Chapter II
CHAPTER II

HEALTHCARE DECENTRALISATION:
REVIEWS, RESEARCH ISSUES AND GAPS

The objective of this chapter is to explain the concepts and components of healthcare decentralisation. It also critically reviews the existing literature on healthcare decentralisation, which is useful to figure out the issues and identify the research gaps for the present study.

2.1.0. Concept of Decentralisation and different forms of Decentralisation:

Many writers have written about decentralisation policy and so far have shared a relatively concise definition of decentralisation. According to them decentralisation, in general term, is the transfer of authority and power in public planning, management and decision making from higher to lower levels of government or from national to sub national levels (Rondinelli, 1981; Collins and Green, 1994; Mills, 1994). This definition is actually formulated in a very broad sense. Therefore Collins and Green (1994) further clarify that it is necessary to distinguish the process of changing power relationship and responsibilities from the centre to the periphery within a specific government sector with similar processes. It has been advised that decentralisation should start in priority areas such as health and education. (World Bank, 1997). The present focus is related to the healthcare decentralisation in the regions across the Union Territory of Pondicherry.

Decentralisation involves both deconcentration, in which local bodies are asked to assume responsibilities that have traditionally been carried out by central
line agencies and Devolution, in which local bodies are granted the political and financial authority to undertake the duties (Blair 2000; Crook and Manor, 1998; Rondinelli et al., 1989). A study shows that devolution can enhance rural livelihoods in a number of ways. First, the establishment and empowerment of local resource user groups can improve the ways in which local people manage and use natural resources, thereby improving the resource base on which poor people are often disproportionately dependent. (IFAD, 2001; Ostrom, 1990). Delegation and Privatization are engaged in the transfer of functions to organisations outside the central government structure. In delegation, some large referral and teaching hospitals are now operating under the management of an agency. On the other hand, privatization involves the transfer of government functions to the voluntary or private sector. In this last form of decentralisation, it is intended to open greater room to public voices and choices. The interest in non-government organisations (NGOs) and private sector’s role of service delivery has grown rapidly over the last decades in almost all developing countries.

Studies based on types of decentralisation provide the necessary background for the analysis of the existing situation in the Union Territory of Pondicherry and they also confirmed the manner in which the different concepts are used for the analysis. Therefore a review of this related studies become a meaningful and logical starting point of the present empirical enquiry

2.2.0. Existing Literature in Healthcare System at Decentralised Levels:

Healthcare system is an institution through which healthcare services has been delivered in any country, which may be explained by the healthcare financing and delivery systems. The challenge of reforming healthcare financing functions, in most developing countries like those of South Asia is to harmonize them through protecting people financially in the fairest way possible. This is achieved by providing appropriate incentives that are given to healthcare providers and motivating them to improve the health of the people which eventually improves
the responsiveness of the system. However, in most conditions the coordination between the healthcare financing and healthcare delivery system is mismatched, which leads to distortions in the healthcare delivery system. Empirical studies on healthcare system over the years have been carried out and came out different policy options and strategies at different conditions. The main thrust of this section is to review those studies and identify the research issues for present study.

2.2.1. Healthcare system: Review of International Studies:

Recent years, studies on healthcare system and its functions are well documented including South Asian countries. The studies like O’Donnel, Van Doorslaer et al. 2005 found that out-of-pocket payments are the principal means of financing healthcare throughout much of Asia. In fact, the threat of Out-of-Pocket Payments (OPP) pose to household living standards is increasingly recognized as a major consideration in the financing healthcare (Whitehead, Dahren et al. 2001; Kawabata, Xu et al. 2002; Meesen, Zang et al. 2003; OECD and WHO 2003; World Bank 2004). The expenditures that financially catastrophic severely disrupt household living standards including trap of these people into poverty. A recent estimate found in India that nearly 25 per cent of those hospitalized fell below the poverty line because of huge medical costs (World Bank, 2001). One can conclude that ill-health depletes household savings and earnings and impair the capacity of adults and children to work and learn, fostering conditions that create and perpetuate poverty. Therefore, the healthcare financing system plays an important role in determining access to healthcare services of the poor at the State level in India. The results of household survey at State level in India also indicate that there is a disadvantage situation to the poor in healthcare financing system as there is a high reliance on out-of-pocket payments for financing healthcare, which is the worst possible option for the poor and vulnerable people at the State level in India (Mathiyazhagan 1998). In fact, the poorer countries rely more heavily on direct payments. The OPP contribution reaches three-quarters or more of total expenditure on health in Nepal, Bangladesh, India and Vietnam (Van Doorslaer et al. 2005). Low-income country like Sri Lanka manages to keep the
OPP share of financing below 50 per cent and therefore the catastrophic and poverty impact of these payments are modest.

