

2nd HM Patel Memorial Lecture

Bringing the Public back into Public Health

by

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Introduction:

Public health in India is at a crossroads. Perhaps it is so the world over. The government run network of health facilities has been falling far short of its goals and there is a crisis of confidence in its ability to pick up. But on the other hand there is little evidence that the large private sector is currently serving public health goals or that it could be harnessed to meet the needs of public health. If neither public nor private provisioning of health services, with or without public financing are able to deliver public health - what could be the way to move forward?

But before we examine this crisis and its roots let us briefly sketch a historical background to the development of modern public health systems.

A historical background to modern public health policy:

Since the Second World War there has been a growing international consensus that universal health care is a basic right and that governments have a responsibility to ensure that citizens are able to enjoy this right. The high point of this commitment was the adoption of the Health for All by 2000 AD Declaration in 1978 at Alma Ata This declaration continues to inspire all public health efforts and it is therefore useful to begin by recounting its social and political background.

This commitment of governments to ensure universal health care arose partly from the rise of Keynesian economics and

the welfare state in the industrialized nations of the world. It is interesting to note that the National Health System of Britain was promised to its people at the height of the blitz against London by Nazi forces, when the victory of the allied forces was least certain, and when more than ever the western governments needed the whole hearted cooperation of its own workforce to resist invasion. Post war Europe saw a major attempt at the creation of public funded national health systems. Most of these were not through government provisioning of services- but by what is called private provisioning and public financing. Today in the countries of Western Europe (and also in Japan, Australia and Canada) the percentage of total health expenditure that is borne by the government is in the range of 90%. Less than 10% of the expenditure is borne out of pocket.

The other context of the Alma Ata declaration was the experience of the socialist world. The Soviet Union first and then Eastern Europe, followed by other third world countries decolonising through armed struggle (and then China, Cuba, Vietnam etc) - constituting the socialist camp - all promised and delivered on such universal government provided health services. The Soviet model itself harks back to the Jacobin ideals of the French Revolution. Some of the French Revolutionaries had raised the vision of a nationalized health system in parallel to or replacing the huge clergy then in existence. (Though this Jacobin ideal did not succeed in the French Revolution, it is worth noting that the medical profession as we know it was constituted in those times). In the Soviet Union the vision of a nationalized health system could be realized by expanding the number of doctors and nurses and health workers suitably trained and deployed in a vast network of state run health facilities. In China, a huge army of barefoot doctors and

integration with traditional medicine was also undertaken to respond immediately to peoples' aspirations.

Faced with these two models, other third world nations with mixed economies opted for various combinations of the two - but the question of state responsibility for the provision of universal health care as a principle was never in question. There was no serious policy position nationally or internationally - that the market or market mechanisms would ever without government intervention be able to deliver health care to the poor. As the process of decolonisation reached its completion, each of the newly emerging third world countries attempted a mix of government run health facilities existing side by side with private sector and non- profit hospitals.

It was in such a context that in 1978, meeting at the city of Alma Ata, (then in the Soviet Union, now in the nation of Kazakhstan), the countries of the world adopted what is now known as the Alma Ata declaration - a call for achieving Health for All by the year 2000 AD. This declaration further specified that the key strategy to "attainment of the highest possible levels of health care" would be a strategy that was called the "comprehensive primary health care approach."

Public Health System in India:

The Public Health System in India evolved in such an international context. Way back in 1946 itself, the Bhore committee had affirmed the key principles that were a generation later to find place in the Alma Ata declaration.

The Bhore Committee report runs into three volumes. But in its very succinct preamble the committee neatly sums up the cardinal principles - and few drafts have ever bettered it before

or since...

1. *No individual should fail to secure adequate medical care because of inability to pay for it.*
2. *In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.*
3. *The health programme must, from the beginning, lay special emphasis on preventive work. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation is essential. So long as environmental hygiene is neglected, so long as faulty modes of life of the individual and of the community remain uncorrected, so long as these and other factors weakening man's power of resistance and increasing his susceptibility to disease are allowed to operate unchecked, so long will our towns and villages continue to be factories for the supply of cases to our hospitals and dispensaries.*
4. *The need is urgent for providing as much medical relief and preventive health care as possible to the vast rural population of the country. The debt which India owes to the tiller of the soil is immense and although he pays the heaviest toll when famine and pestilence sweep through the land, the medical attention he receives is of the most meager description. The time has therefore come to redress the neglect which has hitherto been the lot of the rural areas.*
5. *The health services should be placed as close to the people*

as possible in order to ensure the maximum benefit to the communities to be served. The unit of health administration should therefore be made as small as is compatible with practical considerations.

6. *It is essential to secure the active cooperation of the people in the development of the health programme. The idea must be inculcated that ultimately, the health of the individual is his own responsibility and, in attempting to do so, the most effective means would seem to be to stimulate his health consciousness by providing health education on the widest possible basis as well as opportunities for his active participation in the local health programme.*
7. *We therefore consider it essential to the success of the scheme that its development should be entrusted to Ministers of Health who enjoy the confidence of the people and are able to secure their cooperation.”*

The Bhore committee had defined two approaches to managing the situation that a newly emerging nation found itself in. One was called the long-term solution - the development of the network of public health facilities - a task that is barely completed even today - almost 60 years later. The other was short-term vertical campaigns that address the most pressing problems of those times. Most of these 'vertical' campaigns were disease specific, based on one or two technical interventions to be applied widely by a chain of command stretching from the center to every village. These later evolved into the National health programmes.

The most important of the vertical health programmes were the successful campaigns against small pox and the not so successful programmes against malaria. Unfortunately one of these vertical campaigns - the family planning campaign came to occupy the center stage of the entire health sector, displacing all other elements of primary health care. Undoubtedly population stabilization- population control as it was then known- was an important goal. But this narrow emphasis did disservice even to its own goals.

