WORLD BANK'S AID IN HEALTH SYSTEM STRENGTHENING IN INDIA: A POLICY ANALYSIS

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AMITABHA SARKAR

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH

SCHOOL OF SOCIAL SCIENCES

JAWAHARLAL NEHRU UNIVERSITY

NEW DELHI -110067, INDIA

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CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110067

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DECLARATION

I hereby declare that this thesis entitled **"WORLD BANK'S AID IN HEALTH SYSTEM STRENGTHENING IN INDIA: A POLICY ANALYSIS"**, is being submitted by me in partial fulfillment of the requirements of the award of the degree of DOCTOR of PHILOSOPHY of Jawaharlal Nehru University. This thesis has not been submitted for the award of any other degree of this university or any other university and is my original work.

(AMITABHA SARKAR)

CERTIFICATE

We recommend that the thesis be placed before the examiners for evaluation and consideration of the award of Degree of Doctor of Philosophy.

Prof. Mohan Rao	Prof. Rama V.Baru	Prof. Sanghmitra S. Acharya
Supervisor	Supervisor	Chairperson

Telefax: +91-(11) 2670 4420 (Direct), 26742676, 26741557 (Ext. 4420), E-mail: csmchjnu@gmail.com
Web:http//www.jnu.ac.in/SSS/CSMCH/

Abstract

Introduction: The unbridled suffering of people in Low and Middle Income Countries (LMICs) reinforces the question of efficacy of health system approaches in the debate for health for all. Historically, LMICs have been receiving continuous support from the international agencies to strengthen their health system. This research attempts to address this system strengthening process itself- the aid assistance of the international agencies i.e., World Bank in India.

Concept and Theory: The aim of this research is to explore the instrumental role of the World Bank's health system policy, in particular Health System Strengthening. It is a policy analysis to understand how the Bank's health policy gets formed and formulated (at the international level of macro system), then adopted and modified (at the national level of meso system) and finally implemented and operated (at the state/regional level micro system). It is theorised as the 'governmentality' of the World Bank where it governs the national and state governments with regards to their health system policy and practice.

Methodology: The research is an endeavour of Health Policy and System Research (HPSR) wherein the policy of health system has been studied by analysing macro, meso and micro levels. This policy process analysis has been conducted by using four methods at various levels of the policy; discourse analysis (formation-formulation), situation analysis (adoption-modification), institutional and context analysis, and process evaluation (implementation and operation). The second analytical part of exercise is on the framework of health system and their elements to understand the operational form of health system in any given context. In this regards, the Health System Dynamics Analytical Framework, 2012 of the Institute of Tropical Medicine, Belgium has been applied. Altogether eight qualitative and quantitative data collection tools were employed to collect data as well as to aid the methods chosen for analytical framework.

Findings: The World Bank has been active in the formulation of health system policy for the last four decades by developing various health system approaches. The analysis finds that the Bank's health system policy approaches at the macro level (international) has always been determined by the events of international political economy, and the

relationship between international economic governance and international health governance. At this level, the Bank forms certain specific devices for advancing the health system policy at the country level. At the meso system (India as a case of example), the health system policy with the help of policy tool (Country Assistance Strategy/CAS) and instruments (research and lending) further percolates down to the state level. Finally, the health system policy in the form of health system approach gets implemented and operated at the micro system. This research has done a case study in Karnataka (for studying the micro system) to analyse the Bank financed health system intervention from 1996 to 2017.

The findings from the micro system experience from Karnataka state entails that the first phase was earmarked for the state's policy reform initiative and infrastructural expansion. The operational shift in the health service organisation occurred at the beginning of the second half of the last decade by incorporating the new financial arrangement (assurance/protection) and bringing plurality in service provisions through Public Private Partnership. The end of the last phase is devoted to retaining the sustainability of the changes done in earlier phases and paves the way for new health service governance and management.

Analysis: The Bank has been instrumental in changing the health system orientation through its health system policy approaches. Health System Strengthening as the latest health system policy approach is also functioning in a similar fashion by promoting specific agenda driven policy suggestions, and practices in order to govern the health system as the way Bank wants. This approach is more about engineering the Bank's own idea of health system rather than contributing into the goal of health for all. In general, the HSS approach is instrumental to change both the policy and the practice of the health system through a governance framework. This research argues that the absence of any programmatic framework, epidemiological understanding, and lack of contextual rigour makes the HSS approach to work as a vertical programme that only concentrates to bring change in financing, governance, and service delivery elements of health system. It is to conclude that the health for all goal through HSS remains a distant dream.

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As a researcher I draw inspiration from the spirit of Jawaharlal Nehru University, the seat of solidarity and learning, of study and struggle. When I had first stepped into JNU, I found the atmosphere disseminating with questions; questions which are no more seeing the light of day in the current phase as I am leaving. I am indebted to the numerous discussions and debates which helped me to adopt and sharpen my analytical aptitude over the last six years. The JNU community helped me to shape my understanding on ideas, concepts, theories and practice. The journey is a long one, and I am determined to stay true to my learnings. I am thankful to my supervisors Prof. Mohan and Prof. Rama Baru for their faith on me that always gave me confidence and a sense of responsibility. I would also like to thank the faculty at Centre of Social Medicine and Community Health- Prof. Rajib Dasgupta, Prof. Ramila Bisht, Prof. Ritu Priya, Prof. Sanghamitra Acharya, Dr. Prachin and Dr. Vikas Bajpai for their inputs and invaluable support. Special thanks to PHC 2.0 group of CSMCH, JNU for our innumerable meetings and discussions over the period of time. I also thank the non-teaching staff at CSMCH, School of Social Sciences, and Jhelum hostel for their support.

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Amitabha Sarkar
Wooden Box No. 27, JNU Central Library
Room No. 358, Jhelum Hostel, JNU

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Abbreviations

AGCA	Advisory Group for Community Action
AAA	Analytic and Advisory Activities
AB	Ayushman Bharat
AHINDA	Kannada acronym for minorities, backward classes and Dalits
AIDS	Acquired Immuno Deficiency Syndrome
AIIHPH	All India Institute of Hygiene & Public Health
AIPRG	All India Patient Rights Group
AM	Aide-Memoire
ANM	Auxiliary Nurse Midwife
ARS	Arogya Surakshan Samiti
ASA	Advisory Services and Analytics
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BAMS	Bachelor of Ayurveda, Medicine and Surgery
BATF	Bangalore Area Task Force
BE	Budget Estimate
BHMS	Bachelor of Homeopathic Medicine and Surgery
BJP	Bharatiya Janata Party
BMGF	Bill and Melinda Gates Foundation
BN	Basic Need
BOP	Balance of Payment
CAS	Country Assistance Strategy
CD	Communicable Disease
CGIAR	Consultative Group for International Agricultural Research
CHD	Citizen Help Desk
CHW	Community Health Worker
CM	Chief Minister
CMNN	Communicable, Maternal, Neonatal, and Nutritional Diseases
CPF	Country Partnership Framework
CPHC	Comprehensive Primary Health Care

CSS	Centrally Sponsored Schemes
CSSM	Child Survival and Safe Motherhood
DANIDA	Danish International Development Agency
DC	Developing Countries
DCA	Development Credit Agreement
DD	Deputy Director
DHC	District Health Committee
DHIS	District Health Information System
DOHFW	Department of Health and Family Welfare
DPC	District Planning Committee
DPMO	District Project Management Officer
DPMU	District Project Management Unit
DQAG	District Quality Assurance Group
EAG	Empowered Action Group
EHRS	Electronic Health Record System
EMOC	Emergency Medical Obstetric Care
EMP	Environment Management Plan
ESW	Economic and Sector Work
FBO	Faith Based Organisation
FDI	Foreign Direct Investment
FMR	Financial Management Report
FRL	Fiscal Responsibility Legislations
G77	Group 77
GDP	Gross Domestic Product
GHP	Global Health Partnership
GOI	Government of India
GOK	Government of Karnataka
GP	Gram Panchayat
GRAKOOS	Grameena Coolie Karmikara Sanghatane
GSDP	Gross State Domestic Product
GVK EMRI	GVK Emergency Management and Research Institute
HCS	Health Care System

HCWM	Health Care Waste Management
HD	Human Development
HDN	Human Development Network
HFA	Health For All
HMIS	Hospital Management Information System
HNP	Health, Nutrition and Population
HPC RRI	High Power Committee for Redressal of Regional Imbalances
HPSR	Health Policy and System Research
HPU	Health Planning Unit
HSD	Health System Development
HSDP	Health System Development Project-II
HSP	Health System Performance
HSPRAP	Health Sector Procurement Reform Action Plan
HSR	Health System Reform
HSS	Health System Strengthening
HWC	Health and Wellness Centre
IBRD	International Bank for Reconstruction and Development
ICA	Institutional Context Analysis
ICR	Implementation and Completion Report
ICSID	International Centre for Settlement of Investment Disputes
ICT	Information Communication and Technology
IDA	International Development Association
IDS	International Development Strategy
IEC	Information Education Communication
IEG	International Economic Governance
IERB	Institutional Ethics Review Board
IFC	International Finance Corporation
IG	International Governance
IGO	International Governmental Organisations
IHG	International Health Governance
ILO	International Labour Organization
INC	Indian National Congress

INGO	International Non-Governmental Organisation
INR	Indian Rupee
IP	In Patient
IPP	Indian Population Project
ISEC	Institute of Economic Growth
ISR	Implementation Status and Results
IT	Information Technology
JD(S)	Janata Dal (Secular)
JNU	Jawaharlal Nehru University
KARC	Karnataka Administrative Reform Commission
KDR	Karnataka Development Report
KERL	Karnataka Economic Restructuring Loan
KERP	Karnataka Economic Restructuring Programme
KFD	Kyasanur Forest Disease
KFRA	Karnataka Fiscal Responsibility Act
KfW	Kreditanstalt für Wiederaufbau (German Development bank)
KHSAF	Karnataka Health Systems Additional Financing
KHSDP	Karnataka Health Systems Development Project
KHSDRP	Karnataka Health System Development and Reform Project
KIHN&FWSDP	Karnataka Integrated Health, Nutrition and Family Welfare Services Development Project
KII	Key Informant Interview
KISHP	Karnataka Integrated State Health Policy
KJA	*Karnataka Jnana Aayoga* (Karnataka Knowledge Commission)
KPTCL	Karnataka Power Transmission Corporation Limited
KSHIP	Karnataka State Highways Improvement Project
LDC	Least Developed Countries
LIC	Low Income Countries
LMIC	Low and Middle Income Countries
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MHC	Mobile Health Clinics
MIGA	Multilateral Investment Guarantee Agency

MLA	Member of Legislative Assembly
MMR	Maternal Mortality Ratio
MO	Medical Officers
MOCI	Ministry of Commerce and Industry
MOHFW	Ministry of Health & Family Welfare
MP	Member of Parliament
MTFP	Medium Term Fiscal Plan
MTR	Mid Term Review
NABH	National Accreditation Board for Hospitals and Healthcare Providers
NAM	Non Aligned Movement
NCD	Non Communicable Disease
NGO	Non-Governmental Organisatiom
NHA	National Health Authority
NHM	National Health Mission
NHP	National Health Policy
NHPS	National Health Protection Scheme
NHSRC	National Health System Resource Centre
NIEO	New International Economic Order
NIHFW	National Institute of Health and Family Welfare
NITI AAYOG	National Institute of Transforming India
NPCDCS	National Program for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke
NPM	New Public Management
NRHM	National Rural Health Mission
OBC	Other Backward Class
OD	Organisational Development
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OOP	Out of Pocket Expenditure
OPD	Out Patient Department
PA	Project Administrator
PAD	Project Appraisal Document

PAHO	Pan American Health Organization
PDO	Project Development Objective
PDS	Public Distribution System
PGB	Project Governing Body
PHC	Primary Health Centre
PHC	Primary Health Care
PHCF	Public Health Competitive Fund
PHD	Doctor of Philosophy
PHN	Population, Health and Nutrition
PHRD	Policy and Human Resource Development
PIC	Project Implementation Cell
PIP	Project Implementation Plan
PMC	Project Management Cell
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPP	Public Private Partnership
PREM	Poverty Reduction and Economic Management
PRI	Panchayati Raj Institution
PSAL	Programmatic Structural Adjustment Loan
PSC	Project Steering Committee
PSU	Public Sector Unit
QA	Quality Assurance
RCH	Reproductive and Child Health
RDL	Regional Diagnostic Lab
RE	Revised Estimate
RWG	Redistribution With Growth
SA	Structural Adjustment
SAL	Structural Adjustment Loan
SAP	Structural Adjustment Programme
SAR	Staff Appraisal Report
SAST	Suvarna Arogya Suraksha Trust
SGSY	*Swarnajayanti Gram Swarojgar Yojana*
SHIC	State Health Informatics Centre

SICF	Service Improvement Challenge Fund
SIHFW	State Health Institute of Family Welfare
SIP	Service Improvement Plan
SLCC	State Level Coordination Committee
SMT	Senior Management Team
SOCHARA	Society for Community Health Awareness Research and Action
SPC	State Planning Cell
SPHC	Selective Primary Health Care
SPMU	State Project Monitoring Unit
STG	Standard Treatment Guidelines
SWAp	Sector Wide Approach
TP	Taluk Panchayat
UHC	Universal Health Coverage
ULB	Urban Local Bodies
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
USA/US	United States of America
USAID	United States Agency for International Development
VAS	Vajpayee Arogyashree Scheme
VAT	Value Added Tax
VCHP	Vulnerable Communities Health Plan
VGKK	Vivekananda Girijana Kalyana Kendra
VHSC	Village Health and Sanitation Committees
WB	World Bank
WDR	World Development Report
WHO	World Health Organisation
ZP	Zila Panchayat

Clarification on commonly used terms in the Thesis

Reform: It's a comprehensive process of change based on specific context and need that should lead to greater capacity and integrity. Engagement of all actors is a prerequisite condition for reform, and nurture local ownership. Restructuring, rebuilding/reconfiguring are two means of reform.

Restructure: Changing the structural archetype to regroup and re-coordinate resources and activities of the organisation.

Reconfigure (rebuilding): It revolves around adding, splitting, transferring, combining, or even dissolving units without any structural modification of the organisation.

Capacity: The ability of an individual/organisation to perform the mandated task effectively and efficiently.

Capacity building: It is about the ability of an institution or individual to perform effectively and efficiently.

Integrity: The compliance with human rights and professional ethics/standards by an individual or organisation. **Standard**: The principles followed, adhered to and respected in performing any actions and/or behaviour.

Apparatus: According to Giorgio Agamben, an apparatus is a strategic response to some urgent crisis.

Chapter 1: Debate

Summary of the chapter: This chapter is an introduction to this research and the organisation of this thesis. The central theme of this chapter is to represent a thought-current for understanding the World Bank's aid in India's Health System Strengthening (HSS). The thought-current is non other than the never ending debate on the health for all. The chapter deliberates upon the questions which are necessary to understand the debates surrounding the role of the World Bank in general and specifically its role in reforming the Indian health system strengthening. With the rise of the World Bank in global health gave rise to the emergence of Global Health Partnership (GHP) as part of International Health Governance (IHG). The IHG in order to avail funding from GHPs for disease-based intervention endorsed the HSS approach. The chapter argues this very endorsement is defocussing the debate on health for all that critically examines the effectiveness of health system approaches in terms of financial efficiency and effectiveness. The Bank's engagement in the formulation of health system approaches has to been seen in the context of its engagement with economic policies and subsequently its health policy through its lending programmes. Karnataka is one of the early reform states with active engagement of the World Bank for over two decades. The need to revisit the HFA debate during the post liberalisation period prompted us to undertake this research to analyse the intersection between macro (international-level), meso (national-level/India), and micro (state-level/Karnataka) levels of policy and the Bank's role in policy formulation.

Health for All! This monumental declaration of 1978 pronounced at Alma-Ata has been providing inspiration, justification, motivation, and stimulation to the actors of International Health Governance (IHG) to engage in policy development and intervention practice for last four decades. Their struggle, strife and success in the journey to Health for All (HFA) resemble Anton Chekhov's famous 1898 short story, '*A Doctor's Visit*' (also translated as *A Case History*). The Doctor (Koryolov) in the story without losing his biomedical sight shifts his position to develop a dialogue with the patient (Liza) to search the path for remedy and cure. The international actors like World Bank too have been changing their position in search for appropriate policy to develop a system that could deliver HFA. This research is a contribution in the continuing debate of HFA to analyse the investment of the World Bank in India's health system.

1.1 The Prelude[1]

In the height of populism, worldwide economic slowdown and growing geo-political unrest in different parts of the world, the relative responsibilities of the State and longstanding commitment of international community for social development and human justice have become once again a matter of discussion, subject of argument and policy of practice. The challenge in redistribution of income corresponds not only to increasing income inequality but pose serious threat in access to basic health requirements across Middle, and Low and Middle Income Countries (MIC and LMIC). As a LMIC, India also is faced with these challenges. In 2014 nearly 4·5 per cent of population (approximately fifty eight million) had slipped into poverty because of excessive out-of-pocket health expenditure (WHO SEARO, p. 43). The cause for this is often attributed to a fragile health system that contributes and increases existing inequalities.

Historically, the LMICs and MICs including India have been depending on the aid assistance of the international community for planning, designing, and building its health system. Lack of resource and inadequate capacity in programme structuring and financing make international aid an inevitable part of the health system planning process for developing countries. Historically, international aid in the health sector was focused on disease centric vertical programmes. The focus on disease-based intervention at the ignorance of general health service and community's never-ending vulnerability to avert health related crisis have been acting as whys and wherefores to develop appropriate policy for building health system not only in India but across the world. The role of IHG in this development of appropriate health system policy is noteworthy.

The development of health system policy is a continuum process in the sphere of IHG where constellation of actors, agendas, and interests intermesh with each other to form a health system network. This network of actors within and outside the health system plays a crucial role in the circulating the idea across the world. The idea of health system conceived as health system in the Alma-Ata declaration was different from the idea that

[1] The Prelude is an autobiographical poem of William Wordsworth on the 'Growth of a Poet's Mind', published after a few months of his death in 1850. The Prelude in this chapter refers to the growth of this research.

contemplates health system in present day Universal Health Coverage (UHC). While till 2000 the idea was mostly limited to the individual country's improvement of health system, after 2000 the idea of the health system has got intermittently linked to the agenda of international development goals as evident from Millennium Development Goal (MDG) to Sustainable Development Goal (SDG). Hence, the purpose of health system is no longer to develop and manoeuvre the health care service delivery, but also to accelerate internationally agreed developmental goals. This is the interest for this research to understand how the evolution of the idea of health system at the behest of the World Bank contributes into the development of today's Health System Strengthening (HSS) framework and what strengthening of health system is in operation.

World Bank (hereafter referred to as Bank), as an Inter Governmental Organisation (IGO), has been playing an important role both in the development and transformation of health system from policy to practice. In the case of India, the commitment is reflected in the Bank's two-decade long association with several state-level health system projects in the country since the first half of 1990. The Bank's unswerving interest with the health system projects is so far the only available reference in Indian context where international aid assistance is instrumental with the 'ideas' of health system continuum.

This research has been conceptualised from the perspective where the aid assistance of the Bank is analysed to know its contribution in the strengthening of health system initiative in India. In that strengthening process, the role of the Bank's health system policy at each level (international to national to state) has been studied as a policy process to gather evidence for investment guidance as well as to re-frame the framework of health system intervention for strengthening the health system.

The status-quo of the fragile health system is the bone of contention in the debate of HFA. The trial and error with the ideas of health system had inspired this research to cogitate with number of questions, and in turn they helped in the growth of research problem. What is the health system? What is new about HSS? How health system appears on the map of IHG? How much health system is important in the Bank's lending portfolio? How does the national and local contexts matter in health system intervention? Why is India depending on international actors, especially on the Bank,

for strengthening its health system? What are the ground experiences of health system intervention? These questions are necessary to understand the debate, and debate upon the debate further.

1. 2 Organisation of the thesis

This thesis has altogether nine chapters. This chapter is the general introduction to the thesis topic and understanding the debate to formulate objectives and research questions. The next chapter, methodology, is the anatomy of this research which demonstrates why there is a need for new methodological structure to conduct policy process analysis by synthesising conceptual, theoretical and analytical frames. Apart from the detail study design, the end of the methodology chapter discusses researcher's ethics and value position. Chapter three to chapter seven are divided in three parts, which analyses the policy processes of Bank's health system at the international/macro (formation-formulation), national/meso (adoption-modification), and state/micro (implementation-operation) levels. Chapter three is a discourse analysis of Bank's health system policy since the late1960s to till date in the macro level. Chapter four is a situation analysis of Bank's interaction with Government of India (GOI) with regards to health system policy in the meso level.

Chapter five to seven is micro level analysis of health system policy implementation and operation where Indian state Karnataka is taken as a case study. The contextual analysis of Karnataka has been carried out in chapter five to know the pathway of development in the state on which Bank financed health system projects were financed. Chapter six and seven are the detail description of two Bank financed health system projects' execution experience in Karnataka from 1996 to 2017. This is so far the longest association of Bank in the history of health system project financing where a particular state is the site of intervention for twenty one years at a row.

Chapter eight is an analysis of Bank's twenty one year investment on health system in Karnataka to illustrate how the strengthening of health system is actually happening at the ground. The last chapter is a mental modelling exercise to discuss the role played by the three models of HSS (descriptive, theoretical and analytical) to engage with the health system active in reality in the macro, meso, and micro levels of policy respectively.

1.3 What is health system?

The goal of HFA is depending on the capacity of health system organisation and performance. This is the single most important reason for IHG as well as governments to focus on health system. Health system is a much discussed and debated concept in health development, though this section is not about the historical development of health system ideas, instead a deliberation on the idea that persists at present. The World Health Organization (WHO) developed a conceptual definition of health system in 2000 *World Health Report* that entails "*all the activities whose primary purpose is to promote, restore or maintain health*" (WHO, 2000, p. 5). The limitation of this definition is that it considers only public and private entities who provide services and arrange finances, and thus ignoring the other agencies (or other determinants) which are indirectly playing a crucial role in the development of health (like, education) (Mutale, 2014). Irrespective of limitations, the WHO's conceptual definition of health system is more or less the standard operative guideline for international health actors since the year of 2000. Hence, it can be said that the WHO's idea of health system is the agreed idea of current approach to design and operate health system.

The operative guidelines in any health system intervention comes from the boundary that health system articulates through its conceptual definition. The 'health action' is the fundamental principle to draw the boundary where activities whose "*primary intent is to improve and maintain health*" are the reference points (Murray and Frank, 2000. p. 718). This primary intent is the guiding reference to develop basic frame for health system intervention. Here, the actors interpret the 'primary intention' as per their own agenda and interest to develop the health system frameworks, which is discussed in detail in chapter nine. The framework (determined by the boundary) is a set of health system elements, like financing, service delivery, governance, information technology etcetera.[2] Health system from the aspect of policy development and intervention design are theorised and administered, respectively, based on the need of those elements, as

[2] It is to mention that 'component' is the standard terminology used in the various health system frameworks to demonstrate their primary intention (financing, service delivery, governance and so on) in the health system intervention. However, this research coins the term 'element' to represent the primary intention of the health system frameworks. Both element and component refer to part or section of some unit, but the difference is element is organic in nature and naturally linked to the concerned unit, component is considered as artificial and externally added to the unit. This research considers financing, service delivery, population and others as natural part of any operative health system, and not an affix from outside the environment.

per the guidance of the individual framework, to address the concerns of the system that deals with governance, management and operation of health service. Organisation of health service is the primary motto of any health system intervention.

The above understanding of conceptual definition and operative guideline (boundary driven elements) of the health system influence the notion of public policy also, which has substantive bearings in the organisation of health service. In public policy health is expressed as entitlements. Entitlements are nothing but rights that shape the position and structure of the government (or public policy) to perform certain actions in order to ensure certain standard for its population (Wenar, 2015). The condition of primary purpose (interest) and primary intent (action) make the health system responsible for improving the elements that are related to only health care, such as health care workforce, health care finance, health care technology and so on. It means that education or water or food which has substantive health benefit as social determinants of health is out of the purview of this definition of the health system. This particular conceptual definition is discussed in detailed in chapter three. This idea of health system reflects on the public policy on health in general and specifically on health policy, and that is why in practice entitlements under the spirit of rights-based perspective are limited to health care. Further, the entitlements to health care in policy and planning are attended through health service development and management wherein the elements related to service mechanism usually gets the maximum priority. Thus, often health system represents only health service system in policy and plan documents in order to provide health care.

Ruger (2006) identifies this practice and opines that right to health perspective is more attached to the framework of medical ethics or bio ethics and not a perception of universal social justice. The assumption behind this perception claims that health is an imperfect variable (in comparison of liberties, utilities, community values, opportunities and other primary goods) for assessing social justice or human right.[3] Scholars like Daniels, Hesler, Buchanan repeatedly put emphasis on this assumption and argued that right is expressed best in the form of 'demand for equality of access or entitlement to health care services'. Thus 'right to health' is articulated as 'right to

[3] John Rawls in the Theory of Justice in 1971 first talked about primary goods, which are basically the fundamental interest of citizens, such as rights, liberties, opportunities, income and alike.

health care' (Ruger, 2006). Further, right to health care is diluting the appreciative understanding of health. In terms of entitlements, it means organisation and arrangement of services to meet the need of health events or in other word while the health of an individual or population is getting affected from disease. Interestingly, it is in contradiction to the WHO's own definition of health; "*state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO, 1948). Therefore, it is argued that the present health system is demonstrating a negative expression of health (to cure the disease) by influencing the entitlement criteria of public policy towards health care at the cost of ignoring the social determinants of health.

1.4 What is health system strengthening?

Health System Strengthening (HSS) is an approach to plan, govern, and manage health system operation and performance. The last section entails what constitutes health system, especially in present time. This section elaborates how the present idea of health system functions in policy spaces and intervention logic. According to the Bank, the strengthening of health system necessarily means a set of activities to be introduced within the health system operation; public-private partnerships, payment mechanisms, governance mechanism, decentralised decision making, insurance, and information system (WB, 2007). WHO defines HSS as a process to develop the capacity of a country to address its health and health system challenges by identifying and implementing the necessary changes in country's health system policy and practice (WHO Executive Board Meeting, 30 December 2010). This definition suggests that HSS is a strategic approach to health system for bringing change in a country's health system policy and practice. More definite understanding on HSS as strategic approach comes from the United States Agency for International Development's (USAID) manual on health system assessment. It describes HSS as a set of strategies for the improvement of health system functions in order to increase the efficiency, access, coverage, and quality (USAID, September 2012). Both the WHO and the USAID understanding of HSS depicts that HSS by definition is meant to associate with countries' health system policy and programme processes. This process embodies the engagement with the very functions which operate health system.

The present idea of health system approach, i.e. HSS, at first appeared on the first biennial report of Alliance for Health Policy and System Research (HPSR) in 2004. The report stressed on the development of knowledge (through health system research) for specific actions to strengthen the health system (Alliance for HPSR, 2004). Thereafter in 2007 both the WHO and the World Bank launched their own health system frameworks as HSS model to engage with the functions of health system at the country level (WHO, 2007; WB HNP, 2007). The Bank modelled HSS after control knobs framework, and similarly the WHO exhibited building blocks framework to promote HSS. These frameworks addressing the functional aspect of health system are discussed at length in chapter nine. It is to argue that initiatives from the Bank and the WHO on behalf of the IHG should be considered as the framework driven attempt to develop health system policy and manage intervention operation. The role of Bank as IHG actor in health system policy development and intervention is very important in terms of theorisation and operationalisation of these frameworks through aid investment. Hence, it is to be understood that the Bank through HSS approach is instrumental to bring the desired functional change in the country's health system policy and operation.

1.5 How health system becomes a development agenda in International Health Governance?

Health and development coexist in the theoretical foundation of governance since the nineteenth century. Many international institutes were formed after Napoleonic war (1803 – 1815) to promote peace and industrial development by addressing collective concerns (like curbing the menace of infectious disease). These concerns were associated to the interest of inter-state trade (Dodgson , Lee and Drager, 2002). Similar interests persist among the various present day international institutions which call for disease (especially communicable) specific intervention to minimise cross-broader risk.

The international socio-political changes followed by economic impact, transformed the health from a service component to the 'demand for development' agenda. After the World War-II, Western Europe and the United States of America (USA) realised the need for stabilising international political and economic activity and formed various international organisations. This was one of the many examples of international governance where various actors took a collective consensus and accordingly

prioritised the agenda of work. It was the outcome of those agendas that institutionalises the developmental drive.

The drive for development began with the year of 1945, noteworthy for the foundation of the United Nation (UN), comprising the member states, according to the charter endorsed and settled upon. This body of repute worked towards accomplishing international solidarity for achieving the common goal (UN, 1945). The post Second World War period witnessed countless liberation movements against the colonial rule which ultimately culminated in freedom of humanity and political transformation. But it could not avert unplanned growth in the developing world. The developmental indicators reflected sluggish development and marginal improvement. The health, for example, for an individual and for the population alike, was in danger because availability, affordability and accessibility of care remained out of reach for the populace. These hurdles got magnified by the persistent food scarcity, unemployment/underemployment, inequity of every type, political instability which collectively resulted into serious crisis for providing services to individual or society as a whole. This was the status of doom for the developing countries where majority of the world are located till date. These countries hardly had any organised health system at their disposal that can handle the surmounting pressure of population and the eventual rarity of health services.

The exit of colonial power (started in Asia and then Africa) was replaced by the new political and economic order. This gaping void had invited various UN agencies, FBOs (Faith Based Organisations), INGOs (International Non Governmental Organisation) and bilateral agencies to come together with their brand of development for developing nations. The confluence and collectiveness of international aid agencies with respect to health are known as International Health Governance that has enormous importance in shaping the health service of developing world. That architecture of the IHG was based on the exemplary human interaction across the world and evolved during successive years. It systemised a comparatively new governance mechanism that became an order of the day in the late twentieth century onwards (Held et al. in 1999 cited in Dodgson, Lee and Drager, 2002).

Apart from the presence of bilateral aid, the multilateral aid agencies (like WHO and other UN bodies), the International Financial Institutions/IFI (World Bank,

International Monetary Fund/IMF and other regional economic institutions), and the INGOs in the landscape of IHG, the arrival of the Global Health Partners (GHP) in public private partnership have turned out to be very influential in the governance mechanisms of IHG. The international political economy had got transformed into the new formation, 'global governance for health', in the mid 1990s because of the paucity of funds and the requirement for more research. These two came together to 'close the gap' that existed traditionally in the IHG. The basic difference between characteristics of these two governance system is notable. The traditional IHG recognised the State as the main responsible in spite of acknowledging the considerable presence of non-State actors and their interests. At the opposite end, the 'global governance for health' mobilised IHG to take into account both the State and non-State actors as crucial partners for governance of health issues because of the State's inability to deal with the health related events, keeping pace with progression of the globalisation process (Dodgson, Lee and Drager, 2002).

The transition from traditional to a newer form of IHG may have appeared as a shared space of governance between public and private, however, despite that it is to be acknowledged that the role of traditional actors (for example, WHO or World Bank) remain as important as it was at the time of formation of the UN. In the map of IHG, the WHO by its organisational definition is an apex body on health related issues, and has always been considered as the decision making body in health related events. Similarly, the continuous thrust on the growth paradigm under the spirit of economic development has always been working in favour of the World Bank like IFIs to hold significant position in the IHG mechanism. For example in LMICs and MICs, the IFIs at one hand are responsible to set the macroeconomic policies and streamline the trade rules, and on the other hand provide aid for the improvement in the specific sector, such as health, agriculture, education, rural development and etcetera (Birn, Pillay and Holtz, 2009). This sector-specific aid is the ground of cohabitation for World Bank as IFI with IHG. Because Bank theorises health as "*direct source of human welfare and also an instrument for raising income levels*" (Bloom & Canning, 2014, p. iv). It is important to note that this theorisation does not talk about disease-specific intervention, rather sector-specific involvement. Thus this interrelationship between heath and economic development is the justification for Bank to invest in health system. At the same point of time, this interrelationship is the priority agenda for IHG too since it

addresses the development concerns. The following section evinces that how much the Bank is associated with health system discourse.

1.6 How much does health system hold importance in the Bank's aid investment?

World Bank, popularly known as 'ideas with teeth', has a decisive role in the international health agenda and strategic implementation of policies at national scenario. The importance of the Bank because of its fund pulling capacity and its subsequent interest to invest in health system (highest share among the UN members, and overall second largest donor) gradually lift the Bank as a permanent member of IHG and most crucial actor in shaping the current form of governance (Sridhar, Winters & Strong, 2017). The supply of fund and influence over governance through health policy (or specifically health system policy) collectively place the Bank to have a long standing presence in most of the LMICs and MICs. Though Bank is primarily a financing institute, investment on health system is seen from the point of financing development which is the foundational role of the Bank.

The journey of the World Bank started in June 1944 at the United Nations Monetary and Financial Conference (or popularly known as Bretton Woods conference held in the New Hampshire village of Bretton Woods) where seventeen countries assembled to draft the agenda. The final agreement was signed by forty four countries to ratify the motion to establish World Bank in July 1944. India was part of the league both in agenda preparation and signing the activity charter. India has its association with the Bank since its formation, and in fact the name of International Bank for Reconstruction and Development (IBRD), a financing arm of the Bank, was first suggested by India (WB, 1993).

The Bank being a multilateral aid agency has IBRD and International Development Association (IDA) as lending institutions, together they constitute the World Bank. Apart from these two, its three other affiliates are International Finance Cooperation (IFC), Multilateral Investment Guarantee Agency (MIGA), and International Centre for Settlement of Investment Disputes (ICSID). All these five institutions are collectively referred as World Bank Group.[4] Out of these five institutions, IDA and IBRD offer aid

[4] The information is obtained from the World Bank Group website. (https://www.worldbank.org/en/about. Accessed on 15 June 2015)

in the form of loan to the government of respective member countries for health specific investment including health system intervention. However, IFC's fund allocation in health is only available for private sector development. For the Bank's member countries, the loan to government for any sectoral aid (*per se* health) is based on three lending categories. The IDA members have comparatively lower interest rate than IBRD since they are from low per capita income group. The third category is Blend where the member countries are eligible to seek loan from both IDA and IBRD due to their financial creditworthiness.[5] For example, India was a Blend country until 2018, and now is only eligible for IBRD loan.

The Bank usually through IDA offers loan for health system intervention in LMICs. The funding history apprises that first health-related loan disbursement by the Bank for population control came by in 1970, and thereafter by mid of 1970s the health policy was finally adopted (Koivusalo and Ollila, 1997). Subsequently the first ever health system related project investment was offered to Tunisia in 1981 to improve the basic health care services. From 1990 onwards, the Bank has moved up to gain position of being the largest fund provider in health and started publishing many important policy documents (Ruger, 2005).

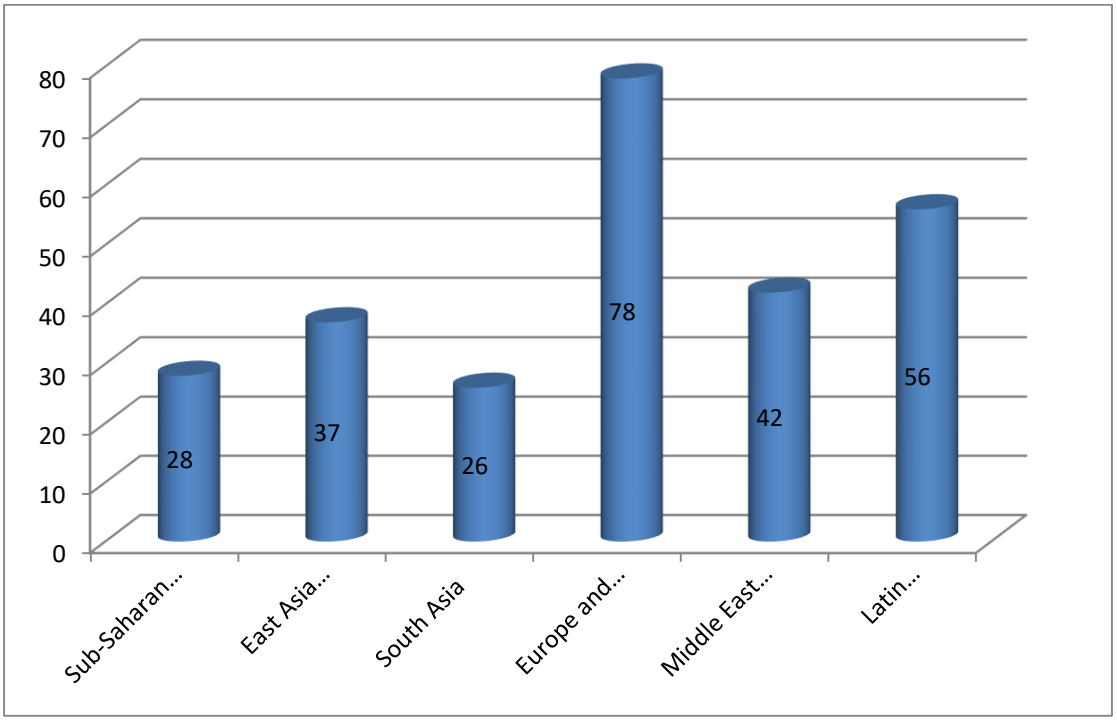
The Bank's steady growth in the international health funding is linked to its increasing interest in health system intervention because of its hypothesised association with economic development as mentioned in the last section. The health system aid is channelised through the sector called Health, Nutrition and Population (HNP). This research had consulted HNP financing portfolio from 1990 to 2014 as per the information available on the Word Bank online database (as of 26 August 2014) for lending).[6] The lending profile informs that Bank always gives priority to health system

[5] More information regarding the Bank's lending categories and criteria can be found on this link. (https://datahelpdesk.worldbank.org/knowledgebase/articles/378834-how-does-the-world-bank-classify-countries. Accessed on 15 May 2019)

[6] The researcher accessed the lending portfolio database in the month of June 2015 from the web address: http://datatopics.worldbank.org/health/lending. The name of the particular file (in excel format) consulted was 'New IBRD/IDA HNP Thematic Commitments by Fiscal Year, Theme and Region (in current US$ million)'. However, it is to be noted that the same file does not exist anymore on the mentioned web address of the World Bank. The existing files carry information about the number of commitment by themes, regions, and fiscal years, but not on the amount of commitment by themes, regions, and fiscal years. The file accessed earlier through Bank database is in the possession of the researcher.

intervention within the HNP. The graph below exhibits the HSP disbursement percentage across the geographical regions for fiscal years 1990 – 2014.

Graph no 1.1: % of Disbursement on HSP under HNP (1990 - 2014)



HSP- Health System Performance; Calculated from the HNP lending information sheet Source: New IBRD/IDA HNP Thematic Commitments by Fiscal Year, Theme and Region (in current US$ million). (http://datatopics.worldbank.org/hnp/ worldbanklending. Accessed on June 2, 2015)

The above graph depicts that Europe (mostly Eastern Europe) and Central Asian countries (78 per cent) were the largest recipients of the HSP loan followed by Latin America and Caribbean (56 per cent) in the span of twenty five years (1990 – 2014). Except South Asia (26 per cent, the lowest) and Sub-Saharan Africa (28 per cent), all other regions had consumed more than 35 per cent of total HNP allocation for HSP. The analysis of HNP lending portfolio from 1990 to 2014 definitely gives the factual support that the commitment of the Bank for aid investment in health system is enormously high.

Interestingly, post 1990s the Bank's involvement in health is marked with the reform of the health sector. Since then Bank has produced three important heath system policy documents to direct investment and shape health system approaches. The 1993 World Development Report, and two sector strategies of HNP in 1997and 2007 are important references in this regard. The development of these health system policies are preceded

by the decades of 1970s and 1980s international political economy crisis wherein the Bank incrementally advanced its engagement with health system intervention by offering loan to poor countries. This entire discourse of the Bank's health system policy evolution is analysed in chapter three in order to understand the present day HSS approach. The HSS approach as Bank's health system policy is embodied as the present form of that discourse, which officially launched in 2007 after the HNP unit came out with second sector strategy, *Healthy Development* (WB HNP, 2007).

It is important to note that among the IHG actors except the WHO, the Bank is the only other actor which has been consistently investing, even before HSS, in intellectual and physical resources on health system. This opportunity gives the Bank to develop its own 'idea of health system' within the larger consensus of IHG in order to change the functional aspect of country's health system. This idea of health system in the decade of 1990 was involved in the reform of health sector. Mackintosh and Koivusalo lament that this reform unfortunately degenerated into rampant commercialisation of health service not only in India but also in other parts of Asia, Africa, USA and Europe (Mackintosh and Koivusalo, 2007). Banerji too dissents with that idea by posing a question that "s*hould the World Bank's interest in strengthening the leverage capacity of the centre receive precedence over the dictates of the national parliament and of the Constitution*" (Banerji, 1990, p. 1209). In another occasion, Buse (1999) also denotes the similar practice by the Bank while working upon his PhD thesis in Bangladesh on aid coordination.

Despite the criticism of Bank's role in the health sector reform across the world, it further gets involved with the HSS approach. Thus this is the case of further investigation that what HSS is all about in practice at the country level. To understand the health system intervention experience at the country level, it is necessary to know the context as well as the nature of the health system the country poses. The next two sections are on India to discuss where Bank financed health system intervention has been occurring, and also to examine whether India needs external assistance for the strengthening of health system.

1.7 What is the context for health system intervention in India?

The development of health system (or introduction of new health system approach like HSS) cannot happened in isolation, it is a part of overall ecosystem. Hence, the context where the health system intervention is taking place is necessary to understand. The Indian context is similar to any other LMIC at broader spectrum where the political and economic forces have failed to be manifested into social development. India is densely populated with diverse cultural milieu. It is also perceived as one of the emerging economies in the world because of its large pool of labour skilled, semiskilled and unskilled. It is a country with striking disparity where urban glitz and show stands in stark contrast amidst a sea of rural backwardness. As a natural consequence, persisting inequality among the social class/caste/religion/gender often suppresses fundamental rights.

The Indian political system is pluralistic in nature and in a democratic set up since Independence, it further veered towards a socialist and secular position, by enacting the constitutional amendment in 1965. The inclination towards socialist economy of 1950-60s had got punctured due to the political turmoil during 1970s over the imposition of emergency. Thereafter the multi-party political system with truncated socialist stance remains more or less the same until 2014 from when the Hindu nationalist party-led National Democratic Alliance is in the power of central government (second time in the history after the term of 1999 – 2004) with ever escalating plight of populist characters. In terms of economic outlook, India turned towards mixed economy after the international deliberation for neoliberal economic policy had reached in 1991, and succeeded in bringing subsequent changes to liberalise, privatise and globalise the country's economy in many fronts. In this macroeconomic transformation, the Bank was one of the chief architects in changing the vision of Indian economic policy (Mukherji, 2007).[7] The changes of 1991 had made some fundamental rearrangement in governance mechanisms. The idea behind those persuasions and negotiations (driven by neoliberal agenda) is to make way for globalisation which prods and pushes the nation states to open up their respective goods and capital markets with an intention to be included in the vast fabric of international economy (Bhaduri and Nayar, 1996). For

[7] Another small scale liberalisation of the Indian economy occurred in 1966 due to balance of payment crisis (Mukherji, 2007).

Indian economy that was definitely an opportune moment to become closer to the international economic order, which is till date a reality. Though with respect to the public policy in health, in a quite opposite turn Qadeer (1999) argues that the policy orientation in the macro-level of economy has transformed the erstwhile outlook in India which once valued health as an outcome of social justice and development and now as a cost recovery system functionally sustained by targeted medical intervention.

In brief, India in post neo-liberal era has witnessed reforms in various sectors (economy, health, agriculture and others), noticeable metamorphism in the constitution of parliamentary politics (most vivid example is proliferation of regional parties), dismal performance of the coalition government at the centre, drive for health sector reform across the country, and a hitherto unseen aspiration to fully realise the phenomenon of economic growth. At the state-level, all these contextual factors further get impacted with the respective Indian state's own development history. The state-level contextual diversity is more important since state is the site for health system intervention. The chapter five of this thesis traces the contextual background of the Bank's health system intervention in Karnataka. This is the evolving context wherein the current form of health system in in operation. Therefore it is required to be understood that health system intervention taken place at the behest of the Bank is ultimately the reflection of the changes going on at the background of macro-economy and state polity of India which are factored in by the development pathway of local/regional history and determined by the events of international political economy. The next section discusses the historical development of India's health policy and planning to understand how India is depending on the international actor with regards to strengthening the health system.

1.8 Why does India need external assistances for strengthening its health system?

The debate on health system is not new in LMICs and MICs. The international health community has been always party to this debate since they have been assisting for long in the development of health care and health service in LMICs including India. On many occasions, these developments have been recommended in line with the suggestion of international aid agencies. Examples are a plenty, starting from WHO's over dependency on DDT for malaria elimination in 1950s to Bank's over emphasis on economic choices in health planning in the report of 'India Health sector Financing' in

the decade of nineties (Banerji, 1990). Thus it is well understood that health service development in LMICs has been influenced by the expansion and expert handling of the IHG since the end of colonial regime (1940s -1950s). To know the status of India's dependency on external resources (both intellectual and physical) for strengthening health system, the relationship between IHG and health service development form historical perspective has to be understood at first.

In India, the historical development of health services was based on the attempts at modernisation, and started at the time of its Independence in 1947. During the colonial regime, the people of India had rarely experienced any efficient health care. Qadeer (1985) notes that before independence the ambit of health care service was restricted only to the maternal and child health care and that too for the upper class or the urban elites. Though the *British Raj* had set up a few hospitals but to protect the soldiers' health in cantonment area by offering services related to venereal diseases for both the soldiers and the native Indian women alike. India finally witnessed the commencement of its first ever health planning exercise right before the immediate years of independence after the appointment of the Bhore Committee in October 1943 for conducting a survey to understand the situation of health and health related organisations in India, and for recommendations for further improvement (GOI, 1946). The recommendations (both short term and long term) of the committee are consulted till date in health system policy and planning exercises.

The spirit of Bhore Committee is debated after the Independence as scholars did have questions on the issues of planning and policy processes related to health. During the time of independence, India was having a dichotomy between the ideology of Gandhian perspective of *swaraj* (self-rule) and Nehruvian emancipation of modern socialistic planning economy. Nehru's interpretation of modernisation vehemently propelled towards international orientation that always ascribed a lot of importance to 'technological fetishism' for mending the quality and standard. Conversely, the Sokhey Committee in 1948 batted for bottom-up planning and opted for people centered pluralistic model, which was more close to the Gandhian idea of self-rule (NPC, 1948). In this debate, Ritupriya (2005) opines that Bhore committee report was rooted in the ideology of Nehru's international orientation whereas the Sokhey committee adopted the Gandhian view. She furthers that the subjugation of Gandhi's ideal to the Nehurivan dream set the policy goals to become imminently by international happenings since the

dawn of independence. Thus according to this perspective health planning and policy formation in India had from the beginning imbibed the idea of the West at the cost of ignoring indigenous planning which would have been more potent.

Apart from the five-year plan documents or committee reports compilation, there has been inconspicuous emphasis on large scale health system improvement programme or project in India. Moreover the progress of health system was further curtailed because the development of general health service had been ignored decades after decades to prioritise the donor driven (international) vertical programmes like family planning, malaria, TB and AIDS. For instance, Rao (1994) analyses that family planning activity under the agenda of population control had been pivotal in Indian health policy and planning and used to call for lion's share of the fund from overall health budget. Noticeably, the bank has much to take credit in this. The Bank financed Family Welfare programme (1992, 1997, and 2004), National Aids Control Programme (1993, 1998, and 2008), Revised National Tuberculosis Programme (1997, 2004, 2009 and 2014), National Vector Borne Disease Control Programme, Leprosy programme, National Blindness Control Programme and the like are the typical vertical funding examples in India.

In opposition to the vertical line of programme management, India does not have as such any concentrated programme to enhance the overall health system operation, and that is the room of opportunity for both the IHG as well as GOI to utilise international experience in health system intervention. In this regards, the Bank's health system intervention at the state-level is so far the only available reference to know how the health system is getting benefitted by the aid investment of an international actor. This investment activity of the Bank across the Indian states is precisely the bone of contention for last three decades. The health system intervention under the aegis of the Bank commenced after the country adhered to the conditions of Structural Adjustment Programme (SAP) as per the changed macroeconomic policy in 1991. Therefore it is to be noted that the Bank started focussing on the issues of health system only after the official endorsement of SAP by the GOI. Subsequently academia and civil society tried to understand that "*how do the rubric of macro-economic changes under the structural adjustment programme impinge on the determinants of population [health]"* (Rao, 1999. p 80).

Baru (2009) finds that these Bank financed interventions are committed to neo-liberal ideological guidelines that pushed for reform. The entire decade of nineties was an experiment of Health Sector Reform on behalf of the Bank by introducing policy-level changes, such as introduction of user fees, reallocation of budget within the health and others. These policy level changes had been accused of promoting private sector in health care service delivery and eventually espousing commercialisation of services. Sections of the academia, political parties, forum for Non-Governmental Organisations came together to vehemently oppose that policy of reform (Kapilashrami and Baru, 2018, p 5.). In a nutshell, the Bank's health system intervention in India has always been under watch for its own brand of health system approach. However, despite all the criticisms the Bank is the only IHG representative providing aid assistance for decades on health system intervention.

The above analysis endorses that Indian health policy and planning have always been designed and implemented mainly by using the expertise of the international resource pool or setting the guidelines based on the international standards. According to this notion the models of health system development in India is thus inevitably guided by internationally agreed upon health system policy currents. One example can be the NITI (National Institution for Transforming India) *Aayog's* (of Health Division) first ever working paper on health published in 2015, which was incidentally on health system. The paper 'believes' that in order to improve the health system of the country "*Health System Strengthening approach is the solution to bridging the gap between our [India's] current performance and potential*" (NITI Aayog 2015, p 4).

Going by the above example, it invokes further interest to know the status of aid dependency of India on health. It is on record that the contribution of Official Development Assistance (ODA) as external aid of the total health expenditure from revenue sources for India was three per cent during 2000 – 2004, thereafter it dropped to two per cent during 2005 – 2008, and finally from 2009 onwards (till 2015) the ODA contribution is constant at only one per cent.[8] With this mere funding, it is inappropriate to give a blanket opinion that international actors influence Indian health system policy and practice. The international approach towards health system does have a bearing at

[8] Calculated from the WHO Global Health Expenditure database for Health Expenditure profile in India. (http://apps.who.int/nha/database/country_profile/Index/en. Accessed on 14 July 20119)

the national level policy perspective, but not through financing, rather by technical assistance. This particular case is analysed in detail in chapter four to understand how the Bank is interacting with the GOI's health system policy. This interaction makes the scope for the Bank to execute health system intervention in the state-level. The next section entails the available experience of Bank financed health system intervention in India.

1.9 What is the experience of the Bank financed health system intervention?

International funding or development assistance has been instrumental in sustaining the health service development in India since the Independence as discussed earlier. So many participating organisations are involved that it is difficult to identify which one of them has been responsible for what kind of transition. INGOs, FBOs are generally charitable organisation and mainly work in association with bilateral or multilateral donors but because of the low volume of aid disbursement from them in the country they can not hold the key position in influencing the health scenario of the country. Most of them are involved in community based projects. Bilateral agencies are quite influential in the country's health planning process but they generally go for phase funding, like for a duration of five years or ten years (for example, GTZ-HSS, the German bilateral agency, had provided India with fund for health sector support for 10 years, from 2001 to 2010). In comparison, the multilateral agencies have more conspicuous presence in LMICs. Especially, the UN agencies including the World Bank have been continuously working in India, transforming or bringing change to the country's health policy. Such institutions are relentlessly endowing the planning activity by giving input on policy decision, programme strategy and even programme evaluation.

The bilateral or multilateral agencies have been funding vertical programmes meant for disease eradication for long. But the actual improvement in health system by such initiatives in India has never been observed to be remarkable going by the standard yardstick of national and international operational approaches. In spite of that, World Bank has started funding health system intervention in the project mode across the country since 1993. States are the direct recipient of the aid for these interventions since health is a state subject in India. Baru (2009) notes that with regards to the Bank's health system projects Indian states can be classified into two categories. States like West

Bengal, Uttar Pradesh, Andhra Pradesh, Odisha and Karnataka that went for the reform proposal with support from the Bank whereas Tamil Nadu and Madhya Pradesh initiated the reforms on their own, and later on the Bank joined as a supporter of the state governments' initiatives.

This research at the beginning did a pilot to understand the experience of project execution at the field. The Bank financed 1996 Health System Development Project (HSDP) - II was taken for secondary review to study all three project states (Punjab, Karnataka, and West Bengal), and in particular West Bengal was covered for primary field visit. It was found that achievements of various projects' states reported in HSDP - II were not exactly exemplary replicable reference but definitely remarkable in restructuring the public system for health system operation. In general, the most important characteristic value that health system projects had brought about in the decades of 1990s and 2000s is the reform efforts for remodelling both the policy and practices (i.e. service delivery). Examples abound, like decentralisation of health administration, privatisation of non-clinical services in hospitals, introducing insurance as financing option, private sector engagement in health care service delivery, engaging human resource contractual basis etcetera (Baru, 2009; Kumar, 2009).

It is well understood that reform measures brought in by the health system intervention have been destined to change the organisational structure of health service at the state-level, but seldom apart there is strong objection also about the undesirable fallout of this reform. Roy (2007) in her PhD research strongly criticised HSDP-II initiatives in West Bengal. She affirmed that such move had led to privatisation of care-giving services (like, laundry, scavenge, diet and others), and it had robbed the public facilities (secondary and tertiary set-up) of it goodwill. Investment in tertiary sector (which made the scope for the corporate hospital to come) gradually dried up because of the policy advice of the HSDP-II. She lamented that the neoliberal adjustment (through HSDP - II) has paved of as a benefit for big businessman and small entrepreneurs to get access to public resources and make profit out of that (Roy, 2007, p. 315). However, it should be admitted that the information documented in the available project reports and research findings are not sufficient to arrive at a constructive criticism on the performance of reform execution process and thereby the analysis of Bank's health system policy efficacy.

The availability of literature on the Bank's health system projects' execution is the biggest hurdle in any analytical exercise. There is almost zero academic treatment on the real-time project experience of the Bank's health system intervention. It is because the project implementation and operation documents (internal memo, meeting minutes, aide-memoires, internal evaluation report etcetera) are not available for external enquiry. The projects are externally financed, and thus always have the caveat of being treated as 'classified category'. The only available source for studying on the project execution is the Bank's website. The project-specific website information offers access to the project documents like project proposal and project evaluation report. The policy as well as academic critique of the Bank's idea of health system has been happening based on the broader policy directions (like, insurance, casualisation of labour, purchasing service from outside the pubic system and so on) the health system project has so far brought in. The unavailability of critical review of project execution is a persistent gap in the Bank's health system policy analysis. Baru (2009, p. 256) has cautioned long back that "*the evidence [of health system projects] is either scanty or lacking as a result of which there are only a few descriptions of these projects that do not lend themselves to detailed analysis*". This is not only the case for India alone, applicable for the rest of the world.

This research has got the opportunity to study the Bank financed health system projects' execution experience in Karnataka from 1996 to 2017. This is the first ever, at least known to this researcher, analysis of Bank's health system project documents in order to understand the policy implementation and operation processes. The experience of aid investment in health system intervention is investigated with analytical description in chapter six, seven, and eight.

1.10 Debating the debate

The discussion on the above questions gives a background of the pertinent issues that have been revolving in and around the centrality of the HFA debate. In this section, the attempt is first to understand what is the present status of the debate, and then reframe the debate if need be. The present approach of health system, i.e. HSS, has come into effect from the second half of 2000 over the non-satisfactory performance of health MDGs. In response to that challenge, the effective health system is considered as mandatory to both control the disease burden and achieve the health MDGs, since the

condition of the health system is too fragile and fragmented to deliver the required quality services (Biesma, Brugha, Harmer, Walsh, Spincer et al. 2009; Ooms, Van Damme, & Temmerman, 2007; Richard, Hercot, Ouédraogo, Delvaux, & Samaké, 2011). Though there is an opposing view citing the instances of high performance of those vertical interventions which bring millions of people close to the life-saving drugs/treatment within a short period (Cohen, Li & Giese, 2013).

In between the above two contesting programme logics, considerably a moderate view has got developed within the IHG that identifies both the vertical and system-wide horizontal programmes are required to be in harmony to organise the health service in an effective, equitable and affordable conditions (Kutzin & Sparkes, 2016). Indeed the spirit of HFA is embedded in the aspiration for effective, equitable and affordable health care services, but the hypothesis suggested behind these aspirations is the programmatic coordination between vertical and integrated approaches. This hypothesis makes the debate at present to hold an opinion that stronger health system along with effective implementation of disease-based intervention can address the concern of HFA. Thus this is the teleology behind the justification that why the typical vertical programmes need support from a strengthened health system, and simultaneously the strengthened health system is in need of assistance from both the government and international actor (Mutale, 2014).

As a dissenting voice, this research wants to interject at this point to question where the HFA is visualised in this teleology; it is in fact acting as reasoning for both the health system and the disease-based funding to go hand-in-hand. Thus this research opines that the present version of the debate (stronger health system for effective disease-based intervention) is getting defocussed from its original goal (HFA), and instead getting incrementally engaged with the 'cohabitation model' to either critique GHPs or advocate for stronger health system, which inevitably means advocates for HSS. But the central point in the HFA debate is which approach of health system should be more effective. Are we debating on that? This is the reason that financing or specifically 'global health financing' is the topic of discussion (McCoy, Chand & Sridhar, 2009; Chang et al, 2019; Ooms & Hammonds, 2014; Gomez-Gonzalez & Reyes, 2017 ; Sridhar, Winters & Strong, 2017), but not the technical efficacy of HSS as health system approach. It is not to say that GHP or the so called global health financing does not need any academic attention, but to show that how the IHG's cohabitation model

dissuades from the moot point of the debate. This derailing of the debate is the inspiration for this research to critique on the approaches of health system for achieving HFA.

1.11 Reframing the debate

The HFA debate started in 1978 after the Alma-Ata Declaration came out. The Declaration proposed Comprehensive Primary Health Care (CPHC) approach to build the health system in LMICs and MICs in order to achieve HFA by 2000 (WHO – UNICEF, 6 – 12 September 1978). As opposed to that, Selective Primary Health Care (SPHC) approach was proposed as cost-effective method to address the underdeveloped health system (Walsh and Warren, 1979). The shift from CPHC to SPHC had been effectuated because of the intervention by the Bank (Banerji, 1984). That was the first disagreement between the health system approaches with regards to HFA, where the Bank was a direct party. The Bank thereafter changed its approach by ascribing to different methods of health system approaches (such as, health system reform or health system strengthening). However, the motto behind those changes is always to publicly articulate the commitment of HFA. This is one dimension of HFA debate where public health perspective is involved in. Today's HSS approach is also in requirement of the same perspective to be analysed from the points of programme and organisational management.

The other dimension to review the HFA debate is through the framework of political economy. The political economy perspective enquires the agenda behind the approaches, interest of the actors, and relationship between actors, interests, and agendas. Needless to say, in this regard the Bank's effort in health system has always been the subject of academic interest. Here, the contest is to argue whether the health system initiatives are policy control or policy coherence in the context of nation-state. However, the political economy lens of introspection on Bank's work is getting decreased especially after the year of 2000 (Moon & Ooms, 2017). Instead a new 'genre' of scholarship has arisen which is informative but lack rigour. In this new practice, the scholarship rely more on the Bank's "*official Web sites and published histories rather than internal memos, archives, and interviews*" to analyse political

economy of the Bank in health (Birn & Dmitrienko, 2005).[9] This research wonders if this is which prompts Moon and Ooms to point out the Sridhar and colleagues' 2017 five-article series on the World Bank "*persistently grapples with two key questions*"; how financial and intellectual power of the Bank be governed (first) in order to reconcile the Bank's market orientation with the public health goals (second) (Moon & Ooms, 2017, p. 1).

It is interesting to see that there is finally a new approach to health system claiming to overcome the hurdles of health system reform, then there is literally no academic treatment on the role of Bank in HSS. This research opines that lack of critical insights on the political economy of the Bank, especially on its role in health system, is because the present structure of IHG where GHP (due to command over financing, again!) is garnering all the attention from academia to policy circles. Hence, neither we are debating on the effectiveness of health system approaches from the perspective of public health nor we are getting closer in any way to understand from the political economy perspective what role Bank is playing at present with regards to HSS in LMICs and MICs. This particular case is explained further in the next paragraph to articulate the reframed debate.

For instance, in India the biggest challenge for existing health system is to accommodate the mixed model of public – private health care service delivery within the public system. This new style of system organisation and functioning need adequate as well as responsive regulation, financial system, payment system, human resource and information architecture (with enabling technology) to govern and manage the health system (Rao S, 2018, p. 32). In this case, the Bank's aid investment (in the form of both physical/cash flow and technical assistance) on HSS should be considered as much needed support for country like India (and elsewhere) to adopt and adapt to the desired skill for reorienting the health system. Then the question is where the debate is. Like in past, the Bank is still instrumental on the health system intervention to address the goal of HFA, but unlike in past it is no more a subject of enquiry, despite its mammoth share on the IHG's health system funding landscape as mentioned earlier

[9] The critique is a letter from Anne-Emanuelle Birn and Klaudia Dmitrienko in response to Jennifer Prah Ruger's 2005 article on 'The Changing Role of the World Bank in Global Health' published in the American Journal of Public Health in 'Public Health Then and Now' series.

also. As per the latest available data, the Bank financed 32 per cent of total IHG's health system support budget in 2010 (Sridhar & Tichenor, 2017).

One possible answer of the above riddle could be the arrival of UHC that suspends all other enquiries with regards to health system approach and its actors. The UHC has appeared on the map of IHG as a health system goal (WHO WHR, 2010), where health system elements (such as, governance, financing, service delivery, human resource etcetera) are theorised as key blocks/knobs/pillars. Similarly, HSS is formulated as a mechanism in UHC to operate the blocks/knobs/pillars. The problem is that the present scholarship on UHC is increasingly engaging with the blocks/knobs/pillars individually (*per se*, for addressing finance or governance or human resource and so on), but not with the mechanism (i.e. HSS) that holds all of them together. Therefore, it is argued that while the elements are necessary to compose a system, at the same time the mechanism behind the composition of the system itself is more important to understand how the system functions. How does the Bank driven HSS make the health system function in India? The debate is back – the reframed debate!

1.12 Scope of the study

The last section has reframed the debate. The thrust for UHC across the world gives a renewed scope to debate upon health system action. In this regard, IHG in consensus has theorised HSS approach as the horizontal design of programmatic 'action' for achieving UHC (Kutzin & Sparkes, 2016; IEG, 2007). The IHG consensus on UHC has happened to be possible only because of its appeal to represent HFA in current context (Zodpey & Farooqui, 2018; Pandey, 2018). This is the sole reason for HSS also to get maximum privilege, as hypothetically it has a potency to accelerate UHC and/or futuristically address HFA. It is because of this hypothesis that HSS is by now a new health system approach in the debate of HFA. Hence, in order to define the scope of the study this research had made an attempt to place the HSS within the debate of HFA.

The Bank being a party to this debate from its inception, has become a frontrunner in HSS in terms of formulating and implementing the very approach. In fact, it is one of the few international actors that has a considerable presence in IHG (for its funding command), among the elected governments/ministries in the nation-state (for its longstanding presence as a donor and relentless intellectual repository), and even at the

state-level where the actual health system intervention under the guidance of health system approach (for instance, HSS) takes place.

In the case of India, the Bank's long presence in the policy domain of India's health and development arenas had helped this research to trace the linkages between GOI's plan and policy orientations and the Bank's policy references with regards to HSS. Similarly at the state-level, several Indian states were/are in contract with the Bank to implement the Bank guided health system approaches since the first half of 1990s. Among them Karnataka is the only state not only in India but also in the world where the Bank implemented its health system approaches for twenty one years (1996 to 2017) continuously. This made the Karnataka state to be the obvious choice for this research to consider as the case for studying the Bank's health system intervention. The Karnataka Health System Development Project (KHSDP) and the Karnataka Health System Development and Reform Project (KHSDRP) were the two particular health system interventions in this regard that had the experience of carrying out the Bank's different health system approaches including the recent HSS. Moreover, during the progress of this research both the Government of Karnataka and the GOI have accepted UHC as their declared health system goal.

For studying HSS, it is acknowledged that HSS is the latest health system approach. However, in order to analyse the theoretical efficacy as well as operational effectiveness of the HSS; the foundational review of earlier approaches is also required. Hence, this research has got the chance to examine all the approaches of the health system since the beginning of the HFA debate. Furthermore, apart from KHSDRP (which was an HSS approach led intervention) the KHSDP intervention in Karnataka had given this research a good break to access the execution experience of the Bank's earlier health system approaches in retrospect that built the path for today's HSS. In a nutshell, this research considers that all these opportunities helped this research primarily to cover the HFA debate from both public health and political economy perspectives. The opportunity to covering the HFA debate became the scope of the study for this research to know the Bank's contribution in strengthening of the India's health system.

1.13 Objectives and research questions

The discussion on the questions, followed by the current status of the debate, and thereafter the reframed debate had made this research to embark upon a goal. The goal was to cover the HFA debate for analysing the role of the World Bank's aid in India's health system strengthening. To achieve the goal, this research had further problematised the Bank's role with regards to health system policy in India. The Bank gets involved with India's health system through health system approaches. The approaches are nothing but the policy guidance that gets theorised at the behest of the Bank in the macro system (international-level) of the policy. The theorised health system approach first comes in contact with the GOI in the meso system of the policy (national-level) in order to get engage with the country's health system policy. Finally, the health system approach goes to the micro system (state-level) of the policy to directly engage with the health system in action for execution purpose.

This research had to cover all these three levels of the policy to address the problem identified. The following objectives and research questions were framed at the beginning of this research to analyse each level of policy. The objectives and the research questions have had undergone moderate modification during the course of this research to cope with some additional challenges posed by the research findings. In this thesis, all the objectives and the subsequent research questions are further mentioned at the beginning of the respective chapter to elucidate the problem for each concerned level of policy.

Table 1.1: Table of objectives and research questions

Policy level	Objectives	Research questions
Macro level (chapter three)	To know the trajectory of the Bank's current day HSS policy that is evolved on the premise of International Health Governance (IHG)	How has the Bank's health system policy been evolving over the period?
		What is the Bank's conceptual, theoretical and operative understanding on health system?
	To analyse the interdependence between the International Economic	How is the IEG interacting with the IHG in the discourse of health system policy evolution?

Policy level	Objectives	Research questions
	Governance (IEG) and IHG focussing on the role of World Bank in designing and modifying the health system policy	What are the factors emerging from IEG – IHG interactions that determine health system policy discourse, and where does the World Bank stand in those interactions?
Meso level (chapter four)	To analyse the interaction between World Bank and GOI in the strengthening of India's health system	What are the tools and the instruments developed by the Bank to interact with health system policies at national level?
		Where are the Bank devised policy tool and instruments actively engaged, and how do they interact with health system policies and practices?
		What are the HSS related policy outcomes of these interactions?
Micro level (chapter five)	To analyse the contextual relationship between Karnataka and World Bank models of development on which the health system projects get implemented	How have the different models of development historically evolved in Karnataka?
		What is the World Bank's model of development?
		How do the contextual factors interplay with one another in order to interact with the World Bank's model of development?
Micro level (chapter six and seven)	To analyse the design and execution of World Bank financed health system projects in Karnataka	How are mechanisms and components of Bank financed projects (KHSDP and KHSDRP) being executed?
		How are the designs of the projects able to cope with the execution-level challenges faced by KHSDP and KHSDRP?
Micro level (chapter eight)	To understand the role of actors (World Bank and Government of Karnataka) in the execution of health system projects, and the projects' relationships with private sector and community.	How does the Government of Karnataka and the World Bank complement each other in the projects' execution?
		What were the relationships of the projects with private sector and community?

