.2%, respectively. This not only explains the reason for such high neonatal mortality but also the unattended morbidity which in these two States was reported to have affected nearly 17% women, while 10%-13% suffered heavy vaginal bleeding (NFHS-2, 1998-99). Such postpartum morbidities go unmonitored, as they are not part of the programme targets to be achieved. Apart from such distortions, vertical programming with line item-wise budgeting provides little flex-

ibility for front-line workers responsible for delivering care, making integration difficult as seen in the case of HIV with Family Welfare or providing treatment for malaria or TB to pregnant women.

Another example of a narrow, programmatic approach is TB. While there is no doubt about the technical efficacy of DOTS for curing TB, there is some concern about the techno-managerial approach to a disease that is embedded in the biosocial determinants of poverty, poor housing, illiteracy, financial problems, migration, and low resilience to the initial side-effects of the drugs affecting the ability to work. UK and other countries that achieved successes in TB reduction and containment had no DOTS - indicating that addressing social determinants such as housing could have manifold dividends as witnessed in post industrial UK. The DOTS programme is a highly sophisticated one and very well designed, ensuring the availability of microscopes, trained manpower and drugs etc. but has little effort or budgetary resources for tackling the root cause of the disease, for spreading awareness about the programme, for social mobilization to see that people in need get the treatment. Inattention to the social causes or community involvement can result in dropouts or the very poor not being able to access or continue with the treatment, for example migratory labour. Besides, a legitimate concern expressed widely is the potential for increase in primary multidrug resistant (MDR) TB, which is currently estimated to be 2.8% in North Arcot near Chennai. This is largely on account of the existence of multidrug regimens being administered by doctors in the private sector and the tendency of shopping that patients resort to, on an average about 6-9 providers, before finally reaching the DOTS center. Such frequent switching of doctors by the patients is not only draining their financial base but also, with the irrational prescriptions given, could well be contributing to drug resistance. In Russia, it is reported that during 1997-99, MDR TB rose from 6% to 13% while among the chronic cases it was over 60%. Drug resistance happens due to inadequate treatment, use of sub-standard drugs, use of inappropriate preparation and non-compliance by the patient due to various reasons. MDR TB is not only far more expensive to treat but may also not be treatable. Yet, India barely has a surveillance network to closely monitor this aspect. The story of TB reiterates the need for social/community control on the process and the need for adopting a public health approach to the disease (Atre and Mistry, FRCH 2005).

#### Weak Evidence Base for Interventions

Neither the Ministry at the Centre nor at the State level has adequate in-house capability to design research studies, collate data and analyze research findings of the various health interventions to enable evidence-based policy-making. Substantial resources are being spent on programmes and interventions that have a poor evidence base. For example, there is no evidence to indicate the current burden of malaria, or maternal mortality. Similarly, hardly any studies are available to assess the efficacy of the use of a drug or of a treatment protocol in different settings and conditions for formulating

differential strategies to suit the diverse conditions prevailing in India.

Such non-availability of good quality research for evidence-based policy formulation is one instance of the health delivery system missing the woods for the trees. For example, the principal goal of the National Reproductive Health Programme is to reduce maternal mortality. Over 100,000 women die every year due to pregnancy-related reasons that necessitate skilled attendance and some surgical interventions. The international definitions of skilled attendants disqualify either the traditional birth attendants (TBAs) or the 18 months' trained ANMs. Surgical interventions on the other hand require a minimum infrastructure such as access to blood, an operation theatre, access to personnel skilled in surgery and administration of anaesthesia, etc. It follows then that, as in Malaysia and Sri Lanka, public policy should in all these years have focused on making investments on development of infrastructure and building-up a professional and skilled cadre of attendants for facilitating safe and institutional deliveries. The failure to link intervention with evidence has resulted in poor outcomes (Table 6).

**Table 6**

#### Maternal mortality per 100,000 live-births

Country	1950	1963	1980	1996
Sri Lanka	555	245	58	24
Malaysia	580	280 (1958)	78 (1976)	20 (1995)
China	1500	1000 (1960)	100	61
India	1321 (1957)	1195	580	440

SOURCES: Bhat M. India. In: Maternal mortality: An update. 2002. For other countries: World Bank, 2003

The clarity and consistency of their strategy helped Sri Lanka succeed in bringing down the MMR. The organizational strategy consisted of three concepts: (i) Village-level clinics conducted by a professional health team consisting of a medical doctor, a trained nurse, laboratory assistant, etc. to provide antenatal care (ANC) and examine other ailments, with the auxiliary nurse attending to mandatory registration of all pregnant women, other public health duties and promoting institutional deliveries, etc; (ii) Investment in establishing well-equipped maternal and child health (MCH) clinics/hospitals for delivery; and (iii) a strong health management information system (HMIS) and monitoring system including a regular medical audit of every maternal death for taking corrective action.

Compared to the above, India for several years promoted training of village-based TBAs, consistently lowered the quality of training and competencies of the ANMs and neglected supervision and monitoring. Resorting to such low-cost solutions helped avoid committing resources required for the establishment of the requisite infrastructure and human resource development. Table 7 depicts the health care strategies followed and outcomes in Malaysia, Sri Lanka and India.

The example of MMR is useful as it is a good proxy for

Table 7

## Comparison of the healthcare strategies of Malaysia, Sri Lanka and India

Intervention	Malaysia	Sri Lanka	India
<b>1950-1957</b>	1950: 534 1957: 282	1947: 1056 1950: 486	1947: 2000 1957: 1321
<ul style="list-style-type: none"> <li>Establishment of systems to train and supervise midwives, regulate midwifery practices</li> <li>Introduce accountability for results, systems for monitoring births and deaths</li> <li>Models for effective communication with women and communities</li> <li>Better obstetric techniques for those who already had access</li> <li>Introduction of modern medical advances into existing services-general health improvement including control of malaria, introduction of antibiotics</li> </ul>			Recognized the importance of maternal care; focused on socioeconomic development and access to nutrition and antenatal care
<b>1957-1970</b>	1957: 282 1970: 148	1950: 486 1963: 245	1957: 1321 1970: 900
<ul style="list-style-type: none"> <li>Improved access for rural population-the critical elements of obstetric care were made available to the bulk of the rural population through development of a widespread rural network of trained skilled midwives as its backbone, along with hands on support from supervisory staff competent in basic obstetrics and a system for prompt access to facilities that could treat obstetric complications</li> </ul>			Created the post of an ANM but merged Maternal and Child Health (MCH) and Family Planning Programme; family planning gained priority
<b>1970 onwards</b>	1976: 78 1985: 37 1991: 18	1973: 121 1981: 58 1992: 27	1970: 900 1980: 810 1990: 519 1995: 440 1998: 540(NFHS)
<ul style="list-style-type: none"> <li>Use of strategies to increase the utilization of existing services through better management, a focus on quality and systemic responsiveness to public needs and expectations</li> </ul>			1983 NHP recognized high MMR and IMR but reiterated the need to train TBAs as the main strategy; In 1985, the technology Mission for UIP was launched. In 1990, the policy shifted to comprehensive CSSM programme Child Survival and Safe Motherhood with focus on providing EmOC in 1720 FRUs. However, only 600 were set up but not one had the full complement of inputs. Besides, the focus on FRU was misplaced as evidence showed that 85% of maternal complication could be handled at CHC/PHC with training in obstetrics and midwifery; and providing 6 days' training in skill improvement for expanding access to skilled attendance. In 1997, RCH-I designed with about 30 interventions, adding RTI treatment, RCH camps, contractual appointees, etc. without consolidating initiatives of the earlier project.