It is important to note that earlier estimations of the impact of OPP payments on living standards in developing countries have relied on micro-level health surveys, which are not nationally representative and often being restricted to rural areas (Sauerbron, Ibrangho et al. 1995; Ensor and Pham 1996; Sauerbron, Adams et al. 1996; Pannarunothai and Mills 1977; Kamara et al. 1999; Ranson 2002; Segall, Tipping et al. 2002; Skarbinski, Walker et al. 2002; Mathiyazhagan 2003a; 2003b; Russell 2004; van Damme 2004). Therefore, the estimations of the micro-level surveys biased towards small sample.

The existing estimations also indicate that healthcare finance out of general government revenue is relatively very low in the Asian countries. It ranges from over 50 per cent in Thailand and Hong Kong to just less than 10 per cent in Taiwan (O’Donnel, Van Doorslaer et al. 2005).

2.3.0. Healthcare system: Studies from Indian Context:

Providers of healthcare services form an important part in the overall delivery of healthcare services. These services are organized through a network of hospitals, dispensaries, nursing homes, diagnostic centers, blood banks etc., in both the public and private sectors. Research studies dealing with various aspects of providers focus on a number of different areas. These can broadly be categorized into four groups

❖ Studies on Health Infrastructure
❖ Studies on Health Human power
❖ Studies on Organisational Dynamics
❖ Studies on Health Finance
2.3.1. Studies on Health Infrastructure:

The information on health infrastructure has been generated by using methods like survey, record checking and physical verifications. The units of analysis have ranged from individual health units to a combination of health units across different states. The key topics that have been covered include

- role and functioning of PHCs and SCs
- location and coverage of various health institutions
- type of healthcare services provided through them
- facilities available for health work
- presence, nature and adequacy of delivery systems
- efficiency of health institutions

In most cases, the survey of PHCs covers more than the expected population of 30,000. Of these, it is only those people living, on an average, within a radius of 6 kilometres who were able to take advantage of the services being offered at the PHC. The percentage of villages not covered by the PHC varied from 23 percent to 94 percent (ICMR, 1991). In addition, to problems of geographical accessibility, 60 percent of the PHCs were inadequately stocked with antibiotics and 40 percent did not have oxygen supply. While PHCs were provided with an adequate supply of vaccines and contraceptives, 30 percent did not have any of the supportive emergency drugs. 25 percent of the PHCs were without labour rooms and 16 percent without Operation Theatres (OT). Wherever present these were poorly equipped and maintained. Transportation facilities were not satisfactory. The studies concluded that the quality of healthcare through PHCs needs to be improved (Chauhan R. C et al, 1985; ICMR, 1991).

Further, the hospital based studies (Mahapatra P et al, 1992) have shown that hospitals are not performing as well as they are expected to, leaving a lot of scope for improvement. It implies that the hospitals in India are cost inefficient and the inefficacy of the public hospitals are higher than the private hospitals.
(Mathiyazhagan 2005), which calls for reforms in the financing of the public hospitals at the State levels in India.

2.3.2. Studies on Human power:

Most of the studies in which the questions of staff training and performance have been conducted in public healthcare institutions and have focused on personnel in rural-based PHCs, including Auxiliary Nurse Midwives (ANMs), Multi-purpose Workers (MPWs), CHVs and TBAs. While studies in private sector are grossly inadequate, those done in NGO sector have looked at the role and functioning of health functionaries with a slightly greater emphasis on the aspect of training.

With some exceptions (Jesani A et al, 1992) studies on health human power have approached the issues related to health staff from an operational-rather than social perspective.