1.14 Limitation of this research

This research is an analysis of policy process where macro to meso to micro systems of the health system policy has been studied. During the journey of the research, many challenges (from conceptualisation of the research to operational activity at the field) were encountered which the researcher had tried to address for academic integrity and the rigour of research. Still it should be admitted that three broad but specific limitations have come up at the end of this thesis compilation that the researcher had also experienced during the progress of this research. They are listed below.

Macro level: The Bank is one of the key (or arguably the most important) actors to theorise the HSS approach. However, by nature HSS approach is a confluence of actors. It operates in partnership where various international health actors (both traditional partners and new 'global health' partners) function in agreement. This agreement is on the funding collaboration and the policy alliance. This research has covered the international health actors' congregation in terms of studying the Bank's HSS approach formation, but the coordinating network of actors for intra-governmental collaboration to develop and promote HSS as health system approach remains out of the scope for this research. It can be a further query in the debate of HFA that how both the fund as well as policy-based partnership is working together in the international-level for the advancement of HSS.

Meso level: This research had paid a detailed attention to study the Bank's policy pathway from international to national to state levels. In India, health is a state subject, however the union government also runs some centrally sponsored schemes. The GOI through central schemes time to time introduce programmes which carry trait of HSS (example, National Health Mission or *Ayushman Bharat* programme). While these schemes are being implemented in a co-financing model proportionately divided between the union and state governments, the implementation of the schemes depend only on the state government. This research could not reach out up to the extent from where the state-centre relationship in terms of technical collaboration between the governments for HSS would have been studied. The growing importance of centrally directive funds at one hand curtails the autonomy of the state to design its own programme, and on the other hand comes as an option to relief the state's budget organ.

This dichotomy and the prospect of HSS in centrally sponsored schemes demand further research from the understanding of state-centre relationship.

Micro level: The policy analysis conducted by this research has covered both the institutional and the community points of view. Still it should be admitted that the community perspective was taken to understand how the HSS is acting as a responsive health system in terms of conversing with the community. This research did not attempt to understand how the community wants its health system to be, and what HSS is doing (or whether capable of) to make the health system the way community wants it to be. For record, this research tried to organise a *gram sabha* (village-level public hearing) in the Amdiar village of Raichur district in North Karnataka during the field work to understand how the village community emancipates the health system embedded within the value of social institution. Unfortunately, it turned out to be a failed attempt since the researcher reached the venue late because of problem in the field coordination. After that failed attempt the researcher did not try for another *gram sabha* due to the preoccupancy with other field work activities, and also it was not directly linked to the any of the research objectives and questions. Nonetheless, health system from the views of the margins is the need of the hour to study.

This debate-chapter articulates a thought which was necessary to communicate and make familiar with the overall research and the thesis composition. Throughout the chapters in this thesis the thought reiterates that health system policy is best to be "*understood both as institutional expression of ethically framed policy commitments and as social institutions embedded in each society's structure and values*" (Mackintosh and Koivusalo, 2007, p. 3). This is the guiding principle for this research. From here the thesis moves on to the methodology chapter for discussing the structure of this research and the factors involved in shaping the structure.

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Chapter 2: Methodology, the anatomy of this PhD

Summary of the chapter: This chapter discusses the anatomy of this research. It is broadly coming under the Health Policy and System Research. The structure is divided in three sets of frameworks; conceptual, theoretical and analytical. The conceptual framework is based on system thinking where the policy system is explored. The theoretical framework ascribes World Bank's health system policy to the governmentality of international governmental organisation. This research follows the multiple case study design to separately study all the three levels of policy process from policy formation-formulation to adoption-modification to implementation-operation. The organisation of field work, as an essential part of this research, is discussed in detail to claim that policy work should not be restricted to only desk research. Altogether eight data collection tools (both qualitative and quantitative) were employed to aid the methods chosen for analytical framework. The methods (total five) range from discourse analysis to process evaluation, and are chosen as per the need to analyse each level of policy process. The chapter ends with detailed account of researcher's commitment to maintain ethics and confidentiality, engagement with validation process, and declaration on reflexivity and biases.

This chapter entails how this research is conducted and in that process what are the methods followed. This is a policy process analysis of different phases. The limitation of literature and lack of practical guideline on how to conduct a research on policy process has made this research to develop a new methodological structure. The structure is assembled of three frames; conceptual, theoretical and analytical. Each frame helps to form next frame in order to conduct the research. This is completely a new approach to policy analysis for conducting health system research.

This research is about the involvement of World Bank's aid in the strengthening of India's health system. To understand the very degree of involvement, the aim is to define the system at first. The broader conceptualisation of health system is already discussed in the introduction chapter and shown that specific health interventions are mainly working with health service system which looks after the service provisions. The current tendency is to address health system research from the perspective of health service system which is limited within the boundary of so called health systems' elements (governance, finance, service delivery, human resource etcetera). The argument is that these elements are determined by many factors (such as, political agendas, economic choices and social issues), which are collectively responsible for the

conduct of health system. If the focus is only on the dedicated system elements, then factors determining and controlling the elements are out of research enquiry. Thus, this research in its analysis has conceptualised 'health system' as process interaction of those determinants (mostly linked to political, social, economic and cultural factors) and their interrelationship with common health system elements. Further, it is necessary to make it explicit that in this research, health system research analyses the evolution process of health system strengthening from the perspective of health system (and not health service system that only concentrates on the elements to perform) as opined in the last argument.

The importance of health system research lies in strengthening the health system to improve the overall system performance for enhancing the utility of health care service delivery. The working definition of health system research denotes that "*health systems research addresses health system and policy questions that are not disease-specific but concern systems problems that have repercussions on the performance of the health system as a whole"* (Remme et al. 2010, p. 4 – 5). This 'systems problems' emphasises the requirement of interdisciplinary approach in health system research. This type of research is categorised as Health Policy and System Research (HPSR), as per the taxonomy of Alliance for HPSR (Remme et al. 2010, p.5). This research has taken HPSR as reference to develop the methodological structure.

According to the Gilson edited Methodology Reader for Health Policy and Systems Research, most current and referred definition of Health Policy and System Research is (2012, p. 21):

"[T]o understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. By nature, it is interdisciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape − and be shaped by − health systems and the broader determinants of health".

Health policies are constituted in consensus to bring 'deliberate and purposeful' change in health service system. HPSR analyses agendas, interests, concepts and formula of the policies, and to explain what factors influenced the policy outcomes. So, it helps in

understanding the policy content and continuous processes of policy change by defining the role of the 'health system actors, relationship of power and trust among them' to examine the influence on the health system performance (Gilson, 2012).

HPSR is relatively a recent practice in health system research and evolved from the guidelines of system analysis. This research has traced the journey of the Bank's health system policy from formation to operation, or specifically the entire policy process. At the beginning of this research, the findings from pilot study done in West Bengal state of India informed that methodological framework should interconnect the linkages between policy formation to policy operation processes in order to discuss the context, mechanism and outcome of the very policy. Considering all these, HPSR is chosen to be a suitable methodological framework to conduct the health policy analysis for this research and also capable to offer solution for better policies.

2.1 Health Policy Analysis

Policy is a value position to set the goal and outline the methods to achieve it. The structural formation of a policy has always an ideological origin. The ideological position followed by the agendas develops the policy which is then subjected to respective intervention. This intervention is determined by the policy measures which are finally implemented by the planning and application. The value position and the evidence constitute the policy which comprises the social norms, political processes and existing knowledge. Value position is the guiding principle for the decision making process which is instrumental for outlining policy proposals. This framework of proposal could be either explicit or implicit in nature. The value system is the foundation of any policy that decides whether the policy is to be pursued along the integrative mode of thinking (holistic approach) or it would take up analytical mode of thinking (reductionist approach). Similarly, the evidence reflects the understanding of the context in terms of the identified cause and effect relationship to assess and control the causal factors. Health policy is similar to other public policy in formulation and associated with various integral components (institutions, political instruments/parties, professionals and people) of implementation, i.e., from local to national to regional to international (Koivusalo & Ollila, 1997).

Public policy is usually made for public interest at the government level, though in recent decades private entities (both profit and non profit) and newly constructed civil societies are becoming an integral part of policy making bodies. Health policy is also not different in characteristics from any public or social policy. Barker (1996) noted that planning stems from policy. Policy acts as a guiding light to plan and design the framework that operationalises the activity to achieve the envisaged goal. Hence, policy analysis is to study the plan, the design and the operational path. It is a 'networks of interrelated decisions' to address the 'complex reality' (Barker, 1996).

History of policy analysis tells that it was awell established discipline in industrialised countries (developed countries). The developing countries had started using it post Structural Adjustment Policy (SAP) policy reform phase onwards while the World Bank came with 'Structural Adjustment with human face' (Walt & Gilson, 1994). The efficiency of policy analysis has been increasing over the period though it has still many limitations. Gilson and Raphaely (2008) did an extensive literature review of 164 articles on health policy analysis from 1994 to 2007 in Low and Middle Income Countries. Walt et al. (2008) noted the following limitations of health policy analysis from the findings of Gilson and Raphaely's 2008 paper:[10]

- No conceptual framework
- Inadequate discussion on research design and methodology
- Dependency over single case studies for doing research on particular issues
- Lack of focus on theoretical base to fortify analysis
- Dearth of endeavours to be more explicit, and explanatory in research analysis
- The popular question is "*what happened*", instead of "*what explains what happened*".
- Hardly any reflection on the individual position of researchers' influence on research interpretations and conclusions

The above limitations reiterate the need to consider the complex reality of policy making process that demands a thorough understanding of policy system. Does the health policy making process involve only with the health related events, or do other

[10]The researcher has drawn these pointers from Beryl Leach's unpublished dissertation work (Policy making, power and politics postponed: The Global Fund gender equality strategy for women and girls) for Master of International Public Health (MIPH) degree in July 2009 at the Liverpool School of Tropical Medicine. The draft dissertation copy has been gained over personal interaction; however, citation permission was not obtained.

issues existing in the eco-system are factored in the policy making process? Policy system involves macroeconomics planning, social milieu, political struggle and many other factors. To consider policy system, many policy analysts opine that political economy approach is analysis wise more close to policy analysis and thus the development theorists, economists and political scientists have important roles in health planning (Walt & Gilson 1994, Buse 1999). Health planning is a part of social/public policy planning where it interconnects with various disciplines. Walt *et al.* (2008) notes that health policy is useful in collecting both retrospective and prospective findings to learn success as well as failure, and plan for the future. In Low and Middle Income Country (LMIC) context, fragile health system makes social issues are always the subject of political apathy and mostly the planning exercise is dependent upon the role of external donors (Walt et al., 2008). All these characteristics of health policy analysis make it an appropriate approach to apply in Indian context.

Though, it has been pointed out that interdisciplinary outlook is one of the principles of health policy analysis in the last paragraph, it should also be acknowledged that influence of other disciplines might undermine the real concerns of public health. Barker (1996) carefully observes the tendency and attributed it to the health sector reform agenda which put management science as a central theme in health field at the ignorance of complex societal reality which public health encounters. The agenda of health sector reform and its impact on shaping the health policy analysis indeed create angst among the public health academia. Banerji (1990, p. 2823) accuses that health policy research is used as an exploitation tool in developing countries to *"promote economic and political dependency and creation of expansion of markets to meet the interests of private foundations and industries in affluent countries"*. Keeping these challenges in mind, this research has taken cautious approach during the analysis of health system policies. In this research, the interdisciplinary approach is used as a technique to explain specifically policy background (formation), changes in the policy approach, and context of policy implementation.

It is also a fact that the health policy analysis is at times swamped away or inadvertently getting influenced with some agenda driven policy, but at the same time it is also true that over the period health policy analysis has itself also evolved. In an interview, a practitioner of health policy research and action says that with regards to health policy analysis "*changes in last twenty-five years, for instance the issues of social justice and*

equity have come in much more strongly now than before at the global level" (Informant 04). She further refers to the international health governance's orientation to the broader determinants of health which came into effect after 2000. According to her, the "*Commission on Social Determinants of Health or the Rio Political Declaration on Social Determinants of Health of 2011"* represents the very changes, and in fact "*the name of the declaration itself is interesting*". Because she thinks, "*it shows an understanding of social justice, of the need to address social determinants or societal issues concerning health*" (Informant 04).

It is to be understood that the changes in the orientation of health policy after 2000, which is different from the policy orientation of the time of health sector agenda, has affected the way health policy analysis is done. This change in case of health policy analysis should be attributed to the emergence of HPSR. However, the question is what change actually HPSR brings in for health policy analysis. To answer this, the same respondent opines that earlier (Informant 04):

"*You were either a researcher or you are a practitioner. I think there has to be a commonality between the two, and I would say this is one of the changes that have happened over the past twenty – twenty five years, that from being a researcher I think the research gives me the understanding that engagement is extremely important*"

This research considers 'engagement' is the agenda of present-day health policy analysis. HPSR is the new orientation of health policy, where system research engages with both research and implementation of health policy.

2.2 Aim of the research

Under the methodological framework of HPSR, the aim of this research is to analyse the evolution of the Bank's current health system strengthening policy, and understand how that policy over the period is getting engaged with the Government of India, and finally being implemented at the state-level (Karnataka, in this case).

To know both the evolution of policy within the institution of the Bank, and the journey of policy from its formation to operation, the HPSR inspired methodological framework develops following frames to conceptualise, theorise and analyse this research.

2.3 Conceptual framework-

The methodological framework of HPSR expands the concept of thinking as well as choice of methods. The classical practice in health tends to go by the reductionist approach to deal with determinants of health and health system behavior (Adam & Savigny, 2012). The health related events are often located within an environment of complex, adaptive and dynamic system. The fast and continuous transformation of social, ecological, political, economic, cultural and technological issues stem from different kinds of fluid, complex, adaptive and dynamic environment (Adam & Savigny, 2012). So, it is difficult to follow and understand how a particular policy is influenced by the environment; unless the health system is considered as an open system that interlinks various components which are interacting within the context where the very health system is situated (Atun, 2012).

The limitation in dominant public health approach has called for a paradigm shift from reductionists to 'dynamic and holistic' perspective to understand the "multifaceted and interconnected relationship' of health system (Adam & Savigny, 2012). The paradigm shift is marked as an introduction of system thinking in public health policy and planning exercises. The practice of system thinking has been common in other disciplines and could be very useful in the domain of health system especially in LMICs (Adam & Savigny, 2012; Peters, 2014). It has been evolving as a field of inquiry and practice consisting of multidisciplinary approaches from social sciences to natural sciences (Peters, 2014). The epistemological source of system comes from the Greek word *"sunistanai"* which represents the idea "*to cause to stand together*" (Peters, 2014, p. 1). It illuminates the structure of a perfect relational arrangement where many elements/actors/agents work in coherence to support the system goal.

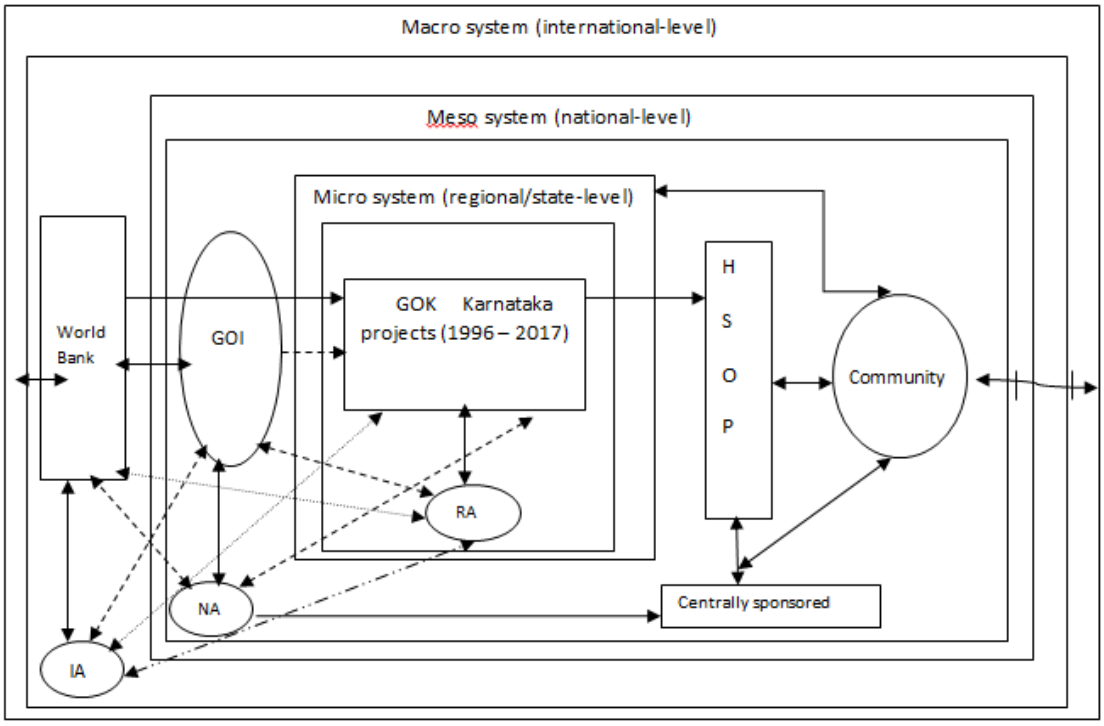
The complex health events are best to cerebrate as system thinking. System thinking is more similar to ecological models corroborating the ideas of human ecology, population health and social determinants of health. Though, it goes beyond these models as it traces the advances of historical proceedings to decode the dynamism and complexity involved into the system (Trochim, Cabrera, Milstein, Gallagher, & Leischow, 2006). Peters (2014) observes that system thinking is a further step of mental modeling that converts an implicit and abstract understanding of any event (like, epidemic or war) to an explicit data processing structure. This is the key utility and

importance of system thinking in health policy research to ameliorate a mental model for an operational model.

The growing importance of system thinking has been occasionally reflected in the scholarship of many contemporary writers. The third flagship report of Alliance led HPSR, edited by Adam and Savigny (2009), was on *System Thinking for Health System Strengthening*. The report gives emphatic recommendation to conceptualise health system as complex and dynamics, and contribute in developing LMIC specific system thinking approach. System-wide thinking is not new but not very old either in understanding complex public health issues. Mutale (2014) notes that system wide analysis is becoming a popular approach to do intervention design and evaluation since WHO has started recommending system thinking in its publications. However, it is also noted that application of system thinking using social, political, and economic factors of health to understand health system remains unavailable in literary source and absent in current practice.

This research has attempted to address this gap by developing a conceptual frame that addresses health system from the perspective of larger factors that determine the health system. In this conceptualisation, the policy process is intermingled with system thinking. Here, the health system is not conceptualised, rather the 'policy system' is conceptualised. This policy system is the system of health system policy. The concept is to trace the policy from its formation to operation by understanding how the systemic factors active at the various levels of policy system contribute into the Bank's health system policy. The levels of policy system are macro system (international-level), meso system (national-level), and micro system (regional/state-level). The following schematic diagram is a representation of the conceptual framework that this research envisages.

Figure no. 2.1: Conceptual framework of the research



HSO&P: Health System Organisation and Performance
IA: International Actors; NA: National Actors, RA: Regional Actors
Strongly interacted: ————, Moderately interacted: --------,
Poorly interacted: ……; Situation specific interaction: -.-.-.-.-.-

The policy system is an open system where community, regional/state-level governments (Government of Karnataka/GOK, in this case), Government of India (GOI) and the Bank are considered as main system since they are interacting throughout the policy process from the beginning to end. The sub-system exists in the various layers starting from macro system (international level) then meso system (national scenario) and finally the micro system (regional/state specific situation). These different layers comprise of various political, economic and health institutions (IA, NA and RA) that directly or indirectly associate with health. Both the main and sub-systems have been considered during analysis.

The outer line denotes the boundary of macro system (run by international political, economic and health institutions, referred as IA) which is interacting with the Bank. Similarly the inner boundary is the meso system (run by the national-level (in collaboration with international and regional) political, economic and health institutions, referred as NA). The Bank is considered as the torch bearer of health system policy in India as it is interacting with GOI by crossing the line of meso system

to bring the health system policy at the national level. The Bank further extends this line of interaction by contacting (for the advancing the health system policy further) with different state governments which are also influenced by the regional political-economic conditions (comprise of regional political, economic and health institutions, referred as RA). The international, national and regional actors play the role of sub actors who interact to the key actors (Bank, GOI and GOK) and also interact with each other by criss-crossing the boundary of macro/meso/micro systems. Sometime, the same sub actor (as an entity) may be relevant at parallel systems. For example, WHO can influence World Bank at macro and meso systems, and also GOI and the state governments respectively at meso and micro systems. These interactions (or linkages) indirectly take a decisive role in health system policy development/modification and so in health system strengthening effort.

In the figure, at the level of micro system the state governments are the end institutions which involve with the health system organisation and performance (HSOP). This micro system is the place where the actual health system is operative in order to restructure the health service system and health care service delivery. The mental modeling is that, the design of health service system (refer to as health system projects) is formed (agenda-wise) and formulated (policy-wise) as policy at macro system, and thereafter adopted as well as modified(in line with the national policy) at meso system; finally after passing through several boundaries, key actors (World Bank, GOI, GOK), sub actors (GA/NA/RA) and their linkages, the policy gets implemented and accordingly operated as health system project at micro system. From the perspective of system thinking, it is necessary to cover these boundaries, key institutions and their linkages to understand the health system policy of the Bank from formation to operation process. Finally, the critical assessment requires us to know that how this policy process driven operational health system model is interacting with the community. The expectation, behaviour and need of the community have also been changing because of the larger political and economic influences persisting in the society. The situation of the community under the changing perception vis-a-vis its interaction with the health system policy is an interesting area of enquiry for this research.

This conceptual framework is of help for the research design that aspires for a natural integration between conceptual, theoretical and analytical frameworks to unfold the policy process. It has also an advantage since system thinking stems from multidisciplinary views and that corroborates a lot of theory, methods and tool from different disciplines (Sterman, 2002; Adam & Savigny 2012; Peters 2014). This framework is developed with an expectation that the mental reference of this framework guides towards a holistic understanding of the policy system.

2.4 Theoretical framework -

The growing importance of HPSR makes new ways to introduce and integrate different theories, methods and tools to address complex health related events. The emergence of system research and its incorporation in health policy bring significant changes in health system research to accommodate and improvise new applications to address the multitudinous factors concerned to the system. Although system analysis is conceived as a comprehensive form of research, still it has limitation in explaining the rationality behind the decisions taken for policy inputs, and instead often interpreting findings in terms of supply – demand interaction of economic viability. This research attempts to address the question of rationality in order to interpret the findings by using the theory of governmentality into HPSR.

The application of governmentality is new in system research, hence an elaborative discussion with practical examples is needed to discuss and justify the theoretical framework for this research. The following segment deals with the conceptual definition of governmentality and how to study it. The section consists of two parts. First part is about a brief discussion on governmentality and the way to study it. The next part takes the reference of the Bank's health system policy considering it as a governance related problem in health intervention and defines it further to study under the theoretical framework of governmentality.

2.4.1 Governmentality: The Mentality of the Govern

Governmentality, the essay written by Foucault is an approach of understanding the nature, pattern and characteristics of government rationality. It is a theory of 'conduct of conduct', as coined by Foucault, where the government from a distance enacts its power to influence others' action (Foucault, 1991a). The power is subtly played out,

and it is administered through various techniques and tactics by aiming at health, wealth and wellbeing of population. According to Foucault, the modern 'mentality' of the 'governs' is a product of historical development in Western societies from society of sovereignty to disciplinary society and latest to the modern society of government. However, the present governmentality approach should not be seen as replacement or alteration of earlier forms of power existing in a society, such as sovereign power or disciplinary power. Moreover, the current forms of government are effective in constituting a governmental triad of sovereignty-discipline-government to objectify population as its target of intervention (Foucault, 1991a).

In the history of governmentality, the government concept emerged in the sixteenth century to oppose sovereign power. Finally the concept of government triumph over sovereign superiority in eighteenth century after political economy emerged as new knowledge to address problem related to population. Over the period, the 'art of government' has been evolved and subsequently co-opted the notion of *laissez-faire* mode of economic understanding in governance rationality to promote the practice of self-limiting of government and individual freedom with responsibility (Joseph, 2009; Lemke, 2001). In recent period, the meaning of government has been reduced to only political band unlike in past when it appeared in the texts of philosophy, theology, medical and pedagogy. Government is also meant to be active in the decision making processes of self-control, guidance for family including children, household management and many others. Foucault signifies governance as "*conduct of conduct*" because of this plurality involves in the processes of conduct that ranging from "*governing the self*" to "*governing others*" (Lemke, 2001, p. 191). Thus it is important to note that according to Foucault the historical development of governance is actually determined by the co-emergence of "*modern sovereign state*" and "*modern autonomous individual*" (Lemke 2001, p. 191).

Precisely, governmentality is about forms of practice. The study of governmentality is primarily a practice of thought to explore 'how' the power is utilised on population. Lemke (2001) points out that political rationality needs to be analysed to know the 'technologies of power' that government exercises. This exercise is performed by the government through specific forms of *representation* and *intervention*. These forms evolve as techniques and tactics to rationalise the execution of power. In Foucault's own interpretation, the political rationality is (Foucault 1991a, p. 102):

"*[E]nsemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security*".

It can be derived that political rationality seeks the forms of practice to understand the reason of power, the power which applies on population. In this process, political economy has a vital role in explaining the reasons of power applied as a form of governmentality. Overall, governmentality in the field of social science has immense role as a concept of observed phenomenon, an application of administrative function and as a method of analysis. Lemke (2001) argues that governmentality is not an absolute concept but does offer different explanation on different context. Foucault's historical account on the essay of governmentality mostly talks about the liberal frame of governmentality and its process development. But later on, Foucault gives further reflection of governmentality under neo-liberal frame in the lecture titled 'the birth of bio-politics' (Lemke, 2001). Hence, it is argued here that governmental rationality may not be always same and depends on context, time and its object (population). This gives impetus to know what actually 'governmental rationality' is. Colin Gordon (Gordon 1991, p. 2) embarks on this question and opines that Foucault analyses government in narrower as well as wider perspective. This openness in thinking formulates a hypothetical definition of the term 'government' as 'the conduct of conduct'. The simplification of government through 'conduct of conduct' symbolises the aim of shaping, guiding or affecting the conduct of someone or the population in general. Gordon (1991) further categorises conduct in terms of relation between self and self (i), private relation at interpersonal level dominated by control or guidance (ii), relations within social institutions and communities (iii), and at last relation in regards to function of dominion of state (iv). Therefore, it is to be understood that governmentality works and exists at every sphere of a system of governance consists of individual, community, institution and even the state.

2.4.2 Theorising the Problem

The above discussion on governmentality argues that the aim of various forms of governmentality is same, i.e., conduct the conduct of population. The discourse of development is theoretically interlinked with governmentality where the political

rationality (of governs) is in reciprocal relation with technology of power (for example, development processes/narratives). The exercise of technology of power in forms and processes of development is carried out by the international institutions on the nation states for ages. The Bank's role in providing aid assistance is also driven by the objective to improve the governmentality of the nation states. Hence, the aid assistance of supra-national organisation like the Bank is also the practice of 'mentality' of the 'govern'.

The Bank has been active all over the world to provide aid assistance for specific development oriented interventions. The assistance usually does not directly go to the population rather the states are the subject of recipient. Though, it is well understood that the assistance is offered with the assumed derivatives that the state-building to be the immediate motto to conduct the conduct of population. The aid assistance for health system projects by the World Bank, which has been in action for last forty years, could be a good opportunity to know how the governmentality is practiced by the Bank that interlinks to the population.

To further elaborate the problem, the Bank's health system policy through its health system projects has been getting implemented across developing and less developed countries. Through this policy, the Bank is involved to create favourable environment for strengthening health system of the nation states in order to deliver affordable, available and accessible health care service among the population. This is a perfect problem for governmentality that brings supra-national agency, nation states, provincial states and even population in one theoretical frame where a single policy has been contextualised in various levels of governing agencies with an aim to govern the population for its development. To theorise it as a problem of governmentality, the following framework is developed.

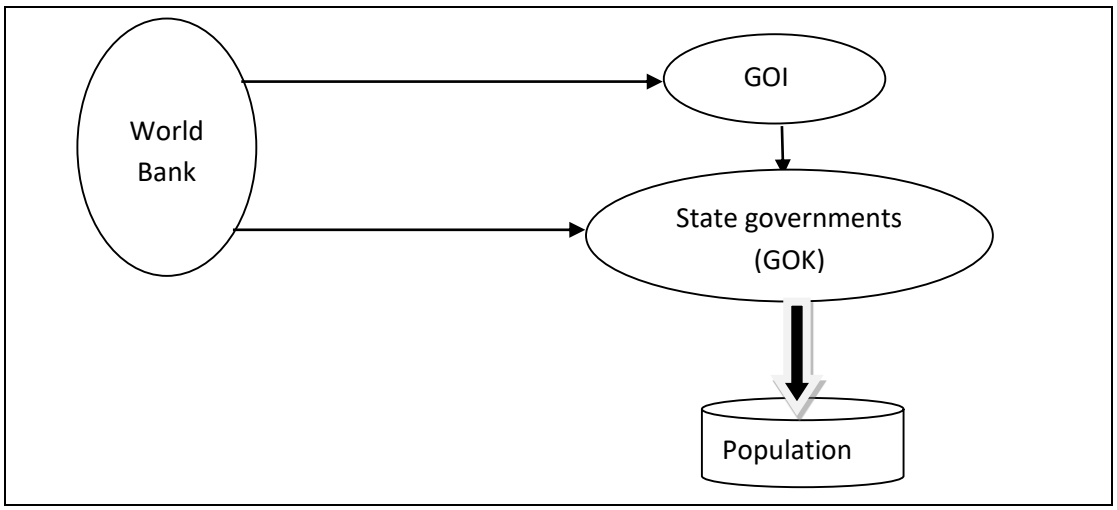
2.4.3 Governmentality as theoretical framework

HPSR primarily implies to both policy research and system analysis. In order to understand the system, a preliminary assessment is needed about how the system functions. Therefore, the "*application of theories of the policy process would enable an appreciation of the range of stakeholders and determinants of policy choice*" (de Leeuw, Clavier, Breton, 2014, p.3). Hence, theoretical framework is becoming the need of the hour in policy research (Rütten et al., 2003). To attempt the question of theoretical

underpinnings, Foucault's perspective on how to analyse governmentality can be of help. It is a *nonessentialist* outlook that do not attach any form of government action as capitalist process of development or based on class interest, rather viewing it as a composite action of changing (or evolving) practices and strategic interventions by the governs (Joseph, 2010, p. 32).

Governmentality, primarily explains the practices and the logic (strategies) behind those practices. The problem shows that three different types of institutes are involved in health system policy led projects; World Bank, GOI, and state governments. The objection from the point of governmentality understanding may be that how the Bank is addressing the population; the population in this case being the states who are its subject of intervention for political rationality. The same kind of challenge has been faced by Joseph while explaining the Bank's initiative on poverty reduction and its role in 'global governmentality'. Joseph suggests to not go by the stated aims of the Bank project, otherwise the analysis would only get involved into the failure of governmentality. The scrutiny should go beyond the operational understanding (like, who is directly dealing with the population) and try to understand the effect of governmentality. The effect of governmentality in population pervades through states, so population as a target of governmentality is just another strategy for international institutions like World Bank to control the behaviour (or conduct) of states (Joseph, 2009). This reference helps to draw an analogy that how governmentality involves in the Bank's health system policy. Below is the diagram to show how it is theorised in this research.

Figure 2.2: Governmentality of health system policy

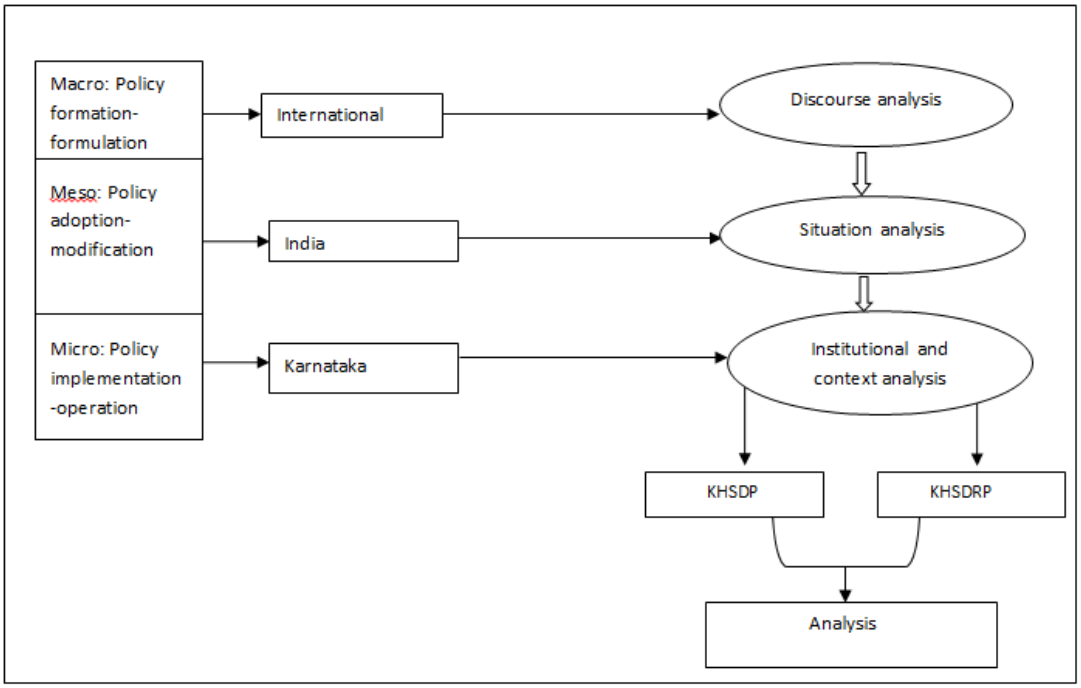


The theory is that the Bank as an advocate of its health system policy is active to 'conduct the conduct' of Indian state governments (in this research, Karnataka), so that the state governments can follow the footstep of the Bank in order to 'conduct the conduct' of its population. The Bank also has parallel interaction to conduct the conduct of GOI. In turn, this interaction makes GOI ensure to conduct the conduct of state governments and via them it conducts the conduct of population. The criticality involved in this theorisation actually helps this research to unfold different types of political rationalities chosen by different governance entity (Bank/GOI/GOK) at the different levels of system (macro/meso/micro). All the entities are directly or indirectly targeting the population but using different techniques and tactics from a distance. The health system policy is exercised as 'technology of power' in this theory that determines how the policy driven projects to be introduced and what role to be played by the government (both GOI and GOK). The theorisation makes it also possible to see how three different types of governmentalities (of World Bank, of GOI, and of GOK), as a process of continuum and not in separation, are applying as well as appropriating the same technology of power (*per se*, health system strengthening) by using similar/different techniques and tactics to govern the population.

2.5 Study design

The multiple case study design is taken for this policy research. Yin (2003) acknowledges the advantage of multiple case study over single case study as it can give an independent analytical inference of various cases. Context of various cases are different which might make varied information as well as an inclusive understanding.

Figure no. 2.3: Multiple case study design in policy process analysis



The above design depicts how the entire research has been conducted. It is a policy process analysis, where the policy has been followed in three different levels (macro-meso-micro). Each level has two policy stages, such as macro system has policy formation and policy formulation stages. Policy formation is the place where goal and agenda for policy get formed over the interaction between international economic and international health governances, in which the Bank always takes an important role. Policy formulation is about the detailed scheme of policy where policy theory, policy objectives and policy levers (the decisions conceived as intervention logic that claim to bring the change in the public system) are articulated by the Bank. Similarly at the level of meso system, the Bank interacts with GOI to get the policy adopted through the help of policy tool within GOI's policy and planning outlook. At the same level, policy modification also happens while the Bank interacts with GOI and state governments through policy instruments in order to prepare the base for next stage of policy (implementation). In the last level, micro system, the Bank in interaction with state government ensures the decision that the policy at first gets implemented as a project by the help of policy mechanism. Finally in the last stage, policy operation, the policy in the form of project gets operated through the policy components.

Three case studies have been drawn from each level of policy to conduct the research. The first case study (chapter three) is a discourse analysis of the Bank's health system policy evolution from 1969 to till date at the level of macro system (international). For meso system, India is chosen as a second case study (chapter four) in order to do a situation analysis of Bank-GOI interaction in the process of health system policy advancement from Washington to Delhi and from Delhi to respective Indian states. Finally, Karnataka as Indian-state is selected as third and last case study at the level of micro system. The Karnataka case study has total three chapters all together. At first, the institutional and context analysis (chapter five) of the state has been carried out to know the feasibility of Bank financed health system projects. Thereafter, process evaluation of two projects in Karnataka (Karnataka Health System Development Project/KHSDP in chapter six and Karnataka Health System Development and Reform Project/KHSDRP in chapter seven) has been done to document how the health system policy are being implemented and operated as health system project. At the end (chapter eight), the findings from implementation and operation of health system intervention in Karnataka have been carefully analysed to assess how the Bank driven policy as health system approach is reconfiguring the health system.

2.6 Analytical framework

Policy research requires extensive literature review to analyse the theoretical position behind specific policy and mapping of the processes for understanding the implementation of the same. The theoretical position of policies comprise of politics, power, knowledge and interests (Walt, 1994; Kingdon, 1995). On the other side, the mapping of processes needs identification and study of practices. The "*[p]olicies [are] influenced by global decisions and domestic actions*" (Walt et al., 2008, pp 309) – thus it needs selection of method/s that can bring both 'global decisions' (underpinned by theory) and 'domestic actions' (confluence of practices) together to analysis. The analytical framework acknowledges that the policy process is influenced by various conflicting ideas, complex institutional settings, competing interests, diverse practices. This is a political economy approach to conduct health policy analysis.

This research has consulted different methods criss-crossing disciplinary boundaries to address the complexity of the problem that is located within and across the systems in order to draw a synergy between conceptual, theoretical and analytical frameworks.

There are no hard and fast rules of selecting analytical frame in HPSR. This research has chosen methods selectively to match with each stage of policy in order to conduct the policy process analysis. Following are the methods used to analyse various stages of the policy.

2.1.1 Discourse analysis
2.1.2 Situation analysis
2.1.3 Institutional and context analysis
2.1.4 Process evaluation
2.1.5 Analysis of HSS frameworks

2.6.1 Discourse analysis:

Discourse analysis as a method is employed to analyse the policy formation-formulation level or the macro level of policy system in chapter three. According to Foucault, discourse is "*to introduce discontinuity and the constraints of system into the history of the mind*" (Foucault, 1991b, p. 53). The Bank's health system policy has been officially active for last forty years. Over the period, the policy got changed many a times to introduce new objective and new means. Despite those changes, the Bank's health system policy is synonymous to reform. It is acknowledged that the health system policy is instrumental to bring reform in the health care service delivery, still it should also be considered that the reform with each change made in the policy manifests different agendas, different practices and different means. Foucault analyses that these differences should be understood by knowing the 'criteria of formation', 'criteria of transformation', and 'criteria of correlation' of the discourses (Foucault, 1991b).

Using discourse analysis to understand health system policy is an attempt to apply discourse analysis in public policy research. Foucauldian discourse analysis and public policy can be complemented each other from the lenses of government, population, institutions, and policy as dynamic processes of many elements (Hewitt, 2009). Similarly, Gasper & Apthorpe (1996, p. 7 – 10) have also shown that discourse analysis can be used in analysing development policy by looking at the policy from the aspects of formation, concepts, devices, frames, and rules of validation. This research did not apply the discourse analysis by its conventional way of practice (by looking at words, styles, and argumentation). Instead it followed the "*roles, locations and social structuring of debate and intellectual exchange in policy-making*" (Gasper & Apthorpe,

1996, p. 3 – 4). Thus discourse analysis is used as a tactic (and not as a technique) to understand how the 'health system' got formed, changed, evolved, and introduced within the policy of discourse.

2.6.2 Situation analysis:

Situation analysis is a widely held method in health policy research to understand the present condition of any given context. It is usually employed in order to study or update a country's national health policy, plan and strategy. It provides a comprehensive and overarching view to present and immediate future of health issues and determinants.[11] This method is applied in chapter four where Bank-GOI interaction is explored. One can raise issue that how the Bank's role in India's health scenario can be a part of situation analysis. WHO lists that situation analysis as a useful method to analyse social determinants of health, health system performance, capacity assessment of health services, health system resources (human, physical, information), and stakeholders position in the national health scenario including external partners. The position of the Bank as an external partner has been assessed to study how this (Bank-GOI) interaction is taking place and what are the policy outcomes of this interaction. The use of this method as a technique is useful to understand both the stages of policy adoption and modification, and at the same time to know how these stages contribute to GOI's policy outlook.

2.6.3 Institutional and Context Analysis

Institutional and Context Analysis (ICA) is a method to study how development works in relation to political and institutional context. It is developed by the United Nations Development Programme (UNDP) to use it as a resource guide for assessing the enabling environment of context where it gives aid for development. According to UNDP, ICA means (UNDP, 2012, p.1):

"*[T]o analyses that focus on political and institutional factors, as well as processes concerning the use of national and external resources in a given setting and how*

[11] More on situation analysis is available on WHO website (https://www.who.int/nationalpolicies/processes/priorities/en/). Last accessed on 5May 2019). There, situation analysis is discussed under policy processes for analysing national health policies, strategies, and plans.

these have an impact on the implementation of UNDP programmes and policy advice".

The purpose of ICA, as detailed above, is to analyse the role of political and institutional factors involved in the context with regards to production, control and distribution of resources. Thus it can be of help for UNDP like multilateral institutes to understand the feasibility as well as likelihood of the aid driven projects/programmes' sustainability. Keeping these advantages in mind, this research has used ICA in chapter five in order to understand the context of Karnataka state where Bank financed health system projects were active from 1996 to 2017. The method is specifically employed for assessing the factors responsible in Karnataka that has been shaping the state's development path as well as characterising development models over time.

2.6.4 Process evaluation

Process evaluation is a method to study the intervention processes (such as, health project intervention) to know why the intervention is successful or not. It is largely known to be a qualitative investigation and its "*topical focus is descriptive*" (Bloor & Wood, 2006, p.136). Descriptiveness is the special characteristic of process evaluation since the method demands each and every detail of the intervention in order to assess, identify, understand and analyse problems related to implementation and operation of the intervention. This type of method is especially helpful to understand the quality of the intervention in terms of efficiency and effectiveness. This research has applied process evaluation to study the micro system, i.e. policy implementation and operation stages. Chapter six and seven are the process evaluation of Bank financed health system projects (KHSDP and KHSDRP). The rigour of process evaluation aided further in the analysis the Bank's health system policy approach at the micro level of policy in chapter eight.

In process evaluation, the data is usually collected before the outcome evaluation (Munro & Bloor, 2010). It is to be noted that for KHSDRP (explained in chapter seven) the data (specifically primary documents related to project) collection for this research was over before the outcome analysis done by the GOK and the Bank. In the case of KHSDP, the project got over in 2004. Hence, this researcher had to do the process evaluation (especially documents scanning and discussion with the staffer) in a retrospective manner.

2.6.5 Analysis of HSS frameworks

According to the concept of various health system frameworks (for example, Building Blocks of WHO or Control Knobs of World Bank and so on), the health system elements are considered as drivers of the system. Hence, both international actors and governments are active in focusing on these elements. The frameworks of HSS thus depend on the nature of health system elements. In order to know the function/action/performance of health system elements, the concentration should be at the level where health system elements act and interact with each other. Going by this analogy, as per the conceptual framework of this research the health system elements operate only at the micro level of policy system. This is the level where health care service delivery takes place (in this case, in Karnataka); thus this is the level (micro) of operative health system. In other words this entail that operative health system is required to be understood to know the performance of the elements active on the ground. In the absence of any definition of operative health system, this research had embarked upon following method to understand the operational form of health system where the various framework driven elements are active.[12]

For this purpose, health system framework analysis had been conducted. Here, the health is conceived of ten different system elements. It is adopted from the second edition of Institute of Tropical Medicine (ITM), Antwerp publication on the Studies in Health System Organisation and Policy for '*Analysing Health System Dynamics: A Framework*' (van Olmen et al., 2012). The ITM's ten system elements have the comparative advantage among the existing health system frameworks to cover both policy decisions, such as goal/values/principles (which are not covered in most of the frameworks), and operational practices at the level of micro system. The system elements are listed below.

1. Goals and outcomes
2. Values and principles
3. Service delivery
4. Population/ people
5. Context

[12] The distinction between operative health system and operational form of health system is discussed in chapter nine.

6. Leadership and governance
7. Financial resources
8. Human resources
9. Infrastructure and supplies
10. Knowledge and information

The above mentioned ten system elements' interaction collectively demonstrates a web of an operational form of health system. In chapter nine, these system elements are considered in detail to discuss the operative health system of Karnataka, and simultaneously analysed from the perspective of the Bank's HSS approach. After the field work done in Karnataka, these elements had been modified further and analytically categorised according to the leitmotifs of system dimension. The introduction of system dimension in health system analysis is the value addition of this research. It has been particularly carried out to explain and understand what an operational form of health system is.

2.7 Unit of Analysis

This research is a multiple case study of policy analysis, where the case is a World Bank's health system strengthening policy. In this policy process, the main and sub actors, as described in the conceptual framework, take part in the policy decisions. The embedded units are the various departments, offices, networks, and organisations of the actors.

2.7.1 Embedded unit of analysis —

Main unit-

- The World Bank (especially the HNP unit)
- The MOHFW of GOI
- GOK: MOHFW, KHSDRP unit, Department of Health and Family Welfare/DOHFW, National Health Mission, District Health Offices, Suvarna Arogya Suraksha Trust (SAST) office
- Community collectives (such as, patient group, identity-based Dalit women group, and rural labour union group)

Sub unit-

- International Health Governance forum: WHO, UNICEF, other bilateral actors active in health (DFID and GTZ-HSS), Global Health Institutions, Trans National Corporations
- International Economic Governance: United Nations Organisations, International Monetary Fund, International Labour Organisation, OECD countries
- Civil society organisations, policy institutes and political parties both at the national and state (only in Karnataka) levels

2.8 Field organisation

This research has conducted field work at two levels of policy system. According to the initial plan, in each level of system the field work was envisaged. For example, researcher was supposed to cover the Bank's Washington office to understand the policy formulation process within the Bank by participating in the Bank's biannual internship programme: Delhi for meso system, and Karnataka for micro system. However, this researcher failed to obtain the World Bank's internship opportunity for Washington assignment despite his two repeated attempts in the summers of 2016 and 2017.[13] The proposal for internship was based on the thesis's macro system (in particular, policy formulation stage) case study. Finally, fieldwork for the macro system could not be pursued because of researcher's inability to access financial support. In order to cover that gap, this research has built a network with the Bank's international health system experts (including retired ones) who have/had the exposure of working at Washington office. This researcher had talked to them many a times (through discussion/interview mode) over Skype and in-person meeting to understand the macro system of health system policy.

For meso system, Delhi was the field area where MOHFW, National Health Systems Resource Centre, National Institute of Heath & Family Welfare and other offices/institutes/departments of GOI were covered. Other than GOI, the offices of the WHO South East Regional Office (WHO SEARO), WHO India, the European Union,

[13]The call for World Bank's internship programme announces twice a year (summer and winter) for Washington and other country offices. (http://www.worldbank.org/en/about/careers/programs-and-internships/internship)

the World Bank had been also visited a number of times. The Delhi field work was carried out over different points of time during this entire PhD research period, since this researcher has been in Delhi because of his institutional affiliation to Jawaharlal Nehru University (JNU). The field work in Delhi was of help to gather information about the policy adoption and modification stages.

The field work for micro system was done in two states of India. West Bengal was visited in the month of February 2015 to conduct a pilot study for this research. That pilot involved visiting *Swasthya Bhawan* campus (health secretariat) in Calcutta to primarily enquire about Bank financed state-level Health System Development Project - 02 (1996 – 2004) and see the status of institutions it created within the health department (such as, Strategic Planning and Sector Reform Cell/SPSRC). During his stay in Calcutta, this researcher had also attended the 14th World Congress on Public Health (11 – 15 February 2015) to meet key stakeholders (from international civil servants to civil society leaders to 'global health' scholars) for the initial conceptualisation and theorisation of this research. The pilot study in West Bengal helped to develop the synopsis for this research.

The long field work for policy implementation-operation level (or the micro system of policy) had been done in Karnataka from November 2016 to May 2017. The field work was supported by the Institute of Social and Economic Research (ISEC), Karnataka. This researcher received the Sir Ratan Tata Trust Visiting Fellowship opportunity at the ISEC for studying the topic '*Two Decades of World Bank Aid in Karnataka: A Case Study of Health System Strengthening Policy Implementation*'.[14] This researcher conceptualised the study proposal (for visiting fellowship) based on his PhD research, and accordingly applied to the ISEC. Subsequently, the proposal got accepted and the fellowship was awarded in the month of October 2016. The Karnataka field was again visited by this researcher in the month of December 2018 (3 - 8 December 2018) to revisit DOHFW, GOK and SAST office in Bangalore to address some data gap.

[14]The study topic and the name of the researcher along with institutional affiliation can be found on the shared web-link for the Visiting Fellowship programme at ISEC. (http://www.isec.ac.in/srtt-fellowships-completed-projects.htm).

The study conducted under the visiting fellowship opportunity had dealt with specifically two Bank- financed projects in Karnataka, namely the Karnataka Health System Development Project and the Karnataka Health System Development and Reform Project. The final study report before submission to ISEC had undergone a double-blind peer review process from two referees. The study report submitted to the ISEC is neither a published document of the institute nor for its library collection of unpublished report. This researcher had to submit the study report to ISEC because of the official requirement of the institute as it financed the field work through visiting fellowship opportunity for this research. The study report is used in this thesis as chapter six and seven to discuss two Bank financed projects' implementation-operation experiences. This research considers the visiting fellowship opportunity at the ISEC was of a strategic advantage for conducting the field work. ISEC is an institute of repute in South India, especially in Karnataka. The academic environment of ISEC had indeed been a great support to this researcher in order to prepare chapter five (contextual analysis of Karnataka), six, seven, and eight. Further, for this research, ISEC has played the role of local institution for an outside investigator to study the aid investment site, i.e. Karnataka.

The field work in Karnataka is divided in two types- one is inside Bangalore (the state capital), and the other is the district visit. The support of GOK for policy implementation-operation level field work was the utmost priority. According to that priority, this researcher in the first two months (from the mid of November 2016 to mid of January 2017) had tried to build rapport with the key personnel in the MOHFW/DOHFW, GOK. Finally, the rapport building exercise along with official request (submission of application request with PhD research proposal and other supporting documents) led the National Health Mission (NHM) of GOK to issue a "Letter of Support" (Office Order No. NHM/SPMU/LS/290/2016 – 17 dated 19 January 2017) in favour of this research to conduct the field study (Annexation 1). That Office Order was circulated to all the District Health Offices, and all other offices under the MOHFW, GOK (the details can be found in the respective annex).

This research is indebted to the support provided by the GOK for pursuing the field work. The support gave access to many classified period documents, and other grey literature, internal data, and helped to speak with the key government officials, even retired staff. Also, the District Health Offices including the *Taluk* (block-level) Health

Offices extended their wholehearted support to this researcher by taking care of logistics arrangement (food, lodging and in many cases transportation also). The support received from KHSDRP, DOHFW, SAST and other health department offices/institutions in Bangalore are also praiseworthy. At the end of the field work, this researcher had shared field observation note with the NHM, GOK office in Bangalore (Annexation 2).

In Bangalore, DOHFW, MOHFW, KHSDRP, NHM, SAST, food safety cell, Public Health Institute (PHI building), Ministry of Finance, Ministry of Labour and other offices of GOK were visited. The KHSDRP being a Bank-financed project unit was this researcher's main interaction unit at the GOK. As per the count on field diary, this researcher had made approximately eighty four rounds of visit to various government offices in Bangalore during the seven-month field work. Apart from government offices, this researcher also visited government medical college (Bangalore Medical College and Research Institute), civil society organisations (SOCHARA/Institute of Public Health), policy research institutes (Centre for Law and Policy Research and others), academic institutes (National Institute of Advanced Studies, Indian Statistical Institute etcetera, Azim Premji University), health campaigns/events organised by civil society groups, and other key stakeholders (retired World Bank employee to independent researcher to World Bank consultant) during the field work in Bangalore. The detail list of organisations/institutes/persons/groups contacted can be found in the acknowledgement section.

The district visits were equally important for the study of Bank financed projects. This researcher had visited four districts in Karnataka. The districts were chosen based on the index of regional inequality between North and South Karnataka. In South Karnataka, visits were made to district medical college, block hospital, PHCs, and district health offices in Tumkur and Mandya districts. Also in Tumkur, this researcher stayed at the *Sri Ramakrishna Sevashrama*, Pavagada (one of the most backward blocks in South Karnataka) to observe and study the role of not-for-profit private sector in health care service delivery. In North Karnataka, which is an economically backward region, this researcher visited Raichur and Gulbarga (renamed as Kalaburagi) districts. In these two districts, apart from visiting government health facilities (from medical college to sub-centre), districts Drugs Logistics & Warehousing Society, *Zilla Panchayat* offices, this researcher also did a community level field study. The

Grameena Coolie Karmikara Sanghatane (GRAKOOS), a union of rural workers especially active in North Karnataka, was the field coordinator for two North Karnataka districts. The organisation's network helped this researcher in interacting with the community for language support as well as for arrangement of other local-level resources to conduct the field work smoothly. In Gulbarga town, for-profit private health care facilities were covered to study the SAST model of strategic purchase of health care service delivery. The extensive field work is one of the important strengths of this research that immensely aided not only the data collection for process evaluation but also in terms of realisation that how the complexity works within the health service system.

2.9 Data collection tools

Both qualitative and quantitative data have been used to conduct this research. Tools have been chosen according to the need of the methods as listed in the analytical framework. Following are the tools utilised for data collection.

2.9.1 Narrative systematic review of relevant literature

Articles or chapters published in peer-reviewed journal, edited books, monographs, books are considered in this research as literature for review of the policy process. This research has separately used literature review and document review. Literature review is more of a presenting published scientific and analytical review with clear conceptual and theoretical clarification, and thus represents rigour in research. The document review is a collection of various forms of materials (resources) from both primary and secondary sources to draw analytical observations for any given problem. In this research, interdisciplinary approach in case of literature review mostly followed, where other than public health, disciplines, like economics, political science, sociology, history, management, international relations, foreign affairs and development studies have been consulted.

2.9.2 Document review

Document review has been undertaken in order to categorise, synthesize, and interpret them. Document review is a way to analyse the documents in the form of "*topic*", though Glaser and Strauss introduces document as data. Thus reports, letter, texts,

photographs, books and even autobiographies are known as "*resource*" in the research (Angrosino, 1989 and Plummer, 2001 as cited in Prior, 2010, p. 418). In this research it is used as a tool for data collection (resource) to know what purpose they are serving and for whose interest. In this technique, the content of the documents represent as they are. Both the primary and secondary sources (including published and unpublished) were used to collect documents. It is the only tool in this thesis, other than literature review and discussion, which is employed in every single chapter (or case) to aid the methods listed under analytical framework.

It was found that typical policy document is often descriptive, less organised and repetitive, which give scope to various actors to interpret the policy according to their own interest. In order to be specific in the analysis of policy interpretation, this research, in most of the cases, used page number and even at times paragraph number (for instance, while referring to declaration/charter) for reviewing documents. This particular technique is also followed in literature review while analysing the case studies (international/national/regional) and research findings. Below table lists the types and sources of documents collection.

Table 2.1: Types of document used in the research

Types of source	Types of document
Primary source	Macro system: Policy brief from supranational organisations (like, WHO SEARO advocacy materials on UHC and SDG health development) Meso system: Programme evaluation report of World Bank, GOI Micro system: Progarmme Implementation Plans (PIP), aide memoires, meeting minutes, email communication, office orders, internal evaluation reports, study documents, contract agreement, cabinet notes, civil society developed advocacy materials etcetera.
Secondary source	Health related policy/programme/plan documents of World Bank, WHO, other bilateral and multilateral organisations, GOI, GOK Annual publications: World Development Report, Annual reports of World Bank, World Health Report, Economic report of GOI and state government, RBI annual report World Bank state-level health system projects' documents from India, health system project documents of other countries (Jordon, Peru etcetera) available on World Bank website Grey literature: Policy paper, working paper, task force reports, white paper of World Bank, GOI, GOK Major international summit/declaration/convention

Types of source	Types of document
	Economic and development policy related documents including reports, meeting minutes, progress reports, background papers, Country/region specific strategic report of multilateral organisations etcetera News paper reportage, blogs, website promotions, magazines, election manifesto, people's charter for health

2.9.3 Quantitative data collection

Since statistical data cannot be a part of document review, the sources of quantitative information are separately used for data collection. Budget documents and mid-term expenditure framework of GOI and GOK, economic survey reports of state government, World Bank data base, WHO Global Health Observatory have been used as secondary sources for quantitative data. GOK's DOHFW managed MIS data base, and SAST Computerised Management Information System data base, data reported in classified official documents/reports/studies were used as primary source of quantitative analysis.

2.9.4 Community consultation:

During the field work, this researcher conducted a community consultation in Raichur district with the help of GRAKOOS. The consultation was held with the residents (total thirty) of the local Naglapur CHC at the *Mallesh Madiwar* Land Development site (MNERGA working site) of Naglapur village. It was conducted in the mode of 'search conference' to understand what the users of that CHC want from that facility. Search conference is a special method of community consolation where participants are snowballed to understand the need of the community in the long run (Carson & Gelber, February 2001).

The consultation has helped this researcher to understand the real-time crisis as well as the expectation of the community which depends on the public facilities in the most backward district of Karnataka. That community consultation helped this researcher to prepare discussion pointers for in-person meeting with government health care service delivery providers (such as, *Taluk*/Block Health Officer) in remote places.

2.9.5 Group discussion with grass root workers:

This researcher had the opportunity to conduct an informal group discussion with the grass root health workers (comprising of Accredited Social Health Activist (ASHA),

Junior Health Assistant, Auxiliary Nurse Midwifery, Anganwadi Worker) in the Galag sub-centre (of Galag PHC), Raichur district. In the group discussion, the number of participants was eight. Group discussion in social science research is another technique to collect field-level data in the forms of opinion and experience from several participants on one common topic (Payne and Payne, 2004). For this research also, the informal group discussion was organised to understand the challenges, grievances, and compulsions faced by the lowest rung of the health care service providers in public system. The discussion pointers have helped to get the provider perspective locating within the challenging context of health workforce.

2.9.6 Participant observation:

Participant observation is a tool that "*entails generating data by observing and participating*" in the context of field work (Allen, 2010, p.353). This research also used participant observation as the most frequent data collection tool in field work. According to the literature, maintaining records in the form of field notes in field dairies is the very method to analytically document scenes, actions, conversations, dialogues, and experiences. Thus it is the only tool which gives the opportunity to collect and analyse data concurrently as the observed field notes give ideas to reflect, identify, categorise and synthesise data (Kawulich, 2005). Participant observation helped this research in getting the perspective of service providers (at the public facilities), service users (community), project staffer/administrator, and policy elites. In priority, it was the first order tool for this research through which this researcher mapped the activities of KHSDRP office (PHI building in K R Circle, Bangalore), Directorate of health (Ashok Rao circle, Bangalore) and SAST office (Shantinagar bus stand, Bangalore).

2.9.7 Discussion:

Discussion is not a very common data collection tool in social science research; rather it is more used as classroom teaching-learning technique. In policy analysis, discussion, according to this researcher, is the thumb rule for understanding the processes involved in the policy path. The literature review informs that well-designed discussion helps the learner for building 'knowledge-seeking inquiry' in order to blend new information with existing knowledge for developing new forms of knowledge as well as new perspectives to that very process of learning (Karen & Yoon-San, 2003).

This tool is used in this research over all the chapters. This researcher's knowledge about Bank's health system policy of various levels was inadequate. It is because of the frequent use of this tool that this researcher over the time has become able to pose 'critical inquiry' and give 'reflective learning' on the Bank's health system policy processes. In this research, discussions were not only used for developing knowledge, it also sufficed the purpose of networking and building rapport with the stakeholders. Discussion also helped to complement the interview information/opinion/analysis because not all the government/Bank's/other supranational organisation's employee were flexible to offer interview.

2.9.8 Primary interviews:

The last form of data collection tool is interview. At the time of synopsis preparation, this research had prepared a list of secondary data base consisting of the potential stakeholders for the research. That stakeholder list had been updated later on as the research progressed. The list was the readymade help to this researcher for drawing discussants and interviewees as and when needed.

2.9.9.1 Limitation of desk based research and scope for interview

Reviewing World Bank data involves a critical task as academic scholarship critiques the Bank's works in health system either from theoretical as well as ideological positions or from the viewpoint of its contribution in the international health governance. On the other hand, the official documents of the Bank and the partners of the Bank in international health governance normally portray positive features (or takes 'soft-line') of the Bank's effort. Hence, the information gap in the process documentation occurs especially on the areas of contextual practices and programmatic reasoning in terms of designing of policy and project execution. The Bank prepared programme/project review documents also have inconspicuous information regarding the contextual challenges and intervention technicalities. Besides, the secondary data (quantitative) with regards to outcome indicators usually suggest more generalised inference about the Bank's contribution. Thus all these gaps are difficult to address without primary information. Considering the situation, s' Interview (KII) was used as a primary data collection tool. KII not only addressed the background picture of health system policy processes but also gave a scope for obtaining first-hand experience, and

which in turn has led to triangulation between the reviewed literature, secondary data and primary interviews.

2.9.9.2 Key Informants' Interview

KII is a tool that involves "*interviewing a select group of individuals who are likely to provide needed information, ideas, and insights on a particular subject*" (Kumar, 1989, p.1). In this research, Key Informant Interviewees (KIIs) were chosen based on their competency in the relevant areas of research. The interview tool was used in all the three levels of the policy system.

2.9.9.3 Sampling

Interviewees were chosen through theoretical sampling. It is a process of interviewee identification based on the informants' institutional affiliations, roles and involvement in the research probes/queries, and work in synchronisation with the analytical framework (Kuper & Lingard, 2008). Further, the theoretical sampling was, at times, supported by snowballing (Ritchie, Lewis, & Elam, 2003) to reach out to key informants.

Following are consulted for selection of KIIs:[15]

- Retired and present World Bank employees/consultants familiar with health system strengthening policy and project activities.
- Retired and present government technocrats/bureaucrats/consultants who involved at the capacity of either serving at/as or decision making of various policy development activity in GOI, and have/had experience with World Bank financed state-level health system projects in India.
- Selective representatives of civil society who had the exposure to work with the Bank from policy deliberation to project implementation, both at the state and national arenas.
- Scholars and activists who are familiar with the Bank's activity, GOI's policy priority, and practice with HPSR.
- Professionals/representatives from private sector having experience of present-day health system policy orientation

[15]Some participants did not give interview because of their present organisational affiliation. The discussion tool was used in such cases, however, they were also chosen from the same list of categories.

It is to be noted that in this list of four broad categories, most of interviewees actually represent more than one category. The sample size was nine. Out of nine, seven were interviewed in person, and two on Skype.

2.9.9.4 Interview techniques

Semi structured interview was used (Britten, 1995 in Leach), where this researcher posed the questions based on the determined areas of policy/project themes. The interview questions varied from respondent to respondent. Thus every interview was guided with the prescheduled list of information (thematic) required to fill the data gap and/or validate the information. In this research, all the interviewees are addressed through code number in order to maintain the anonymity.

2.10 Ethical consent and confidentiality

This research had obtained the ethical clearance from the Institutional and Ethics Review Board (IERB) of Jawaharlal Nehru University at the beginning of this research (Annexation 4). The major part of this research is a secondary review using the authentic data sources available in public domain. All the literary, conceptual and operational references have been acknowledged appropriately. The primary interviews were conducted in accordance to the guidelines of IERB, i.e. to brief the research topic, share the themes to be covered in the interviews, explain the advantages and disadvantages for participating in the interview, ensure anonymity, and obtain written consent from the interviewee (Annexation 3). For interviews, all taping and note taking had been done after obtaining due consent in written form. The primary documents from government and institutional sources were obtained after taking due permission from the concerned authority. The permission process involved submission of official request letter, certificate of this researcher's institutional affiliation and academic need for the documents, PhD research confirmation letter issued by the University, and IERB certificate. This research has not dealt with any laboratory/clinical investigation involving human beings and animals.

2.11 Validation of the research:

Generally research on aid investment has always tied with context specificity. To carefully understand the context specificity, expert opinion should be sought in order to test the research findings. The experts should be familiar with both the context and

the nature of aid investment. In this research, external dialogues with the public health (including social science academia) fraternity had been done quite a number of times in order to validate the research design and findings, and also to incorporate the feedback. The external validation technique was used in Karnataka to study the Bank-financed projects, because this researcher as an outsider was not familiar with local dynamics. At the beginning and in the end of the Karnataka field work, two seminars were organised at ISEC to present research design and research findings respectively.

The Society for Community Health Awareness Research and Action (SOCHARA), a Bangalore based civil society organisation involved in policy research, also organised field work dissemination seminar at the end of Karnataka field work in Bangalore. Those three seminars had immensely helped this research to strengthen the research design as well as match the research findings with the understanding of local experts. The experts in all those three seminars varied from social science academics to public health worker/scholars/activists based in Karnataka. Further to mention that all the four chapters (chapter five, six, seven and partly eight) from the micro system in Karnataka (policy implementation-operation level) had undergone peer-reviewed process to comply with publication (a large portion of chapter five was published in ISEC working paper series) and fellowship (chapter six, seven, and partly eight were part of the study report submitted at ISEC for visiting fellowship assistance, as explained in the field work section) requirements.

At the end of this thesis writing, the Government of India's National Health System Resource Centre (NHSRC) organised final PhD dissemination seminar in Delhi. That dissemination seminar had the opportunity to present, discuss and share the overall research findings comprising of all the three levels of policy system with the national-level health system experts. The seminar has benefitted this researcher to further validate the research findings and improve the discussion chapter. This research, apart from holding dialogues with policy experts, has also shared research findings through publications including newspaper op-eds, a detail list can be found in the respective annexation (Annexation 5).

In terms of external validation to generalise the research findings, it can be said that the policy processes at the macro system and meso system are actor specific (i.e. World Bank and India). Thus in the case of the Bank's health system policy in any other

country, both the systems' findings from this research may be applicable because of the similarity in the general structure of the policy. However, the policy outcome from the Bank and respective country's interaction (in the meso system) may not necessarily be identical. For micro system (implementation-operation), the generalisation may not be possible in-toto because 'inferential generalisation' (Lewis & Richie, 2003) from one study to other contextual setting need multiple case study design (Yin, 2003). It is true that this research also has a multiple case study design, but that multiplicity is not at the level of policy implementation-operation. Seeing this limitation, it can be said that abrupt generalisation of micro system is not possible, but the generalisation of implementation types and operational styles are feasible. It is because the Bank's health system policy driven projects are, design-wise, quite similar (can be found in chapter four and eight), thus they always create a pattern in health intervention.

Considering all these factors, this research opines that conceptual and theoretical generalisations of this research are possible. The analytical generalisation can also be drawn since the policy objectives are same. It is only the analytical generalisation with regards to findings from policy implementation and operation stages which may need further context specific attention.

2.12 Declaration on reflexivity and biases

The researcher's position is crucial in health policy analysis. The *positionality* of the researcher is determined by the power and its relation with research subjects (what and whom are researched). Power is constituted by the factors (race, class, sex, age, gender, religion, knowledge and language), and these factors identify the position of the researcher (insider or outsider) (Walt et al., 2008). Barker (1996) cites the research of Ratcliffe and Gonzalez-del-Valle in Bangladesh (1988) and Engelkes in Colombia (1990) to show how the 'outsider' identity of researcher, as defined by the above mentioned factors, made them to misunderstand the contextual reality in those studies and thus misinterpreted the findings. This gives more responsibility to critically locate the position of the researcher.