**ABM:** auxiliary nurse-midwife; **NFHS:** National Family Health Survey; **NHP:** National Health Policy; **MMR:** maternal mortality ratio; **IMR:** infant mortality rate; **TBA:** traditional birth attendant; **UIP:** Universal Immunization Programme; **CSSM:** Child Survival and Safe Motherhood; **EmOC:** emergency obstetric care; **FRU:** first referral unit; **CHC:** community health centre; **PHC:** primary health centre; **RCH:** Reproductive and Child Health; **RTI:** respiratory tract infection.  
**SOURCE:** World Bank, 2003

demonstrating the effectiveness of the health system. A similar mismatch between goal and strategic intervention is evident in the case of reducing the IMR. While 40% of deaths take place within one week of birth, and nearly 23% on account of upper respiratory tract infections and diarrhoeal diseases, strategies required to address these causal factors have been overshadowed by the immunization programmes, particularly the one for polio. The single-point pursuit of polio eradication has resulted in adversely affecting the routine immunization programme, which was initiated in 1986 as a Technology Mission for achieving full protection against all vaccine-preventable diseases by 2000. As per a household survey conducted in 1998 and again in 2003 (Indian Institute of Population Sciences 2004), the data for 220 districts showed that in the majority of the districts, there was either a declining performance or no improvement at all under the Universal Immunization Programme (UIP). Second, the high percentages of drop-outs for oral poliomyelitis virus (OPV3) indicated the wrong perception among mothers of the need to adhering to the immunization protocol (Table 8).

Discussions with field staff seemed to suggest that this decline was largely on account of the emphasis given to polio, which not only commanded better resources and visibility in the media but also consumed nearly one-third of the time, 30 times the cost and exhausted the staff

In 2003, the Government of India (GOI) had to dispatch half the departmental officers to oversee the Pulse Polio Initiative (PPI) Round due to resistance from the local staff which had got tired of participating in one campaign after another—4 rounds of PPI with each round requiring one whole month of preparation, two family health awareness programmes camps of the National AIDS Control Organisation (NACO), health melas of the GOI, leprosy household rounds for identification of left-out cases, registration of patients with guinea worm infection, RCH camps, family planning targets, and so on. Such isolated programmatic approaches have made it impossible to allow the health system to develop. Therefore, even as we get set to achieving zero polio prevalence in India, the question remains as to whether vertically driven strategies implemented in a campaign mode, which are also resource intensive and neglect equally important public health

functions, are worthwhile.

### ***Inadequate Capacity to Plan and Implement at the Centre, State and District levels***

Failure to develop a public health cadre and widening the eligibility criteria to include clinicians, without making public health training a mandatory requirement for working in posts that need public health skills, have adversely affected the implementation of public health programmes. Non-reservation of posts or the absence of a dedicated public health cadre have also reduced the employability of persons trained in public health resulting in an accumulated shortage of the critical mass of epidemiologists, biostatisticians and other personnel. With radiographers, orthopaedicians, surgeons working as additional chief medical officers in charge of the RCH programme or programmes for malaria or TB, or IAS officers as project officers of HIV/AIDS, etc., the lack of technical capacity in providing the required level and quality of leadership at the State/district-level has been a serious handicap.

Mavlankar (Mavlankar 1999), persuasively argues that one reason for the successful implementation of the maternal health strategies by Sri Lanka and Malaysia is the availability of technical capacity to design and monitor at all levels, from the village to the Central Government. While Sri Lanka with its small population of 180 lakh has a Family Health Bureau (basically dedicated to maternal care) and 3 technical officers and consultants exclusively for maternal health (MH) at the Central level, India with a billion population has one Director-level officer for MH in the Ministry of Health at the Centre. Besides the gross inadequacy of the number, technical posts in the Central Government are manned by personnel drawn from the Central Health Service with no fixed tenure nor any pre-qualifications. For example, a Director of MH should have knowledge of public health, obstetrics and midwifery and related fields. While so, unlike Thailand, the personnel of the Central Health Service have a distinct handicap of not only not having these technical qualifications but also no experience of working in a PHC or a CHC, made worse with no field training upon recruitment as is the case with IAS officers.

Lack of technical expertise and non-availability of the critical mass or a minimal number at the Central and State levels are reasons for public health programmes lacking in focused designing, development of national treatment protocols and standards, the non-integration with other related sectors/programme such as TB with HIV, HIV with MH, MH with malaria, health with nutrition or water, etc.; or absence of technical leadership in States and districts on the operationalization of interventions based on technical norms; or assessing and building up of technical skills and human resources required by the programme. Most importantly, this absence of adequate technical skills have also been responsible for the near absence of operational research for obtaining the evidence base for designing better targeted programmes in keeping with the wide social and geographical disparities that characterize India. Instead, at the Central and State levels, almost

**Table 8**

### **Comparison of performance under the routine Universal Immunization Programme in 220 districts between 1998 and 2003 (%)**

Vaccine	Positive decline	Stagnant	Improved
BCG	13.2	72.3	14.5
DTP3	40.4	53.8	5.8
OPV3	54.1	43.6	2.3
Measles	30.0	57.7	12.3
Full immunization	48.2	43.2	8.6

BCG: bacille Calmette-Guérin; DTP: diphtheria, tetanus, pertussis; OPV: oral poliomyelitis vaccine  
SOURCE: IIPS, GOI

40% of the time of these ill-equipped officers in charge of complex programmes is spent in attending to administrative duties.

The situation in the States is no better. A survey conducted in 6 States to assess the technical capacity of these States for maternal health (MH) programmes, (or for that matter malaria) showed that except one Deputy Director-level officer in Kerala, in none of the other 5-States of Tamil Nadu, Maharashtra, Rajasthan, Gujarat and Chhattisgarh was there even one officer exclusively earmarked for monitoring the maternal health programme (Mavlanar 1999). The situation in the districts is worse. The void in the unavailability of such capacity for surveillance and monitoring at district levels has temporarily been addressed under the TB control and Polio Pulse programmes by taking persons on a contract basis—many from the government itself, thus further weakening the already fragile technical capacity required for implementing the large number of government programmes. In addition is also the question of the State Governments ability to sustain these programme-based consultants after withdrawal of external support.