It is not till the eighties, after even blatantly coercive approaches to family planning had failed, that it came to be recognized that without situating the family planning campaign within a comprehensive approach to reproductive and child health care its goals could not be met. Decreasing IMR is known to be associated with smaller family size, as a perception that the children borne have a good chance of survival is an essential concomitant of any major decline in fertility rates. Also it became clear that social determinants like women's education and empowerment, access to social security and a reduction of poverty, are keys to fertility control. Though today much of this has changed the design flaws that it has left in the structure and functioning of facilities still need to be overcome.

The long term strategy of building a pyramid of government run health care facilities proceeded - but all too slowly. Nevertheless as of today there are 142655 Sub Centers, 23109 Primary Health Centers and 3222 Community Health Centers in the country (2004). In addition almost every district has a district hospital. There are under the government 5479 hospitals having 380993

beds in the country. The population served per Government Hospital is 197096 while the population served per Government Hospital Bed is 2834 (2004). In addition there are over 22,551 dispensaries and 1354 hospitals under the AYUSH systems. This is an impressively large network even for a country of our size. One could argue that it should be larger, but very few third world countries have been able to establish such a network.

This public health system has been able to record significant achievements especially in its initial years. Life expectancy at birth for example has now gone up to over 63, from the mid twenties at the time of independence. The infant mortality rate is 58 now compared to nearly thrice this amount 129 in 1970. Famine and epidemics of the scale witnessed before Independence are no more seen. Millions used to die of small pox, typhoid, plague and malaria. Malaria alone was estimated to have had close to 70 million cases annually - of a total population of 300 million. The huge improvement in control of malaria led to at one point of time to less than 1 lakh cases annually and this was a great achievement. Unfortunately, eradication eluded us, and malaria climbed back upwards, though it never crossed the 5 to 10 million range. Thus as we enter the 21st century, we find that though the public health system has contributed to substantial progress in health status in the last century, the nation lags far behind not only the developed nations but more than half of the developing nations as well.

The Crisis in the Delivery of Public Health:

The system is today beset with a number of problems - some of which seem insurmountable. We list a few important examples of what I would call a "crisis in the delivery of public health."

1. There is stagnation in key public health indicators. Maternal Mortality Rates over three decades have shown little change. In 1983 the goal was to reach an MMR of 100 by the year 2000. Yet 24 years later the NRHM has to set the same goal for itself for the year 2012. IMR in contrast did decline much faster, by about 34 points in the eighties, but even this has relatively slowed down to a 12- point decrease in the nineties.
2. There have been persistently high levels of communicable diseases- especially of tuberculosis, malaria and diarrhoeal disease. Tuberculosis prevalence has gone up almost six times since independence, to about 12 million cases, and the number of deaths has remained constant, at about 5 lakhs per year. Some diseases did make a dramatic decline - notably small pox, guinea worm, yaws, polio and even in the first two decades, malaria. But then these are very few. And there has been the emergence of new epidemics as well as the parallel rise of non-communicable diseases. Despite a tremendous increase in expenditures on HTV control, HTV transmission continues to increase. The pulse polio campaign has reduced polio but at very high costs and a mirage-like recession of the goal. The nearer you come the further it moves.
3. The achievement levels in immunisation, which were expected to achieve 100% by the year 2000 are declining. Thus between NTHS - I (1993) and NHFS - H (1999) and the RCH key indicators study of 2003, there have been significant declines in immunisation achievements in many of the larger states. In 220 districts studied by the Institute of Population Studies - as part of the district

level household survey between 1998 and 2003, full immunisation declined in 48.2% of the districts, remained stagnant in 43.2% of the districts and improved in only 8.6% of the districts. Since immunisation has been the most prominent part of child survival strategies, the declining outcome of immunisation is likely to be a reflection of the overall access to child health care. This year we have had reports coming in from both NFHS and UNICEF coverage evaluation surveys. In 3 out of 5 states where the NFHS survey is available there has been a decline in coverage. The UNICEF coverage evaluation shows that the percentage of children immunized with BCG, DPT3, OPV3 and Measles is at 83.4, 67.3, 61.3 and 68.1 respectively. But the "full immunization" (Receiving all the four vaccinations — BCG, DPT3, OPV3 and Measles) level was 54.5 percent; that is, only 54.5 percent children aged 12-23 months were found to be fully immunized. The percentages of eligible children receiving the booster dose of DPT/OPV, was 30.5% only. Moreover there were statistically significant differences in the coverage levels of rural and urban areas - urban coverage levels were about 20 percentage points - higher than rural. (UNICEF coverage evaluation survey 2006). Immunization has been one of the priorities of the public health system since the seventies and its delivery is a good indicator of the delivery of public health. The stagnation of the immunization figure at about 50% for over a decade is indicative of the crisis.

4. The same is even truer for family planning programmes. Though family planning has been the narrow focus of the entire health system since Independence, even in this area

the constraints are on the supply side. There is not much of a demand side problem. This means that family planning is no longer constrained because people are not willing to limit their family size, but because there are not adequate contraceptive or sterilization services that can meet the increased demand. Thus when the NFHS -3 survey assesses the percentage of women with two children, that is those who have completed their family and who want no more children - the figures are 75% for Chhattisgarh, 82% for Orissa, 86% for Gujarat, 88% for Maharashtra and 91% for Punjab. Even this gap is due to the problem of son preference. It is found that 50% of those with two daughters want more children. Thus in most states, the only families not willing to limit their family size are those with two daughters. If the goal is population stabilization, maintaining the sex ratio is an essential component. In which case without addressing the issue of son preference, pushing family planning messages alone fuels sex selective abortions and worse. Academic and to some extent public perception is of targeting and coercion to force unwilling couples to adopt sterilisation. But the reality is of queues of willing couples and such poor service delivery that targeting is needed to drive the system to deliver some part of the services that it is committed to providing.