In this research, the researcher's *positionality* reflects a unique identity. As a citizen of India, researcher's identity is 'insider' since he belongs to Indian society and carries the common sociocultural traits. At the same time, because of researcher's linguistic identity (i.e. Bengali) in the multi-lingual Indian nation-state, he was an outsider to

Karnataka where the field work was done. It is also necessary to mention that in the Indian geopolitical dynamics, both the West Bengal and the Karnataka uphold linguistic identity over all other identities. Thus this researcher represents a position of being 'insider-outsider' in this research. Being an insider, the common Indian traits, normative knowledge, lived experiences had given this researcher access to go for finer details at much deeper level in order to understand the complexity of health system from worm's-eye view. On the other hand, the outsider tag made this researcher to encounter new practices and different understanding of meaning system. That viewpoint was more critical and saw the dynamics of health system from bird's-eye view. Thus it is the insider-outsider identity that contributed to imbibe to a new value position which has always been in contestation between the two views! This insider-outsider position is usually advantageous and helps to inculcate innovation and creativity (Shahinian, 2016). The researcher is also of same opinion with regards to his experience in conducting this research.

Apart from the insider-outsider identity, this researcher's position is also influenced by the position of researcher's institutional affiliation. Centre of Social Medicine and Community Health, JNU is a 'powerful institution of knowledge production' (institutional knowledge as power is theorised by McDowell in 1992 as cited in Rose 1997), and has 'critical public health' value position with regards to the research topic. So, researcher's positional advantage in respect to this research may be divided into two ways. One is his own position, shaped by the insider-outsider identity and the institutional affiliation where he is located at. Second is the researcher's organic value position which is based on his ideological orientation and perspective. This researcher's ideology does not complement the ideas that the World Bank believes in, and professes that health and health care should be delivered under human and social justice conditions and not through economic cost-effective measures. Researcher's perspective is again based on the ideological orientation and that stands for a Realist perspective to conduct this research.

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Chapter 3: Banking on health system for last half a century

Summary of the chapter: This chapter is a discourse analysis of World Bank's health system policy evolution. The time period is from 1969 to date. The analysis consults the disciplines of macroeconomics, political science, international relationship, anthropology, and health policy. Both policy formation and formulation stages are analysed to explore policy agenda and policy levers respectively. Policy agenda shapes theory and formula, which in turn devise the policy levers. The World Bank's health system policy is divided in five phases. The Bank's health system policy was formulated in the first phase only in response to the WHO's Alma-Ata Declaration. In the next phase, the Bank advanced the policy by designing basic health care projects for lending purpose. In the next three phases, the Bank has been incrementally involved in augmenting the reform from care-based to value-based to function-based. All the three types of reform have articulated increasing development of state-market relationship. The analysis finds that the Bank's health system policy has always been determined by the events of international political economy, and the relationship between international economic governance and international health governance. It is found that the Bank's health system policy is not theoretically sound, and mismatch with some of the key policy levers. The most recent example, inclusion of financial protection objective in the health system strengthening phase, the fifth phase, contradicts with the theoretical formula of the Bank's health system policy.

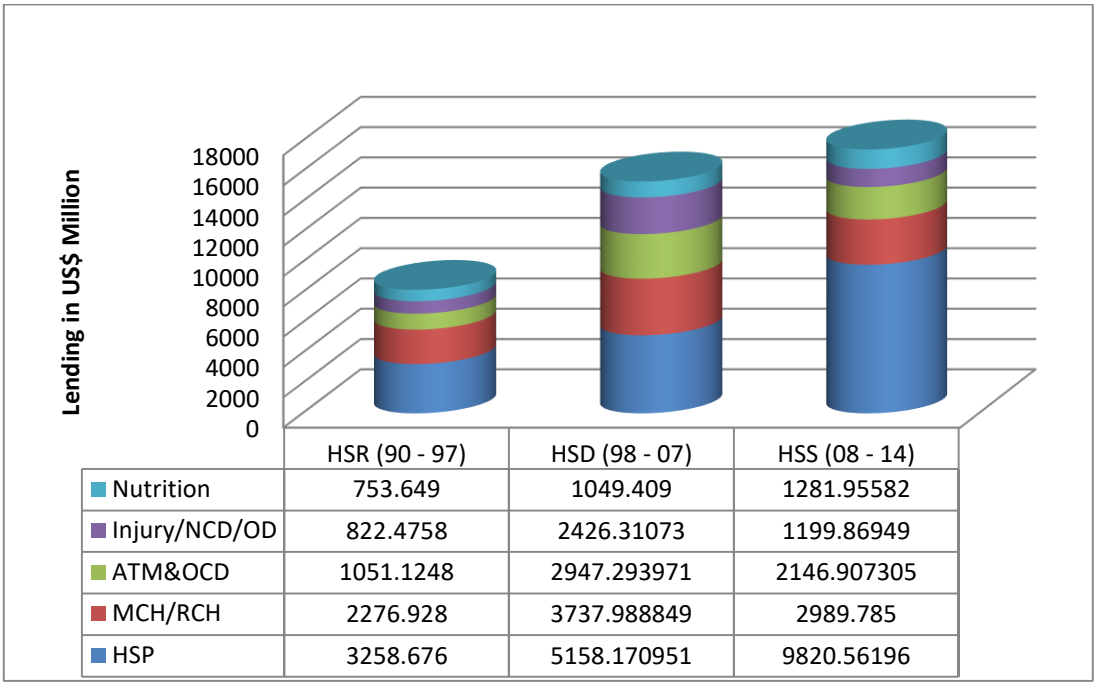
Strengthening health system has taken on a centre stage in the International Health Governance (IHG) in the leg up to achieving Universal Health Coverage (UHC), especially after the pronouncement of the Sustainable Development Goal (SDG). The SDG target number 3.8, i.e. achieve UHC by 2030, has even prompted the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) to launch a renewed Primary Health Care (PHC) approach on the fortieth year of Alma-Ata to support UHC and health SDGs by upholding Astana Declaration (WHO – UNICEF, 25 – 26 October 2018). The 2010 *World Health Report* declares that effective Health System Strengthening (HSS) operation is the path towards UHC (WHO World Health Report/WHR, 2010). The perspective of system thinking in international health policy

and planning exercises is not new, the age old PHC approach of Alma-Ata Declaration had also been developed on the line of health system thinking.

Given the importance of health system interventions' role in organisation and management of health care service, the Bank's contribution in this area is obviously sought for deeper analysis. The Bank has occasionally received subject of attention from the critiques mostly from two frames of reference, i.e. power (position of the Bank as lending institution in influencing health policies) and practice (reorganisation of resources in public system in order to reform the health sector) (Buse, 1994; Scot, 1999; Abbasi, 1999; Ruger, 2005; and Sridhar, Winters, & Strong, 2007). While both the power and practice, infused into policy levers, of the Bank in IHG have undergone spasmodic scrutiny, the primacy to examine the theoretical base of a particular policy (in this case, health system) has remained scanty. This chapter analyses the role of the Bank in the discourse of health system policy development in IHG.

The actors in IHG, especially the World Health Organisation, have always played a pivotal role in developing and guiding the health system policies (Alma-Ata 1978; WHO's Annual World Health Report in 2000, 2007, 2010; Commission on Macroeconomics and Health 2002 etcetera). Contrary to this conduct, the World Bank, hereafter the Bank, as an Inter Governmental Organisation (IGO), never limited itself only to the policy guidance; instead financed the countries in need of money to implement health system policies. The health system policy is a core part of the Bank's Health, Nutrition and Population (HNP) sector, mandated for financing social sector projects to the Low and Middle Income Countries (LIC and LMIC). The lending portfolio of health system intervention from 1990 to 2014 shows it is the primary commitment for the Bank within the HNP sector.

Graph 3.1: HNP Lending by Theme and Region (1990 - 2014)



	HSR (90 - 97)	HSD (98 - 07)	HSS (08 - 14)
Nutrition	753.649	1049.409	1281.95582
Injury/NCD/OD	822.4758	2426.31073	1199.86949
ATM&OCD	1051.1248	2947.293971	2146.907305
MCH/RCH	2276.928	3737.988849	2989.785
HSP	3258.676	5158.170951	9820.56196

Source: World Bank lending for HNP (http://datatopics.worldbank.org/health/lending), Accessed on 27 October 2014 (data update till 26 August 2014).
Some themes are clubbed (RCH/MCH: child health with population and reproductive; ATM: HIV/AIDS, TB, Malaria, other communicable diseases; Injury/NCD/OD: Injury, Non Communicable Disease, and other human development)

The above graph entails the importance that health system intervention has been getting in the Bank's HNP sector. Out of ten thematic lending of the HNP sector, Health System Performance (HSP) is consistently the single highest lending theme in all the three phases (Health System Reform/HSR, Health System Development/HSD and Health System Strengthening/HSS) of the health system policy evolution. In the overall HNP lending between 1990 and 2014, health system intervention consisted of 40 per cent in HSR (1990 – 1997), 34 per cent in HSD (1998 – 2007), and 56 per cent in HSS (2008 – 2014) phase. This revelation negates the myth that Bank mostly earmarks its fund towards disease based and population control interventions instead of making effort to strengthen health services.

With this background, this chapter analyses the following research objectives and questions.

- To know the trajectory of the Bank's current day HSS policy that is evolved on the premise of International Health Governance (IHG).

- How has the Bank's health system policy been evolving over the period?
- What is the Bank's conceptual, theoretical and operative understanding on health system?

- To analyse the interdependence between the International Economic Governance (IEG) and IHG focussing on the role of World Bank in designing and modifying the health system policy.
    - How is the IEG interacting with the IHG in the discourse of health system policy evolution?
    - What are the factors emerging from IEG – IHG interactions that determine health system policy discourse, and where does the World Bank stand in those interactions?

The analysis of health system policy has its root in late 1960s when the Bank launched its social sector (especially on HNP) lending. Initially, lending was available for population (unit was set up in 1969) and nutrition (unit was set up in 1972) programmes (Kapur, Lewis & Webb, 1997, p. 236 & 253). After the combined Population, Health and Nutrition (PHN) (officially renamed as HNP in 1997) unit got established in October 1979 (Kapur, Lewis & Webb, 1997, p. 345), the Bank commenced its stand-alone intervention in health in 1980 (Buse, 1994). The evolution of health policy is interlinked with the lending practice. The HNP sector lending can be categorised in four or five phases, starting from the issue of addressing population question to the present day health system strengthening (Fair, 2008; and Tichenor & Sridhar, 2017). Not going by the similar nomenclature used by earlier works, this research periodises lending into five phases:

3.1 Embryonic health system (1969 – 1979)
3.2 Health care system (1980 – 1987)
3.3 Health system reform (1988 – 1996)
3.4 Health system development (1997 – 2006)
3.5 Health system strengthening (2007 onwards)

In all those phases, the HNP lending has been made available to all the three major themes (health, nutrition and population) and other sub-themes (health system, HIV/AIDS, child health and so on). The present-day health system policy, i.e. HSS, of

the Bank is evolved from all these previous phases. Like any other policy, health system policy has also contextual factors which are principally defined by actors, agendas and interests. The combination of these three has been in the mode of triadic interaction for last half-century. The following phases trace that half-century to analyse how the policy formation (policy agendas as factored by the actors and their interests) paves the way for policy formulation (by devising policy levers).

3.1 Embryonic health system (1969 – 1979)

The World Bank first published its health policy in 1975, and thereafter in 1980 it brought out health sector policy paper as lending document (WB, February 1980). The 1980 sector policy was the first official launch of Bank's health system policy. Like every other policy, the Bank's health system policy also had an incubation period and was factored by number of cross-cutting issues. The embryonic phase entails the initial days of policy formation – macro factors of policy, which cemented policy formula (the theoretical base of the policy) and also streamlined subsequent policy phases. This particular phase discusses complex of international political economy in the decade of 1970s, role of development strategies, and politics of social sector lending, especially on population control and nutrition. All these factors worked in an inter-related manner, and that led to policy formulation of health system.

The Bank always is predominantly an institution for IEG. Its expansion from IEG to the arena of IHG could be identified as gestation period for present-day health system policy. The seed of system thinking in health intervention was not linked to the formation of PHN department, or even with the commencement of Bank financed Selective Primary Health Care (SPHC) designed projects. The origination embodied within the agenda of political and economic empowerment of poor nations against then existing international political economy. The emergence of Non Alignment Movement (NAM, formed in 1961) for political independence, and cohesion of Group 77 (G77, formally grouped in 1964) for economic independence of the Developing and Least Developed Countries (DC/LDC) had made significant impact in the International Governance (IG) for social and economic development. They remained consolidated as the Third World (NAM and G77 countries) in the effort to destabilise the United Nation (UN) bi-polar (US and other developed countries as First World vs. Soviet Bloc as Second World) power-structure in the decades of 1960s and 70s (Alden, Morphet &

Vieira, 2010; and Geldart & Lyon, Winter 1980 – 1981). The dissent had the potency of becoming radical for the First World to reorder IG structure. As a result, it frightened the United States of America (USA/US) government to retreat to neo-Malthusian logic of resource scarcity (officially approved by the Draper Committee in 1958), because of excessive population in the Third World. That resource-scarcity logic subsequently contaminated the IG, and laid the path to conceptualise population control programmes in the 1960s and 70s (Hartman, 1997). This was the first political effort of IG to converse with the dissent of Third World through 'non-economic' means.

The dissent was impelled by two primers; the debt crisis (growing debt and payment of debt service for amortisation and interest) and collapsing of human standard of living (WB – IDA, 1964 – 1965, p. 58). Slow rate of economic growth, primarily linked to trade and industrialisation, was recognised as an outcome of both the primers. In response to slow economic growth, the newly crystallised 'South group' in March 1964 under the interest of G77 formed United Nations Council for Trade and Development (UNCTAD) to address the 'Western-centric' biases on international trade (Geldart & Lyon, Winter 1980 – 1981). The Bank as a representative of IEG was alarmed by the formation of UNCTAD, and adopted the rhetoric of population control in order to address the dissent of South group.[16]

In the 1964 – 65 *Annual Report* for the first time in official document, Bank diagnosed that 'population explosion' was behind the slow rate of growth, and advocated for required policies and aid purposes to check population growth in the Third World (*Annual Reports*: WB – IDA, 1964 – 1965, p. 52). This neo-Malthusian logic of the Bank had been reiterated in the entire second half of 1960s that agricultural output is inadequate to meet the growing number of population, which hampering the economic growth and also limiting the increase of per capita income (*Annual Reports*: WB – IDA, 1964 – 1965; 1965 – 1966; 1966 – 1967; 1968; 1969). Thus the investment on population control emerged as a suggestive measure to 'rescue' the poor countries from slow growth rate.[17] Finally in 1970, Bank constituted Pearson Committee report gave legitimacy to the family planning activity by endorsing it as lending conditionality due

[16] By the middle of 1960s, population control efforts made a strong footprint (such as, establishing United Nations Population Fund – UNFPA, UN Declaration on Population in 1966) on IG.
[17] The benefit from population control was theoretically linked to the economic growth in three distinct ways (per capita income, employment, and income distribution) (WB, 1972, p. 304 – 305).

to its impact on social development (WB, 22 June 1970, p. 25 – 26). In the social sector lending, population control within a short span of time had become an *antidote* for alleviating poverty in the Third World, the cause behind slow growth.

The Bank's compulsion for economic and social development trailed further by taking the lead (along with Food and Agricultural Organisation and United Nations Development Programme) to establish a Consultative Group on International Agricultural Research (CGIAR) in 1969. CGIAR became a technical backbone to invest in rural development and nutrition components (Ozgediz, 2012). The initiative was further sharpened by *The Nutrition Factor* (Alan Berg's book in 1973) and other internal policy advocacies (Ruger, 2005, p.64). However, it is found that Mr. McNamara had never wanted Bank to get involved in "*mass food distribution programs"* and rather restrict *"to development-oriented work* for *effective population planning*" (Kapur, Lewis & Webb, 1997, p. 254). Hence, Bank reasoned food aid as equal to '*technical export*' of nutrition support for development assistance (*Annual Reports*: WB – IDA, 1971, p. 13; WB, 1974). This reasoning made nutrition to be identified as a supplement for physical growth and productivity, as well as mental development. These three attributive factors of nutrition formed the productivity notion while in the search for economic growth. Therefore nutrition was increasingly being financed as sub-project components under the projects like rural development, agricultural lending until it became a stand-alone support in 1976 (in Brazil) (*Annual Reports*: WB, 1974, p. 13; 1975, p. 73; 1976, p. 54). So, Nutrition was articulated as *antigen* for developing productive population in order to increase growth.

The investment both in population control and nutrition gave the Bank a two-fold advantage in international governance; it justified its position as a financial institute to invest in *social overheads* by associating the lending with economic output, and successively established its foothold in development aid.[18] So, poverty, a cause of 'underdevelopment', but a result of population explosion (Ruger, 2005, p. 64), hence the population control activity was ascribed to human welfare circa 1972 (WB, 1972). On the other side, nutrition intervention was taken off for 'human development' priority

[18] Edward S Mason and Robert E Asher, in their pioneering work on the first quarter century of the Bank, coined the term *social overheads* to mention the areas (sanitation, education, nutrition, health etcetera) which are traditionally meant for public investment. The Bank was known for investment in economic overheads (big infrastructure projects), but with time it expanded to social overheads (Ayres, 1984).

(Buse, 1994, p. 94) against malnutrition to enhance labour productivity circa 1974/75 (*Annual Reports*: WB, 1975, p. 73; 1976, p. 54). The identification of causes of underdevelopment of nation-state (due to poverty) and reasons of un/under-productivity of labour (malnutrition) helped new form of knowledge to surface. This new knowledge proclaimed that population control and nutrition support hold the key for Human Development (HD) in order to address the fundamental problem, economic development (to address slow growth).

It is important to mention that HD approach was not first introduced by Bank, in IG it had a prior history. The tussle over power-structure within the UN for equal trade policy and industrialisation in the Third World in the entire decade of 1960s forced the IG to change the international aid strategy. As a result, the International Development Strategy (IDS) for the United Nations Second development decade got formed in 1970. The Strategy advised the IGOs to take policy measures in consultation with the DCs/LDCs for investing in human development as one of the development measures, such as control population as per the need (para 65), make provision of basic health services (para 68), meet nutrition requirement (para 69) etcetera. The IDS at one hand planned to release the "*world tension"* (Third World vs. First World), and on other hand schemed to pull the Third World out from "*abject poverty"* by focusing on the social sector (UN General Assembly Resolution, 24 October 1970).

It is a matter of great surprise that in the rich history of post Word War- II international governance and development economics, IDS is found to be in the abyss of oblivion. However, Bank, being a financing institute, utilised IDS as gateway to invest in social sector by focussing on HD. In the entire decade of 1970s, the Bank tried to compensate the Third World demand for economic and social development by increasing its lending activity on HD (especially on population control and nutrition). It became the torch bearer of HD model of development aid, and in that journey it got transubstantiated into development agency from a financing institute. Noticeably, it was HD that made the Bank exposed to the concept of system. Because HD, as hypothesised in 1970's IDS, was based on systemic cooperation among the identified components (population control, nutrition, health, housing, employment, education, child and youth development and ecology) (UN General Assembly Resolution, 24 October 1970). Thus it can be said that with the adoption of HD, the Bank formally entered into the 'system' called development.

This development embraced health component after Bank started lending basic health care projects. Though the phase began in 1980, the entire decade of 1970 was the premise for the Bank to arrive at rationales for investment logic in basic health care (Kapur, Lewis & Webb, 1997, p. 254). The active involvement of the Bank in health was noticed at first after the debate on Alma-Ata was blown up over technical and economic efficiency of prescribed Comprehensive Primary Health Care (CPHC) approach (discussed in detail under technical assistance). The debate started after the Rockefeller Foundation sponsored the Bellagio Conference, 1979 in Italy to deliberate upon 'alternate perspective' of CPHC approach on the ground of low cost intervention for poor countries. The World Bank (represented by none other than McNamara), Ford Foundation, the US and Canadian bilateral agencies were some of the key conference organisers (Cueto, 2004, p. 11). The Bank began its journey in the health system policy discourse with the commencement of that alternate perspective (i.e. Selective Primary Health Care/SPHC) to CPHC approach.

The Bank was not a major international actor in health till 1978. In-fact, McNamara, while designing the Bank's first ever population control loan for Jamaica in 1970, had once denied even a partial assistance to general health service on the ground that health facilities usually decrease death rate, and thereby helping in population explosion (Kapur, Lewis & Webb, 1997, p. 250). Till 1978, the Bank financed health as another auxiliary component of poverty alleviation programs (WB, 1 – 5 September 1975, p.37, Kapur, Lewis & Webb, 1997, p. 254; and WB, 1975, p. 19). However, in 1975 Bank diagnosed in its first health policy paper "*that inefficiencies and inequities in health policies should be removed*". Therefore it decided to incrementally invest in research and development to "*test out more effective health care systems*" (WB, 1975, p.19). That very incremental investment finally became a full-fledged intervention from 1980. Buse (1994, p. 97) justifies this policy reversal *"on the grounds that the Bank could provide valuable analytical skill and programming experience to country policy development*". As opposed to that, this PhD research finds that Bank's entry into health as well as policy design of health system was caused by an interplay of three factors in IG; political management, economic rationale, and technical assistance (knowledge innovation). All the three factors interacted simultaneously and developed incrementally. The following section is the analysis of all three factors to re-search the embryo of health system policy.

3.1.1 Political management

The growing unity of the Third World against the First World was translated into two crucial UN announcements; proclamation of the UN's International Development Strategy of 1970 (under the inducement of G77: Geldart, C & Lyon, P, Winter, 1980-1981, p. 94), and the UN Declaration of the New International Economic Order (NIEO), 1974. The IDS was a technical manifesto, but NIEO was the political manifesto. Health was a part of the IDS's HD approach as mentioned earlier, whereas in NIEO the issue of health was abstracted within the demand of new economic order. NIEO conceptualised health as one of the end outcomes. The main agenda of the NIEO was to pull the developing countries and LDCs out of the yoke of dismayed conditions factored by inequality, injustice and poverty by the expansion of 'industrialisation' (aided with science and technology) (UN General Assembly Resolution, 1 May 1974). Industrialisation was envisaged to be as means to reverse the then exclusive nature of political and economic systems for achieving the 'ends': "*better conditions for all peoples to reach a life worthy of human dignity*" (UN General Assembly Resolution, 1 May 1974, para.6).

If IDS posed a crisis, then NIEO appeared as an emergency on the forum of IG. The demand for NIEO got overwhelming support owing to the three major aspects; dissatisfaction from unjust trade policy, caucus of oil countries to restrict oil export which escalated the international energy crisis (known as first oil shock), and ever escalating economic inequality resulting social disparity especially in the developing countries (*Gebremariam* , 2017, p.24). The NIEO outrage within the UN system made a political outcry for not having any just world economic policy. The Bank primarily as an international economic institution could not avoid its role in the NIEO crisis. Apart from focussing on HD programme oriented lending practices, it was also in search of a new theory to overcome slow economic growth. Finally in 1974, the Bank moved from the age old trickle-down theory of growth to "Redistribution with Growth" (RWG) theory for economic development. The Bank published (in association with the Institute of Development/IDS, Sussex, United Kingdom) RWG was indeed a landmark theoretical referent to address the growth issue in Third World by alleviating poverty (Chenery, Ahluwalia, Bell, Duloy, & Jolly, 1974).

This RWG thesis of the Bank later on served as theoretical background for the Bank's health system policy (as discussed in the next part), and that was the bone of contention between Alma-Ata and World Bank. This discontentment over theoretical understanding evokes the question of perspective, the development perspective. The Bank's adoption of SPHC over CPHC was at the behest of RWG theory of development perspective. On the other hand, CPHC approach was the strategic outcome of the IDS, 1970 where the IG actors were asked to "*assist the developing countries in their health planning and in the establishment of health institutions*" (UN General Assembly Resolution, 24 October 1970, para 68). WHO-UNICEF, "*based on the New International Economic Order*" ultimately wanted to materialise the development perspective of IDS, 1970 (IDS was the technical reference of development in NIEO), thus declared that economic and social development '*is of basic importance*' for fulfilment of Health for all (WHO – UNICEF, 6 – 12 September 1978, Declaration No. III, p. 2). The Bank debilitated the Alma-Ata through SPHC in order to cripple the political line of NIEO and fetter the development strategy of IDS, 1970 in IG.

3.1.2 Economic rationale

The NIEO dissent pushed the Bank towards the brink. The change in the economic theory of growth in 1974 at the onset of NIEO crisis was significant, and had subsequent effect especially in social sector policies of the Bank (Ayres, 1984, p. 82 – 83). RWG was a promise to the dissenting Third World that economic justice would be met by adopting that path of development. It became a cornerstone in the Bank's fight against poverty and also theorising health system policy formula. Yet the Bank's new *knowledge* was harshly critiqued as a production of 'preoccupation with poverty' to manage political unrest, and termed as target group politics (addressing only the population below poverty line), instead of offering any genuine solution for the Third World economic distress (Leys, 1975). To the Third World, the Bank's poverty approach (of RWG) was a substitute, but not the ultimate solution of the central problem as demanded in NIEO, i.e. industrialisation (Ayres, 1984, p. 79 – 80). Concomitantly for Bank, RWG was not only a new knowledge of economic growth theory pitted against the NIEO demand, but also a counter to the IDS, 1970 development strategy as shown in the case of political management.

Out of criticism about the opacity of RWG, the Bank's search for 'development' under the clout of NIEO was on. In that journey, the next stop was basic human needs. The International Labour Organisation (ILO), by the mid of 1970s (1976 – 77), in assistance with the UN system and World Bank, UNICEF, UNDP, and OECD countries developed the Basic Need (BN) approach as development strategy through World Employment Programme (Emmerij, 2010, ILO, 1977; ILO, 1978). The approach emphasised on meeting basic human requirements (food, shelter and housing) and services (public transport, sanitation, education safe drinking water, and health) (Singh, 1979, p. 585). Though the basic need strategy got developed in response to the NIEO demand, the fundamental agenda of the NIEO (industrialisation in the Third World) remained "*hard questions*" and had "*no absolute, definite answers*" (ILO, 1978, p. VIII; and Singh, 1979, p. 586).

The basic need development strategy got political back-up in IG, probably owing to its human development concerns. This made the Bank to soon encapsulate the RWG's poverty alleviation strategy into the basic need development strategy (Emmerij, 2010, p. 1- 2).[19] Thus the capsule of development strategy might be basic need, but within that the ingredient salt was RWG. RWG thesis not only shaped the SPHC approach, but also served as a point of reference for all other future health system policy – designs – projects. In fact, its fundamentals can be found even in present-day HSS initiatives. In the box, the gist of the RWG thesis is presented especially focussing on the Bank's definitive understanding on health.

Table 3.1: RWG Economic Framework of Health

Problem	Health was considered as a factor of absolute poverty, since poverty (cause by poor health) inversely correlate with income and consumption levels (p. 10).[20]
Solution	Long-term subsidy for the creation of physical (infrastructure for public provision) and human assets (human skill/capital) in order for greater productivity and increased purchasing power of the poor (p. 48). In the economic framework, one of the five main suggestive strategies was "*some direct consumption supplements for specific target groups (child nutrition, maternal health services) are a necessary supplement to an investment-*

[19] The strategy, 'Redistribution from Growth', was first introduced by Prof. Hans Singer in 1972 for an ILO Employment Mission to Kenya. The idea of Basic Needs was conceived as a ballpark figure within that strategy (ILO, 1972, p. 201).

[20] Absolute poverty is when lack of income affects the absolute standards of living. Some other factors are nutrition (for calorie intake), education, and sanitation etcetera.

	oriented strategy, since they are the only way to alleviate some types of absolute poverty" (p. 48 – 49).
Postulate	Public consumption goods and any investment on this area are equal to subsidy schemes. The provision of consumption goods is closely related to "*production-oriented approach*" (p. 85). Here, RWG thesis did not distinguish health and public health separately, rather they were used intermittently.
Justification	"*Provision of public infrastructure, health, nutrition, and education, are better viewed as parts of a package designed to raise the productive capacity of the labor force*", thus any distinction between investment and public consumption is a discretion based on the actual need (p. 85, footnote 18).
Strategy	Consumption subsidy is an important distributive strategy, since it does not get affected by the behaviour/technologies of factor and commodity market, and at the same time the types (consumption goods) and beneficiary (target group) can be easily nominated as per the production need (p. 85). In addition, population policy was also considered as a long term strategy (p. 99).
Instrument	The public consumption goods deserve to be financed (for example, "*public health expenditure*") through fiscal system (p. 85).
Mechanism	Poverty groups: The bottom forty per cent represent low-income group based on the socio-economic characteristics. Inequality determinants: Inequality in terms of income is a measure of relative poverty, which determines access to services (or consumptions). The inequality determinants (services) to be identified for possible policy measures (p. 18).
Policy intervention: infrastructure	Knowing that due to lack of institutional capacity and organisational infrastructure, consumption subsidy would be a highly capital intensive and time taken programme in the poor countries. The suggestion was made "*that consumption support schemes should be carefully chosen to minimize costs of infrastructure development*" (p. 86).
Policy intervention: service package	Health policy in the Third World was advised to focus on the needed public health measures including "*mass immunization, out-patient care in clinics, and quantity oriented hospital care*". The emphasis also added for producing paramedics and auxiliary health workers, instead of investing on preparing qualified doctors, to serve poor (p. 151).[21]
Policy intervention: technology	The thesis did not give any concrete suggestion on the production, usage and transfer of technology for health and nutrition intervention, except urging the poor countries to invest in the appropriate area of research. It acceded that the monopoly of First World would continue in the production and use of technology, and Third World is unlike to get any support/benefit from the former (p. 88 – 89).

Source: The Redistribution with Growth thesis is consulted to prepare this table (Chenery, Ahluwalia, Bell, Duloy, & Jolly, 1974).

[21] This particular set of measures was made for urban target (poor) groups, however at the end of the chapter (VII) joint urban and rural health policy was recommended. Separate health intervention strategy for rural area was not mentioned.

In a nutshell, The Bank's RWG thesis (Chenery, Ahluwalia, Bell, Duloy, & Jolly, 1974, p. xiii) found that traditional welfare economics model of separating optimum growth from distribution policy is ineffective, and the empirical necessity is to identify "*different approaches to policy and for evaluating their effects on poverty*". Thus the new theory for the Third World was to frame development strategies with "*growth implications for different groups in society that can be modified by fiscal measures only within fairly narrow limits*" (p. xiii). To address poverty, it was hypothesised due to the presence of rich farmers, big businesses, "*so-called petit bourgeoisie*", and organised unions, the asset transfer (transfer/redistribution of ownership of land/property) as a principled public investment is a risky strategy compared to consumption subsidy (p. 262). Hence, consumption subsidy was strategised as governance principle for dealing with poverty. Accordingly Bank developed "*policy package*" of services for addressing the need of "*poverty groups*" (p.xv).[22] This would become the economic rationale behind the Bank's health system policy formed in 1980.

This is, in short, the background of Bank's health system policy formation in IHG. The complex over appropriate development strategy (IDS, 1970 or RWG, 1974), dissent of the Third World, and the tussle of power within the IG had acted together to prepare the structure for not only Bank's health system policy but also uphold Alma-Ata in IHG. The following section discusses the role of the Bank in IHG in the formulation of health system policy.

3.1.3 Technical assistance

The spirit of NIEO percolated from economic development to other social development arena. It inspired WHO-UNICEF in IG and IHG to uphold the Alma-Ata Declaration in 1978 to achieve Health for All by 2000 (WHO – UNICEF, 6 – 12 September 1978). The Declaration's strategy of CPHC approach to plan and organise the health system is a landmark in the organisation of health service, and considered a watershed moment in IHG. In the discourse of Bank's health system policy, the CPHC approach and its difference with the SPHC approach are required to be discussed to understand two critical points. First, the basic characteristic attributes of health system policy that

[22] The RWG thesis identified the "poverty groups" based on economic characteristics (industry sectors-rural/urban, employment status, ownership and availability of capital.

remains the guiding principles for last forty years, and second to know the theorisation of Bank's health system policy formula.

The counter to Alma-Ata prescribed health system policy began after the alternate perspective launched in 1979 – *Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries* – that was projected as "*most cost-effective form of medical intervention*" for the poor countries (Walsh and Warren, 1979, p.145). The alternate perspective of SPHC proposed selective disease-package based on the methods of descriptive (prevalence, morbidity-disability, mortality) and analytical (feasibility of control intervention with regards to efficacy and cost) epidemiology to cater the need of mostly poor population (especially targeting children and women). This had fuelled debate within the academia. The merits of economic efficiency (by Walsh and Warren), political freedom (by Boland and Young), and resource management (by Evans and team) in SPHC were challenged by others pointing out the demerits of methodological imperfections, analytical flaws, and lack of empirical evidence found in the Walsh and Warren's 1979 paper (Banerji, 1874; Barker and Turshen, 1986).[23]

The contestation of two health system approaches between CPHC and SPHC is till date relevant and seems never ending, courtesy to differences over ideologies – perspectives – positions – interests – effectiveness, but not on the line of scientific reasoning as follows.[24] This section embarks upon an analogy to delve into the embodiment of the conceptualisation of health to analyse the methodology of two approaches of the health system (CPHC and SPHC) in order to understand the Bank's health system formula. The Bank was instrumental as a provider of technical assistance in IHG in all these three steps (conceptualisation, methodology, and formulation).

3.1.4 Conceptual definition of health

The concept of health in the Bank's health system is found to be definitive (and not abstract) and interrelated with classical model of management approach (discussed in

[23] Boland and Young argued that political freedom was restricted in the CPHC run countries (namely Cuba, China and Tanzania)

[24] Scientific reasoning is a method of abstract thinking that consults multiple dimensions, propositions and probabilities to test hypothesis systematically. (Source: https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199734689.001.0001/oxfordhb-9780199734689-e-35#oxfordhb-9780199734689-div1-228. Accessed on 11 December 2018)

the methodology part). The definitive concept of health is best captured in the Bank's first ever health policy paper of 1975 (*Annual Report*: WB, 1975, p. 19):

The issue is one of more than equity alone; it is also economic, for ill health imposes economic costs by impairing the productivity of both workers and capital goods, and by reducing the availability of labor. To promote economic development, the poorest in developing societies must be permitted and encouraged to become as productive as resources permit. As health conditions and economic development are fundamentally related, the majority of the people cannot be denied access to better health care without damaging national development prospects.

The definition of health is based on the economic understanding of the body. A productive body is required for economic purposes, and an opposite of that is considered economically ineffective. Thus, the body should be protected to remain productive and economically effective. The objective is health intervention should ensure productive body (or labour) for capital output in order to generate economic growth. Hence, productivity is the benchmark for any health system to achieve economic prosperity. This conceptual understanding indeed has a theoretical root in the Bank's RWG thesis of 1974. Important to note, Bank's conceptual understanding on health surfaced (in 1975) after the RWG thesis (in 1974) developed the theoretical frame with regards to health care services. Hence, conceptual understanding on health was definitive as it was preceded by theory.

This notion of conceptualisation shows why the two health system approaches are fundamentally different. Alma-Ata conceptualised health as an "*action*" for the "*economic and social development*" for "*the fullest attainment of health for all*" (WHO – UNICEF, 6 – 12 September 1978, Declaration no. I and III, p.2). It theorised that *socially and economically productive* lives are "*social target"* (or ends) for the national and international communities, wherein the means was CPHC approach (WHO – UNICEF, 6 – 12 September 1978, para. V, p.3). Thus CPHC approach was entrusted to develop a methodology that would "*evolve from the economic conditions and socio-cultural and political characteristics of the country and its communities*" (WHO – UNICEF, 6 – 12 September 1978, Declaration point VII, p.4). In contrast, the above definitive concept of health reflects that the Bank theorised productive bodies as means for the economic development (end). Thus the body is considered as a point of

intervention, the body of poor! Hence, inadvertently SPHC was given the task to make those 'poor' bodies "*as productive as resources permit*". This resource allocation versus production assumption is essentially a statement of cost-effective intervention – the core of SPHC methodology. Without doing much, SPHC inevitably became the 'magic bullet' methodology for protecting productive bodies assuming to benefit the economy.[25] The Bank finally developed *antibody* called SPHC to 'protect' from the health events.

3.1.5 Methodology of two health system approaches

Both the CPHC and SPHC approaches are two different methodologies to organise health system. These two methodologies provide functional base to develop and operate health intervention programme. In other words, they are programme management frameworks. In the following table, the WHO – UNICEF Alma-Ata, 1978 Declaration (WHO – UNICEF, 6 – 12 September 1978) and the Bank's 1980 *Health Sector Policy Paper* (WB, February 1980) are used to identify, understand and analyse the contrasts between the two methodologies. Both the documents are health system policy documents and have historic importance in terms of designing the system and shaping the future policy actions. This research develops system-level variables to compare the methodology of two approaches under three distinct dimensions.

Table 3.2: Comparison of methodology of health system approaches (CPHC vs. SPHC)

System variables	CPHC (1978 Alma Ata Declaration: WHO – UNICEF, 6 – 12 September 1978)	SPHC (WB 1980 Health Policy paper: WB, February 1980)
System method		
Problem	Complex, costly, and ineffective health care system (p. 38, para. 4 and 5) Reasons: Prioritisation of medical technology centric health care system which are devised outside the domain of economic and social development	Poor health status (p. 20 – 27) Reasons: - Population explosion - Malnutrition - Basic standards of living (water, sanitation, and housing)
Management Approach	System approach: To design health system in harmony with economic and social sectors (p. 38 – 39, para.7 and 8)	Classical approach: To Identify the most productive investment for better health in order to attain socio-economic development (p. 30 – 32)

[25] The cost-effective intervention of the Bank was known as magic bullet medicine (Beaglehole and Bonita, 2004, p. 268).

System variables	CPHC (1978 Alma Ata Declaration: WHO – UNICEF, 6 – 12 September 1978)	SPHC (WB 1980 Health Policy paper: WB, February 1980)
Role of the state	Health as a fundamental human right (p. 2, Declaration point: I)	Health as a productive investment (p. 30)
System policy		
Goal	Quality of life and maximum health benefits to the majority of people (p.38, para:8)	Reduce disability (p.31), mortality, and morbidity (p.55) in order to get *freedom from the threat of disease contribute to economic development* (p. 30)
Strategy	Health service development	Health care service delivery development
Mechanism	A) Intersectoral development: agriculture, gender, water and sanitation, housing, public transportation, education, mass media, industrial sector (p. 46 – 49) B) Community coordination: through internal coordination of community workers (p.49, para:40), representation of local bodies (p.49, para:41) C) Community participation: self-reliance/technological independence (p. 50, para:43), Collectivisation (p.50, para. 44 – 47)[26] D) Political will: Safeguarding of necessary human, material, technical and financial resources using legislative and administrative routes (p. 51 – 52, para:48) E) Decentralisation: Coordination between central administrative level and local level by strengthening the intermediate level at the province or district (p.52, para:49)	A) Basic infrastructure: (i) Development of primary (managed by six-month trained CHWs) and secondary care (staffed by two-year trained paraprofessional) (p. 44 – 45) (ii)Training of CHWs and paraprofessional (p.63) B) Logistical management of drug and other supplies (p.45) C) Healthcare financing (p. 46): (i)Additional resource generation for first two tiers by the government. (ii)Local fund generation (through existing insurance/cooperative schemes) (iii)Centrally administered fund based on per capita instead of direct payment (it was hypothesised to strengthen local participation in management, control and optimise waste) D) Technical Support: *Development of management capacity* (p.63)
Planning	Three-stage (bottom-intermediary-central) planning with multidisciplinary outlook (p. 54 – 55, para: 52 and 55)	No plan outline (in one occasion, the policy document accedes that Bank never involved into health planning, p. 60)
Service delivery	Bio-social model that includes essential health services package along with education, food safety, nutrition, safe drinking water and sanitation (p. 4, para: 3)	Bio-medical model that deals with only essential health service package (p.17, footnote 18). Package: named as 'basic health care' – *maternal and child health care, family*

[26] Collectivisation as a concept is linked to the practice of collective ownership of community production. The concept was recommended (without mentioning the term collectivisation) as a method for community participation in the management of health service. Prof. Debabar Banerji contemplated that as 'social control' of health service (Banerji, 1984, p. 314).

System variables	CPHC (1978 Alma Ata Declaration: WHO – UNICEF, 6 – 12 September 1978)	SPHC (WB 1980 Health Policy paper: WB, February 1980)
	Package: essential health services (a set of public health measures along with M/RCH services, and vaccine preventable diseases) (p.34) Coverage: Universal, especially targeted for socially backward categories (p.40, para: 12)	*planning, immunization, prevention and control of endemic diseases, and treatment of common diseases and injuries* (p.17, footnote 18) Coverage: Targeted, permissible to expand over time (p.63)
System levers		
Role of the government	Ideal: To be active in *national managerial process* from planning to financing (p. 67 – 68, para. 97 – 98), and with a secondary role (to community) in implementation (p. 69, para.101 – 104 Situational: May collaborate with local voluntary organisations for service/financing (co-payment, in extreme cases) (p. 72 – 73, para.112 – 115)	Practical: Government to manage the entire service since market mechanism is theoretically unfounded. (p. 34 – 36)[27] Futuristic: Government to promote private sector development measures (both financing and service delivery) for *relatively affluent* (p.35)
Role of the community	Community was considered as the primary owner of the PHC (p. 49 – 52, para. 40 – 48)	Community was considered as beneficiary, and not as stakeholder, (p. 61 – 62)[28]
Role of the technology	Technology to be appropriated (based on local needs and local resources) in order to be subordinated to the people (p. 59 – 61, para. 72 – 76)	Medical technology should "*obtain the respect and cooperation of the community*" (p. 61).[29]

The above comparison shows that two approaches formulated methodology for design and development of health system policy in the Third World by using three system dimensions (methods, policy and levers). The concern was same, to get rid of abominable condition of health. The problem diagnosed by two approaches was from two different understanding of development (IDS vs. RWG as discussed earlier). For the poor status of health, CPHC identified that isolated medical technology induced health care delivery is not in sync with the socio-economic context. In opposition, the

[27] The policy noted that market mechanism can not address (i) information asymmetry, (ii) negative externalities, (iii) moral hazards (over medicalization/technology induced). Similarly, private sector boosters, such as effective demand (due to poor purchasing power) and competition (lack of presence of private sector), were missing. Thus the Bank's advice was that government should lead the large scale cost-effective programmes (WB, February 1980, p. 34 – 36).

[28] Community participation was, earlier in the Bank's projects, experimented through the activities of 'change agents'/community leaders (for advice) , community meetings (for collective decisions), and community mobilisation (for sustainability of the intervention)

[29] The Bank's understanding of appropriate technology was not 'appropriate'. For example, it listed relying on mid-level health worker, using simple and inexpensive building – infrastructure, and modest administrative and supervisory capacity as usages of appropriate technology (WB, February 1980, p. 63).

Bank prescribed SPHC identified that excessive population, malnutrition and living standards were behind the conditions of poor health. To address the problem, the Alma-Ata took a 'system approach' to design a system that would ultimately manage health care delivery but primarily to be based upon the larger socio-economic development. The Bank, in turn, bestowed its faith on the 'classical approach' of management organisation (investment vs. return) in order to find socio-economic development.[30] Thus for State, as per SPHC, health is to be a subject of investment instead of right, and a policy of protection (mortality, morbidity, disability) and not wellbeing (quality of life) as conceptualised in CPHC.

The strategy (philosophy, as per Banerji, 1984, p.314) of CPHC was health service development, and not the development of health care service delivery (of SPHC) in specific.[31] It is more evident in the way the mechanisms were devised; CPHC outlined the foundation of organisational structure of the health service, whereas the Bank stressed on the infrastructure and skills building to provide care. The Bank's preference for SPHC over CPHC on the grounds of cost-benefit (saving government's finance) and cost-effective (maximum coverage to population) criterions under the investment viewpoint are found abstruse (WB, February 1980, p. 35). Because both the health system approaches advocated for almost identical basic/essential health care packages (service delivery strategy). Finally difference over management approaches and mechanisms at the end impacted on the system levers also. As a result, according to the SPHC, government was considered as financer and provider, and not overall manager; the community as clients/beneficiaries, instead of owner/provider/manager; and the technology was conferred with 'big is better' school of thought, as an alternative to the '*small is beautiful*'.[32]

In the time of distressed socio-politico-economic conditions, CPHC advised to adhere to the principles of self-care (for individual), self-reliance (for community) and self-

[30] There are five types of method (management approaches) to deal with management and managerial activities, system and classical approaches are two of them. Classical approach is a method of cutting cost (investment/input) and achieving results (return/output) by improving efficiency, productivity and output. Whereas System approach deals organisation of any management as whole system (consists of the elements/components involved in the steps of input, process, output, outcome, impact) to take actions and make decisions (Source: http://wiselifemag.com/blog/4-management-approaches/).

[31] The distinction between health and health care, health service and health care service, health system and health care system are discussed in detail in the next section.

[32] Small is Beautiful, 1973 is a name of the book of Dr. E F Schumacher, popularly referred in the debate of appropriate technology to opine people's domination over technology.

determination (for nation-state) in order to attain technological independence, rather be contingent on medical technology – the only economic measure taken by CPHC but on technical efficacy ground.[33] Alongside, the SPHC's logic of economically effective (based on costing exercise) intervention approach was based on assumption, and undefined in the seminal work of Walsh and Warren, 1979, and in the Bank's 1980 *Health Sector Policy Paper*. SPHC overshadowed CPHC not because of economic rationality. The Bank lent its weight behind SPHC on political purpose, to neutralise the effect of NIEO (constituted Alma-Ata), and to denounce the presence of USSR, because of tension between First vs Second World, as it financed the Alma-Ata event (WHO – UNICEF, 6 – 12 September 1978, p.12). However, it is not clear whether Bank perceived collectivisation method of CPHC was a strategy for 'revolution from above'.[34]

Irrespective of that, CPHC, as a technical manual of health system approach, first got plummeted into the debate of economic efficiency and then wedged in between political crisis of South and North, as a result health system was infected at the stage of embryo and eventually got delivered as health care system. This is the difference over the chosen methodology of two health system approaches. The de-legitimisation of CPHC to SPHC may appear as a cause of Bank's technical assistance, however the technical assistance was driven by political management and economic rationale as discussed in the respective sections.

3.1.6 Theoretical understanding of health care service

The negation of CPHC in IHG could be symbolised by the formulation of Bank's health system policy in 1980. The formula again like conceptualisation is theoretically linked to the RWG thesis, which outlined the principles to deal with health care service delivery as discussed in the economic rationale section. The RWG model made a simulation, which was not very definite as per the thesis but still suggested that package

[33] In a quite opposite view, Navarro (Navarro, 1984, p. 170 – 171) once fiercely critiqued Alma-Ata Declaration for representing the interest of development establishments of West by not coming out of hegemonic medical ideology and ignoring the politically determined factors responsible for poor status of health in the Third World.

[34] For record, Alma-Ata PHC report did not even use the term "collectivisation", though the advisory on community participation mechanism (as mentioned in the CPHC – SPHC table) had the tenets of collectivisation (*per se* consolidation of community ownership) tendency. In November 1927, Joseph Stalin launched twin goals (rapid industrialisation and collectivisation of agriculture) of Soviet domestic policy under the strategy of 'revolution from above'.

of "*better nutrition, health, and access to education opportunities*" is perhaps the most important production-oriented public consumption goods (Chenery, Ahluwalia, Bell, Duloy, & Jolly, 1974, p.221). This proposition had formed the theoretical bedrock of the Bank's health system policy. It means that production-oriented public consumption goods (health care service delivery package) have high value of labour productivity (protecting the labour from ill health/diseases) and therefore may increase capital output ratio in labour-intensive economy sectors in future.

The Bank brought in the theory of RGW economic framework for health after the CPHC-SPHC debate erupted in order to formulate health system policy. This research develops the table below to depict the Bank's formula of health system policy.

Table 3.3: Policy formula: World Bank's health system

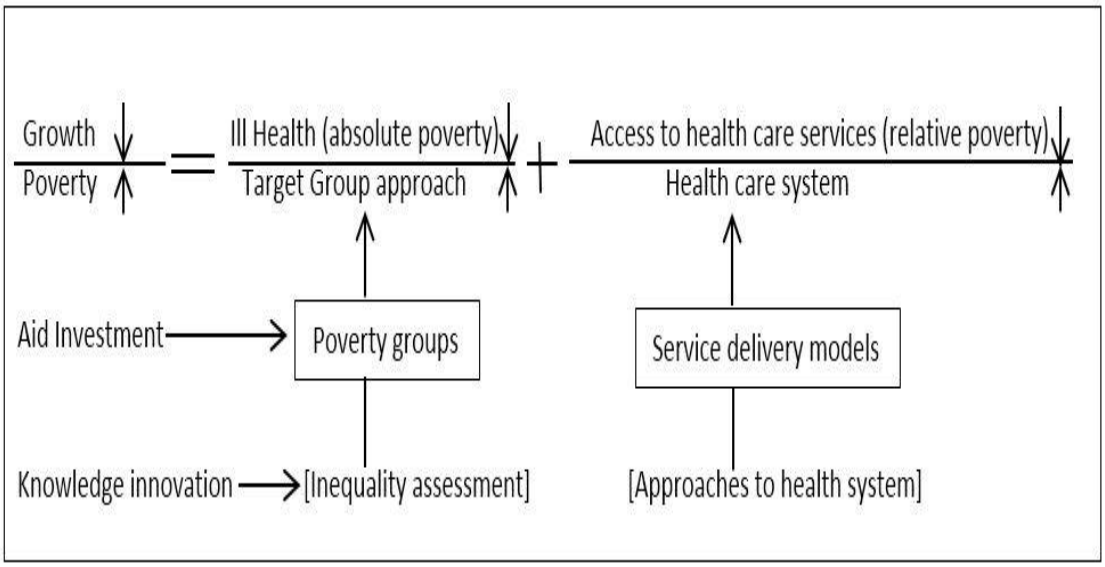
Problem identification	Slow economic growth resulting poverty and thus causing ill health
Problem statement	Trickle-down theory of growth is ineffective, and to be replaced by the RWG to address poverty and the poor status of health
Reasoning	i. Poverty causes ill health and thus hamper productivity of the labour force ii. Ill health is unproductive and negative for capital growth iii. Productive labour is required for increase in capital output ratio to generate growth[35]
Goal	Alleviate poverty: i. Absolute: Health events (disability/morbidity/mortality) ii. Relative: Access to health services
Policy formulation	i. Health protection: Protect the bodies (of target/poverty groups, the bottom forty per cent.) ii. Access to health care services to reduce inequality: Select disease-packages, accordingly organise logistics, building infrastructure, and develop skills

The above table shows that slow economic growth was diagnosed as cause of poverty which snowballed to ill health. That was the justification to bring an economic growth theory (i.e. RWG) in developing health system formula. The formula was based on the goal of alleviating poverty by addressing health events and access to health care

[35] Economic growth is calculated from the level of saving and rate of investment. Incremental Capital Output Ratio (ICOR) is the additional capital (investment) that is needed to generate additional output in the economy.

services. It formulated that body to be protected (definition of health) and therefore necessary services to be organised (design of service delivery) for the target groups which essentially means bottom forty per cent of total population. The below sketch further illustrates the theory behind health system formula.

Figure 3.1: World Bank's health system theory



The growth and poverty (divided between absolute and relative) have an inverse relation in the Bank's understanding of slow growth rate of economy. This causes absolute and relative poverty and finally impacts as ill health and poor access to health care services respectively. Based on this reasoning, the Bank strategised two-fold method, aid investment and knowledge innovation. Through aid investment (physical resource), it first stressed to cater to the target group population who suffered mostly from ill health to address absolute poverty. Second, it focused to finance the service delivery model that would reduce access to service related barriers for addressing relative poverty. Knowledge innovation came as a technical resource to identify the target groups by assessing inequality and devising effective methodology of health system approach (i.e. SPHC in the Bank's case) for designing and organising service delivery model. Aid and knowledge in the Bank's health system formula are complementary to each other since the inception.

This formula of health system was fundamentally different from Alma-Ata's health system formula. Alma-Ata's proposed Primary Health Care was a combination of essential health care service package along with social determinants of health (food

supply, water, education etcetera) (WHO – UNICEF, 6 – 12 September 1978, p. 4, Declaration no. VII, point 3; and p.24). Conversely, the Bank proposed the 'basic health care' to deal with only essential health care service package, and not with any social determinants (WB, February 1980 , p.17, footnote 18).[36] Thus with these two different health system formulas, the IHG arrived at two different service delivery models, basic health care (of the Bank) and Primary Health Care (of WHO). The service delivery model worked as normative factor to ring-fence the boundary of health system. In the case of the Bank, the model limits the health system policy to consider only disease-based care component. Thus fundamentally it can not cater to social determinants of health unlike Alma-Ata that put wellbeing as a category for economic and social development (WHO – UNICEF, 6 – 12 September 1978, p. 2, Declaration no. I). This justifies why the Bank's health system always has acted as health care system (disease-based) instead of covering wellbeing. Indeed the Bank's first health system policy formula is an all-time winner, and the central plank of both the definition of health and boundary of health system.

3.1.7 Bank's health system policy: Neo-liberal or new-knowledge?

In the timeline of the Bank's health system policy action, the immediate post RWG years were noteworthy. The theory of health system was developed in 1974 in RWG thesis, the conceptual definition of health came up in 1975 Bank's first health policy paper. Thereafter from 1976 to 1978 fiscal years, the Bank supported 70 health (as sub-components) projects in 44 countries (WB, February 1980, p. 56). The Bank undertook a serious turn towards health system after the Alma-Ata Declaration (happened in 1978) by co-organising Bellagio Conference in 1979. In 1980, it finally brought out health system policy formula in the health sector policy paper. So, the timeline of the Bank's health policy action denotes that logical coherence of concept-theory-formula in policy making exercise was replaced by theory-concept-health policy formula dynamics. This dynamics was the outcome of the Bank's political management and macroeconomics justification to address the NIEO stalemate in IG. In that process, the Bank's health system policy had become nothing but semantics. Thus health system policy was a product of the Bank's political skill in order to handle the South-North crisis.

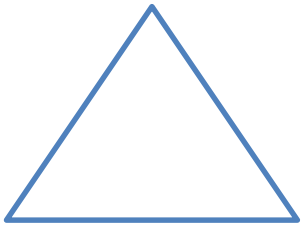
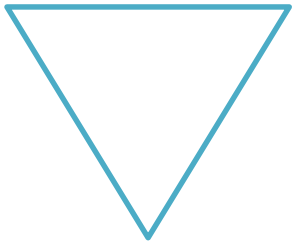
[36] The World Bank's Health Sector Policy Paper, 1980 clearly mentions that basic health care does not include any social determinants of health (WB, February 1980, p.17, footnote 18).

The discourse of health system has always been debated over two types of thinking; ideological and developmental. The Bank's political manoeuvring for establishing economic argument in SPHC has contributed much in producing the first debate; conceptual ambiguity over the ideological affiliation of SPHC. The Bank's weightage for SPHC always has been credited to its marshal of neo-liberal ideology (Cueto, 2004, p. 1872). However, terming SPHC as neo-liberal mechanism, launched by Thatcher (in 1979's UK), Reagan (in 1980's USA), and Kohl (in 1982's Germany), is too generalised. Indeed, the Bank's dominant ideology was (and is) neo-liberal where economic growth is a fundamental principle. But that ideology did not engineer all the mechanisms produced in the decade of 1970 (Ayres, 1984, p. 74 – 75).[37] The Bank's ideological affiliation is nothing but a primer in the discourse of health system. The brick (RWG) and plaster (poverty alleviation) were completely different from that primer and veneered as knowledge innovation, which employed much before the so-called official neo-liberal regime launched by the Developed countries.

Similarly, the Bank's acrobatics with regards to finding economic rationale to promote SPHC created misperception over the approach's development orientation. In one view, SPHC was masqueraded as an outcome of basic need development strategy (Buse 1994, p. 97; Ruger, 2005, p.65). On the other side, CPHC was also once considered as an advancement of basic need approach (Barker and Turshen, 1986, p. 73). Of course, the credit should go to Bank for obliquely taking the idea of human development into RWG from IDS, and thereafter repackaged RWG as basic need.[38] The primary worldview of basic needs was human development (or human skill building). Whereas human development was actually one of the ten policy measures in IDS (*number 8*), and constructed as a unified approach of economic and social development (UN General Assembly Resolution, 24 October 1970).[39] Human development was the common link between IDS (1970), RWG (1974), and basic need approach (1975) of development strategies, however with different connotations. That gave the opportunities to the Bank to tactically use human development as and when needed.

[37] "Liberal" is used in the sense of classical economics. The term neo-liberal is used in its original sense, i.e. Mont Pelerin Society's neo-liberal framework for political management of economic affairs.
[38] It is evident that international aid under the patronage of International Economic Governance (IEG) was strategically directed towards basic need linked aid investment (Streeten, Burki, Ul Haq, Hicks, & Stewart, 1982; Mathieson, December 1980).
[39] In fact, the PHC report of Alma-Ata did not use the terminology 'basic need' even for once in the entire Declaration (WHO-UNICEF, 6 – 12 September 1978).

Figure 3.2: Development models in CPHC and SPHC

		
Base	Economic and social development	Human development
Approach	CPHC	SPHC

The neo-liberal bracketed CPHC-SPHC debate has been hovering around to critique the ideology driven practices, while the Bank has been active in producing incrementally innovative 'knowledge' to validate those practices. Amidst these debates and discussions, the above diagram drawn from the previous argument depicts that fundamental difference between CPHC and SPHC is the theory of development. SPHC was built on the theory of human development, whereas the CPHC was theorised as a dependent variable of economic and social development. The unavailability of this distinction has made enormous difficulty not only in planning, designing but also in analysing health system. The health system paradigm is reduced into socialist vs capitalist, public vs private and bottom-up vs top-down debates at the cost of theoretical wrong.

The CPHC-SPHC conflict made structural changes in IHG. The WHO's Alma-Ata was political in nature (since the Declaration made in the spirit of NIEO, WHO – UNICEF, 6 – 12 September 1978, p.2), but technical (CPHC) in form. Concomitantly, the Bank's basic health care projects (1980 health sector policy paper) was technical in nature (SPHC), but political in form (due to its lending power). The WHO is a technical organisation, but the Bank is a financing institute. Adopting WHO's technical advice (on CPHC) was considered as culpable to uphold NIEO, but accepting Bank's technical assistance (of SPHC) appeared as a financial complement to development projects. The WHO gave an outlay for the countries to design the health system for developing the health service, but the Bank's basic health projects offered finance to design the health system according to the health care delivery system. The poor countries were financially distressed (due to debt cycle), and politically vulnerable (because of

abominable conditions of basic standards of living). They were in need of finance, and not only advice. This is how in IHG, political (power of lending) appropriated technical (CPHC), and over time technical (SPHC) replaced political (Alma-Ata). As a consequence, knowledge has become political!

Political knowledge over the time got materialised into governance aid in the IHG. The materialisation (from knowledge to aid) worked in two ways in IHG. First, it bought in an *instrumental change* (over the time) by characterising a different form of health system. Second an *intrinsic change* (onetime) was introduced by professing that SPHC led health system would only deliver economic growth. While the intrinsic change was a kind of change in theory, the instrumental change was operational. The knowledge as an instrument replaced the character of Alma-Ata proposed health system with Bank's health care system.[40] That sustenance of instrumental change was possible because of the intrinsic change (the efficacy of SPHC over CPHC) took place at the beginning. The differential characteristics enlisted below have already discussed to draw contrast between Alma-Ata's CPHC and Bank's SPHC. The tabular format is prepared to give an understanding that which health (care) system was finally championed under the aegis of IHG, and especially by the Bank.

Table 3.4: Difference between health system of Alma-Ata and health care system of World Bank

System Characteristics	Health system of Alma-Ata	Health care system of World Bank
Integration	Health	Health care
Organisation	Health service delivery	Health care delivery
Interdependence	Economic and social development	Human development
Objective	Wellbeing	Protection
Interaction	Bio-social	Bio-medical

The above table depicts the physical characteristics of two different health systems. The Alma-Ata proposed health system was replaced by the Word Bank financed health care system because the Bank set the tone of health system discourse in IHG through its aid

[40] The Bank from the beginning was referring health system as health care system on the grounds of stated differences.

investment in health. The Bank's commencement of health system was a pathway of innovations made on antidote (population control to eradicate poverty), antigen (nutrition assistance to enhance productivity), and antibody (health care to protect the body) to address the failure of IG in the economic and social development of Third World. The innovations were the outcomes in response to the politico-economic crises in IG, and devised as inputs for technological assistance. Thus the embryo of health system was conceived over the dynamic interaction of poverty-productivity-protection complexity. However, this complexity of embryonic health system phase did not make the Bank to develop an aid investment policy on health care system.

The health care system was formed in response to the development crisis. The Bank's roles during NIEO crisis were not determined by neo-liberal principles (or as such favouring the market) at the phase of embryonic health system, neither the Bank had ever offered any state-led development model. The model adopted by the Bank was a techno-political management to handle international economic crisis. Both the political (aid) and technical (policy prescriptions) *governmentality* collectively devised an economic rationale, i.e. growth through the proposition of poverty eradication. The eradication of poverty, Bank's model of development, became an international movement and not the reorganisation of power structure as demanded by NIEO to achieve development. The Bank's health care system was actually the newly formulated means to steer that poverty movement since the end result of the movement was development as proclaimed.

3.2 Health care system (1980 – 1987)

The Bank's health system policy was already theoretically formulated in the stage of embryonic health system. The health care system phase was the physical expansion of health system policy (the Bank refereed the policy as health care system policy).[41] The Bank financed 'basic health care' projects outlined in the 1980 *Health Sector Policy Paper* helped the health system to acquire its physical characteristics by operationally being implemented in the Third World.

[41] World Bank in the decades of 1970s and 1980s always used health care system and not health system in its policy and lending documents. In the health care system phase (1981 – 1988), this PhD research refers to Bank's health care system policy as health system policy, which existed between 1981 and 1988.

The reason behind the Bank's financing for basic health care projects needs special attention to understand why the present-day health system is interlinked to macroeconomics. The period between 1978 and 1982 is of concern in this case. The second oil shock in 1979 (post Iranian revolution) overlapped with the failing raw material prices in the international economy (Toussaint, 2008, p.148). That made the poor countries to become more dependent on the International Financing Institutes (IFI), e.g. International Monetary Fund (IMF) and Bank, for loan. For the record, the Bank increased its lending by hundred per cent between 1978 to 1981 despite knowing that debt crisis was nearer for poor countries owing to spike in interest rates and increasing value of dollar (Toussaint, 2008, p.148). At that point of time, the Bank's maverick president McNamara (Joined in 1968) announced for about-turn to activate *structural adjustment* of the economy in May 1979 at the UNCTAD conference, and the very next year the Structural Adjustment Programme (SAP) was formally launched as conditional assistance programme by the Bank (Kapur, Lewis & Webb, 1997, p.506 and 509). This research considers that launching of SAP paved the way for financing of basic healthcare project and accordingly established the superiority of the Bank's 'health care system policy' over Alma-Ata's health system policy.

The debt crisis in the Third World was looming since 1979, and it finally broke in 1982 (Toussaint, 2008, p. 149). The poor countries were gasping for money to finance even minimum needs for their population. Health care as a part of public service was also in need of budget financing. In that watershed moment, the Bank was also in need to implement SAP for three reasons; establish pro market economy, save the debt trapped countries from economic disaster, and rescue the international commercial banking system (used to offer private capital as loan to the Third World governments) based in the West from getting collapsed ((Dasgupta, 1997, p. 1094 and 1097). That gave an opportune moment to the Bank to design basic health care project funds, and in return implement SAP in the Third World. The basic health care projects were the incentive for the Third World to accept SAP. So, one hand dependency on IFIs for loan weakened the NIEO struggle within IEG. On the other side, Alma-Ata proposed health system policy was still at inchoate level without having any real taker in IHG. In between, the lending for basic health care projects came as a determinant for the poverty strapped Third World population.

3.2.1 Basic structure of basic health care project

The launch of the Bank's health system policy coincided with SAP, both commenced in 1980, but agenda-wise they were completely different. The SAP was a loan-based policy package for countries tied with conditionality to ultimately achieve liberalisation, privatisation, and globalisation in order to make the economy more market oriented (Dasgupta, 1997, p. 1097). However, through basic health care Bank promoted government managed health care intervention. Design-wise also, the SAP was atypical policy-based lending, whereas health care system policy led basic health care projects were typical Bank's project-based lending. The private or market intervention in health care was neither in the agenda nor in the project design of the Bank. Rather it was acknowledged that "*[k]nowledge is still evolving*" in that regard (WB World Development Report/WDR, 1980, p. 53). All the same, the suggestions of these two different policies (SAP and health care system) in regards to private sector may appear as contradictory, but for aid investment purpose they were in quite mutual symbiosis as discussed above. The Bank also stressed for this "*symbiotic relationship*" to make the Bank's contribution more meaningful at the country-level (Dubey, V, 2 May 1985, 1985, p. 7).

Through 1980's health care system policy, the Bank aimed at to build health care service delivery system at the primary level of the countries, the policy emphasised (WB, February 1980, P. 63):

[D]evelopment of the basic health infrastructure, training of community health workers and para-professional staff, strengthening of logistics and supply of essential drugs, promotion of proper nutrition, provision of maternal and child health care, including family planning, prevention and control of endemic and epidemic diseases, and development of management, supervision, and evaluation systems.

This array of efforts was known as basic health care. Thereafter the Bank started lending basic health care projects under the nomenclature of 'primary health'. The policy at the level of operation began with the efforts of strengthening public infrastructure and management services. One of the early basic health care projects financed by the Bank in Peru (November 1982 – November 1993) had all the components (total seven) for developing the capacity of the public system to organise and operate health care delivery services, especially at the level of primary care. In fact, when the main

objective (reduction in mortality and morbidity) could not be achieved, the project modified its strategy to shift the focus to infrastructural expansion (WB, 17 November 1993, p. ii and 11). Another basic health care project in Jordon (May 1985 – May 1993) also shows that Bank interpreted the policy by taking initiative to strengthen the government infrastructure and management services in health care delivery (WB, 13 June 1994, p. ii). The programme theory was to strengthen the government health care service delivery at the primary level by financing on infrastructure and equipment, skill building on management organisation, and training to reduce mortality and morbidity from the most affected diseases.

Bank's model of basic health care was an example of competitive governance in IHG to surpass Alma-Ata's CPHC. This model indeed came to an aid for recipient governments' to develop infrastructure at the primary level of care, but could not be claimed a model of state building in the Third World. The primary reason is that the Bank preached basic health care as cost effective choice, which was nowhere nearer to the definition of state-led development that symbolises strong state intervention and planning. At the same time, it is also required to note that the Bank deliberately kept "*private market*" away from heath care because of its lack in "*social perspective*" and inability to deal with market failure from three dimensions; information asymmetry for "*consumers*", "*presence of externalities*", and furthermore "*health care system possesses many of the characteristics of public utilities*" (WB, February 1980, p.34). That is why none out of four objectives (or even any component) in the Jordon basic health care project had even remotely linked to private sector involvement in health (WB, 13 June 1994, p. ii). Hence, the government was found to be necessary for health care intervention in the Bank's health system policy. This again confirms that the Bank led SPHC or basic health care initiative was not a neo-liberal driven policy. However, the Bank did give a private sector development strategy in 1980's health policy by advising to develop insurance schemes/prepayment mechanisms for affluent section for which public subsidy is unjust (WB, February 1980, p.35).