The collection and review of data is hardly given any importance, leave alone analysing it for future planning. Monitoring is essentially confined to the bare minimum of NHP targets and now, polio pulse immunization targets. In the absence of any system of surveillance or epidemiological data gathering, planning interventions lack an evidence base and also make it impossible for the system to be responsive to felt needs.

A study conducted in Zenana Hospital in Udaipur, Rajasthan found that during 1983-93 nothing had changed despite the improved road network and awareness levels (Pendse 1993). Table 9 compares the cause of deaths over the decade. The report further observes the failure of the system to provide ambulance services, which resulted in incurring expenditures on transport ranging between Rs 150 and 300, borrowed from moneylenders 'leaving the people poorer both materially and emotionally when despite their desperate efforts the woman's life could not be saved'. The study also showed that during this period while there was a drop in eclampsia, there was a 6-fold increase of deaths on account of malaria-induced anaemia and abortions induced by unqualified prac-

**Table 9**

**Comparison of causes of death in Zenana Hospital, Udaipur, 1983-93**

Indicator	1983-84 (in %)	1994-95 (in %)
Number of deaths	7	12
Poor	55	68
SC/ST	45	77
ANC	28	50 only change was increase in tetanus toxoid (TT)
Ambulance	8	6

SC: scheduled caste; ST: scheduled tribe; ANC: antenatal care  
 .Source: Dr. Pendse, HOD Gynaecology Department, Zenana Hospital, Udaipur

tioners. 'Abortion and emergency obstetric services remain almost unavailable to the vast majority of the rural women.'

**Inconsistent procedures**

Rules and procedures do not synchronize with objectives of a programme or foster any accountability among the functionaries. For example, unsafe abortion is said to cause at least 8% of all maternal deaths. Yet field surveys showed that untrained and unqualified providers in the informal sector routinely conduct illegal abortions. This flourishing clandestine business is because of government procedures that take over 15 months for getting a centre certified the the conflicting provisions such as the requirements for a person trained in medical termination of pregnancy to be working at the centre, but then having no facilities to train such private providers, etc. It is for such reasons that a large State like Rajasthan has only 338 certified private facilities with 78% of them in 9 districts, 5 districts having no private facility and 6 having one (Iyengar 2002). With no effective intervention to ensure government facilities having all the required skills, equipment and drugs, the number of deaths due to unsafe abortions remains high.

**Management failures**

Management failure due to a combination of reasons such as low budgets, untimely and irregular supplies, corrupt practices and poor governance has adversely affected the functioning of the health system. The dispersed and disaggregated nature of responsibilities, and conflicting job profiles make accountability a difficult proposition. While the Secretary of the Department of Health has no control on when and how much money will be made available to implement programmes, the medical officer (MO) in the peripheral centre has no administrative powers over the front-line workers and other functionaries working under him. With most supplies such as vaccines and drugs being provided by the Centre for the NHPs, the States have little control to ensure outcomes, as in several instances procurement delays by the Centre can take as long as over one financial year, affecting the credibility of the system. All these factors have serious implications for the quality of management and efficiency. We now discuss the most frequently cited and widely accepted reasons for management failure.

**Performance-based monitoring**

There is absence of accountability in the system. To this end, Andhra Pradesh introduced performance-based monitoring in 1998-99. Primary health facilities, where the maximum absenteeism among doctors and health workers were observed, were graded into four categories, and based on programme targets/achievement indicators, scores/grades were given. This was then the basis for review at the highest level. It enabled identification of the problems and corrective action to be taken.

Under various programmes and in some States, such performance-based monitoring is done but is neither timely nor systematic, except under the donor-funded programmes of blindness, TB Control Programmes and the Pulse Polio Initiative. It is however pertinent to note that an estimated 1500 consultants were appointed by WHO at the field level to monitor the TB and polio control programmes. In addition, common to these three programmes is the extensive computerization of monitoring and review systems that provided access to information at the district level. Such systems need to be adopted by other programmes and also for other aspects of implementation.

### ***Absenteeism from place of work***

A majority of doctors opt for specialization and/or urban practice. The reluctance to serve in rural areas has become a major impediment in the government's ability to provide health services to the rural population. Not surprisingly, absenteeism among doctors and front-line workers from their place of work is high. A study conducted by the World Bank (2004) and other studies (Mohan et al. 2003; Rao 2003) show absenteeism ranging from 40%–45% among doctors working in primary health centres. The World Bank Study based on a simple regression analysis showed the relationship between income and absenteeism, which suggested that higher income States have lower rate of absenteeism with point value at 0.001, meaning that every increase of Rs 1000 State per capita income is associated with a reduction in absence of 1% point, with p values on the co-efficient on income at 0.13. However, this is a crude analysis as, at another level, absenteeism is high in these rich States where doctors are also engaged in private practice. Punjab has the lowest utilization of public facilities only because of large-scale absenteeism of doctors.

### ***Quality of service delivery – An imbalanced mix of inputs***

Vehicles without POL budgets, beds without washing allowances, X-ray machines lying idle for the want of consumables or maintenance budgets, empty shelves in pharmacy counters, etc. also contribute to management failure. In addition, quality is also perceived to be low due to the often

unfriendly, rude, corrupt behaviour of the personnel working in these facilities, distance, inconvenient timings and lack of reliability in the availability or the skill of the provider, etc. reflecting management failure. The subcentres are never open as the single ANM is required to undertake village visits, attend to fixed day immunization schedules, domiciliary deliveries, disseminate health information, oversee the work of the TBA, coordinate with the anganwadi worker (AWW), conduct household survey, attend review meetings in PHCs maintain records, etc. With better rearrangement of these factors utilisation can be drastically improved.

### ***Lack of policies for human resource development***

The recruitment policy is a contributory factor for the lack of motivation among doctors to provide services in rural areas. Quite often, postgraduate students are recruited by the governments and placed at PHCs where the skills acquired by them during postgraduation are of little relevance. This is made worse by the lack of equipment, drugs and adequate caseload. Similarly, there is almost always a mismatch of skills—a gynaecologist is posted at a CHC where there is no anaesthetist resulting in the underutilization of skills. Likewise, transfers are often arbitrary and without adherence to any norms, resulting in the low morale of doctors. Even the States that do have a transfer policy rarely adhere to it. Recently, there was an instance in a State where at a CHC all the 7 doctors were transferred out in one go, leaving behind a hapless lot of patients. Often, the skills needed or acquired in a training programme are not taken into consideration. Therefore, under the NHP, money may be spent in training a doctor in anaesthesia, intraocular lens (IOL) implantation surgery, or a manual vacuum aspiration (MVA), but fail to impact on the programme as, more often than not, on return from training, he or she is posted to a place where the acquired skills are not required or the required equipment is not available. The absence of transparent transfer policies, norms for deployment of personnel, and reward for merit, are some of the factors contributing to the deviant behaviour among providers.