5. Infrastructure and manpower gaps constrain access to health care but even where it is created its utilization remains very poor. There are a large number of hospitals built in the public sector that have few patients. There are an even larger number of operation theatres built which have seen no surgeries. Often it is due to failure to staff facilities adequately or there are shortages of equipment or

supplies. Often there are mismatches. There are surgeons without operation theatres and operation theatres without surgeons, or equipment without adequate infrastructure and lack of equipment where infrastructure is available. This failure to make these facilities functional undermines public demand for expansion of infrastructure and manpower. If on the other hand a government facility is functional, it tends to be over-utilised, as happens to many district hospitals and tertiary care centers in the public sector. This also leads to poor quality of care. Obviously both public health management and human resource policies need considerable strengthening.⁶ There is an overwhelming consensus today on the need for increasing public expenditure on health. The National Health Policy affirms it. The National Rural Health Mission affirms it. International funding agencies demand it. Political parties demand it. Yet on the other hand there is a consistent decrease in state expenditure as a percent of GDP and even as a percentage of the state budgetary outlay. The stated goal of the NRHM for example is to raise public health expenditure from 0.9% to 2- 3% of the GDP. Yet in the very next year despite a 20% increase in budgetary allocation, there was a net drop in expenditure as percent of the GDP because the overall public expenditure did not keep pace with the rising GDP and partly because the system was struggling to absorb the funds already allocated to it. The inability of the public health system to absorb the money that is becoming available for is central to the crisis of public health.

6. The public health system has been unable to adequately address the key problem of inadequate doctors willing to

serve in rural areas in the public health system. Doctor population ratios approach desirable levels in many states but there are large areas where there is no doctor. Even if we manage to force doctors to go there, how can we manage to make them serve with the dedication that the doctor-patient relationships needs? This also implies that where doctors are concentrated there are such tremendous competitive survival pressures that in the prevailing context of a lack of regulation, unethical practices flourish. (What is true for doctors is true to a lesser extent for nurses and paramedical and technical staff also).

7. Endemic corruption eats into the heart of the public health system. Decentralization and local accountability are agreed upon as ways of addressing this problem as well as for improving management, but this does not happen.
8. Further figures from a number of studies are showing that in about 20% of all illnesses, no treatment whatsoever is sought, from the public or the private sector. The main underlying reason being the inability of the poorest sections to bear the cost of health care. This is because even so-called free public health costs money. There are costs of transport and food for patients and their escorts. There are out of pocket expenses on drugs. There is loss of livelihood costs. And on top of these there are often illegal charges as well. Another evidence of this "exclusion of the poor" is the rate of hospitalization. Thus, the top 20% by economic status have a rate of hospitalization ten times greater than the bottom 20%.

Can the current public health system deliver?

Given some of the factors described above, many would conclude that the public provisioning of health care is failing, or at least has reached its limits. They would argue that therefore we need to turn to the private sector.

Underlying the poor performance of the public sector are problems of governance, problems of workforce management, problems of capacity building, and poor professional quality of public health management. There is also a considerable failure of financing of the public health sector to rise at the same rate as growth of population and inflation. Creation of new capacities in core areas like medical education and new hospitals, or urban health infrastructure etc has been particularly hit.

However the dominant perception in the nineties was that though the reasons stated above are correct, they are irremediable. The public provisioning of health services was inherently far too inefficient and dysfunctional to justify investing more money in it. The government cannot and should not provide health care services. It should only finance the access of the poor to it. Influenced by the economic thinking associated with globalization, there was a policy of looking to the private sector to provide solutions and an assumption that promoting private sector growth would take care of the supply side of health care needs, especially for secondary and tertiary care. It was considered adequate if government intervention was confined to a few selective elements of primary health care and some form of social insurance or demand side financing to address the needs of the poor to access private health care services. Key documents that expressed this were the World Bank Annual reports of 1991 and 1993.

Is Private Provisioning of Health Care the solution?

Large and impressive as the Indian public health system is, it is dwarfed by the private health sector. The total value of the health sector in India has been assessed as over Rs.1500 billion or Rs. 1.5 lakh crores per year. This works out to about Rs.1500 per capita which is 6 per cent of GDP. However, of this 15 per cent is paid by the government, 4 per cent is from government insurance and 1 per cent is private insurance. The remaining 80 percent of this Rs 15.00 per capita is spent out of personal resources and of this 85 per cent is spent in the private sector.

Thus of the total health expenditure only 17.9% is government funded. 82.1% of all health expenditure is in the private sector. The public health system accounts for 45% of all hospitalizations and 19% of all out patient care (1995-96). Indeed, this makes India one of the most privatized health systems of the world. Consider this- the percentage share of public health expenditure to total health expenditure is 75% for the industrialized western nations. That is only about 25% is paid by the individual seeking health care; the rest is paid for by the government. Even in this average if we take out the United States the public expenditure share rises to almost 90%. The United States is a large economy and considered the most privatized amongst these countries. Yet even in the United States public expenditure as percentage of total health expenditure is at 44%, more than twice India's figures. Only 8 countries in the world have a lesser share of public health expenditure than India.

However our *total expenditure on health care* has risen to about 6 % of GDP, which is comparable to world standards. But total expenditure on health does not correlate well with

improvement of health status. In our context, this implies an increasing out of pocket expenditure and impoverishment due to health care. And if we look at our poor health status, it also implies inefficient and irrational use of resources. While it is clear that the private health sector is doing quite well and contributing to the growth of the economy, it is unclear what contribution it makes to the achievement of public health goals. As a purely market driven economic proposition, the growth rate of this sector would accelerate if there were more diseases and therefore more drugs and more hospitalization needed.

One of the main problems with the Indian private sector has been that it is almost impossible to regulate it - on the grounds of costs, on quality of care or on ensuring access to the poor, even during emergencies. Many states have passed Private Nursing Homes or Private Clinical Establishments Acts but were either restrained politically from framing the rules or have had the process stayed in courts. Even registration and information is not possible to enforce today, let alone closures for not adhering to quality standards or ethics. Regulating costs of services has not even been considered in any of these acts.

The private health sector also abides in "sharp" practices. Conflict of interest situations that most nations specifically legislate against and would punish as crimes are established as norms of service here. For example the commissions that are paid by any CT scan center for referrals made to it - a practice now extended to almost all diagnostics - would be considered an illegal kickback in most countries. Here in India, it is seen as legitimate, even a right!! Another commonplace example is a doctor in government practice, also doing private practice, often setting up a nursing home and cross referring cases from

the public facility to his private facility. Or commissions and gifts for prescriptions of certain drugs from private drug firms to doctors.

