CHAPTER 1
Chapter-I
Review of Literature

The decade of nineties:
In the nineties Human Development Index or HDI was used for the first time by UNDP\textsuperscript{17} and it identified three measures like longevity, education and per capita income to measure a country's HDI. With the adoption of this index by the United Nations the whole notion of development was reduced to some measurable index. This also caught the imagination of various world leaders and finally in the year 2000 Millennium Development Goals\textsuperscript{18} were adopted for which targets were set to be achieved by the year 2015.

The adoption of HDI index by various countries also brought into front the idea that the sectors like education and health requires the role of state not only for regulation but also for financing and provisioning. Thus the agencies like World Bank, which had been in the forefront of giving the argument that the state had a very little role in social sectors, started to argue for a larger role for the state in these areas,\textsuperscript{19} in the later part of the nineties. However a close look shows that these arguments have remained only at the realm of ideas and has not been implemented at the ground level.

There was another event that shows a different direction of movement in the nineties and it was the 1994 Cairo Conference on Population, which emphasized a change in approach to population policies. It suggested about integrating population control with maternal and child health. It talked about interlinking the issue of population growth with larger aspects of development. These were lofty ideals as it presented a case for respecting human life particularly for women and to give people more power to control their lives. However the agreements at Cairo could not bring any substantial changes in various

\textsuperscript{17} UNDP suggests United Nations Development Program.
\textsuperscript{18} It is interesting to note that at present the donor agencies like World Bank and European Commission or DFID have set their developmental funding in accordance with the targets of Millennium Development Goals.
\textsuperscript{19} This could be observed from the annual documents of the World Bank.
countries population policies\textsuperscript{20}. One of the major reasons was that the dominance of liberal model of economic growth around the world nullified any movement toward these goals.

Another significant event in the 1990s was the formation of World Trade Organization or WTO in 1995 with 144 member countries agreeing for free trade among them. The formation of WTO legitimized the opening off of various economies of the world and those that were out of this group were in the danger of facing the blocked of these 144 countries. The importance of WTO could be observed from the fact that China, which was not a member of the WTO, tried to give many concessions\textsuperscript{21} to USA to become a member. WTO was being seen as one of the few democratic institutions at the international forum where its rulings have been followed by every member country\textsuperscript{22}. The arrival of WTO has further legitimized a liberal model of economic growth and the democratically elected leaders at the national level have left with few choices for taking economic decisions, which could address the immediate needs of the poorer sections of their population.

HSR: A Review of International experience:
The adoption of a liberal capitalist model of economic development\textsuperscript{23} by different countries around the world not only created an atmosphere for greater role for the market in larger economy, it also legitimized the rationality\textsuperscript{24} of market forces in the social sectors like health and education. With the collapse of communism in former USSR and its disintegration led to the adoption of market economy by the newly created countries out of it and also by the East European countries which were earlier following a socialist model of growth. Similarly communist China had liberalised its economy in the late seventies of the twentieth century.

\textsuperscript{20}This has been observed by various authors.
\textsuperscript{21}In terms of access to its market.
\textsuperscript{22}For example see the speech by Indian Prime Minister Dr. Manmohan Singh published in Indian Express, 22 October 2005.
\textsuperscript{23}After the collapse of communism in the former USSR.
\textsuperscript{24}The rationality of the market forces means the inherent assumption that if market is left on its own without any state intervention than it can produce best results for every body in the long run. However this is an unquestioned assumption or an assumption, which is not based on verifiable research.
Thus major powers in the world and most of the countries except perhaps Cuba have accepted the liberal capitalist model of economic development where the private sector and the market forces are playing the dominant role and the state is trying to facilitate this process through favorable legislation and playing the role of a regulator to promote fair competition among the various private players. Along with economic liberalization many developed and developing countries have allowed the increasing role of private sector in the healthcare. This was the trend in UK, USA, China, Canada, Australia and many of the countries of Europe where the private sector was playing a dominant role in different aspects of healthcare.

Now let us have a look at the process and experience of reforms in health sector in various countries.

**United Kingdom**\(^{25}\): Over the years the healthcare system in UK had been based on National Health Service or NHS, funded from central taxation. The NHS created in 1948 had the universal coverage and was based on the principles of equity. However in the 1990s the market elements were introduced to make the system *efficient, effective, and responsive to the needs of the patient* and adoption of management practices of the private sector. While in the 1980s the NHS was being under funded, the reforms in the early 1990s focused on *structure and management* of NHS. The effort was to utilize the existing resources ‘efficiently’ to improve performance. To generate additional resources private finance was encouraged. The reforms in NHS were closely linked with the reforms in education and civil service and with the then government’s approach to public sector reforms.

One of the major assumptions of reform initiatives taken was that the competition between NHS healthcare institutions would produce greater efficiency and responsiveness to the users. However there were no independent studies to assess the impact of reforms introduced between 1991 and 1997 in NHS. Beginning with early

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1970s a series of organizational and managerial changes were introduced to improve the efficiency and the effectiveness of healthcare provisioning through NHS. However these initiatives were taken to improve the functioning of National Health Services. At that time the element of large scale privatisation of public sector had not emerged in the public domain.

In the 1980s there were allegations of under funding of NHS, however the reforms focused on utilising the existing resources judiciously, rather than increase in funding. In this context a review of the entire NHS was done by the prime minister’s office rather than the department of health in 1988. The NHS review suggested introduction of new management practices, introducing competition among the institutions of NHS and creating more user choices. The basic idea was to generate greater efficiency among the NHS healthcare institutions and responsiveness to the users of healthcare.

As part of reform initiative within the NHS, a patient’s charter was created which mentioned about patients rights with regard to issues like, right to information about services available in a particular institution, waiting times, guaranteed admission date in a hospital etc. However these were not legal rights and critics were of the view that this had raised expectations among the public which the NHS was not in a position to provide with its then existing resources.

Therefore the reforms introduced in the NHS were not based on pure scientific evidence and had more to do with the ideology of privatisation. Thus while the Conservative government led by Thatcher tried to give role to the private sector in healthcare provisioning within the publicly funded NHS, the Labour government elected in 1997 continued with this practice of mixed provisioning of healthcare.

