CHAPTER VIII
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Summary and Conclusion

The broad objective of this thesis was to study the process and experience of health sector reforms in Orissa. Here we have tried to explore the provider’s perspective, like the government officials in health sector and the donor agency officials with regard to issues of health sector reforms. The study was conducted in Orissa by using an ethnographic approach. However it was used in a limited way in terms of intensive interviews and observations in the field.

Before documenting about various country experiences we have tried to define health sector reforms as a phenomenon of scientific enquiry. Our main argument was that there was nothing called health sector reforms out there in the field. It’s a constructed category like any other concept. This very basic understanding was missing in the existing literature. Our analysis of existing literature showed that the term ‘health sector reforms’ have been accepted as a given category. Therefore as a field of scientific enquiry we have defined the term ‘health sector reforms’ as any initiative by the state since the later part of twentieth century, which tries to reduce the role of government in health sector while creating a space for a larger role for the private sector. Therefore while the private sector existed prior to 1980s in different countries, it never got such an overwhelming support from the state in terms of defining the priorities of health sector in the long run. Our new definition also captures the dominant trends in health sector across the world since eighties. In defining the term health sector reforms we have also looked at those policy initiatives, which could not be termed as reforms but as systemic changes. This has helped us in classifying the phenomenon of ‘health sector reforms’ in a better way. At the same time we have included various initiatives by the state of Orissa as health sector reforms, which were for the first time being classified in such a way. In analyzing the implications of reform initiatives structural constraints were taken into account.

In chapter I we have reviewed the existing literature on health sector reforms in different parts of the world, covering different country experiences. Using our new definition of
health sector reforms we have classified different country experiences in terms of pre
reform period health services system in that country, the circumstances in which reforms
were introduced in health sector and thirdly to see whether there were any study of
outcomes of the reform initiatives. Here also we have included various policy initiatives
as health sector reforms using our new definition and also excluded other initiatives
which were termed as reforms in health sector by various studies.

Different country experiences showed that health sector reforms were mostly introduced
in the beginning of 1980s and in some countries in the 1990s. These reforms have tried to
increase private participation in different aspects of health sector and at the same time
tried to reduce the role of public sector. One of the main areas of focus was to reduce the
public financing on health and encourage other sources of financing like introduction of
private or community insurance mechanisms. In provisioning aspects the private sector
also was encouraged in different levels of care. While the terms like ‘efficiency’ and
‘effectiveness’ were coined to argue that the limited resources in health sector should be
used in a judicious way, the real driving force for the reforms was the neo liberal
ideology of encouraging market forces in different aspects of a country’s economy.
Therefore health sector reforms need to be analyzed in the context of economic
liberalisation being followed by most of the countries in the world. There were very few
studies which looked into the aspects of impacts of health sector reforms. Those which
analyzed this aspect have found that the reforms in health sector have increased cost of
care and have created inequalities in terms of access for different social groups.

In chapter II we have discussed about the methodology used in this study. While the field
of study was Orissa, interviews were also conducted with senior officials of the donor
agencies like DFID, World Bank etc. at their New Delhi offices. In the capital of Orissa,
Bhubaneswar, senior officials of the Health and Family Welfare Department as well as
senior officials from the donor agencies were interviewed. Apart from this, two well
developed districts within Orissa were selected on the basis of purposive selection from a
ranking of various districts done by the Population Commission of India. In each district
two blocks were chosen on a random basis and thus four blocks were studied intensively.
At the district level the CDMOs and his allied staffs were interviewed and at the block level the medical officers' in-charge and the other medical officers in that block were interviewed. At the block level group interviews were conducted with ANMs/Male workers and weekly meetings in these four blocks were attended. In one district the monthly meeting of all the MO in-charge was attended to get better understanding of the functioning of the health care services structure in that district.

Apart from using in-depth interviews as primary sources of data collection, secondary sources like State Bureau of Health Intelligence, DHS, Orissa, CBHI data, the documents from donor agencies, journals and books etc. were used.

In chapter III we have given an overview of health care services in Orissa in comparison to India. Our study of the evolution of health services showed that since independence there was increase in public expenditure on health care till late sixties. However due to the oil shock of the seventies expenditure on social sectors like health started declining and an increasing space was created for the private sector by different mechanisms like liberalizing import duties on medical equipments in the eighties. This process of increasing privatisation was also facilitated by growth of new middle class due to Green revolution and the investment by NRI doctors in super-specialty hospitals. At the same time public investments in health care was more toward secondary and tertiary levels of care, whereas in terms of epidemiological priorities the state should have invested more toward the primary level care.