### ***Limited promotional avenues***

In many States (such as Orissa, Bihar, Uttar Pradesh, Rajasthan) an MO often gets the first promotion after 15–20 years of service. There are many doctors who continue to remain MOs without promotion while their counterparts in civil services might have been promoted from the post of an SDM to Special Secretary or even Secretary and from Accounts Officer to Financial Advisor. Career stagnation affects morale. In Madhya Pradesh, the Departmental Promotion Committee (DPC) meeting has not been conducted in the past 20 years. In Chhattisgarh, all chief medical officers have been posted on an ad hoc basis.

### ***Poor payment systems and dual practice***

To compensate for the relatively low salaries, doctors are

#### **Box 3**

#### **Management issues in the rural health Care**

- Doctors do not stay at PHCs and absenteeism among PHC staff is high.
- Training during MBBS is not geared to impart skills for providing service in rural areas.
- Doctors need to be provided financial and non-financial incentives for staying in rural areas.
- There is a need for increasing paramedicalization of primary health care services.

permitted private practice outside office hours or are given a non-practising allowance, often 25% of the basic pay. Lack of monitoring, effective supervision and, at times, collusive relationships are causes for the abuse of this facility affecting patient care in public facilities. Due to financial constraints, most States have now stopped recruiting MOs in the regular pay scales and instead are now offering contractual services for as small a remuneration as Rs 8000 per month, a strategy which has a high turnover with doctors joining services only for getting rural service experience for admission to Post-graduate Entrance Examination, or as a makeshift service for preparing for the PG entrance exams, or joining service and just lingering on to it in the hope that some day their services might get regularized. Time has come to review such arrangements keeping a long-term perspective in view. Doctors, particularly, specialists need to be paid better and there is a need to sanction posts of specialists and public health managers in hospitals at district and State levels. Low cost solutions or decisions based on present day contingencies cannot sustain the system which will develop fissures, and cost more to repair.

### **Poor Facilities at work**

The most demotivating factor is the lack of appropriate facilities and required inputs to enable a qualified doctor to do his best for his patient and derive job satisfaction. In addition, lack of decent housing facilities and educational facilities for their children are further contributory factors to the reluctance to work in rural and underserved areas. The working conditions of nurses / midwives is worse, ranging from the lack of basic amenities such as toilets to physical safety. Inadequate and unreliable supply of inputs, absence of supervision and technical guidance, limited opportunities for career advancement, absence of accommodation with over 60% of the subcentres functioning in rented places hired for about Rs 100-300 per month, and often doubling up as a part of her residential accommodation are other factors that contribute to sub-optimal outcomes. Initially, subcentres were envisaged to consist of a multipurpose worker (male) (MPW-M) and one multipurpose worker (female) (MPW-F). However, 60% of the posts of MPW-M are lying vacant, thereby increasing the workload of the ANM and affecting the ANM's quality of services. In the community setting, female health functionaries face many problems with regard to transportation, accommodation, gender-based harassment and lack of security, in addition to lack of incentives, stagnation of career due to inadequate development opportunities and inadequate provision for living with the family and education of their children.

### **Corruption**

This then brings us to the key issue of corruption. As per Transparency International India, health has the maximum public interaction and is the second most corrupt sector. The Karnataka Lok Ayukta has estimated that at least 25% of the

### **Box 4**

#### **The ANM – first interface with the community**

The ANM still continues to be the only worker for delivery of primary health care in rural areas in the public sector. She is presently working in isolation without a team and with no support or supervision from either the lady health visitor (LHV) or the Medical Officer. She is overloaded with too many functions and activities to be delivered at too many places to too many groups of clientele. She is required to deliver health services, travel, educate communities, counsel clients and mobilize communities. She has to fill in several registers and submit several reports. The mean number of years of gap between her obtaining qualification and joining service is 4.2 years. Few subcentres operate from government-owned buildings which are poorly maintained and many are in rented buildings. The subcentre is a small area and cannot accommodate an examination or labour table, and the supplies are inadequate, irregular and erratic. About 40%-62% ANMs do not live at headquarters, the most common reason for their non-availability being security concerns. In about half the cases, the subcentre, are located far from the village.

Source: Rangarao, 2003, Mohan et al. 2003

budget is siphoned off through corrupt practices. An analysis of the Lok Ayukta shows that all categories of government health functionaries-ayahs and ward boys to nurse, doctors and specialists-are involved. Corruption is in many areas ranging from indulging in unauthorized private practice to issuing medical certificates, transfers, postings, recruitment, in 'tolerating' absenteeism, etc. The most sensitive areas are in the procurement of drugs and licensing of blood banks, where unlicensed manufacturers have been recipients of orders and action on spurious drug suppliers tardy.

The pervasive spread of corruption is not limited to the public sector. The private sector is also working under low thresholds of integrity. Patients are exploited by being made to undergo unnecessary tests only for making money. Providers in private practice are seen to own pharmacies and diagnostic centres. They get 'cuts' and commissions for referrals and such fee splitting is the mainstay of many doctors' monthly earnings. There are adequate studies that have shown the disproportionately large number of caesarean sections-66% of all deliveries in private hospitals in Kerala (Kutty 1995). The rate of hysterectomies being performed among young women is one example of the absence of ethical standards that need to be effectively countered by fostering transparency, widening participation, strictly enforcing inspections and, above all providing leadership, in technical, administrative and political organizations in reiterating and reasserting value systems.

Enforcing good management and governance is then absolutely essential since the implication of bad practices in the health sector hurts persons who are poor and suffer the double tragedy of being sick. No market can function or sustain itself unless there is a minimal level of integrity, fair play and rule of law. Therefore, if insurance and contracting the

private sector are to be the new ways of expanding access and financing health, then it is essential that values of probity, nurturing of informed consumers and wider participation through good governance be ensured. Consumer forums, patient management committees, village health committees, patients /citizens' charter, Transparency Act, right to information, imparting of value systems and training in management practices, e-governance, redressal systems, etc. are some of the instruments that need to be employed by the government for counter-checking malpractice.