_Sweden_: The healthcare system in Sweden was based on central planning and the wider philosophy of welfare state from 1950s to 1989. By 1990 the debates shifted toward _competition, markets and privatisation_. The reform initiatives like Health and Sickness

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Care Law in 1982, decentralized all responsibility for medical care to the counties, including decisions on allocation of resources. The right to set standards for training and ensuring quality remained with the central government. The new law encouraged the private sector and as there was no regulation of private practitioners, the healthcare expenditure increased rapidly at the primary level care.

Similarly the Adel Reform in 1991 shifted the responsibility of primary care of the aged from counties to the municipalities. This has been termed as a successful reform initiative as it reduced the number of days spent for in-patient care by the elderly. The care guarantee reform 1992, made it mandatory that the patients could seek treatment in any county if their own county did not treat them within three months. As it was observed that the clinic chiefs used to keep long waiting lists because it provided justification for budget increases. As a result of this new initiative, the queues for elective surgeries had shortened significantly.

Another significant reform initiative was the Huslakare reform in 1993, which made it mandatory that every resident of Sweden to register with a primary care physician. The bill encouraged the private physicians who could set up practice without restriction and could compete for contracts as primary care providers. This new initiative not only increased the number of private physicians but it also increased the cost of primary level care. At the county levels experiments were made where by the provision of services was left for the private players, which would be reimbursed by the public authorities. The idea was that the private players would be efficient and would reduce the cost of care.

Thus the reforms in Sweden in 1980s and in 1990s were not due to the inefficiencies or ineffectiveness or inequity in the medical care system, rather it was mostly ideologically driven.
Canada: The healthcare system in Canada popularly known as ‘medicare’ by the Canadians consisted of ten provincial and three territorial health insurance plans. Over the years although health was seen as a provincial responsibility, the federal government had played important role in funding and setting national standards for the provincial health insurance programs. Prior to World War II, when the modern Canadian healthcare system was adopted, the costs of hospital and medical care were primarily paid by individuals as out-of-pocket expenditures.

However due to slow economic growth and increasing deficit and debt load, the share of federal government’s expenditure for provincial healthcare declined from 38 percent in 1988 to 33 percent in 1994. The decline continued till the year 1999. This increased the healthcare costs of provincial governments, which were also experiencing a slow economic growth. All these developments led toward the arguments for balancing budgets and reducing deficits and taxes and hence reducing public spending on healthcare.

In the 1980s it was observed that while the public expenditure on healthcare was increasing, the length of stay of patients was declining. This was happening partly due to rapid proliferation of costly drugs and diagnostic procedures etc. However, the reforms closed some hospitals; merged some of them and restructured hospital service delivery to make it less expensive. Due to these new measures, there were pressures to keep patients from entering the system. Similarly there were efforts to create new nursing homes, which would be less expensive for the elderly, but it has grown slower than the closure of hospitals. For the treatment of patients who were discharged quickly, required home care and it was observed that the home care expenditure by the government had doubled during the 1990s. Thus there have been efforts to shift the responsibility of care to the community.

A new office called the Canadian Coordinating Office for Health Technology Assessment was created in 1989 by the federal, territorial and provincial ministries of health which collects, analyses and disseminates information on the cost and effectiveness of a technology and its impact on health. In the 1990s its mandate further increased to conducting and managing pharmaceutical-product economic assessments. Off late it has been engaged with rationale use of drugs.

Similarly provinces have come out with legislations to make health professional more accountable to society and to regularize the emerging professions like midwifery, physiotherapy and nurse practitioners. Further under the provincial health insurance most physicians were remunerated on a fee-for-service basis. However as the cost was going up the provincial governments removed some services from the insurance coverage and these services were made available though the private sector.

To check the growth in number of physicians, the medical school enrollment was reduced by 10 percent and the immigration policies, which restricted the number of physicians from outside the country, were strictly implemented. Earlier the provincial drug plans used to cover the elderly, the poor and catastrophic drug costs and these were adding to costs of public drugs plan. To address this, the availability of drugs was reduced to those of known effectiveness. Similarly efforts were made to regulate the prices of patent medicines by the federal government. Decentralization measures have tried to give more authority to the regional level for planning, management and for funding decisions.

Thus reforms in Canadian healthcare system have tried to introduce market mechanisms to make it more 'efficient' and 'effective' in achieving its targets.

*United States of America*²⁸: According to the World Health Organisation in 1997, 55.9 percent of American health expenditures came from private sources, whereas in other

²⁸ For reviewing the experiences of USA we have referred to Wessen, 2002; American Hospital Association, 2000, 2001; Anderson and Poullier, 1999; Blau and Marshall, 1987; Blendon, 1975; Enthoven, 1985a, 1985b; Evans, Tandon, Murray and Lauer, 2002; Ginzberg, 1991; Gray, 1991; Haber, 1999; Hellander, Himmelstein and Woolhandler, 1994; Himmelstein, Lewontin and Woolhandler, 1996.
OECD countries except Mexico and South Korea, the private healthcare expenditure was in the range of 10 percent to 30 percent. Further in US, government financed health insurance was available to a small section of its population compared to other OECD nations\textsuperscript{29}. While historically the regulation of healthcare in US had been not strong enough, since the Reagan era the deregulation of healthcare has been emphasised. Further the role of charity and philanthropy has been on gradual decline in second half of the 20\textsuperscript{th} century.

The public hospitals and health facilities in US were expected to function within the framework of the market system but to a large extent the American healthcare institutions have always been dominated by voluntary community based organizations. The voluntary health insurers begun as non-profit community based entities but at a later stage many of them shifted to for-profit status. Gradually over the years for-profit insurers have dominated the market. Similarly many public hospitals have been acquired by the private sector. Thus in US the trend has been toward increasing privatisation.

Instead of a single payer system of financing in countries such as Canada, UK and Sweden, in America there are a variety of payment mechanisms. In terms of health policy making in US, except for the enactment of Medicare and Medicaid, federal legislation on the healthcare system has not resulted in major systemic changes. Therefore in case of US the private sector has played a dominant role over the years and in recent times, with mergers and acquisitions of private players in health sector, the market mechanisms were in full play.

\textit{Eastern Europe}\textsuperscript{30}: Here we would be discussing about the health sector reforms in Czech and Slovak Republics, Hungary, Poland, Croatia and Slovenia.

\textsuperscript{29} Wessen, 2002.