Studies show a wide gap exists between the number of sanctioned posts and those which are actually filled. (Ghosh B, 1991). Lower level staff in PHCs suffered as a result of poor supervision (Durgaprasad P et al, 1989). Many of MOs are busy with their private practice. Hence lower level functionaries are expected to carry out their responsibilities with whatever training they have been given. As a result, health functionaries exhibit a number of gaps in knowledge and skills (IIHMR, 1991)

2.3.3. Studies on healthcare financing:

Broadly, the studies covered under this area focus on the costs of programs, projects, revenue raising methods, cost benefit studies, earnings of health providers, etc. The studies on the public health sector have covered topics like cost analysis of PHCs (Kataria M et al, undated ) and operational efficiency of

The studies on the private sector have mainly looked at the earnings of the health institutions and practitioners. The studies show that many of them are dependent on outside sources for funds to run their projects. Fees constitute, on an average, only 20 to 30 percent of the total cost incurred on running a particular service. The cost analysis of PHCs show that the per capita expenditure incurred is far too little (Kataria M et al., undated).

As per Kansal S.M., 1992 brought the fact that the average monthly net income of a doctor practicing at a clinic/residence earns about Rs 29,800 per month while a doctor running a nursing home ranges about Rs 80,000 per month.

2.3.4. Studies on Organisational Dynamics of Healthcare System:

The major focus of the studies has been on Management Information Systems in the public healthcare model. This covers from the secretarial level to the program officer level. The studies show that there exists a lot of duplication of reports and no prescribed standards. Moreover, studies show that factors affecting utilization were due to an inappropriate program approach, lack of administrative control, absence of monitoring and supervision, financial constraints, poor staff motivation and demand constraints (Public Systems Group, 1985).

2.4.0. Studies on Access and Utilization of Health Services in India:

The prominence of the private sector in terms of location access appears to be less pronounced in another study conducted at the national level (NCAER, 1992). This is mainly because they have taken the frequency of the facilities utilized as the base, instead of the episodes under each distance category. As per their analysis, while 74.89 percent of episodes treated in urban areas by government doctors, were from the one to two kilometre category, the same for rural areas was only
33.52 percent. This is because of the inadequacy of treatment facilities for serious illnesses in public or private sectors in rural areas, more people content themselves with the public sector, because of its less expensiveness. The study also brings out that while treatment for diseases was available in 80 percent of cases within one to two kilometres in urban areas, in the rural areas medical aid was sought only in 39 percent illnesses at short distances 20 percent of all cases in rural households travelled for more than 10 kilometres distance for treatment (NCAER 1992).

Most of the studies analyze the data on utilization by class and rural-urban differences. One of the important studies done in urban area by the Operations Research Group shows that even in urban India, where location accessibility of public health services is quite high, people are forced to go to private health sector because of following reasons

- Long waiting time
- Not satisfied with treatment
- Govt. Doctor/facility too poor
- No transport
- No staff for emergency
- Lacks personal attention
- Lack of availability of medicines

2.5.0. Reviews from Studies based on Decentralisation

Democratic decentralisation is often presented as necessary conditions for effective rural development. But there is little evidence that either democracy or decentralisation is necessary for poverty reduction in rural or urban areas. The case for democratic decentralisation is also predicated upon the nation that greater participation in local political affairs will improve the quality and reach of government services, particularly one aimed at improving the lives of poor and
politically marginal groups in society. For proponents of democratic decentralisation, a central challenge of improving the delivery of public services becomes one of 'crafting' (Ostrom, 1990) institutions, which can maximize participation in political life.

Studies of decentralisation have shown that devolution of authority can enhance systems of local governance in a number of ways. First, the establishment and empowerment of local resource user groups (delegation or privatization) can improve the ways in which local people manage and use natural resources, thereby improving the resource base on which poor people are often disproportionately dependent (Baland and Platteau, 1996; Ostrom, 1990).

Secondly, the collaboration between public agencies and local resource users can produce 'synergistic' outcomes (Evans, 1996a; 1996b; Ostram, 1996), in which citizens and civil servants cooperate to provide goods that would be unobtainable were they acting alone.