### ***Lack of Discipline and Work Ethic***

In India, government employees often explain the omissions or commissions on 'lack of political will'. It is however, a fact that more often than not, there is large-scale abdication of responsibility at the field levels, say for example when a head of the department or a CMO does not undertake field visits, conduct review meetings, monitor the implementation of various activities, attend office on time and check attendance registers, listen to grievances, fill vacancies, promote people, punish the wrong, reward the good, then there is abdication of duty. When the CMO 'allows' doctors and other functionaries to absent themselves from duty, then it is collusion. No amount of funding or administrative reforms can help till there is an overall institutional discipline enforced at all levels and pride for good work instilled. Creating such an environment again carries the implication of having systems and tools that facilitate its emergence.

### ***Use of IT for Better Decision-Making***

Effective leadership rests on access to organized information which is increasingly becoming possible due to e-governance. Information about health inputs and outcomes, achievement of targets and goals are necessary for formulating policies and monitoring activities, be they related to technology, human resources or infrastructure. Since quality monitoring based on performance indicators on a concurrent basis is fundamental to curbing errant behaviour, the need for the use of IT cannot be overstated. IT should be used for record maintenance, monitoring supply and inventory control, tracking events and disseminating information to consumers. This would place a great amount of power in the hands of the government to guide, monitor and correct. Such data analysis also reduces subjectivism in transfer policies and personnel development, and ensures transparency in all transactions, the only check to abuse of discretionary power. Besides, even for patient care through the use of telemedicine, or establishing call centres for giving instant advice on coping with a small emergency or advising which hospital to check into etc. technology has the solution. Such a system development will become even more important with the government shifting its role as a financier of services rather than a provider; as a regulator of providers; and as the final protector of patient and consumer rights to medical practices that are safe and appropriate.

### ***Urgent need for infusion of new skills***

What emerges from the recounting of the several areas of management failure particularly at the point of service is the need to institute a class I All India cadre of Public Health Managers—directly recruited and trained in public health and posted at district levels, like the IAS officers. Over a period of time these young recruits will become the backbone for providing leadership in the public health area. Such persons need not necessarily be doctors—they could be from a wide variety of related disciplines such as a PG in microbiology etc but possess a Masters in Public Health. In such a system, those keen to specialize can gradually be veered to work in the hospitals and be provided career opportunities to work in teaching hospitals and super specialize etc. Such options for human resource management will be critical for steering the country from out of the veritable mess we are in presently.

### ***Dysfunctional structure—the role of the State***

Though health is a State subject, the Central Government has certain powers and responsibilities related to the control of infectious diseases, family planning, education, drugs and research. Therefore, the departments dealing with health and family welfare, at the Central and State levels are large in terms of the human resources employed and the wide span of work covered. At both levels, there are several directorates headed by doctors and technical units dealing with the myriad issues in the health sector. For discharging their multiple functions of provider, regulator, facilitator, educator and promoter, the departments employ a large number of technical people—doctors, nurses, paramedical staff, etc. for running hospitals, dispensaries, health centres, medical colleges, nursing schools, and public health laboratories, for inspecting the quality of food and pharmaceutical products, for providing information on public health issues, production of vaccines, etc.

Structurally, the administrative units do not take into their purview the functioning of the private sector, which is seen as an independent, autonomous entity. This disassociation is in part due to the fact that various ministries administer matters that directly effect health outcomes and have no mechanism to ensure coordination among them. For example, in the Central Government, the pharmaceutical industry is under the Ministry of Chemicals, policies related to import or export of drugs and technology are the responsibility of the Ministry of Commerce, drug regulation is under the Ministry of Health, programmes related to nutrition are part of the Department of Women & Child Welfare, while water and sanitation is looked after by the Ministry of Rural Development, research in medical diagnostics or vaccines by the Department of Biotechnology, health insurance by the Ministry of Finance, etc. Such intense fragmentation across departments and States is the single most important factor that confines the Ministry of Health to narrowly focus on the implementation of budgeted programmes and activities.

The second structural mismatch is the fragmentation of

the Ministry itself: into the Departments of Health, Family Welfare and AYUSH. Such fragmentation that took place in the 1990s had negative downstream effects down to the implementation level, making interprogramme integration problematic, diluting the technical capacity to think holistically and duplicating resource use. For example, the Reproductive and Child Health (RCH) programme rarely addresses HIV/AIDS, malaria or tuberculosis (TB). Likewise, the programme for malaria control has no indicator focusing on pregnant women; or nutritional deficiencies in the child health programmes.

In addition to the inadequate technical oversight, the departments also function more like 'casualty wards' where managing themselves rather than the system has taken centre stage (India Health Report 2003). The Department of Health, for example, spends over three-quarters of the time addressing VIP claims under the Central Government Health Scheme (CGHS); sanctioning medical colleges; procuring medical drugs and supplies, and transferring doctors and court cases. Lastly, the problem of governance, whether at the Centre or States, has also been compounded with the frequent transfers of ministers and officers. During 1998-2003, there were five ministers in the Central Government and as many Secretaries.

### Restructuring of the Administrative Departments

The issues raised above have been felt for a long time. The Ministry of Health itself commissioned studies to restructure its organization to suit the emerging challenges. The three reports: Administrative College of India (1986); the Bajaj Committee (1996) and the Center for Policy Research (2000) made some important recommendations which are waiting to be implemented:

- Constitute Hospital Committees and delegate administration to them;
- Outsource and decentralize promotional and publicity functions;
- Convert the CGHS to an autonomous board;
- Constitute an Advisory Body to advise the ministry on policy issues;
- Decentralize planning and programme formulation to States, confining the Centre to monitoring adherence to national policy goals and providing technical support;
- Outsource procurement to an independent body;
- Establish a Federal Drug Authority and a Commission for medical education;
- Transfer all Delhi-based hospitals to the Delhi Government and make the Central hospitals autonomous;
- Merge all the three departments;
- Create a Indian Medical Service such as the Indian Administrative Service (IAS);
- Establish an institutional mechanism for interdepartmental coordination;
- Establish a manpower planning cell in the ministry.

Implementation of the above recommendations would 'free' the Ministry of Health at the Central and State levels to address

the more important issues of governing the health system as a whole. In other words, the Ministry of Health is not only expected to be concerned with the implementation of its programmes but the functioning of the health system comprising both the public and private sector, by diligent oversight safeguarding the interests of the public in general and patients in particular. Such a change in understanding of the functional responsibilities would not only require space in terms of time but also capabilities and skills to address such a role.

Organizational structures reflect the objectives and aims of a policy. For example, since RCH objectives emerged as a consequence of the failure of a family planning strategy, it was added on to the Family Planning Programme and renamed as Family Welfare (FW), explaining the anomalous position of the DGHS who does not have any role in the technical aspects of the RCH programme. In the districts, such disassociation of FW from the technical head, namely the Director of Health Services, has had a negative impact on the technical quality of the program. In States where the Health Department is divided into Health and FW, implementation of the FW programmes has been problematic due to non-alignment between authority and responsibility. Due to these factors, recently, the two departments have been merged at the Centre. While this is a positive step, there is still need to restructure the set-up on a functional basis all through the chain.