\textsuperscript{30} For reviewing the experiences of Eastern European Countries of Czech, Poland and Hungary, Croatia and Slovenia we have referred to Ackerman, 1994; Albert, Bennett and Bojar, 1992; Avah, 1995; Bodenheimer and Grumbach, 1994; Chinitz, 1995; Deppe and Oreskovic, 1996; Dorozynski, 1996; Hayo, 1997; Hebrang, 1994; Kalman, Massaro and Nemec, 1994; Karcher, 1996; Maynard and Bloor. 1996; McKee, Bobak, Kalina, Bojan and Enachescu, 1994; Smolen, 1992; Wloch, 1993.
Czech and Slovak Republics: In 1990 the Czech and Slovak Republics moved from a controlled socialist structure to an insurance-based, fee for service model.\textsuperscript{31} This was due to the report of the Health Reform Task Force constituted in late 1989. The payment of hospitals and physicians on a fee-for-service basis was introduced in Czech republic in 1992. Membership was made compulsory for its citizens and the contribution was 13.5 percent from the members. With the separation of Czech and Slovak republics in 1993, this insurance system became autonomous, collecting premiums and disbursing payments without direct government involvement. After the creation of two republics, the general Health Insurance Company of Czech Republic, which was a publicly financed private firm, became the primary insurer covering 8.5 million or 83 percent of its population. The remaining 1.8 million populations who were mostly government employees like, police, army, bankers, miners and large individual firms were covered by sickness funds.

However this new system was a burden on the GDP, which was found to be unsustainable and it was also the time when the economy was moving through an inflationary phase. Thus the healthcare expenditure in 1993 was more than 50 percent compared to 1991 figures, in Czech Republic. To meet these additional expenditures, individual contributions were about 30 percent. Premiums were collected from 95 percent of the employers and 60 percent of the self-employed. In terms of effort toward privatisation, about 50 percent of doctors and 40 percent of clinics have been privatised.

Hungary: The second largest country in Central Europe with a population of over 10 million in 1996 had a GDP growth of 2 percent. After 1948 a centralized healthcare system was developed, consisting of three levels of care: physicians (primary), polyclinics and hospital care. However in 1990s with the collapse of former Soviet Union, the Health Insurance Act was introduced in 1992, which formalized the separation of health insurance funds from the state budget and it also established a managing committee to be chosen by national election. This new fund paid for health services and sickness benefits and was underwritten by the government. In terms of premiums collected, employees paid 4 percent and the employers paid 23.5 percent of their pre-tax

\textsuperscript{31} Oreskovic, 2002.
salaries. The employees also paid 4 percent toward a solidarity fund, which was a contribution on behalf of the unemployed.

Further this new act established a network of family physicians and made possible the *free choice of general practitioners and the pediatricians*. However the companies and those individuals who could not fully pay their contributions due to economic hardship, either the reimbursement payments were withheld or the assets of companies were seized. The private health insurance was introduced in late 1990s, which was aimed at higher-earning portion of the population.

**Poland:** Poland was the first country to adopt market economy in Central and Eastern Europe in early 1990s. However the growth rate in GDP declined by 17 percent from 1990 to 1993. As the economy was in transition phase, the healthcare expenditure experienced a negative growth of 4.8 percent during 1991 to 1994. Prior to the introduction of economic reforms the healthcare system in Poland was financed and planned by the central government. The preventive aspects of the healthcare were also closely linked with the curative aspects.

The reforms in health sector was based on a document which was the outcome of an international conference on health policy being organized in Poland by the Ministry of Health and Social Welfare, which was cosponsored by WHO, World Bank and Project Hope. The reasons cited for health sector reforms were, deteriorating healthcare services, poor health status and patient dissatisfaction with the existing system etc. Hence efforts were made to make the healthcare system more ‘effective’ and ‘responsive’ to the local needs.

After the initial period of indecision at the highest level of the Polish government, National Investment Funds was *created to start a mass privatisation program* in different sectors of the economy. While the privatisation of pharmacies had started in 1989, in case of the polyclinics only 10 percent had been privatised. The Social Democratic government, which was very concerned about extensive privatisation and wanted a
national health service being funded by the state, lost the 1997 elections. Many attribute this loss to the effort toward recentralisation of the healthcare facilities by the Social Democratic government.

Thus the countries like Poland, Hungary and the Czech Republic started health sector reforms in the provisioning and the funding of their healthcare systems. It has put forward the concept like ‘freedom of choice’, signifying that the responsibility of healthcare rests on an individual. However the introduction of market mechanisms has allegedly weakened the referral system as the patients have direct access to the specialist of their choice. Unlike the earlier system, the ministers of health and finance did not have control over the level of expenditure in insurance funds, which was driven by the market. While the introduction of compulsory health insurance has increased healthcare expenditures in total, the poor have been unable to pay their contributions and hence have been left out of this process. This has further created problems of risk adjustment, financial distribution between sickness funds, increasing burden of contributions and as a result increasing evasion of contributions in the initial phases.

*Croatia:* Croatia in the 1990s was one of the most open economies in Central Europe. It had a population of 4.5 million and services sector accounting for 60 percent of its GDP. The health sector reforms in Croatia were part of the larger economic reforms, which tried for structural adjustment. There had been effort toward developing a healthcare system, which would be compatible with market economy and resembling the models of developed European countries. The introduction of Health Insurance Act and Healthcare Law, created a new compulsory health insurance scheme for the entire population. The other mechanisms of financing were funds allocated in budgets for certain types of healthcare and certain groups of the population. These were people who could not pay health insurance contributions, like the children, pregnant women and persons above 65 years of age.
Besides there were voluntary health insurance schemes for those who could pay in private sector and there were compulsory forms of healthcare service which the employers had to pay directly, like the occupational diseases and accidents for workers.

While the per capita income in Croatia declined from US $5,106 in 1990 to $2,079 in 1992, the health share of GDP declined marginally from 10.6 percent in 1991 to 8.5 percent in 1992. It was being said that the health reforms in Croatia in a short period could contain costs and could improve the health status of its population. According to one estimate in October 1998, 10,000 Croatian enterprises were insolvent and if these were forced to close under new bankruptcy law than it would make 1,50,000 people as unemployed. Besides there were many Croatian firms which were not paying for their insured employees and the Croatian Institute of Health Insurance, which operates the health insurance in Croatia was in debt for US $115 million in 1997. Thus by the year 1999, the Croatian Health financing system was facing a severe financial crisis.