Thirdly, the democratization and empowerment of local administrative bodies can enhance participation in decision-making. However, the notion that improving participation through decentralisation will necessarily lead to improvements in people's wellbeing is not entirely consistent with documented evidence (Mayo, 1996: 60, Craig Johnson, 2001).

To summarize, the most ambitious forms of decentralisation (i.e. devolution) constitute a substantive shift in power from national or regional levels to more local spheres of political life. Decentralisation empowers new actors (at local and non-local levels), and (in theory) creates conditions for new lines of participation and accountability.
2.6.0. Lessons from the Reviews of decentralised healthcare planning in China:

It is important to review the decentralised healthcare planning of China and lessons from the Chinese health sector could be useful for the Indian health sector reform especially in the decentralised healthcare planning. China was basically a socialistic pattern of planning before the late 1970s of reform process. India was also similar situation in terms of annual planning. The only difference between these countries is the rule of governance. India’s governance is based on democratically elected government with multi-party system since in 1950 while Chinese’s governance is under a single-party system since the state’s establishment in 1949. However, both the countries are considered to be emerging economies in the world with a sustained economic growth. The Chinese health sector reform has led lots of lessons for the countries like India in terms of decentralised healthcare planning. Though there are lots of successful countries in the decentralised health planning, the present study reviews only the latest studies in healthcare system of China.

The People’s Republic of China where the health service is not only nationalized but also socialized best illustrates the decentralised model. The Chinese describes their social decentralised approach as the Yenan way, which emphasis popular participation and community power and rejects domination by an administrative or technical elite operation through a centralised bureaucracy (Selden, 1971). The yenan way translates into a health administrative structure in which the Minister of health, at the centre is part of the council of state. At the provincial level, the health department is responsible to the Minister of health. At the next lower level, the bureau administers all hospitals and health centre within the country. Within the countries, there are communes and municipalities. There are approximately 14 communes per country and about 50,000 communes in all. Each commune is typically served by health centre which has ten or more short-term or transfer beds and is staffed with physicians. There are ten to twenty
production brigades within the commune which supports barefoot doctors are small health stations. This administrative structure encourages democratic participation.

The reform of the Chinese healthcare financing system has been reviewed by Xing-Yuan and Sheng-Lan (1995) concluded that the radical changes, which have, take place in the Chinese economy since late 1970s have influenced the health sector and the healthcare financing system. The study also found that a rapid increase in medical care costs in the last decade has placed a heavy financial burden on the government and enterprises and a vast majority of the rural population. The public service medical scheme for government employees and labor insurance for enterprise workers are facing a great challenge of cost containment through a series of reforms in the mechanisms of fund collection and management (Liu et al., 1995).

Bloom and Xingyuan (1997) study have noted that as a result of China’s transition to a socialist market economy, its rural health services have undergone many of the changes commonly associated with health sector reform. These included a decreased reliance on state funding, decentralisation of public health services, increased autonomy of health facilities, increased freedom of movement of health workers and decreased political control. These changes have been associated with growing inequality in access to health services, increases in the cost of medical care, and the deterioration of preventive programs in some poor areas (Gao et al 2002). Study by Liu (2004) concluded that a decentralised and fragmented healthy system, such as the one found in China, is not well suited to making a rapid and coordinated response to public health emergencies. The commercial orientation of the health sector on the supply-side and lack of health insurance coverage on the demand-side further exacerbate the problems of the under-provision of public services, such as health surveillance and preventive care. For the past 25 years, the Chinese government has kept economic development at the top of the policy agenda at the expense of public health, especially in terms of access to healthcare for the 800 million people living in
rural areas. A significant increase in government investment in the public health infrastructure, though long overdue, is not sufficient to solve the problems of the healthcare system.

