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A perspective on reforms

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LISTENING to presentations in an Asia regional meeting on the gender and reproductive health impacts of health sector reforms,[1] one was struck by the similarity of interventions that are currently underway in diverse economic and political systems.

The People's Republic of China with its 50 years of experience with barefoot doctors and an extensive primary health care network and Vietnam with a similar system, were once hailed as *the* model for poor countries. On the other hand, the Philippines and Thailand have leant more towards the private sector. Bangladesh and India, in contrast, have opted for a state funded primary health care system with an extensive network of primary health centres and sub-centres. China, Indonesia, Malaysia, Bangladesh and India also have a high profile family welfare programme. The Philippines and Pakistan, in contrast, have treaded a more cautious path on contraceptives. Each of the countries in this region has different priorities, problems and political compulsions. Yet the dominant discourse among the HSR gurus in the globalisation era is strikingly similar.

As Bennett and Muraleedharan point out, 'Despite differences in country contexts the proposals for reforming government have common themes. These include a shift away from direct provision of services by government towards a stronger role in policy-making, coordinating their actors, regulation, facilitating and providing informationÉ In pursuing these aims governments have used a number of mechanisms, including contracting out of services to private sector providers, the creation of autonomous public organisations, corporatisation of government organisations, reforms of civil service structures, privatisation, decentralisation, consumer charters and a host of other instruments.'[2]

User fees have been introduced in hitherto free services and health insurance has become the new *mantra* to offset the negative impact of household expenditure on health care. The general belief is that privatisation, corporatisation, user fees and contracting out services will make the system more efficient and responsive to clients. The

government is now called upon to regulate cost and quality, set standards and adopt new management techniques to manage the system. In short, the government is now called upon to act as a referee and step back from service delivery.

Has this made a difference? The common refrain across the region is that people's access to basic primary health care has not improved. The cost of medical care has been steadily rising and household expenditure on health care has gone up. This observation by health economists (who, along with health management professionals dominate the HSR field) is invariably followed by a statement that the hidden cost has now become visible.

Researchers point out that private health insurance has not only increased costs but that unnecessary diagnostic tests are now being conducted. There is growing evidence that appendectomy, caesarean section (CS), hysterectomy, coronary bypass surgery and blood transfusion are on the increase and being done without valid medical indications.[3] While there has been a staggering increase in the number of private hospitals, clinics and nursing homes, the poor are left to cope with a decaying public health delivery system.

Another debate is also sweeping the world – the global movement for reproductive health.[4] From the United States to Guinea-Bissau, from the Caribbean to South Asia, those concerned with women's health are engaged in a movement for reproductive health and reproductive rights. Focusing on a range of demand side issues, this movement has turned the population and family planning world upside down. Women's access to basic health care (not just maternal health and family planning), health care needs throughout their life (life cycle approach), attitude of service providers (who only see them as baby producing machines), male responsibility in sexual health and contraception and the increasing burden of work on women have been the focus of this movement.

On the management side the movement had turned the spotlight on low skill and low status of female paramedical workers who shoulder a disproportionately large burden of service delivery and the burden of home based care shouldered by women (especially of the elderly, HIV-AIDS patients, mentally ill etc). It almost seems as if the two worlds are speaking a different language.

This schism between women's health advocates and 'mainstream' health economists and management experts is evident throughout the world. The separation of the departments of health and population (family planning) in India, China, Indonesia, and Bangladesh has only legitimised this trend. As a result, the discourse on women's health is conducted in the domain of

population stabilisation. This has unfortunately left women with little choice but to wrestle with the population control hawks.

The debate on HSR is anchored in the larger framework of Structural Adjustment Policy, globalisation and the health sector (as distinct from the population and family planning sector). As expected, the latter is conducted in a gender-neutral framework. Health care seekers are 'clients'; their social and economic situation, gender and occupational profile not factored in. Similarly, service providers too are not differentiated, even though a majority of field level and extension workers (mostly paramedical) are women. They are low-skilled, poor and vulnerable, and often burdened with both health care and family planning responsibilities. In India the two worlds – health and family welfare (now known as reproductive and child health) – converge at this level.

The global RH movement has called for the state to assume greater responsibility in meeting women's health needs, containing population growth, the HIV-AIDS pandemic and making people aware of sexually transmitted diseases (especially adolescents and young people). The combination of long term economic impact of population growth and the HIV-AIDS pandemic has propelled this movement. On the other hand, the HSR pundits argue for greater privatisation and want to absolve the state of its responsibility for providing basic health care.

The Regional Ford Foundation meeting assumes importance in this context. There are two important streams pushing for reforms within the health delivery system across the world. There are two powerful lobbies backed by the World Bank, major bilateral and multilateral donors and international foundations. Yet, for all practical purposes the two have remained distinct with little linkage between the two worlds.