Slovenia: With a population of 2 million and a per capita GNP of $9,161 in 1997, Slovenia was the most prosperous country in Central and Eastern Europe, with the services sector accounting for 60 percent and the industry accounting for 32 percent of its output. The health care reform was introduced in March 1992 when a new healthcare law was accepted. The reform measures introduced were a national insurance scheme compared to the earlier budget financing, creating contracts between providers and the national insurance plan and a possibility of independent contracting with the national insurance plan.

In the economic front while the government followed a policy of fiscal prudence; however the social expenditures increased in 1990s. Whereas the healthcare expenditure was 8 percent of the GDP since 1991 to 1998, the actual health expenditure increased by 51.8 percent during this period due to the growth of per capita GDP. As the primary care providers and the specialists were paid according to a fixed number of points for service, the primary care givers had an incentive to refer and the specialists had an incentive to accept referrals. Due to this new law, the number of consultations per person per year increased significantly. Health insurance cards were introduced in 1998 by the Health
Insurance Institute of Slovenia. Simultaneously health professional cards were distributed to the doctors, medical nurses, pharmacists and other workers. Off late the institute was trying to evaluate the health insurance card project to better implement the health insurance scheme.

Therefore we have seen that the countries of Central and East European countries, which were going through a transitional phase in the 1990s were seeking alternative methods of funding for health services like, introduction of user fees, private health insurance, community based financing and general taxation etc. However since the insurance in these countries is employment based, it would be increasingly difficult for the poor, elderly, unemployed and the chronically ill to afford insurance coverage.

Russia\textsuperscript{32}: With the collapse of former Soviet Union in 1991, reform measures were undertaken in it's under funded healthcare service, which was known as Soviet Socialized Medicine. Untill about 1960s the healthcare services in Russia was one of the better performing sector in its economy. It was symbolic of the welfare aspects of the Soviet state. It was the first country in the history of the world, which made a constitutional guarantee of universal entitlement to free medical care to the entire population as the responsibility of the Soviet state. Thus provisioning and financing of healthcare became the responsibility of the state. There was no private sector. The entire manpower in the health sector was state employees. The other significant features of the Soviet systems were, health policy was closely integrated with national planning, the health system was highly centralized and the preventive aspects of healthcare were a significant aspect of the health system.

However the new Russian federation that came into existence in 1991, while emphasizing that all citizens have right to free healthcare, it suggested that the financing could be from variety of sources. On the other hand the broad reform measures suggested were:

\textsuperscript{32} For reviewing the experiences of Russia we have referred to Field, 2002; Burger, Field and Twigg, 1998; Cohen, 2000; Ellman, 1994; Farmer, 1999a; Friedman, 2001; Garrett, 2000; Godbeng and Kishovsky, 2000; Mckinlay, Mckinlay and Beuglehole, 1989; Preker and Richard, 1995; Rimashevskaiia, 1993; Sheiman, 1997; Shishkin, 1999; Smith, 1999; Woolhandler and Himmelstein, 1985.
decentralization, introduction of health insurance, market mechanisms and competition among the various players. Further the provisioning and the funding aspects of healthcare were separated. For the regional insurance funds, a 3.6 percent tax of the salary fund for every enterprise of the region was levied.

The evidence suggests that the new insurance scheme has not succeeded and the growth of private insurance companies has been quite slow. It was also been observed that funds available for various regions have differed significantly.

Israel\textsuperscript{33}: By the year 1994 Israel had four private not-for-profit sick funds, which offered voluntary comprehensive health insurance and it covered more than 95 percent of its population. Significantly apart from the curative and acute hospital care, preventive community care was also been covered under this insurance scheme.

The health sector reforms in Israel were initiated with the passage of National Health Insurance Law in 1994. This new law aimed at universal health insurance coverage, promotion of equity, defining a universal benefit package, creation of multiple providers, to improve the quality of care and to free the ministry of health from operational responsibilities. Since 1980s the private health insurance market has grown rapidly in Israel. An analysis of healthcare expenditure pattern in 1994 showed that 27 percent of the national health expenditure came from the central budget, 22 percent came from the employers, 21 percent by sick fund membership fees and 25 percent from payments for services and medicines. In the 1990s while the share of government expenditure to healthcare declined, the share of membership fees increased and out-of-pocket payments remained unchanged. It has been observed that the household healthcare expenditures in Israel increased by nearly 50 percent from 1986/87 to 1992/93.

The larger causes for reforms in health sector of Israel were same as in other countries like the reevaluation of the welfare state and its underlying ideologies. The rising costs of

\textsuperscript{33} For reviewing the experiences of Israel we have referred to Gross and Anson, 2002; Chernichovsky and Chinitz, 1995; Chinitz, 1996, 1994; Gross and Harrison, 2001; Gross, Rosen and Chinitz, 1998; Shirom, 1995; Twaddle, 1996; Yishei, 1982.
healthcare and the welfare measures had exceeded the economic growth and the government was unwilling to increase taxes. At the same time the public healthcare was criticized as inefficient and in many cases it was termed as wasteful expenditures and in its place new terms like cost containment, accountability, competition and pluralism were used. Further to introduce reform elements other countries initiatives were studied. Thus the recommendation to transform hospitals into competing legal entities resembled the hospital reform in Britain.

Argentina 34: Since 1940s the healthcare services in Argentina was based on the concept of welfare state. However the beneficiaries were some selected sections of the society like trade unions having closer ties to the state apparatus. These trade unions were given the task of managing the sickness funds, which was created out of compulsory contributions from the employers and employees and from the state subsidies. The rest of the population got health services either through participating in mutual aid institutions or through the public services, which were expanded during 1946 to 1952.

The public healthcare services were divided into national, provincial and municipal jurisdictions, which were intended to serve the poorer sections of the society. However as the sickness funds were controlled by the traded unions it became difficult for risk pulling so that all the working class population could be covered for necessary healthcare. From late 1950s onwards the sickness funds started only the financing of healthcare services and the responsibility of provisioning of healthcare was left to the professionals, which was earlier being done by the sickness funds through remuneration of professionals in its own hospitals and ambulatory clinics since 1940s.