Treatment in most private clinics neither follows standard protocols, nor attracts any penal action, even where unnecessary or irrational treatment is obvious. The huge and growing number of unnecessary hysterectomies and cesarean section surgeries have been written about and evidenced - but this is only the tip of the iceberg of what is called the moral hazard of over consumption of care - most of it irrational, if not hazardous. Or take this chilling statistics, even amongst pharmaceutical formulations- about 90% of those on sale are irrational, irrelevant, wasteful or downright hazardous. As against a list of only about 300 essential drugs, we have over 60,000 formulations on the market and we face a near complete inability to legislate any price or quality controls.

The commercial private sector as it is today, far from being a solution is a major part of the problem. It is one of the leading causes of indebtedness and economic ruin. It grows on diseases related to poverty and contributes to the exacerbation of poverty. Indeed, though the public health system accounts for only 0.9% of the GDP and the private health sector may account for about 5 % of the GDP, most of the gains that public health have made flow from the former rather than from the latter.

By the end of the nineties it was becoming clear that neither market forces not insurance mechanisms would be able to address public health issues and a proactive role for the government was essential. But now the solution was seen to lie in public private partnerships that would harness the private sector to provide public services.

Constraints on the Public Private Partnerships Route:

The question then changes to whether the private sector could be guided by the government in a stewardship role - part regulator, part promoter - into serving public health needs. One argument for this approach is that the private sector is a fact of life - with an overwhelming presence. There is a need to engage with it to make it contribute to some national health goals. Hence the search for meaningful Public Private Partnerships to enable some access to the poor through demand side financing measures. This would also protect people from the costs of private medical care. Such measures could take the form of social insurance or of simpler risk pooling strategies or voucher schemes etc. However, given the nature of the private sector, despite many efforts over the last ten years, few proven models of such partnership with the commercial private sector have emerged. There has also been a failure of any major health insurance or even social security against illness for the poor to take off despite this having been prioritized for over a decade. Insurance schemes like the Assam social insurance programme have either had very poor claims ratios, making it a questionable deal or like the Yeshwasini programme in Karnataka have had such large claims that they are unsustainable. Such large claims could be due to both over consumption or due to premiums fixed too low. If the premiums are fixed on actuarial principles then the cost of social insurance is likely to be much higher than the current approach of social protection through public provisioning of free health care services. In other approaches like franchisee and demand side financing options - where the government pays for the cost of treatment of the poor at previously decided rates, the wholly unregulated nature of the sector, and the internalization of poor ethical practices in

the private sector pose problems. Of course, better monitoring and better contracting arrangements could solve many of these issues but then the problems of governance which so effectively damaged the public provisioning of health services would affect private provisioning with public financing with redoubled intensity. Unless governance issues are attended to and the overall environment of the private sector is regulated, partnerships would be struggling forward.

We note that international experience with private provisioning and public financing are also lessons of caution to us. World over social insurance or almost all forms of insurance have led to huge escalation of health costs. Canada may have a model universal social insurance, but its costs are close to 14% of the GDP. Containing the costs is now the main problem these nations are contending with - and most are just not able to cope. Also countries with successful public financing and private provisioning have had extremely tight regulatory policies negotiated between government, insurance companies and providers- something we have been unable to do. In the process of such negotiation, public participation in decision making suffers and often large sections of the population are excluded and have to fall back on a much reduced government provisioning of services - like in Mexico, for example. Indeed there is little evidence that even government-led partnerships with the commercial private sector have helped in reaching health care to the poor.

Going Beyond Current Understandings of “Public” and “Private”:

If the public health system needs to overcome the current stagnation of health indices and the rising costs of health care,

there is a need to go beyond understanding the public to mean the centralized state - and there is a need to go beyond understanding the private to mean the commercial, increasingly corporate private sector. We need to look at people and different forms of their organization - the village community, the self help group, the cooperative, the trade union, the voluntary organizations and associations and the elected local bodies all as resources and as part of what constitutes the public. We need to look at motives for health care providers beyond the maximization of profit. We need to refuse to see health as a commodity that the market can arbitrate. We also need to go for a demystified understanding of health - where the doctor is not a magical giver of health - but only a facilitator of one's own actions. There is therefore a need to re-examine the basics of what health and health care means at the level of the individual, the level of the family/ community and at the level of a nation.

Re-examining the Basics- Where is Health Made?

Health is 'made,' first and foremost at the level of the family, then at the level of the community and finally at the level of society. Health is largely decided by the set of practices of day-to-day living, of childcare and hygiene and of responses to illness that the family adopts. A very large number of illnesses we know can be prevented by simple practices of good living. Take a few examples - the incidence of diarrhoea in children is estimated to be anywhere between 3 to 7 episodes per person per year. Mere handwashing before preparing feeds and before feeding the child and after toilet has the potential to reduce diarrhoeal rates by two thirds at least. A recent publication in Lancet looked at the contribution of different public health measures towards the reduction of infant mortality. Appropriate breastfeeding led - with a possible contribution of 16% reduction.

Adequacy of complementary feeding could contribute another 7%. Sanitation and hygiene, another 5%. Keeping the newborn warm about 3%. In comparison achieving 100% immunisation would contribute to about 1% reduction in infant mortality - almost all of that contributed to by only one immunisation - that against measles.

Health is “made” also at the level of the community. It is determined by food, safe water, good working and living conditions and a reduction of discrimination and violence and a promotion of harmonious living and cooperation. The conditions of living, the relationships between families, the norms and values and traditions and culture of a given community and society also have a large impact on health status. This is largely because the family, much less the individual does not exist in isolation. The family - its values and its practices - are defined by its relationship to the community. These also change to the extent that community level processes change. Thus though it is important to address each family as a unit, it is also equally if not more important to address the community as a unit. Thus for much of the gains of health to be realized- the initiator, primary participant and beneficiary would be the community- or in other words, the public.