In terms of health status there were divides in rural and urban areas in case of India and Orissa. In Orissa the major communicable diseases were TB, Malaria and gastroenteritis. While the allopathic institutions had experienced a growth over the years, the ISM and H system had experienced a stagnant growth. While more than 57% of sub centres had no government buildings, most of the categories of vacant posts were at the level of PHCs and CHCs. In the tribal areas the sub centres and the CHCs were requiring urgent attention. The infrastructure at the periphery level institutions was at the dilapidated conditions. The major strength in the health care services in Orissa was that even the rich
utilized mostly the government services; therefore a minimum standard was being maintained. In terms of structural constraints, there was no transparent transfers and postings policy for the medical officers and the paramedics. As a result medical officers and other staffs were refusing to stay in remote and difficult areas. Further medical officers were inadequately trained in public health aspects which had affected in their optimum performance in different positions of the health care services. The ANMs were inadequately trained and had poor knowledge about various national programs. Even where there were government sub centre buildings, they were staying in nearby town areas because most of these institutions were at the end of the villages and many were in burial grounds! The male worker was hardly visiting the fields. This had increased work load on the ANMs. Along with this the supervision aspect was very poor. These have serious implications for the implementation and expected outcomes of various national programmes.

Chapter IV has focused on SHSDPs and OHSDP, which were being funded by the World Bank, in the context of Structural Adjustment Programmes adopted by India in the 1990s. We have included the SHSDPs as major health sector reform initiatives by different states. These State Health Systems Projects were meant to upgrade the secondary level institutions in various states including Orissa. Because the idea was that, as most of the money for national programs went to primary level care and the states mostly focused on tertiary levels of care, it was the secondary levels which were the neglected ones. Therefore the World Bank shifted its focus from population and nutrition programs in the early nineties to upgrading the secondary levels of care in the second half of nineties. While in the first group of states selection criteria for this project was their own willingness to implement it, in the later stages the selection criteria was based on a state’s capacity to achieve Millennium Development Goals.

Apart from introducing ‘efficient’ and ‘effective’ use of public health care resources, through these projects the World Bank has also tried to introduce various public-private partnerships measures. However our analysis showed that it has tried to adopt a uniform model for all the states and giving an example of, handing over PHCs to NGOs, we have
shown that this won't work. While the SHSDPs were meant to increase referrals from primary level care, it did not happen. Therefore in the next group of states like Tamilnadu and Rajasthan, the primary level care would also be upgraded along with secondary level care. Apart from encouraging for new sources of financing health care, through SHSDPs the World Bank was also emphasizing that the state should limit its role only to issues of policy, regulation and accreditation.

The Orissa experience showed that the line department directors were sidelined in the project formulation and implementation phases. Besides, the state government was also not increasing its share of expenditure every year. This had serious consequences for expected project outcomes and in sustainability of the project institutions. With the introduction of user fees, the proposal to create referral cards and by the creation of a large number of contractual posts under this project, an element of increasing privatisation was being introduced in these secondary level institutions. This has the potential to cut off these institutions from primary level care in the long run and this has serious consequences for universal access to health care in a state like Orissa where the government health services were the dominant providers.

In chapter V we have analyzed the process and experience of health sector reforms in Orissa. We have said that in the context of Orissa the process of health sector reforms has to be seen along with the process of systemic changes. The formation of House Committee of Orissa Legislature and the evaluation by DFID of its earlier projects led to an initiative toward a series of changes in health sector covering both systemic changes and health sector reforms in the second half of 1990s. While consultations for reform initiatives were held at different levels of health services personnel, it was not a comprehensive one. While Orissa economic Review package was not a reform initiative in health sector, the World Bank was planning to influence the health policy making in the state to a large extent through leverage gained by this package. Similarly while the PSPU was being created, with 100% funding from DFID, to act as a think tank for the health and family welfare department of government of Orissa, the DFID and World Bank were trying to play a more direct role in the health policy making in the state.
through it. This raises serious issues about democratic process of prioritizing health interventions in Orissa.

Our analysis showed that in terms of presence of various donor agencies, the World Bank was playing a more influential role in Orissa health sector followed by DFID and European Commission. However presence of various donors had created problem of donor coordination and different styles of reporting for different donors were taking a lot of precious time of the health and family welfare department. In terms of systemic changes while the new drugs policy had reduced the price of drugs and increased its availability in most of the government institutions in the state, the major lacunae was the exclusion of the private sector. There were no mechanisms to control the price of drugs available in the private sector and the mechanisms of quality checks were inadequate. In case of Pancha Byadhi Chikitsa scheme, patients were not aware about their rights in most of the cases. On the other hand the disease surveillance programme had successfully created an institutional mechanism for collection of epidemiological data in a systematic and regular way. However here the major question was, as the ANMs were poorly trained, had limited knowledge about various national programs and they used to visit their fields occasionally, therefore to what extent the disease surveillance data collected through them would be reliable? Similarly the creation of ZSS had helped in better utilisation of districts resources. However the supply of money was irregular under the petty maintenance scheme for block PHCs. The schemes like, mandatory pre-PG rural scheme and the training of medical interns under the guidance of a CDMO were failures because the structural issues like creation of transparent transfers and postings policy and a genuine emphasis on public health were missing.