In the late 1950s the professionals created their local, provincial and national confederations, thus taking charge of the services being provided by their members and the management of the respective contracts. As a result liberal medical practices like, choosing a physician of patient's choice, professional autonomy, user fees and the promotion of curative care were promoted. While the sickness funds and the private

34 For reviewing the experiences of Argentina we have referred to Belmartino, 2002; Acuna, 1994.
sector provided services to the working population and the large part of the middle class like the businessman and the professionals, the public subsystem provided free healthcare to the population outside the labor market. Therefore while the sickness funds and the private sector were catering to the population living in urban areas, the public subsystem catered to the population living in semi-urban and shanty towns characterized by unavailability of adequate infrastructure.

In the late 1960s the private health insurance associations begun to develop but maintained a limited presence till 1980s. These were promoted by professional groups or private hospitals. In the 1980s the Argentine economy faced serious crisis of foreign debt and fiscal crisis at home. This had a deep impact on the social sectors like healthcare. To address the ills of the economy, reform measures were introduced and simultaneously reforms were introduced in the health sector.

Some of the reform measures were like, making it compulsory for every worker to channel his or her contributions to the obra social or sickness funds associated with respective trade unions. The idea was to generate greater efficiency among the sickness funds through introducing competition among themselves. Secondly, to help the hospitals and health centres to generate resources, it was made mandatory for the sickness fund to pay for the services, their members had utilised from these institutions. Further the choice of joining different sickness funds was left to the workers to be decided. However the efforts to deregulate the sickness funds from trade unions could not succeed.

Mexico\textsuperscript{35}: The healthcare system in Mexico had been a public-private mix in financing and delivery of healthcare services. With 98 million population it was the second largest country in Latin America and also a middle-income country with a GNP of $ 4,410 in 1999. The healthcare system in Mexico had developed over the years with the patronage of the state. Prior to getting independence in 1921, the healthcare in Mexico was mainly being provided by the Catholic Church, which created various nursing homes and

\textsuperscript{35} For reviewing the experiences of Mexico we have referred to Arenas, Cervantes, Dantes, and Rubi, 2002; Cassels, 1995; Cleaves, 1987; Donabedian, 1980; Frenk, Dantes, Cruz, Freeman, 1994; Hsiao, 1994; World Bank, 1993, 2000.
hospitals. After getting independence the healthcare system was based on the concept of welfare state. With the growth of industrial economy in 1940s, institutional mechanisms were created to provide healthcare to the most organized sector workers and by 1960s this provision was also extended to the working class population. Along with these public healthcare institutions, there were individual and group private practitioners who catered to the small section of a population with a high socioeconomic status.

The healthcare reforms initiated in 1980s was intended to check the disorderly growth of medical care in both public and private sector. It also aimed at addressing the problem of access to healthcare for all. The reforms during 1982-1988 increased the space for the private sector and gave it legitimacy as an important aspect of healthcare. Prior to the 1980s, the Mexican state used to contract most of the physicians active in the medical labor market. However since 1993, with the influence of international agencies, efforts were made to crate pluralistic systems in healthcare in the model of medical care institutions in USA.

The 1984 general health law tried to establish a national health system according to which the public institutions had to cater to needs of the uninsured population, which was 35% of the total population; the social security institutions and the social services were supposed to cover 59% of the total population and the remaining 6% were to be covered by the private services. Further the decentralization process was created in 1987, which created a number of health agencies in different parts of Mexico with autonomy for financial management and healthcare delivery. Efforts were also being made to create managed care institutions for those sections of the population who could pay for their health insurance; thus creating ‘freedom of choice’ for the users, which would increase the efficiency of entire social security system.

*Chile*³⁶: Since 1920s the Chilean system of healthcare was based on the state responsibility for the public health. The Sanitary law in 1918 established the public responsibility for sanitation and preventive health programmes. With the creation of

³⁶ For reviewing the experiences of Chile we have referred to Jara and Bossert, 1995; Reich, 1995; Grindle and Thomas, 1991; Bossert, 1994.
National Health Service in 1950s this trend was further strengthened. It utilised the social security contributions and general tax revenues to provide healthcare through public hospitals and clinics. This was possible because at that time a coalition of political parties known as Popular Front was in favor of a democratic socialist state intervention in the social sector.

With the introduction of market mechanisms in Chile in early 1980s, health sector reforms were also introduced. In the 1980s decentralization of primary care and privatisation of health insurance mechanisms were introduced in the health sector. In the 1990s the public-private partnerships were encouraged more and this further strengthened the increasing role of market in Chilean healthcare.

Australia: According to the many observers, the modern Australian healthcare system had been influenced by one- the requirements for public services for the needs of soldiers and felons who were servants of the crown, two- private services for wealthier sections and three- charitable or volunteer services for the poor and sick. Thus the development of Australian healthcare system had been influenced by colonial settlements of the white population. The free settlers were expected to develop land and commerce without any dependence on the state. Therefore all immigrants were seen as 'assets' and this also reflected that the state would take minimal responsibility for the well being of its citizens.

In this context the healthcare system in Australia has developed as a mixture of public and private sector involvement. The national healthcare delivery system, which was financed mostly by the general taxes, had provisions for free healthcare for public patients in public hospitals. Another important feature of Australian healthcare system was the Medicare Levy introduced in 1984 to generate additional revenues for healthcare. Thus the medicare Levy has increased from 1% in 1984 to 1.5% of the taxable income by the year 1997-98. According to one estimate the medicare levy was generating 20% of the commonwealth health expenditures in Australia.

Near about fifty percent of the private sector has been owned by for-profit organizations. Many of them had been listed in the Australian stock exchange and with substantial overseas shareholdings from Southeast Asia and the United States of America. The rest of the fifty percent of the private sector was being owned by not-for-profit organizations, mostly the Catholic Church. These not-for-profit healthcare institutions enjoyed various tax exemptions. The health insurance existed in both for-profit and not-for-profit private organizations.

In 1973 Health Insurance Act tried to introduce universal access to healthcare, which was opposed by the medical profession on the ground that it was interference in the realm of medical autonomy and professionalism. Thus by 1978 the universal health insurance scheme was almost abandoned and by 1983 private sector was subsidized to create voluntary health insurance schemes. Thus in 1984 while 50% of the Australians were covered by private insurance scheme Medicare, by the year 2000 the number declined to 32.7%. The Medicare system reimbursed about 85% of the cost of medicare. The idea was to prevent patients from overuse of the system and to make them aware about the cost of care. Over the years due to high fees of insurance those having least need for it were just giving up.