Public health, arising as it was from a mystified understanding of health - tends to address the community or the public only as the target. The word public in public health has developed a connotation of public being somewhat passive and needing to be acted upon. Health care and health messages need to be fed to the community like a strict father would persuade his child to take bitter medicines - with a combination of persuasion and coercion. In such an approach even “EEC”

becomes a form of victim blaming. Thus people are projected as being ill because they are dirty and illiterate and ignorant. The population is seen as growing because poor people breed irresponsibly and irrationally. Public health sees it as necessary to have incentives and disincentives, persuasion and coercion to keep the population healthy. This was most evident during the population control programmes, but such an understanding permeates most aspects of public health. Thus in tuberculosis control, there is an emphasis given on direct observation of the patients swallowing drugs. Such direct observations seldom occurs in practice, yet the notion is important for the programme. In malaria control the dependence was for a long time on spraying the villages with insecticide through an army of workers. For many diseases hopes are pinned on immunisation - apparently a simple procedure that the family can be persuaded to take in contrast to other measures where peoples understanding and cooperation is needed. But there are only one or two relatively low prevalent public health problems currently susceptible to control through this route. Yet, so much effort for a successful public health strategy is directed to trying to find a magic bullet - some technical option, which through a structure of command and control can be uniformly deployed across the population and which requires very little public cooperation, because the health care system has so little confidence in the ability of families and communities to take care of their own health.

The truth is different. All people make rational choices - as suits their circumstances and as conditioned by the cultures they live in. At any rate it is quite impossible to keep people or a population healthy if they are not themselves determined to be healthy. Often one needs to understand the circumstances and the cultures much better in order to understand the behaviour,

so that what appears irrational can be better understood. If this is understood, however, then one can construct an understanding of public health where the public is not the object of state or corporate action but its prime mover.

This rediscovery and redefinition of the word public in public health can take place at many levels. We can explore what it means to increase public participation at the level of the family/ community, at the level of outreach of public services and at the level of institutions of health care provision.

Given below are two examples, that are often quoted as examples of the inability of communities to understand or cooperate with health care programmes but which on closer examination turns out to be an insufficient understanding of the problem.

Thus for example health systems insist that poor patients fail to take a full course of medicines due to poor awareness, implying that strong persuasion or coercion or monitoring is required.

Studies of the earlier tuberculosis programme have shown that quite often what appears as a case of poor compliance for tuberculosis control turns out to be the difficulty in accessing a regular supply of drugs. When the patient is so sick that he is unable to go to work, he decides to come to the health facility. But once the symptoms improve then they have to return to work to earn their livelihoods or else the family would starve. And if they cannot access the drugs without loss of livelihood then treatment becomes irregular. Also look at culture determined perception. To the doctor the patient was suffering from tuberculosis of which the cough was only

a symptom. The disease itself is a lesion at the tissual level that has not healed. But to the patient there is no difference between symptom and disease. Cough is the disease - not the symptom. The relationship between different humors would perhaps have been understood as a causative explanation but not the notion of a lesion in a tissue. Of course creating such an understanding is easy - if only the health care provider is conscious of it. But too often the doctor is carried away by his own mystification. His pronouncement along with blandishments is considered enough. He feels, "since I have told him that he must take treatment for six months - he should obey. If he does not - it needs inducement or force." Any question by the patient or any attempt to counter the advice too often meets with a gruff - are you the doctor or am I the doctor? This simple phrase - better than any other explains the problem with the doctor patient relationship as it is constituted today.

Another common complaint is the lack of cooperation public health functionaries like ANMs receive from the local community. The ANM in the sub-center offers a lot of services no one has asked for. For example she provides immunisation against diseases that no one has seen (like diphtheria and pertussis) or against diseases where it has little effect (BCG). She provides IUD insertions and antenatal check ups in normal pregnancies, which while important public health needs are not felt needs. However her ability to respond to felt needs - common illnesses - conjunctivitis, a scorpion sting, a wheeze etc is absent. And the credibility of the public health system suffers. Even in an area like antenatal care if she actually detects a health problem she often has

no place to refer the patient to which the patient can afford. In such a situation the poor cooperation she would receive for antenatal care is a rational response. It does not help that often the health care provider, in poor imitation of the doctor, is ordering people to do this or that - for their sake of course. This way of talking to the public makes the breakdown of communication complete. To the ANM and the doctor, the perception is that people refuse to take care of their health as they refuse to make use of even the services they provide. For the people, the public health system as they encounter it has little relation to their needs.

Community Health Workers & Public Participation in Public Health:

The need for public participation is most evident at the level of community. The major part of all preventive and promotive action needs to happen at this level of the family and community. Health education and changes in health care practices are family level changes and can be secured best by community action, led by more conscious and skilled persons within the community.

The next issue is what role can be played at the community level in curative care. A four village detailed study carried out by the State Health Resource Center (SHRC), Chhattisgarh is indicative. This study showed that approximately 14% of the population reports an illness episode in a month - including both chronic and acute illnesses - both minor and major. Further the distribution of illness by type was as follows: In a population of 1000, if the total number of episodes of any illness is 140 in a month, then of these 35 are likely to be fever, 28 are likely to have pain/headache, 14 are likely to have diarrhea, 36 are likely to have

a respiratory infection, 6 would have an injury, wound or ulcer, 6 would have weakness including symptomatic anemia, 6 would have a medical noncommunicable problem (the range included hypertension, sickling, mental illness, epilepsy, cardiovascular disease, paralysis, cancer, goiter), 4 would have skin problems, 2 would have female reproductive tract illness, 2 would have jaundice, and a similar number would have minor surgical problems" This study is on what illnesses people reported and therefore does not include conditions like anemia, malnutrition, asymptomatic hypertension which people may not complain of, but which examination would have revealed. Of these illness episodes, the study estimates that about 43% of cases could have been managed by a community level health worker or a paramedical health care provider with home remedies or with a simple set of relatively inexpensive basic drugs. This is a large amount of illness and in practice payment to local doctors for treatment for these self-limiting illnesses is a big drain on household incomes. Also, one could postulate, that at least a part of the major illness could have been reduced had it been treated when minor. In young children prompt management of many of these illnesses can be life saving.