Among the reform initiatives, the creation of contractual doctors’ scheme had not helped in filling the vacant posts in remote and difficult areas. While the introduction of user charges in 157 OHSDP institutions had helped in petty maintenance of these institutions, the poor were not getting exempted from paying user fees as per the provisions under the scheme. The creation of contractual district cadre for paramedics and allowing private practice by government doctors were other examples by the state government to increase
more elements of private participation in the health care of the state. However the contractual district cadre for paramedics had not helped in meeting the shortage of these personnel's in remote and difficult areas because the structural issues like providing basic infrastructure and amenities and ensuring a transparent transfers and postings policy were missing. The introduction of private pay clinics in the dental wings of government medical colleges, initiative to create three new private medical colleges and the idea of joint operation of hospitals were other examples of the state government increasing the space for private sector in health care of the state. The broader trends show that there was an unquestioning faith in the efficiency of the private sector in providing quality health care. However the larger question about implications for access to health care for the poor and marginalized was missing.

In chapter VI we have analyzed the reform process in Sundergarh and Khurda, the two developed districts of Orissa. In terms of structural constraints, it was found that most of the sub centres in these two districts had no government buildings. Block headquarter PHCs were requiring urgent repairing at many places. In terms of staffs, there were severe shortages in category of male supervisors and MPHW (M). Apart from this the existing health worker (M) were hardly visiting the fields. This had put a lot of work load on the ANMs. Besides, the infrastructure at the PHC (N) institutions was in a very bad shape. Medical officers were absent in most of these institutions. In most of the sub centres and the PHC (N) institutions, there were no water or electricity facilities. Further from the block headquarter PHCs to various PHC (New) s and to the sub centres, in most of the places, there were no all weather roads. This had serious implications in terms of health personnel’s willingness to stay in these institutions, effective supervision of field staff, people’s accessibility to primary health care and in the effective implementation of various national programs.

In terms of reform experiences it was found that there were no consultations held with the CDMOs concerned about various reform initiatives in health sector taken in Orissa. This had serious implications in terms of program implementations, monitoring and in their expected outcomes. Besides at the district level it was observed that neither the CDMOs
nor the block PHC medical officers’ in-charge had any conceptual clarity about the ongoing reform process. The reform initiatives like contractual doctors’ scheme and systemic changes like introduction of mandatory pre-PG scheme and internship training of medical graduates in these two districts were a failure, because the structural issues like transparent transfers and postings policy for medical officers, shortage of staffs at various levels, inadequate infrastructure and a genuine emphasis on public health were neglected. On the other hand, the new drugs policy had improved the quality of drugs available at all the levels of government health care institutions in these districts. At the same time people were not aware about their rights under the Pancha Byadhi Chikitsa scheme. Similarly the creation of ZSS had helped in better channeling of these districts resources. Under the scheme of petty maintenance of PHC headquarter buildings, money was not coming regularly and there were allegations of misuse of funds by the MO in-charge. While the user fees had helped in petty maintenance of health institutions, the poor were not getting exempted as per provisions in the scheme. However from CDMO to the block medical officer, all were in favor of introduction of user fees for more categories of services and at all levels of health institutions. In Sudergarh district they were identifying indigenous medical practitioners to involve them for referrals to PHCs.

In chapter VII we have looked at the financing, structure and utilisation patterns of the public/private sector in Orissa and across major states. We have also given a picture of donor agency funding for health sector in Orissa. In this chapter we have tried to examine whether the health sector reform initiatives were taken keeping in view the dominant presence of the private sector in various states in terms of financing, structure and utilization patterns.

In terms of health care financing to the percentage of total state budget, there was up and down turns in case of Orissa since 1980s till mid nineties. However the upward trend since 1998 may have been due to the implementation of OHSDP and PSPU, as these expenditures were included in the general budget of the state. However the health care expenditure as percentage to the total budget in 1990s had declined in Orissa compared to 1980s. Among the donor agencies, World Bank had emerged as the lead investor in late
1990s followed by DFID, UNFPA, UNICEF and European Commission in the health sector of Orissa. Along with this the World Bank had also emerged as the most influential donor in the state.