The introduction of medicare scheme had increased the cost of healthcare in general and the in-patient care in particular. The effort by the National Health Strategy of 1990s to contain the increasing healthcare delivery cost had not succeeded much. In the 1990s it had been observed that a large section of the population who had the private health insurance used the state public hospitals. One explanation has been that the patients were reluctant to pay extra private hospital charges.

China\textsuperscript{38}: The healthcare reforms in China were closely related to the economic reforms introduced in 1979. In 1949 when the Peoples Republic of China was established, the

\textsuperscript{38} For reviewing the experiences of China we have referred to Anson, 2002; Berrios, Koponen, Huiguang, 1997; Chen, Hu, Lin, 1993; Dezhi, 1992; Dong, Bogg, Rehnberg, Diwan, 1999; Henderson, Jin, Akin, Li, Wong, Ma, He, Zhang, Chang, Ge, 1995; Hesketh and Zhu, 1997; Huang, 1988; Kan, 1990; Lawson and Lin, 1994; Lennart, Dong, Wang, Cai, Vidon, 1996; Liu, Hsiao, Eggleston, 1999; Normile, 2000; Popkin,
health indicators like IMR and MMR were very high and the healthcare service were very weak. Most of these services were located in urban areas and they were privately owned. The rural population mostly had to depend on the traditional healers.

The first five year plan introduced in 1949 laid out the policy that the healthcare should be provided to workers, soldiers and the farmers through publicly financed and owned healthcare services. It tried to integrate the traditional Chinese medicine with Western medicine, gave priority to prevention of communicable and infectious diseases, aimed at creating mass movements for eradicating these diseases and emphasized the aspects of personal hygiene and benefits of nutrition. These policy goals were implemented in second and third five year plans.

With the creation of a communist state, the government confiscated private capital and land. In the health sector the private institutions were also handed over to the government and the doctors in private practice were gradually recruited by the growing public sector. As a result by 1962 only 3.2% of the doctors were in private practice compared to 56.5% in 1950. By the end of 1950s these policies improved health status of the population and also had created a well-developed health network for the rural population.

The Cultural Revolution from 1966 to 1977 introduced by Mao Ze-dong led to near about 20 to 30 million loss of lives. This was an effort to speed up industrialization and allocating most of the resources and rural manpower for this purpose. During this period the remaining private sector in healthcare was banned, the research in higher medicine was abandoned, hospitals were closed, and the number of health facilities declined by 33%. While there was a decline in the total number of healthcare personnel by 5%, the number of nurses and midwives increased by 25% during this period. Thus on the one hand while the urban healthcare institutions were adversely affected, the rural healthcare institutions continued to grow. The barefoot doctor scheme was introduced and 2 to 4 barefoot doctors served a population of 1,000 to 3,000. During the first three five year

plans the rural cooperative insurance schemes were introduced and later these were made compulsory during the Cultural Revolution.

These initiatives made the healthcare accessible to all the rural population and all the rural and urban population were entitled to at least one health insurance scheme. However the Cultural Revolution ruined the economy and with the introduction of economic reforms in 1979, collective agriculture was disbanded and land was distributed to families according to household size. Due to this changed policy the cooperative medical schemes collapsed in rural areas. As the medical insurance was left for the farmers' choice the collection for the premiums failed. The private ownership of land created a wealthier section in the villages; those preferred the county or city hospitals. As the demand for barefoot doctors declined, their standard of living also started falling. The fee-for-service scheme was introduced for the village doctors. Further the cost of running the county hospitals and the township health centres was left on the user fees. This closed down many of these institutions and also many of them reduced the number of staff and beds.

With the increasing privatisation of healthcare in rural and urban areas, the cost of out-of-pocket health expenditure has also gone up since 1980s. However efforts have also been made to improve the quality of care by introducing licensing procedure for the village doctors and establishment of pharmaceutical standards. Thus along with the change in the larger economy of China, the changes were also introduced in the health sector in terms of financing, provisioning and manpower.

Zambia: Zambia got independence in 1964 and it inherited a medical system biased toward the urban and copper mining areas. The healthcare services during the colonial period were free from the public sector. However due to its bias toward urban based tertiary care, it was out of reach for a large section of the population. Since independence
an effort was made to address this anomaly in the healthcare through a state led intervention in health services.39

In the 1980s Zambia faced economic crisis with falling copper prices, which was its primary source of income, and the rise in oil prices. This forced the Zambian government to approach the IMF for a loan under the structural adjustment programmes. In 1987 the government of President Kaunda tried to cancel this process but could not succeed. Thus with the SAP introduced in the economy, it affected the health services structure in the country. Due to the cost containment measures introduced in health sector, the per capita health expenditure by the government declined by 30% in 1992 compared to the year 1982. This led to shortage of drugs and medical supplies and further one-third of the senior medical personnel left their jobs and most of them went abroad. Child mortality and infant mortality increased during this period and 1980s also saw the emergence of malaria and HIV/AIDS, which further increased pressure on the under funded healthcare in Zambia.

The health sector reforms introduced aimed at providing cost effective and quality healthcare through introduction of essential health package.40 It further emphasised on the primary and preventive care rather than on the high-tech tertiary and curative care. As a cost sharing mechanism user fees were introduced in 1992-93. Although exemptions were there for the poor and the vulnerable, in practice these were not fully implemented. While the healthcare expenditure increased from 5.7% in 1991 to 13.7% in 1997 to the total government budget, the allocations were made according to the priorities identified in the health sector reforms.

The Indian scenario41:

39 “Health Sector Reforms in Zambia: Implications for Reproductive Health and Rights” by Priya Nanda, Centre for Health and Gender Equity, working papers, October 2000.
40 The six major thrust areas of this package were, maternal and child health, malaria, family planning, HIV/AIDS/STDs, Tuberculosis, Water and Sanitation. -Ibid.
In India the reform initiatives have to be seen in the larger context of economic liberalization in the nineties. In the health sector over the years India was able to develop a network for healthcare provisioning in primary, secondary and tertiary levels of care. The private sector had been allowed to grow in the mixed model of economic development followed by India. Even the private practice by government doctors had been allowed in many states. Initially in the years after independence the idea was to focus on the preventive care supported by the curative care. However over the years the developments in the health sector followed a path where the health services structure grew mostly in the urban areas and with a focus on the curative aspects. With the abolition of import duties on high-tech equipments in the eighties, the curative care had moved more toward a high-tech care and as a result the cost of care had increased much more in the nineties than the earlier decades.