Community health worker programmes are one of the most effective forms of ensuring community participation in rural health care to achieve this level of preventive and curative care. The effectiveness of community health worker programmes in the Indian context is well documented. Jamkhed programme, the Mandwa programme, SEWA rural in Gujarat, RUHSA in Vellore, Pachod, SEARCH programme of Ghadchiroli - the list is long. In India policy recognition of such a need was best articulated in the Shrivastava committee report of 1975 and later in the

National Health Policy of 1983. Unfortunately scaling up from the above 60 to 100 village NGO run models to a government led state level programme eluded the nation. The 1978 CHW programme, the village health guides programmes, Madhya Pradesh's Jan Swasthya Rakshak programme all failed to deliver. Despite these failures, such is the compulsion of requiring some form of community health worker for ensuring effective delivery of public health care, that the programme keeps coming back. It was not until the Mitanin programme of Chhattisgarh that a viable model of scaling up CHW programmes to a state level was worked out.

The Mitanin Programme:

In the Mitanin programme in Chhattisgarh, 60,000 women volunteers were selected by the community - one for every hamlet — and trained by a specially constituted training force. The programme was run at every level - the state level, the district level and the block level by a partnership of government and civil society. At the state level the NGOs came together to organize the state health resource center to support the Mitanin programme. Further 7 NGOs established pilot models of the programme. Then in 50 blocks where there were capable NGOs, the programme was contracted out to them or they were made part of the project committee and given the space to carry out the project components. Even in the other blocks where there were no NGOs to contract out the training programme to trainers were selected from active NGOs. At the village level women's health committees were formed or the help of local women self help groups was taken to ensure that the Mitanin was supported to reach all the families in the hamlet. A strong component of social mobilization and

community level processes like village level planning ensured that public participation was effectively secured.

The impact of the programme has been dramatic. For one, the rural IMR of Chhattisgarh, which stood at 95 in the year 2000 had declined to 85 in the year 2002 and then it dropped by a further 24 points to reach 61 in the year 2004. In contrast the all India rural IMR figure had declined by 5 points in the first two years (74 to 69) and then by a further 5 points to 64 in the year 2004. If we use the state of Madhya Pradesh as a control, we find that from a figure of 93 in 2000 it dropped three points in the first two years to 90 and then by another 6 points to 84 in the year 2004, which is about the same rate as the national decline. So what had led to the tremendous acceleration of the child survival in Chhattisgarh - by an unprecedented rate? For an equivalent drop at the all India level it took 28 years - what Chhattisgarh was to achieve in a mere two to three years. The only real difference between these states was the Mitadin programme. Fortunately this period is rich in a number of external evaluation statistics - the NFHS surveys (1999 and 2005), the UNICEF coverage evaluation surveys - year 2002 and 2006, and the DLHS survey 2002 to 2004. We can use these statistics to search for co-relations. We find that in this period institutional delivery had increased very marginally, we find that though measles immunisation had also increased by 30%, total immunisation had increased much less. We find that no other parameter improved dramatically except one - breastfeeding in the first day had shot up from 24% to 88% - (UNICEF coverage evaluation survey 2006). Indeed, the evidence indicates that the Mitadin made a decisive contribution to accelerating child survival in two ways - firstly by altering health seeking behaviour and secondly by altering child care practices - especially as

regards initiation and exclusiveness of breast-feeding. There is a tribal saying that a tree bears many flowers but few fruits. In Chhattisgarh society till the sixth day the child is not named, the father and family is not shown the child and the birth is not announced. Only if it survives to the sixth day is it even considered born, put to the breast and given a name. Such is the experience of high neonatal mortality and the inability of these societies to do anything about it - that such neonatal wastage has come to be considered as "natural" and the culture has adopted ways of coping with such loss. But once convinced that it is possible to save lives by changed practices, change was quick to follow. If the practice of public health dismisses village beliefs as superstition, and tries to persuade people to change behaviors by "marketing" strategies, change may be difficult to ensure. If on the other hand, public health practice constructs a programme on the basis that people are enabled to make rational choices and the information comes from a member of the community itself, and an enabling environment for change is built up then many deeply entrenched traditional harmful practices can be changed rapidly across a state with a dramatic impact on health status.

Chhattisgarh continues to build on this Mitani programme. It has now set out to re-design the whole approach to village health planning - and place it on a sound scientific and participatory basis and thus make it one important tool of public participation, and indeed public leadership in health sector reform.

Public Participation in Public Health Facilities:

But to what extent does a community have the ability to take care of its own health needs? Community health worker programmes and village health planning are essential components

of public health. But they are not sufficient. We run the danger of trivializing the nature of illnesses that the poor face and romanticizing the possibilities of community action if we project community health care as being able to take care of all illnesses that the poor face. We noted earlier that about 43% of illnesses were self limiting or admitted of community level care. On the other hand for the remaining 57% medical care was advisable and at least 10% of this may have required referral care. This means that the poor need access to health care facilities that provide quality care. Visualising the role of community action in this area is also important.

One of the most important immediate steps that can be taken to improve the functioning of public health care facilities is ensuring public participation in management of health facilities.

The Rogi Kalyan Samiti. This refers to a hospital development committee or patient welfare society created to raise funds for and improve the functioning of public health facilities. This started as an almost spontaneous district collector led initiative in Indore's district hospital when with immense public participation - both in cash and in effort, a poorly functioning district hospital was transformed into a model hospital. Seeing the success of this initiative, such a society was soon made a policy for all hospitals run by the government in Madhya Pradesh. Similar committees have also contributed to improved hospital functioning in Kerala and in a few other states, and now under NRHM this concept is extended to all of the country. To the extent that these societies functioned as institutions for promoting public participation in management these were successful. However, perhaps because they were seen primarily as a way of maximizing user fee collections for cost recovery,

or became part of an understanding that people value services only if they are charged, or that such user fees would by themselves make services more accountable, the programme did not deliver and indeed in some states like in Andhra Pradesh they were resisted by the public. In Chhattisgarh, basing oneself on a critical review of the RKS experience, these societies have been renamed Jeevandeep Samitis and transformed into forums of public participation charged with achieving a prescribed quality of services for which they are empowered to take any initiatives. The Jeevandeep Samiti need not depend on user fees and their major income would come from untied government grants to that would enable them to implement institution-level annual development plans to achieve publicly declared quality standards. At best user fees are a token amount meant to provide financial indicators for a better allocation of resources and better management policies. The aim would no longer be to maximize user fee collection. Rather, they would be monitored to see that access to the poor is being facilitated. The challenge is to genuinely strengthen and improve the quality of public participation through improved quality of public representation, improved committee functioning and building up capacities of such committees. There is lot of work ahead - but certainly this is the direction we need to move in.