3.2.2 Governmentalisation and globalisation of Bank's health system policy

The Bank's health care system phase was important from two aspects; 'governmentalisation' and 'globalisation' of health system. The Bank's policy might involve in enhancing the government capacity, but foundationally it was at odds with

the CPHC. This created difference within the IHG as WHO raised objections on SPHC for being technologically deterministic, vertically implemented, and not people centric. This impelled the Bank to get involved in dialogues with WHO and UNICEF – two meetings were held in Bellagio coordinated by Rockefeller Foundation in February 1983 and March 1984. As a result, Bank clubbed with UNICEF (for Universal Childhood Immunisation) and WHO (for expanded programme on immunisation) to form an intergovernmental consensus for prioritising cost-effective services (Warren, 1988, p. 892 – 893). This very international consensus on SPHC was started symbolising as GOBI – FFF model.[42] This governmentalisation of health system helped the Bank to not only acquire recognition as an important health actor in the IHG, but also infuse the health care system policy (and more importantly the 'mind-set' of cost-effectiveness) within the UN governance system.

The other advantage the Bank garnered in the health care system phase was the spreading of the policy in various parts of the world. The power of lending made that possible through the operationalisation of basic health care projects. Also, the interventions of WHO and UNICEF in immunisation and disease-specific programmes indirectly aided the policy since they were in requirement of basic health care infrastructure to deliver the services. The poor countries hardly had any formal structure and policy for general health care services, the Bank financed projects made enormous influence in those areas. This research argues that through health care system policy the Bank implemented basic health care projects, and through basic health care projects it created SPHC type cost-effective policy atmosphere in the Third World. This strategy of aid investment influenced many countries to develop/amend national health policies on the line of Bank's thinking of health system. So, it can be said that long before the policy of economic globalisation materialised, the globalisation of health system (or the Bank's health care system) policy was fallen upon the earth. In the leg up to SAP, the complexity of health system policy made the Bank inadvertently experience a policy paradox!

[42] The GOBI was the acronym for the strategy devised by the UNICEF in 1982 based on the approach of SPHC. The strategy was to address the child health issues through growth monitoring (G), oral rehydration therapy for diarrhoea (O), the promotion of breastfeeding (B) and childhood immunizations (I). The strategy subsequently adopted family planning (F), food supplementation (F) and the promotion of female literacy (F) within the SPHC approach led health intervention, and became known as GOBI – FFF.

3.3.3 Macroeconomics and the causes behind reform the health system

The health care system phase stayed for about seven to eight years. The overarching drive of SAP engulfed the redistribution theory of growth from 1980 onwards, and accordingly subsumed the poverty movement (Jolly, 1991, p. 1819). The change of economic theory from RWG to SAP had made some fundamental modification in the health system policy. The Bank's commitment to fight against poverty became rhetoric and in due course watered down into the Bank's annual flagship publication (i.e. *World Development Reports*, 1980 – 1985) only. Despite all, human development agenda (education, health, nutrition and population control) somehow managed to sustain since Bank did not adopt SAP's 'state withdrawal' principle in this regard. It was evident in the Bank's attempt to stress for the need of budget protection in human development during initial adjustment years of SAP for the respective country (WB WDR, 1980, p. 98). The economic rationality (redistribution theory), political appeal (welfare benefits) and technical superiority (knowledge expertise) of human development programme had convinced the Bank to transmit it from RWG to SAP.

If the beginning of heath care system phase is known to be the transmission point for the RWG led human development model into the Bank's health system policy, then the end of same phase should be known as transgression point for the RWG led human development model from the health system policy. The former was a consequence of the commencement of SAP in international aid politics, as argued earlier, and the latter was the outcome of continuation of SAP. The structural adjustment policy taken by the World Bank became the referent for theoretical reconfiguration of health system policy. The period between 1985 and 1987 was the reconfiguration period. To analyse the reconfiguration, the brief elaboration of SAP is required to understand the 'about-turn' that took place to go for reform in health system, and why the present-day health system is instinctively linked to macroeconomics planning and market.

The structural adjustment was a combination of two broad goals, macroeconomic stabilisation (led by IMF) and microeconomic supply-side reforms (guided by the World Bank) (Paloni, 2008, p.1039). The stabilisation programme, led by IMF, consisting of monetary and fiscal policies is in the domain of the Central Bank of the country (for instance, Reserve Bank of India), whereas the reform in supply-side of the economy (structural adjustment), led by the Bank, is the subject of government in

office. For IFIs, stabilisation fund is generally a short term engagement unlike the Structural Adjustment Loan (SAL) spanning over three to five years.[43] This research is only concerned with SAL since it had been the vehicle of Bank for almost a quarter century (1980 – 2004) to formulate as well as modify many other policies including health system. The structural adjustment had four objectives – liberalisation, deregulation, public sector reform, and formation of institutions (Paloni, 2008, p.1039 – 1040).

Table 3.5: Structure of structural adjustment

Objective I: Liberalisation		
Removal of price control/ceiling	Abolition of trade protection	No restriction for capital market, especially in Foreign Direct Investment (FDI)
Objective II: Deregulation		
Domestic goods market	Domestic financial market	Domestic labour market
Objective III: Public sector reform		
Fiscal reform	Institutional reform	Budget reform
Objective IV: Creating/strengthening independent institutions		
Enforcement of property rights	Independent judiciary	Independent central bank

The four objectives were formed to put the market first and push the state back. The above table is further elaborated to denote the following programme theory of SAL.

Table 3.6: Programme theory of structural adjustment

Agenda	In order to open up the economy, the removal of controls of the state (liberalisation) for free exchange of trade, unrestricted inward flow of foreign capital and investment needs to be in sync with the reduced/eliminated government power (deregulation) especially at the fronts of domestic goods, finance, and labour markets.[44]
Measures	Public sector reform predisposes the process of reorganising fiscal space management, restructure the institutions (conferring autonomy, privatisation etcetera), and reconfigure the budget mechanism.
Conditions	The multiparty democracy is a requirement for the country where the institutional independency of judiciary, central bank, and other democratic institutions to be espoused.

[43] SAP consists of both stabilisation and supply-side reform. SAL is only about the supply-side reform (or structural adjustment) under the policy based lending of World Bank.
[44] Liberalisation and deregulation are often discussed as single unit.

With this structure, the Bank defines the Structural Adjustment (SA) policy as per the World Bank Operational Manual, Statement No. 3.58, Annex II, November 1982 (Greenaway, 1992, p. 906):

"*[N]on-project lending to support programs of policy and institutional change necessary to modify the structure of an economy so that it can maintain both its growth rate and the viability of its balance of payments in the medium term*".

The programmatic follow-up of this definition is known as neo-liberal policy that essentially means capture of the state at the hand of market. It is extremely important to note that Bank exercised the neo-liberal policy on the nation-states' economy based on the assumptive merits that it would increase *growth rate* and enhance the capacity for *balance of payments*. It interprets that Bank again moved back to its trickle-down theory of growth, a quite departure from RWG (Paloni, 2008, p.1040). The difference is that this time it was not state led intervention, rather minimum intervention of state was suggested for a sustainable growth. The two interventions had different means (state plus model of Keynesian economy vs state minus model of neo-liberal economy), but were connected with same ends – capital! No doubt, that SAL "*embodies the drastically new viewpoint that development is hampered not so much by capital shortage as by domestic economic policies that impede the operation of market forces*" (Paloni, 2008, 1040). Why do the market forces need to have a free operation? The answer is, once again, free flow of capital to invest, to create employment, to finance welfare, to develop infrastructure and so on. Capital was the principal base of structural adjustment, and based on it the *domestic economic policies* – reform policy – was formulated.[45]

The return of capital in the search of growth had immensely impacted on the policy structure of health system. It was not the alteration of economic theory (from RWG to SA) but the replacement of principal base (from human capital to capital) should be symbolised as watershed moment in the discourse of health system. The Bank's health system policy was formulated on the basis of human capital (so far refereed as human development) logic, but in line with the structural adjustment, the structure of the policy

[45] The argument on the role of capital in SAP is also briefly mentioned by F E Ogbimi in an article published in the African Technology Forum (Volume 8, No. 1) (Source: http://web.mit.edu/africantech/www/articles/PlanningAdjust.htm. Accessed on 10 January 2019)

got replaced with capital. Though the human capital argument was not warded off, rather it became the base for health system policy. The structural adjustment led economic growth policy reinstated capital as new structure for health system, wherein human capital had been made new base of the health system policy. This is the structural reconfiguration done in the health system policy, which is so far completely unnoticed. The structural reconfiguration was accompanied by practical underpinnings. SA became the guiding principle of Bank's country-level planning framework by the mid of 1980s wherein health was also a part. It was reflected in the then new Bank president's (Alden W. Clausen from July 1981) direction to study "*macro-conditionality*" in order to plan "*package of projects*" for overall country policy which were contextually relevant and could be able to suffice both the growth and poverty alleviation agendas (Ayres, 1984, p. 237). This overall country-level (macro-conditionality) planning under the drive of SA substantially influenced other Bank led projects. Circa 1987, Bank's health system policy at last started flowing as a tributary of SA. The next section deals with the reasons for transgression from RWG led human development model in order to understand why the Bank went for health system reform.[46]

The general consensus is that it was the SA led neo-liberal ideology that convinced the Bank to go for health system reform. Though an analysis of the percentage of government expenditure on health for the years of 1975, 1980 and 1986 is showing that neo-liberal might be the way out for Bank to get into reform, but not necessarily be the cause to roll out reform. Rather, HSR came because of neo-liberal policy took place in the economic policy and planning outlook, i.e. SA. The table below tracks down data of selected countries from the groups of sixteen Bank financed Adjustment Lending Countries (ALC) and twelve Non-adjustment Lending countries (NLC) including the average of all ALCs.

[46] Health system reform is also known as health sector reform.

Table 3.7: Percentage of government expenditure on health (1975, 1980, 1986)

	Countries	1975	1980	1986
ALCs	Brazil	6·5	6·6	6·4
	Mexico	4·2	2·4	1·3
	Tanzania	7	6	5·7
	Pakistan	1·5	1·5	0·9
Average of 16 ALCs		4·6	6·6	5·5
NLCs	Egypt	2·7	2·2	2·3
	India	2·4	1·6	1·9
	Sri Lanka	6·1	4·9	3·9
	Venezuela	9·1	8·8	10
Average of 12 NLCs		4·8	4·5	4·7

Source: Data used from the table 6 World Bank's 1990 working paper (Kakwani, Makonnen, & Gaag, 1990, page 20)

The above table shows that countries underwent SAL registered negative increment from 1975 to 1986 for the public expenditure on health. Compared to that, the countries did not go with SAL till 1986, however, managed to register marginal increment (by 1·2 per cent) of public expenditure on health. Only exception was Sri Lanka that decreased its expenditure by 1 per cent from 1980 to 1986 and 2·2 per cent from 1975 to 1986. All the countries, except Venezuela, including the average of sixteen ALCs and twelve NLCs experienced negative growth of public expenditure on health between 1975 and 1986. During the SAL period (1980 – 1986), the average public expenditure percentage on health for total sixteen ALCs got decreased by 1·1 per cent (from 6·6 per cent to 5·5 per cent). On the other hand, the average public expenditure on health for twelve NLCs registered 0·2 per cent (4·5 per cent to 4·7 per cent) increase during the same period. This research opines that overall crisis in the macro-economy impacted regressively on the countries' public expenditure on health, irrespective of their acceptance to SAP or not. Moreover, the countries which did not officially adhere to SAP are found to be slightly better with regards to expenditure behaviour compared to their counterpart in the SAP group.

The depressing government expenditure on health had definite link to the larger economic crisis, otherwise it would not have had made the same impact across the borders. A 1986 Pan American Health Organization (PAHO) study on Mexico, Honduras, Ecuador, Brazil and Uruguay (all adopted SAL) also reported that economic

crisis made "*heterogeneity in health expenditure patterns*", however, it concluded on somewhat ambivalent observation (cited in Kakwani, Makonnen, & Gaag, 1990, page 21):

"*[F]ive national experiences confirms that there definitely was a crisis of resources for health at the central government level and that, in the typical case, the precrisis expenditure per capita had still not been regained in 1986. However, one cannot conclude from this that the health sector suffered discrimination on account of the crisis. It neither systematically suffered a reduction of its relative share of the reduced total product nor was it revealed as not having priority for the national governments"*.

It is not about whether or not the countries were suffering from gradual reduction of government health expenditure in proportion to GDP growth or losing the priority in the national planning exercise as concluded by the PAHO study. The question is why the countries in the Third World were not able to pull up the government health expenditure, because the promise behind SAP was that adjustment would lead to economic stabilisation followed by growth. So, if there is no economic growth then how there could be increase in government expenditure. The second oil shock, debt crisis followed by the cut in fiscal expenditure made it almost impossible for poor countries (irrespective of acceptance to SAP or not) to allocate and spend more on health. Furthermore, it was not only health, but also education and in fact entire welfare expenditure had not seen any significant upward change in government expenditure during the period of 1975 – 86 (Kakwani, Makonnen, & Gaag, 1990, page 20). The *World Economic Survey* of 1987 captured this best, it notesd that average annual GDP growth rate for developing countries was 5·6 per cent in 1971 – 80 and that came down to 1·3 per cent in 1981 – 85 (UN, 1987, p. 35). The whole world economy was in distress during that phase; hence despite human development being considered as a priority programme, still it failed to get any special attention in fiscal planning.

This was the time when the Bank brought in the logic of economics into health system to utilise the minimum resources optimally. The economic rationality was invented in order to save or maximise the benefit for bottom forty per cent (the target group) under the constraint of static government health expenditure factored by macro-economic crisis. Neither the Bank's RWG led human development model (1975 – 1980) nor did the SA policy (1980 – 1986) contributed in any substantial enhancement of government

expenditure on health. The primary reason was both the economic theories (RWG and structural adjustment) were ineffectual to solve the Third World problem. The Bank's aid governance had to find some rationality to continue the economic influence on Third World in IEG and retain the stake built on knowledge front in IHG. Thus economics came as a direction of knowledge to find rationales for getting 'Good Health at Low Cost'.[47] The discourse took turn towards reform path not because of favouring market over state, rather equipping the state to govern (and not cater to) its population (and not target/poverty groups) within the limited resources available. However, this research is unsure of the roles and/or presence and influence of medical technology and big pharmaceutical companies during that time. Hence, there might be a secondary motive involved at the behest of West, i.e. to find new markets in the developing and less developed world for the big MNCs, especially based in US (Dasgupta, 1997, p. 1094). Still it needs to be thought, how much those countries were even financially empowered to be considered as desired destination of so called 'new health care markets' in the late 1980s.

Two factors compelled the Bank to invoke economic rationality within the Bank's health system policy. The Bank displaced CPHC on the cost-effectiveness ground, but the Rockefeller Foundation's report on Good Health at Low Cost showed the opposite. The report endorsed that political determination and social contextualisation are important for improved health and social outcomes. Interestingly all four case-studies in the report were drawn from Left ruled governance systems; Costa Rica, China, Sri Lanka and the Kerala province of India (Balabanova, 2013). Furthermore, the Rockefeller report through its four case studies out right rejected the myth that economic growth was a precondition for health improvement, instead validated the need for wider determinants (education, nutrition, community engagement etcetera) in health care (Balabanova, 2013, p. 2118). Second, the Bank's economics theories since 1970 were unable to address economic restlessness, and that impacted negatively on the poor countries' health expenditure as discussed previously. Neither the Bank's health system approach (SPHC) nor were the Bank's economic models (RWG led human development or SA) working.

[47] Rockefeller Foundation organised a conference in Bellagio, Italy on Good Health at Low Cost in 1985. The conference report opined that political will and wider determinants of health and wellbeing were the key factors behind good health at low cost.

The Bank's basic health care service delivery model was proved technically to be inferior. The Bank knew that then existing international political economy order was imperfect to deliver equity-based resource distribution in order to develop the economies of poor countries. It was a catch-22 for Bank; neither it could go back to CPHC because by then the approach was apparently levelled (or closed to) as Communist style of governance (Cueto, 2004, p. 1865 – 1867, Boland and Young cited in Banerji, 1984), nor it could sort out the imperfection rooted deep in the international governance because of the consistent interest of rich countries. The Bank was again in need of new knowledge!

3.3 Health system reform (1988 – 1996)

In the search for new knowledge, two successive policy documents in 1985 and 1987 were brought out by the Bank to offer the most capable cost-effective health care services. Though the actual reform phase started from 1988, but the internal processing of building theoretical underpinnings for reform started at the end of health care system phase. The Bank's deliberation on "*paying for health service in developing countries*" in 1985 was an attempt to initiate internal dialogue to rescue the poor countries from their debilitating health expenditure under the continuous macroeconomic hardship. The Working Paper identified efficiency (from cost-effective understanding of health care services), equity (in terms of distribution of health care resources), and financing crises (with regards to health care services) were major reasons for "*deciding how health service should be paid*" (Ferranti, 1985, p.4 and 18). In its solution, user fees, insurance modes of payment (social/employee-based to cooperative-based/community-based), public-private mix (for both service and finance), and importance of subsidies as well as effective incentives structure in public system were suggested as alternates (Ferranti, 1985). The paper opined that overall economic orientation of the country should also be considered before organising health care services. Hence, the dialogue for reform did not literally leave any space for Bank's HCS policy to be continued as it was.

3.3.1 The new definition of health system

The Bank finally came up with a new policy to modify its health system policy structure in 1987. The *Financing Health Service in Developing Countries: An Agenda for Reform*

had changed the earlier health system policy upside down. The policy advised for restricting government expenditures mostly for public goods (preventive and promotive care), and withdrawing from the curative care, identified as private good. The policy categorised the goods and services of the health system based on the types of beneficiary; community and individual. The intervention which is beneficial for community was called public good (and mixed good where public benefit is substantial). In opposition, the curative care was recognised as private good, since individuals are more willing to pay for their own health events, but not the same for community benefits. Four fundamental policy measures were suggested to build the new perspective of health care service organisation. They were user charges in government facilities for self-sustainability (or financial autonomy) of the facilities, insurance or other risk protection measures, engagement of 'non-government' sector to cater the need of individual health events, and make the government service decentralised regarding planning, budgeting and purchasing (WB, April 1987, p. 3 – 6).

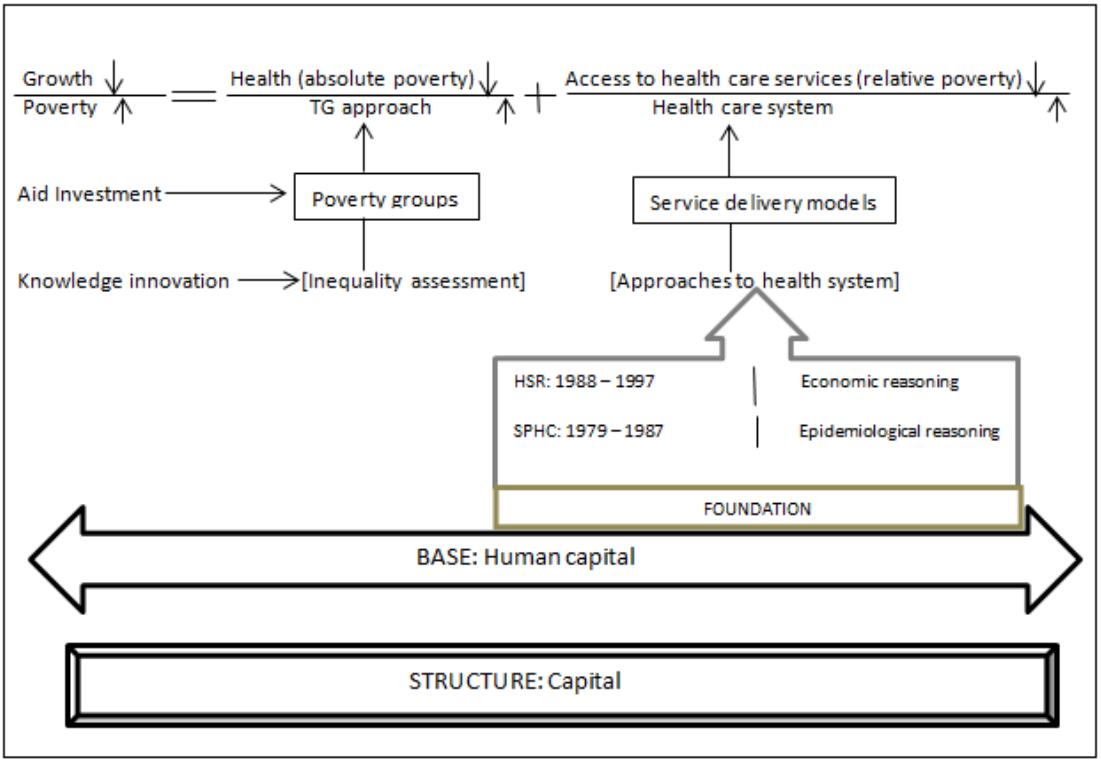
The Health System Reform (HSR) measures were different from the Health Care System (HCS) policy structure. In HCS, the agenda was to strengthen the public system for basic health care service arrangement. The HSR took a turn towards the health care financing arrangement by dividing the responsibility between the government and population for taking care of medical needs. The crux of the HSR policy was that health system to be determined only by the cost-effectiveness benchmark, and no more by the service delivery models (such as, basic health care) as epitomised by SPHC. In this paradigm shift in the IHG, the HSR came as a knowledge solution for poor countries who were already striving for financing health care. This new innovation along with greater share of funding command gave legitimacy to the Bank to become an uncontested leader in IHG (Buse, 1994, p. 98). It is to be noted that departure from HCS for HSR altered the foundation of the health system policy. In HCS, it was epidemiological reasoning (mortality and morbidity of diseases in various groups) that determined the system design. For HSR, it was economic reasoning that redesigned the health system. For example, the categorisation of health care services in 1987 policy document (promotive, preventive and curative) was done based on the criterion of public and private goods. It stemmed from 1985 working paper, where for the first time user fee-based categorisation in a tabular format was prepared to divide curative care between non-referral curative and referral curative, and to split preventative care into

patient-related preventative care and non-patient-related preventive care (Ferranti, 1985, p.67).

3.3.2 Reformulation of health system

The HSR phase was a renewed formation of health system from every aspect. It was not like earlier HCS phase where the health system policy was detached from the economic outlook of the Bank. The reformation was done at three different levels. First, the adoption of HSR made the capital to *re-form* the 'structure' of health system policy by replacing human capital as argued earlier. Second, the human capital was pushed from the level of structure to form another level called 'base' of health system policy to uphold the same theoretical logic, i.e. to protect productive population (target groups/bottom forty per cent) for economic growth. Finally the move to economic reasoning from epidemiological reasoning for designing service delivery created another new level called 'foundation' wherein HSR replaced with SPHC approach of health system policy. The below figure illustrates this argument further.

Figure 3.3: Reform-based health system policy



The above figure depicts that reformulation created new levels, and not caused any change to the basic theory of health system (protect the productive body). With the

creation of these three new levels (structure-base-foundation), Bank's HSR led health system policy built up a governance system. The system had become structurally synonymous with economic policy and planning in order to generate productivity (human capital) by articulating a new formula of health system, i.e. HSR approach. In other words, it was hypothesised within the larger frame of economic planning where the thrust on human capital could be achieved by the implementation of HSR. So, that goal of the governance system was to strengthen human capital to support capital. The HSR in that process was considered as an appropriate approach to facilitate the process. In the discourse of health system, post HSR phase, the approach keeps changing according to the phases but architect of the governance system remains intact.

The importance of HSR approach was it made the health system policy to cross over to the economic policy and be integrated with. It was possible because Bank justified that "*[w]ell-designed public finance policies can be powerful tools for relieving poverty*" in development (WB WDR, 1988, .2). That was the strategic breakthrough for Bank to find rationale for bringing in economic principle to invest in human development programmes (such as, health). This opportunity gave the Bank to engage with the countries' overall health planning and policy making process. For instance, Bank for HSR policy exercise in Poland outlined a strategic programme to address lacunae in health care service delivery system, challenges of fiscal space management, and lack of directions in the national health policies (August 1992, p.52). Thus, Bank through HSR advanced its health system policy goals in organising the service delivery, budget planning, and national health policy development. It is acknowledged that Bank used its 'aid power' to surpass WHO in IHG. Yet it needs to be recognised that Bank's singlehanded advantage came after the health policy got linked to the country's overall economic policy. This intersectoral policy coordination required new knowledge which Bank brought in through economic reasoning in health system planning, and that finally gave the edge to Bank over other international health actors in IHG. Bank's command in IHG further strengthened after the new development took place in international political economy at the end of 1980s.

3.3.3 HSR in the context of Washington Consensus

The SA policy did more harm than good. The Bank was under heavy criticism for its inhuman face over the dreadful impact on human and social development in the decade of 1980s owing to SAP especially in large part of Africa and Latin America (Geo-JaJa and Mangum, 2001; & Veltmeyer, 1993).[48] Especially in Latin America, the stream rolling of SAP (and US foreign policy) led to debt crisis which was vilified as 'lost decade' in social and economic progress (Hayes, 1988/1989; & Ocampo, 2014). In this context, the Washington Consensus was proposed in 1989 with a set of ten policy recommendations (Williamson, 2004, p.16). They were featured broadly under privatisation, liberalisation and macro stability (precisely price stability) measures (Stiglitz, 2008, p.41). It came as a new development strategy where the economic stability through fiscal adjustment and market orthodoxy were envisaged by reducing the role of the state (Serra, Spiegel, & Stiglitz, 2008, p.4). Originally, the Consensus's ten policy recommendations were meant for Latin American countries. Over the time, the Consensus arguably became the 'consent' for IEG to apply the recommendations on all the developing countries (Williamson, 2004, p.1 – 2). Thus the IFIs (IMF and Bank) inducted the 'appeal' of Consensus within the foray of SAP and started offering "*consensus-inspired*" tailor-made conditional policy reform loans (Naím, 2000, p.90).

From the point of health system research, it is expected to consider only the recommendation number two of Washington Consensus; i.e., reordering the public expenditure by prioritising pro-growth and pro-poor expenditures to finance basic health care, education, and infrastructure instead of giving subsidy to non-merit goods (Williamson, 2004, p. 4 – 5).[49] However, the health system policy and planning after HSR had become synonymous with the economic policy and planning of the country as argued earlier. This synchronisation of health system policy with economic policy had made health as a subject of economic governance under the nomenclature of health sector.[50] The health sector comprises of both public and private sectors in the economy of nation-state. In this regard, Bank's 1987 health system policy (on reform) suggestion is extremely important, which voiced to include non-government actors from private

[48] In 1987, UNICEF came up with a report namely Structural Adjustment with a Human Face to show its concern over the setbacks in health, education and child nutrition due to the implementation of SAP, and influence the policy of IMF and World Bank to prioritise human and social development.
[49] Non-merit goods subsidy means the benefit of the subsidy goes to individuals, and the recovery chance is very low. The non-merit goods are usually for personal consumption and used by the rich consumers.
[50] This research finds that available scholarship intermittently uses health system and health sector in respect of reform. In this thesis, health sector refers to economic governance of health care industry, whereas health system symbolises health governance.

sector in health care service provisions and financing. To facilitate the process, Bank also strategised less regulation and subsidy for organising "*cost-effective alternative to the direct provision*" of services usually offered by the public system (WB, April 1987, p.5). Thus the entire gamut of private sector related strategic position adopted by the Bank eventually and incrementally brought the HSR close to Washington Consensus.

3.3.4 HSR approach based health system policy

The prescription of 1987 policy strategically helped in private sector development (through subsidy) and engagement (through deregulation) by restricting the role of the government. Thus the HSR driven policy prescription got a 'booster dose' from all the ten Consensus recommendations (fiscal discipline to tax reform to FDI to liberalisation of trade to privatisation and so on) to 'reform the health sector' (in public and private). It is interesting that the Bank used the Consensus as a new lease to continue with SAP and accordingly modify its health system policy. The macro system was also in favour of reform since the demographic and epidemiological transitions, rapid economic changes (both growth and fiscal crisis) in developing countries, and political transformation in the Community ruled countries made the way to go for reform (Berman & Bir, 1996, p.2). In this regard, the *International Conference on Health Sector Reform in Developing Countries: Issues for the 1990s* in Durham, New Hampshire was an important event, which preached the idea of health sector reform as based on increasing efficiency, equity and effectiveness (Berman & Bir, 1996, p.1). Efficiency, equity and effectiveness became the most cited reasons for 're-forming' the health sector by clearly marking the role for the public sector and taking measures to develop the role of private sector in health care service delivery system (Gwatkin, 2001).

The Bank, enthused by the Consensus and pro-reform atmosphere, upgraded its HSR approach in order to show the human face of structural adjustment by advocating for '*Investing in Health*' in 1993 *World Development Report* (WDR). Though the Bank initiated the reform dialogue in the late 1980s, yet the 1993 WDR should be held high as a point of policy referent to amplify the reform through a structured policy proposal. It laid down the conceptual as well as operational motives of the health system to be developed in future. If 1987 HSR policy gave the structure for the impending reform, then 1993 WDR offered the content to magnify reform. In other word, it was the first

attempt on behalf of the Bank to independently develop the health system policy by shunning away the old habit of reactionary policy framing (such as, SPHC in response to CPHC or HSR in response to macro-economic crises).

Below is the methodology of HSR, as extracted from the 1993 WDR (WB WDR, 1993). It entails problems, theory and prescription of HSR. The Bank's shift from HCS to HSR phase was also marked with replacement in its health system approach from SPHC to HSR.

Table 3.8: HSR methodology

Problem identification	Misallocation (of public resources), inequity (in access to resources), inefficiency (in resource utilisation), and rising cost of health care (WB WDR, 1993, p. 3 – 4)
Approach	"*Ensuring basic public health services and essential clinical care while the rest of the health system becomes self-financed will require substantial health system reforms and reallocations of public spending*" (WB WDR, 1993, P. 11).
Prescription	i) Compendium of policy guidelines ii) Package of basic health care service delivery for targeted population

The 1993 WDR identified financing as the moot point behind all the four mentioned health system problems. Accordingly the very problem definition guided the approach that splitting the health care financing between individual and state would ensure HSR and rationalisation of public spending. It is important to understand that in HSR approach, the role of the state in service provision (health governance) is secondary, the primary motto was reconfiguration of public spending (macroeconomic policy) for health care financing of nation-states. So, the primary motto was the guiding principle for the secondary motto. This is the fundamental relationship in HSR approach that macro-economy to govern health system. Thus the health system was no more about the organisation of basic health care, rather a statement of macroeconomic health governance. This new formation of macroeconomic health governance is the character of health system reform.

The Bank, through its lending modality, advanced this new formation as a mix of policy and project based funding. From the borrowers' perspective, the countries were in need

of fund to organise the service delivery system, vis-à-vis the Bank was in need to infuse the policy to form the economic health governance. This two-fold need made the Bank to develop a two-prong strategy for the HSR approach; a compendium of policy guidelines for forming economic health governance and a package of basic health care service delivery for targeted population as per the need of borrowers. In the following section both the strategies are discussed. Below the table lists the policy prescription of the HSR approach as per the 1993 WDR (WB WDR, 1993).

Table 3.9: HSR policy prescriptions

Policy objectives	Policy levers
Integrating with larger system: Enabling environment for households to improve health care	Growth with equity to make poor enable to deal with health events
	Focus on education, especially in girls education
	Political and economic representation, and legal safeguard of women for ensuring rights and status
Restructuring immediate system: Enhance government spending on health care	Decrease in public spending on tertiary care, specialist training
	Allocate and organise resources on public health intervention for addressing externalities
	Allocate and organise resources for providing essential clinical service
	Introduce decentralisation of fund and functions in order to implement public health and essential clinical service management, and implement contracting out of services
Forming immediate system: Endorse diversity and competition for the services not covered under public health management and essential clinical package	Encourage social and private insurance
	Induce competition for services and goods (drugs, equipment) provided by public and private sectors for publicly and privately financed services, and no protectionism for domestic suppliers
	Information and transparency to empower patients

The HSR policy objectives were developed to tie both the larger and immediate system fronts under the reformulated health system. Therefore the first objective is articulated as a form of linkage to the macro system and opined that household (or specifically

individual) status of health care is outside the ambit of health policy in particular, rather depended on the issues of social and political factors (per se, income, education, gender, and democracy). In the second objective, the state was identified as key system operator with a revised role to manage the resource and service delivery organisation (objective two). The change of policy direction with regards to public financing and service delivery mechanism of the state was advised here.

The third objective introduced the private sector participation in health care (mostly at tertiary level) by incorporating market principles. This objective was devised to form the private sector in supply of health care services and goods. One of the policy levers of objective three, encouraging social and private health insurance, was particularly created to fill the gap in service delivery created by another policy lever of objective two (to decrease government spending in tertiary health care and specialist training).

The Washington Consensus recommendations became pertinent here, for instance the domestic protection clause for health care goods manufacturer was suggested to put off by the policy (WB WDR, 1993, p. 6). The 1993 WDR furthered pro-private advocacies by pointing out that apart from tertiary care, the selected package of secondary care services also could be delivered through private sector (WB WDR, 1993, p. 5). Some of the options suggested were subsidising the private sector including NGOs, and choosing the provider through voucher schemes for delivering the services (WB WDR, 1993, p. 5). Most notably, WDR advocated for strategic purchase back then by mentioning that "*where feasible, private supply of health care services paid for by governments or social insurance*" may be outsourced (WB WDR, 1993, p. 7). This research opines this was the beginning of neo-liberal era of health system where the market was artificially created within the policy sphere at the cost of 'unloading the burden of the state' and at the same time propagating the rhetoric of consumer empowerment (WB WDR, 1993, p. 5). Unlike objective two in regards to the state, none of the policy levers of objective three did specify the role of the market, instead stipulate the role of the state in order to develop the market. The neo-liberal direction is also evident from the delineation of policy components (private sector subsidy, voucher schemes, strategic purchase etcetera) even before the rolling out of actual policy.

The three objectives together do not represent the Bank's world view of health system; they were developed in particular to successfully implement HSR approach. The first objective was outside the purview of HSR approach as per the policy formula, whereas second and third objectives were the fundamentals of HSR's economic health governance. The first objective was a strategic selection of the Bank in order to convey the borrowers' countries that fulfilment of the first objective would only ensure the desired achievements from two other objectives. Needless to say, like HCS in past the HSR approach also thought that these three policy objectives would lead towards Health for All (WB WDR, 1993, p. 6). Amid at this backdrop of HSR approach, Bank's objectives for health system were to improve outcome (health status), control costs, increase equity, and satisfy users (WB WDR, 1993, p. 71). It again validates the argument that objectives of health system was no more only the reduction of mortality and morbidity, and instead got expanded to cover the overall system efficiency determined by economic means.

The second leg of the HSR was service delivery package. The guidelines of reform fixed the role of the state in terms of health care service organisation and management into three distinct areas; public health management, provision of essential clinical service, and regulating private health care institutions.

Table 3.10: HSR's service delivery package

Intervention areas	Intervention types	Rationales
Public health management (WB WDR, 1993, p. 106)	Immunisations, school based health services, family planning and nutrition, and AIDS prevention	Public good character because of externality
Provision of essential clinical health package (WB WDR, 1993, p. 112 – 113)	Grouping of five common health events (pregnancy related care, and care for illness of children, family planning services, TB control, and STD control)	Poverty reduction by saving the poor from excessive OOPs

The above table entails the technical management of health care service delivery. In brief, the reform policy mainly advocated for developing government financed cost-effective public health measures (for primary care) and selective clinical services (for secondary care) for targeted population (i.e. bottom forty). The rest of the services (especially tertiary care) were suggested to be covered by the private sector since they

are not cost-effective (WB WDR, 1993, p. 112 – 113). This is nothing new, rather a continuation of SPHC approach of service delivery, but from the perspective of economics. What was new was that the service delivery leg of HSR proposed one technological tool and measures for private sector regulation.

The disability-adjusted life year (DALY) was introduced as a technological tool along with the HSR, but it always has its own distinct character in the health system discourse. Hence, DALY became a part of health system's (and not HSR's) core policy structure. DALY is used as a measure for Global Burden of Disease (GBD) that consists of loss of life from premature death and loss of healthy life from disability (WB WDR, 1993, p.26). So, GBD is a tool of data collection, and DALY is a tool of data analysis. The data collection is a method to upkeep the records by conducting the mortality and morbidity estimation through the review of causes of death (or community survey to record incidence of cases for disability) and expert consultation. The estimation is calculated by sex, age, and demographic regions based on the assessment of number of years of life (or healthy life in case of disability) lost. On the other side, the DALY as a data analysis tool is basically a metric of quantitative assessment to analyse the impact of various diseases on death and disability. Thus impact on death and disability is conceived as a measure of productivity and wellbeing for affected population (Parks, 2014).

It is important to note that productivity notion again came back within the mould of DALY. Thereafter DALY has been responsible to weigh the diseases which are affecting the productivity most. This theorisation made the DALY to become the central plank of policy intervention guidelines especially on selecting disease packages. This research wants to argue that with DALY the Bank's health system theory – protect the productive body – had found cost-effective technology for making a productive body.

Since the inception, DALY has been the subject of criticism. Hammer, an ex-World Bank economist, argued that DALY fails to address two of the three goals of 1993 WDR health system. According to him, DALY can reasonably address only the goal of improving aggregate health status, and not improving equity and reducing poverty, and contributing in individual welfare (Hammer and Berman, 1996).[51] Further, economists

[51] This researcher is grateful to Dr. Jeffrey Hammer for his valuable suggestions in the development of DALY critique in this chapter.

downplayed DALY for not providing any creditworthy measure for resource allocation based on the context specificity (Anand & Hanson, 1997). In fact, Murray (the proposer of DALY) opined that woman died prematurely at the age of forty should be given same weightage in GBD estimation "*irrespective whether she lives in the slums of Bogota or a wealthy suburb of Boston*" (Murray, 1994, p. 431). It is not clear if the measurement of a lost life should be unrelated to the income of the person, then how can be DALY, as a GBD estimation tool, claimed, as defined by the Bank, a measure of "*effectiveness of health interventions*" (WB WDR, 1993, p. x). Because the effectiveness of intervention is decided based on the notion of productivity, which is nothing but again a measure of income capacity. This oversimplified estimation drew criticism from one of the interview respondents also, who accords DALY as a technical package with full of socio-political opacity (Informant 07). The lack of socio-political orientation restricted DALY to perform as a technocratic and managerial exercise of "*objective description of disease and suffering*" (Ritu Priya, 2001, p. 170 – 171). The debate is never ending, even in 2019 also the GBD estimation is under question for its role in IHG because of the vagueness, which exists in producing numerical assessment of data 'from a distance' (Tichenor & Sridhar, 2019, p. 8). After having discussion with a number of international experts in health economics and health system, this PhD research opines that DALY offers a '*guesstimation*' of data. However, irrespective of all the odds, DALY has been the most important cost-effective technology in the design of policy packages till date in IHG.

The 1993 health system policy also proposed measures to regulate private sector. The private sector was not in general recommended to operate in the primary and secondary levels of care because of public good – private good reason. The state intervention was justified in those two levels from the logic of uncertainty and market failure (WB WDR, 1993, p. 55 – 56).[52] These economic rationales not only made the state to take responsibility of the primary and secondary care, but also advised to play the role of a regulator for private health care providers and insurance agencies. The measures suggested were self-regulation by the professional bodies, capacity building exercise

[52] i) Uncertainty: The behaviour that demotivates insurance companies to cater to the high risk groups because of adverse selection (the individuals who are more prone to fall ill).
ii) Insurance market failure: The situation may occur in the case of moral hazard (where both the patients and hospitals pose low level of accountability, such as overmedication) or information asymmetry (as patients are unaware of cost, treatment regime and procedures).

for government personnel, and formation of national as well regional licensing bodies and ethics committees (WB WDR, 1993, p. 164). This research finds that measures were very general in nature and recommended in an indecisive manner. The health system policy rather should have provided a definite policy tool like DALY to deal with the regulation clause.

The 1993 WDR was an agenda driven (and not a reactionary) health system policy of the Bank. The technical management of health care service delivery remained same in the 1993 policy. The difference from earlier health system policy was the agenda of market creation by developing the private sector. This policy agenda was sharply critiqued in many developing countries including India, where the Bank was accused of 'Disinvesting in Health' through its 1993 health system policy (Rao, 1999). This agenda was adopted as per the 'consent' of the Washington Consensus. Albeit the government was advised to take precautionary step in the form of private sector regulation. Yet the regulation clause was more on paper than on principle as evident in the suggestion of 'self-regulation'. Hence, the Bank on one hand articulated new ideals for economic health governance (role of the state), and on the other hand persuaded for the development of private health sector. The revised role for the state in health governance was proposed at the virtue of more effective role for the market. Thus this research would argue that Bank brought in health system reform (within health governance) to fulfil the agenda of health sector reform (economic governance). The agenda (Consensus driven) devised the means (reform through health system) to reach the ends (reformation of health sectors).

3.4 Health system development (1997 – 2006)

The advancement of HSR in the IHG coincided with the financial crisis of several United Nations' organisations. This financial crisis and followed by new form of governance in IG triggered the Bank to form another health system approach in IHG, Health System Development (HSD). The contexualisation of HSD is needed to understand why another approach was needed and to analyse what the approach was. This phase entails that health system's reform was no more only the Bank's agenda, rather an international consensus was developed to expedite the reform under a new form of development vocabulary

3.4.1 Zero growth budget led UN reform

The origin of financial crisis first occurred in the second half of 1980s. The zero real growth budget policy for UN organisations was behind the origin of UN financial crisis. The policy was adopted by major contributors (member states), and also fuelled by US's (being a highest contributor) decision to contribute twenty per cent less of its total commitment demand over the non-compliance of budget reform by UN (known as Kassebaum-Soloman Amendment, 1986) (Taylor, 1991, p. 365). This financial crisis of IG snowballed to IEG and IHG. UN organisations experienced fall in regular budget, but growth in voluntary contributions (Extra Budgetary Fund/EBF). For example, WHO's EBF had been increased from 25 per cent (1970) to 40 per cent (1980) to more than 50 per cent in the year of 1990 (Vaughan, Mogedal, Kruse, Lee, Walt, & Wilde, 1996, p. 242). The growing share of EBF within the overall budget had a negative impact in the autonomy of UN organisations (such as, WHO) (Vaughan, Mogedal, Kruse, Lee, Walt, & Wilde, 1996, p. 242). Because EBF was (and is) widely known as donor driven contribution that influences policy of organisation like WHO in a number of ways (Walt, 1993).

The growing importance of EBF as well as crisis of fund was becoming major issue for UN organisations in the first half of 1990s. The World Bank's role in IG especially after the 'revolutions of 1989' (dissolution of Soviet Union, 4 Jun 1989 – 26 Dec 1991) was noteworthy.[53] The Bank voiced for market friendly development approach in the 1991 WDR. In social spending, it advocated to explore the possibilities of successful public private partnerships (WB WDR, 1991, p. 69). The environment of Washington Consensus, no doubt, had fast-tracked the possibility for UN to forge partnership with commercial entities as evident from the Bank's position taken in 1991 WDR. Yet specifically two other factors also worked in favour of forging the partnership; greater role of civil society and ideological approval for the market to get involved in public service. International actors especially World Bank started inducting civil society in the process of governance management since early 1980s. In 1982 Bank established NGO-

[53] The 'revolutions of 1989' was a wave of dissent among the citizens of Central and Eastern European countries in order to overthrow the Communist rule, took place between late 1980s and early 1990s. Arguably, that was the end of Second World in the United Nations bi-polar power structure.

World Bank Committee to advance reform.[54] Though there were initially objections on the grounds of conflict of interest and trust deficit regarding civil society's participation in public service, but by the end of 1980s the apprehension was subsumed by the enthusiasm for partnership between NGO, industry and public sector (Buse and Walt, 2000, p. 551). Concomitantly, the adoption of 'third way' method of governance (including market in public policy making exercise) by the Labour party in 1995 (symbolised as old to New Labour) to tie social justice with market was interpreted as an ideological endorsement to explore the viability of partnership with industry (Buse and Walt, 2000, p. 551).[55] The civil society and ideological endorsement were co-factors, the chief factor was the lacklustre financial status of health that pushed the UN to go for alternative financing arrangement.

3.4.2 GPPP, a new development methodology

The gasping financing state of affairs put a question mark on the efficiency and significance of UN system in the first half of 1990s (Buse and Walt, 2000, p. 552). The market came at that juncture to rescue the UN from financial crisis but at the cost of reform. Thus politics (ideological acceptance to market) legitimised technical supposition (i.e. Public Private Partnership/PPP could be an effective form of governance) in IG in order to embrace Global Public Private Partnership (GPPP). Bank termed GPPP an "*emerging development methodology*", because the industry and society were theorised to complement each other's interest through UN since the market was given the passage to operate in the functional domains of government (Buse and Walt, 2000, p. 554). Needless to say, thereafter the policy stream in IHG also adapted PPP path. The academia has divided opinion about the contribution of GPPPs especially in health. While governments' inefficiency, capacity of producing quality services/products, multisectorality and self-regulation are considered as advantage of GPPP, on the other hand the conflict of interest, trust issue, ethical concerns, and capturing of public institutions by private entities are cited to oppose GPPP (Hernandez-Aguado & Zaragoza, 2016, p. 5- 8). Critics even referred this new form of

[54] Further information in this regard can be obtained from the World Bank website on the history of partnership with Civil Society Organisation: http://www.worldbank.org/en/about/partners/brief/history. Accessed on 29 January 2019.

[55] New Labour was an ideological reorientation of old Labour party in order to rethink over the participation of market not only in economy but in social terms. It is symbolically known as repeal of Clause IV ("common ownership of the means of production", done under the leadership of Tony Blair in 1995.

international governance as 'corporate globalisation' to reconfigure the state-market relations. Indeed, GPPP brought in fund in IHG. Still it is also found that in health or especially pharmaceuticals, the 'global partnership' and 'patent protection' grew up hand-in-hand as like the case for Pfizer (Utting & Zammit, 2009, p. 45 – 46). The HSD approach was a direct outcome of that international consensus made on GPPP as described below.

WHO's role in this new development was noteworthy. It published a volume on *Health Policy and Systems Development: An Agenda for Research* in 1996, which later on was used as a base for the formation of Alliance for Health Policy and Systems Research (HPSR) in 1999 (Bennett, Frenk & Mills, 2018, p.1). Alliance HPSR is a policy think tank in health system, and probably the first GPPP in health system policy dialogue supported by both bilateral and transnational corporation (Bill and Melinda Gates Foundation/BMGF).[56] The Bank's first ever sector strategy paper for HNP in 1997 came at this time only when 'emerging development methodology' was getting its root in IHG.

3.4.3 First HNP Sector Strategy: Guideline of new methodology

The first sector strategy was coincided with the Bank's own institutional reform – Strategic Compact – an initiative to reorganise the Bank's work. The Strategic Compact was a three year compact (1997 to 2000) between the Bank and its shareholders to invest USD 250 million for a fundamental transformation of the institution (WB. (13 March 2001, p. iv). This Compact was nothing but a reform of the World Bank to get along with the changing international development methodology in order to reorient all of its sectors to support state-market development model. Strategic compact indeed played an important role in the modification of Bank's health system policy, since the reform of the Bank led to the development of first sector strategy for HNP (Fair, 2008, p.14).

The sector strategy was meant for Bank's overall HNP work, and not solely on health system. Even so, addressing health system has always been a central policy focus of HNP. The first sector strategy was also not different from that practice. In fact, the 1997 HNP sector strategy hardly had any discussion on HIV/AIDS (Fair, 2008, p. 22).

[56] Further information in this regard can be obtained from the Alliance HPSR website: https://www.who.int/alliance-hpsr/partners/en/. Accessed on 1 February 2019.

The other issues also, such as population control, RCH /MCH and communicable diseases were not featured that much in the 1997 sector strategy. The sector strategy admitted that early investment in Bank's overall health intervention was only able to gain moderate success in infrastructure and supplies. Hence, the advice was (WB, September 1997, p. ix):

"[I]t became apparent that institutional and systemic changes were often needed for a sustained impact on outcomes of the poor, improved performance of health systems, and sustainable financing".

It is clear that the sector strategy prioritised health system as its core work by aiming at engaging with the institutional levels to moderate the system elements. This led to form HSD as new approach to health system in 197 HNP sector strategy. This new approach of health system policy modification was done in consultation with two developments. First, the policy was modified in response to the architectural remodelling of Bank's own institutional structure (strategic compact). Second, the policy was encompassed within the HNP sector, instead of in separation like in earlier cases, to match with Bank's overall post compact internal changes and comply with external consensus established through GPPP. The reform in the Bank, like in any other UN organisation, was done to explore the state-market development model. Similarly HSD approach based health system policy modification was also taken place to experiment with the state-market relationship in health system as well as health sector. Hence, the policy modification at this phase was still based on the principles of HSR approaches but developed on the new ideals of state-market relationship.

3.4.4 Development of new health system

The 1997 sector strategy notes that because of the poor implementation at the country-level, and imperfections in the market (especially on public goods), despite progress in past, the policies and programmes of the Bank often turned out to be a flop in regards to impact of health system and sustainable financing (WB, September 1997, p. 5). Keeping these shortcomings at the backdrop, the Compact led HNP sector strategy had proposed three objectives. Out of these three, upgrade the health care system and secure sustainable health care financing were directly linked to the Bank's health system concerns. The other objective (improve the population level outcome) was more general in nature and applicable for the all three themes (health, nutrition and population) of

HNP. Markedly, the first sector strategy expanded the definitional meaning of health system by incorporating health care financing (and not just reallocation of public spending) within the health system policy.

The HSD approach further devised policy lever to change, direct and shape public services. In this case, policy levers outlined the scheme of health system reform by designing health system development type projects in the borrowing countries. Below is the table listing relevant HSD approach led health system policy levers (WB, September 1997, p. 6 – 9).

Table 3.11: Policy levers of health system development approach

Policy objectives	Policy levers
One: Improve the population level outcome	Targeted approach over universal coverage - Poor individuals/households - Poor regions/population groups - Focus on malnutrition, communicable diseases and reproductive problems - Attention to the types of health care services (essential service package) which are used mostly by the poor
Two: Upgrade the health care system	Value-based reform of public delivery system - Equity (access to preventive and essential clinical services for poor) - Efficiency (managing scarce resources through policymaking, governance, market incentives, public-private mix of provisions, decentralisation, and accountability) - Effectiveness (cost-effective intervention, managerial and clinical skills, technology assessment, treatment protocol, and to prevent over-medicalisation) - Quality of care (incentives, information, training, accreditation, peer review, and monitoring) - Consumer satisfaction (choice of providers and client survey)
Three: Secure sustainable health care financing	Risk pooling, expenditure management tool and cost-effective intervention - Risk pooling with a primary agenda of social protection in LICs through taxation, international aid and community-based collection; for MICs, risk pooling increasingly through taxation and co-payments - Measures to form and regulate effective expenditure management tools for cost containment and fiscal discipline - Measures to allocate budget for cost-effective intervention, with an attention to targeted population

From the above table, it is explicit that the Bank retained the theoretical understanding of health system by upholding once again the target group (limited to bottom forty per cent) approach to protect the poor. The policy levers of second objective (upgrade health care system) reiterated the same commitment of reforming public delivery system, but with different mode of reform. The policy lever proposed value-based reform and not the traditional mode of care-based reform.[57] This is the departure in terms of organisation of health care service delivery. In the HSR phase, reform in health system was designed based on the levels of care where tertiary level was always the main target of reform in public system. Hence, it can be said the method of reform was reformed from care-based to value-based in HSD approach.

HSD's value-based reform in another way brought a change in the health system organisation approach. The HSD phase like in HSR phase did also talk about reform especially in service delivery (policy objective two) and financing (policy objective three). In regards to service delivery, the ideal institutional roles for the government in order to pursue reform were information, regulation, mandates (insurance), provision and financing (WB, September 1997, figure: 1.6, p.8). It is not clear from the sector strategy what should be the ideal role of the government in service provision except vaguely mentioning about securing (and not providing) preventive health care for the entire population, and providing basic health care for target population (WB, September 1997, p. 7).[58] In opposition to that, the sector strategy cited OECD countries' reference to advice LMICs/LICs for greater private sector participation through co-financing, management contracts, outsourcing and trusts (WB, September 1997, p. 8). This research opines that this was the strategic shift by the Bank in terms of health care service delivery organisation where the reform (or public-private mix) was tacitly introduced in all levels of care. The values were cited as justification for that strategic shift in the reform of service delivery. However, this justification forgetfully deviated from public good and private good argument, at least in the case of government as service provider, given by Bank at the time of bringing HSR approach as elaborated in

[57] The word 'value' is attributed by this PhD research, it is not mentioned in the 1997 HNP Sector Strategy.

[58] The 1997 HNP sector strategy notes that governments successful in reform "have shifted their attention and scarce resources to: securing access by the whole population to services with large externalities (preventive public health services); providing basic health, nutrition, and population services for the poor; and assuming sectoral oversight responsibility for financing, medical education, R&D, and quality control (WB, September 1997, p. 7 – 8).

last phase. As per HSD approach, private entity can also provide public good with the mediation of public entity.

The third objective's policy levers were actually the addition in this phase of health system policy. While the cost-effective intervention of public spending in primary and selected secondary care were already prescribed in HSR, the introduction of risk pooling and expenditure tracking of the public spending became the new levers of health system policy. The risk pooling was advised as new mechanism to protect the poor from impoverishment effect due to catastrophic health expenditure either from tax-based financing or seeking insurance routes. One important point is all the policy levers prescribed in the HSD phase were prepared to develop the capacity of the state. That capacity development should be seen as a precautionary principle to deal with the market. This is the difference from HSR phase where how to change the role of the state was suggested, and not how to deal with the state-market interaction. Thus HSD gave a new orientation to the Bank's two decades old health system policy after the reformation took place at the HSR phase, i.e. how to develop the health system. This new development of health system was a precondition to embrace the new emerging methodology.

3.4.5 Action plan for health system development

The Bank's HSD approach aimed at larger policy convergence at the country level by developing health system project interventions. Four actions were proposed in the 1997 HNP sector strategy as strategic means to prescribe guiding principles for developing health system projects. Those strategic means put the HSD as central agenda of HNP sector, and in turn the HNP sector made the HSD as main thrust for health system governance. Hence, the 1997 HNP strategy had become a plan document (especially chapter three) for the expansion of HSD across the world (WB, September 1997, p. 17).

This research contemplates that those four actions (or strategic means) laid down the programmatic outlines, lending conditionality, and panned out as implementation guide to the health system projects. The brief discussion of those four actions/strategic means is required to understand how the health system policy traversed from Washington to Delhi! In the Indian case, the transfer of this policy had been translated into lending of state-level health system project. This research has done an extensive analysis of one

of those projects (Karnataka Health System Development Project) in the decade of 1990s in chapter six.

Action - 1: Sharpening strategic directions (WB, September 1997, p. 17 – 19)

Out of the four actions of the first sector strategy, the first action was the most significant in the discourse of health system. The first action mapped out strategic directions for all three mentioned health system objectives.

For the first objective (improving health outcome), three principles were adopted to include in the programme design; targeted approach from population perspective, Sector Wide Approach (SWaP) in donor assistance, and demand side financing models in service delivery. Along with them, the promotion of intersectoral coordination (food, agriculture, water, transport etcetera) was also proposed in government policies (not via health system approach). Finally, the action stressed on the Bank's internal coordination of the projects/programmes with Human Development Network (HDN), Poverty Reduction and Economic Management (PREM) and Environment and Socially Sustainable Development Network.

The second objective (performance of health care system) was the place of work where HSD policy apparatuses were formed. This was the first time the Bank created policy apparatuses to strategically response to the health system challenges. Except cost-effective intervention (which was used as financing rationale till HSR phase), the 1997 policy developed new apparatuses (private sector regulation, organisational management, and private sector engagement) to advance the HSD approach.

Health system development was not conceived to be implemented in isolation. In order to link the health system policy with the economic policy, two different routes of linkages were planned. Outside the Bank, the policy was recommended to build close association not only with the Ministry of Health, but also with the Ministries of finance, privatisation and planning at the country level. Within the Bank, the policy should be in consultation with the International Finance Corporation (IFC), World Bank Group's member for private sector activity, and Finance, Private Sector, and Infrastructure (FPSI) Network for the purpose of divestment of social assets, and to assist supply of finance (private sector investment through loans) for non-governmental health care providers.

The direction for the third objective (sustainable health care financing) was strategised by introducing four methods; taxation (social security tax and revenue), mandated health insurance (social or community-based), private sector regulation (from arbitrary price), and direct subsidies to private sector. Along with those three methods, financing instruments for effective allocation and budget management were also strongly recommended. For successful implementation of health care financing methods and instruments, Ministry of Finance and Ministry of Social Security were identified as 'principle counterparts' along with Ministry of Health to coordinate with. The Bank's PREM network was also recommended to include the implementation of policy objective, since they closely work with the lending countries' economic wings (finance ministry/planning commission).

This particular strategic direction (devised for objective three) did not directly recommend for increase in public spending in health care, instead innovated financing methods and propose for financial instruments to attain sustainability of health care financing within the usual budget constraints. This is a new 'product' generated by Bank that suddenly claimed to achieve financial sustainability without advising for budget increment. Further, the mandated health insurance method was also proposed to assure health care coverage for bottom forty per cent (already adopted as a principle for objective one) by the state. This mandated health insurance in present-day context is nothing but a strategic purchase (through health insurance/assurance) model. These directions with regards to third objective were significant in the discourse of health system, because financing (and not any more budget) became part of health system policy from HSD phase only with the rationale of risk pooling and an aim of sustainability.

The summary of strategic directions outlined in the first sector strategy for three interlinked health system policy objectives informs that the basic tenets of health system policy structure were same, the sector strategy additionally provided a logical framework to design future health system project. The strategic directions were made to adopt principles, policy apparatuses, financing methods - instruments, and build a network of policy dialogue within and outside the Bank. The network building was an important strategy, and taken to ensure the sustainability of the policy (or longevity of the product). The Bank knew that success of modified health system policy (driven by HSD) would be depended on inter-ministerial coordination and assistance of the Bank's

internal coordination. Most importantly, HSD within the health system policy had planted the seed of commercial expansion of health care provisions by deciding to finance for profit nongovernment health care providers through IFC.

Action 2: Achieving greater impact (WB, September 1997,p. 19 – 21)

Under this action, four principles were formed in order to achieve the impact of the policy objectives and strategies set for. The principles were for overall HNP sector, this PhD research interprets them in relation to the HSD phase of health system policy. It is found that with those four principles the Bank actually devised tools and instruments for advancing health system policy to the country and further state level.

The Bank knew that new approach of health system would be in need of strategic direction at the country level for policy implementation purpose. This logic made the Bank to utilise Country Assistance Strategy (CAS) to strategically direct the health system policy (principle one), *per se* from Washington to Delhi. Thus in health system policy process, this research opines that CAS should be considered as policy tool to coordinate between HNP staff and Bank's country team for implementing HSD led health system policy. Utilising CAS as a policy tool is extremely smart move by the Bank, because CAS is officially linked to the planning mechanism (for example, Planning Commission in case of India) of the borrowing country. Apart from that, CAS is also a viable policy tool as it is an analytical compilation of all other sectors (education, social protection, transport, water etcetera).

In the second principle, Bank devised knowledge dissemination platform through mounting on research and analysis activity for health system policy adoption purpose at the country level. According to the Bank's terminology, it was known as Analytics and Advisory Assistance (AAA), and later on rechristened as Advisory Services and Analytics (ASA).[59] AAA initiative was started by then Bank President Wolfensohn (1995 – 2005) to nurture the idea of Knowledge Bank (Informant 07). AAA instrument was not same like lending instrument as explained in the next principle. Through AAA and other research activities, Bank wanted to have policy correspondence with the

[59] The Bank did not use the terminology AAA/ASA in the 1997 HNP Sector Strategy. However, the principle two of action two in the concerned section does refer to the roles of AAA.

nation-states' planning cycle by conducting studies on mostly policy mechanisms. The role of AAA conducted studies/researches is analysed in detail in chapter four. Those research serve as feedback mechanism to Bank about implementation-level challenges as well as means to persuade the borrower country for policy level adoption and implementation. This research opines that AAA in other way is a policy instrument to diffuse the Bank's health system policy, and at the same time to disseminate new knowledge in regards to health system approaches (such as, HSD).

The third principle (increasing selectivity in lending) outlined two types of selectivity, product and country. The product selectivity in regards to health system is done to assess the need, capacity and expected benefit of the country. The other selectivity criterion is the condition of the lending country, where "[s]*electivity based on the degree to which policy dialogue and project activities influence the allocation of existing recurrent expenditure is another way for the Bank to leverage its financing*" (WB, September 1997, p. 20). It means that Bank needs to assess whether the lending would lead to restructure the government's financing policy or not. Thus increasing selectivity principle is nothing but a policy instrument (lending) of the Bank in order to secure the successful implementation of the policy. For lending instrument, policy levers, as listed earlier, are important in order to design policy mechanisms and components for implementation and operationalisation of the project. Lending instrument assesses the viability of health system projects as product, and check the likely efficacy of the product's performance in the concerned product site (country and/or state). Hence, the instrument works from two different sides. The product selectivity is carried out from the country's perspective. Conversely, the country selectivity is assessed from the perspective of product's future performance efficacy. This instrument has special significance in this research. The implementation of all the state-level health system development/strengthening projects financed by the Bank in India (and in the other parts of the world also) have been implementing through this instrument. In chapter four, the role of lending instrument at the country-level is discussed in detail.

The Bank also developed client friendly services (principle four) in order to popularise the health system projects and policy suggestions among the borrowers (or client countries). In that process, four measures were taken. HNP was envisaged to transform

as knowledge hub. The dedicated resources were arranged to assist the client countries for appraisal of project design and implementation support. SWaP was introduced as a new type of funding assistance where other actors can be pulled in. All the initiatives were taken to make the health system projects' loans available for carrying out systemic reform.

Action 3: Empowering Bank HNP staff (WB, September 1997, p. 21)

The sector strategy identified manpower as one of the needed strategic mediations that Bank should deal with for its own institutional reform in order to support the client countries with health system policy implementation. Three aspects (skill, recruitment shortage, operational management) were drawn upon in this regard. The issue of staff empowerment also gave thrust on the health system agenda as the Bank demarcated that the staff should be capable to work with complex policies, and have an understanding of political economy of reform.

Action 4: Building partnerships (WB, September 1997, p. 22)

The 1997 sector strategy understood the importance of forging partnership with the client countries, civil societies, UN agencies and other Global Health Institutions (GHI). WHO appeared as an important partner under this strategic direction. The Bank decided to take the technical support of the WHO at the country level to design, supervise, and evaluate the Bank financed projects. For GPPP, Bank through Global Forum for Health Research decided to work in partnership with pharmaceutical, vaccine and biotechnology industry to strengthen research and development.

The 1997 sector strategy served as operational manual of HSD approach to health system. However, the Bank's own analysis in 2007 second HNP sector strategy shows that 1997 HNP sector strategy did not have smooth operational experience. HNP sector was the lowest performer among the all other Bank's lending sectors (WB, September 1997, p. 37). More importantly, it is found that Bank's HNP staff had declined in between 1997 and 2007 by fifteen per cent despite the increased commitment of the Bank in both lending and non-lending streams (including international partnerships) (WB, September 1997, p. 44). It means that HSD led health system had to face strong implementation level challenges.

In the 1997 HNP sector strategy, the Bank's prescribed HSD approach prepared the structure for state and market to participate in health system organisation and management. Thus the plan of action was drawn to ensure that HSD approach should follow the spirit of PPP in the development of new health system. Till HSR phase the Bank was mostly involved in directly financing projects through lending instrument for the expansion of health system. In the 1997 policy document, the Bank advanced/sharpened as well as developed new tool (CAS) and instruments (AAA and lending). Those tool and instruments were essentials in order facilitating the HSD projects as well as creating an enabling environment wherein HSD oriented health policy could be adopted in the national plan of the countries, and subsequently get implemented.

The Bank used coordination and partnership as methods to advance the HSD approach. It proposed various types of internal and external coordination with other units/ministries to create a platform of dialogue. Importantly, the interaction was planned to hold with state bodies only, but agenda of interaction was envisaged on the prospect of state-market relationship in health system. Simultaneously, the partnership with GHIs was also envisaged as a direct support to GPPP. The HSD approach was a planned move of the Bank in IHG to advance the agenda of reform and confirm the commitment made on GPPP. This research argues that Bank deliberated on HSD approach to orient the health system as strategic operational resource for facilitating state-market interaction by bringing PPPs and making room for private sector at the service delivery level. The financing objective was introduced to create categories where to spend and where not to spend, and the message was that financing sustainability in public system be achieved by strictly following the categories. Through HSD approach, the Bank undoubtedly took the role of leadership on behalf of IHG for developing new health system in LIMCs/LICs.

3.5 Health system strengthening (2007 onwards)

Within ten years of launching HSD approach, the Bank moved to another approach of health system, i.e. Health System Strengthening (HSS). The HSS approach is endorsed through the Bank's second HNP sector strategy, *Healthy Development*, published in 2007. The same approach is so far the last as well as latest health system approach. Unlike in the past, the HSS approach is not apparently linked to any outcome of IEG.

Question is why the Bank went for another health system approach. Following is the analysis of IEG and IHG with regards to MDG and UHC in order to understand the origin of HSS and how the Bank got involved into HSS.

3.5.1 International Economic Governance consensus on MDG

In the international political economy, the Washington Consensus proved not to be very effective even after one decade of successful globalisation of the policy. The sharpest critique of the Consensus was it did not consider the equity question (Krugman, 2008, p.34). Stiglitz opined that reform in global governance should be the first order priority (by proposing a set of eight mechanisms including changes in the governance of World Bank, IMF and World Trade Organisation/WTO) to have any post-Washington Consensus consensus or beyond that (Stiglitz, 2008, p.319 – 322). However, till date no common consensus has arrived yet in IEG, rather the post Consensus phase is still going on. The equity question, crisis in development finance, widening poverty again compelled the IG to embark upon a new development declaration, the Millennium Development Goal (MDG) in 2000. Meanwhile, the Bank finally dropped the structural adjustment policy (adjustment lending policy) and moved to development policy lending in August 2004 (Paloni, 2008, p.1042). Arguably, the development lending policy is more democratic and participatory in nature than the SAL. Though, the criteria for lending are similar, such as CAS consultation, coordination among development actors, macroeconomics capacity etcetera (WB, August 2008).

The HNP second sector strategy came out in that context where the normalisation of Washington Consensus, and emergence of MDG occurred together. The launch of MDG was indeed the origin of a new development dialogue in IG.[60] Though MDG was a target bound declaration, still it was recognised as a major thrust for health system. The hypotheses conceived was that the performance of a robust health system would hold the key to achieve health MDGs (goal number: 4, 5 and 6). For example, the objective of the Bank financed Karnataka Health System Reform and Development Project was to help the Karnataka state of India in achieving health MDGs. The MDG movement undoubtedly accelerated the effort towards better health system intervention

[60] See further on MDGs at https://www.un.org/en/mdg/summit2010/pdf/List%20of%20MDGs%20English.pdf. Accessed on 13 February 2019.

at the country-level (Bennett, Frenk & Mills, 2018, p. 2). Simultaneously it also needs to be recognised that the movement gave required 'legitimacy' to the Bank to continue with the development methodology that endorsed public private partnership. It is further evident from all the post-MDG aid consultations; Monterrey Consensus (UN, 18 – 22 March 2002), Rome Declaration in Harmonisation (OECD, 2003), Paris Declaration on Aid Effectiveness (OECD, 2005) and Accra Agenda for Action (OECD, 2008) where the importance of private sector/capital was unequivocally accepted for meeting MDG. This acceptance stemmed from two aspects, aid coordination and partnership.