Therefore we could say that the changes in the health sector in India have occurred due to:

1- The inherent needs of the country at large and of the state governments.
2- Policy interventions at the Central and the State government levels.
3- It has occurred also due to the influence of World Bank through its various projects and specifically through its State Health Systems Development Projects.
4- The larger phenomenon of economic reforms have also changed the perceptions among the political parties and among the middle class, who were the main beneficiaries of economic reforms and they argued that except at the primary level care, the state should not get involved in secondary and tertiary level care.

*Classification of reform elements*\(^{42}\):

Here we would be discussing about eleven states\(^{43}\) where reforms have been initiated. We would be making a distinction between the initiatives, which could be mentioned as

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\(^{42}\) Here we have classified various initiatives by different state governments in India in terms of 'health sector reforms' and 'systemic changes' according to the new definition we have given in this thesis. In Chapter V we have classified health sector reforms and systemic changes in the context of Orissa and Chapter IV has specifically discussed about State Health Systems Development Projects and Orissa Health System Development Project as major reform elements.
systemic changes, and the initiatives, which could be mentioned as health sector reforms using our new definition of health sector reforms.

**Systemic Changes:**
Systemic change means that a system trying to respond to new situations to remain efficient. It becomes necessary because the earlier arrangements were not able to respond to new challenges and hence some changes need to be made in the earlier set up. So let us first look at those initiatives, which have been mentioned as reforms but more appropriately could be termed as systemic changes.

**Decentralization:**
This was about bringing the primary health centers under the control of Panchayati Raj Institutions. Thus the *Punjab* government had thought about giving the supervisory, administrative and financial powers to the Panchayats over the PHCs. Similarly block health office has been created in *Gujarat* from where one person would act as an interface between the district and the block PHCs. This person would also intermediate about implementation of the national programs. In *Himachal Pradesh* Parivar Kalyan Salahkar Samities or PARIKAS have been formed at all the three levels of Panchayati Raj Institutions. At all these levels the Panchayat president was also the president of PARIKAS. Funds under family health awareness camp and Mahila Swasthya Sangh had been given to these *samities*. Also the state government had tried to make aware the PRIs about health related programs. On the other hand *Kerala* was an exception, where the healthcare institutions along with the funds have been handed over to the PRIs for a responsive healthcare system. In Tripura PRIs have been involved in the implementation of national health programs.

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43 Punjab, Rajasthan, Gujarat, Himachal Pradesh and Uttarakhand, Andhra Pradesh, Kerala, Madhya Pradesh, Delhi, Tamilnadu and Tripura. These states have been selected as mentioned in the Proceedings of Workshop on “India’s Health System: Role of Health Sector Reforms” held on September 4-5, 2003 at India International Centre, New Delhi, India. This did not include the states like West Bengal, Karnataka, Orissa and Uttar Pradesh, which have accepted the State Health Systems Development Project funded by World Bank as we have discussed about these initiatives in Chapter IV in detail.

44 This nature of control varies from state to state.

45 The personnel were expected to help the district authorities about planning, implementation and review of activities related to block PHCs.
Changes in the drugs system:

This systemic change has been widely quoted following its successful implementation in Tamilnadu and this was later implemented in different aspects by Orissa, Rajasthan, Himachal Pradesh, Andhra Pradesh, and Delhi governments. Although it has been identified as drug reform it was in fact a systemic change. Under this an essential drugs list, centralized purchase, use of generic drugs, rationale use of drugs had been incorporated. It needs to be mentioned that the changes in the drugs system has been limited to only the government healthcare institutions. The widespread private sector has not been covered and this was a major flaw of this initiative because the utilisation pattern\(^{46}\) across states both for in-patient and out patient care shows that private sector was accessed by maximum number of people.

Others:

This category includes a variety of initiatives by different states to strengthen their healthcare delivery systems. Some of these initiatives were: Introduction of mobile health clinics, reviewing the performance of all hospitals on a monthly basis etc. by Punjab government. Training of personnel to fully utilize the available manpower in Orissa\(^{47}\); Giving some financial power to the medical officer in charge at the block level for petty maintenance in states like Himachal Pradesh and Orissa; Creation of hospital advisory committees for greater autonomy and accountability at hospital level in Andhra Pradesh; Grouping of CHCs in Gujarat to make available the expertise of specialists; Integration of ISM and H practitioners for better implementation of national programs in Himachal Pradesh; Establishment of Emergency Obstetric Care in remote and inaccessible areas in Gujarat to address the high maternal mortality rates; Creation of ZSS in states like Himachal Pradesh and Orissa for better functioning of district societies; Introduction of Disease Surveillance mechanisms as it was the case of Orissa, Kerala and Himachal Pradesh; At the national level the change in population policy from MCH to RCH in the 1990s.

\(^{46}\) See for example the National Family Health Survey I and II figures.

\(^{47}\) In case of Orissa these were Lab Technicians. It needs to be mentioned here that if the existing staffs are trained to fulfill the shortage of staffs than that initiative could be termed as a reform initiative for it talks about the use of existing staffs efficiently. This issue has been discussed in chapter V where Orissa experience has been analysed.
The above list was not an exhaustive one, however these have been some of the initiatives those had been taken by many states and identified as health sector reforms. Here it has been argued that these changes were meant to improve the existing healthcare system, which was an integral part of any system.

**Health Sector Reforms:**

Now let us have a look at the initiatives, which could be termed as health sector reforms according to the definition that we have provided.

**Introduction of User charges:**

User charges have been introduced in all the states, which have implemented the State Health Systems Development Project funded by World Bank. The rationale of this project has been to focus more on secondary level care so that the states could invest their limited resources in primary level care. While creating facilities like addition in terms of beds, equipments and specialist care, it has tried to impose a price for it. The argument was that those who could pay for it should be charged and introducing user charges would deter people from unnecessarily using healthcare facilities, just because they were available free of cost. However the difficulty lies in when the matter comes about exempting the poor from user charges.

User societies have also been created at the district level for management of funds. It has been ensured that the money generated in one institution was spent in that institution only. However the International experience and the experience from states show that the collection from user charges were very low and hence it was good to the extent that the money generated helps in petty maintenance. It was not sufficient enough to run an institution.