Decentralisation and Public Participation:

Public participation in hospital management through facility level committees has limitations. It is unable to address more fundamental problems of governance and workforce management. To address these issues one needs genuine decentralization where health facilities are placed under effective institutions of local governance and where health

planning occurs at the village, block and district level. Both are aspects that the National Rural Health Mission is seized of but where progress is difficult. In placing the institutions under local governance there are serious constraints- poor capacities of local government bodies, and the dominance of local bodies by local vested interests. But despite these constraints where serious efforts at decentralisation have been made, where actual powers and resources that need to go with the increased responsibility are also devolved, there has been a favorable impact.

Potentially such decentralization could also help address some of the core problems of the public health system in its human resource management strategies. For example, in some states devolving powers of appointment and payments of doctors and nurses for dispensaries have to panchayats have helped close vacancies. Of course the state must devolve funds to the panchayats to make such payments. Negotiated compromise solutions that help move in this direction, like basic salaries being paid by the state government with incentives from the panchayats, may be needed as interim measures, for there is much resistance to decentralization from government employees and bureaucracies to a reduction of their powers and influence. Yet without such flexible appointments and payments the system is unable to provide higher salaries and perks to doctors posted in more difficult areas, nor address problems like discriminatory transfer policies.

But such devolution of powers for appointments is not going to be useful if skilled staff is not available or if available skilled personnel have to be forced to work in rural areas. Ultimately doctor-patient and nurse-patient relationships are such that an

unwilling doctor or health care provider cannot provide the desired quality of care.

There is therefore a need to look for alternative policies of human resource development to meet the shortage of skilled persons in currently medically underserved areas. For example one of our initiatives is to explore the possibility of higher secondary schools in tribal areas offering a vocational plus two stream for creating community nurse-midwives. Community health workers similarly can be offered 8th class to 10th class level vocational streams. From amongst the community nurse midwives some may be upgraded in coordination with well functioning district or civil hospitals to become nurses and then through short term medical courses to become doctors. Thus, many young women who have family commitments to stay and work in these areas, can be sponsored by local communities to get trained, qualified and certified to provide quality medical care in these areas. Thus even a problem like the lack of skilled personnel for remote areas admits of a solution if the public became active participants in the process of generating such personnel. However if decentralization is limited to merely a narrow range of functions, without creating all the enabling policy changes it needs, then such a potential cannot be realized.

Public Participation in Local Health Planning.

Improving local governance involves, beyond the transfer of powers and resources, the building up of capacities, of responsiveness and of accountability. District and block level planning, which takes into account local needs and addresses local issues creates a responsive system and the process of doing so builds capacities to govern. For these reasons district level planning for health assumes a new importance. We in

Chhattisgarh had already begun walking down this road - and so had a few other states - and now within the next two years so would every district in the country.

The challenge in district planning is however to find the space for informed public participation in this process. If this process is left only to the bureaucracy then the major potential of district, block and village health planning to actually address local needs and priorities tends to get lost. For bureaucracy, by its very nature, is attuned to serving the perceptions of those above it in the chain of command.

We also need to add that by public participation we mean not just a few nominees of the bureaucracy or politicians - but actually representatives of different sections of the people who have been working for people's rights including people's health rights of vulnerable sections. Constructing such "citizen participation" is itself a challenge.

The other challenge of public participation is to build capacities. We are not referring to only training here, though training no doubt is a key element of it. We are referring to building institutional frameworks so that the memory of each year's experience of planning can be accumulated and used and built on in subsequent years. We must also commit to creating an enabling environment for the entire exercise of such planning.

Forms of Public and Private Ownership:

A far more contentious issue is the nature of ownership of health care facilities and maximizing the role of the public in this regard. In India we have seen three forms of ownership. One is ownership by the state departments of health or by the central government, which we refer to as centralized state ownership.

The term public is often equated with this. The second form of ownership is by the private commercial sector. The typical representative of this form of ownership is the corporate hospital, the owner or owners of which may have little to do with health care at all. Their interest in the sector is because investment in it brings good returns. The goal of this sector is to maximize the rate of return on investments, taking care that this is done as part of a long-term strategy so that profits are sustainable. However though the ideal of this sector, corporate hospitals account for only a small part of it. The major part of this sector is constituted by many small scale nursing homes, typically run as a family concern with a husband and wife pair operating it or as an individual self-employed enterprise. Though still motivated by maximizing profit, these units' compulsion to do so varies depending on their immediate professional environment and private predilections and therefore their costs, quality of care, ethics of care and access to the poor also range widely. A major part of this sector is also the informal and unqualified (one could say illegal) rural medical practitioners. The third sector is the not for profit sector, estimated to account for about 5% of the current delivery of services. This includes philanthropic trusts, worker-run, NGO-run, and cooperatives-run hospitals, faith based managements like mission hospitals and so on. There are also many government owned hospitals which are not under state government ownership - these include hospitals under urban local bodies and those under public sector undertakings like railways, mines etc. These could also be categorized in this not-for profit group for the purpose of planning. Where there is no subsidy from the government and full cost recovery is intended, provision of quality care can be quite expensive, thus making access to the poor impossible. On the other hand, where

the government is willing to provide demand side financing so as to pay for the costs of the poor, many of these units are the most willing to join in and this could considerably increase the access of the poor to quality care services.

Redefining Public and Private Ownership

Since the line between what is commercial and what is not-for-profit can be quite thin the requirement is to make for a policy wherein those who do have a motivation of service, who see healing as a vocation, who provide ethical services, and are reasonably priced but sustainable have an advantage and that an environment is built which enables not only participation by this sector but its active growth.