### Part III Case for systemic reforms: Restructuring Institutional Frameworks

The process for systemic reform will need to start from the Central Ministry of Health, looking at the big picture- setting standards and laying down rules and regulations to be followed by all stakeholders; mobilizing resources; providing leadership based on its knowledge and technical superiority; and facilitating and steering the health system to ensure that the goals of equity, efficiency and quality are met.

Such a role would require the Central Ministry to restructure its work allocation based on functional homogeneity. The Ministry should also shift from micromanagement by divesting and delegating powers and authority to functional units. There is also an urgent need to establish new institutions, such as an autonomous institute for health information and disease surveillance, a food and drugs authority; a social health insurance corporation to take care of government employees and the labour in the organized sector by merging the CGHS and the Employees State Insurance Scheme (ESIS); enable the Indian Council of Medical Research (ICMR) to have more autonomy (such as the National Institutes of Health, USA) by generating its own resources; and outsourcing all procurement work to professional bodies. The manpower and time that would be available with the removal of this historical burden of functions would enable the Ministry to discharge its stewardship functions which require laying down standards on health infrastructure and quality, classification of diseases, costs and norms for monitoring utiliza-

tion levels, carrying out research to evaluate the cost-effectiveness of the various interventions being implemented, training, etc.

The functions listed under the stewardship role are not simple, and entail mobilizing multidisciplinary groups and collecting and collating evidence for revising existing policy or formulating a new one. Standard setting is a tedious process and has cost implications. For example, setting a standard to include five ultrasound tests for an antenatal protocol would have substantial financial implications, besides driving investment to expand availability of this technology, though there is no evidence to establish its efficacy in assuring better outcomes of pregnancy. Likewise, it is through research that long-term consequences of policies need to be studied before taking decisions. For example, India's hasty decision to relax vigil in the 1970s and disbanding the malaria programme resulted in its resurgence in a form more serious and also more expensive. Such decisions therefore need inputs from public health specialists as well as economists to state which interventions work and which do not, and what policies should be adopted and why. If public policies fall short it is because such expertise is sadly lacking and in short supply in the country. Thus, good governance is not only dependent on political commitment but also having the appropriate tools, instruments and information. Bad policies need not only be the result of careless oversight or narrow sectional interests, but also due to lack of evidence and information.

In addition to the above, the administrative departments of health, including those at State levels, need to achieve greater efficiency in reference to some aspects described below.

### **Regulation in the health sector: accreditation of facilities**

The role of the government in the health sector is to look after patients' welfare. Canada and the US have some scores of regulations on or related to health. Drawing up legislation in a sector like health is complex and requires an understanding of the incentives or disincentives such a legislation may have on human behaviour and a balanced approach. For example, if the legislation is too inflexible and specific, putting all risks on the provider, then it may result in mindless litigation, increasing defensive medicine and higher costs for the patient, endanger the patient-doctor relationship which should be based on trust and entail harassment and outright corruption at the hands of the bureaucracy. If, on the other hand, it is too considerate to provider concerns, the patient may end up getting shortchanged. Besides, it is the enforcement of the laws that is more important. In other countries, inspectors and assessors sent to evaluate provider facilities for accreditation or licensing are trained, so that at all times the focus is on achieving the objective of increasing awareness and creating a sense of accountability among providers regarding the quality of patient care, and not the blind and mindless application of a standard or a rule. Thus, supervision requires to be supportive, not prescriptive or fault-finding, as the objective is not to drive away the providers but to per-

suaude and convince them of the need to adhere to quality and patient safety. This calls for a different mindset to be cultivated through intensive training programmes and performance monitoring systems. Supportive supervision is a new skill that needs to be nurtured in the government sector.

The key challenge to governance is the enforcement of regulations related to the 'quack' or the unqualified practitioner in the villages. In a setting where the public health system does not function and the private sector is too expensive, it is this quack who enjoys social consent. Rational arguments of quality or harmful practices, lack of qualification, etc. do not matter as, for the people, the quack is able to provide instant relief to a need at affordable cost. How then does the Government achieve its norms for quality and standards of patient care while allowing this clearly illegal and perhaps harmful practice to continue? Good governance would require a political will to resolutely enforce discipline and make the public health system work, besides educating the people on the rational use of medical practices or drug use.

### **Devolution of authority- The district societies: A mechanism for better utilization of funds**

A major problem being faced by the Department of Health was the untimely release of funds. Routinely, Central assistance meant for specific programmes would be diverted by the State finance departments for tiding over their ways and means position, resulting in delayed release of funds, stalling the implementation of health programme activities. Therefore, under the National Programme for the Control of Blindness, district societies for blindness control programmes were first constituted during the early 1990s. Under this arrangement funds were directly released to the district societies. This mechanism was subsequently used by all programmes resulting in the constitution of over 4-5 societies, one each for TB, Blindness, Malaria, RCH, and Leprosy. The experience has been a positive one as it has enabled better absorption of funds and quicker implementation. The experience of district societies is now being used to integrate them into District Health Societies so as to facilitate district-level health planning and monitoring activities to achieve health goals.

A review conducted on the functioning of these different societies in the Pune district of Maharashtra brought forth some interesting suggestions from programme officers:

- Develop capacity for better management through training;
- Establish more rigorous monitoring and programme review systems to improve outcomes and ensure cost-effective utilization of funds;
- Standardize reporting and auditing formats; and
- Sensitize officers on programme goals and objectives, and increase the involvement of civil society to reduce the temptation to misuse or misallocate funds.

Based on the above, training in data analysis and planning processes, developing indicators for performance review and

monitoring for corrective action will need to be accorded priority focus. The societies also need better expertise, persons trained in health economics, financial planning, statistics and data analysis, epidemiology etc. In the absence of such expertise and evidence-based planning, the tendency is to merely repeat what was being done earlier, nullifying the benefits of a bottom-up planning concept.

Resources are not only financial. It is the government's responsibility to monitor the availability of human resources as well. What skills are needed, what are being produced, where and by whom are they being utilized, where are they concentrated, etc. are the sort of issues that should attract priority attention, as 5-8 years are needed before the required human resources are available. Past neglect of human resources is the cause for today's imbalanced skills mix, acute shortage of trained nurses. This function will gain even greater importance in future years as with the General Agreement on Trade in Services (GATS), more professionals from India will be able to find employment abroad. The government needs to establish mechanisms to know the migration flows of skill and identify areas of shortage so that corrective action can be taken in advance.