User charges have also been introduced by states like Himachal Pradesh by creating institutions like Aspatal Kalyan Samities at Zonal and District and sub divisional

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48 Any system tries to incorporate changes in it keeping in view the new challenges it faces in its day-to-day functioning so that it retains its relevance. However there is a thin dividing line here, which suggests that we need to separate the health sector reforms from systemic changes. Although the private sector has existed in healthcare prior to the 1980s in many countries, still the space the state has been providing to the private players in health sector since the decade of eighties is unprecedented for last two centuries.

49 This issue has been discussed in detail in Chapter V.
hospitals level. These Samities were also engaged in generating resources through community financing. Similarly Medicare Relief Society in Rajasthan$^{50}$ had been created to collect user charges at district, sub district and at CHC level.

Contracting out services$^{51}$: 
Another reform initiative has been contracting out or out sourcing of services in secondary and tertiary level institutions. The services, which have been contracted out to the private sector were security, sanitation, ambulance services, and dental services in Punjab. The IEC activities in Gujarat; Cleaning in Orissa; Scavenging, laundry and diet in Himachal Pradesh; Sanitation, laundry and diet services in Uttaranchal; Security and cleaning in Andhra Pradesh; Cleaning, laundry and security in Rajasthan; Diet, catering, laundry, security and IEC in Tamilnadu and maintenance of hospitals in Tripura.

Public private partnerships:
This aspect has taken various forms in different states. For example some states had tried to hand over the PHCs in remote areas to the NGOs, as it was the case of Orissa and creation of pay clinics in medical colleges or leasing out operations and maintenance of hospitals, as in case of Punjab etc. In Gujarat Initiatives have been taken toward providing primary level care to the urban population, through community based health volunteers; to address the shortage of specialists in medical services private doctors have been appointed in some institutions; one PHC and three CHCs have been handed over to NGOs etc. and handing over one PHC each in the tribal areas in Andhra Pradesh to NGOs. In Himachal Pradesh medical treatment by government employees were reimbursed if it had been availed in select private institutions. On the other hand Tamilnadu had involved the business groups in adopting a local PHC or sub center or a district hospital to ‘improve their performance’.

Setting up Private Institutions:

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$^{50}$ It needs to be mentioned that Rajasthan was one of the states where the State Health Systems Development Project was going to be implemented as part of phase II of this project.

$^{51}$ Here we have mentioned it as a separate reform initiative. However the initiatives taken under this sub heading could also be included under the category of public-private partnerships.
Encouragement to the private sector for establishment of medical colleges in Andhra Pradesh and Orissa and to create training institutions for paramedics by the private sector in Andhra Pradesh, were some of the initiatives in this direction. Rajasthan on the other hand had allowed private sector to provide medical education and training.

**Contractual paramedics and doctors at the district level:**

This has been created in the states of Rajasthan, Orissa and Andhra Pradesh. It needs to be mentioned here that while the states like Himachal Pradesh have made the paramedics as district cadre\(^52\) they have not made their appointment contractual. In states like Uttarakhand, ANMs and medical officers were appointed on a contractual basis in remote areas. Similarly in case of Orissa contractual doctors could be appointed by CDMOs to fill the shortage of staffs at periphery\(^53\) level institutions.

These were some of the initiatives by the state governments in India which has been classified here as health sector reforms. However our definition of reforms in health sector has kept a wider scope for inclusion of any other private initiative or increasing space for the private sector as a reform initiative in healthcare.

**Conclusion:**

The review of existing definitions with regard to health sector reforms showed that they were trying to include all the changes being taken by various states in the decade of 1990s within the health sector as an element of reform. This was creating a definitional confusion and hence also in classification of this phenomenon. According to our new definition, health sector reforms were an effort by various states to increase the space for the private sector in health care since 1980s. Using this definition we have identified different reform measures being carried out in various countries of the world. In the context of India we have made a distinction between health sector reform measures being carried out in different states and the phenomenon of systemic changes.

\(^52\) However Orissa had made the district cadre for paramedics as contractual in nature.

\(^53\) At the PHC level institutions.
We have said that the term health sector reforms have been broadly associated with the concept of Structural Adjustment Programmes. It was part of the ‘reform measures’ being followed in the social sector of different country economies. The elements of market were also introduced to the health sector and the focus was mostly on the healthcare services and the financing aspects.

Describing about various country experiences from Europe, North America, South America, Russia, China, Australia, Africa and India, we have shown that the phenomenon of health sector reforms were carried out since the beginning of 1980s. It was part of the reform measures being introduced in the larger economy, which tried to give a larger role to the institution of market, and at the same time tried to reduce the role of the state as a regulator, which promotes fair competition among the private players. Therefore as the allocation of resources was reduced in the social sectors, health was seen as an individual responsibility. Similarly the concepts like ‘efficiency’ and ‘effectiveness’ were introduced in the health sector. It was argued that the limited available resources need to be used efficiently to achieve maximum output. This was to be done through reorganization of the existing healthcare services, introducing private managerial practices, increasing users choice through encouraging private sector in provisioning of healthcare, cost cutting measures through focusing resources more on the selective primary level care, reducing the budgetary expenditure on secondary and tertiary levels of care etc. To generate resources for the health sector it encouraged private participation through introducing private or community insurance mechanisms and by introduction of user fees etc.

Our review of various country experiences showed that while the process of health sector reforms have been documented, there have been very few evaluative studies about this phenomenon.

However concerns have been raised about this new understanding of healthcare, which places the responsibility of good health on an individual. In this new approach
interlinkage between various levels of care and the inter-sectoral aspects\textsuperscript{54} of healthcare has been missing. Further it has been criticized on the ground that it promotes a unified model of healthcare and in that process neglects various country contexts. It also emphasizes on curative care and neglects the preventive aspect, which is such an important element of raising health status in developing and under developed countries. Therefore it has raised apprehensions in many quarters that years of gains in health sector could be undermined due to the introduction of market elements. This has got serious implications for the health status of the poorer sections of populations in various countries adopting health sector reform measures.

\textsuperscript{54} Here various levels of healthcare suggests about primary, secondary and tertiary levels of care. The inter-sectoral approach places health within the framework of socio-economic and political developments of a country.