The aid coordination and partnership have come hand in hand in the IEG. The initiative was first proposed in the *Monterrey Consensus on Financing for Development* in 2002 where mobilisation of financing (from domestic and international sources including FDI) and international trade were theorised as key strategies for development (UN, 18 – 22 March 2002). In a follow-up, Paris Declaration on Aid Effectiveness in 2005 had stressed for a "*single framework*" of development aid to "*strengthen development capacity*" of the recipient countries in order to continue with "*[r]eform procedures and strengthen incentives*" (OECD 2005, p. 3, 4 and 6). Thereafter in Accra Agenda for Action of 2008, the "*effective and inclusive partnerships of development*" action has been suggested to stop the fragmentation of aid (OECD 2008, p. 17). The precedence of aid consultations inform that finance became the priority for development in IG, and thus financing development came with the conditionality of coordination and partnership. This is the origination of aid coordination and partnership which subsequently impacted IHG also.

3.5.2 IHG consensus on HSS

On the IHG front, the disease-specific focus of international financing and followed by vertical health interventions was in principle contradicting the IEG's aid coordination and partnership agenda. Then newly developed financing mechanism (public private partnership) mobilised both the GPPPs (GAVI and GFATM through Advanced Market Commitment) and WHO (partnership model of Roll Back Malaria, 1998 and Stop TB programme, 1999) to concentrate on vertical disease-based interventions (WB, 2007,

p. 146).[61] This mobilisation had a negative impact in the progress of health MDGs (Travis et. al., 2004, p. 900). The slow progress of MDG was the moot point for the IHG to take retreat to health system, since the assumption "*that through the implementation of specific interventions the system will be strengthened more generally*" was by then null and void (Travis et. al., 2004, p. 900). IHG was in sheer need of better health intervention design that would overcome the barriers of vertical (single disease-specific intervention) vs horizontal (integrated health care service) debate, and also justify the meaningful contribution of GHIs in the Development Assistance for Health (DAH).

Finally WHO in April 2005 made an attempt to resolve the vertical-horizontal conflict of programme design by developing "*the health system action agenda*" for "*Making Health System Work*" in the Montreux meeting (Travis, 2006). The action agenda theorised 'component' based contribution by proposing HSS metrics to make the health system work. The action agenda defined HSS "*as building capacity in critical components of health systems to achieve more equitable and sustained improvements across health services and health outcomes*" (Travis, 2006, p.4). The components were policy, financing, human resources, supply systems, service management, and information and monitoring system. The component-based design of health system helped HSS in two ways to become acceptable. HSS opened new routes of financing approach to design programme, such as diagonal approach, which can justify the financing of GHI (Ooms, Van Damme, Baker, Zeitz, Schrecker, 2008).[62] Also, technically HSS has the potency to integrate all types of intervention under one umbrella, i.e. health system, because the contribution in HSS not programme specific rather component specific. For example, GFATM as a disease-based funding mechanism of GHI is also contributing in HSS by addressing governance, financing, medicine and technology. Hence, HSS made GHIs to become 'partner' for 'aid coordination' in the IHG as explained below (Travis, 2006, p. 1):

"For each of the six components of health systems, there are opportunities, roles and

[61] AMC is a legally-binding contract in order to subsidise the purchase of yet to be explored vaccines against the diseases that cause high mortality and morbidity. This is strategised as stimulus to research on orphan drugs – the drugs which are mostly needed by the poor for selective diseases.

[62] The diagonal approach is a financing methods in oppose to horizontal (for the betterment of health system) or vertical approach (focussing only at disease-specific intervention) of financing to improve results for disease-specific intervention through the betterment of health system.

responsibilities for GHIs, and some emerging platforms for more concerted action in countries. GHIs can invest in health system strengthening in four ways: through direct funding; by participation in critical policy dialogue in countries; by more informed advocacy on health systems by GHIs to their partners; and by finding ways to align better with national policies and systems, as set out in the Paris Declaration on Aid Effectiveness".

The HSS was developed to justify the involvement of GHIs in IHG in order to keep the funding sources intact from the initiative called Global Health Partnership (GHP) for accelerating MDG progress and follow the aid coordination principle.[63] Thus it is required to understand that HSS did not propose any effective programme management framework. Through its components, it proposed a governance framework. This framework was essentially envisaged to foster partnership between supranational actors and GHIs in IHG, and maintain aid coordination at the national-level. The governance attribute had made the HSS to operate as a partnership tool for all the IHG actors. World Bank joined into HSS effort in order to confirm the IHG consensus on aid coordination and partnership.

The HSS as governance framework for GHP and aid coordination took turn towards functional approach for getting involved in the operation of health system.[64] Arguably the seed of functional approach in health system can be traced into the *World Health Report* of 2000 where "*health systems*" performance is sought to be understood by stating "*what they do – how they carry out certain functions – in order to achieve anything*" (WHO WHR, 2000, p. 24). Thereafter in 2002 – 03, control knobs framework identified that financing, payment, organisation, regulation and behaviour are key functions to assess health system performance (Robert, Hsiao, Berman, & Reich, 2002). This is the framework which was later on adopted by the Bank through World Bank Institute's Flagship Program on Health Sector Reform and Sustainable Financing (1997-2008).[65] At present the framework is active within the HSS since the flagship programme is now renamed as HSS.

[63] GHP terminology is used in the WHO's Health System Action Agenda working paper (Travis, 2006).
[64] Functional approach refers to in this thesis is as an approach that considers health system is a complex organisation, and must be segregated into functional departments/components in order to govern.
[65] More information regarding the Bank's flagship programme on health sector reform is available in the link. (http://documents.worldbank.org/curated/en/589951467994653581/pdf/80763-Reflections-on-WBI-Capacity-Building-in-Health-Box-377336B-PUBLIC.pdf. Accessed on 21 January 2016)

The WHO also endorsed health system's functionalist approach emphatically. The organisation altogether published three health system policy documents (2000, 2008 and 2010) between 2000 and 2010 for its annual flagship publication – *World Health Report*. The functionalist model of health system preached for macroeconomics integration. In this regard, the WHO set-up Commission on Macro Economics and Health (CMEH) in January 2000 advocated that *cost-effective health interventions* should be in line with the national macroeconomics framework, and recommended IMF and Bank to work with recipient countries in order to build conducive environment for effective health interventions and poverty reduction (WHO Commission on Macroeconomics and Health, 2001, p. 18 – 19).

The next leap was when WHO in 2007 came up with six Building Blocks framework where six functions of health system (service delivery, workforce, information system, supply and technologies, financing, leadership and governance) had been identified for strengthening health system (WHO, 2007, p. 3). These health system frameworks have become operational/functional references to health system. At this point of time, Bank proposed, in its 2007 HNP second sector strategy, HSS approach because "*well organised and sustainable health systems are necessary to achieve results*" (WB, 2007, p. 5).

The above discussion on the utility of HSS's functionalist approach tells us that it is instrumental at macro level for GHP in IHG, meso level for aid coordination in the country set-up, and micro level for operational health system. This research has found that various international health actors and platforms in the second half of 2000 started taking HSS in cognizance for governing health system at various levels. The International health Partnership and related activities (IHP+) got formed in 2007 to develop a common M&E framework for assessing country-level HSS initiatives (WHO, October 2010, p. vii). Around the same time, Global AIDS Vaccine Initiatives (GAVI) and Heiligendamm Summit of G8 countries also financially endorsed HSS in IHG (German Institute for Development Evaluation, 2016, p.15). This poses the question as to what governance was expected from HSS. The answer is IHG found the methodological consensus in HSS to aim for achieving Universal Health Coverage (UHC). While the methodology is related to the functionalist model of HSS, the consensus is actually a common agreement on the governance of UHC. This research considers that the consensus over HSS is the motivator behind IHP+ like forum's

transformation, as assessed by Dr. Philida Travis, from a forum for aid effectiveness to an advocacy platform of UHC (Dr. Phillida Travis, Team Leader - HSS at WHO SEARO, personal communication, August 26, 2016). The HSS became more pertinent after WHO launched the UHC movement in 2010 (WHO WHR, 2010).

In UHC, IHG has found an international harmony to uphold once again Health for All goal. This has made UHC to be applicable in all the three levels of system (macro-meso-micro). It demands for partnership at macro system, aid coordination at the meso system, and service coverage at the micro system. Thus the effect of GHP (macro system) and efficiency of aid coordination (meso system) is intermittently linked to the performance (micro system) of UHC. This performance is based on the UHC essential service indicators (SDG indicator 3.8.1) that consist of RMNCH, communicable diseases, non-communicable diseases etcetera (Hogan, Stevens, Hosseinpoor, & Boerma, 2018). Hence, like financing of GHP, aid coordination in DAH is also required to achieve targets of communicable diseases, immunisation coverage etcetera. It is argued here that inter-linkages of UHC from macro to meso to micro systems create the room of opportunity for HSS to operate as 'single framework' of development aid as agreed on the Paris Declaration on Aid Effectiveness in 2005. This single framework is the framework of HSS governance. In this governance framework, UHC is "*at the centre of the health goal*" in SDG (goal number 3.8) for WHO (WHO SEARO, 2018), and HSS is widely recommended means for achieving the ends – UHC (Kutzin & Sparkes, 2016, p.2).

Though chronologically the Bank's HSS approach led health system policy (2007) came before UHC (2010), but the commitment of partnership and principle of aid coordination paved the way for the Bank to forge a policy-level alliance on HSS for aid effectiveness in IHG. Further, technically there was no problem for the Bank to invest in health system through HSS, since HSS is a governance framework and not a programme management framework, which otherwise might pose challenge to the Bank's viewpoint of health system operation. Thus HSS interventions can be ranged from single disease programmes (disease-specific HSS, e.g. GFATM rounds) to multiple disease programmes (cross-cutting HSS, e.g. GTZ basic health care project) to capacity building of state in policy making or system building (sectoral HSS, e.g. World Bank health system projects) (Shakarishvili et. al., 2011, p. 319). After 2010, Bank also joined the UHC movement by articulating its HSS approach in health system.

3.5.3 Formula of HSS approach

To understand the HSS's contribution in the partnership model of development at the micro level, the formula of HSS approach has to be analysed. In the 2007 second sector strategy, the Bank introduced HSS as a new formula for health system approach. It has embarked upon a set of functions to uphold them together as HSS initiatives. According to the Bank, any contribution to those activities would be considered initiatives towards HSS. The HSS approach has modified the health system policy by formulating a "*right chain of events*" (WB, 2007, p. 5):

Financing – regulatory framework for PPP – governance – insurance – logistics – provider payment and incentive mechanisms – information – well-trained personnel (human resource) – basic infrastructure and supplies.

The Bank denotes that "*the failure of any of the nine key functions may compromise overall health system performance, partners need to closely monitor collaboration at the country level*" (WB, 2007, p. 80). This is a new formula because the health system is envisaged to address through functions and not from the perspective of values as in the case of HSD approach. The HSS phase brings more definitive action in the organisation of health system. The organisation is indicated to be based on the four effective health system functions (service provision, service inputs, stewardship, and effective financing mechanism (WB, 2007, p. 174). These four effective functions in operative design can be considered a combination of health system elements (total five - financing, governance, human resource, information, and infrastructure and supplies) and components (total four - regulation for PPP, insurance, logistics, and provider payment and incentives).

It is important to note that in the 2007 second HNP sector strategy, the Bank did not specifically mention about any objectives of health system; rather it set strategic objectives for overall HNP sector. The objectives are result achievement, financial protection, financing sustainability, and good governance (WB, 2007, p.57). All the four objectives are directly linked to health system objectives, but putting them as HNP sector objectives reinforce that the Bank has indeed considered HSS as a governance tool to steer the entire sector. It is well validated in Bank's own admission that HSS approach is conceptualised as a "means" to achieve all the four objectives (WB, 2007,

p.57). HSS as means has revised the policy structure of Bank's health system by employing the four objectives.

The first objective is a reiteration of the improvement of overall health status along with the push for result-based achievement. In this objective, HSS approach is considered as cornerstone because "*well organised and sustainable health systems are necessary to achieve results*" (WB, 2007, p. 5). The focus on result-based achievement was given to rally behind support for health MDGs (WB, 2007, p. 58). The second objective (financial risk protection from illness) is not a completely new entry in the HSS based health system approach, since it was already proposed as a mechanism for risk pooling in the HSD phase. In HSS, the risk pooling has got a higher order priority by being elevated as an objective. It needs to be understood that financial protection may appear as a health financing function, but it is basically an outcome of service delivery. The excessive cost to health care service is envisaged to address primarily by arranging/providing services for patients. The financial protection comes as efficiency outcome (secondary) of service arrangement/provision in order to test whether the services are causing any financial hardship or not.

The Bank introduced risk pooling mechanism (tax-based, social/private/community insurance), withdrawal of user fees (provided government compensates the resource gap), and effective pro-poor subsidy policy measures as inputs to address the service delivery concerns (WB, 2007, p. 61, 63 and 64). The Bank's inputs are an advisory to develop financing mechanism (risk pooling) and components (insurance/user fee/subsidy), and have nothing to do with service delivery. Those inputs, as per the Bank, would protect the patients from any financial hardship with regards to access to health care services. This is the covert tactic of the Bank's policy prescription where astutely the suggestion is made to purchase service from the private sector. Pro-poor subsidy is nothing but a subsidy to the private sector to provide free or affordable service to poor patients. The financial protection is schemed to introduce strategic purchase (publicly purchased private health care services) in health care service provision. This research wonders what reason stops the Bank to directly say so.

Regarding the third objective i.e. financial sustainability in the health Sector, and its contribution to macroeconomic, fiscal policy and country competitiveness, it is found that the Bank has advised health sector policy to be in conversation with

macroeconomics policy to manage and create fiscal space, foster productivity, employment and growth (WB, 2007, p. 64). Linking health policy with fiscal space management brings a new dimension in health financing that proposes health to be guided as a subject of market and economic conditions, and not anymore a budget exercise. It is implicit in the objective that health financing needs to consider market investment, public debt situation, growth and employment generation.

It is to be further noted that, like strategic purchase of second objective, the third objective also shows vagueness in properly describing the objective. The 2007 sector strategy is completely silent about the meaning of country competitiveness. It uses 'global competitiveness' and 'country competitiveness' terminologies number of times without explaining what do they exactly refer to in relation to health policy or *per se* 2007 second sector strategy. The country competitiveness may be interpreted as the ability of health policy to create environment of competition for the growth of health care market. Similarly the 2007 sector strategy fails to describe what fiscal space in health is. Fiscal space management may be used to restrict finance in public health care infrastructure in order to invite investment from market. This research observes that with this objective Bank through HSS approach wants to create a public policy for private health sector development.

The fourth objective (improve governance, accountability, transparency in the health sector) addresses the concern of governance in the organisation of health system. The objective is again very general. It refers to strengthening of bureaucratic actions, management organisation, community monitoring and legislative framework. It also stresses on the regulation side including self-regulation by professional bodies (WB, 2007, p. 66 – 68). The analysis of objectives shows that they do not cover the service delivery role of public sector. The strategic purchase is 'strategised' in replacement of service delivery. The financing mechanism is risk pooling with insurance as most the favoured option. The role of the state is suggested as financer and arranger of health care service, with a narrow space of direct provision for only preventive and promotive health care services. The second and third objectives are found to be complementing each other. The demand generation through strategic purchase for health care service (second objective) is planned to be met by the creation of new market of health care sector through fiscal space management (third objective). HSS approach at the level of operational health system is devised as a 'means' to purchase service from private

sector, building capacity of public sector in financing and service arrangement, and develop market for private health care sector. This strategic means how that wanted to support MDG is not clear, because none of the objectives gave a blue print for achieving MDG except merely asking for result-based achievement. The HSS approach has indeed changed the structure of health system policy. This changed health system policy structure is the outcome of same partnership model which both IEG and IHG have collectively emphasised. The Bank's HSS approach has been tasked to advance the partnership model (public private mix) at the operational level of health system for service delivery.

The assessment made on HSS approach's partnership-based operative health system is further strengthened by some key proposals listed in the Bank's second sector strategy. The most important among them is Bank's HNP sector has been advised to collaborate with Private Sector Development (PSD) and IFC units of the Bank for better health indicators and the development of public policy to govern private health care (WB, 2007, p. 49). In HSS phase, similar to HSD phase, the Bank intends to promote coordination with the Ministry of Finance, this time especially on fiscal and macro-economic policy (WB, 2007, p. 48). This research finds that the Bank interprets the HSS approach as an agenda of implementing innovation based on partnership model to organise health system at the operational level. The policy levers of HSS approach, as mentioned in the 2007 sector strategy's result framework, says that the intention behind implementation of innovation agenda was to improve the MDGs and NCDs for targeted population and financial risk protection (WB, 2007, p. 133). Needless to say, the same intention after 2010 has been geared towards UHC in order to offer service delivery and financial protection as declared in the 2015 UN General Assembly Resolution for sustainable development (UN General Assembly Resolution, 25 September 2015).

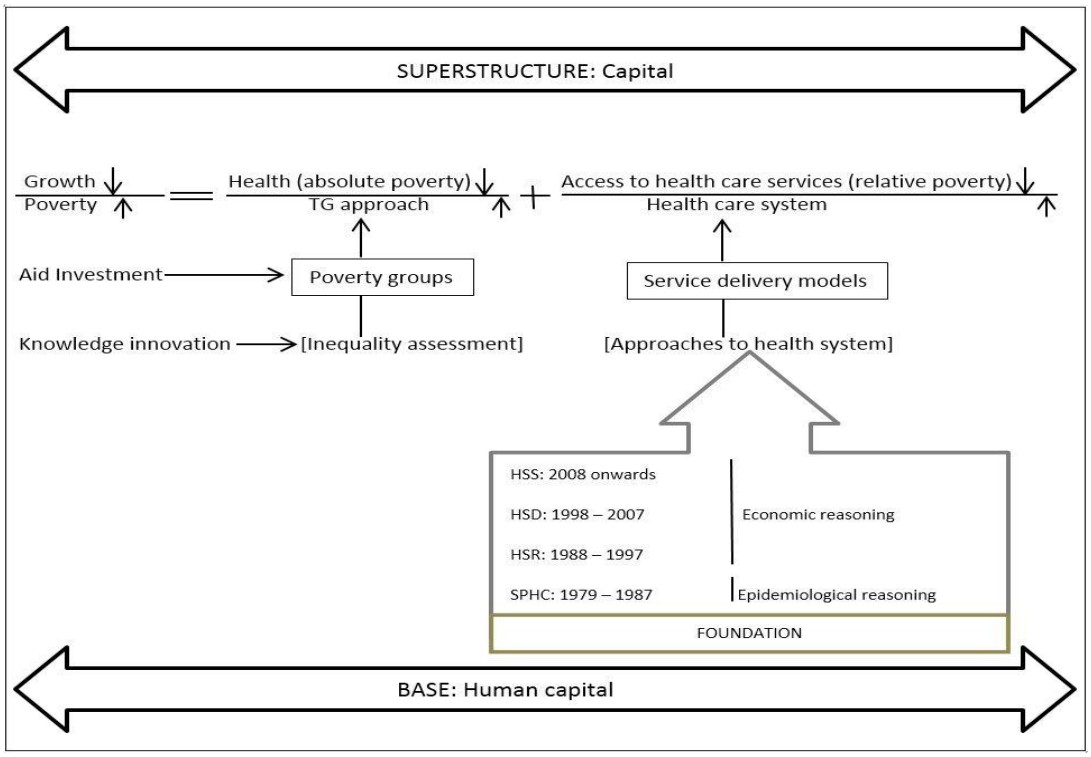
3.6 Summary of analysis

The discourse of the last fifty years (started from 1969) of World Bank's health system policy analysis shows that health system is fundamentally rooted into IEG. So far the changes made in health system approaches in IHG are the impacts of IEG. The political economy of IG and the decisions of IEG together act as policy formation stage where the agenda for health system gets formed. That very agenda gets translated in IHG as structure and theory of health system at the policy formulation stage. The relationship

between IEG and IHG under the context of international political economy denotes as macro system of health system policy formation-formulation level. For example, the policy agenda at the policy formation stage so far were human development (embryonic and health care system phases), optimal utilisation of minimum resource in health expenditure (HSR phase), GPPP (HSD phase), and MDG (HSS phases). Those agendas got formed respectively because of struggle over UN bi-polar power structure (embryonic and health care system phases), over emphasis on SAP (HSR phase), Washington Consensus (HSD phase), aid harmonisation and coordination (HSS phase) at the stage of policy formation.

Unravelling the process of amalgamation of policy formation and formulation is the key to understand the World Bank's health system approaches. Therefore, to meet the agendas the approaches change. The diagram below shows the evolution of different approaches of health system, reformulation of policy, and reconfiguration of policy structure.

Figure 3.4: World Bank's health system policy evolution



Till date four health system approaches have been employed to organise health service system for health care service delivery. The health system approaches keep changing because of the design of service delivery, which organises health service system. The

first change occurred after the replacement of SPHC approach with HSR approach. That replacement also was symbolised as the change in epidemiological reasoning in the planning of health service system organisation. Thereafter economic reasoning has been the prevailing rationale of Bank's health system policy in all of its approaches. This shift from epidemiological to economic reasoning happened because of the reformulation of the policy, where human capital was repositioned from structure to base, and capital was made as new structure. This reformulation had a long term impact in the discourse of health system policy. Because based on that reformulated health system policy, all the subsequent economic reasoning led approaches were able to incrementally change the service delivery design. In turn, those changes also reconfigured the Bank's health system policy structure. The structure is conceptually oriented towards cost-effectiveness, theoretically claims to protect the body for increasing productivity, and operationally suggests risk pooling mechanisms.

The reconfiguration of health system policy structure was linked to policy formation stage. In the policy formation arena, the budget deficit of UN organisations including World Bank in 1990s and post 2000 onwards increasing financial dependency on GPPP for global health financing had changed not only the structure of IHG but also the Bank's health system policy outlook. In the drive for ameliorating the GPPP initiatives, the Bank first moved from HSR to HSD, and then HSD to HSS. These shifting of approaches had changed the service delivery models (as determined by economic reasoning) also. Thus in the service of bottom forty per cent of population, which is always at the realm of public system, the approaches kept moving from care-based to value-based to function-based reform in order to redefine the state-market relationship for more and more involvement of private sector in public service. Yet on the other hand, the Bank maintains strategic silence on the role of public policy for the rest of the population – upper sixty per cent. As a result, the Bank's health system policy documents both in HSD (1997 HNP sector strategy) and HSS (2007 HNP sector strategy) phases represent health system policy of both public and private sector as shown earlier. Overtly they prescribe private sector participation in public system for the service of 'bottom forty'. Covertly, they restrict public policy to deal with private health care service delivery and instead facilitate development and engagement of private sector for 'upper sixty'.

The Bank's two-way health system policy always have one common goal; stronger private sector participation. Because the omnipresence of private sector is required for '*free flow of capital to invest, to create employment, to finance welfare, to develop infrastructure and so on'*, as argued earlier in this chapter. All these are done at the behest of capital in order to generate economic growth. So, not investment on human capital, but investment on capital generates economic growth. In health system policy, capital (positioned as structure till HSD phase) also influences human capital (base) to serve as the base of productive relationships between health care and population for maximising growth. It is argued here that in this process of growth maximisation, human capital under the influence of capital keeps changing health system approaches (foundation) to form new productive relationships. According to this research, the continuous change in health system approaches for having more productive relationships create a reciprocal understanding between structure (capital) and base (human capital) within the health system. This reciprocal understanding in the HSS phase has reconfigured health system policy structure by elevating capital from structure to superstructure. The HSS phase is considered as the phase of reconfiguration because in the HSS phase only the Bank explicitly link health system policy with economic growth as discussed earlier (*also see* WB, 2007, p. 64).

The reformulation in health system policy had made another permanent change in the Bank's method to organise health service system. In the SPHC approach, the Bank had a programme management framework to organise health service system. But after the reform-based approaches started (HSR/HSD/HSS), the Bank gradually adopted to governance framework for the organisation of health service system. The governance framework does not have any management model, rather policy-based functions to perform the task. This is especially observed in HSS approach. In the governance framework, only functions are considered, and not the management of care. Thus it is being argued HSS like approach conceptually promotes vertical design of health service system organisation.

It is important to note that despite the change in policy formula (during the HSR phase) and reconfiguration in the policy structure (in HSS phase), the Bank's basic theory of health system policy remains the same, i.e. protection of body from absolute poverty by organising necessary services in order to overcome the challenges of relative poverty for bottom forty per cent of population. The aim was (and is?) to protect the productive

body, where poverty was (and is still) conceptualised in absolute and relative directions. It is to argue here that poverty is now widely accepted as multidimensional, still the Bank's health system theory is revolved around age old absolute-relative model of poverty. In fact, Bank's annual flagship report *Poverty and Shared Prosperity* of 2018 recognises "*that many dimensions of well-being are not all readily available through markets*", thus nonmonetary dimensions are also needed to measure poverty (WB, 2018, p.108). The acceptance of multidimensional poverty means, the health system policy would need to re-theorise by shunning away the bio-medical model of intervention, and instead give due importance to bio-social model of intervention where social, political and economic determinants would also be considered along with medical factors. Is the market readily available to provide bio-social model of health care service delivery?

The Bank may not change its theory, but definitely change its aim of health system policy, i.e. 'to protect the productive body'. The second objective of Bank's 2007 HNP sector strategy is indirectly proclaiming that. The objective is to "*prevent poverty due to illness (by improving financial protection)*". HSS approach is active to address this objective through strategic purchase as argued earlier. It is a bitter truth that all other previous health system approaches of the Bank failed to address the challenges of excessive health care cost resulting in impoverishment, and that has paved the way to objectivise financial protection within the policy. But in order to address the failure of those health system approaches, a fundamental change is done in the Bank's health system theory. Selecting financial protection means that the Bank's health system has replaced the theory of protection of productive body with protection of individual/household finance. This change is so far completely unnoticed in the health system debate; however, it also silently rules out justification for Bank's further involvement in health system.

The Bank justifies that in health system financial protection is necessary because "*[i]llness is a determinant of poverty due to both excess health expenditures and loss of income resulting from nonparticipation in the labor market (or reduced productivity)*" (WB, 2007, p. 59 – 60). So according to this logic the Bank's HSS approach is addressing the effects of poverty (excessive health cost and loss of income), and not the cause of poverty (illness). This means the productivity is determined by financial security (capital), and not by the body of human beings (human capital). Then

it can be said that the Bank has accepted that growth needs capital, and not human capital as argued in the base-superstructure section. Further, since the main goal of health system remains the same, prevent poverty, then it is to be understood that the Bank also accedes that not human development (through income redistribution), but economic and social development (industrialisation and equal opportunity to market) can only address growth and poverty questions. Undoubtedly, the Bank's silent persuasion to bring strategic purchase has brought the Bank back to forty years' ago strategic choice, human development or economic and social development. The embryo (Alma-Ata delivered health system) was infected but not killed!

At the end of the last fifty years' discourse analysis of Bank's health system policy, this research finds that Bank's policy in health system is theoretically unfounded in its own health system approaches. It is high time for the Bank and IHG to think that how HSS is contributing into the strengthening of health system. The Bank admits that the experience with the macro issues of health system put itself in advantageous position. At the same time, the inability to deal with the micro-level issues is a cause of concern for the Bank. In the Bank's own assessment *"a large part of health system advice has to do with the micro issues of health service delivery and provider organization, for which the Bank has little comparative advantage"* (WB, 2007, p. 51). The next chapter analyses how these macro issues of health system helped the Bank to form interaction with Government of India at the meso level of policy system in order to go to micro issues of health care service delivery. Nevertheless, if the Bank's expertise on macro issues of health system is measured from the viewpoints of planning, employment generation, private sector growth, and private capital inflow-outflow, then both the design of HSS approach and Bank's policy theorisation are commendable. However, if Bank's expertise on micro issues of health system or specifically provision of health care service delivery is required to analyse from the rigour of policy theorisation, then PhD research is of opinion that Bank's assessment about its self-capacity, as quoted above, is inordinately overrated.

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Chapter 4: Situation analysis of World Bank's role in strengthening of India's health system

Summary of the chapter: The discourse of health system policy in last chapter analyses how the Bank from Health System Development phase started using specific policy tool and instruments for advancing the policy at the country level (or meso system). In this chapter the focus is on the Bank's role at the country level. It is a situation analysis to understand the practices of the Bank in terms of interacting with Government of India (GOI) for advancing the health system policy through the developed policy tool and instruments. The policy tool (Country Assistance Strategy/CAS) forges policy alignment with GOI's overall policy and planning outlook in order to ensure that the policy gets adopted within the national planning frame. Through CAS, the Bank further sharpens policy instruments (research and lending) for building direct interaction with the GOI and the state governments. Research is a useful instrument to initiate policy dialogues and advocacy on the Bank's health system approaches. On the other hand, lending through programmatic convergence with GOI's health intervention programmes create opportunity to offer direct support to the state governments for implementing the Bank's health system approach-led policy at the state-level. Both research and lending are acting as knowledge navigators to steer the Bank's health system policy from formulation (macro system at the international-level) to implementation (micro system at the national-level) stage. In this journey of navigation, they actively interact with GOI through knowledge dissemination (through research) and knowledge production (through lending). It is found that the policy outcome of these Bank-GOI interactions especially under the approach of Health System Strengthening (HSS) manifests into the articulation of National Health Policy 2017, and unveiling of strategic purchase scheme (PMJAY) in 2018. In the end, this chapter argues that HSS-led policy outcomes decision-wise are not evidence-based, and in practice re-engineer the public system towards UHC in order to cultivate private sector engagement in health care service delivery.

The entirety of health policy framing and intervention has been hovering in and around the concept of the Health System Strengthening (HSS) in India nearly for the last one decade. The drive for UHC has made the Government of India (GOI) also to take cognizance of HSS approach in its policy standpoint (for example, National Health Policy of 2017) and prioritisation of intervention schemes (for instance, *Pradhan Mantri Jan Arogya Yojana*/PMJAY). HSS's governance framework at one side is active to roll the wheel of UHC as nationally adopted policy goal, and on the other side is instrumental to operationalise PMJAY like strategic purchase scheme. The World Bank, hereinafter only Bank, has been a steady support to GOI and other Indian state

governments for institutionalising HSS approach that one may fulfill both the goal of UHC and the implementation of PMJAY.

The Bank's effort to build the governance framework of HSS in India is preceded by its long engagement in the domain of health system. HSS is the latest form of reform (i.e. function-based); but in the definition of state-market relationship, the stages of reform need step-wise elevation (from care to value to function) in order to reach to the level of HSS. This chapter is a situation analysis of the Bank's role in the strengthening process of India's health system. It is important to note that the situation analysis is not about the country's present health system performance, rather the Bank's interaction with GOI with regards to present health system performance. The chapter at first elaborates how the Bank has developed policy tool and devised instruments to advance its health system policy that has been shaping policy and practice of both union and state governments' health system. The second part analyses the HSS outcomes currently from Bank-GOI interactions at policy arena, and their conduct with population. The following are the research objective and research questions.

Objective

- To analyse the interaction between the World Bank and GOI in the strengthening of India's health system.

Research Questions

- What are the tools and the instruments developed by the Bank to interact with health system policies at the national level?
- Where are the Bank devised policy tool and instruments actively engaged, and how do they interact with health system policies and practices?
- What are the HSS related policy outcomes of these interactions?

The Bank has been active in the development of health system policy primarily for lending purpose. The respective health system approaches, as discussed in the last chapter, are the implementation guide for health system lending projects. In India, the Bank has been offering financial assistance to the several state governments in the form of loans for health system projects since 1994. These projects have not only been functioning as hands-on policy implementation of the Bank's health system approaches, but also serving as reference for India's health system orientation. The

Bank's policy before directly going into the state-level needs to interact with the Government of India. This intermediary level is the place for the Bank's policy to get adopted and modified in order to sync with India's health system policy. Thus the Bank devised policy tool (Country Assistance Strategy/CAS) and instruments (research and lending), as identified in the last chapter, are required to be analysed to understand the policy adoption-modification level.

4.1 Policy tool: Country Assistance Strategy

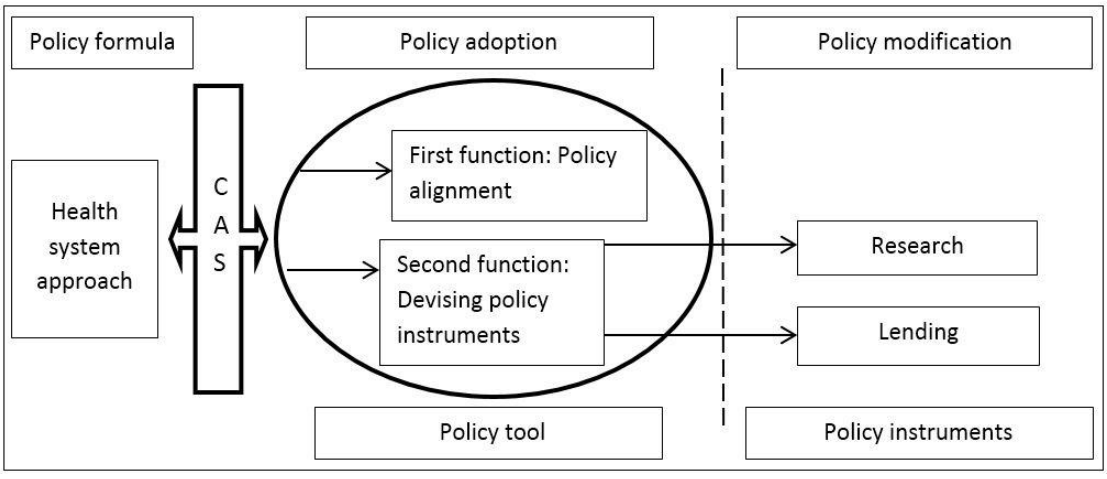
Country Assistance Strategy (CAS) got developed in the early 1990s to provide a strategic direction to the Bank's overall contribution in any given context, e.g. sector, region or country. From 1994, it became an independent country support document (WB, 1 September 2009, p. i). The method of CAS preparation is to assess national and international macroeconomics scenario, and accordingly develop a country-level strategic planning document in consultation with the Ministry of Finance (and also Planning Commission like bodies). For India, the Bank's development finance is a useful resource in various sector of the economy, and CAS is the vehicle of the Bank for that development finance. The health system policy financing is also a part of that development finance. Because CAS is a reflection of Bank's poverty reduction strategy, and thus designed as development plan to support the government programme (WB, 1 September 2009, p.iii). Since 1996, CAS has been active in India as three-year strategic plan document. From 2018 as per the change in the Bank's nomenclature, CAS was replaced by Country Partnership Framework (CPF, a four-year strategic planning document). However, the core of CPF is also to advance strategy for development finance in line with government policy.

CAS/CPF after 2005 Paris Declaration on Aid Effectiveness has become more relevant in the development scenario of the recipient countries for promoting harmonized development assistance (WB, 1 September 2009, p.v). Its significance in India's development planning can be best understood from the statement made by Mr. Subhash Chandra Garg (Secretary, Department of Economic Affairs, Government of India) in the inaugural event of the World Bank Group's India CPF (2018 – 2022) ("World Bank endorses", 2018):

"*I compliment the World Bank Group for aligning the CPF with India's development and investment objectives of high, sustainable and inclusive growth. I hope that the World Bank Group will be able to use its global experience and expertise in assisting India to achieve its objectives*".

The World Bank, because of its financing leverage and position in the international economic governance, has always commands a valuable role in the country's (India, in this case) development planning, wherein CAS/CPF has a distinct role to work as a channel between the Bank and the GOI. In the Bank's health system policy, CAS has two important functions. First, it establishes policy alignment between the Bank's policy formula and GOI's overall policy outlook. Second, it designates instruments to put the policy at the implementation level. The first function is all about consultation with the Ministry of Finance and Ministry of Health and Family Welfare and relevant planning bodies for policy alignment. Second function is to device instruments (research and lending) through which the policy would be reached to the level where it can be implemented. Both the functions neither take part in policy formulation nor policy implementation, rather active in transferring the policy from former to later. In this transformation there are two stages; policy adoption and policy modification. In brief, CAS's both the functions are employed in these two stages only. The following diagram explains it further.

Figure 4.1: Transfer of policy from macro system to micro system



CAS is active to bring the respective health system approach from policy formulation to policy adoption-modification stage. The ultimate objective of CAS is to get the policy implemented. Before implementation, at the policy adoption stage (first layer),

the first function (policy alignment) is under the direct command of CAS where the purpose is to ensure that the policy gets adopted within the national plan. The adoption of the health system policy by the GOI is necessary since the union government's approval and participation are prerequisites for the Bank's programme in any state (WB CAS (Country Assistance Strategy), 13 March 2001, p.ii). After the policy adoption, the second function of CAS is to devise instruments (research and lending) through which the policy can be reached at the stage of implementation. The policy implementation stage is falling under the state category. Because as per the Seventh Schedule to the Constitution of India (Article 246), health is a subject of State List (II), and not falling under Union List (I) or Concurrent List (III).[66] Hence, the second function designates roles to the instrument (research and lending) in order to put the policy at the stage of implementation. The policy instruments are active at the stage of policy modification (second layer) to reach to the stage of implementation after due negotiation with the respective stakeholders (both the state governments and the union government). The modification of the Bank's health system policy is carried out based on political and contextual factors varying from case to case. However, the basic tenets of the policy remain same. The following sections analyses the functions of policy tool.

4.1.1 First Function: CAS in policy alignment for advancing health system approaches

In analysing the role of CAS in policy alignment of health system, this research has tried to understand the particular purpose of alignment between the Bank and the Government of India. Since India is a part of international financial economy system, it is obvious that both GOI and the Bank's economic outlook are same. Thus the role of CAS in policy alignment needs to be analysed by identifying the rationale behind the alignments; otherwise the analysis would be just a set of findings of policy similarity between the Bank and GOI. It is identified that policy alignments has so far happened three times in last twenty five years at the policy adoption-modification level.

In the post macroeconomics reform (took place in 1991) context of India, the Bank got upset with the slow pace of reform. The primary reason was that the GOI was unable to push the reform at the state-level because of political differences, as constitutional arrangement and historical understanding give autonomy to the states to deal with

[66] The details of Seventh Schedule to the Constitution of India (Article 246) can be found at https://www.mea.gov.in/Images/pdf1/S7.pdf. Accessed 15 March 2018.

health, education (primary and secondary), industrial policy, taxation and other governance related issues (Kirk, 2007). Though it was beyond the purview of the GOI, still the 'second generation reform', scheduled to take place at the state-level for institutional reform, was a crucial concern for the policy makers of the GOI also. On the other hand, state governments by the middle of 1990s started facing fund crunch to invest in social sectors because of poor tax to GSDP (Gross State Domestic Product) ratio and surmounting interest payment for loans already taken (Kirk, 2007). This became the opportune moment for the Bank to provide state-level finance but on the condition of reform especially in social sector. In the case of health, it is evident from the Bank's 1996 – 98 CAS where it proposed to increase three-year HNP lending assistance from USD 618 million (1993 – 95) to USD 1090 million (1996 – 98), and also intended to finance state-level health system project (WB CAS, 19 May 1995, p. iii and 15).[67]

From the point of the GOI, external financing for state-level health system projects was absolutely fine because liberalisation policy was too difficult to pursue at the states owing to federal politics. and thus the GOI had accepted to the Bank's proposal to directly deal with the states. Further, the design of the Bank's state-level health system projects endorsed strong decentralisation drive, which on the one hand was an administrative requirement for reform, and on the other a chosen political line of governance after 73rd and 74th Constitutional Amendment took place in India. The strategy of choosing decentralisation had brought both the Bank and the GOI on same page in order to pursue governance reform at state-level. This policy alignment got reflected later on in the Ninth Five-Year Plan (1997 – 2002) where state-level reform was explicitly recommended (WB CAS, 2001, p.i). The GOI wanted to use Bank to pursue its reform agenda and the Bank was also in doubt about GOI's capacity in driving reforms at the state levels. So the crisis of finance at the state-level, strategy of decentralisation, and obligation of reform (for both GOI and the Bank) became the purpose of policy alignment. This policy alignment facilitated many health system projects lending in the entire second half of 1990s and continued till 2002/03.

[67] The Karnataka Health System Development Project, analysed by this research in chapter six, was a part of that three-state health system project.

The second policy alignment came with the launch of National Rural Health Mission (NRHM) by the GOI in the year of 2005. After the preparatory years of NRHM, the Bank gave a serious thought to complement NRHM activities by matching with the state-level health system project. The Bank's 2009 – 2012 CAS found that NRHM's innovative programmatic elements required robust service-delivery process, which the states were definitely lacking due to weak public systems. This became the rationale for the Bank to finance health system projects for overall capacity building of institutions, improving governance system and helping in result achievement for health Millennium Development Goals (MDG). The slow progress of the MDG was definitely a cause of concern for the GOI (WB CAS, 14 November 2008, p. 31 – 32). The Bank's project became not only the programmatic support, but also the financial support to the state government in order to match the state side of contribution for implementing NRHM. This particular practice is explored in detail in chapter seven under the Karnataka Health System Development and Reform Project. An interviewee with the knowledge of this matter in great detail confirms that after the actual operation of NRHM began, the Bank's health system projects lend their support to NRHM in almost every project states (Informant 08). For the GOI, the Bank financed health system projects became the additional support for implementing various programmes under NRHM.

The third and so far the last policy alignment is the common zeal for achieving Universal Health Coverage (UHC). The first thrust came from the High Level Expert Group constituted by the Planning Commission of India, where strengthening health system was recommended as the only way to achieve UHC (Planning Commission of India, November 2011). Thereafter the Twelve Five-Year Plan (2012 – 2017) also emphatically endorsed that health system pillars to be strengthened in order to continue the public private mix of health care service delivery for achieving UHC (Government of India, 2013, p. 9). The Bank's HSS approach led health system policy is an inevitable choice for both the GOI and the state governments in need of finance to chase the UHC milestone. The 2013 – 17 CAS has identified this area of strategic engagement for policy alignment by referring at the priority of inclusive growth under the twelfth plan (WB CAS, 21 March 2013, p. 36).

Decentralisation along with state-level reform, NRHM and UHC are the areas of three broad policy alignments which the Bank strategically formed since 1990s to till date

for ensuring the policy adoption of the Bank's health system approaches by GOI. The Bank's lending of health system projects has been continuing in Indian states because of these three alignments which took place over different points of time. It is found that policy alignments are done by the Bank in mutual understanding with the GOI.

4.1.2 Second function: CAS strategies for policy implementation

The analysis for the second function of CAS shows that from the very beginning, two strategic devices had been adopted for advancing the implementation of health system policy. These two strategic devices are operated as policy instruments (research and lending), that are active at policy modification stage in order to carry forward the policy to the implementation stage. The basic role of these two policy instruments were decided at the beginning of state-level reform in India. It is well documented in the 1996 – 98 CAS, which strategised that Economic and Sector Work (ESW), a non-lending service product for research and analysis, to provide "*technical assistance"* and initiate "*policy dialogue*" at selected states for fiscal and sectoral analysis. At the same time, lending was also strategised as "*starting point of discussion on state-level fiscal adjustment and sector reform*" (WB CAS, 19 May 1995, p.11). The division in roles between research and lending was made to address the same ends, state-level reform. This research was strategised to initiate dialogue and hold advocacy with both union and state governments. On the other side, lending was strategised to offer financial support to the state governments. The two policy instruments are discussed below in detail.

4.2 Research as policy instrument

The research, as policy instrument, is active both at the national and state levels to conduct policy dialogue and advocacy events. Going by the Bank's nomenclature, research as an instrument can be put under the category of non-lending services. The non-lending services have ranges of product from ESW to Analytic and Advisory Activities/AAA (later on rechristened as Advisory Services and Analytics/ASA) to Technical Assistance etcetera.[68] These different types of products have distinct meaning in Bank's operational terminology. For instance, as per the acronym of ASA,

[68] The detail list of the Bank's non-lending services is available at http://projects-beta.worldbank.org/en/projects-operations/products-and-services#3. Accessed on 22 March 2018.

Advisory Services is reserved only for government, whereas Analytics is utilised for the Bank's own internal purpose and at times serves governments' request too (Jorge Coarasa, Programme Leader for Human Development at World Bank Delhi office, personal communication, January 23, 2019). However, all the activities' (or products') primary assignment is the same, i.e. research. In India, ESW used to be the only service product for research on health system till 2000. Though post 2000 AAA/ASA became a specifically designed service product for conducting research on health system. At present there are roughly three types of product (ESW, ASA, and Technical Assistance) active in India for conducting research activities on health system.

The role played by these products holds the key in health system policy advancement. The fundamental role of these products is disseminating knowledge. In an interview, an international health system expert informs that AAA/ASA was created to provide "*global knowledge and best practices*" in specific issues (Informant 07). The knowledge as a product of ASA service, according to Bank, is utilised to "*develop and implement better policies, programs, and reforms that help to sustain development over the long term*" (WB Annual Report, 2018, para. 3). The importance as well as utility of non-lending services is common, i.e. through research they disseminate knowledge for 'developing and implementing better policies'. It is a practical challenge to identify the research activities that the Bank has been carrying out since 1990 for developing knowledge in regards to health system policy advancement. It is largely because of unavailability of any annual/periodical research portfolio of the Bank. Besides that the Bank's 'knowledge repository' on its website hosts a sea of research information from all over the world, from which it is a painful struggle for a single researcher to list down the research activities of non-lending service products particularly associated with health system policy in India.

This research has consulted India CAS documents from 1996 to 2018 in order to find the research activities conducted by the Bank. The list below may not be exhaustive of all the Bank's research activities related to health system policy in India, however, it contains chronologically most up-to-date list of health system research conducted by non-lending service products' in India.

Table 4.1: List of health system related researches under non-lending service products

Serial No.	Year	Research topics
1	1993	Health Sector Financing: Coping with Adjustment Opportunities for reform
2	1994	Policies and Finance Strategies for Strengthening Primary Health care services
3	1994	Burden of Disease and Cost-effectiveness in Andhra Pradesh
4	1997	State health reform/ New Directions in Health Sector Development at the State Level: An Operational Perspective
5	2000	Public-Private Partnerships in Health Care (Phase I) (*formal report*)
6	2001	Review of Centrally Sponsored Schemes in the Health Sector (*informal report*)
7	2003	Andhra Pradesh HNP Strategy (vision 2020) (*formal report*)
8	2004	Urban Health Issues (*formal report*)
9	2004	Private Health Services for the Poor (*informal report*)
10	2004	Urban Health Issues (*informal report*)
11	2009	Tracking Results for Better Performance of India's Health Sector (TF Stat. Cap. Build.)
12	2009	Developing Certification System for Health Procurement
13	2009	Detail Implementation Report (DIR) Follow-up notes (corruption, competition, accountability studies)
14	2010	HR Capacity for Effective Health System
15	2012	Health Insurance System of India
16	2012	Health Policy Notes & Client Engagement
17	2014	HR for More Effective Health II
18	2014	Service delivery and public spending in health
19	2015	Improving social inclusion health insurance
20	2015	HNP technical assistance to North East States
21	2015	Karnataka impact evaluation of result based funding hospital care
22	2015	Building institutional capacity of Rashtriya Swasthya Bima Yojana (RSBY)
23	2016	Urban Health, Nutrition and Population
24	2016	South-South Knowledge & Learning
25	2016	Science of Delivery
26	2016	Resource Optimization Study
27	2016	Technical assistance to government sponsored health insurance in India

Source: WB CAS, 19 May 1995 (page 4, attachment 1); WB CAS, 19 December 1997 (Annex 6); WB CAS, 13 March 2001 (annex 4b, p. 1); WB CAS, 15 September 2004 (annex 2); WB CAS, 14 November 2008 (annex B4, p. 1); WB CAS, 21 March 2013 (annex B4); WB CPF, 25 July 2018 (p. 142 – 143)

The above list represents only the topics listed in India CAS documents. Apart from that the Bank's Washington office also prepares research/working/policy paper on India's health system, which is not featured here. As per various CAS documents, the above research activities were conducted for union and state governments, and the Bank's own purpose in order to generate knowledge, hold public debate, and address problem. Keeping those roles in mind, an interviewee argues that AAA in health system "*often has a long life*" because knowledge dissemination needs time until the point it gets "*digested by leadership*" for policy incorporation (Informant 07). This explains that why the process usually takes a longer time. He opines that AAA needs political will, so "*if Bank brings on right people, it can have enormous influence*" (Informant 07). However, the interviewee also acknowledges that AAA can not deliver overnight impact, usually strong AAA gives medium-term impact (Informant 07). It is clear from this expert analysis that AAA like products is involved in knowledge dissemination through policy-level dialogue and advocacy. This dissemination process is extremely political in nature, and need articulation and patience. In this process, negotiation takes place in order to advance the Bank's health system policy. During this negotiation, some policy levers (formed in policy formulation stage) are included, and others are parked if not excluded fully. This is how the Bank's health system policy gets modified as well as adapted for moving towards implementation stage.

It is also evident from the above list that research-based policy instrument is becoming more significant in the Bank's health system policy activity. For instance, out of twenty seven research, eleven research were conducted after the year 2013. Besides, it is also found after review of several CAS documents that apart from health system or health policy related issues, there is hardly any other HNP issue covered under the research activity. Though, there were research on nutrition (not covered here), but not on any other disease or population control, except two research on HIV/AIDS and one on family welfare. This research opines that health system related research topics are chosen more in number in order to prioritise the Bank's health system approaches over other HNP issues. Those approaches are in need of political support at the center for policy adoption purpose, and also in requirement of ground-level opportunity at the state for future policy implementation purpose. Hence, the research activity as a policy instrument has been active in knowledge dissemination through policy dialogue (to initiate discussion) and advocacy (to continue discussion) to facilitate both the adoption

and implementation of the health system policy. In that process, some modification of health system policy occurred to accommodate political compulsion (like, selective user charges) and economic obligation (such as, reallocation of budget instead of actual increase).

4.3 Lending as a policy instrument

Lending is another policy instrument of the Bank for the advancement of its health system policy. Lending often works as a follow-up activity of research. The Bank has started taking interest in India's health system policy after its first ever research activity was done in 1993. The report (the first topic listed under research activity in table number 4.1) on India's health sector financing at the time structural adjustment notes (WB, 30 June 1992, p. 1):

"The purpose of this Health Sector Finance Study is to initiate discussions between the Government of India (GOI) and World Bank (WB and "the Bank:") on Health Finance and Policy issues. This dialogue will serve to determine the main areas of cooperation between the GOI and the Bank for the next few years".

The very next year the Bank formally started its health system project in Andhra Pradesh. This particular instrument forms a triangular interaction between the Bank and GOI and state government. In the Bank's official project lending documents, lending is noted as a financing contract between International Development Association (IDA), a Bank's lending unit, and GOI (as a recipient of the loan). The state government plays the role of an implementation agency. The GOI and the respective state government have different official agreement in regards to the IDA loan. The state government holds the maximum importance in lending activity, because it is the state government which decides whether the project is needed or not, and accordingly takes lead in implementation stage (Bhaskar Dasgupta, ex. Director at Department of Economic Affairs, GOI, presently Director at Cabinet Secretariat, GOI, personal communication, May 17, 2019). Below is the list of health system projects financed by the Bank in India from 1994 to March 2019.

Table 4.2: World Bank health system projects in India (1994 – 2019)

Project duration	Project name	Funding (in USD million)
1994 – 2002	Andhra Pradesh First Referral Health System Project	IDA: 133 Borrowers: 25
1996 – 2004	State Health Systems Development Project (02) – Karnataka, West Bengal and Punjab	IDA: 350 Borrowers: 66·70
1998 – 2006	Orissa Health Systems Development Project	IDA: 76·40 Borrowers: 14·30
1998 – 2005	Maharashtra Health System Development Project	IDA: 134 Borrowers: 24·10
2000 – 2008	Uttar Pradesh Health Systems Development Project	IDA: 110·83 Borrowers: 20·76
2004 – 2011	Rajasthan Health Systems Development Project	IDA: 89 Borrowers:16·98
2004 – 2010	Tamil Nadu Health Systems Project	IDA: 110·83 Borrowers: 20·76
2006 – 2016	Karnataka Health System Development and Reform Project (KHSDRP)	IDA: 141·83 Borrowers: 64·65
2010*	Tamil Nadu Health Additional Financing	IDA: 117·70 Borrowers: 13·80
2011 – 2019	Uttar Pradesh Health Systems Strengthening Project (UPHSSP)	IDA: 152 Borrowers: 18
2012 – 2017	Karnataka Health Systems Additional Financing	IDA: 70 Borrowers: 30
2016 onwards	Nagaland Health Project	IDA: 48 Borrowers: 12
2017 onwards	Uttarakhand Health Systems Development Project	IDA: 100 Borrowers: 25
2019 onwards	Tamil Nadu Health System Reform Program	IBRD: 287 Borrowers: 4990·75
2019 onwards	Andhra Pradesh Health Systems Strengthening Project	IBRD: 328 Borrower: 3112·98

Source: World Bank Website for respective project page; for details, see Annexation 6. Name of the states are underlined.
*The closure of the project data is not available on the World Bank website. The document section of the project page informs that project was active till 2014.

The World Bank financed first-ever health system project was in the year of 1994 in Andhra Pradesh. Till date, it has financed total seventeen (the 1996 state health system project - 02 was implemented in three states) state-level health system projects in eleven

states of India. Among those eleven, only Nagaland is a small state representing North Eastern part of India. Out of those seventeen projects, two were additional financing projects (Karnataka and Tamil Nadu). Those additional financing projects were sanctioned to extend the duration of the on-going projects operation in the respective state. The projects had been implemented both in Empowered Action Group (EAG) and non-EAG states. Moreover, number of projects was more in economically challenged EAG states (six) than non-EAG states (five). All projects were financed by IDA unit of the Bank, except the projects started in Tamil Nadu and Andhra Pradesh in 2019, which are being supported by the International Bank for Reconstruction and Development (IBRD). All together in the last twenty five years, the Bank has financed total USD 2248·59 million, of which USD 1633·59 million was financed through IDA and recently in 2019 IBRD has sanctioned USD 615 million.

In the above list, health system projects have been financed as investment lending, and not as adjustment lending. The investment lending is long term (five to ten years) as opposed to short term adjustment lending, and support economic and social development (WB, July 2001, p.3). The analysis on lending is not the analysis of the projects' lending, rather the analysis of investment lending. It poses two sets of question; why there is a requirement of investment, and how the investment is done.

Both the Bank and state governments need each other for investment based on their requirement. Dr. Sanjay Baru, Media Advisor to ex-Prime Minister Manmohan Singh of India from 2004 to 2008, reminds us that World Bank's lending is not simply about money, they are interlinked with an idea. Because "*if they do not have money, then why do we take their idea*" (Dr. Sanjay Baru, personal communication, May 9, 2019). Money and idea are mutually interdependent in Bank – state government relationship. In any health system project, money is a primary requirement for state-government to ask for the Bank's investment. Contrarily, the Bank's investment requires money to be linked with its own 'idea' of health system. This mutual relationship of money and ideas together construct the instrument called lending. So when the Bank involves in lending, it not only involves with money but also its own idea of what and how a health system should be. Here, investment symbolises the very act of 'financial exchange' – money and ideas, but lending as an instrument embodies how the idea gets exchanged with money. The following paragraphs entail how lending operates in this exchange.

The Bank financed health system projects in India have been active in reforming the health system. The analysis of various project designs' confirm that in the process of reform, the Bank has introduced or modified project mechanisms by using two controllable variables (financing and provisioning) in order to build and/or strengthen service delivery system (Sarkar, 2016a). The Bank's lending on health system projects in India can be divided in three phases. The Bank's lending strategy has systematically introduced ideas especially in the areas of financing and provisioning to process the same care-based, value-based and function-based reforms, as discussed in chapter three, in all these three phases. The common idea of all these phases of reform is to redefine the role of state. This research takes an example of Bank's first phase of health system projects (from 1994 of Andhra Pradesh to 2004 of Rajasthan) to analyse how ideas were exchanged in return of money at the behest of lending instrument's strategy. The examples used below are the features of a particular phase, and not an individual project.

Three key features of first phase of health system projects were policy modification/development, physical resource support and institutional strengthening. The idea came with policy modification/development was on budget and service delivery activities. Budget reallocation (by prioritising primary and secondary levels of care over tertiary level) and introduction of user charges were brought in through care-based reform practice. In service delivery area, the value-based reform was introduced by outsourcing non-clinical services at secondary level facilities, and engaging NGOs at primary level of care especially to serve tribal population under the notion of quality, access and effectiveness of services. At the end of first phase, the Rajasthan project (2004) further envisaged policy development on PPP and private sector regulation framework.

The idea was exchanged with the deal of resource support for investment and recurrent costs. Under investment cost, mostly civil work (expansion/renovation of secondary level facilities, selective construction of administrative building), equipment upgradation, and vehicles were supported. On the recurrent side, staff salary, and maintenance of building and equipment had been provided. Though the support was selective in terms of region (district) and care (facilities), but it still shared the state's burden of budget expenditure.

In between the exchange of policy modification/development and resource support, the common things of all those projects were they devised a means called institutional strengthening to operate the exchange. The role of institutional strengthening was to ensure the implementation of ideas driven by policy-level modification/development, and create space for future ideas. The strengthening was supported by two wings – management development and technical advancement. The state and district-level project management bodies were created within the structure of public administration system in health department. Another important creation was strategic resource cell which was mostly effective in conducting/arranging evaluation (to test the efficacy of new ideas, like outsourcing of clinical and non-clinical services), studies (for creation of new ideas, such as insurance), and training (management and clinical). The technical advancement was about introduction of tools to strengthen the service delivery. For example, developing surveillance system for communicable disease tracking, medical waste management in secondary facilities, referral management system, initiation of Hospital Management Information System, standard operating procedure for clinical guidelines, Financial Management System (FMS) were significant examples of how the projects envisaged technical tools for building the capacity of the public system.

The role of institutional strengthening in health system projects was important from the point of programme design. Planting the project management units (both at the state and district levels) within the department gives a horizontal base to the projects, which allowed them to provide system-wide management for both GOI programmes and state government run general health care services. At the same time, technical tools gave the projects due leverage to tie with Centrally Sponsored Schemes (CSS) (such as, single disease programmes) for better implementation of vertical programmes (for instance, disease surveillance to help single disease programmes), as well as to provide technical support to state government for better management of general health care services (such as, HMIS, FMS etcetera). Lending instrument crafted this two-way approach by designing projects in such a way that could forge programmatic convergence with both CSS and state government run service delivery system.

Convergence is the key strategy in lending, because it suffices the purposes of all the actors. The programmatic convergence is found as all-time strategy of lending instrument in each phase of health system projects. In response to the query regarding the convergence between health system projects and NRHM, which took place in the

second phase of health system projects' lending, an interviewee who has been closely associated with various health system projects argued that "*the idea was that eventually all of these [health system projects] will get integrated into the existing NRHM*" (Informant 08). The interviewee further clarified that integration was a plan of the Bank's long term investment to ensure that many of the project activities (especially PPPs, like Mobile Health Clinic, ambulance service) could be merged with NRHM. Thus it was a "*natural convergence because many of the objectives of state health system projects were very similar to the NRHM objectives*" (Informant 08). According to the interviewee, that convergence possibly helped in the fulfillment of many of the NRHM objectives because of infrastructural and institutional strengthening support offered by health system projects (Informant 08). This interview confirms that at the national-level both the Bank and the GOI's policy outlook with regards to health system are always same, and work to mutual benefit. This research finds that in all three phases of health system projects' lending, convergence build a programmatic relationship with both state and union governments to get the ideas translated into the policy implementation stage in exchange of sharing the state governments' fiscal burden.

In second and third phases also, the pattern of idea-money-convergence is found. In the second phase (from 2004 of Tamil Nadu to 2012 of Karnataka), two specific ideas were dominant. Insurance/assurance (directly purchase of health care service) became the main idea in financing. In service delivery, two major changes were introduced. The basic health care package was extended to provide full coverage of curative care in secondary and tertiary levels, and NCD care was included in primary level. Further, apart from the different types of PPPs in service delivery at the primary and secondary levels (from care to diagnostic support to ambulatory service), NCD screening, quality certification for public and private facilities, and insurance mode of financing emerged as prevalent ideas in the Bank financed projects. The nature of support was also changed as investment costs got less importance, and instead the focus was on purchasing of services from private sector (strategic purchase), and financing of various models of service delivery pilots. The strategy of programmatic convergence with CSS (for example, NRHM/National Health Mission - NHM) and state governments' service delivery system had been continued, only the technical tools were replaced with different models of service delivery piloting (from food safety to road safety to NCD screening to quality assurance/certification to social accountability intervention).

The 2016 Nagaland project is not typically a representative of any particular phase. Instead this could be an example to understand how the Bank initially strengthens public system to develop private sector. In the first phase, community strengthening, infrastructural upgradation (water and electricity) and capacity building of the public system (human resource, information communication and technology) have been proposed. According to the Nagaland project proposal, these efforts would help the project in the second phase to apply innovative strategies and involve other sectors (WB, 28 November 2016, p.4 – 7).

In the third phase (2017 Uttarakhand project onwards), the strategic purchase at primary level (including NCD screening and diagnosis), and telemedicine have come up as main ideas in Uttarakhand project. At the time of submission of this PhD thesis, the Bank initiated two more projects in Tamil Nadu and Andhra Pradesh in 2019 as listed above. Among them Andhra Pradesh is worth mentioning for bringing in ideas of Electronic Health Record (EHR) system, inclusion of private pharmacy in public delivery system, and NCD equipped e-sub centres. EHR is a patient record management system which, according to the project, can be accessed from any facility (public/private) as per patient's choice. At the advent of Artificial Intelligence (AI) in medical care and the search of private sector for new medical market, the Andhra project may be of special importance in the future.

It is observed in all the post 2010 projects that a major portion of financial investment is reserved for supporting Information Technology (IT) enabled infrastructure. Lending strategy through its ideas over time has made change in the requirement of support. The role of the state has become purchaser from provider that demands stronger information data base, digitisation of administrative works (like, payment, verification), monitoring and evaluation through Computerised Management and Information System and so on. So it is argued that requirement of support have been shifted from physical infrastructure to IT infrastructure for state governments.

Lending as an instrument is a huge success in the Bank's advancement of health system policy. Many of the ideas of the Bank financed health system projects have become mainstreamed in policy (of GOI) as well as in practice (of state governments). These examples are analysed in detail in the Karnataka chapters (six and seven) of health system projects. The project implementation sites have also given advantage to the

Bank. The near to equal representation of EAG (five) and non-EAG (six) states in the participation of state-level health system projects has been helping the Bank to profess the merit of its health system approaches in the Indian context. These projects are being used for implementing the ideas, and in turn the projects are producing knowledge. Thus lending is instrumental in the production of knowledge by paving the way for implementation of health system projects. Lending, in the process of transferring the ideas, modifies the Bank's original policy levers (as formed in policy formulation stage) since the requirement of states are always not in sync with the Bank's idea of health system. The actual role of lending at the policy modification stage is to slowly but steadily move the state towards the direction where both the Bank's ideas and state governments' requirements would be in sync.

4.4 Research and lending as knowledge navigator

The analysis of the Bank's policy tool and instruments depict that policy needs to be navigated through adoption and modification stages in order to get transferred from formulation stage to implementation stage. Without factoring in knowledge, analysing this navigation is very difficult. The two instruments (research and lending) work hand-in-hand as instrumental knowledge navigator. The research-lending cooperation is required to understand at first in order to analyse how knowledge navigates. The cooperation can be better understood from the topics have had undergone research activity from 1993 – 2018. Only financing (especially, insurance), PPP and service delivery have been given the most attention in health system research. Interestingly, these three are the most common components in any of the Bank financed health system projects. Surprisingly, access to medicine, shortages of grass root health workers, and complexity of health governance are not even featured once as health system research activity, despite they are widely acknowledged as system-level problems in health care service delivery in several Indian states.

This above example shows that research as a policy instrument is complementing another policy instrument, i.e. pursuing lending by the act of knowledge dissemination. On a similar note, a respondent also opines that AAA like research activities are "*often implicitly, if not explicitly tied to lending programmes*" (Informant 07). In this case, the knowledge disseminated through researches act as an advocacy opportunity for the Bank to convince the union and the states governments to adopt (by GOI) and

implement (by state government) the Bank's health system approaches. Consequently, the state governments' participation in the implementation process ensures that knowledge is produced through lending also. So the role of these two instruments may be different in the policy modification stage, but their only purpose is to provide knowledge. Here, the research is a platform for advocacy exercise to disseminate knowledge, and the lending is a facilitator of practical workshop for production of knowledge.

The main objective of the Bank's two instruments is to interact with governments' policy and operation. Because that very act of interaction puts the Bank's health system policy from policy modification to policy implementation stage. This act is nothing but navigation, which is performed with an aid of knowledge. Thus knowledge here acts as navigator. The interaction of the Bank's instruments in GOI's health system policy or even state governments' health system operation is interceded by two different variants of knowledge; knowledge as political interaction and knowledge as technical interaction. The knowledge through political interaction is more subtle, and acts in a negotiation mode. A senior health system expert of the country having experience of working in government system for decades explains this political interaction of knowledge dissemination practice. He elucidates that the Bank staff attend national-level multistakeholder meeting to understand the viewpoints of leadership, and on the spot they broadly agree on the viewpoints (Informant 09). It is from the follow-up meetings, they individually reach out to the leaders in health ministry (bureaucrats/senior technocrats/minister) and subsequently influence the health ministry in order to consider the Bank's viewpoints through one-on-one negotiation in 'formal meeting', sometime with the support of finance ministry, as they usually partner with them for finance, in some rare occasions through the intervention of Prime Minister's Office, and of late through NITI (National Institution for Transforming India) *Aayog* (Informant 09). This explains that how political interaction plays an important role in creating a network of governments' policy making or operation exercise. Here, the policy making/operation network uses knowledge as a rationale to conduct formal and informal meeting/discussion/seminar/dialogue.

The use of knowledge as technical interaction is rather direct, and not subtle as in the case of political interaction. Having familiarity with this mode of interaction also, the respondent analyses that the Bank's data analytics produces the kind of research, which

academics usually fails to provide since they are not fundamental research (Informant 09). In other way, the Bank's research is very informative, and therefore most of the government documents refer to the Bank or WHO. According to him, these works inadvertently comes with "*certain narratives*" to set a discourse (Informant 09). This research thinks it is very important to understand this discourse. He continued that *"this discourse is in the realm of ideas, concepts….. and very important categorisations. It nudges the policy community to think within a certain direction…….to think within a certain structure…….and that has its own benefits"*. Thus "*before even World Bank money hits the ground, it is the entire set of concepts that it has brought together, which actually started doing network*" (Informant 09). In this occasion, technical interaction successfully supplies the required evidence to the policy making network. The network using knowledge as navigator with the collaboration of two instruments contributes in the making and implementation of 'evidence-based' policy. The Bank shields the role of policy tool and interactions of policy instruments under the shadow of knowledge, and instead represents knowledge as evidence-based policy product. The next part of this chapter discusses the outcome of the knowledge.

4.5 HSS policy outcomes from Bank-Government of India interaction

Under the current health system approach of HSS, the Bank-GOI interactions have so far produced two important policy outcomes. The UHC is accepted as national health policy goal in 2017, and PMJAY is launched as principle service delivery scheme in 2018. HSS as governance framework for UHC is behind both the outcomes. At the national-level (meso system), it is expected that HSS is supporting the drive for UHC through aid coordination/ consultation body of all the actors as discussed in the last chapter. Similarly, HSS ropes into strategic purchase model of service delivery for operational-level (micro system) to implementation of UHC through PMJAY scheme. This is what exactly this research has argued in the last chapter while discussing HSS phase that HSS operates as single governance framework to frame UHC as policy and implement UHC as scheme. In the case of India's HSS, both the adoption of UHC as NHP goal and the introduction of strategic purchase as UHC implementation scheme are policy decisions. Despite the widely known fact that the Bank has been vociferously promoting both UHC and strategic purchase through its policy briefs and projects implementation practices, it is not to claim that these behaviours at the level of policy

adoption-modification are solely the contribution of the Bank. Instead, this always wants to maintain that these behaviours are the outcomes of Bank-GOI interactions. The next two sections discuss the 2017 National Health Policy (NHP) and the implication of strategic purchase scheme in India's health budget in order to understand the relevance of these two most important HSS related policy outcomes in India.