Recent evidence from countries like China – especially in the era of a one-child family – show that women now assume the responsibility for two sets of parents. The pandemic of HIV-AIDS has thrown up a similar situation. Evidence from Africa and Asia indicate that women have to shoulder the added responsibility of caring for terminally ill people. Similarly, the gender impact of the DOTS regime for tuberculosis treatment is rarely acknowledged.

The experience in India suggests that access to continued medication (after the overt symptoms disappear) is determined by women's status and bargaining power within the family. The design and construction of maternal health centres or public health clinics also reveal a lack of sensitivity towards privacy (audio and visual) during medical examination. Waiting rooms are rarely provided with toilets. The ability of women suffering from TB to

take oral or injectible contraceptives is not factored into the FP programme. Similarly, an increase in abortion rates across the country and the unfortunate trend toward sex selective abortion have added to women's health burden – making women weaker and thus more susceptible to other infections.

It is indeed ironic that while the two worlds crisscross and meet in the lives of women, formal institutions involved in HSR and RH are more concerned about retaining their turf and identity. This unfortunate division is best illustrated in India's experience with reproductive health in a system that is geared for immunisation and disease control on the one hand and population control on the other. Recent HealthWatch studies[5] on the implementation of the new approach reveal that there are systemic barriers to implementation of the integrated reproductive and child health programme. What are these systemic barriers?

* The sub-centres, which are the field units and the headquarters of auxiliary nurse and midwives are under-equipped and often are little more than a physical space. Over the years training for collection of data and maintenance of records has been given more importance than clinical training. As a result ANMs, who shoulder the primary responsibility of extension work, are not only under-skilled, but also overworked and disempowered. Workers at higher levels lord over them. For example, the dying cadre of male multipurpose workers have almost no significant responsibility. Neither the ANM not the male-MPW can handle infectious diseases (except for children through ORT), accidents and complicated pregnancies. They can at best refer people to the PHC.

* The primary health centre is another neglected unit of the health care delivery system. The infrastructure is bad (despite repeated grants for construction under various foreign aided projects[6]), there is no running water or sanitation, electricity supply is unreliable and in many parts of the country not even a doctor! Lack of transparency in construction and maintenance of public buildings and the prevalent culture of corruption only exacerbates the problem. The prevailing system of medical education and training does not positively encourage doctors to work in rural areas,[7] resulting in an oversupply in urban areas. The government has no plan to rectify this imbalance (unlike China that has a range from the barefoot doctor to full-fledged specialists).

* Appropriate drugs and equipment are rarely available where most needed – i.e. in rural areas and urban slums. The logistics and supply of essential drugs is inefficient and corrupt.

* The attitude of service providers down the line remains a problem – women continue to be viewed as perpetrators of the

population problem. There is little concern for the dignity and privacy of women. The quality of care is poor. The range of services available is also limited to immunisation, pregnancy registration (not care) and sterilisation. As a result, women stay away from government services for abortion and contraception.

* The impact of the separation of health from family planning can be felt right up to the PHC level. The schedule for immunisation, maternal health and family planning services do not match with services (where available) for tuberculosis, leprosy, malaria etc. Women have little access to non MCH-FP services. Over the years the campaign mode of delivery of immunisation and seasonal sterilisation camps have effectively undervalued routine and sustained service delivery throughout the year. The former is more visible and can be 'monitored'.

* The functioning of referral units providing MCH services, treatment for sexually transmitted diseases, complicated pregnancies and abortions leaves much to be desired. Most district hospitals have become overcrowded and inefficient. Without reliable back-up services, the ANMs and even the medical officer at the PHC do not feel confident to refer patients.

In short, in most parts of the country the health care delivery system does not work, thereby reducing the chances of success of the recently introduced RCH programme. Service providers admit that radical reforms are called for. Yet, these changes are not really woven into the health sector reforms strategy.

Is it not logical that a health sector reform programme should ideally look at barriers to the implementation of government programmes and projects – reproductive and child health, tuberculosis control, HIV and AIDS, leprosy, among others?

Unfortunately, HSR – as we know it in India – is more about macro policy changes related to contracting out services and formation of corporations and autonomous bodies. What has been initiated so far? The government has primarily experimented with contracting out services for laundry, hospital food, cleaning etc. There is talk about health insurance, community based group insurance linked to savings and credit, opening the insurance business to MNCs and so on. With the exception of a corporation for the supply of drugs in Tamil Nadu, we have made little progress in this area. Health sector reforms are today limited to insurance, privatisation and user fee. Even the quality of care issue raised in the reproductive health programme has not found its way into HSR! Will the two streams ever meet?