Good examples of such hospitals have always been recognized. Whether it is the worker built and run Shaheed hospital in Chhattisgarh that SHRC has studied as the example of the cheapest and most cost effective medical care, or whether it is the peoples polyclinics run by sympathizers of left parties in Andhra Pradesh, or whether it is the base hospitals of the different community health worker programmes, or whether it is cooperative-run medical facilities like those run by Sewa Rural, or whether it is the corporation run nursing homes of the Kolkata Municipal Development Corporation or the mines hospitals run by public sector undertakings, there is no doubt that there is a distinct advantage of such hospitals over those of both the commercial private sector and the usual public sector hospital. Some of the above examples would be categorized under private ownership, but in true spirit they are much more publicly owned than the usual public hospitals. Others above would be called public ownership but they have much of the positive features of not-for-profit private ownership. Management of such hospitals

is local and highly motivated, and driven by the need to provide high quality care at affordable costs and there is considerable public cooperation and recognition of their services. However planners, who tend to lionize market mechanisms and the profit motive, have always tended to dismiss such forms of altruistic ownership or of functional local ownership as exceptions. Even where their services are recognized, the perception is that these must happen by themselves and that there is little that the state can do to promote them or even utilize them. There is a need to change this. Similarly those calling for public provisioning of health services have tended to confuse all forms of local autonomous ownership with private ownership or privatization and have also failed to bring them into the planning grid.

Public private partnerships could be made consciously - not around the myth of market forces as inherently breeding efficiency and quality - but around its opposite, the recognition that there are many players who are not profit minded and they have a high degree of motivation and a spirit of service. Constructing a public policy such that there are opportunities for many more such units to come up and also helping them come up in such a way that they become part of the "public" rather than the "private" is the challenge before public-private partnerships.

There is a set of seven simple principles that the people's health movement has been articulating to guide the making of such Public Private Partnerships. These principles are ensuring access to the poor, building partnerships as supplemental and supportive to public health system not as substitutes to it, careful monitoring of agreed upon quality and costs and ethics of care, no transfer of state resources into private hands,

prompt payment with dignity, and ensuring fair employment policies especially as regards nursing employment and exclusion of conflict of interest situations (like government doctor run private nursing homes).

One can discuss these issues with reference to the Chiranjeevi scheme in Gujarat as an example of the problems of constructing public policy on involvement of private sector. In the Chiranjeevi scheme the state government has entered into contracts with the private sector units to provide institutional delivery as well as emergency obstetric care for people below the poverty line, the latter being unavailable in most public sector facilities in these districts. If in such a context monitoring of costs and quality is rigorous and no double charging is allowed, then what is likely to emerge is that, over time not-for-profit and more ethical practitioners would sustain while those who charge high rates or indulge in sharp practices would leave the scheme- as they would be unwilling for these lower rates of return. Of course to organize such monitoring would be a big task and this again would require active community support. More not-for-profit institutions and organisations of working people or cooperatives could also be encouraged to open up health services that in such an environment would be viable and sustainable. If on the other hand, the scheme becomes driven by the necessity of somehow keeping the private sector involved then it would be forced to make more and more concessions to them and turn a blind eye to its transgressions. Such a scheme would eventually be doomed. Of course care must be taken to see that the institutional deliveries done under such schemes are an addition - not merely a shift of cases from public to private sector and not a winding down of the public sector capacity. If the latter happens, the commercial private sector

would be able to force its terms which would neither be of assistance to public policy or to the not for profit sector. Also we need to remind ourselves that Chiranjeevi scheme provides services for less than 10% of health needs. It is the public health system that remains the main form of social protection of the poor from the costs of health care. And keeping it viable would still mean developing within it the capacities of the level needed for providing emergency obstetric care. Necessarily therefore a scheme like Chiranjeevi is an auxiliary and not a substitute to the existing public health system.

However if schemes like Chiranjeevi are able to bring in a significant number of health care providers of diverse ownerships into the public health system, then the possibility opens up for encouraging such initiatives even in remote rural areas for paramedical-based services, in addition to medical services. Thus trained nurses or midwives and paramedics could be supported to set up services in remote areas and funded /reimbursed for services they provide to the poor by panchayats empowered to do so. Trade unions and cooperatives of unorganized and of organized workers could come forward to organize such services. Or panchayats could be enabled to do so. District and state governance bodies with adequate public participation would be needed to ensure that the skills are in place, that the state commitment of funding is not reduced, that quality is maintained and that equity concerns are attended to. Such a network of facilities cannot be confused with private facilities though they are not state government-run facilities. The public health system must expand to embrace these forms of ownership.

In conclusion:

If health is not a commodity of exchange, health care is not an area where market forces will succeed. If health requires active participation by the individual and the family, public health cannot be something that a patriarchal centralized state imposes on a passive beneficiary. Public health must instead be founded on maximizing involvement of the public. Such maximization of public involvement would happen in the community level through community health worker programmes and village health planning. It would happen by an increase in the management of public health facilities and in the making and implementation of block and district health plans and by increase of public participation at the level of framing policy and choice of strategy. If public involvement must be maximized then the institutional mechanisms and organizational processes must be such that it is as decentralized and as demystified as possible. This would enable not only public participation in organizational and institutional decision making but also increase the ownership of "the means of production of health care" by the people. This in turn would mean that it is not values generated by competition and the profit motive that would deliver health care but instead values like trust and cooperation and the spirit of health care as a social and humanitarian service. Similarly changes to healthy lifestyles and health care practices would need neither coercion nor the persuasion of commercial marketing strategies, but informed participation and an enabling environment of peace and harmony within the social and natural environment.

It may be that in trying to claim this understanding for the health sector we come to realize that this understanding of values and its relation to markets and competition and ownership is

true not only for the health sector, but for all social sectors and eventually could even be extended to understand what is needed for the 'creation and sustenance of livelihoods. Perhaps the crisis in delivery of health care merely illustrates the weakest spot in current social and economic relationships/organization, where the flaws in the system were most obvious. That would be an interesting possibility to examine.

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