4.5.1 National Health Policy – 2017

The new National Health Policy (NHP) was launched on 16 March 2017, and declared that apart from preventive and promotive health care, the "*universal access to good quality health care services without anyone having to face financial hardship as a consequence*" as policy goal (GOI, 2017, p. 1). [69] It is a third national policy on health after 1983 and 2002. This research after reviewing the NHP 2017 prepares the following analysis.

In a nutshell, the policy offers three broad mechanisms with a long term vision apart from reiterating the existing commitments (Sarkar, 2017a). The mechanisms include gradual increase of budget allocation from existing 1·15 per cent to 2·5 per cent of GDP, more attention towards primary care (roughly 65 per cent or more of total budget) and strategic partnership with private sector to purchase secondary and tertiary care (and in some occasions, primary care in urban areas) until the gap is filled by the public health care system. The proposal of budgetary increment is expected to be subsumed for expanding service provisions (for example, free drugs/diagnostics, adequate equipment/human resources etc.) and increasing purchase of care capacity. On the other hand, the government assistance for secondary and tertiary care (curative and rehabilitative) is certain to dry up more because of confining more fund at the level of primary care (preventive and promotive). Then the most critical question is how the infrastructural gap exists in secondary and tertiary care in public system is going to be covered. The NHP 2017 does not offer very convincing suggestions except mere utterance of the need for building new tertiary institutions especially in the less developed regions.

[69] The section on National Health Policy, 2017 is published as an op-ed in *The Telegraph* on 23 March 2017. It was a part of PhD research's progress publication. (https://www.telegraphindia.com/opinion/health-first/cid/1458109#.WNdcLGf-tLN)

The central problem of current India's fragile health service is two-fold. First, the inability of the government to ensure service provisions due to budget constraints as diagnosed by Dr. Srinath Reddy chaired High Level Expert Group Report on Universal Health Coverage for India (Planning Commission of India, November 2011, p. 96 – 100). Second, the failure of the governance to monitor and regulate the private sector from exorbitant charges and medical malpractices as evident in the cases of Clinical Establishment Act, 2010 or state-level constituted Acts for West Bengal, Karnataka, Delhi etcetera (Sarkar, 2017b; Sarkar, 2017c). NHP 2017 neither understands the constraints of the government (for budget increment) nor the limitations of the governance (in terms of private sector regulation). Instead, the suggested mechanisms accommodate private sector even with greater role than ever at the risk of making governance more complicated to manage. Hence, the mechanisms are contradicting with the aim of the policy that claims to strengthen and prioritise the role of the government.

It is found that three policy mechanisms, as mentioned above, are in sync with the vision of the policy, i.e. assurance based approach in service delivery. The policy tries to justify that the system is not prepared to declare health as a right, so aspires for assurance. It is required to understand that this mere admission of inability with the commitment of right based approach in health care automatically limits the range of population into target population, and at the same time drive towards assurance eventually creates a popular pressure on the government to arrange service irrespective of who provides service (public or private). Thus it is a win-win condition for private sector. It could cater to 'bottom forty' per cent of population (targeted population) by selling care to government under publicly financed health insurance/assurance schemes. On the other hand, it can expand its reach for the left out 'upper sixty' per cent of population through privately insured schemes or social/employer-based health insurance.

This research opines that NHP 2017 legitimises the so far experimental practice of inclusion of private sector in health care service delivery. The NHP 2017 recommends the engagement of private sector almost in every sphere of health service system, from training to skill development to care (primary to tertiary) to tissue and organ transplantations. Despite that, the policy hardly offers any blueprint to regulate the private sector, instead "*private sector is encouraged to invest-which implies an*

adequate return on investment i.e on commercial terms which may entail contracting, strategic purchasing" and so on (GOI, 2017, p. 19). Needless to say that NHP 2017 with regards to private sector is on the similar line with the World Bank's 2007 HNP second sector strategy (as mentioned in the last chapter), both the policy documents emphatically approve the requirement of private sector engagement in public system yet fail to provide adequate public policy measures for handling the private sector.

4.5.2 Budget implication of PMJAY as strategic purchase scheme

As a follow-up with the NHP 2017, the GOI has launched the world's biggest health assurance scheme in September 2018. [70] The scheme is officially named as *Pradhan Mantri Jan Arogya Yojana* (National Health Protection Scheme) or PMJAY under the ambit of GOI's flagship programme *Ayushman Bharat*. As per the website information of National Health Authority, PMJAY aims "*to accelerate India's progress towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3)*" (GOI-NHA, n.d., para. 2). The operation mechanism of PMJAY is strategic purchase model of service delivery, and run in the mode of centre-state collaboration. The scheme assures to financially protect 10·74 crore/100·74 million poor families (approximately 50 crore/500 million population) for only in-patient hospitalisation expenses up to INR 5 lakhs (or approximately 7163 USD) per family per annum (GOI-NHA, n.d.)

It is recognised that strategic purchase at the operational-level is a service delivery model which is mostly at the realm of state governments since they take lead in implementation. This research has also discussed extensively the Bank developed and financed Karnataka's *Suvarna Arogya Suraksha Trust* like strategic purchase model implementation experience in chapter seven and eight. However, in this chapter for the national-level situation analysis, the focus is at policy and planning of GOI with regards to strategic purchase. Because for the GOI, the choice of strategic purchase as service delivery model over direct public provision of service is more of budget exercise as it

[70] The section on budget implication of PMJAY as strategic purchase scheme is published as an op-ed in *Ananda Bazar Patrika* in Bengali on 12 March 2019. It was a part of PhD research's progress publication. (https://www.anandabazar.com/editorial/ayushman-bharat-scheme-may-actually-a-step-for-privatization-of-health-policies-1.965233)

finances sixty per cent of the scheme.[71] Hence, this section analyses only the implication of PMJAY scheme in India's health budget to assess the merit of this particular HSS policy component as a service delivery model.

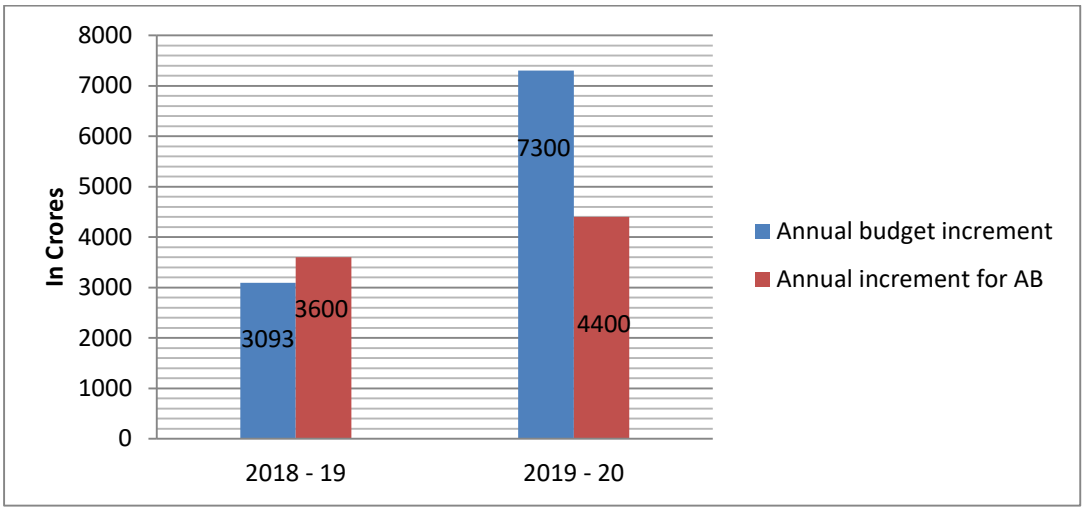
The PMJAY has made its maiden entry in GOI's budget cycle a few months ahead of the country's recently finished parliamentary election in 2019. Because of the impending election, the government has placed the last health budget as an interim budget. It is important to note that 2019 interim health budget is the first full budget outlay of Ayushman Bharat, as the programme was launched (September 2018) seven months after the 2018 – 19 budget declaration. Thus in order to discuss the implication of PMJAY in the overall health budget of GOI, this research has analysed three different health budgets; 2017 – 18's actual expenditure, 2018 – 19's Revised Estimate (RE) and 2019 – 20's Budget Estimate (GOI, 2019).

In 2019, overall health budget (including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy/AYUSH - Indian Systems of Medicine) is increased in absolute term by nearly INR 7300 cr. from last year (from 57738 cr. in 2018 – 19 RE to 65038 cr. in 2019 – 20 BE). This year's hike is in-fact more than double comparing to the increment reported (3093 cr.) between 2017 – 18 and 2018 – 19.[72] The credit to the last two years annual increment should be given to the two legs of Ayushman Bharat, i.e. PMJAY (for insurance/assurance coverage) and Health and Wellness Centre (HWC). On the inaugural year 2018 – 19, the Revised Estimate for Ayushman Bharat was 3600 cr., where 2400 cr. for PMJAY alone. In 2019's interim budget, the total outlay for Ayushman Bharat is 8000 cr. (4400 cr. increment than last year), divided between 6400 cr. under PMJAY and 1600 cr. under HWC respectively. This implies that without Ayushman Bharat, the entire annual health budget increment would have been faced a negative growth of 507 cr. in 2018 – 19, and a mere increase of 2900 cr. than the earlier calculated 7300 cr. for 2019 – 20 as shown in the graph below.

[71] In the last chapter, it is already discussed that why strategic purchase is a service delivery model and not a financing method.

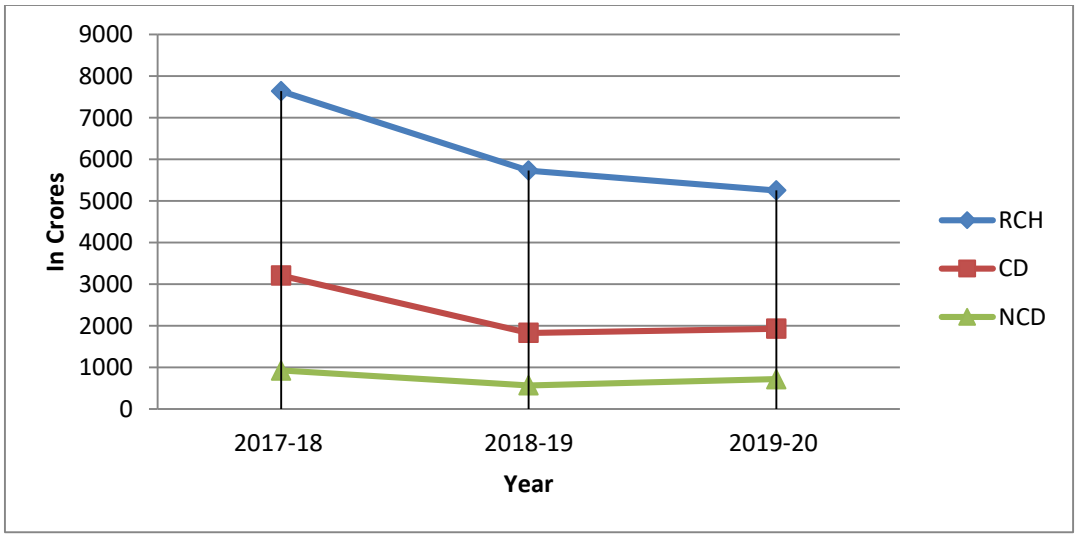
[72] The budget analysis figure is calculated in Indian currency (i.e. INR), since the GOI budget copies provide figures in INR only. The figures are not converted into USD to maintain the accuracy of budget figures. The exchange rate of USD to INR on the 2 February 2019 (budget announcement day) was 1 USD = 71·30 INR. https://www.poundsterlinglive.com/best-exchange-rates/us-dollar-to-indian-rupee-exchange-rate-on-2019-02-02)

Graph 4.1: Ayushman Bharat's contribution in annual budget increment (2018 – 19 to 2019 – 2020)



After the 2019 budget, it is proved that overemphasis on Ayushman Bharat or in particular insurance-based PMJAY scheme deprioritised other important health service functions for the last two years. However, it is found that in order to fund Ayushman Bharat's two legs (PMJAY and HWC) the National Health Mission (NHM) has been compromised severely. The NHM is known as a mainstay for sharp decrease in maternal and infant mortality, and increasing institutional delivery. As depicted in the following graph, fund cut for NHM adversely impacts on the allocation for Reproductive and Child Health (RCH) services including immunisation, Communicable Diseases (CD), such as Tuberculosis, Malaria, Diarrhoea etcetera, and also Non Communicable Diseases (NCD).

Graph 4.2.: Allocation of resources for RCH, CD and NCD (2017 – 18 to 2019 – 20)



2017 – 18: Actual, 2018 – 19: Revised Estimate, 2019 – 20: Budget Outlay

Further to note, HWC, one of two legs of Ayushman Bharat, is introduced under NHM to boost infrastructure at the primary-level care for NCD. However, only 1600 cr. is allocated in 2019 to achieve an incremental target of 1.5 lakh HWC. It is further argued that neglect of NHM means neglect to HWC, since HWC is the conceptual unit of programmatic convergence for all field-based programmes (NCD screening to disease-specific outreach). The excessive focus on Ayushman Bharat, especially insurance/assurance based PMJAY, scales down NHM, after excluding HWC, from actual 31521 cr. (in 2017 – 18) to 29483 cr. (2018 – 19 in RE) to 30145 cr. in 2019 – 20 in BE. Needless to say, the PMJAY based 2019 budget is more redistributive than incremental in nature.

The GOI's thrust on the PMJAY is tailored to directly purchase services from private and public health facilities for in-patient care. But, NSS 2014 data confirms that it is out-patient care, and not in-patient, which caters to more than 95 per cent of illness episodes in India (NHSRC, 2016). According to GOI's 2013- 14 household expenditure report, the out of pocket expenditure is more for out-patient care (55 per cent) than in-patient hospitalisation care (32 per cent) (NHSRC, 2016). Thus the PMJAY scheme is ineffective for poor both in cost-saving formula and as treatment support strategy. Given the lackluster condition of public facilities, it is found in the Karnataka model of strategic purchase that beneficiaries mostly choose private health care facility, further elaborated in chapter eight. In the case of PMJAY, the same practice can only be expected. That means ultimately private infrastructure to be benefited from strategic purchase scheme. With PMJAY, the government has created opportunity to finance private corporate hospitals from public coffers. On the other hand, the budget redistribution fails to restore the collapse of health infrastructure in public system, such as capital outlay on medical and public health has fallen from actual 3048 cr. in 2017 – 18 to 2391cr. in 2018 – 19 (RE) to 1676 cr. in 2019 – 20 BE.

Needless to say, this budget is an advancement of the adopted National Health Policy of 2017. The NHP's two important footprints are purchasing health services under market principle and scaling up of public finance in health to 2·5 per cent of the country's GDP by 2025 as discussed earlier. The first footprint is decided to operationalise through PMJAY. With regards to the second footprint, budget analysis shows that PMJAY led post-Ayushman's health budget percentage share of total budget is just 2·2 per cent in 2019 – 20, which is even below the proportion of 2·4 per cent

outlay in 2017 – 18, a pre-Ayushman year. The burden of fiscal pressure, and macroeconomics constraints restrict GOI to prioritse health in the overall budget. Hence, the public spending in health is ranging at 1 - 1·5 per cent of GDP in recent years (Ravikumar & Abhraham, 2019).

In terms of policy outlook, two important features stand out of the 2019 budget; the focus of the care is shifting from communicable disease to NCD intervention. Second, the fund allocation preference is changing from public sector to private sector because of strategic purchase. It is really surprising that while public system governed teaching institutes and hospitals are languishing over fund crisis for years after years, GOI finds policy justification in UHC to finance private sector. For the record, Calcutta's All India Institute of Hygiene & Public Health (AIIH&PH) is one of the Asia's oldest public health institutions. In this Central government-run institute, total 29 per cent post is lying vacant possibly for more than a decade, including 53 per cent (23 out of 43) vacancy in key teaching posts.[73] This research opines that if this 'redistributive budget' of 2019 is believed to represent current health policy orientation of the country, then it is to be understood that India's adopted health policy in 2017 is suffering from ill-health.

It is a great matter of concern that while the various types of Clinical Establishment Acts to regulate private hospitals are found to be ineffective in many states (West Bengal, Delhi, Karnataka to name a few), the government reorients its health system towards private sector provided health care service. Further, given the continuous poor status of government expenditure on health, this very reorientation questions the sustainability of strategic purchase based UHC model of service delivery.

4.6 Role of HSS in the path towards UHC in India

The critical analysis of NHP 2017 and PMJAY elucidate the role of HSS playing at the background for streamlining the present policy outlook of GOI to effectuate UHC. In the role of HSS, Bank's contribution is more significant than GOI, since HSS at the national-level is primarily a mechanism of international health governance for aid-coordination. Further, the Bank's policy thrust on HSS and investment commitment on

[73] The detail strength of human resource at AIIH&PH can be found at http://aiihph.gov.in/human-resource/. Accessed on 15 February 2019.

UHC has made it indisputably the most prominent international actor of HSS in India. Thus the role of HSS in India's drive towards UHC also involves the role of international health governance, and specially the Bank. UHC in GOI's policy outlook is stood as policy goal as well as envisaged as an intervention objective. The role of HSS is required to understand for both the purposes of UHC. To understand the contribution of HSS for achieving UHC as policy goal, this research has done field work in New Delhi, and visited the offices of Ministry of Health and Family Welfare (MOHFW), GOI office at *Nirman Bhawan*, World Bank, European Union, WHO India, WHO SEARO (South East Asia Regional Office), and the National Health Systems Research Centre (NHSRC) of MOHFW, GOI.

McCoy, Chand and Sridhar (2009) have categorised international development partners active in health are broadly six types in LMICs; bilateral (United States Agency for International Development/USAID, Department for International Development/DFID of UK etcetera), inter-governmental organisation/multilateral (World Bank, WHO, UNICEF, European Council etc.), GHPs (GFATM and GAVI), Philanthropic-capitalist organisation/private foundations (BMGF), INGOs (such as, Plan International/Plan India), and corporate/private entities. At present, all these six types of international actors are active in India. It is to be noted that despite the presence of various types of international actors and much advertised campaign of 'India towards UHC', the actual governance framework of HSS at the national-level is absent. This research has learnt that so far there is no country-level coordination platform or even a dedicated body of international actors' consortium to discuss, track and monitor UHC in India (Dr. Ved Prasad Yadav, National Consultant – Health System at WHO India country office, personal communication, May 13, 2019). However, the body like donor coordination is not in India's health programmes. During the implementation of NRHM, donor partners' (World Bank, European Union, DFID, UNFPA) came together for a country-level coordination body (Joint Review Mission) to help GOI (Mr. Shouvik Datta, Health Specialist – European Union at India office, personal communication, June 15, 2018).

The NRHM donor partners' coordination body was active during the NRHM programme period (2005 – 2012). Thereafter GOI did not think to develop similar kind of platform, or continue the same with different objectives. At present from GOI side, there is no initiative to form a country-level coordination to hold regular dialogue on

UHC. After repeated attempts of search, this researcher has managed to spot the so called 'IC-IH' section (on the sixth floor, room no. 648) in the *Nirman Bhawan* office of MOHFW, GOI, which is related to international health activities within the GOI.[74] However, the International Cooperation (IC) - International Health (IH) section is no way related to any coordination activity, in fact many health ministry personnel are not even aware about the very existence of this section. According to the staffer of the section, they have no idea about any aid coordination platform of international health actors for UHC or any other purpose. The section is serving as "*post office*" to receive, record and forward official documents (such as, memorandum of understanding/MOUs, agreement, meeting agenda etcetera) with regards to bilateral and multilateral activities in health (staffer of IC-IH section at the MOHFW - GOI, personal communication, May 13, 2019).[75]

The absence of any effort for coordination from GOI makes the drive for UHC more fragmented. The international health actors directly work with state governments for providing technical support with a blend of infrastructural assistance. In this process, the MOHFW or even NHSRC is kept completely out of the loop. The international actors are in one-on-one channel of communication with GOI and state governments instead of collective deliberation. The meeting or workshop on any health system issue may be called as forum of collective discussion, however they are conducted at the initiative and interest of individual actors. So the policy discussion, in this case on UHC, is very one-to-one. It is the international policy consensus on UHC, as discussed in last chapter, which guides both the GOI and the World Bank (and other actors) to form an invisible network. This network may think collectively, but act varyingly.

Regarding UHC as an intervention objective, it is required to understand that strategic purchase is not the only way to achieve UHC. A senior WHO health system expert steadfastly puts that in general UHC has two legs (mechanisms) – financing and service delivery – now it is up to the respective government how they want to achieve UHC by using two general mechanisms (Dr. Phillida Travis, Team Leader - HSS at WHO SEARO, personal communication, May 6, 2019). But this research wants to argue that

[74] There is another office called IHR (International Health Regulation) under the Director General of Health Service, GOI in the same building of *Nirman Bhawan*. IHR deals with the issues of cross-border diseases at the Indian ports, airports and other transaction places in border areas.
[75] Names of the staffer are not mentoned based on the request of anonymity.

these two general mechanisms are not very specific about how to attain the two main proponents of UHC (service coverage and financial protection). The answer is strategic purchase – it is accepted as a special strategy because of its merit to address both service coverage and financial hardship. It has the potency to target those diseases which cost most to population (or in particular poor). Thus, this research analyses the rationale behind the choice of service delivery package under PMJAY, which is supposed to protect poor from those diseases that cause financial catastrophe.

PMJAY as a strategic purchase scheme as on 10 February 2019 covers 1393 in-patent treatment packages.[76] The 2017 *India State-level Disease Burden* report has been consulted to understand the present status of disease burden as per DALY ranking. The table below categorises the types of diseases in three distinct disease groups; CMNN, NCD and injuries. It is found that entire CMNN (communicable diseases, maternal, neonatal, and nutritional) disease group is out of PMJAY coverage, except the other neonatal disease type, of which only basic neonatal package (sl. no.: 1258 and code no.: M300001) is available under the listed PMJAY packages. The PMJAY list is largely applicable for NCD group and road injuries.

Table 4.3: Disease groupings

Groups	Types of Diseases
Communicable diseases, maternal, neonatal, and nutritional (CMNN)	Diarrhoeal diseases, tuberculosis, neonatal preterm birth, iron-deficiency anaemia, other neonatal
Non-communicable diseases (NCD)	Ischaemic heart disease, lower respiratory infect, COPD (chronic obstructive pulmonary disease), stroke, sense organ diseases (includes mainly hearing and vision loss), diabetes
Injuries	Road injuries, self-harm (refers to suicide and other nonfatal outcomes)

Classification is done as per the 2017 state-level disease burden study (source: ICMR, PHFI, & IHME, 2017)

The DALY ranking of causes of disease burden from different state groups are listed in the table below. The states are divided in three groups; EAG states, North Eastern states,

[76] The detail list of treatment packages is available https://www.cmchistn.com/package/PMJAY_Packages.pdf. Accessed on 21 April 2019.

and other states. Contextually, these three divisions capture the overall India quite well. Both EAG and North Eastern states are backward, but still because of the other contextual factors (such as, community practice and access to social resources etcetera), the health outcomes are different. Similarly, the states other than EAG and North Eastern are relatively good (or affluent) in socio-economic parameters, and that affects their health outcomes also.

Table 4.4: DALY ranking of causes of disease burden across state groups (2016)

Rank	EAG states	North-East states	Other states
1	Ischaemic heart disease	Diarrhoeal diseases	Ischaemic heart disease Rank
2	Diarrhoeal diseases	Stroke	COPD
3	Lower respiratory infect	Lower respiratory infect	Stroke
4	COPD	Ischaemic heart disease	Iron-deficiency anaemia
5	Tuberculosis	COPD	Sense organ diseases
6	Neonatal preterm birth	Neonatal preterm birth	Self-harm
7	Iron-deficiency anaemia	Tuberculosis	Road injuries
8	Other neonatal	Iron-deficiency anaemia	Neonatal preterm birth
9	Stroke	Sense organ diseases	Diarrhoeal diseases
10	Road injuries	Road injuries	Diabetes

Source: ICMR, PHFI, & IHME, 2017, p.50

The above table primarily informs that CMNN disease group (leveled in blue) (communicable diseases, RCH/MCH related diseases and nutrition deficiency) still exists as major causes of disease burden across the state groups. It supersedes NCD diseases (leveled in olive green) in EAG states. In North Eastern states also, CMNN disease group (four positions in first ten DALY ranking) shares almost equal weightage with NCD disease group (five positions in first ten DALY ranking). Even in the relatively affluent states (other states), three types of CMNN diseases are in the first ten DALY ranking. The NCD diseases have almost equal share in all three types of states groups. Road injuries exist as one of the ten major causes of disease burden in all the states groups, holding the bottom position in EAG and North Eastern states. It is clear

from above table that both CMNN and NCD groups have more or less equal share in the DALY ranking of major causes of disease burden in all the three states groups.

Further, it is found that the presence of iron-deficiency anaemia related cause of disease burden in all the three state groups indicate the challenges with regards to access to food followed by nutrition deprivation among the population. Similarly, the presence of diarrhoeal diseases in all the state groups raise questions over sanitation and access to safe drinking water facilities. Going by the above table, it can be said that PMJAY packages are more useful for the population of relatively affluent states as NCD group is more in number than CMNN disease group. Conversely, the strategic purchase scheme is relatively less effective in the backward states groups (both EAG and North Eastern). The below table is further discussing all India DALY ranks of major causes of disease burden between 1990 and 2016.

Table 4.5: DALY ranking of causes of disease burden in India (1990 and 2016)

Rank	1990	Rank	2016
1	Diarrhoeal diseases	1	Ischaemic heart disease
2	Lower respiratory infect	2	COPD
3	Preterm birth complications	3	Diarrhoeal diseases
4	Tuberculosis	4	Lower respiratory infect
5	Measles	5	Stroke
6	Ischaemic heart disease	6	Iron-deficiency anaemia
7	Other neonatal disorders	7	Preterm birth complications
8	COPD	8	Tuberculosis
9	Neonatal encephalopathy	9	Sense organ diseases
10	Iron-deficiency anemia	10	Road injuries

Source: ICMR, PHFI, & IHME, 2017, p.48

The causes of disease burden between 1990 and 2016 depict that CMNN disease group still dominates the DALY ranking of causes of disease burden. In 1990, total eight positions out of ten were belonged to CMNN group. The number has come down to five in 2016. Road injuries have made an entry in first ten (tenth rank) DALY rank of

causes of disease burden in 2016. The NCD disease group has total four positions in the first ten DALY ranking in 2016, compared to two positions held in 1990. The first and second DALY ranks of causes of disease burden (ischaemic heart disease and COPD) are from NCD group in 2016. NCD group has surely come up as new leading causes in India's disease burden map.

The analysis of DALY ranking for causes of disease burden is clearly showing despite the recent dominance of NCD group, the CMNN disease group continues as major causes of disease burden. These findings raise question behind the logic of PMJAY's package selection. As per PMJAY treatment packages, only four out of ten major types of causes of diseases (ischaemic heart disease and COPD, stroke, and road injuries) are covered. It is already discussed that because of PMJAY, how much NRHM/NHM budget is being neglected in last two years' health budget. This negative budget increment for NHM impacts adversely the CMNN disease group. Further, the continuous negligence of CMNN disease group could be devastating for EAG and North Eastern states, since these backward states already have relatively large share of CMNN diseases as causes of disease burden.

It is not to argue that PMJAY like strategic purchase scheme is not helping the poor for in-patient care. However, from the policy decision perspective this particular decision is questionable. Given the pattern of government expenditure on health, it is extremely unlikely that budget allocation is going to increase. It means the resources needed for NCD disease group via strategic purchase will be eating the share of resources meant for CMNN disease group which is at the realm of public system. It is of high chance in near future that PMJAY scheme at the population level is going to increase inequality in terms of access to health care services especially for CMNN related diseases since the public facility may not be able to be at the disposal of such services often. The governance framework of HSS is being utilised as an invisible network to ring-fence fund for strategic purchase in order to buy care, without considering the implications on the overall health care service delivery. Thus it is being argued here that in the name of HSS, the policy decision objectivises a vertical design of intervention.

The absolute overlooking of DALY ranking of causes of disease burden confirms that PMJAY is not evidence-based policy making exercise. Overlooking DALY means overlooking of the cost-effective technology of designing policy package, as analysed

in the last chapter. It is a matter of concern that why Bank-GOI interactions are unable to find these flaws in policy decisions. In order to address why Bank-GOI fail to address these flaws, the design of UHC should be a point of enquiry. This research has done a methodological critique from an epidemiological perspective of a seminal report on UHC in order to understand "*the theory behind the financial structure of UHC and how the very theoretical structure shapes the country's health system for service provisioning purpose*" (Sarkar, 2016b, p.31).[77]

The report, *Transitions in Health Financing and Policies for Universal Health Coverage: Final Report of the Transitions in Health Financing Project*, published on the 24 August 2012, has been prepared under the aegis of the Result for Development Institute. Since then it has been serving as one of the central guiding documents for designing UHC in many countries. The analysis of methodological critique demonstrates "*that the report is based on the assumption of growth 'phenomenon' and not on the reality of complex medical market. From design to findings, the epidemiological concerns are given less priority and as a result many areas remain untouched by the research*" (Sarkar, 2016b, p.41). The priority of economic growth over epidemiological reasoning is not only the limitation of this report, rather the drawback of policy interpretation in the UHC discourse. At least in India, the UHC as policy intervention is planned in such a way that only takes care of private sector's 'growth', instead of considering the findings of causes of disease burden. Thus what methodological critique pointed out in 2016, GOI's *Ayushman Bharat*'s Chief Executive Officer, Mr. Indu Bhusan, is accepting that in 2019 (Bhushan, 2019):

"*It [PMJAY] covers 50 crore people. So far in the last six months, more than 18 lakh people have benefitted already. Most of these 18 lakh people have gone to the private sector. Right now, more than 15,000 hospitals are empanelled and 50% of those are from the private sector. So, the private sector actually has been a good part of the story. Unless we have a rate which is viable and we pay the hospitals on time, the enthusiasm of the private hospitals and even public hospitals will be muted. In terms of the increase*

[77] The methodological critique was published as a commentary in the *Indian Journal of Hygiene and Public Health* in 2016. It was a term paper for Prof. Ritupriya's Operation Research and System Analysis course at the Centre of Social Medicine and Community Health, JNU, and carried out at the behest of PhD synopsis preparation for this research.

in the footfalls, it is early days yet but I have had interactions with some hospital chains and they have informed me that because of Ayushman Bharat, in the last six months, the footfalls have increased by about 20% in their hospitals. So, we have opened the doors of private hospitals for the first time to the 40% poorest people in the country, that is about 50 crore people, and obviously the volumes are going to increase slowly but surely".

Thus it can be interpreted that if 'bottom forty' is an official government endorsement in public policy today, it is because of the World Bank. So, UHC through the support of this bottom forty per cent of population helped in the growth of private sector in India. This policy position may not have adequate public health justification, but has the backing of economic planning outlay. The 'assumption' is growth of private sector in health is in turn contributing into the GDP by creating new jobs, new businesses, new markets, and of course 'new consumers'. This economic growth through health care service delivery has become a phenomenon and followed across the world. For instance, the United Nations General Assembly has adopted a resolution on the 15 December 2016 to uphold "Global and foreign policy: health employment and economic growth" to encourage "*in support of the creation of some 40 million new jobs in the health and social sector by 2030*" in LICs and LMICs as recommended by the High-Level Commission on Health Employment and Economic Growth (UN General Assembly Resolution, 15 December 2016, p.9). It is obvious that these 'some forty million jobs' can not be created by public sector alone, rather greater role of private sector is expected here. Hence, both nationally and internationally it is accepted that UHC like large-scale mechanism is required for economic growth.

This in-depth analysis of current-day health system policy outlook with regards to UHC is done to understand the policy outcome from Bank-GOI interaction. The Bank is interested for economic growth which needs more private sector participation. The GOI policy is also inclined to the same assumption of growth. This becomes the point of policy collaboration under the governance framework of HSS. UHC is the outcome of this policy collaboration.

The Bank-GOI interactions (in collaboration with other international/national/regional actors) have created UHC as an outcome in public policy domain. However, that very outcome is creating another outcome (subordinate outcome) by engaging private sector.

The role of HSS in policy exercise with regards to this subordinate outcome is negligible. In fact, over a candid discussion with this researcher, Dr. Phyllida Travis, a senior international health system expert, has said that there is no answer on how HSS should deal with private sector (Dr. Phillida Travis, Team Leader - HSS at WHO SEARO, personal communication, May 6, 2019). This research has also found the same, HSS does not have any specific role to shape/develop public policy for dealing with private sector. The only role that HSS is playing is how to engage private sector in public provision. In this case, the Bank as an advocate of HSS approach is playing a dual role. On one hand it is active in generating policy evidence through research and lending for engaging private sector in public system by promoting UHC, on the other hand, it is financing private sector in health care through its unit of International Finance Corporation (IFC). In both the occasions, the Bank is cultivating ways to involve private sector in health care service delivery, but not helping the GOI to develop its policy for dealing with private sector.

Private sector participation from the point of health care service delivery may not pose any problem, but it is a serious limitation for the government to not have any private sector policy in health care service delivery. Considering this behavior of public system towards private sector, this research briefly analyses the role of Bank and GOI at present to deal with private sector (subordinate outcome) in health care in India.

4.7 Bank and GOI with private sector

The private sector in Indian health care is a less explored and analysed topic. The academic reference as well as critique about private sector participation in public service delivery is ample, but 'what is private sector in health care' still remains a case of further enquiry. It is not the objective of this research to enquire on the private health care sector in India. In this section, the private sector discussion is to know what constitutes private sector and the related roles of the Bank and the GOI in this sector.

The health care is by now a full-fledged industry in India. The industry can be divided in four areas, which are essential for health care service delivery. They are hospital and diagnostic centres, medical education, drugs and pharmaceuticals, and medical equipment and surgical appliances. The private sector investment qualifies for all these four areas. Their share both in economy and health care service have been growing. For

record, the Foreign Direct Investment (FDI) equity inflows in India's hospital and diagnostic centres are USD 567·85 in 2013 – 14, USD 742·35 in 2014 – 15, and USD 747·38 in 2016 -17 financial years (GOI – Rajya Sabha, 2017). Similarly, the share of intake capacity in private medical colleges was spiked to 52·1 per cent in 2014 from 13·7 per cent in 1980 (Choudhury, 2014, p. 4). These figures prove how much importance private sector has in health care service delivery at present. It is of need for future research to segregate the private sector in these categories and understand how they interact with the public policy.

The Bank has a long association with the private sector in health care. The review of CAS documents track that from the beginning of 1990, the Bank is incrementally active to develop private sector in health care. The 1991 CAS document first mentions the possible exploration "*to promote private sector participation*" in health care for providing "*low cost, efficient and responsive services*" (WB CAS, 18 July 1991, p.20). Thereafter in 1997 and 2001 CAS documents, the Bank talked about IFC's plan to invest in private health care sector (WB CAS, 19 December 1997, p.16; WB CAS, 13 March 2001, annex B9- p.7).

In the late 1990s, IFC specifically concentrated in the tertiary health care (WB CAS, 19 December 1997, annex-2). This move was quite well with then Bank financed health system projects' which promoted reallocation of budget to concentrate primary and secondary levels of care. The gap in government financing for tertiary care was planned to be the area of investment for IFC. For example, in 2003 Max Health Care got a loan of USD 19·59 millions from IFC (WB CAS, 15 September 2004, annex B8 – p.3). From the mid of 2000s, the Bank used its state-level health system projects to engage private sector in the primary and secondary levels of care also. In this regard, it specifically devised three strategies; developing regulatory framework for private sector, "*contracting model for increased private participation in primary healthcare*" through PPP, and developing private health insurance market as well as community health insurance plans (WB CAS, 15 September 2004, annex-7 p.11). It is also to be noted that apart from investment, IFC provides advisory services too to companies for business development. One example could be IFC's technical advice for Assam-based (from North East of India) private sector hospital chain, GNRC, where IFC provided technical advice to develop business model in order to transform community medi-

shops into retail pharmacy for providing medicine, health planning and counseling (Independent Evaluation Group/ IEG, 2009, p.87).

Of late in IFC's investment in the private sector, private equity fund has emerged as an investment opportunity for private hospitals. As per 2018 – 2022 CPF, the Bank invested USD 11·75 million in 2016 to HCG hospital and USD 50·46 million in 2017 to Fortis Health through private equity fund (WB CPF, 25 July 2018, p. 151 – 152). Private equity fund investment has become a new lifeline for India's private hospitals. Business information data shows that the investment in the hospital sector was almost doubled from USD 395 to USD 642 between 2016 and 2017 (Khanna, 2019). This type of investment is ethically questionable in health care sector since the private equity fund works based on profit maximisation model, where the actual investors are least bothered about medical ethics and human lives. The model works on 'buy to sell' logic, where a financially struggling hospital is bought and then turned into a profit making entity within a short span of time in order to sell it at inflated price. This kind of business model has high chance to commercialise health care services through overmedicalisation and unwarranted diagnostics (Khanna, 2019). It is on the Bank to justify why this model of investment for private hospital financing has been bought.

The role of IFC in private health care is repeatedly a matter of concern. An interviewee with a vast experience of previously working in government system has been consulted by this research to reflect on the private sector from Bank-GOI interaction. He alleges that IFC's "*actual contribution [in health care] is very ill understood*", and "*completely nontransparent to the health ministry*" (Informant 09). It is partly because GOI does not have any policy to track what investment is coming in health care, from which source, and in what way. The investment in health care, especially in hospital care is looked after by the Department of Industrial Policy and Promotion under the Ministry of Commerce and Industry (MOCI). It is found that GOI's two ministries, MOHFW and MOCI, have almost zero coordination. Being asked about the inter-ministerial coordination between MOHFW and MOCI, the interviewee confirmed that MOCI "*does not really formally concern [the] health ministry*" (Informant 09). Because "*it does not see health as an outcome of health industry, it sees growth of health industry as its own*" (Informant 09). From the part of MOHFW also, no initiative is found to sensitise or build inter-departmental coordination with MOCI. So with regards to

private sector investment in health care, the only concern for MOCI is "*greater investment and greater profitability in the health care*" (Informant 09).

The interviewee opines that NITI *Aayog* is supposed to be the mediator between the two ministries. Hence, it is up to *Aayog* what to prioritise, what to give importance. However, he suspends that "*clearly the current dispensation is to prioritise the need of industry*" (Informant 09). That is why even the intervention target for health programme is also directed towards industry generation. He reasons by citing NITI *Aayo*g's vision direction, which says that in one year *"two-third of top corporate hospitals to join PMJAY*" (Informant 09). According to him, the current orientation of health policy demands more funds and more industry, therefore "*NITI Aayog is much bother about economic growth rates*" (Informant 09). So in that orientation, as the interview concludes, the hospital industry does matter for its contribution into the economic growth.

In conclusion, this researcher opines that the behavior of GOI (or its policy think tank like NITI *Aayog*) in health care service delivery is not different from the international outlook that symbolises UHC movement as discussed in the last chapter, i.e. partnership-based health care service delivery. HSS in this case is the so called governance framework that provides the platform to host UHC, where the Bank has to take much of the responsibility for its propaganda on HSS approach. The situation analysis of the Bank's role in India's HSS entails that the Bank through HSS is definitely contributing into the drive for UHC, but it is unfounded as to how that contribution strengthens India's health system in the policy front. The HSS approach which the Bank is advocating at present is neither epidemiologically sound nor design-wise cost-benefit for the government. Moreover, HSS creates a vacuum in the policy direction for managing private sector, which, apart from its own market for 'upper sixty', is now an integral part of government's health care service delivery for 'bottom forty'. This policy paralysis of the GOI is required to address urgently, since the limitations of policy create problems in practice. The struggling health care service delivery at the state-level is the direct outcome of such policy paralysis.

The next part of this research is the Bank's health system policy implementation-operation level, where the Bank provides hands-on support for testing its brand of policy efficacy at the ground. At the state-level, the Bank's ownership in the

development as well as strengthening of health system is undoubtedly much higher compared to the national-level. It should be an interesting enquiry to know how the Bank owned policy interacts with the actual reality. The next three chapters (five, six and seven) analytically present the actual reality. Chapter five is on the context of Karnataka to trace the historical development of the state and understand post-1990 onwards corresponding economic models. Those models have been guiding references for the state's overall public policy direction, hence, their compatibility is necessary with any other externally infused model in public system. Thereafter, chapter six and seven are on the direct interface of Karnataka with the Bank's post-reform health system approaches (Health System Reform, Health System Development, and Health System Strengthening) to understand the policy implementation-operation level.

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Chapter 5: Karnataka: The journey from enlightened modernity to reformed development

Summary of the chapter: The chapter entails the journey of Karnataka from the seed of modernity to the models of development. It is divided in two sections; the embodiment of modernity in the discourse of development and the evolution of development models. The formation of the state in the post-colonial India is not a gift from the colonial project. The governmental rationality was instrumental since the beginning of Mysore modernity. That modernity shaped and incrementally institutionalised a tripartite contract between the Mysore Kings, British rule and community. This triangular interaction impelled the modernity to become competitive and enlightened. The pathway of modernity got interjected after the unification of Karnataka effectuated on the state polity in 1956. The emotion over language got merged with the aspiration of economic prosperity. The acculturation of Kannada speaking communities took place at the cost of segregation of Kannada population in various socio-political blocks. This unification made the modernity to get lapsed (between 1960 and 1990) into the model of development. The new paradigm began with the commencement of economic liberalisation in the decade of 1990s that widened the scope to adopt and adapt new models of development for Indian states to plan fiscal space management and improve on the service delivery. World Bank theorised model of development came at this context. The model worked as reform instruments (strategies, techniques and tactics) in restructuring the state economy and reorienting the governance system. The model eventually became the conservatory of the Karnataka's own evolutionary development model in order to govern the policy making spaces. The findings infer that contextual determinants need to be studied thoroughly to understand the governmental rationality behind policy decisions and actions. The outcome should be measured against the employability of reform instruments (process indicators) instead of only depending on the imperceptible progress of impact indicators, most commonly the annual growth of Gross State Domestic Product.

The structure of the health service organisation at present in Karnataka is linked to the larger contextual determinants operating at the systemic level of the state macro-

economy situation. A judicious evaluation of the state-level macro-economy is necessary for analysing and understanding the pathway of embodiment of the health service management. The projects financed by international agencies, state policy guidelines and institutional changes therein are all linked to the happening in the macro-economy of the state.

The State Polity has a long legacy in characterising the very macro-economy. The state projects financed by the World Bank are the de-facto conditions of the political economy of the state in move. These projects have become embodied in the governance of health service organisation and management in Karnataka. This chapter entails the very evolving context of the state that has been continuously accommodating these projects and paving the way to form the present-day health service system. The institutional context analysis method, as detailed in chapter two, is used in order to understand the development pathway of the state, and the contextual factors that determine role of public policy. Following are the objective and research questions of the chapter.

- To analyse the contextual relationship between Karnataka and World Bank models of development on which the health system projects get implemented
    - How have the different models of development historically evolved in Karnataka?
    - What is the World Bank's model of development?
    - How do the contextual factors interplay with one another in order to interact with the World Bank's model of development?

To address the above research objective and questions in this chapter, this research presents relevant literature review, supplemented by discussion with eminent scholars.[78] The two-pronged aim is to reflect upon the historical development of the state and to elaborate upon the political economy of Karnataka during post-liberalisation era in India.

[78] This research is indebted to the faculty and research scholars of Institute for Social and Economic Change, Karnataka and National Institute of Advance Studies, Karnataka for their intellectual inputs shared over discussions on this chapter. The names of the faculty and Research Scholars are mentioned in the acknowledgement section.

5.1 Emergence of the 'Modern'

The development of Karnataka, as a State, is linked to the modernisation of the state precisely the time while the state took the turn towards becoming modern. The concept of modernity is an heirloom of the process of state formation in India, though that formation of the state was not simply a replication of Western concept, rather punctured with the diaspora of traditional Indian society (Kaviraj, 2000, p. 141).

The present condition of the Karnataka state is a sequential consequence of the historical events. The development of the state is a journey stemming from the modernity. March of the State towards 'modernity' can be traced long back to the Eighteenth century. The period of late eighteenth century to the mid of twentieth century was the prime time when most of the important institutions, modalities and practices emerged and shaped the foundations for present day modern Karnataka (Nair, 2012, p. 1). This section attempts to outline brief account of the journey of Karnataka towards modernity. The phenomenon of pre-independence modernity was mostly limited to the Mysore region of Karnataka, a princely territory of British occupied India.

Mysore state in the British occupied India is referred to as the most modern state. The Wadeyar dynasty, rose from feudatories to the position of Kings, was the early ruler (1399 – 1761) of Srirangapatna, the then kingdom of Mysore. The Wadeyars' regime was interrupted between 1761 and 1799 by the two successive regimes of Haider Ali and Tipu Sultan. The British rule finally "*restored*" the Wadeyars of Mysore again in 1799 after defeating Tipu Sultan. The Wodeyars started ruling again with controlled autonomy under the British rule till the British Commission took over in 1831 (Rao, 1936).

In the most recent records on Mysore history, Janaki Nair (2012) periodised the idea of 'modern' in three phases; the indigenous modern (led by Haider Ali and Tipu Sultan), colonial modern (under the direct British rule) and national modern (led by the *Dewans,* the bureaucrats, appointed by the British Raj). These phases though distinct character but are interlinked in nature.

5.1.1 Mysore Modernity: The formation of the State

The journey towards the 'modern' started under the leadership of Haider Ali (and propelled by his son Tipu Sultan), the ruling power getting more centralised. The need for a centralised system of administration had been crucial in face of the aggression by the East India Company that escalated to war. The slow move towards bureaucratisation of the administrative areas, state patronisation for indigenous production and interference in trade regulation, organisation of the military forces and many other measures were taken to finance the war (Nair, 2012, p. 5). After seeing the Europeans, Haider Ali and Tipu Sultan came to understand that force (and not righteousness) is the tool for retaining authority and thus the state assumes the role of manager for controlling economic life of the country (Nair, 2012, p. 5). Such new adoptions of governing techniques were needed to become self-reliant while competing with the East India Company's bellicosity. Nair (2012, p. 6 and 269) suggests this indigenous modern's rule was absolutist in nature (as argued by Partha Chatterjee and cited in Nair 2012) but it paved the path of modernity towards future trajectory.

The defeat of Tipu Sultan in the hands of British initiated new forms of governance arrangement in the Mysore princely state. After the departure from the Haidar-Tipu indigenous model of modernisation, the British crafted out a mechanism, the colonial modern, keeping on view two different yet interconnected motives, the target being a stronghold on the Mysore state. Their first move was to separate the administrative responsibilities from the command of kingship by gradual bureaucratisation of the system. As expected, the power of King and his control over principality were detached from one another. The next strategy was to intensify this bureaucratisation further by appointing *Dewan* to ensure that the maximum revenue extracted must come to the British, and at the same time direct control on the subject (population) can be administered. The British Rule continued with this practice (1799 – 1831) of deepening this bureaucratic structure in order to make the state a patron of the institutions (be it family or religious), and it was not the king's domain anymore (Nair, 2012, p. 6 – 10). It is important to note that division of power and authority between the King and the *Dewan* in subsequent times resulted into unprecedented competitive interventions from both the sides to govern the population in order to appease the British Rule and also the population of the state. Nair (2012, p.12 – 13) brings out those governance practices that were occasionally performed by both the regencies, such as, offering doles to

brahamans, temples and other religious institutions as well as rescheduling caste pyramids to make government jobs and education more inclusive.

This regime of 'colonial modern' got accentuated after the death of Krishnaraj Wodeyar III when the state came under the full control of the British Rule during 1831 – 1881. This phase of modernisation compelled the monarchy to completely fall out of sync from the governmental activities by succumbing to the institutionalised rules and regulations meant for generating more revenue. The British finally reinstated the Wadeyar X (Chamarajendra) in 1881 but he was allowed to exercise a very restricted authority compared to the appointed *Dewans* (Nair, 2012, p. 11). This period of a near-absolute control of the British rule ushered in a new era of Mysore modernity in future.

The most thriving phase of this modernisation regime in Mysore was heralded with the nationalistic view propagated by the *Dewans*, like M Visvesvaraya (1912 – 1918) and Mirza Ismail (1926 – 1940). Nair reckons that the higher rank of Mysore bureaucracy was dominated by the upper caste, mostly *brahamans*, who also held the cultural tag of Western-educated visionaries. They had grown out of this aura of colonial modernity and vouched for greater involvement of the state. They started rebuilding the state aiming at better production and efficient management of resources. This new exercise of assertive state intervention had an assortment to building public institutions (e.g. Bank, University, birth control clinics, chamber of commerce etc.) to founding state aided socio-cultural associations (for example, *Kannada Sahitya Parishat* and the like). This pre-independence modernisation resembles with the Nehruvian development model of planning which enthusiastically called for economic independence (Nair 2012, p. 13 – 16). Indeed, this modernity as a practice had greater concern for economic democracy over and above the political one. For instance, denouncing the erstwhile colonial modernity and commitment for restructuring the existing social discord were fought off with sheer motivation. The default difference was noticed while the Miller Committee report was tabled in 1918, by the then king Krishnaraja Wodeyar IV. This report attempted to institutionalise the reservation for lower order castes (or depressed castes) but the move was opposed by M Visvesvaraya (Nair 2012, p. 14).

Similarly, the making of the first Representative Assembly (1881) and the first Legislative Council (1907) among the princely states might be considered the examples of harbinging democracy in governance (Nair, 2012, p. 16). However, the miniscule

autonomy delegated to these representative and legislative bodies in governance and administration demoted the political system (led by the Congress) in the state that remained underdevelop compared to the rest of British ruled India (Manor, 1975). Contestation (along with rivalry) and competition (accompanied by strife) were the two basic characteristics of the Mysore modernity, especially, for the national modern, because of the multiple contenders aspiring for governmental management. These very features earned Mysore the nickname of an "enlightened" modern and kept it ahead from other princely states. Impact of such a 'national modern' was pivotal while setting up many public sector industries in pre and post-independent Mysore.

This Mysore modernity was the stepping stone for state formation, the ideals of ideally being modern. The modernisation strategies adopted by Tipu (indigenous modern) or Wodeyars/*Dewans* (national modern) had had some compulsions. Both Tipu and Wodeyars did not do the needful to have a tactical network (at the structural level) with the land-owning powerful castes who could have been mobilised otherwise for political consolidation at best, at the local level (Ikegame, 2012, p. 11 – 12). This dearth of insight compelled them to improvise upon governance mechanisms (through the various stages of modernisation) under different disguises, to retain the authority in order to control the communities and maintain legitimacy.

The three phases of modernisation (indigenous, colonial and national) in pre-independence Mysore were timed towards more or less a similar governance-related goal, i.e. to have a strong foothold structurally within the community and further develop the state. The conflict resulted from the cross-purpose of governance mechanisms that colonial modern (maximising revenue generation) for example clashed with the values of indigenous or national moderns (creating legitimacy among the communities as well as being relevant to the British rule for retaining principality). Further, the national modern led by the *Deewans* was more focussed on state building and comprehensive economic development. The independent Mysore or later on Karnataka as a state joined the assemblage to become a part of overall Indian discourse of modernity and thus, eventually got synced with the policies of the Union government.

5.1.2 Unification of Karnataka or Kannadigas?

In the historical antecedents of Karnataka, the unification of Karnataka has been a landmark event. The Mysore modernity which had erstwhile become a benchmark for the rest of the country encountered an impending political crisis within the state and outside (in *Kannada* speaking areas) regarding the proposal of amalgamation of all Kannada speaking areas into one state. The unification process as a phenomenon speaks volumes inherent about disparity that exists between North and South Karnataka.

Karnataka ekikarana (unification of Karnataka) was a movement driven by the aspiration of the language-centric homogeneity, and further impetus followed after the Congress formally adopted the principle of language based state formation in 1930 (Nair, 2012, p. 246). Apart from the pockets of developed Mysore region, Kannada speaking community were settled in undivided areas of Bombay, Madras, Coorg and in parts of Hyderabad regions. The fervent love for language escalated to the chorus of *Kannada nationalism* – that is, to reunite the Kannada speaking areas with its 'epicentre of moderns' - the Mysore state. Nair (2012, p. 246) points out that the displacement of Kannada people from their homelands root started after the defeat of Tipu Sultan followed by the stranglehold of British rule in 1799.

This unification movement became a popular feed of public debate just after the immediate years of independence. The advocates of this unification were bent upon the "emotional unification", where the language factor dovetailed with the prospect of development. The opposition (mostly from the core Mysore region) vehemently defied the unification call in apprehension of losing control of the caste domination since it might give an edge to the Lingayats (who mostly inhabited the North Karnataka and were in numerical majority in the proposed geographical territory of the unified Karnataka) over Vokkaligas (the dominant caste in South Karnataka).[79] The other major concern was the prominent fear of resource scarcity for Mysore inhabitants. The opponent voices included prominent visionaries of Mysore state (such as, M Visvesvaraya and Mirza Ismail), Vokkaligara *Sanghas* and other public intellectuals (Nair, 2012, p. 247). The supporters of an united Karnataka rallied for the need of

[79] A dominant caste is one whose numerical strength coupled with the power to wield economic resources and political command. (M N Srinivas in 'The Social System of a Mysore Village' (1955) in the book (M. Mariott and A. Beals (eds.) *Village India: studies in little community*. Chicago: University of Chicago Press.)

integration, the issue being complementing each other's (North and South) economy (in the sectors of agriculture, industries, banking, insurance and co-operatives) to emerge as an exclusively Kannada speaking development state of independent India (Aparanji, 1949). Ultimately, the logic of development prevailed over all pros and cons. It was proved to be a suitable manifesto to mobilise political mandate, to garner public support and automate administrative alignments in favour of unification of Karnataka. Nair (2012, p. 249) argues that the drive for development dissuaded the caste tension; as the booty of development (i.e. generated from the supposition of collective resources from both the North and South Karnataka) was proved to be a sound calculation to let out the steam of emotion over the common unifying factor which was the language. Undeniably, modern Mysore's nationalistic model was so vivid and persuasive that economic planning in the development agenda had to be an indispensable precondition for a united Karnataka.

For the political psyche though, that very development was meant to be exclusively assigned for the prosperity of *Kannada* speaking people. This new image of development was not an appropriation of the forerunner state-centric Mysore moderns' philosophy. It is rather, an acculturation of the *Kannada* population (and not any more community) dispersed over the various regions to form an integrated whole to develop Karnataka economy. Equating Karnataka, as a state, with *Kannada*, as a population at large, is the crux of '*Kannada* development model'. The torrent of *modernity* detoured into the tributary of *development*. As a result, the category of community was reassembled as population in governance.

As envisaged in the *Kannada* development model, Mysore state became united with other *Kannada* speaking areas by the 1st November 1956 to form a new state named after Mysore only. *Kannada* development model was covertly an aspiration of larger economic integration for prosperity and overtly an emotional outcry for linguistic unity. In the official unification agenda, economic wellbeing and prosperity of the population (and not community) were given more priority in planning and decision-making over and above the question of their social identities (such as, language and caste). It is apparent that the leadership, though divided in their opinion, was also deeply influenced by the success of the Mysore modernity and thus imbibed the logic of an integrated economic development for unification of Karnataka. It was the modified as well as improvised political rationality of the then leadership which articulated this unification

as a victory for *Kannada* nationalism (the victory of *Kannada* 'people', the *Kannadigas*!) and at the same time it was able to politically dodge and dribble with the contradictory views of caste based 'community'-wise territorialisation (i.e. a two-state propositions dividing North and South Karnataka). This unification had contributed constructively indeed, but a quizzical question remains whether this journey towards development for post-independence unified Karnataka (erstwhile Mysore state was renamed as Karnataka in 1973) was a move propelled by the Mysore's 'nation-ness' modernity or the search sought after for any other development alternatives.

5.1.3 Karnataka at a glance

The unified Karnataka is a commendable assemblage of topographical diversity – from hills to plateaus to coastal regions. Prior to independence, it is the administrative zonation delineated the areas of old Mysore presidency, districts of old Madras presidency, districts of old Bombay presidency (Bombay Karnataka), and the districts of Hyderabad's Nizam dynasty (Hyderabad Karnataka) (Pani, 1998, p. 67). At present, the Karnataka government has divided the state into four revenue divisions for administrative convenience; Bangalore and Mysore divisions represent the South Karnataka region whereas Belgaum and Gulbarga/Kalaburagi are from the North Karnataka region.

5.2 Development as modernity

The immediate years of post-independence Karnataka strengthened the Mysore modernity perspective of state building further and the conducive environment spawned public sector led industrial growth in 1950s. But all the good thing came to an abrupt stop after the unification of Karnataka (or specifically after 1960), when the state had presumably embarked upon an altogether different trajectory to detour the pre-independence values of Mysore modernity. The old Mysore earned impressive laurels for economic development and democratic practices which became a clear by itself when compared to the other newly added areas of united Karnataka. For instance, at the time of unification, the state capital owned a whopping 92·26 per cent of total capital structure in old Mysore compared to 55·05 per cent of total capital allocation meant for other annexed areas (Pani, 1998, p. 68). A concerted effort in improving and maintaining canal and irrigation system had contributed copiously in bountiful

agricultural output, for streamlining the banking system (brightened the economic prospect by financing irrigation) in old Mysore region (Pani, 1998, p. 69).

Such strategies continued after the unification of the state, but with a different political agenda. In a united Karnataka, the earlier dominant caste Vokkaligas (of South Karnataka) got marginalised with the Lingayats coming up as dominant cast in the state. This transitory caste mosaic shifted the focus of development priority from South Karnataka to North Karnataka as power changed the hands – from Vokkaligas (based in South) to Lingayats (located in North) (Pani, 1998, p. 74). However, one of the key features of the Mysore model was spared, i.e., ascribe to maximum priority to the State investment and industry building.

The years at beginning of the post-unification politics brought in a few interesting changes in the political scenario of the state. Karnataka economy during the sixties decade was mostly agrarian in nature. Allotting lump sum investment decision in irrigation turned out to be a boon in changing the caste (and to some extent the class) politics in the state. The tenants (tenancy practice was there in coastal areas of Karnataka) and the small farmers (in old Mysore region) of South Karnataka were bestowed with the economic benefit of land irrigation. In social diaspora, this newly found technology-led upliftment provided leverage to the small farmers and tenants for asserting their power and authority. This empowerment snowballed into organising movements and reconstructing the inter-caste hierarchy. Paradoxically, this same state initiative in investing for irrigation had generated much less impact in altering or starting new political dynamics in the Northern part of Karnataka (both in the Bombay and Hyderabad regions of Karnataka).

This reason is the workforce characteristics- agrarian workers were landless labourers and their fate was determined by the big farmers' discretion (Pani, 1998, p. 69 – 71). Hence, the politics of confrontation and power struggle was somewhat halted in the northern part of the state. Apart from the state investment in the irrigation and agriculture, the state-led industrialisation drive mostly centralised around Bangalore area. The PSUs- Public Sector Unit (like, BEL, HMT, ITI and HAL) were handpicked for Bangalore over other regions due to availability of basic infrastructure. It led to unionisation of labour force in urban areas and followed by the conspicuous growth of

small scale industry (as well as good number of business class), which was a conducive support service for the big PSUs (Pani, 1998, p. 73).

This doctrine of immediate post-unified Karnataka is a reflection how the political decision-led economic interventions could impact the political reorganisation of the various parts of the state as well as fuelled urbanisation, especially in and around Bangalore area. The initial developmental incentives in unified Karnataka could not bring along a sound mechanism to address the distress of Northern part of the state, the eminent shortfall were democratic deficit and economic underdevelopment. On the contrary, the heritage of early democratic foundation and economic stability of the Mysore modernity elevated the South Karnataka in an enviable developed position, in spite of the fact that it was a non-priority region under the changed political circumstances of the unified Karnataka. Such is the fascinating anecdote of the unification of Karnataka (or rather *kannadigas*) – the dynamic movement that transformed the Mysore modernity to be integrated into the discourse of development.

5.2.1 Transition from Mysore modernity to Kannada development

In the unified Karnataka, the changing state polity driven by economic priority created diverse social and political transformation in the state. This transformation was not an instantaneous, rather it spanned over three decades, i.e. between the period of 1960 and 1990. This slow but sure process of transformation clearly indicates how deeply intense was the outcome of such transformations that hastened the process of institutionalisation.

As mentioned earlier, the power equation started to lean towards the deprived and lower castes both in South (small castes, economically poor Vokkaligas, tenants settled in in the coastal regions of South Karnataka) and North (small castes who vented their anger against the Lingayats for appropriating all the irrigation benefits) Karnataka . Those communities grouped together and became consolidated and fortified their political authority under the leadership of Mr. Devraj Urs of Indian National Congress (INC). With time, Mr. Urs could win the confidence of all small caste groups and economically weaker Vokkaligas from both South and North Karnataka, especially, because of the ambitious outcry of Mrs. Indira Gandhi – the '*garibi hatao*' (Pani, 1998, p.74). Mr. Devraj Urs's strategies (land reform and reservation) had reaped the rewards – the political vocabulary of the state shifted its focus on the hitherto backward sections of

the society which finally culminated to new political crescendo (Rao, 1995). The electoral success of the coalition (of various small castes and groups) processed to a new design of economic intervention that can match with the expectation of different coalition factions. Hence, a shift in the state economic objective from large scale projects to welfare schemes became inevitable for securing the gains and utilities to individuals (from communities fragmented alone caste lines) (Pani, 1998, p. 74 – 75). This is a new face of Karnataka politics which realigned its policy perspective from large scale state building to individual/community interest. But eventually, the resource allocation got skewed for infrastructural development (like, power sector) and such trends eventually led to borrowing from external sources at the risk of detrimental for the state finance in the long run. Pani (1998, p. 77) justly argues that the obligation to the political coalition compelled the government to amend the economy of a vast area of the countryside and that ultimately boomeranged – it started challenging the prevalent social order.

It was becoming increasingly difficult to manage and assuage the diverse interests of the community who got divided into various social and economic groups by 1980. The defeat of INC in 1983 prompted the state towards adopting a new form of politics. The Janata Party engineered political decentralisation to counter the practice of centralised politics and power holding for vested interests. Pani (1998, p. 79) observes that the decentralisation of politics through '*Panchayat Raj* System' was largely needful to the local demands (for example, access to water) and also provided scope to induct new leadership across the state. However, the political decentralisation effort could not prove its merits while centralising finance and administration which otherwise could have been a probable follow-up. As a consequence, the people remained dependent on the state for resource generation and allocation (Pani, 1998, p. 79).

The period between 1960 and 1990 was a witness to the transition from the Mysore's nation-ness modernity (i.e., state building through economic wisdom) to a *Kannada* development model. *Kannada* development model was also instinctively relied upon the Mysore's nation-ness modernity while dealing with economic policy and planning. Nevertheless, the model failed because of its incapacity in addressing or 'annihilating the caste' question. Hence, the political consolidation of 'one language one state' ethos could not be reserved for long. However, the model of *Kannada* development generated a series of transformation steered by the political interests and shaped by the economic

governance. Initially, this clamour for political interest continued in full steam because of social discrimination and caste sentiment fallout (mostly anti-Lingayat bias). Consequently, the institutionalisation of political and economic decisions over the three decades brought with the mushrooming of small social units with sectarian political motive and diverse economic base. The zeal imbibed from the Mysore modernity for state building had got diluted over the years since *Kannada* development was overtly preoccupied with governing the population instead of improving upon the efficiency, producing quality service/utility or enhancing productivity of the State economy (agricultural/industrial) outputs.

5.2.2 The dawn of a new development paradigm

Karnataka, like any other state of the Indian Republic, had little to do with the adoption of economic liberalisation policy by the Government of India (GOI) in 1991. The political and social transition of 1960 – 1990 followed by flawed economic planning degenerated the state into financially a debilitated entity in the first half of the 1990s. Persistent fund shortage, combined with the spirit of the then Union government regarding economic policy, proved detrimental and the state started to withdraw itself from various sectors. The only alternative was inordinate dependence on private sector, including incursion of the foreign capital. The immediate brunt was borne by the farmers settled in peri-urban areas who had to sell out their lands to industry and housing projects. Economic liberalisation brought about sizable investment in the software (known as Information Technology) industry because of an easy availability of skilled manpower and comparative low cost of investment (Pani, 1998). In-fact, the state economic policy was quick to decipher and catch up with the characteristics of liberalisation and accordingly made the IT a priority industry. Bangalore was the obvious choice, because of business-friendly land acquisition rules extremely low infrastructure build-up cost, with the added advantage of foreign capital availability.

This IT boom had contributed reasonably well in the state's industrial growth. In late 2000, a study pointed out that the contribution of IT services in GSDP (Gross State Domestic Product) increased from 1·70 per cent to 2·95 per cent (in constant price) between 2001 – 01 and 2003 – 04. Also, the growth of Information and Communication Technology (ICT) had a positive impact (for the period between 2001 – 01 and 2002 – 03) on per capita income, on the share of income of the state in tertiary sector and in

the expansion of tele-density (Narayana, 2008). However, this phenomenal growth had not been free from socio-political binaries. Pani (1998) opines that right after the post-liberalisation industrial surge, sectors like IT created a different blend of social and political tension by creating jobs only for skilled manpower and leaving out the unskilled labour force at bay. With all these counter intuitive questions as well as findings, Karnataka finally moved into the phase of reform process. If the *Kannada* development model bared the load of transition from modernity to development, then the Karnataka's entry into reform process from the valve of *Kannada* development model should be considered as completion of that transition.

The health-system projects brought in by the World Bank, to gain entry in the state level came as a pretext of the post-liberalisation new development paradigm. This new development paradigm was neither meant for all-out development of the state nor is it based on the population centric approach. In its true sense, it was an economy only model. In earlier decades, economy was the indeed to pursue the development models, but in post-liberalisation times, the economy itself has become the fundamental platform for promoting development. This 'typical' model of development is of utmost interest for this research work. The entire context of the health system related projects and their operational consequences are motivated solely by this new development paradigm. The next section elaborates upon this new development paradigm, that is, development through reform!

5.3 Karnataka's rendezvous with reform: The new model of development

The 25-year mark of economic liberalisation in India (1991– 2016) once again brings back the long contested question as to whether this reform helped people lead a better life (Sarkar, 2018).[80] From academia to politics, opinions are not only divided but also fractured to fully appreciate the reform-led liberalisation. The scholarship is abundant with regards to policy impact of reform in various social and economic indicators, especially for health, education and income. The reform in Indian context usually refers to the economic liberalisation policy adopted by the Government of India in 1991. This

[80] This entire section (Karnataka's rendezvous with reform: The new model of development), except the portion on political reform, is published in the Working Paper (No. 408) of Institute for Social and Economic Change in 2018 as 'World Bank's Reformed Model of Development in Karnataka. It was a part of PhD research's progress publication (http://www.isec.ac.in/WP%20408%20-%20Amitabha%20Sarkar%20-%20Final.pdf).

policy decision has vertically percolated to the multi-layers of the government (Union to state to local bodies) and horizontally expanded to the various sectors (health, education, transport, power, agriculture etc.) of governance.

In scholarship, the sector specific assessment is limited to the changes made in the policy within the sector and followed by the outcome achievement for respective governance services. This outlook of assessment gives little scope to understand how these sector specific reform policies are intrinsically linked to the overall macro-economic adjustment and co-opted/dissented by the different political regimes. Hence, the recommendations of the outcomes mostly deal with the intra-sector governance shortcomings without addressing the issues of governmental limitation as determined by the political decisions and economic priorities. This gap in academic enquiry underscores the importance of public policy to deal with fundamental issues of governance faced by the public sector. Thus the evaluation of any sector-specific governance reform needs an understanding of the incremental reform processes which is linked to the development of state polity and economic restructuring. This research attempts to understand the very evolving context of the reform processes, and not any particular sector, determined by the political decisions, economic choices and basic governance arrangements. This research is based on the review of various secondary literatures including academic writings, declassified World Bank documents, newspaper reporting and government reports.