### Local bodies

In the health sector in India, decentralization has to be viewed, not only in the context of devolving authority and power to States by the Centre, to districts and States but to the multilayered local bodies as well. Such devolution of authority has taken place only in Kerala. Kerala has invested both time and resources in systematically focusing on building capacity for governance among elected leaders. Leadership and governance means having the ability to plan, budget, implement, manage, monitor, review and accept responsibility for the decisions taken. The strategy of the 'big bang' approach adopted in Kerala where, in one sweep, functions, powers and responsibilities were transferred rather than the usual cautious approach, of training and building capacity before delegating responsibility, has proved to be successful when compared to the experience of other States where devolution has been incremental, halting and sporadic.

Devolution of powers has, however, not been easy. The Kerala experience shows that despite the transfer of some proportion of the budgets and bringing all-district level institutions under the control of the local bodies, the benefits in terms of health indicators have not really been visible (Vijayanandan 2003). This is largely because of the lack of technical guidance at the panchayat level, lack of standardization of facilities laying down clearly the functions, duties, responsibilities and outcomes of health personnel working in facilities located at different levels, lack of clarity and clear delineation of what services ought to be available where, making it difficult for the local bodies to understand what exactly should be their priorities and areas of focus. Lack of integration between different systems of medicine, ego problems between the highly educated doctor, senior in rank, to functionaries of the local government, dual control, multiplicity

of bodies handling health budgets such as the chief medical officer (CMO), hospital superintendent, zila parishad, district societies for each national programme, hospital development committees, etc. are other reasons that were found to have complicated matters. Kerala is therefore now working towards evolving minimum standards of care and conduct, a citizens' charter and community-based monitoring of health programmes.

Decentralization to local bodies has been under consideration for several years but was never implemented in true spirit due to various reasons. The attitude towards the involvement of local bodies has nearly always been to sensitize the representatives and use them in an advisory capacity or for execution of government works under the Rural Development Programme. In the health sector, utilization of the local bodies as agents of change or in social mobilization has been minimal and perfunctory. Experience shows that unless the local bodies are provided funds, specific responsibilities and powers, the benefits of decentralized systems cannot be fully realized.

In this context, it would be useful to keep in mind the international experience in fiscal decentralization as they provide a few lessons to be learnt based on certain principles (Sethi 2004). For fiscal decentralization, all aspects and components need to be addressed such as:

- Assignment of expenditure responsibility to local governments to be followed by revenue responsibilities;
- Availability of a strong state ability to monitor and evaluate the intergovernmental fiscal system;
- Devolution of powers and responsibilities in keeping with capabilities;
- Linking of revenue-raising and expenditure decisions;
- The intergovernmental system should be designed to match a set of clearly specified objectives, kept simple and flexible, while at the same time be subject to the discipline of budget constraints.

Applying these principles will mean having a clear-cut delineation of duties and functions to be carried out by the local bodies at different levels vis-à-vis the government departmental hierarchies; the financial implications of those functions and systems for utilization and reporting; and finally the kind of authority, powers, or control they have on the functionaries responsible for discharging those duties. Such delineation needs to be based on clear government orders or legislation as the case may be and backed by intensive training and guidelines provided in simple, easy-to-understand formats. Without such a systems approach merely 'orienting' locally elected representatives to be 'involved' in health activities is as valuable as the paper on which it is written.

Given the vastness and diversity, India will find it difficult to reverse the trend on communicable diseases such as malaria and TB unless the local bodies and the wider community are also fully involved. However, such involvement needs to be formalized. For example, the local bodies should be made responsible and accountable for certain health actions, for example, registering births and deaths, carrying out all anti-malarial activities such as plugging the breeding grounds of

mosquitoes, etc. In fact, later when social health insurance picks up, it will be necessary to have such a capability available at the local level for making the health insurance scheme function at minimal cost. Wider participation of the communities through village health committees working in coordination with management committees at higher-level facilities is the only way the health system can be made more accountable to the people they are meant to serve. More inclusive approaches and greater democratization is essential if health gains are to be achieved.

The initiatives would remain platitudes unless there is close monitoring by the State and provisioning of technical advice. This would require having a team at primary health centres (PHCs) and community health centres (CHCs) to work exclusively on the development of the community-based strategies—the village health workers, village health teams, local bodies, etc. In the absence of such administrative restructuring to guide, facilitate and supervise the development of the demand side of the health system, decentralization may not really go beyond tokenism.

## Conclusion

Technological advances, investment and good policies can be turned to naught in the presence of a system lacking in leadership, direction and a core sense of integrity pervading all levels of health care. Unless all stakeholders are motivated by a set of values—of compassion and human concern for the sick and ill, of not accepting a system which allows people to be denied care only because of circumstances beyond their control, of a minimal sense of equality and dignity among all—the health system will continue to reflect the cement and mortar issues of the expanding medical and drug industry, which can, in the absence of the guiding hand of the state, degrade human suffering into an opportunity for making profits. It then becomes critical to define the role of the State as the current utilitarian liberal approach of the health sector offers no acceptable solution. The issue is broader and needs to be examined within the context of the principles that underlie the concept of social contract of Rousseau or sense of justice of Rawls. If these principles enshrined in our Constitution are adhered to, then the State will need to intervene both intelligently and firmly.

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## Annexure I

## Utilisation and Expenditure Pattern of Health Services in India

	% utilisation of PHC/CHC for OP care (out of total OP)	% utilisation of private facilities for OP (out of total OP)	% Untreated Ailments (out of total number of ailments)		Average total expenditure for treatment per ailment (out-patient) (in Rs.)*		Average total expenditure per hospitalised case (in Rs.)*	
	1	2	3		4		5	
			Rural	Urban	Rural	Urban	Rural	Urban
India	6.4	82.0	17.3	9.3	144	175	3202	3921
Andhra Pr.	5.7	85.2	25.5	15	116	143	6428	4886
Assam	27.13(for north-east)	58.1 (for north-east)	44	36.4	83	110	1945	3790
Bihar	2.0	92.1	21.9	15.5	220	176	3860	3724
Gujarat	9.9	77.4	8	3.5	144	211	2663	3327
Haryana	5.1	85.7	3	1.6	183	402	3224	6537
Karnataka	11.0	77.9	22.3	8.6	91	155	2997	3593
Kerala	5.4	69.0	11.7	10.8	119	108	2293	1927
Madhya Pradesh	8.9	75.1	16.3	6.7	129	351	2191	2774
Maharashtra	6.4	87.0	11.4	7.6	144	170	3089	3997
Orissa	18.4	58.4	32.3	13.4	99	117	1641	3868
Punjab	1.8	92.2	1	3.5	173	155	6171	5712
Rajasthan	10.2	58.2	10.2	10.4	172	176	3971	3149
Tamil Nadu	7.2	70.0	22.4	8	79	117	4333	3934
Uttar Pr.	1.5	94.0	9.4	6.5	202	212	4521	5896
West Bengal	4.3	86.3	19.9	10.1	105	124	4303	3217