In terms of cost of treatment it was expensive in urban areas for both the public and the private sector hospitals compared to the rural areas. However the cost of treatment in private hospitals was almost 200% compared to the cost of treatment in public hospitals. Along with high cost of care the private sector in India and particularly in Orissa, was not regulated at all in an effective manner. This has implications for identifying the quality care being provided in the private sector.

Our analysis showed that the private sector was present mostly in the developed states of India and in the urban areas. In case of Orissa the private sector was mostly located in the urban areas. While there was overall growth in private and voluntary hospitals since 1980s, there were states like Orissa and Haryana which experienced a negative growth rate during this period. Since 1980s both the private and public beds had grown in absolute numbers. However by the year 2000 the number of private beds was double the amount of public beds. Among the major states analyzed Orissa had the lowest number of private beds.

In terms of utilisation pattern the private sector was catering to more than 80% of the outpatient care and even in case of in-patient care the private sector was the dominant provider. However there were inter-state and intra-state disparities in the utilisation pattern of health care. By ignoring these ground realities the health sector reform measures were trying to follow a uniform model across states. Our analysis showed that health sector reform measures were emphasizing 'access to better health care' in terms of 'access to better curative care' and in this process neglecting the preventive aspects, which has a very significant role in improving public health in a poor state like Orissa.

By interpreting the concept of 'health' more in terms of an individual's responsibility, the inter-sectoral linkages between economy, existing social structure in Orissa, the nature of polity and health were being neglected.
Therefore in a state like Orissa where less than 15% of its population lived in urban areas, where near about 48% of its people lived below the poverty line, where about 39% of its population was scheduled castes and scheduled tribes and where government was the dominant provider of health care for both in-patient and out-patient care, this could adversely affect the public health care services in the long run and the poor and marginalized sections would be at the receiving end.

**Hypothesis Tested:**
Our first hypothesis was that, the health sector reform process in the long run would undermine the universality of health care which was an essential feature of public health. Our study shows that these apprehensions were true to a large extent. Our second hypothesis was that, the public health services in the long run would try to withdraw from provisioning of the secondary and tertiary level care; this would weaken the sustainability of primary level care. Our study shows that the public health care services were indeed moving away from provisioning of secondary and tertiary levels of care. However to what extent it would affect the primary level care was difficult to predict at this moment. Our third hypothesis was that, with increasing privatization of health care the cost of care would go up; this would affect the poor most and would also affect their overall quality of life. We have found this hypothesis to be true to a large extent.

**Difficulties faced in data collection:**
During the field visit to Orissa it was one of the big challenges to get the required secondary data because the Directorate of Health Services, which was supposed to maintain regular data, did not maintain it. The Health statistics related data was available since 1990 onwards and that too they were not maintained systematically. It was quite surprising that in the statistical section of the Directorate of Health Services, in two registers the information related to manpower was available year wise and that too in terms of addition of personnel in different categories at different levels of health services structure. That means the total number of health personnel existing at different levels was not available year wise! These two registers were maintained manually. Further the statistical division of the Directorate of Health Services was very uncooperative and it
was told to this researcher that the person concerned had gone for a leave and would be back within a week. However one month went by and still that person did not turn up. Finally with a signature from the director of health services the files started moving and the required data could be collected.

In terms of the data collected through primary sources like Interview, there were different kinds of challenges in the field because the respondents to be interviewed were mostly the top officials in both the donor and government agencies. They had their own responsibilities and prior appointment was needed for an interview to be possible. In case of donor agencies the respondents were available on the fixed date of interview and hardly there was any change in the last minute. However in case of the persons in government departments, in some cases there were changes in the last minute for scheduled time of interview as the respondents had to attend some important meetings. While the senior technical directors in the Directorate of Health, Orissa were interviewed after much effort, the donor agency officials were not that much difficult to get an appointment with. Overall senior officials were very cooperative in providing information. This was true in both the cases of government and the donor agencies. Only in one case there was difficulty in interviewing a medical officer who was closely involved with drugs reform in Orissa but was unwilling to talk and after getting permission from senior officials this person could be interviewed.

At the district level prior appointments were taken from the concerned CDMOs and during the interview date other senior staffs of the CDMO were also present during the interview. There was not much difficulties faced in collecting the statistical data here. At the block PHC level the medical officer in charge were interviewed without taking prior appointments.

Future Issues:
1- How the official data with regard to health sector was being generated in India?
2- The implications of health sector reforms on primary level care.
3- To explore the quality of health care being provided by the private sector.