5.3.1 Karnataka: Cradle for India's state level reform

Liberalisation was a result of Balance of Payment (BOP) crisis in 1991 where Government of India (GOI) had to accept the policy of economic liberalisation, privatisation and globalisation at the suggestion of the World Bank and International Monetary Fund and in return obtained conditional loans. Though the macro-economic policy level reform takes place at the level of Union government, the implementation of the macro-economic led state economic and sector specific governance reform occurs at the state level. The first effects of liberalisation were felt at the state level around 1995.

The thrust for 'second generation reform' (as coined by P Chidambaram) started at the state level during 1995 – 96 and became the primary concern of the policy makers of GOI. At the same time, state governments were also facing fund crunch to invest in

social sectors because of poor tax to GSDP ratio and surmounting interest payment for loans already taken. In the middle of this fund crunch, then newly-appointed World Bank Country Director Edwin Lin took 'anti-egalitarian' and much more selective approach to woo the states to join in the reform initiatives. He promised to raise the assistance from 5238 Cr. (USD 1·5 billion) to 10476 Cr. (USD 3 billion) for the overall country in the mid of 1990s.[81] The states were selected on the basis of their eagerness for reform and ability to achieve the economic growth. The Bank officials thought to showcase the achievement of growth in future to attract other states for accepting reform agendas (Kirk, 2007).

The speeding up of reforms in Karnataka was one of the primary outcomes of the Bank's 'focussed states' approach to advance reforms at the state level. Karnataka is considered to be the model state for reform-led development. It has implemented the Bank's financed economic restructuring programmes for two consecutive fiscal years. The strong commitment towards the structural adjustment of the economy in initial years had fetched a number of sector-specific funding from the Bank. For example, the state was extensively supported by the Bank for projects in sectors like health, transport, *panchayat raj* etc. Karnataka's rapid adoption of the reforms was a result of issues like the limitation of federal politics at the centre level, compulsion of fiscal contraction at the state level, tactics of the World Bank and other macro-economic concerns.

The next section is about the context where the reform is executed. This context is an evolving one where the macro-level changes in the economy are implemented in consultation with the sector-specific governance reforms. The post-liberalisation period of Karnataka is experienced of many policy initiations as well as modifications in order to match with the basic principles of liberalisation policy. The context for the case of Karnataka is a context of 'policy of reform'. The question is why reform is featured as main programme of this evolving context.

> *"Let us believe not only that it is necessary because it is just and ought to be, but necessary because it is inevitable and must be"* (Shelley, 1920, p.1).

[81] Actual values are mentioned in the reference documents as Billion/Million unit of USD. In this chapter, all the corresponding INR figures in Crores are calculated retrospectively as per the exchange rate of the respective years.

Shelley's philosophical take on reform applies across the centuries and contexts to highlight why contextual evolution is a prerequisite to understand the 'inevitable' phenomenon, the reform. The staggering state finances, economic slowdown, rapidly losing political legitimacy and inefficient public systems of 1990s, all led to the economic policy of the Union government trickling down to the states. The acceptance of reform was thus 'inevitable' for Karnataka. The post-liberalisation reform is the single largest change in policy paradigm where economic choices, political decision and governance management have come together to overhaul the public systems. Liberalisation policy is therefore always marked as a policy of reform that introduced in the state polity.

In Karnataka, like in rest of India, the reform takes place mostly in economic and governance management. There is no political reform as such, though transformation occurs in political priorities. These transformations are propelled by the political decisions, as inputs, which are rationalised time and again to implement reform. The economic reform is the process of execution of the rationalised decisions and governance reform is the output of the decision taken and process executed.

5.3.2 Political reform

The experiments with political representation and deliverables are common in Karnataka since the unification of the state happened in the 1956. Each passing phase is marked with new form of politics to acquire electoral confidence. The post-liberalisation phase in Indian states wider the scope to study how the politics of the regional states adjust with the obligations of the restructured economic policy. The role of the politics at the state level after liberalisation varies as the role of political leadership differs from one state to other. Three distinct features made the political leadership most important stakeholder of the reform at the state level (Jenkins, 2004, p. 16):

- The leaders are capable to *"balance economic policy considerations against political survival"*.
- In some cases the *"changing social composition of the political elite"* creates new vocabulary for political exertion to change/alter the political representation.

- The leadership is assumed to protect the *"civil society's poised state"* for influencing the policies rather than appropriate them within the political conflict.

The politics of the Karnataka state undergone fundamental makeover after 1980s and later on the liberalisation policy had given it a new dimension. Two significant factors had worked before the liberalisation era formally started in the state; political accommodativeness and localised development policy (or decentralisation). The political reform started by then Chief Minister (CM) Devraj Urs in the year of 1972 to include socially backward groups for trying to change the state's structure of 'power-sharing' which until then only limited to the two dominant castes (Vokkaligas and Lingayats). The same formula was accelerated by the Janata Dal (Secular)/ JD(S) to defeat Indian National Congress (INC) in 1983 election and thereafter all the political parties got accustomed to the formula of 'rainbow-coalition' for electoral command (Manor, 2008). The second factor is the new model of political deliverables which propelled under the JD(S) government by initiating decentralisation politics after coming to power with full majority in 1985. The decentralisation politics fundamentally changes the view of development planning by prioritising the local need through grass root development projects. This new model of development later on got acknowledgement from INC led government (1989 – 1994) also to remain electorally viable in the state (Manor, 2004). These two factors turned the state to have more inclusive political leadership comprising of different social groups in all the parties (political accommodativeness) and made politics more grass root oriented in terms of delivery of economic development (political deliverables).

Manor (2004, p. 274) argues that the long tradition of power sharing (between privileged and underprivileged groups) or rainbow coalition at the state cabinet evident of deep presence of political parties into the reality of social structure. Thus this political inclusiveness makes the scope for almost all social groups to have representative in the main power structure irrespective of the parties who control the power. Indeed, this political accommodativeness of the Karnataka parties makes them more organisationally decentralised institutions with strong foothold on grass root politics. The entire decade of 1990s (till 1999) was about advancing of decentralisation agenda. It is also captured by Manor's (2004, p. 283) analysis that the influence of national level

issues (externalities) on state political events (or elections) remained low to medium from 1985 to 1999.

Karnataka politics turned a new dimension after S M Krishna took over the post of CM in the year 1999. His opening observations had registered an unprecedented economic commitment by imbibing for structural changes in policy spaces. The Nehruvian model of top-down planning was already replaced by JD(S)' decentralisation politics in the decade of 1980s. The S M Krishna's era saw a different model of policy making, deliberative policy planning. Under the patronage of Mr. Krishna, Karnataka politics had started playing with a new pool of "business-scientists" who were originally locals (or mostly Bengalurians) but internationally command great deal of respect in competitive economies. These new policy entrepreneurs were *"able to push their demands through groups, task forces and commissions"*, and successful in creating a different approach to the state politics which echoed the spirit of post-reform federal politics in India (Scoones, 2003, p. 33).

This model of policy making was a departure from the decentralised model of planning, but considered as scientific, validated and standard methods of policy making in the era of reform. This is quite opposite to the earlier public sector led development model. For example, the Karnataka Biotech policy of the government was to support the privately sponsored Biotech companies by offering tax concession, assistance in export/import permission, intellectual property protection, a special pool of biotech fund and a biotech park with minimum infrastructure. The newly emerged business-scientist community was persuasive enough to the CM regarding the assured success of Biotech industry and which in-turn made the CM hopeful about the Bengaluru's prospective future as international destination for global economic power houses (Scoones, 2003, p. 34). The biotech policy of Karnataka had definitely received state patronage but schemed to lead and implement by the private sector. It also marks how the development goals have been slowly bestowed upon the private entities from the state.

The Krishna government constituted several Task Forces and Committees to strengthen the public services including health by involving private sectors. The government also gave special focus to Bengaluru for its development (as evident in the formation of BATF- Bangalore Area Task Force) and was able to achieve considerable growth for Information Technology (IT) industry. However, these policy measures had less to deal

with the rural reality and grimy regional disparity. So, Krishna's government could not able to manage the second term in 2004 state assembly election probably because of its alleged favour to Bengaluru centric development and outrage against repeated droughts (Gowda, 2011).

In the meantime, another important development happened in Karnataka politics since BJP (Bharatiya Janta Party) came up as strong political contender for INC and JD(S). The arrival of BJP led to a hung assembly in 2004 election. As a result, the first ever INC-JD(S) coalition government formed in the 2004 (led by late Dharam Singh of INC) but could not succeed for more than twenty months since the rebels of JD(S) legislatures (led by H D Kumaraswamy, Deve Gowda's son) moved with BJP to form JD(S)-BJP coalition government (Gowda, 2011).

The adjustment made in the combination of coalition governments from INC-JD(S) to JD(S)-BJP is an important political conduct in the recent history of Karnataka politics. Post JD(S)-BJP alliance, the oppositions of Deve Gowda - Kumaraswamy lobby within the JD(S) had vacated the party ranks and switched over to INC or BJP. The self-declared coup of Kumaraswamy, that made him CM in the new coalition for the first twenty months, turned the JD(S) into a dynasty driven regional party from a national outfit. JD(S) leaders' decision of switching over the party loyalty or even before that the alliance of Kumaraswamy's fraction of JD(S) with the BJP appeared as an end of ideology based politics in the state (Gowda, 2011). Thereafter shifting of political loyalties every now and then in order to retain legitimacy has become common in Karnataka party politics. With an end of ideology based politics, the political culture of the state replace political accommodativeness with political competitiveness. Compare to the earlier practice where political representations were based on the leadership's association with different social groups to manifest their concerns, the new practice manipulates with the win and loss equations between political parties and the leadership to arrive at best possible negotiation where political party can be benefited from the confidence of the electorate vis-à-vis the leadership can be of also sure about their future prosperity. This political competitiveness was hitherto unprecedented and added a new dimension to the state politics.

The JD(S) – BJP coalition did not complete its full tenure as Kumaraswamy again pulled out the support right after Yeddyurappa (from BJP) stepped in as CM in 2008 to

complete the next twenty months of the coalition government. This opened up an untimely election where BJP emerged as a single largest party in the state by capitalising the vote bank of Lingayats (even religious institutes like Lingayat *mutts*, supported BJP openly). Lingayats were away from power for long because of INC's inclusive politics (started by Urs) and Vokkaliga domination of JD(S). BJP successfully enchased this resentment of Lingayats with the help of few other splintered backward communities, and banking on the sentiment of being back stabbed by the JD(S) (Gowda, 2011).

The BJP's governance in Karnataka (2008 – 2013) had facilitated another political development that paved the way for cash-rich businessmen entered into electoral politics. The real estate boom in Bengaluru owing to the massive expansion of software outsourcing industry and the 'over-night' prosperity of 'Bellary Brothers' (because of their alleged closeness with then BJP government) in iron ore mining industry have facilitated the path of these *nouveau roturier* to ally with political class (Gowda, 2011). These new businessman-turned-politician have furthered lower the moral of the politics as formally the private interests made inroad to the public decision making spaces. Concomitantly, political parties have also co-opted this new league of self-financed 'political cronies' for generating fund.

This new practice is an addition to the increasing political competitiveness where the capital (primarily the wealth, but also the social relation) has become the only discretion for decision making. The ideological bankruptcy and greed for power became exposed in the worst ever form when the BJP government started 'Operation Kamala' to evade Anti-Defection Law. That was a ploy exerted by then BJP leadership to gain numerical supremacy in the state Assembly/other bodies and ostracise the Oppositions by luring the Opposition parties' MLAs/MPs/and even *panchayat* representatives with money and/or post to resign and get re-elected through by-poll in order to join the BJP camp. BJP had managed to re-elect quite handful number of representatives from Opposition camps through Operational Kamala. It continued for few years during the BJP's term and even the then State President of BJP defended the malicious practice for *"the stability of the government"* (Makeed, 2010). The Yeddyurappa led BJP's term in the government was never free of controversies, from the charges of corruption against CM's family members to BJP's struggle to remove Yeddyurappa from the post of CM (Gowda, 2011). Finally, Mr. Yeddyurappa had to resign from the post of CM on the

charges of several corruption filed by the Lokayukta in July 2011 (Kumar, 2011). In 2013 election, BJP had tested defeat to INC. The loss attributed to the massive corruption, in-fighting and aggressive Hinduvta politics of BJP (Shivasundar, 2013). It is further to point out that BJP was not the first party charged by corruption allegations but definitely it had improvised the rationality to legitimise as well as normalise corruption in politics. This is distinct from the earlier regimes. The current regime of INC controlled government is also occasionally accused of corrupt practices.

The reform context could not bring as such any 'reform' to the political system, however the politics of the state is definitely getting 're-formed' in last twenty five years. The political accommodativeness of the state has got transformed into the political competitiveness. This shift is to be considered as the most crucial moral degradation of the state politics. Devraj Urs was the first non-dominant caste CM of Karnataka in 1970s and his model of poverty alleviation and social inclusiveness had shown a new dimension of state politics (Srinivas and Panini, 1984). That politics had the potentially to make the state come out of its caste based groupings and get rid of social exploitations. However, after the departure of Devraj Urs again caste politics resurfaced but not very overtly. The JD(S) – BJP feud in the year of 2008 is probably the biggest catalyst for revival of caste dominant politics in the state.

The first half of the first decade of this century has boasted of a political commitment for executing a new economic plan with different policy outlook in opposition to the age old state led development models. The second half of the decade has completely underscored the long legacy of plan and policy oriented politics of the state and instead professed new articulation of the state politics based on power-capturing and not power-sharing. The decade of 2010 is for sure the dramatic decade for Karnataka. Post 2005 political development in Karnataka has become the new normal in the state politics after 2010 and continuing till date.

The reform process is an economic and governance affair, but the role of the politics has a sheer importance in these processes for taking decisions and necessary actions. The state politics has undergone several changes in the forms of political representation, deliverables, values, plan and policy perspectives. Interestingly, these changes have not opposed ever the reform processes rather always extended cooperation. The state level reform has become politically incentivised for the regional leaders once they understand

that it gives an opportunity to regain power with superior command. The same political class has created and/or aligned with quasi-political institutes (deliberative councils, NGOs, Task Forces etc.) to expedite the reform processes. Finally, it is the political skill that the leadership of all the parties have managed to develop in order to continue the reform processes over the period of time. Indeed, Karnataka politics has always publicised a very high level of commitment towards reform despite its internal overhauling.[82]

5.3.3 Economic reform

The economic reform in Karnataka and other Indian states started in the second half of the 1990s. At the state level, the economic reform is mostly concentrated on fiscal reform. Fiscal reform is about the management of state revenue and expenditure to help the economy function smoothly. Indian states were driven to the fiscal reform because of tremendous stress on fiscal spaces, which appeared in the second half of 1990s (Howes, Lahiri and Stern, 2003). Hence, fiscal reform has become the central agenda of economic reform at the state level.

This is the time when Indian states came across a new model of development which is more technical, authoritarian, top-down and donor driven. The background of the state level fiscal crisis of 1998 was similar to the balance of payment crisis faced by the GOI in 1991. Both the reforms were initiated primarily because of the economic crisis. The fiscal crisis of Indian states pushed them to approach the GOI and multilateral agencies for "cash for reforms" (Howes, Lahiri and Stern, 2003, p. 5 – 6). The Eleventh Finance Commission, 1999, of GOI introduced special 'Fiscal Reforms Facility' fund for the states to incentivise the participation in the fiscal reform programmes for correcting fiscal imbalances and reduce revenue deficit. That was the formal entry of Karnataka into India's state level fiscal reform programme (GOK Finance MTFP, 2006).

Reasons for Fiscal Crisis:

Karnataka's economy was strong in 1990s compared to other major states and the national average. The growth rate of Karnataka was 8 per cent per year as against 5·6 per cent per year for other fourteen major states between 1995–96 and 1999–2000.

[82] The concepts of political incentive, institution and skill have taken from Rob Jenkins edited volume on 'Democratic Politics and Economic Reform in India', 1999.

Karnataka also experienced largest rise of Foreign Direct Investment (FDI) from first half (3 per cent) to second half (19 per cent) of 1990s among the six major states of India. Irrespective of these strong growth indicators, the state fiscal crisis started appearing from 1995 – 96 onwards. The revenue receipt decreased from INR. 159 Cr. (surplus) to – 2325Cr. (deficit), and fiscal deficit had also escalated from INR 513 Cr. to INR 4276 Cr. between 1990 – 91 and 1999 – 2000 (GOK Finance MTFP, 2001). The surmounting pressure on the state revenue generation avenues and dependency on loans (both from the external and market) at the risk of debt trap condition convinced the state to formally adopt fiscal reform measures under the new thrust of economic liberalisation policy.

There are number of reasons behind the fiscal pressure in Karnataka. According to the first Medium Term Fiscal Plan (MTFP), 2001, revenue deficit (both tax and non-tax), fiscal deficit, increasing debt servicing, mounting losses in public sector enterprises, tacit subsidies in social sector (urban health, education) and irrigation projects, slow growth of tax and non-tax revenues, revision of salary and pensions (due to Fifth Pay Commission) and escalating fiscal pressure at state-level local bodies (municipality/corporation and *panchayat*) were the main reasons of fiscal stresses (GOK Finance MTFP, 2001 and 2005). Apart from the above mentioned factors, the situation further got worsened by the practice of off-budget borrowing on regular intervals to finance its loss making public sector units and big infrastructure projects.[83] For example, the state budget of KPTCL- Karnataka Power Transmission Corporation Limited (erstwhile Karnataka Electricity Board) got increased by INR 270 Cr. from 1997 – 98 to 2000 – 01 as against the financing need of INR 1380 Cr. over the same period of time. Thus, the KPTCL had to opt for market borrowing to meet the shortfall (Khuntiya, 2003).

S M Krishna, the Political Image of Reform:

The S M Krishna government, after getting elected in the latter half of 1999, took serious note of the state's degrading fiscal condition. Mr. Krishna, from the very beginning of his tenure, tried to create a public debate on fiscal policy. The government

[83] Off-budget borrowing is the loans incur from the market (through various corporations) are not part of state budget but the debt servicing of those loans (both principal and interest amount) directly fall on the budget.

brought out a White Paper on state finances in 2000, to highlight the dismay reality of state's financial situation and followed it by announcing in the 2000 state Assembly budget speech, a ten-point reform programme to overhaul the governance system. The mood of the reform is best captured in point number 5 and 6 of the ten-point reform programme (Khuntiya, 2003, p. 218).

Point 5 of the reform programme spoke about the need to expand the state's infrastructure by allotting more resources and also promised better management via innovative organisational mechanisms.

Point 8 promised to provide the people of Karnataka with a transparent, responsible, responsive and decentralised government.

The political adherence to reform is evident with the introduction of new institutional mechanisms for managing infrastructure better. The government also declared that it was committed to offer good governance to the people of Karnataka. Hence, public dialogue was complemented by legislative action and administrative measures. The government tried to take people into confidence to make them accept the path of reform by creating a public debate and democratising the information regarding the fiscal position of the state.

5.3.3.1 The dawn of 'Fiscalised Development'

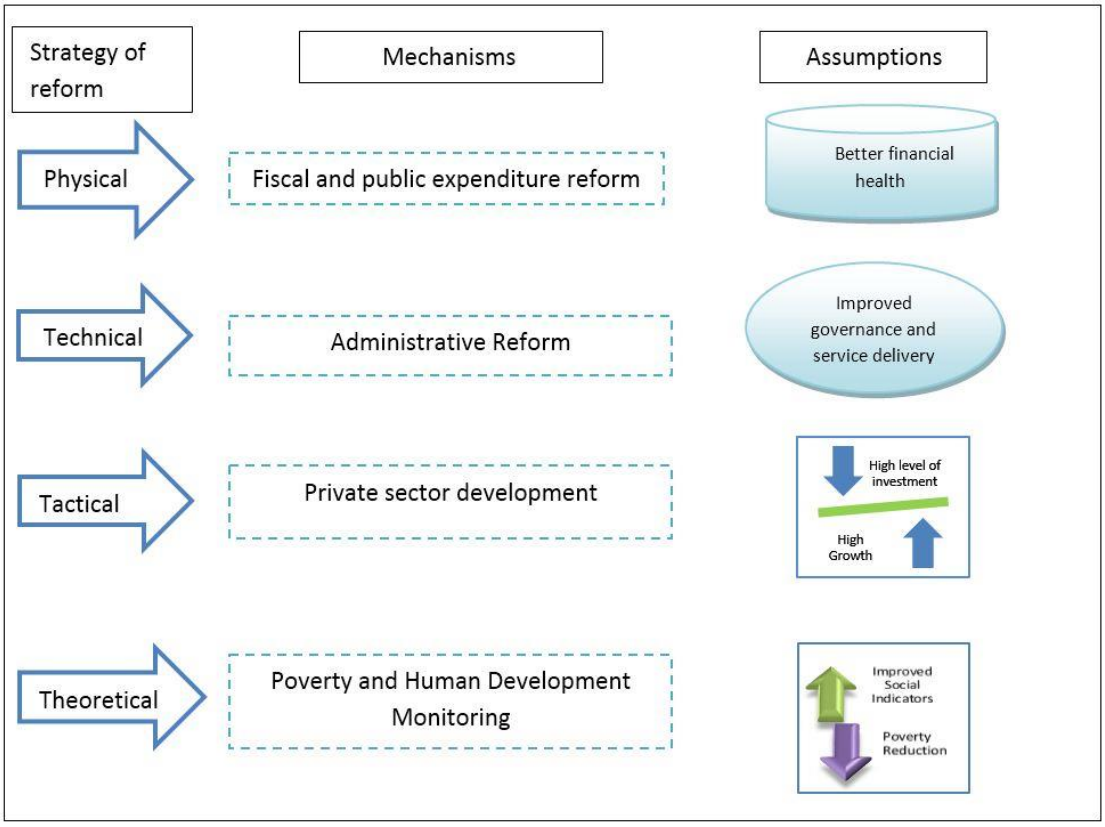
The state's fiscal crisis offered two contradictory ways for the regional political leadership, either to accept the macro-economic reform and participate in the competition or to perish being a force of resistance towards reform. The performance was incentivised by the Union government.'s special assistance for fiscal reform initiatives and World Bank's financial backing (Khuntiya, 2003). World Bank has been instrumental in steering the fiscal reform process in Karnataka through technical assistance. World Bank adopted a policy in the year of 1998 in its Country Assistance Strategy to support the reform inclined Indian states (World Bank, 2001). Thereafter it came up with the Karnataka Economic Restructuring Programme (KERP), modelled after a different form of development, to support state-level economy under the endowment of Programmatic Structural Adjustment Loan (PSAL).

Reducing access to financial resources was a trigger for already cash-starved Karnataka to accept a new form of development, the "*fiscalised development"*. It is a model of

development designed to ‘modernise’ the state’s finances by developing channels for non-state financing. This new mode of development is different from earlier Mysore state-led development or population-centric development also known as *Kannada* development model. Despite having the commonality of a top-down style of functioning, fiscalised development is more technical, tactical and theoretical in design and is governance dependent. The role of politics is secondary here and surrender to the conditions of economic restructuring is the central factor.

Karnataka Economic Restructuring Loan 1 (KERL 1) by the World Bank was the first in its kind where the state got a one-tranche (one-time) operational assistance for the fiscal year of 2000 – 2001. It was a conditional assistance based on the four specific mechanisms to restructure the entire economy. The assistance was divided in half loan (INR 3594.75 Cr./USD75 million) and half credit (INR 3594.75 Cr. /USD75 million) form. The mechanisms focussed on fiscal and public expenditure reforms, administrative reforms, private sector development, and poverty and human development monitoring (World Bank, 2002). The Second Karnataka Economic Restructuring Loan 2 (KERL 2) was also made in line with the KERL 1 to advance the same mechanisms for reform. KERL 2 assistance was also equally shared between loan (INR 2283 Cr. / USD 50 million) and credit (INR. 2283Cr. / USD 50 million) support from the Bank for the fiscal year of 2001 – 2002 (World Bank, 2003). World Bank-guided economic reform interrupted the legacy of state’s politics-driven planning exercises. The Bank, already a party to the Union government for state level reform for long, has a theory behind the state level economic restructuring. Below is the Bank’s model of fiscalised development in Karnataka which the state has been following since the beginning of 2000.

Figure 5.1: World Bank Model of State Level Fiscalised Development



The Bank had introduced four types of mechanism powered by the long-term strategies to ensure the reform pathway for Karnataka (World Bank, 2002). The next section explains the operational logic of each mechanism, their interrelation, and their implementation processes.

Fiscal and public expenditure reform:

The first mechanism, fiscal and public expenditure reform, is physical in nature. This component pursued the state government to create structural bindings for fiscal management by enactment of necessary Fiscal Responsibility Legislations (FRL) and operation of administratively-improvised policy instrument. Karnataka Ceiling on Government Guarantee Act, 1999 (to put a cap on increasing contingent liabilities) and Karnataka Fiscal Responsibility Act (KFRA), 2002 (the first in the country to eliminate revenue deficit and limit fiscal deficit within 3 per cent by 2005 – 06) were the two statutory laws enacted to make fiscal space management compulsory in state finance activity (GOK Finance MTFP, 2005). Subsequently, a series of fiscal management agendas were taken up to honour the legislations. Revenue management, expenditure management, debt management, public finance management and procurement

transparency were the outcomes of fiscal and public expenditure reform initiatives. An administrative measure entitles MTFP (Medium Term Fiscal Plan) was devised as an innovative apparatus to serve as a technical guide for the implementation of reform agendas and act as a performance-monitoring tool for the reform yardsticks (World Bank, 2002).

MTFP is one of the most important reform apparatuses ever devised for fiscal space management; it has been utilised as both policy tool and operational instrument to keep the reform on a steady path for long. It was introduced in 2001 and thereafter regularised within the fiscal management system. MTFP usually serves two purposes. The draft MTFP is exercised as an operational instrument of internal-guiding documents to various departments before the budget preparation. The final MTFP is used as a policy tool for larger stakeholders to discuss the fiscal plan and performances. In the context of economic reform, the introduction and regularisation of MTFP should be considered as a milestone. It has been envisaged as an apparatus (like MTFP) backed by the legislative laws that could fulfil the objectives of fiscal management policy to restore the financial health of the state accounts by slowly neutralising debt trap, eliminate the revenue-deficit problem and limiting fiscal deficit within the reach.

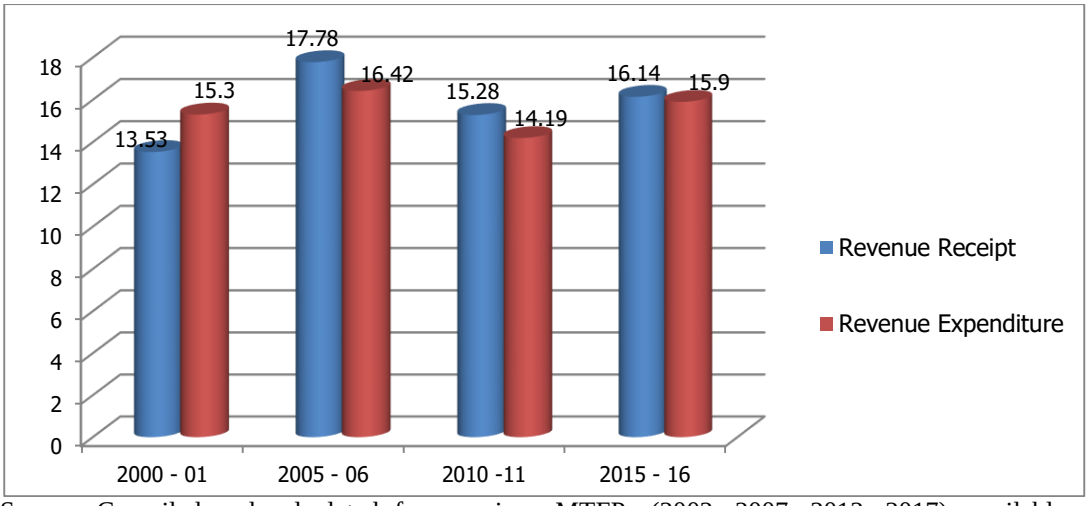
The three major agendas of fiscal reform in Karnataka:

Revenue reform was started by constituting a Tax Reform Commission in 2000, to improve the tax base and rationalise tax rates (GOK Finance MTFP, 2001). Subsequently, the VAT (Value Added Tax) system was also introduced on April1, 2005 to replace sales tax (GOK Finance MTFP, 2006). Regarding non-tax sources of revenue, from the very first day of economic reform, the government wanted itself to withdraw from 'implicit subsidies' because of the poor cost recovery system, especially in secondary and tertiary healthcare services, irrigation, drinking water supply, higher and technical education (GOK Finance MTFP, 2001). As a result, cost recovery in health sector was pushed to scale up from 1·15 per cent in 1999 – 2000 to 2·9 per cent in 2007 – 08 (GOK Finance MTFP, 2003). Revenue deficit was brought down to nil by 2004 – 05 against the target of March 31, 2006 (GOK Finance MTFP, 2012).Thereafter, the state revenue was always in surplus. However, of late the gap between revenue receipt and revenue expenditure is shrinking. In recent years, ever-increasing subsidy burden (14 per cent of revenue expenditure for FY 2014 – 15), continuous hike in

committed expenditure (salary, pension and interest) and disappointing growth in non-tax revenues bring the fiscal pressure back (GOK Finance MTFP, 2015).

Expenditure reform aimed at reducing the financial burden on salary, pension and interest payments. Major reform has also taken place in power sector to unload the subsidy burden (GOK Finance MTFP, 2005). Simultaneously, Karnataka Transparency in Public Procurement Act, 1999, was enacted in the backdrop of reforms, to bring transparency, competition and standardise the cost as well as procurement process (GOK Finance MTFP, 2006).

Graph 5.1: Revenue Receipt and Expenditure as % of GSDP



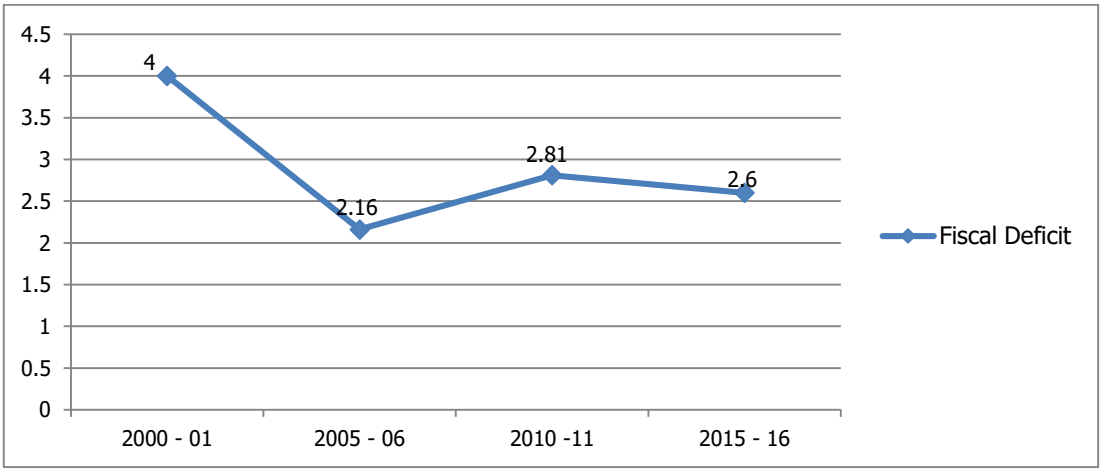
Source: Compiled and calculated from various MTFPs (2002, 2007, 2012, 2017), available on http://www.finance.kar.nic.in/mtfp/mtfp.htm. Accessed on 17 June 2017.

The graph no. 5.1 shows that the fiscal reform reduced the revenue deficit as per the commitment of FRLs. At the beginning of the reform, the revenue deficit was -1·77 per cent of GSDP (Gross State Domestic Product) in 2000 – 01 where revenue receipt and revenue expenditure were 13·53 per cent and 15·3 per cent respectively. The successful implementation of reform management brought down the revenue deficit to nil and even converted into revenue surplus. Karnataka has registered revenue surplus for the financial years of 2005 – 06 (1·35 per cent), 2010 – 11 (1·1 per cent) and 2015 – 16 (0·24 per cent). In-fact, Karnataka never experienced revenue deficit after 2004 – 05. Strikingly, despite fulfilling the KFRA, 2002 obligations, the state could not increase its revenue receipt significantly. From 2000 to 2015, the state has increased its revenue receipt by only 2·64 per cent (from 13·53 per cent to 16·14 per cent) of GSDP. As a consequence, the corresponding growth in revenue expenditure was severely hampered.

In the last fifteen years of reform, revenue expenditure is increased by only 0·6 per cent of GSDP. It is a matter of concern that reform process is unable to enhance the revenue receipt and expenditure accounts of the state finance which are crucial for the development of state financing.

Debt management reform was pursued by taking an important decision at the beginning of reform itself that government should shift from short term/high cost loan (from market sources) to long term/low cost loan from multilateral (such as, World Bank) and bilateral agencies (GOK Finance MTFP, 2001). Thus the practice of off-budget borrowings was purposefully discouraged by opting for budgetary grants and restricting the mounting debt servicing payments. With the help of FRLs and successful implementation of MTFPs, the fiscal deficit reduced to 2·83 per cent of GSDP by 2004 – 05 (GOK Finance MTFP, 2005).

Graph 5.2: Fiscal Deficit as % of GSDP



Source: Compiled and calculated from MTFPs (2002, 2007, 2012, 2017)
http://www.finance.kar.nic.in/mtfp/mtfp.htm

The graph 5.2 shows that the fiscal deficit has been bought down from 4 per cent of GSDP in 2000 to 2·16 per cent of GSDP in 2005. The fiscal deficit target was kept within limit as reflected for the years 2010 (2·81 per cent) and 2015 (2·6 per cent).

After the implementation of KFRA, 2002, Karnataka has been consistent in meeting the fiscal responsibility-related obligations unless there is any direction from the Union government to cross fiscal deficit limit (for example, fiscal deficit limit was omitted for the years of 2008 – 09 and 2009 – 10 to counter economic slowdown). As per the Thirteenth Finance Commission's recommendation, KFRA, 2002 had been amended

as KFR (Amendment) Act, 2011 to follow the new set of ceilings on fiscal deficit, revenue deficit and outstanding debt as a percentage of GSDP (GOK Finance MTFP, 2012). The 2011 KFRA amendment is another example of a *condition-precedent* set for the states to obtain Union government's specific grants and debt relief measures.

Table 5.1: Karnataka's Accounts for Primary Deficit/Surplus in Absolute Value

Years	1990	1995	2000	2005	2010	2015
Value (INR in Crores)	-122·88	-409·08	-1831·7	77·97	-5046·5	-9552·3

Source: GOK Finance Accounts, (2016): Accounts at a Glance (1960 – 2015), Karnataka Finance Dept. (Computer Cell)

It is necessary to mention that during the fiscal reform years, the state finance documents do not give necessary importance to the primary deficit/surplus indicator. Primary deficit/surplus is actually fiscal deficit minus interest payment for debt servicing. Primary deficit/surplus is studied here to understand as to whether the state needs to borrow for paying debt services, i.e. only interest payments. Karnataka's primary deficit indicator is always negative since 1960 – 61 till date except for the years of 2004 – 05 (193·58 Cr) and 2005 – 06 (77·97 Cr). For the first time in the history of Karnataka, primary deficit was positive for those two years (GOK Accounts, 2016). It indicates the state could successfully avert the vicious practice of borrowing in order to pay interests at least for those two years. However, the state had again gone back to the practice of borrowing for paying interest since 2006 – 07. The absence of primary deficit/surplus indicator in fiscal indexing is undermining the vulnerability of revenue collection status in the state in order to meet the compulsion of expenditure requirements and obligation of borrowing to pay debt services (per se, interest payments).

Administrative reform:

The second mechanism was formulated as technical assistance to initiate governance reform for better service delivery (World Bank, 2002). It is to be noted that this mechanism is related to governance management still encapsulated under the economic reform scheme. The governance reform has been separately going on in sector-specific areas, such as health service, transport, *panchayat raj* (local governing bodies) etc. and these were few of the most important reforms in Karnataka. It was implemented under

KERL 1 to make the management competent for augmenting economic reform and reorient the outlook of other public services for sector-specific areas. Governance reform has been initiated based on two strategic decisions. The first one is to rationalise (or limit) the state's role to deal only with the "most critical public goods and services" that private market is incapable of supplying effectively. Second one is to strengthen the role of the state by increasing its effectiveness, transparency and accountability (World Bank, 2001, Annex D, p. 1).

The main aim behind this mechanism was to strengthen the government bureaucracy for advancing fiscal reform and transform public services (limited to basic needs) to become more accountable. MTFP 2005 – 09 notes the importance of the same effort by mentioning the essentiality of Public Finance Management and Accountability System (PFMAS) to make fiscal policy reform a reality (GOK Finance MTFP, 2005).

Private Sector Development:

The third mechanism is a tactical strategy adopted to develop private sector in place of public sector. This component was instrumental in closing/merging the state-run PSUs to promote deregulation of business. The decision was taken "*that investment in Public Sector Enterprises should be restricted to strategic sectors or sectors of social concern and that Government need not continue to involve itself in production of consumer products and marketing enterprises, particularly if they are not generating profits* (World Bank, 2001, Annex E, p.2)". A reasoned argument was that priority of investment needs to be changed from public sector to social sector as per the policies of economic liberalisation. This tactical shift is overtly projected as shift of government investment from public to social sector, but within social sector also the concept of public goods and private goods were introduced. For example, World Bank supported Karnataka Health System Develop Project, 1996 and Karnataka Health System Develop and Reform Project, 2006 guided the state to concentrate only on primary and secondary care (public goods) and let the tertiary care (private good) be left for private sector engagement for health service provisions.

As a part of private sector involvement strategy in public systems, the Krishna government constituted altogether ten Task Forces to invite suggestions of non-government entities in health, education, Information technology and biotechnology, infrastructure etc. BATF (Bangalore Area Task Force) was particularly important in

initiating private sector-led solutions for Bangalore Municipal Corporation (World Bank, 2001). Various tactics were taken up to systematically reduce budgetary support for public enterprises by disinvesting and restructuring. Schemes like Voluntary Retirement Scheme (VRS) were adopted to downscale the workforce (GOK Finance MTFP, 2002).

The sole intention of this tactics is to bring investment from private capital that contributes in high growth and create jobs. It is important to note here that tactics as a reform strategy is not a short-term measure for private sector development mechanism. Tactics is employed as a long-term arrangement to act as an opportunity for disinvestment of public sector, and in turn fetching investment from private sector.

Poverty reduction and human development monitoring:

The last mechanism is poverty reduction and human development monitoring. This is in-fact the mechanism to measure the impact of the performance done by the above mentioned three interlinked mechanisms. This mechanism helps in establishing Poverty and Human Development Monitoring System by institutionalising the Human Development Report and enhancing the state's statistical management capacity. The mechanism holds the theoretical relation of the three former mechanisms. Fiscal and public expenditure reform makes the state finance structurally restricted towards public systems financing. The administrative reform is initiated to build the technical capacity of the governance management for implementation of fiscal and public finance management. In third mechanism, the tactical alliance with the private sector has been tried to fill the gap in financing (created through fiscal reform) and right-size as well as de-unionise the workforce (administrative reform). The main assumption behind the private sector development is that private investment leads to high growth, leading to massive job creation and that ultimately reduce the burden of poverty and thus improve the social indicators.

The fourth mechanism is envisaged to capture the success of the very theory propounded by the World Bank; high growth will reduce poverty and improve social indicators. The state government echoes the same to accelerate the theory.

As noted in the White Paper on State Finance, 2000 (GOK Finance MTFP, 2003, Box 1):

"The White Paper's recipe to break out of this fiscal conundrum into a virtuous cycle of fiscal balance, high growth and poverty alleviation, was the reform troika of elimination of revenue deficit to free internal resources for enhanced priority sector spending, improvement in efficiency of public spending and facilitating private sector development."

This reform strategy is not changing any structure of the economy or management of the governance but developed as an 'evidence' to track and maintain the theoretical success of the fiscalised development model. Though apart from the theoretical reform, special drive for poverty alleviation has always existed. As per *Karnataka Development Report* (KDR), 2007, Karnataka has fifteen poverty alleviation programmes run by the state government other than the nine centrally-sponsored poverty alleviation and employment generation programmes (KDR, 2007). They are important for the Bank as well as for the state in the long run to keep the reform momentum alive and neutralise any adverse effect of reform. This fiscalised development model is the backbone of the Karnataka's economic restructuring.

5.3.4 Governance reform

There is perennial confusion between fiscal and governance reform. Often the dividing lines are blurred between the two reform processes. In theoretical understanding, governance reform is to improve the service delivery management whereas the fiscal reform is to improve the financial management of the state accounts. Governance reform is the pre-condition for achieving the fiscal reform (Saxena, 2001 as cited in Howes, Lahiri and Stern, 2003). Tax, revenue, expenditure management are part of governance exercise. The more efficient governance is expected to bring more sound fiscal management.

This economic restructuring of Karnataka gives scope for a discussion on the state's efforts in the area of governance. As mentioned earlier, governance reform in Karnataka has been instrumental in sector-specific areas. The sector-specific reforms have distinct design of their respective reform processes but fundamentally committed to the two of the basic tenets of the fiscal reform strategies —techniques and tactics. The objective

of the governance reform is to enhance the quality and access to service delivery. The goal of governance reform is to fulfil the technical and tactical strategies of the fiscal reform.

The tactical and technical part of the governance reform is often interrelated and interdependent. For example, the Karnataka Administrative Reform Commission (KARC), 2001 report is a combination of technical inputs and tactical solution. The commission's report is a strategic document of the administrative-reform mechanism to identify the lacunas exists in governance management. The technical findings of the report suggest that many departments were overstaffed with overlapping functions. The staff composition also did not commensurate with the workload of the department at state and district levels. The same strategic document uses privatisation as a tactical strategy to implement the technical inputs received from the KARC, 2001 to meet the reform norms. Hence, the tactical solutions of the KARC, 2001 was outsourcing of support services (housekeeping, dietary, catering and security) and technical services (maintenance and innovations) in government offices and institutions to curtail the workforce and make savings.

This section provides an understanding of the tactics improvised and techniques formulated to change the organisational and operative outlook of the governance management of the state.

Tactical Strategies

The reform improvised three major tactical strategies (privatisation, decentralisation and participatory management) for implementing the reform agendas. The reasons for those strategies are not under the purview of governance decisions. The reasons were adopted as per the guidelines of economic restructuring programme and fiscal reform necessities.

Privatisation:

Already fiscal space management section briefs about private sector engagement as a reform agenda. The reasons behind the privatisation of public sector units are service efficiency and cost minimisation. The intention behind privatisation is that the outsourcing of work to private agency increases the accountability of the service

delivery. Similarly, right-sizing the human resource decreases the administrative cost to the government.

Privatisation has been executed in two ways, privatisation of services and disinvestment/closure of public sector units. KDR (2007) notes that privatisation has been widespread in health and education sector. In health sector, government adopted two specific practices, i.e. outsourcing of services and application of user fees to privatise the system. Contracting out NGOs to run PHCs and handing over hospital to corporates are the instances of privatisation of health service facilities as well as services. Privatisation was also encouraged by opening up the service for competition (like, in transport sector and in power distribution) and giving autonomy to the institution for target achievement.

The spirit of the fiscalised development model is reflected in the World Bank guided policy paper on "Public Sector Reform and Privatisation" which was approved by the GOK Cabinet to withdraw state intervention from all commercial activities through either sale or closure. Importantly, the policy also guides that PSUs involved in non-commercial activities to be merged/reorganised and even at times, may also open to other stakeholders for strategic partnership. Subsequently, various committees have been set up under the body of Public Sector Restructuring Commission to either close or disinvest the loss making PSUs in phases (World Bank, 2001).

Another tactical move towards privatisation is the deregulation of the business environment. In this occasion too, the Bank led policy paper got the approval of the GOK Cabinet to streamline and simplify regulations, rules, procedures and upkeep of records. As a result, Karnataka Udyog Mitra was formed as a nodal agency for business investment and introduced combined application form as a single window system for all investment related works (World Bank, 2001). Thus, tactical strategies were formulated to develop private sector in the state.

Decentralisation of governance:

The decentralisation politics has deep roots in the history of Karnataka state polity. In recent history of the state politics, it started in 1980 and finally enacted as a legislative Act in 1985 followed by its implementation in 1987 election. Finally, the Seventy-third Constitutional Amendment in 1992 paved the way for Karnataka Panchayat Raj Act,

1993 (Aziz, 2000). Decentralisation is also acknowledged in the *World Development Report*, 2000/2001 as a pro-poor solution to alleviate poverty (WDR, 2000). The fiscalised development model certainly uses the state's decentralised orientation of governance to execute various sector-specific reforms.

The decentralisation component of the administration is used to suffice the purpose of political intervention as well as economic restructuring. The significance of decentralisation in the Bank's model of fiscalised development made it easier for the state to formulate a parallel initiative to keep alive its political legitimacy by using the decentralisation as a tool for development. Karnataka government constituted High Power Committee for Redressal of Regional Imbalances (HPC RRI), 2000 (known as Nanjundappa Committee) to address regional disparity. The analysis of the committee report (submitted in 2002) is based on the *Taluk* level, with an aim to promote *Taluk* as main micro-level planning unit (HPC RRI, 2002). This is an important move to set *Taluk* as a nodal point for development which recognises the structure of decentralisation as well as the viability of grassroots-based development politics. HPC RRI is indeed an improvised mechanism from the state's side to remain politically viable using PRIs under the new narrative of development. Decentralisation is used as a political choice for development practices, i.e. equity (one of the two components of Karnataka Model of Development). Oppositely, the World Bank's model has used decentralisation as a tactical choice to expedite the reform process.

Political decentralisation is a reality of the Karnataka model of decentralisation. The reservation for female members (25 per cent) in *panchayats* was ratified much before the Parliamentary Act came into existence (Kumar and Sangita, 2011). The backward caste representation is also satisfactory (KDR, 2007). The voter turnout for TP (*Taluk Panchayat*) and ZP (*Zila Panchayat)* is more than assembly and parliament elections. However, there is a trend (30 per cent in 1993 and 27·7 per cent in 2007) in GP (*Gram Panchayat)* elections that many candidates win unopposed. It shows the presence of traditional power structure in PRIs (KDR, 2007). Another study reveals that poor knowledge about the functions and budget of *panchayat*, and low level of importance of *gram sabha*s (GS) among the elected members and people is a persistent crisis (Babu, 2010). In Tumkur district, the GSs are often socially, politically and gender wise exclusive in decision making processes even though they are conducted regularly to make budget and planning (Kumar and Sangita, 2011). It indirectly indicates the crisis

of inclusive empowerment for *panchayat* members as well as lack of involvement of people in the decentralisation politics. Aziz recently laments that despite achieving vertical decentralisation (through political and economic power), the increasing threats of dynastic politics curbs the prospect of horizontal decentralisation (sharing power and opportunity) for different social groups (Aziz, 2016).

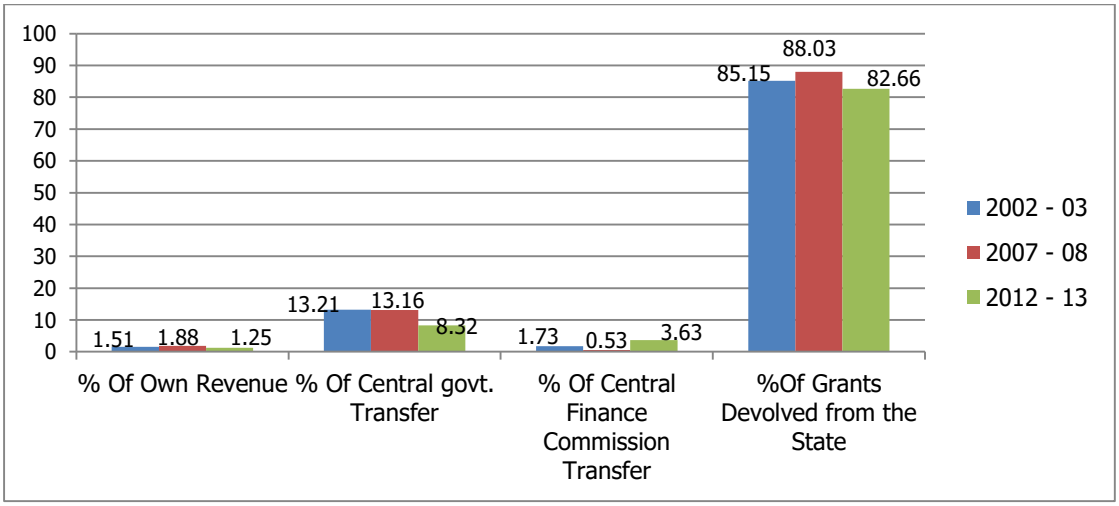
Administrative decentralisation happens with regards to the management of functions but not at the degree of decision formation. The ULBs (Urban Local Bodies) are responsible for providing roads, bridges, water supply, public health and sanitation, solid waste management and some other amenities. The state has transferred all the eighteen functions delegated to the ULBs as per the Twelfth Schedule (Gayithri, 2015). State has also transferred all twenty-nine functions to the PRIs as per the recommendation of the Eleventh Schedule (KDR, 2007).

The administrative decentralisation is facing several challenges. The capacity and availability of the staff are a matter of concern in all the three tiers of the *panchayat* system. District Planning Committee (DPC) is the most essential instrument of the *panchayat* administration. Study shows that many district DPCs are not formed or even formed then not very active (Kumar and Sangita, 2011). Further, the presence of various parallel bodies (such as village health committees, education committees, water users' bodies etc.), regional development boards underscore the autonomy and importance of the PRIs (KDR, 2007). Similarly, the obligation of tied funds persists since the beginning of *panchayat raj* system to continue the dependency on state and central funding. This hardly gives any scope to ZP or TP to plan according to their need. They usually plan for the programmes/schemes they are already entrusted upon. This very nature of governance actually negates the original idea of normative process of planning (integration of plan from GP to TP to ZP) as recommended in 73rd Constitutional Amendment (Babu, 2010).

Financial decentralisation is a contentious issue in the state. The taxation power (for some items) is only with the *Gram Panchayats* (and also with ULBs) in three tier *panchayat* system. Hence, the ZP and TP are acting merely as implementing agencies for the schemes (either loan/grant-in-aid mode) funded by the state/union government (Rao, Nath & Vani, 2002 & KDR, 2007). GPs total share in the overall *panchayat*

expenditure is less than 6 per cent (Rao, Nath and Vani, 2002).[84] This extremely low level of expenditure at the GP level restricts the participation of people in planning and implementation as GP is the primary interface between *panchayat* system and people. Aziz (2000) questions the rationale behind this practice and warns that this distorts the philosophy of decentralisation.

Graph 5.3: % Of Income of PRIs (all the three tiers) in Karnataka



Source: Gayithri, 2015, p. 163 (calculated from table 8.1)

The status of PRIs' own income generation is a matter of disappointment. The graph no. 5.3 reiterates the poor state of income of PRIs from own sources which is always below 2 per cent between 2002 – 03 and 2012 – 13. This own amount of income is actually GP-level collection since the TP and ZP do not have any power to collect taxes. All other forms of assistance are either state devolved or central assistance. State continues to command above 80 per cent of income sources for the PRIs. PRIs are striving for their own revenue collection sources to gain and retain the autonomy. State is also ignoring the suggestion of Second and Third State Finance Commissions' recommendations regarding the sharing of royalty for mines and minerals which comes under the jurisdiction of the PRIs. Certainly, the dependency level of *panchayat* system on state and central is high since the most of the fund is in the form of loan/assistance/grant from state/centre level which financially as well as administratively controls the PRIs.

[84]It is important to note that this expenditure calculation was based on the Twelfth Finance Commission's Report. Thereafter both the Thirteenth and Fourteenth Finance Commission Reports do not give the segregated expenditure of three tier *panchayat* system. Hence, it is the last representable segregated expenditure level data for *panchayat* system in Karnataka till June 2018.

The financial dependency of PRIs forces them to remain implementer rather than planner. Aziz found in 1993 that local bodies are better in implementation than planning in Karnataka. The workforce needs more technical and institutional strengthening along with political and financial autonomy (Aziz, 1993). The reform process too has been using decentralisation as a tactics for implementation purpose and thus the shortcoming of the decentralisation remains the same. The administrative and financial decentralizations are restricted because of the economic restructuring of the state. The centrally-sponsored schemes and state-sector fund are developed based on the projects/programmes of the sector-specific reform which comes with certain condition and predetermined goals. Certainly, they do not allow any locally-oriented planning. Hence, the fund devolution (financial accountability) and administrative responsibility (reporting, target management) are linked to those schemes. This form of reform probably contradicts the original philosophy of decentralisation, i.e. community owned and managed government.

The tactical dependency on decentralisation is coming from the need to make the reform participatory and horizontally expand the vertical nature of the growth benefit. Decentralisation as a catalyst to eradicate poverty is not showing many positive evidence. Rajasekhar, Gayathridevi and Satapathy (2007) finds the poverty eradication programme entitled *Swarnajayanti Gram Swarojgar Yojana* (*SGSY*), started in 1999, is fashioned after the model of 'decentralisation for development' to serve as a medium between state and society. The Karnataka's experience with this programme has not shown satisfactory results.

The reason for linking the state and society is to increase participation and empower the community. The involvement of people could generate demands for good governance from the community itself. It is therefore important to study as to whether several reform-led schemes are enhancing the participation as well making people empowered.

Participative management:

Apart from the decentralised institutes, parallel bodies have also come up to make reform more democratic and publicly acceptable. Two forms of bodies are formed. User groups/citizen groups (like, *Roogi Kalyan Samiti* in health sector reform) get formed to take part in the grassroots-level management and decision-making process of the

service delivery institutions (such as, Primary Health Centres) (KDR, 2007). The main problem with these parallel bodies is that they often undermine the importance of PRIs. They are aided with small amount of financial and autonomy power. Similarly, deliberative councils (various Task Forces, like BATF) come into existence where representatives from private sector and civil society join on the same platform with public servants and peoples' representatives to give policy inputs (KDR, 2007).

Technical Strategies

Governance reform's executive performance depends on technical strategies. Ideally, technical part is to be preceded by the tactical part. The mechanisms chosen for technical intervention are considered to be the core of governance reform and play an important role in the outcome of the reform. In Karnataka, the overall (and not sector specific) fiscal-led governance reform were carried out under the mechanism of administrative reform.

5.3.5 Administrative reform

Governance reform is based on the foundation of administrative reform. As discussed in the economic reform section, administrative reform is a technical strategy of the fiscalised model of development to ensure the smooth passage for the fiscal reform and deliver good governance.

Karnataka has constituted Administrative Reform Commission (KARC) in 2001. It is a part of KERL 1 project mechanism where six components (civil service reform, freedom of information, service agency reform, anti-corruption initiatives, decentralisation and e-governance) have been introduced as per the guidelines of the Bank (World Bank, 2000). These components are responsible for governance management and strengthening service delivery. Administrative reform is a set of technical guidelines in the form of transparency, accountability, effectiveness and efficiency to strengthen the tactical move (development of private sector and restrict the public system to basic services) of the governance reform.

Transparency: The government has tried to establish transparency by simplifying the filing system, computerisation of accounting works, streamlining of tax and licence systems, introducing single window system for investment stimulus (procedures) and setting-up of regulatory authority (regulations) within the government system with an

aim to simplify the administrative works and limiting the corruption (KDR, 2007). Similarly, these procedures and regulations were backed by the legislative actions. The Second Karnataka Economic Restructuring Loan report acknowledges the importance of legislative backing for reforms in India. Karnataka has altogether made seven laws to fulfil the transparency criteria of reform. Electricity Reform Act, Anti-Power-Theft Act, Transparency in Public Procurement Act, Ceiling on Government Guarantees Act, Fiscal Responsibility Act and Industry Facilitation Act and Right to Information Act were enacted at the beginning of reform process (World Bank 2003). The legislative backing is the key for the GOI and World Bank to make the state accountable to the people as well as taking the onus of reform performances.

Effectiveness: Karnataka has jumped into e-governance bandwagon to ensure effective service delivery. It is one of the most progressive states in utilising the benefit of ICT (Information Communication Technology). It established a computer centre way back in 1971 to computerise government departments. Various e-governance schemes have been introduced to make information accessible to the people and increase efficiency of the government works. *Bhoomi* (land records), *Khajane* (treasury system), *Kaveri* (land registration), *Mahiti* Centre (IT Kiosks) are few of the examples of successful e-governance projects (KDR, 2007).

In the reform context, though the decision is influenced or inspired by an external entity (like, international institutes/committee/commission etc.), the effectiveness of the decision depends on the system's administrative capacity. For instance, all the six districts of Hyderabad – Karnataka region has got special status of reservation for locals under the Article 371(J) in government jobs and education institutes in 2012 after the recommendation made by the HPC RRI, 2002 (HPC RRI, 2002). Notwithstanding the decision, the administrative snags make the task difficult for the residents of the Hyderabad – Karnataka region to avail the reservation with dignity and fairness (Buradikatti, 2015).

Efficiency: Civil service reform is one of the major recommendations of KARC to bring efficiency in the governance management. World Bank report mentions in the year of 2000 that politicization and premature transfers are the jolts in the administration. Thereafter, GOK introduced the New Transfer Policy, 2001 as well as

recruitment policy (Word Bank, 2001 and KDR, 2007). However, it is doubtful whether the policies are followed in letter and spirit.

Accountability: Corruption is a persistent crisis in Karnataka's governance management and that always affects the service delivery negatively. For instance, the corruption in health service is always a cause of concern for good governance in Karnataka (Sudarshan and Prashanth, 2011). The reform period initiated number of measures to curb corruption. Empowerment of *Lokayukta*, implementation of Citizens' Charters, initiation of social audit in rural and urban local bodies, public hearing (water *adalat*) and online complain registry are some of the reform measures Karnataka has adopted to make public service accountable (KDR, 2007). The agenda is to bring accountability to make service delivery effective.

Decentralisation-dependent activities are also part of the administrative reform's suggestion. Decentralisation is a political structure where the local-level institutions are the base for governance management. Karnataka always had a good base for decentralisation politics. Using the already existing structure of decentralisation is a tactical strategy of reform expansion but making the same structure conducive for managing the reform agendas is a technical assignment. Hence, using the decentralised bodies/institutions are tactics but to make them capable (by bringing transparency, effectiveness, efficiency and accountability) for advancing reform is a technical necessity. On one hand, these administrative reforms have technically improvised laws, regulation, rules and management procedure to make governance system robust, while on the other, the same laws, rules, regulation and procedures are tactically applied on the structure of decentralisation systems (to deliver basic services), and facilitated the private sector to develop.

5.4 Karnataka model of development

The reform has changed the philosophy of the state polity, anatomy of the economic structure and orientation of the governance management. This reform is celebrated as Karnataka Model of Development which professes that technology-led (mostly Information and Bio-Technology) growth combined with decentralised governance can address the challenge of achieving "*growth tempered with equity*" (Kadekodi, Kanbur and Rao, 2008, p. 17). This model of development is not exactly the World Bank guided model. This model is crafted as 'growth with social justice' by the state. It is

acknowledged by the state leadership that growth alone cannot ensure equitable distribution of income and other resources (HP CCI, 2002, chapter - 34). Hence, the model mixed the assurance of equity with the prospect of growth to pronounce as a macro-economic statement.

The World Bank has guided the reform process which is based on fiscalised development (as explained earlier) model. However, the presence of decentralisation component in the fiscal-led governance reform made it easier for the state to appropriate its long trusted political tool within the planned Karnataka development model. The Karnataka development model is developed from the confidence of the World Bank's fiscalised model but adjusted to the state's long tradition of development-based politics. This adjustment conjures the promise of fiscalised development (growth) with the commitment of the state's own developmental politics (decentralisation) in collective spirit to ameliorate as 'reformed model of development'. The tradition of decentralised politics is co-opted within the fiscalised development model for the purpose of administrative necessities. The normative planning of decentralisation is ignored but not its political legitimacy.

The presence of decentralisation component in the Karnataka development model convinces scholars to argue that Karnataka development model is actually derived from the "Mysore Model". The foresightedness of the Mysore Modernity (led by Wodeyars and their *Dewans*) in early twentieth century paved the way for building many academic institutions to generate skilled human resources in science and engineering and that eventually helped in developing a temperament for scientific and technological innovation. Bengaluru's emergence as an IT capital of India is a result of these historical proceedings (Kadekodi, Kanbur and Rao, 2008). Indeed, the easy availability of skilled human resources is a factor for IT-driven growth but that growth is state led or state supported. The fundamental difference between these two models is while Mysore modernity was a state-led development, the modern Karnataka's development model is a state-supported, private capital-led development. This difference raises question on various governance reforms to know how the state is acting as a facilitator to advance private capital led development.

The reform in its nascent stage was benefitted by the enthusiasm and commitment of S M Krishna. Mr Krishna is not only an important character in the reform discourse but

also a change maker in the political strategy of state's economic development. The style he adopted for co-opting corporate representatives in various deliberative councils (like, the composition of BATF) had inadvertently reduced the importance of elected representatives in policy-making process. This move allowed the state formally to accommodate the private interest. Similarly, private entities also got the privilege to pursue this opportunity for their own benefit. Pani (2006) notes this new form of governance arrangement at the top level of state secretariat has profoundly influenced to develop a new form of state – society interaction. This is the tipping point when the market replaces politics in planning and organising economic development through policy framing. Gradually, the political class has also adjusted itself with this new mode of policy making.

Mr. Krishna's promulgated model of development could not secure the confidence of the pro-reform institutions (as both the World Bank and GOI refused to offer further loan for reform) as well as was unable to gain the mandate of the people. However, the essence of the model has remained at the centre of the macro-economic statement for the state. Thus this model has in incremental way made the path for the private entities to establish long-term strategic interest with the political class, but furthermore, the model in-fact gave private entities access to the functioning on the public directives. This development is not the departure from the model's primarily advocated agenda, 'growth tempered with equity' rather an inevitable outcome of the very advocacy.

The Karnataka model of development has suffered from two blots. The first pillar, decentralisation, remains an idea of its original value and instead being used as a special purpose vehicle for reform as discussed under the section of governance reform. For example, social audit for various development programmes, implemented under decentralised governance structure, has been introduced to check corruption and ensure delivery at the grass root. Study finds that social audits are not effective as the audit and vigilance teams are heavily influenced of social and political hierarchies and often indifferent to serve the interest of poor (Lakha, Rajasekhar and Manjula 2015).

The second pillar, IT and Biotechnology growth is flourishing in the developed structure of Bengaluru. However, a question arises as to how much this growth has made an effect in rural Karnataka, or in particular regionally backward part of the state. Pani (2015) critiques that industrialisation in Karnataka has always been Bengaluru

centric from Mysore Wodeyar's time to post-liberalisation era. Since Bengaluru is located in the South Karnataka region, the benefit of the growth has been mostly gone to the already developed region. It further broadens the gaps of regional imbalances with North Karnataka (Pani, 2015).

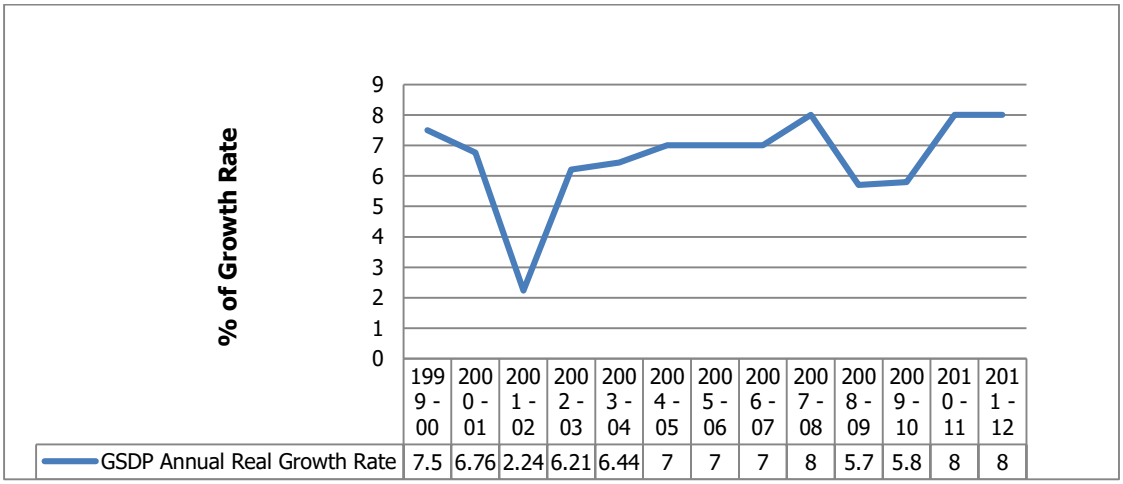
The Karnataka Development model is an 'adjusted' experiment. The experiment was based on the dependency of external assistance (especially form the World Bank), both in the forms of fund and technical supports, and political farsightedness. The experiment had its first jolt while the fund for KERL 3 was disapproved (after being delayed by one year) in 2004 by the Bank on the grounds of deteriorating political commitment (partially arrested by the dispute over Cauvery water, death of a former Minister under the captivity of forest brigand Veerappan), inadequate reform measures in power sector, lack of business deregulation, and deferring the advisory on agricultural tariff hike (World Bank, 2003). The Bank also objected the state's strategy of "*reform through consensus*" which succumbed at the face of "*resistance from vested interests*" (World Bank, 2003, p.29).

The denial of KERL 3 had severely disrupted the state's own fiscal management plan as it was interlinked to financial assistance of the external funding and incentives from the Union government Mr. Krishna registered his protest to GOI for depriving Karnataka from the Bank's structural adjustment loan assistance over Andhra Pradesh (Arun, 2004). The second attack on the Karnataka development model was the departure of S M Krishna as CM after failing to secure absolute majority in the state assembly election of May 2004. Post S M Krishna period, Karnataka has moved ahead with the reform agenda, modelled after fiscalised development. After each passing year, the model of Karnataka development has been ostensibly getting diluted to the fiscalised development model.

The main declarations behind the fiscalised development model were the increase of growth rate and restructuring of public finance. These declarations should not be considered as means for only economic restructuring rather they have been designed with an agenda to 'redefine the role of the State'. The portion of public expenditure in GSDP got reduced from 23·3 per cent to 19·45 per cent between the year of 2002 – 03 and 2013 – 14 BE (Gayithri 2014). The decreased public expenditure indicates reducing role of the state especially in the organisation of public systems. The growth

rate scenario was also not offering anything convincing. The graph no. 5.4 shows that over the period of thirteen years, the annual real growth rate of GSDP (Gross State Domestic Product) increased from 7·5 per cent (1999 – 00) to 8 per cent (2011 – 12). The average growth rate was 6·58 per cent for the entire period. The lowest growth rate recorded for the year of 2001 – 02 at 2·24 per cent while the highest was 8 per cent for 2007 – 08 and later on for two consecutive years (2010 – 11 and 2011 – 12). The annual real growth rate data shows that despite the model being implemented since the beginning of the 2000, the impact on growth rate was not very significant for next eleven years. The fundamental question to the fiscalised development model is that how come the fluctuating growth rate can deliver equity.

Graph 5.4: GSDP Annual Real Growth Rate (in Current Prices)



	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
GSDP Annual Real Growth Rate	7.5	6.76	2.24	6.21	6.44	7	7	7	8	5.7	5.8	8	8

Source: Compiled form different MTFPs (2001, 2005 – 2009, 2008 – 2012, 2011 – 2015, 2013 – 2017), Karnataka Finance Department.