Note: 1 - Total OP for a reference period of 15 days: 375.3 lakh, 2 - Total OP for a reference period of 15 days: 375.3 lakh, 3 - Total number of ailments (rural): 408 lakh; Total number of ailments (urban): 154.5 lakh  
4 and 5 - Total expenditure for outpatients is for the reference period of 15 days and for hospitalisation is for a reference period of 365 days. Total expenditure includes medical expenditure and all expenses other than medical expense incurred by the household for availing the treatment. SOURCE: NSSO, 52nd Round; Mahal et al. 2002

## Annexure II

## Status of health infrastructure and outcome

	Rural population (2001)	Number of PHCs/CHCs per 100,000 population	Number of ANM/nurse-midwives per 100,000 population	Percentage of CHCs with obstetrics/gynaecology	Percentage of CHCs inadequately equipped in infrastructure	Safe delivery	Full immunization coverage (%)	% of children under 3 years of age severely malnourished (below 3SD)	Full ANC	Institutional deliveries	IMR (2002)	U5 MR
<b>Well performing States</b>												
Kerala	23,574,449	4.4	31.0	100.0	21	96.5	91	4.7	64.3	96.4	10	18.8
Tamil Nadu	34,921,681	4.3	30.7	100.0	61	80.0	92	10.6	20.0	76.0	44	63.3
Andhra Pradesh	55,401,067	2.9	21.5	94.7	38	67.9	72	10.3	35.2	56.0	62	85.5
Maharashtra	55,777,647	4.2	23.5	-	3	60.8	85	17.6	23.8	53.0	45	58.1
Karnataka	34,889,033	5.5	32.2	71.9	19	62.0	81	16.5	29.5	52.9	55	69.8
<b>Moderate performing States</b>												
Gujarat	31,740,767	3.9	26.2	63.2	18	59.1	68	16.2	22.1	51.1	60	85.1
West Bengal	57,748,946	2.4	19.5	-	20	42.3	78	16.3	11.7	40.2	49	67.6
Punjab	16,096,488	3.7	28.9	33.3	43	61.3	74	8.8	13.6	37.7	51	72.1
Haryana	15,029,260	3.1	14.6	61.1	20	44.1	56	10.1	9.9	28.5	62	76.8
<b>Poor performing States</b>												
Rajasthan	43,292,813	4.5	48.5	62.0	25	37.7	20	20.8	3.6	26.3	78	114.9
Orissa	31,287,422	4.8	23.4	-	79	36.9	56	20.7	11.3	25.9	87	104.4
Madhya Pradesh	44,380,878	4.6	25.7	26.4	74	32.1	77	24.3	5.6	20.5	85	137.6
Uttar Pradesh	131,658,339	3.1	17.8	41.1	21	25.8	27	21.9	3.9	17.9	80	122.5
Assam	23,216,288	3.1	26.5	80.0	75	20.5	57	13.3		13.8	70	89.5
Bihar	74,316,709	3.2	10.1	52.9	-	17.5	13	25.5	4.5	13.3	61	105.1
India	Census, 2001	Rural Health Statistics, 2002	Rural Health Statistics, 2002	Facility Survey, 2004	Facility Survey, 1999	MICS, 2000	CES-02, UNICEF	NFHS -2	RCH -2	MICS -2000	SRS, 2004	NFHS -2
<p>PHC: primary health care; CHC: community health care; ANM: auxiliary nurse-midwife; ANC: antenatal care; U5MR: under-five mortality rate; NFHS: National Family Health Survey; RCH: Reproductive and Child Health; SRS: Sample Registration Survey</p>												

## Annexure III

## Current Status of the Goals Laid Down in The National Health Policy of 1983

1. Indicators	Status in 1983	Goals set for 2000 by NHP 1983	Current status
MMR	4-5 (1976)	Below 2	4.1 (1998, SRS)
IMR	125 (1978)	Below 60	63 (MoHFW, 2002)
Leprosy	20 (% of disease arrested cases out of those detected)	80(% of disease arrested cases out of those detected)	
Tuberculosis (% of disease arrested cases out of those detected)	50	90	86
Blindness (%)	1.4	0.3	1.03(MoHFW, 2003)
Immunisation status			
TT (pregnant women)	20	100	60.3 (MICS-2000)
TT (school children)	20	100	
DPT (children below 3 years)	25	85	46.6 (MICS-2000)
Polio (infants)	5	85	58.9 (MICS-2000)
BCG (infants)	65	85	67.7 (MICS-2000)
DT (new school entrants 5-6 years)	20	85	
Typhoid (new school entrants 5-6 years)	2	85	
Pregnant mothers receiving ante-natal care (%)	40-50	100	62% (MICS-2000)
Deliveries by trained birth attendants (%)	30-35	100	42.5% ( Deliveries by Skilled birth attendant - MICS-2000)

**SOURCE:** NHP 1983; MoHFW various years; SRS, 1998  
We could have saved 14.3 lakh infants and 8 lakh mothers, if we had achieved the IMR and MMR goals set by NHP 1983.

## Annexure IV

## Implementation of National Health Policy, 1983

2. Strategic interventions as per NHP 1983	Current status
Universal, comprehensive primary health care services	Not Done
Integration for all plans for health and human development i.e. agriculture, food production, water, sanitation, housing, education, drugs and pharmaceutical, prevention of food adulteration, conservation of environment.	Not Done
To formulate a National Medical and Health Education Policy	Policy brought out in 2000
Primary health care system to be given importance and to be decentralized. Achieve a well-dispersed network of comprehensive care, transfer of knowledge, simple skills and technologies to health volunteers, use of inexpensive interventions, and more community participation.	Not done
The decentralization of services to be linked to a well worked out referral system.	Not done
Establish nation-wide chain of sanitary-cum-epidemiological stations at the primary or secondary levels depending on local situations.	Not done - beginning made recently under the Disease Surveillance Project funded by the World Bank, 2004
Location of curative centres should be related to the population they serve keeping in view, densities, distances, topography and transport connections	Not done
Establish a 'Health Team' approach and to phase out the system of private practice of government doctors	Not done
Dovetailing of the functioning of the practitioners of various systems of medicines	Not done
Device State-wise health insurance schemes	Not done

**SOURCES:** NSSO, 52nd Round; Mahal et al. 2002

**NOTE:** The total OP for a reference period of 15 days: 375.3 lakh. The total number of ailments (rural) is 408 lakh. The total number of ailments (urban) is 154.5 lakh. Total expenditure for outpatient is for the reference period of 15 days and for hospitalization is for a reference period of 365 days. Total expenditure includes medical expenditure and all expenses other than medical expense incurred by the household for availing the treatment.