Maybe there is another way of looking at HSR in India. From the perspective of poor women and men and the thousands of under-

skilled and disempowered service providers, HSR should take a worm's eye view and not a bird's eye view of the systemic changes that are necessary to make the system work.

Perhaps HSR should start with medical education and training. If the mainstay of our health delivery system is the paramedical worker, then enhancing clinical and diagnostic skills of ANMs, male-MPW, lab assistants, etc. should logically be a priority. Higher skills could lead to greater self-confidence, community acceptance and effectiveness. This might turn the system around and make it more service oriented. Why has India shied away from a shorter duration medical education programme for midwives and frontline medical workers? If we cannot get doctors to serve in rural areas, maybe the only way out is to create another cadre.

Similarly, recognising the importance of enhancing the clinical skills of traditional birth attendants (*dais*), especially in states like Rajasthan where the proportion of institutional deliveries is abysmally low (and not likely to increase in the near future) could be the only way to reduce infant and maternal mortality. Unfortunately, Unicef has lobbied for cent percent institutional deliveries; as a result the TBA training programme has lost its importance. From a 40-day training programme in the 1960s in India, we now have a token three day course to teach TBA about the Five Cleans! While the intentions of this advocacy programme may be laudable, the situation on the ground is far from ideal. With the exception of forward states, women continue to depend on family members, local midwives and others.

For almost 40 years India's health and family welfare programme has been overshadowed by demographers, resulting in lopsided priorities. As of now a large proportion of the time of service providers, from the medical officer downward, is spent filling forms and compiling data. This has also eaten into valuable in-service training time. Separating the service delivery functions of the system from data gathering functions could provide a major breakthrough. Service providers must be liberated from the responsibility of demographic data collection and cumbersome reporting through complicated formats to concentrate on service provision.

Infrastructure development has become synonymous with corruption and rake-offs. Inviting community participation and private cooperation for construction and maintenance, from the sub-centre upwards, could be encouraged on a large scale. A meaningful partnership through a representative committee at the functional level would not only enhance the quality of service but also break the influence of contractors. Involving women at the design and planning stage could take care of issues of privacy, toilets and other facilities. The experience of Tamil Nadu (see

Leela Visaria's paper in this issue) has been encouraging.

Similarly, creating a drug bank through public contribution, setting up a more transparent drug supply corporation with greater freedom at the functional level to order and scrutinise the quality of drugs, could be explored. This has been tried out in Tamil Nadu with some encouraging results.[8]

Changing attitudes is not easy anywhere in the world and India is no exception. A tight monitoring system for essential quality of care indicators (including privacy and dignity), service availability and service provision indicators could force some change in the way women and indeed the poor are treated in our health delivery system. Involving panchayati raj institutions, local women's groups and other consumer protection groups in surprise inspection of quality of services, or gram sabha meetings to discuss quality and availability of services could be introduced. This may enhance accountability and in the process make service providers more cautious.

Finally, the question of user fee and payment for services could be resolved after public discussion. Linking user fee to monitoring by the panchayat and gram sabha, and introducing some degree of flexibility to fix charges (with a stipulated ceiling) could be explored. A national policy or a state-wide office order introducing user fee in the absence of a corresponding monitoring system may be counter productive.

Essentially, what the region needs is a more people-centred health sector reform and not economist or demographer driven restructuring programmes. Macro managerial solutions that seem to prevail across different countries and even different social sectors may well be irrelevant and not work. Evidence from the region suggests that so far health sector reforms have done little else than make health care expensive and unaffordable for the poorest of the poor.

Footnotes

1. Regional meeting of the Ford Foundation held in Lijiang, Yunan Province, China, 12-17 March 2000.

2. Sara Bennett and V.R. Muraleedharan, 'New Public Management and Health Care in the Third World', *Economic and Political Weekly*, 8 January 2000, pp. 59-68.

3. Madhukar Pai, Unnecessary Medical Interventions: Caesarian Sections as a Case Study. Paper presented in MFC meeting, December 1999.

4. This movement gained momentum at the 1994 International Conference on Population and Development, Cairo.

5. HealthWatch Trust, The Community Needs-Based Reproductive and Child Health in India – Progress and Constraints. October 1999. See overview of main findings by Leela Visaria and Vimala Ramachandran.

6. For example, in Rajasthan almost every PHC and sub-centre were built and rebuilt under World Bank and UNFPA funded projects over the last 15 to 20 years. These grants were channelled through the PWD. Even a casual visitor to a PHC cannot miss the state of neglect.

7. Recently, Tamil Nadu has made postgraduate admissions easy for doctors who have served in a rural PHC for at least three years.

8. Sara Bennett and V.R. Muraleedharan, op cit.