Study by Liu and Mills (2002) have studied the financing reforms of public services in China and drawn lessons for other countries. This study has revealed that financing reforms of China's public health services are characterized by a reduction in government budgetary support and the introduction of charges. These reforms have changed the financing structure of public institutions. The study also found that before the financing reforms, in 1980, government budgetary support covered the full costs of public health institutions, while after the reforms by the middle of the 1990s, the government's contribution to the institutions' revenue had fallen to 30-50 percent, barely covering the salaries of health workers, and the share of revenue generated from charges had increased to 50-70 percent. The Chinese experience has generated important lessons for other nations. Firstly, a decline in the role of government in financing public health services is likely to result in decreased overall efficiency of the health sector. Secondly, levying charges for public health services can reduce demand for these services and increase the risk of disease transmission. Thirdly, market-oriented financing reforms of public health services should not be considered as a policy option. Chinese experience strongly suggests that the government should take a very active role in financing public health services.

2.7.0. Summary of Reviews from Indian Studies and research issues and gaps of the present study:

In the supply-constrained public system of the poorer countries like India, sick people have not waited for the government to find a way to provide more health services. They continue to bypass the inadequate government facilities to seek care in the private sector, which is expanding in almost all parts of the country. Though many studies have discussed the preferred healthcare provider (in most cases private provider/practitioner), few have explained the details of private sector utilization, distribution, and its magnitude in relation to various classes of
Studies show that the utilization of private sector in Maharashtra State for acute episodes was high as 83 percent, while the same for Madhya Pradesh was 69.5 and for Kerala state was 66 percent (DANIDA, 1986). The NCAER (1992) study which has clubbed acute and chronic episodes together found 52.25 percent utilization of private sector in rural areas and 57.54 percent in urban areas.

A study (Duggal & Amin 1989) shows that out of 100 people who fell sick, only 13 went to the government hospital, 77 to the private sector and the rest resorted to home remedies in Maharashtra State. Another study by Yesudian (1988) found that the slum communities in Deonar and Naiguam in Bombay used more private sector facilities than public facilities for short-term and minor ailments. Vishwanathan and Rohde (1990) estimated that nearly 80 percent of the rural people in India reported to private practitioners in diarrhoea cases while only 10 percent used the government facilities. The VHAI (1988) of Rajasthan showed that the number of beds in the private sector of the rural and semi-urban areas in Jaipur had increased thirteen times during the last two decades. The number of in-patients in the private sector had increased eighteen times during the same period.

Study by Duggal and Amin (1989) showed that the private sector was a significant source of primary healthcare resource as well. These included services like immunization that was available in both rural and urban areas and for all income groups. On the other hand, studies (DANIDA, 1986) show a relatively low utilization of private sector in some parts of Madhya Pradesh and Tamil Nadu States. It also shows that evaluating the private sector indicate that the situation in the private sector is not better despite the tremendous increase in the number of private nursing homes/hospitals in the last two decades. They have failed to invest in developing and maintaining even the basic minimum standards.

Despite significant successes in controlling a number of communicable diseases in low and middle income countries, important challenges remain, one being that a large proportion of patients with conditions of public health
significance, such as tuberculosis, malaria or sexually transmitted diseases, seek care in the largely unregulated 'for profit' private sector. Private providers (PPs) often offer services, which are perceived by users to be more attractive. Studies have shown that PPs, especially, perceive or experience patient and community pressures to provide inappropriate treatments.

In the recent past the impact of structural adjustment in the Indian healthcare sector has been felt in the reduction in central grants to States for public health and disease control programmes. This falling share of central grants has had a more pronounced impact on the poorer states, which have found it more difficult to raise local resources to compensate for this loss of revenue. As a result, a number of notable trends are appearing in the Indian Healthcare sector. These include an increasing investment by Non-Resident Indians (NRIs) in the hospitals, increasing participation by multinational companies in diagnostics aiming to capture the potential of the Indian Health Insurance market. The policy responses to these private initiatives are reflected in measures comprising strategies to attract private sector participation and management inputs into Primary Healthcare Centres (PHCs), privatization or semi-privatization of public health facilities such as non-clinical services in public hospitals, innovating ways to finance public health facilities through non-budgetary measures and tax incentives by the state governments to encourage private sector investment in the health sector.

It is important to note that democratic decentralisation is not a panacea and often contributes little to poverty reduction. But it may strengthen the livelihoods of poor people in rural areas. In particular, it is necessary to find the right balance between autonomy and accountability, and to engage the support of external actors.

The principal findings suggest that health expenditure of the household members of rural India is sensitive to changes in household income levels and the elasticity of health expenditure with respect to income is largest for high income groups. It indicates an income elastic situation for spending on treating both
Short-Term Morbidity (STM) and Long-Term Morbidity (LTM) by the upper income groups. It is also the same in case of drugs and medicine. It is an important issue in healthcare planning and financing such an income inelastic situation of the lower income rural households in relation to total health expenditure and expenditure on drugs and medicines in India.

Thus there is a need for providing protection to lower income people in terms of supplying quality healthcare by the government. Quality healthcare includes the delivery of drugs and medicines at the appropriate timings. The changes in the Indian Patent Act 1970 may have serious impact on the entire healthcare system in India; it affects mainly the poor people with both STM and LTM, as most of the anti-drugs for these morbidities are under patent protection. Hence serious steps have to be taken for the individuals for the availability of drugs for both STM and LTM. Considering the infrastructure in the hospitals, even though government has allotted enormous amount for providing necessary facilities, the allotted amount and the facilities provided in the hospitals, is not enough to manage the population.

To sum up, a major point emerged from these studies that more people used the private healthcare services due to the reasons that the existing government healthcare provider’s services are not (a) perceived to be quality oriented; (b) easily accessible; and (c) cost effective. It is also relevant to mention that in spite of the private sector being used on a large scale by the patient, the government sector still plays a dominant role in the public health programs like immunization, eradication of vector borne and air borne disease.

The private sector can affect the provision of health services and their utilization, but in its more common forms can have fairly desirable effects on both these aspects. It argued that the private sector could increase the total share of resources available for healthcare from either internal or external sources. The resources may also substitute for achieving an optimal allocation of resources within the sector and reduce the chances of providing alternative publicly
operating systems. Inefficient or unnecessary medical practice with the treatment used may occur in private practice where consumer information is limited in a country like India as a result of the profit motivation and fee-for-service payment systems.

Earlier studies emphasized the choice of healthcare provider through utilization pattern of the healthcare services and not on the issue of patient’s satisfaction through their perception and judgment. Indeed, the patient’s satisfaction is a crucial factor in deciding the choice of healthcare provider. In this context, this study not only examines the choice of healthcare provider of the people but also the people’s satisfaction through their opinions and judgment on existing healthcare provider and their services in the Union Territory of Pondicherry. Further, there is little evidence to show from the existing studies that there is any feasibility of alternative health financing schemes through people’s participation in the healthcare delivery system. There were only two studies undertaken in India on assessing the feasibility of alternative healthcare financing especially through health insurance scheme in the Indian context. The study by Mathiyazhagan (1994) assessed the healthcare situation through both household survey and the time series data for Karnataka State in India. The major findings of this study were: morbidity prevalence rate was very high and varied significant socio-economic conditions of the people (Mathiyazhagan 1994); private healthcare providers were emerged as the people’s choice (Mathiyazhagan 1994; 2003a) ; there is a viability for rural health insurance scheme through community participation and could be managed by the village Panchayat system (Mathiyazhagan, 1994); and most of the people were willingness to pay for the health insurance scheme (Mathiyazhagan 1998). Other study by Gupta (2001) there is a visibility of urban health insurance scheme and people were willingness to pay for this scheme in Delhi. It is evident from exiting literature that assessing the feasibility of viable alternative healthcare financing systems is the main research gaps for the UTP.
It is also important to draw some basic questions from the exiting studies in the light of the present study on the healthcare delivery system at the decentralised level in the Union Territory of Pondicherry. The rural people bypass the supply constrain of government healthcare services and seek care from the private sector.

❖ Does this suggest that the people are already paying out of their pockets for healthcare?
❖ Does this give a basis for the scheme that the private or non-governmental organisations could be the service provider, which is expanding in almost all parts of the country?
❖ If so, what are the policies options in the provider provisions of healthcare in rural areas?
❖ Is there any viability of community based health insurance scheme at the decentralised level?
❖ If so, are people willing to pay for such a scheme?

Answers to these questions are important in the context of decentralised governance in organizing and delivering healthcare services at the Union Territory of Pondicherry, which is the main focus of the present study.