Fiscal rationalisation is still followed by Karnataka but the accountability of the state is getting constricted because of the involvement of private sector. The current regime of the INC and its focus on inclusive development is noticeable political move. The government's announcement of pro-poor schemes, especially targeting the farmers, imparts a significant sway in changing the public perception about political intervention in governance management. The last Chief Minister Mr. Siddaramaiah's (2013 – 2018) much publicised AHINDA (*Kannada* acronym for minorities, backward classes and *dalits*) philosophy propounds for an inclusive development which aims at catering to weaker section, especially minorities, OBCs and Dalits. Though such moves are till now politically committed and well-conceived, the full impact is yet to materialise. Interestingly, the political will has again resurfaced which speaks volumes about development inclusiveness. Is this a course-correction effort to compensate for the

earlier aggressive reform, leading to excessive income inequality and causing distress for the socially and economically neglected class? Only time will tell whether this new move may change the political mindset, thus, facilitating perspective shift in the development planning in Karnataka or whether the state will remain stuck up as it is.

The decentralisation component implicitly combined in the Karnataka development model convinces the scholars to argue that this Karnataka development model is actually a derivation from the earlier "Mysore Model". A difference between the two models was fundamental: whereas the exemplary intervention of Mysore modernity was a state led development, the modern Karnataka's 'Karnataka Development' model is a state supported but private capital financed one. This methodical difference between these two models leaves questions to be answered since reforms are crucially related to issues of governance. To be precise, the role of the State acting as a facilitator, championing the venture of private capital led development, needs to be thoroughly investigated.

5.5 Development model of Karnataka: The future

The reform in its nascent stage was immensely benefitted by the enthusiasm and commitment of pro-reform political leadership. Of course the macro-political picture credits Mr. Krishna as not only as an influential character in the reform discourse but a change maker in the political strategy of State's economic development also. He was the first to come out of the age old practice of advocating the *Kannada* development model and embarked upon a new economic policy commitment. This research wants to interject at this point to flag off that the political leadership is just the image of the reform, but it is the formula of the reform that always works from behind. In popular democracy, the leadership is always credited (or criticised) with the implementation of the reform. This populism fails to understand that the socio-political obligation factored by the economy and electoral outcome are always at the backdrop behind those implementation commitments. The leadership is nothing but a competitive criterion in reform management. The Bank's formula of reformed model of development mechanistically created fiscal space for private involvement within the state finance. This mechanisation externally infused opportunity for corporate representations in various deliberative councils (like, the composition of BATF) that had inadvertently curtailed the influence of elected representatives in policy making process. This move

prepared the state to formally accommodate the private interest. Private entities themselves at the same time availed the privilege to pursue this opportunity for their own benefit. This interaction of state, market and society is the strategic means of reform.

Pani (2006, p. 256) notes that this new form of 'governance arrangement' at the top rank of state secretariat has significantly contributed in configuring a new formula for the state-society interaction. This is the pinnacle when the market forces spearheads politics while planning and organising economic development through policy framing. This predomination of market forces over politics has in fact interchanged the *Kannada* development model with Karnataka development model.

The *Kannada* development model evolved from the state-led development endeavour of the Mysore modernity. It aimed for welfare of its population, scattered across diverse social groups. In this case, the political priority was synonymous with population welfare. The Karnataka development model on the other hand, is distinguished by a collateral partnership between 'citizen, government and corporates'. The objectives of these three models of development are distinct from each other. The spirit of state building (the mainstay of Mysore modernity) got transcended into population welfare (i.e. *Kannada* development) as a consequence of electoral politics. Unfortunately, this obligation of population welfare but sheer ignorance of state building culminated into a lopsided development episode. The state was compelled to take the path of private capital mobilisation (Karnataka development). In post-liberalisation Karnataka, departure from the Mysore modernity's value system in state polity, provided ample opportunity for the International Governmental Organisations (IGO) to connect with state planning and implement reform. Gradually, the political class also had fallen in line with this new mode of policy making and governance management.

The health system projects of the Bank should be analysed on the basis of this evolving interplay of developmental models. The health system projects are not just some operative assignments for any government. The projects are preceded by policy prescription and followed by execution. Hence, the Bank's health system projects carry two distinct characteristics; policy implementation and policy operation. The policy implementation denotes the decisions taken place at the state level to implement the project mechanisms. The policy operation signifies the activities performed to

operationalise the project components. The health system projects are the agent of policy implementation-operation process.

In general, it can be interpreted that the Bank financed health system projects had been approved and executed on the context of World Bank's reformed model of development. But this generalisation would only ascribe to the role of the Bank and not complement the governance of the state. The reformed model of development is a combination of the Bank prescribed fiscalised development formula and the state's own evolved Karnataka model of development. The health system policy implementation (project mechanisms) had been taken place on the foundation of the Bank's fiscalised development model. The health system policy operation (project components) was performed on the surface of Karnataka Development model. The policy implementation (decisions) was conducted at the behest of the Bank, but the policy operation (activities) was executed at the directives of the state, i.e. Government of Karnataka. The policy implementation-operation process (detailed in next two chapters) has been analysed keeping this development dichotomy of Karnataka at the background.

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Chapter 6: Karnataka, investing in health system development

Summary of the chapter: At the advent of the liberalisation policy, Karnataka, the Indian state, got exposed to competitive federalism and the predicament of fiscal contraction. The state began its twenty one year long journey in the1996 after it in-principle adopted the World Bank's Karnataka Health Systems Development Project. This chapter harks back to the initial year of health system reform to map how an external assistance project became a foundation of health service development in the post-reform order. The project got diffused by modifying policies, developing institutional architectures, and arranging services. In response, the GOK restructured its financing, reorganised its governance, and reoriented its service delivery respectively. The re-formation of financing, governance, and service delivery was identified as the development of health system in Karnataka. The state embarked upon another Bank financed health system project in continuation to KHSDP, however at the cost of compromised autonomy.

Karnataka is one of the first states where the World Bank offered aid assistance for health. As per the World Bank's website information till 19 May 2016, the Bank has altogether ten projects in Karnataka which had or have health as one of the (or only) project themes. The Bank's first loan in the health sector for Karnataka was made way back in 1971 for the Karnataka Population Project. This research only considers the projects that address health system development/strengthening.

6.1 World Bank in Karnataka

This research takes the following World Bank funded projects for analysing the experience of Karnataka with the Bank's health system initiative.

Table 6.1: World Bank financed health system projects

Sl. No.	Name of the project	Time period	Overview
1	Karnataka State Health Systems Development Project/KHSDP (02) (Project No. P035825)	1996 – 2004	This is a first generation of reform project in health with high concentration on the infrastructural assistance. This is a multi-state (three) project where Karnataka was also a part.
2	Karnataka Health System Development and Reform Project/KHSDRP (Project No. P071160)	2006 – 2017	This is the second generation of reform project in health and applied with mainly technical assistance
3	Karnataka Health Systems Additional Financing/KHSAF (Project No. P130395)[85]	2012 – 2017	This is actually the continuation of the KHSDRP under the additional financing assistance. The Bank offered additional financing to extend the KHSDRP project cycle.

The above mentioned projects had been implemented in tandem, starting from 1996 and ending in the year 2017. There was no discontinuation of funding between the start of KHSDRP and end of KHSDP. The interim period was funded by the International Development Association (IDA) (World Bank's lending organ for Low and Middle Income Countries/LMIC) using KHSDP resources to cover only staff salary (as per the information gathered from the Directorate of Health and Family Welfare during field work). Both the KHSDP and the KHSDRP are the examples of the Bank financed health system intervention in LMICs and MICs. The continuity of the projects at a stretch for two decades provide the opportunity to not only study the intervention experiences of the Bank's health system approach but also to follow the change in the state's health service system with respect to the Bank's project design guided by the respective health system approaches (such as, health system reform to health system strengthening). This research had the following objective and research questions to analyse the execution experience of the Bank financed projects in Karnataka.

[85] The Bank uses 'Health Systems' for HSDP and KHSAF, and 'Health System' for KHSDRP.

- How are mechanisms and components of Bank financed projects (KHSDP and KHSDRP) being executed?
- How are the designs of the projects able to cope with the execution-level challenges faced by KHSDP and KHSDRP?

The above research objective and research questions had been framed to conduct a process evaluation for both the projects. This chapter (on KHSDP) and the very next chapter (on KHSDRP) describe the processes that both the Bank and the GOK had to adopt and/or adapt in order to implement and operationalise the projects. For Bank, the health system intervention falls under the micro level of policy system where policy implementation and operation are conducted. The Bank through the lending instrument advances its health system policy from policy modification stage to policy implementation-operation level for actual health system intervention.

Both the implementation and the operation stages collectively constitute the project execution activities which have governance-level decisions and management-level activities. The policy implementation is basically about the governance decisions which had taken place for the execution of the project (for instance, introduction of user fee or initiation of Public Private Partnership/PPP in clinical services). Whereas policy operations are hands-on management action to carry out the decisions already adopted for rolling out the activities, such as preparation of user fee tariff or initiation of contract agreement document or skill-based training for government staff for PPP management). In the execution of project, these two stages happen simultaneously. With this micro level background of policy system, the next section starts with the commencement of the first Bank financed health system project to apprise of the situation in Karnataka at the arrival of the Health Systems Development Project (HSDP-II).

6.2 Health service profiling of Karnataka

The World Bank carried out the technical exercises by conducting a mission visit (comprised of technical specialists, ranging in fields from economics to public health) before the commencement of the project to review the epidemiological situation, health infrastructure, service utilisation and health expenditure behaviour of the state. The information is important to understand the health service system's situation of the state.

Karnataka was found to be a slightly better performing state than the India average on key indicators of the population's health status and epidemiological profile at the start of the project. The state had started experiencing epidemiological transition (communicable to non-communicable diseases) in and around the late 1980s and early 1990s. The infant, neonatal and post-natal mortality were decreasing in opposition to the increasing trend of trauma and injury related cases (WB, 20 February 1996, pp. 3).

Karnataka's public health care system in 1996 was like that of any other Indian state, divided into three layers, primary, secondary and tertiary health care. Following is the structure of the health services that existed at the time of the project's initiation:

Table 6.2: Karnataka Health Infrastructure in 1995

Facility level	Services	No. of Units	Controlling unit
Primary Health Centres and Primary Health Units	Family planning and MCH services, basic curative services, preventive and promotive services	1,875	Directorate of Family Welfare controls
Community, sub-divisional and district hospitals (First referral/secondary level hospitals)	Ranging between 30 – 550 beds offering both IP and OPD services with diagnostic tests	239 (14,858 beds)	Directorate of Health Service (the quality of the service was inadequate at this level)
Tertiary hospitals including teaching hospitals	Usually no. of beds more than 750 with specialised services and more skilled staff	17 teaching hospitals (apart from the medical colleges, the state also had specialised TB/mental/ID/leprosy hospitals)	Directorate of Medical Education

Source: WB, 20 February 1996, p. 4 and 5

The above table is summarised from the World Bank SAR. In brief, three different directorates were there to manage health services at three different levels. However, the SAR did not carry out any separate exercise on the infrastructural gap/shortage of facilities in different levels except mentioning about the capacity of secondary health care services.

The prevalence of the allopathic system of medicine over other systems of medicine was dominant both in hospitalisation and outpatient care, irrespective of the socio-economic background in India. Access to health care, especially among the ST population, was severely low for availing hospital services both in public and private facilities. In Karnataka, the overall bed occupancy rate was 60 - 70per cent in public hospitals for secondary level of care. Mostly the poor used the government facilities to generally seek treatment for communicable diseases in Karnataka. On the other hand, the well-off section of the society preferred the private sector as the quality and availability of services in the government set-up were inadequate (WB, 20 February 1996, p. 5).

The status of government health care expenditure in Karnataka saw a marginal increase from 6·1 per cent to 6·4 per cent in the revenue budget from 1990 to 1995. The primary level of care in those five years also got considerable attention by attracting an allocation about 40per cent of the total health budget. However, the Bank was concerned about the specific practices regarding resource allocation to the hospital sector:

- Allocation expenditure for hospital services compared to LMICs was low, it was about 33 per cent of the total health budget for FY 1995 for Karnataka.
- Allocation to hospitals, especially secondary hospitals, got decreased over the year even at a time of favourable increment of overall health budget.
- Secondary hospitals had been least favourable within the hospital group in terms of resource allocation.

The Bank's mission team felt that the increasing recurring expenditure in health, especially in hospitals, for personnel cost adversely affected the non-salary recurring expenditure for items like drugs, supplies and other consumables (WB, 20 February 1996, p. 6).

6.3.1 Conditions of co-existence factors for the development of the KHSDP

The project was a culmination of the larger political economy driven policy orientation that took place in the Washington Consensus, 1990 and pervaded into LMICs too. From 1990, the World Bank has also brought in new knowledge in organising and delivering health services. The 1993 *World Development Report* (Investing in Health) of the Bank

has become the single-most widely consulted policy reference for restructuring the health sector across the world.

At the country level, the discretion of choosing common themes (for a project like HSDP-II) had been mooted by the recommendation of the then sector work on 'India Policy and Finance Strategies for Strengthening Primary Health Care Services' (WB, 15 May 1995) to organise health care financing. According to the Bank's Staff Appraisal Report (SAR), the recommendation of the sector work was "*that the financing of health care in India needs to be increasingly viewed within the context of structural adjustment and stabilization policy since the latter are likely to affect government health spending at the central and state levels*" (WB, 20 February 1996, pp. 6). This guiding recommendation confirms that HSDP-II (for this research, only KHSDP) project was constituted in line with the Bank's fiscalised development model.

The KHSDP is designed based on international and national macro-economic proceedings and the percolating effects of those policies at the state level. The factors that existed at the state level, mostly linked to the health service, have paved the way for several conditions which have come together. The co-existence of the factors at different levels (international, national and regional) pushed both the Bank and the GOK to execute project like KHSDP.

6.3 The beginning of a health system project in Karnataka

The entry of Karnataka on the route to a health system was way back in 1996. The World Bank organised a workshop in Goa for many states to initiate the dialogue for building a health system. Following the workshop, the Bank approached the Department of Economic Affairs (DEA), Government of India (GOI) to apprise them about the states most eligible for the Second Health System Development Project in India. The project proposal was prepared by a technical consultancy agency, Centre for Symbiosis of Technology, Environment and Management (STEM). [86]

Rationale for investment in KHSDP

[86] In the decade of 1990s, STEM was a one-stop shop for many state governments (Andhra Pradesh, Karnataka, Uttar Pradesh etcetera) to prepare a health system development project proposal to apply for a World Bank loan (STEM, 2011).

KHSDP implementation was a direct Bank – state government interaction, and the central government was not party to its daily operational management. The state funding for the Bank was not a common practice in the decade of nineties. The Bank cited three opportunities to extend support for the KHSDP since the logic of the very state funding matched with the Bank's own policy lines and became an ally to support other national programmes. First, the Bank's chief policy document, the Country Assistance Strategy (CAS) (WB, 19 May 1995), agreed to go for strategic funding at the state level to support Government of India's (GOI) initiative for creating an enabling environment for private sector to accelerate growth and progress of human resources (WB, 20 February 1996, pp. 13). Second, KHSDP was also considered as an advantage for two other bilateral funding (KFW, German funded secondary level services project and DANIDA, Denmark support on blindness control programme). Further, it was assumed that the project would also complement the then ongoing Bank funded Population Health and Nutrition (PHN) projects (for example, IPP-V, IPP-IX, CSSM) and centrally sponsored national programmes on AIDS and leprosy (WB, 20 February 1996, pp. 12 and 13). KHSDP was fitted into the criteria of policy guidance as well as became a potential ground for playing a supportive role for other donor assistances and field intervention.

On the other hand, the effect of macro-economic changes in 1991 impacted on the economic and governance arrangement at the state level. The policy of fiscal space management and continued lack of public investment in health convinced the political class of Karnataka to adhere to the World Bank's prescription on reform. The Karnataka Economic Restructuring Loans – I & II in 2000-01 and 2001-02 of the Bank are one such example in this case. This Bank guided economic restructuring projects were economic reform, and the Bank financed health system reform projects were governance reform in health sector. Both the streams of reform in Karnataka stemmed from the model of fiscalised development as argued in chapter five. In the process of politico-economic governance, the GOK adopted the Bank's fiscalised development model driven health system projects in principle to spearhead growth, but executed within the mould of the state's own developmental politics to ensure decentralisation. The health system projects (both KHSDP and KHSDRP) were operated on the surface of Karnataka's own development ideals and implemented on the subsurface of the Bank's identifiable development formula.

The KHSDP was envisaged as a project of *investment operation* with relevant policy inputs to develop a 'coherent, efficient and sustainable' health system. The system was expected to build the linkages between primary and secondary health care by introducing effective packages to enable the state to deal with priority needs for the coming ten years (WB, 20 February 1996, p. 14).

The total project cost of KHSDP (as a part of Health System Development Project/HSDP-II) was USD 136 million, of which IDA's contribution was USD 111.4 million and the Government of Karnataka (GOK) gave USD 25 million. World Bank moved the loan amount through GOI as per the standard norm. GOI on lending to the states came with a formula of 70 (loan): 30 (grant) proportion to the GOK and two other states at the rate of 12 per cent annual interest for 20 years, on the rupee equivalent to the loan proportion (WB, 20 February 1996, p. 28). According to the Bank's SAR, the GOI got 35 years to reimburse the loan amount (USD350.0 million for total HSDP-II) to IDA on standard IDA terms (WB, 20 February 1996, p. 46).

Key concerns of the health sector in Karnataka

At the very beginning of the project, the Bank identified the concerns that were in need of sector-level attention. The concerns were identified and finally used to prepare a broad outline for developing the project proposal. The World Bank Mission team picked up the following common themes to develop the project focus areas (WB, 20 February 1996, p. 6-8).

Table 6.3: Themes for developing health system project in Karnataka

Themes	Concerns
Budgetary/resource allocation	Health sector constitutes of a tiny proportion of the overall state budget
	Excessive budgetary concentration on tertiary care over primary and secondary care
	Unfavourable allocation to non-salary recurrent expenditure (such as operation and maintenance)
	Inefficient user charges scheme that yields low revenue collection
Institutional issues	Ineffective referral system that increased burden on tertiary set-up

Themes	Concerns
	Unsatisfactory clinical skills at secondary level and unplanned structure of service delivery
	Poor technical support at primary level to build strong surveillance and cope with public health emergency
Management and Planning	Weak management at the primary and secondary level facilities
	Poor incentives for hospitals to upgrade management organisation
	Lack of ability for planning and monitoring from the end of the health service organisation and management for epidemiological profile, cost-effectiveness, human resource and private health care development
Technical and quality (the Bank's SAR only gives information about secondary level and not on primary and tertiary level)	Facilities at secondary level of care were underutilised due to absence of standard guidelines on clinical and support service norms
	Shortage of diagnostic facilities and unavailability of equipment for laboratory
	Poor communication and transportation made the demand for health care pervasive
	Lack of trained human resource
	Poor repair and maintenance of equipment
	Issue of absenteeism among the medical doctors and other clinical personnel, especially in backward regions
Access to health services	SC/ST group and women were less able to avail hospital services
	Urban-rural disparity in hospital infrastructure led to overutilisation of service at urban opposed to the underutilisation of service in rural facilities at secondary level
Role of the private sector and the involvement of Non Governmental Organisation (NGO)	Information was not adequate about the scope, quality and size of the private sector
	Considerable growth of private sector in Karnataka (private sector had 33 per cent of all hospital beds, and 80 per cent of those were in urban areas)
	Quality of care in private sector was a big concern due to unqualified providers, weak licensing, lack of regulations and ineffective legal solutions

Themes	Concerns
	Government ‘s intervention to ‘monitor, regulate, register and certify’ might be helpful to engage private sector in service provisions
	NGOs were considered as potential providers in remote areas to deliver services and health promotion activities

The above concerns under the different themes had become an opportunity for the project to intervene. The project design did accommodate most of the concerns in its mechanisms and components. It is important to note that the Bank considered only the above mentioned themes as the representatives of the health sector. The concerns related to the themes had become converted into the prevailing conditions for the project to improve the health system.

6.4 KHSDP implementation experience

The project was designed based on the conditions identified for health sector development. The conditions were supposed to create new rules to manage the health service further. KHSDP, as a discursive formation, is definitely a guiding manual (or rule book) that forms new object, operation, concepts and theoretical options. The following section discusses the project in detail to understand how the project unfolds within the existing system and to bring changes.

This section gives an analytic representation of the project’s operational experience. The objective of the KHSDP was divided in two parts. The first part of the objective was focussing on the policy reorientation and institutional development. The second part looked at the development of the health care system in order to improve the health status of the people. Altogether, the project had six mechanisms and fourteen components. The objective, mechanism (M) and component (C) were set in order and complemented each other.[87] The project design had set the objectives according to the agenda of health sector reform, and accordingly either strategised (as long term goal), or employed tactic/technique (as an immediate measures) to pursue the designed objectives.

[87] The SAR document refers to reform programmes and investment components. The categorisation of mechanism and component is developed by this research for the purpose of analysis.

6.4.1 KHSDP Objective IA

Table 6.5: KHSDP Objective IA

Objective IA: To improve efficiency in the allocation and use of health resources in the Project States (Karnataka) through policy (modification) and institutional development.	
Mechanism	Component
M1: Increase Financing and Improve Resource Allocation for the Health Sector	M1-C1: Adequate Budgetary Allocations to the Health Sector
	M1-C2: Increasing the Share of Health Sector Resources to the Primary and First Referral Levels
	M1-C3: Increase the Allocation in the Operations and Maintenance Heads for the Secondary Health care
M2: Cost Recovery through User Charges Policy	M2-C4: Implementing Existing User Charges More Rigorously
	M2-C5: Retention and Use of Revenue Collected
	M2-C6: Exemption of Poor from User Charges

The first part of the first objective is about budgetary reallocation. The state is envisaged as an object to perform the task keeping in view the responsibility of the state to decide on the key policy decisions. The Bank's strategy is to go for policy modification mainly focussed on budget allocation and revenue generation. It was theorised that selective policy modification would bring the desired efficiency in the health services.

This objective (IA) used policy modification as an operational exercise to implement two mechanisms, i.e. increase financing (to address budget support) and implement user charges (to generate revenue). The following section elaborates the mechanism (M) wise components (C) and their behaviours under the objective IA.

M1: Increase Financing and Improve Resource Allocation for the Health Sector

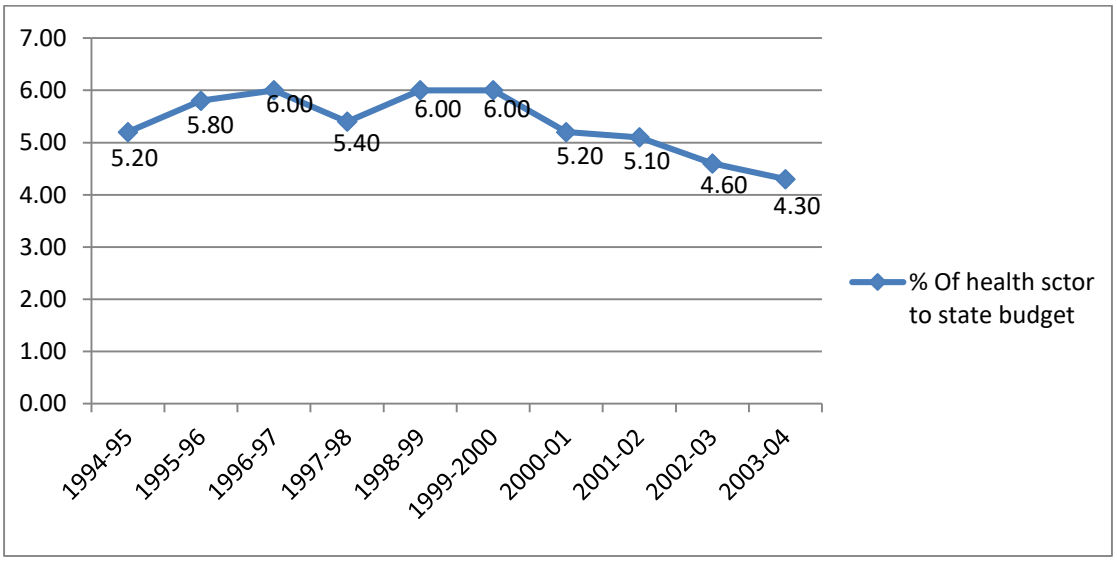
The project proposal had analysed that poor public expenditure in health and lack of resource availability at the secondary level of care were the key reasons for the crumbling health service of the state. The expenditure for social service (health and family welfare, education, water supply and sanitation) was at an average 38 per cent of total revenue expenditure during 1995. Health accounted for 25.7 per cent of social

services expenditure from 1990 – 95 (GOK - KHSDP, 1996, p. 24). Hence, it was strategised to increase the health budget and reallocation of resources within the health sector for more public expenditure in health and cost effective utilisation of health resources.

M1-C1: Adequate Budgetary Allocations to the Health Sector

The project identified that the poor public expenditure (1·3 per cent of GSDP) and less priority to health (6·4 per cent of state revenue budget) had made the overall budget provision bleak for the health sector. So an agreement was made to ensure that health sector budget to total budget should not be lower than the level of FY 1994 (5·2 per cent) for the entire project period (WB, 20 February 1996, Annexure-2, p. 2).

Graph 6.1: Percentage of health sector to state budget in Karnataka (1994 - 2003)



Source: Calculated from KHSDP Implementation and Completion Report (WB, 21 September 2004, Annexure-1,Table-8, p. 18)

The above graph illustrates that the budget allocation component could not stick to its commitment. It shows that it increased from 1994-95 to 1996-97, and then plateaued at 6 per cent. However, from the very beginning of the new millennium, it got decreased gradually and stopped at 4·3 per cent (3·74 per cent for FY 2004 – 05), the lowest during the project tenure, in 2003-04 FY. It is necessary to mention that the health budget further got reduced to 3·74 per cent in the next financial year of 2004-05.

The World Bank in its end evaluation report (known as Implementation and Completion Report, ICR) makes attempts to justify that the state's fiscal condition was beyond the control of the state government and it inadvertently caused deterioration of public

investment in health. It also observes that the lack of involvement from the finance department acted against the interest of the project's commitment on desired budget allocation to health (WB, 21 September 2004, p. 8). Notably, according to the Bank, this is the only factor identified as outside the state government's control. The ICR's assessment is that the project failed to improvise any tactic for the strategy of budget increment in health. Adequate budget allocation to health was a negotiable component for the state as it was linked to macroeconomic circumstances and the larger political arrangement. The macroeconomic situation is surely out of the project's immediate boundary, but that cannot be the reason for not garnering any political support in favour of the health budget.

Greater share to the health sector in state budget was the most basic requirement since the low allocation of health budget was identified as a barrier for improving health service at the start of the project by the Bank's mission team. Surprisingly, the Bank's periodic (usually bi-annual) supervisory missions, as reported in aide-memoires, had neither given any justification for the decline in budget nor offered any solution to address the challenge. Further, the aide-memoires reported the annual health expenditure and total budget allocation to health in actual values instead of giving the percent-wise proportion of health budget in the state GDP. The annual health expenditure increased over the years, but in real terms, the proportionate share of health budget to the overall state budget decreased. The Mid-Term Review (MTR) (WB MTR, November 1999, p.3) of the Bank mentions this point on a lighter note that there is moderate increment in constant terms but there has been very little increase in terms of real resources for the health sector.

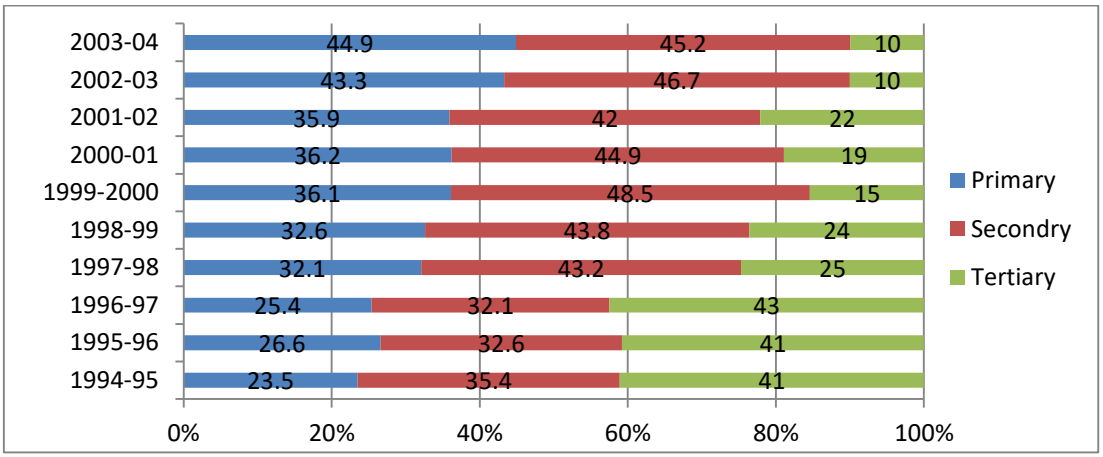
On some occasions, aide-memoires revised the value of the reported yearly health expenditures. For example, the 2002 aide-memoire (AM) (WB AM, 30 May– 02 June 2002) revised the amount for health expenditure by the government to INR 1100 cr. from INR 936 cr. (as mentioned in WB AM, May 2001 and WB AM, November 2001 aide-memoires) for FY 2000 – 01. The 2003 aide-memoire (WB AM, 21 – 23 May 2003, p. 1) for the first time reports the decline of health budget in absolute values for FYs of 2002 – 03 (INR 1160 cr.) and 2003-04 (INR 1096 cr.) in the state. Though the decline of proportionate health budget to overall state budget already started from 2000 – 01 (5·20 per cent) after the highest ever budget allocation made to health during the KHSDP period in 1999 – 2000 FY (6·00 per cent).

This research could not get any year-wise break-up of KHSDP contribution in overall state health budget for the project time. Otherwise, the actual increment of health budget from the state's own resources could be tracked.

M1-C2: Increasing the Share of Health Sector Resources to the Primary and First Referral Levels

The second component is specific about the intra budgetary allocation in health. The mission team observes at the beginning of the project that because of the tertiary sector, most of the plan resources were kept away from the secondary level. Thus a strategy was made to give more concentration to primary and secondary levels for both plan and non-plan resources. ICR reports that the state has achieved almost 30 per cent rise in total budget allocation for primary and secondary level from 1995 to 2003 (WB, 21 September 2004, Annexure-1, p. 15). The graph below further portrays how the GOK's internal health budget allocation had undergone a shift during the project years.

Graph 6.2: Internal health sector budget allocation of Karnataka (1994 - 2003)



Source: WB, 21 September 2004, Annexure-1,Table-8, p. 18 (Note: The ICR gives % of share of health budget only for primary and secondary care. % of tertiary care is estimated from the available figures of primary and secondary care)

The above graph confirms that the project had successfully switched the focus of the government from highly financed tertiary care services to primary and secondary care. Till 1996 – 97, tertiary level was the single largest receiver of budget allocation. The allocation for tertiary care in government health budget got slashed by 18 per cent (from 43 per cent in 1996 – 97 to 25 per cent in 1997 – 98) within the first year of project. Thereafter, a gradual decrease of budget continued in tertiary care vis-à-vis increment that happened for primary and secondary care at regular intervals. At the end of KHSDP, the project succeeded to motivate the state government to restrict 90 per cent

of the total health budget for primary (44·9 per cent) and secondary (45·2 per cent) levels of care. All the interim aide-memoires during the project time including Mid-Term Review Report of the World Bank expressed their satisfaction for meeting the compliance on gradual budget increment for primary and secondary levels of care.

M1-C3: Increase the Allocation in the Operations and Maintenance Heads for the Secondary Health care

The project took a significant decision to scale-up non-salary recurring expenditures (for operational and maintenance, drugs, maintenance of equipment, consumables etc.) which was against the usual practice of heavy (primary) concentration in recurring expenditure (mostly marked for human resource). ICR shows that the budget allocation got increased for drugs, essential supplies and consumables. Overall, these items covered 7 per cent of the health budget in FY 2003 (WB, 21 September 2004, Annexure-1, p. 15). Another 2002 World Bank aide-memoire (WB AM, 25 – 29 September 2002) registers that the enhancement of per bed per annum budget from FY 1996 - 97 to FY 2001 - 02 for drugs (INR 11,989 from INR 9,477) and maintenance (INR 2,235 from INR 383).

The underfunding of recurrent cost in secondary health care had weakened the condition of hospital buildings, equipment, drug availability and consumables. This is a well-devised tactic that allocated more funds to operation and maintenance in order to improve the infrastructure of secondary care.

M2: Cost Recovery through User Charges Policy

The second mechanism was taken to implement user charges for availing health services. User charges existed earlier also in Karnataka, but not very effectively; the charges were revised last in 1988. At the beginning of the project, no user charges were there for OPD services, though IPD services were charged both in general ward and paying bed for the patients with above INR 8,000/year income (WB 20 February 1996, Annexure-5, p. 85). The Strategic Planning Cell (SPC)[88] study (conducted by the Centre for Environment and Social Concerns) under the project in 1998 shows that 46 per cent of IPD, 39 per cent of OPD patients and 86 per cent households agreed to pay for the

[88] SPC was constituted under the initiative of KHSDP to conduct studies, do planning and give policy inputs.

services. The study recommended user charges for registration, beds, diagnostic tests and surgeries. Revised Government Order (G.O No. AaKuKa/72/AaY o /Sum 01 Bangalore dated 15/09/2003) was finally issued in 2003 to collect user charges (KHSDP Office File, 2004). The following components had been designed to successfully implement user charges.

The user charges were considered as a cost-sharing practice especially for curative care in hospitals to generate additional resources for drugs availability and facility maintenance (GOK - KHSDP, 1996, p.32). The user charges constituted as a strategy to generate additional resources as well increase the accountability of the facilities for quality services.

M2-C4: Implementing Existing User Charges More Rigorously

The average revenue generation from user fee (within 2 per cent of total health expenditure of DOH&FW) in Karnataka was poor compared to the scenario of developing countries with a higher per capita income (15 - 20 per cent of total health budget). Thus a strategy was developed by using the then already existing resource of District Health Committee (DHC). DHC was given the responsibility to manage the revenue generated from user fee and then redistribute it locally, that was contrary to the practice of user fee driven revenue addition into the general treasury. It was decided that 20 per cent of beds would be set aside as paying beds and the revenue used only for non-salary recurrent purposes (WB, 20 February 1996).

The government seemed to move with the relatively risky idea despite having a fear of direct public anger. The acceptance towards user charges might have been mooted by the suggestion of a study on user charges made in Karnataka on the pretext of KHSDP. The study suggested that diverse user charges might fetch about 9 per cent of the total expenditure or even 29 per cent of non-salary recurring expenditure in health (WB, 20 February 1996, p. 39). It was not easy for a resource-crunch state to completely refuse such a lucrative opportunity to manage its fiscal crisis in and out.

KHSDP had utilised DHC as a tactic to accelerate the user charges implementation policy. The GOK formed the DHC (vide G.O. no. EAP 94 (V) Bangalore dated 26-12-1995) in 1995, before the commencement of KHSDP, for coordinating several district health activities. KHSDP had utilised the institutional power of the DHC by giving it

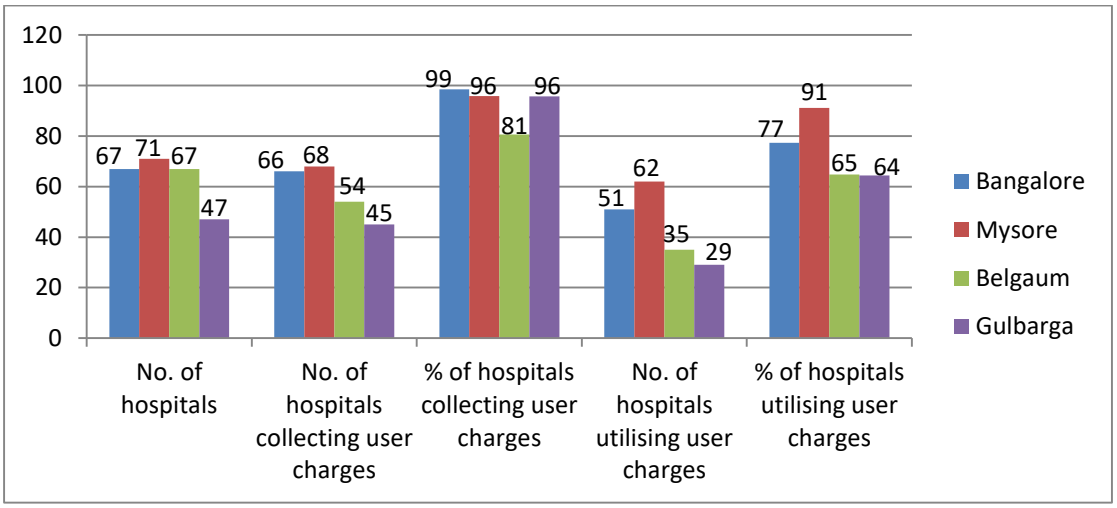
the responsibility to look after user charges too. The hospitals used the user fees generally for regular maintenance expenses, such as minor civil works, maintenance of ambulances and in some occasions purchase of small supplies (WB MTR, November 1999). DHC was represented by the District Collector and other key officials of the district, and used as an autonomous body with dedicated staff. It had defined guidelines to hold and manage the reallocation of revenue generate from user charges among the hospitals. The move to lend autonomy to the district bodies to manage the collection and expenditure of the user fee revenue instead of it being routed through the treasury was introduced to encourage the local bodies to directly participate in the implementation of the user fees. It is an example of the financial autonomy which was considered for using the administrative power and authority of DHC to successfully implement the user charges policy.

M2-C5: Retention and Use of Revenue Collected

This component is used as a technique to successfully implement and operate user charges. Retention and use of revenue at the district level has benefits for all the actors. First, hospitals already facing a cash crunch have got some opportunity to generate revenue on their own as well as utilise it as needed. The second one is interlinked with the first since the opportunity of utilisation may instil competition into the system and thus make them bound to comply with patient satisfaction and quality enhancement criteria. Third, the state government might have some breathing space of an additional source of income. Fourth, the Bank's objective of generating more funds for secondary care could be reached by the retention of user fee at the level of district and earmarked for hospitals, especially for secondary level.

The collection of user charges increased by almost fifteen fold from FY 1997 - 98 (INR 3·12 M) to FY 2003 – 04 (INR 44·85 M) (WB, 21 September 2004, p. 33). The following table shows the implementation and utilisation of user charges policy in the four revenue divisions in Karnataka.

Graph 6.3: Revenue division wise % of hospitals collecting and utilising user charges in Karnataka



Source: Calculated from the figures noted for KHSDP's internal office memorandum (KHSDP Office File, 2004)

A total 233 hospitals out of 252 had implemented the user charges policy during the project tenure. Except Belgaum division, all other divisions reported above 90 per cent implementation of user fees in hospitals. Hospitals in Belgaum and Gulbarga divisions registered lower utilisation of user charges than the developed divisions (KHSDP Office File, 2004). ICR reports that user fee had helped in improving the services in hospitals by raising their accountability (WB, 21 September 2004, p. 33). User Charges' Committees were also set up at district and block levels for managing the collection and utilisation of user fees (WB AM, 21 – 23 May 2003).

M2-C6: Exemption of Poor from User Charges

The project had come out with a provision to exempt the poor from user charges. The exemption was given to the green card holders under Public Distribution System (PDS). Instead of ration card, green card was chosen for focussing only on the economically most deprived category. Green card holders were eligible to avail subsidised grain (for nutritional support), subsidised cloth and subsidised kerosene. The discretion of selecting green card over ration card in existent PDS was supposed to reduce the number of beneficiaries for free health care service from 9 million to 5·3 million (WB, 20 February 1996, p. 18 – 19).

The first part of the first objective was more about policy level changes. The second part of the first objective was meant to be for institutional mechanisms to initiate a new

management structure and ensure sustainability. The next section discusses the mechanisms and components of the second part of the first objective.

6.4.2 KHSDP Objective IB

Table 6.5: KHSDP objective - IB

Objective IB: To improve efficiency in the allocation and use of health resources in the Project States (Karnataka) through policy and institutional development.	
Mechanism	Component
M3: Capacity building of the State for Health Sector Analysis and Management	M3-C7: Creating Special Unit/Cell for Health Sector Analysis within the Government
	M3-C8: Enhancing the Role of the State in Administrative Management
M4: Enhance the Role of the Private and Voluntary Sectors in the Delivery and Management of Health Services	M4-C9: Contracting-out Selected Services
	M4-C10: Linkages with the Private and NGO Sectors

Source: WB Development Credit Agreement, April 18, 1996

The second part of the first objective is focussed on the institutional development. The institution involves both the state (GOK) and non-state entities. The concept behind the operational model of institutional development is to make health service management more efficient. The objective is theorised based on the assumption that the state is capable in planning and management to effectively manage the health services with the available cost-effective resources and steering the private sector in managing service provisions.

Two mechanisms were strategised, first to strengthen the capacity of the GOK in sector analysis and second involving the private and voluntary sector in service provisions.

M3: Capacity Building of the State for Health Sector Analysis and Management

GOK's capacity building has taken place at two levels. The component (M3-CA) of strategic planning was executed by creating a dedicated unit, i.e. State Planning Cell (SPC). Another component (M3-CB) was assigned to address GOK's lacuna in administrative management to handle operational services; thus the component was aimed to develop the management structure, setting up of an engineering wing for

construction work (limited to the expansion and maintenance of secondary level facilities), and building a surveillance system for major communicable diseases. So, the first component is aimed at strengthening policy and planning activities to manage the requirement of other components in the project (such as private and voluntary sector involvement). The second component is added on as an administrative measure to deal with management, civil works and surveillance activities. Surveillance network activity is not mentioned as a part of the second component in the Bank's SAR, and instead kept under the budget head of component two. It is discussed here as it is in sync with the commitment of institutional development from the second part of the objective.

M3-C7: Creating Special Unit/Cell for Health Sector Analysis within the Government

This component should be considered as a pillar of the KHSDP. The main agenda behind this component is to strengthen the capacity of the state in managing the health service. The project identified that apart from the physical infrastructure expansion, the DOHFW needed to increase its intellectual resources in order to plan, organise and manage the health service system, and not only limited to the role of service provider. Strategic Planning Cell by the KHSDP is an example of the project's effort to create specialised units for policy exercises to address the health sector issues. Further, the project tactically accommodated the government's enthusiastic effort on the first Task Force on health by the government of Karnataka.

State Planning Cell (SPC):

KHSDP had introduced many hardware (physical infrastructure related support) and software (policy inputs and technical skill building) components which were new for the Department of Health and Family Welfare (DOHFW). There are possibly two reasons that made the Bank set up a specialised unit for health sector analysis. The DOHFW did not have the desired skills and capacity to assess the health sector issues as flagged by the Bank's mission team at the time of project design. Second, the introduction of various components needed constant departmental support and approval; hence an internal unit was needed to give the consent for the implementation of each new component. One such instance was the initiation of the Nosocomial Infection Control Programme, issued through an Executive Order and finally passed by a GO, which was launched after the study findings on microbial contamination in public hospitals (WB MTR, November 1999). The project set up a strategic planning unit to

develop the institutional capacity of the state for studying health sector issues and challenges and accordingly give suggestive policy inputs. For institutional strengthening, the establishment of a SPC at state level was a distinguished move within the DOHFW. The cell was given a multidisciplinary look as positions for Sociologist and Economist were also created initially (WB MTR, November 1999).

SPC dealt with studies, workshop and seminars for taking opinion on key health sector issues and giving inputs to complement the project objectives. During the project period, a total of eighteen studies had been carried out under SPC. Only three were in-house studies, and the rest were outsourced through consulting services. The scanning of the internal file reports suggests that study recommendations were used in the progress of various project components (PPP, environment management, training etc.), initiation of new activities (health insurance) and issuing of Government Orders (user charges, waste management) (KHSDP Office File, 2004). It is not clear from the records whether the SPC just accepted or communicated the study findings (especially in the case of outsourced studies) to the project leads or had created an internal set-up to analyse the findings to make an informed choice. However, given the fact that only three studies were actually done by the SPC, the question appears whether SPC was a unit for strategic planning or a unit for strategic outsourcing. It had been decided at the very beginning of the project implementation by the Bank mission supervisory team that SPC would outsource most of the studies; however, no justification was made for that (WB AM, March 1997).

The SPC unit got merged with the DOHFW approximately between May 2001 and November 2001 (Dr. Suresh S Shapeti, Ex-Joint Director – Planning of DOHFW, GOK, personal communication, April 28, 2017). SPC activities got featured in the aide-memoire of May 2001 for the last time. The very next aide-memoire (WB AM, November 2001) dropped the SPC activity from its regular bi-annual reporting without detailing anything. Post May 2001, subsequent aide memoires did not mention anything about SPC activities. Rather the September 2002 aide-memoire reports as achievements that a "*Strategic Planning Cell was formed*" (WB AM, 25 - 29 September 2002, p.3). It is surprising that suddenly, an important component had been taken off from the Bank's periodic supervisory mission report without mentioning any reason. SPC was the single most influential component for the state's capacity building, and it got shifted to the department in the middle of the project. The sudden transfer of the

SPC invokes another question: How the project then developed the institutional capacity of the DOHFW in analysing health sector issues and building skills for offering policy inputs, since the cell's mode of functioning was capacity outsourcing, and not capacity building.

Task Force on Health and Family Welfare:

A parallel policy level initiative was taken by the state government at the behest of the then Chief Minister, S. M. Krishna, to form a Task Force on health and family welfare in 1999, vide G.O No. HFW 545 CGM 99, Bangalore dated 14-12-1999 (GOK - Task Force, 2001). The report was focussed on Primary Health Care and Public Health to improve population stabilisation, management capacity of DOHFW, clinical as well as public health education system. The initiative was an outcome of a collaboration between progressive civil society and a committed political leadership to initiate reform and achieve 'equity, quality and integrity' for Karnataka in health and family welfare.

It is without any doubt that the Task Force commissioned report was the best ever health system document produced in the history of Karnataka. The Task Force members were from diverse backgrounds and participated voluntarily. It was mostly represented by the civil society collectives including the Task Force chairman; among others were academicians from medical colleges, ex-GOI technocrats and possibly one representative from private sector[89]. The only representative from the DOHFW was the then KHSDP Project Administrator (PA) who served as a Member Convenor to the Committee.

The report gave both short term and long term recommendations. The report carefully looked into the three different elements of the health system, i.e. structure (state policy and legal aspects), governance (management and administration) and finally health services delivery to analyse the contextual situation, identified challenges and made plans of action to achieve the desired outcomes (equity, quality, integrity and coverage) for the implementation of health sector reform (GOK - Task Force, 2001).

[89] Task Force or the Government Order did not mention about the association of Dr. M. Maiya who was in-charge of the sub-groups for NCD (jointly with Dr. B. S. Ramesh) and strengthening partnerships with corporate/private hospitals/GPs/NGOs. However, Dr.Maiya was a retired Prof. Of Medicine-GOK service, known to be a founder of Maiya Multispecialty Hospital located in South Bangalore.

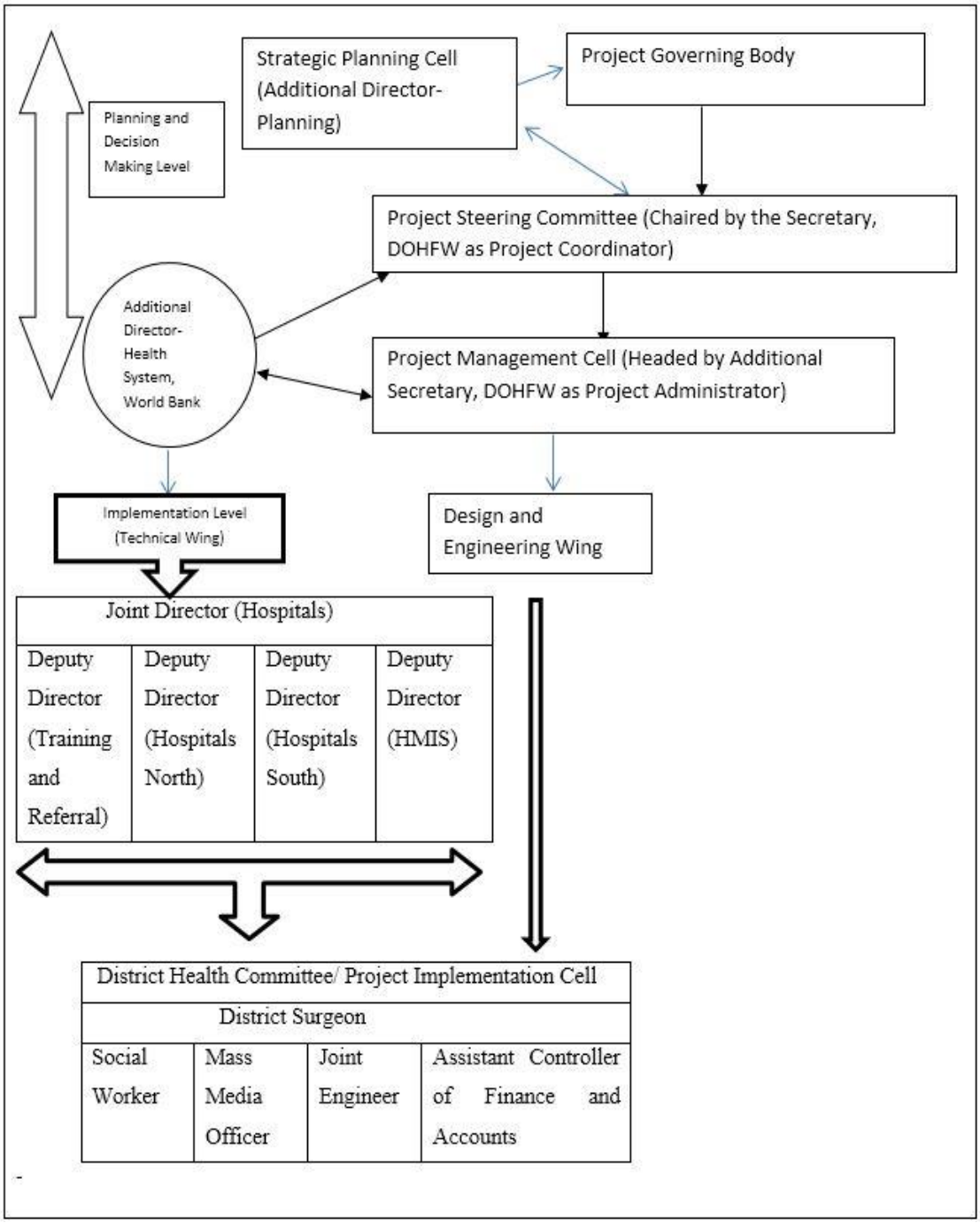
KHSDP on its own neither proposed to form the Task Force nor outlined as an activity under any of its mechanisms/components. Still, this research considers this initiative of the GOK under the project's institutional development component. It is evident that Task Force's suggestions were considered in many future government interventions and project activities of KHSDP/KHSDRP. KHSDP had supported the Directorate of Health in implementing many of the Task Force's recommendations. The Task Force commissioned all nine studies that were funded by KHSDP (WB AM, May 2001). One of the aide-memoires (WB AM, May 2001) also noted that SPC worked closely with the Task Force team to conduct the nine studies. The findings and suggestions of Task Force report are extensively referred to in this research.

M3-C8: Enhancing the Role of the State in Administrative Management

This component was implemented to form the structure that ensures efficiently managing the project activities and coordinating with other projects. The structure consisted of units/committees/cells/bodies who were supposed to act as an independent entity networked with the overall management system. They had been established with an aim to strengthen the management structure introducing technologies, imparting soft skills and building staff capacity. The project created the management structure by reorganising and deputing government officials in the newly formed bodies. Two important new set-ups came up, an engineering wing (for dealing with all forms of civil works) and disease surveillance unit (to check and control outbreaks).

Below is the schematic outline of the project's management structure (mentioned as organisational structure in aide-memoires). The structure was created to implant into the department and worked as per the project implementation guidelines of KHSDP.

Figure 6.1: Management structure in KHSDP



The project had three different levels of management, i.e. planning-decision, coordination and implementation. The entire project was headed by the Project Governing Body (PGB, a gathering of all relevant state level representatives) followed by the office of the Project Steering Committee (PSC). PSC was given charge of the nodal implementation centre. The planning-decision management was in the domain of PGB and PSC. Further, separately, a Strategic Planning Cell was created under the direct observation of Principal Secretary, DOHFW at the state level to build capacity

development and planning exercises as discussed earlier. SPC, as a technical body for policy decision-making forum, used to report to PGB and closely worked with PSC. The execution level comes under the Project Management Cell (PMC) which was headed by the Additional Secretary, DOHFW (named as Project Administrator in KHSDP). Additional Director, Health System was the in-charge of all project management activities for implementation level. PMC at the state level supervised two key project wings - Technical Wing (managed by the Joint and Deputy Directors of the DOHFW, GOK) to introduce policy level decisions and monitor the regular activities, and Design and Engineering Wing (headed by the Chief Engineer) to ensure a infrastructural implementation plan for civil works (construction). The PA position was strategically used to maintain the coordination between planning-decision and implementation activity.

The Project's implementation activity had trickled down through the Technical Wing and Engineering Wing to the District Health Committee/Project Implementation Cell (PIC). The basic difference between PMC and PIC was that PMC played a supervisory role to assess, plan and allocate the activities whereas PIC was active in executing those planned activities as per the schedule mapped. The District Surgeon (now the post is obsolete) was responsible for looking after the KHSDP activities at the level of PIC with the support of four dedicated staff. Also, an additional resource of Resident Medical Officers (RMO) at district hospitals was extended to District Surgeon for implementing standard referral system and user charges (WB, 20 February 1996, Annexure-6).

DHC at the district level was an important introduction to the health service system. It was formed under the chairmanship of the Zilla Panchayat CEO (Chief Executive Officer, a junior rank IAS level cadre) to regularly monitor the hospital functions (KHSDP Office File, 2004). However, this research has not found any information about the involvement of Zilla Panchayat (ZP) in KHSDP or district health affairs in the regular decision making process at the district level. Further, district and block level referral committees were formed to improve the referral system. The project had created almost a parallel structure within the directorate with an aim to implement the targeted project activities (such as infrastructural expansion through the design and engineering wing) and using the project units/bodies as a vehicle to implement the

desired policy level decisions across the state in collaboration with other units in DOHFW.

The KHSDP developed a management structure to address three main issues: Operational management, fund flows and recruitment.

Management: The entire structure was prepared in three distinct ways to manage the project: Planning-decision, project coordination and project implementation. Notably, the entire decision-making process was restricted to an initial three steps: PGB, PSC and only to the level of PA in PMC. All these units were led by bureaucratic heads of the state government, usually the IAS officers (PGB by Chief Secretary, PSC by Principal Secretary of Health and PMC by PA). The KHSDP had utilised the clout of the IAS (Indian Administrative Service) cadre which is always a highly ranked cadre for its administrative superiority. Thus the project got an edge to overcome the bureaucratic barriers in project implementation. However, the technocrats (mostly the medical educated professionals) in health service cadres were limited to the role of project implementation. The PA of PMC had played the role of coordinator between planning-decision and implementation. In the entire eight years of the KHSDP period, altogether seven PAs worked with an average serving time of one year and one-and-a-half months.[90] The continuous shuffling of PAs reflects that the PA post was utilised only to capitalise on the authority of the post for an uninterrupted project operation. The actual integration of the PA post with the health service system (dominated mostly by the government employed doctors) had not been tried. It is a pertinent question whether the PA, executive head of the project, used to get enough time to cope with the complexity of the project within that short span of time. This may be the reason that the operational challenges probably did not fully come to the notice of the planning-decision level since the coordination between the two levels (managed by the PA) remained very weak throughout the project period. The management structure created knowingly or unknowingly had a gap and because of that the limitation or the challenges of the team of implementation managed by the technocrats did not reach the team of planning-decision making led by the bureaucrats.

[90] The list of Project Administrators (for both the KHSDP and KHSDRP) along with their service tenure was collected from the KHSDRP office in Bangalore during the field work.

The project also tried to develop coordination among all the externally funded health and population projects (such as IPP VII, IPP XI and KfW/GTZ) by placing the Principal Secretary of Health as a point of coordination. According to the Bank's supervisory mission, it helped in developing linkages for training, referrals and IEC actions (WB AM, November 1998).

It is to be noted that KHSDP was a mix of hardware and software components. The hardware was mostly the responsibility of the designing and engineering wing. The technical wing dealt with the software which addressed recruitment, training, MIS, GIS, disease surveillance, user fees, referral system etc. in order to improve the service quality and patient outcome. The software components were quite new for the departmental staff and to the overall structure. The central question for the management structure which was created by the KHSDP is about the efficiency of the structure to handle the newly introduced components along with the existing challenges.

The management structure got implanted into the DOHFW because the project components were aimed to be carried forward by the department after the project ended. In line with that, KHSDP had transferred many project activities (such as contracting out of non-clinical services, disease surveillance and yellow card schemes) to the DOHFW to further carry them forward after the closure of the project. Re-commissioned hospitals were also transferred to the DOHFW (more than fifty-bed hospitals) and ZP (less than fifty bed) (WB AM, 25-29 September 2002). However, the project's execution and management planning are not above question. The management strategy should be at first to improve the capacity of the DOHFW and ZPs before transferring the upgraded facilities. This wrong strategic decision is evident in the Bank's aide-memoire where strengthening of the capacity for ZPs and DOHFW had been recommended on an urgent basis because of the poor outcome shown in the patient satisfaction survey from the facilities despite implementing the quality related measures (WB AM, 21 - 23 May 2003). This is an example of the project's limitation to be not able to strengthen the management capacity of the public system in health service.

Three areas were identified where investment was made to strengthen the management structure. It was anticipated that recruitment, human resource training and information technology would strengthen the management structure.

Recruitment: Meeting the shortage of manpower was given a very high priority throughout the project tenure. Various aide-memoires observe that the recruitment for vacant posts had been done from time to time. The Bank's Mid Term Review found that the Public Service Commission conducted recruitment was not in sync with the project's timely implementation roster. Hence, the project managed to get 'one-time exception' for the recruitment of doctors and paramedics (WB MTR, November 1999). The implementation cell of the project management unit also calculated the human resource gap at various points of time. The analysis estimated the need for human resource (medical and paramedical), requirement of physical infrastructural expansion, and availability of medical equipment and consumables.

Human resource training

The tactic adopted was to send senior officers for training, fellowships and workshops within India and abroad. The orientation and exposure of the staff were considered to make significant changes in the attitude and practice of health service organisation management. Internal file documents suggest that apart from management related training, service delivery oriented trainings were also taken up, such as Health and Hospital Administration and Rural Surgery. The intention was to equip the project team as per its needs. An interview with former KHSDP personnel has shown that project management officers, technocrats, (both at district and state levels) were preferred for capacity building on operational management and medical service workers was considered for training on improved service provisions (Informant 01). Further, KHSDP was a great support for the government in mitigating human resources shortage, especially in appointing clinicians in underdeveloped regions.

Information Technologies

Hospital Management Information System (HMIS) was introduced to collect the data and monitor the performance indicators. GIS training was organised for disease surveillance activity both at state and district level. HMIS was introduced by computerisation of all hospitals (WB, 21 September 2004, p.5). The project introduced biometrics card for attendance tracking on a pilot basis in Nelamangala CHC (KHSDP Office File, 2004).

Developing a Surveillance Capacity for Major Communicable Diseases and Response Capabilities

Disease surveillance is an example of the project's technical inputs to organise the health service system. It was considered as a successful implementation of technology driven health service coverage. KHSDP supported in setting up a state surveillance unit in Bangalore (WB AM, November 1998). Thereafter, several district-based surveillance units came up phase wise. It also covered the logistics and technical support for established district-level disease surveillance labs/units. KHSDP had introduced the Geographical Information System (GIS) for the surveillance system which covered all the facilities up to village level. The district health officials were given training on GIS. Both disease surveillance and HMIS data had been inducted into GIS and electronically sent to the HMIS section in Bangalore. This entire facility-wise expansion vis-à-vis technological upgradation for network of data collection and management had been done step wise (WB AM, 21 – 23 May 2003). This was indeed a good support for the state since until then it lacked communicable disease tracking and reporting activities.

However, getting technical people for managing the technical unit had never been easy in the project. For example, the Bank's mission supervisory team in November 1998 recommended appointing twelve Entomologists for the proposed twelve district level surveillance laboratories (WB AM, November 1998) by 31 March 1999. The unavailability of the Entomologists and Microbiologists for district surveillance units were reported way later in the first half of 2001(WB AM, May 2001).

M4: Enhance the Role of the Private and Voluntary Sectors in the Delivery and Management of Health Services

The fourth mechanism was strategised to involve the private and voluntary sector in managing health services. The first component (M4-CA) was contracting-out selective services, especially support services (laundry, cleaning etc.) to reduce cost and increase efficiency. The second component (M4-CB) was to meet the gap of availability of health services at primary and secondary level of care, especially for geographically challenged areas and socially disadvantage groups.

M4-C9: Contracting-out Selected Services

The practice of contracting out services to the private sector started over two assumptions, productivity and work culture. Productivity is determined by effectiveness and efficiency in work. Government employees are in lack on both the parameters, whereas private sector staff is believed to be more productive because of job insecurity. Also, the government sector in India is troubled with absenteeism and slow pace of recruitment which altogether made it difficult to provide uninterrupted services. KHSDP had pursued the GOK to go with a contracting out practice to reduce cost and increase efficiency. The services mostly were non-clinical (such as laundry, cleaning, manufacturing, IV fluids, constructional activities etcetera) except on one occasion while separate arrangement was made to fill the gap of anaesthetists in government hospitals (WB MTR, November 1999). Devanahalli block hospital was the first pilot where all non-clinical services were outsourced to a private contracting agency (WB AM, November 1997). Gradually the number of hospitals got increased for adopting the practice of contracting out as observed in different aide-memoires. Like many other policy tools in KHSDP, the contracting out practices too passed on to the DOHFW for better management in April 2002 (WB AM, 30 May - 02 June 2002). During the project period, a total 170 out of 204 hospitals in Karnataka had been adopted for contracting out practices for non-clinical services (WB, 21 September 2004, p.5). Apart from non-clinical service in hospitals, other supporting health services were also contracted out in some cases. For example, the Bijapur (pilot district) maintenance organisation and workshop facility for equipment services was contracted out for three years as per the approval of the mission team (WB AM, March 1997).

SPC's in-house study (Documenting Experiences Regarding Contracting out Non-clinical Services, completed in 2000) was of the clear opinion that Group D and cleaners were unwilling to comply with the maintenance job. Hence, contracting out of cleaning (and other non-clinical) services was needed and a timely decision. However, the same study points out that the scheme of contracting out non-clinical service was not cost effective and successful because of the lack of skill of contracting agencies in the work, defects in contract terms, non-cooperation from the district health management and local leadership. One serious issue raised by the study was the 'clear violation' of the provision of Contract Labour (Regulation and Abolition) Act of 1970 and Gazette Notification No. KA-E 24 LWA 96 of April 1997 by the KHSDP. The study in fact disqualified the World Bank's opinion that hospitals and nursing homes had been

exempted from the Contract Labour Act. As per the study findings, during the course of the project implementation, the state government initiated the process to obtain necessary permission from the Labour Department of GOK to exempt the KHSDP project hospitals from the application of the Act (KHSDP Office File, 2004). This view of the study is quite contradictory to the claim World Bank had already made in the time of project preparation*"....that there are no legal barriers inhibiting the use of contractual services for support functions and that the Contract Labor Regulation and Abolition Act (1970), which prohibits certain institutions from contracting-out perennial services, exempt hospitals and health care facilities"* (WB, 20 February 1996, p. 17). The SPC study also gave a recommendation to expand the contracting out services to security and dietary services. The study also recommended training on support services especially on waste management and the arrangement of safety measures for waste handlers (KHSDP Office File, 2004).

The move of contracting out non-clinical services was not very effective as evident in different patient satisfaction surveys. The second last aide-memoire of the Bank voiced the same concern by suggesting the need to enhance the capacity of the DOHFW and ZPs on an urgent basis to manage non-clinical services better as the patient satisfaction survey was not very impressive (WB AM, 21 – 23 May 2003). This finding also questions the rationale of the project's decision for handing over this component to the DOHFW and ZPs in 2002 even before upgrading their capacity.

M4-C10: Linkages with the Private and NGO Sectors

The second component was used as a tactic to involve directly non-state actors in service delivery. The World Bank mission team at the project design phase observed that a sound private sector exists in Karnataka, especially in ambulatory care or consultation purpose. Hence, the participation of the private sector was planned with a strong regulatory framework in place. Two areas were identified where non-state actors could be roped in. Initially, it seemed that the project was using the private sector as a strategic resource for reaching out to the disadvantaged community and remote areas. Contracting in of 'government facilities' (primary and secondary levels of care) to NGOs was considered since in remote areas, historically, government infrastructure is poor, and thus NGOs' presence as well as community's acceptance of the NGOs in those areas could be utilised. It was also decided that the state government should

embark on a legislative framework (like Nursing Home Registration Act) to maintain quality (WB, 20 February 1996, Annexure-2, p. 4 – 5).

It is found that broadly two resources were managed by involving the private sector in KHSDP, manpower and health facilities (especially primary health centre). Under manpower, non-clinical services were contracted out to the private sector and also to recruit (contract in) specialists, doctors, and paramedical staff on contractual terms. SPC reported a study (Involvement of Private Medical Practitioners in Implementing Government Health Programmes, 2001 by University of Mysore) where the private practitioners showed their eagerness to be involved in government health programmes given they were adequately trained and prescribed a defined role in the programmes (KHSDP Office File, 2004).

The involvement of the private sector in direct service provision had a bit of a secretive pathway in the project. The issue of uninterrupted service provision, especially in remote areas at primary level health facilities, was a matter of concern in KHSDP. An in-house study done by SPC (Pilot Study on Patient Satisfaction by Opinion Poll through Reply Post Cards, 2001 by SPC) on patient satisfaction observed that most of the challenging issues were related to PHC. 25 per cent of the patients reported the unavailability of lady doctors, medicine and ambulance, and also demanded transfer of doctors who were involved in malpractices. 28 per cent respondents complained about extortion of money by the hospital staff against the service provided (KHSDP Office File, 2004). Interestingly, even after thirteen years, the money extortion is still a widespread practice, at least in underdeveloped North Karnataka region. During a field visit in Arkeri CHC (Devadurga block of Raichur district), from discussion with a community member, it was found that hospital staff often ask for bribe to administer injection (INR 10), saline (INR 50), and Anti Rabies Vaccine (INR 50) (Vittal Chowhan of Pujari Tanda village, personal communication, February 5, 2017). This unofficial rate chart is standard from PHC to CHC to block hospital in the district.

The KHSDP under the Bank's guidance responded to the findings of the in-house SPC study on patient satisfaction with a solution by involving the private sector in service provision at PHC level. The contracting out of PHC did not happen for the first time in KHSDP. The first such type of experience was done in the year 1996 under the IPP-VIII in Gumbali PHC in Karnataka (IIHMR Bangalore, 2004). It is not clear exactly

when and how the KHSDP decided to hand over Primary Health Centres (PHC) to NGOs as a private sector engagement strategy. However, one of the retired deputy directors of the project hinted that the process started most probably in the year of 2001.[91] The commencement of the scheme was also in coincidence with the SPC study conducted on patient satisfaction through post card.

The agenda behind the contracting out of PHCs was to increase the efficiency of the facilities with regard to service management and ensuring the availability of the staff (especially doctors). World Bank's project documents including supervision reports are not very informative and expressive about this new strategy adopted by the project; rather, they appeared to be abstruse. The review of secondary documents shows there are three instances where this very thought appeared, but again in piecemeal condition.

The first time, in November 1998, the Bank's mission report appreciated a concept paper on public/private mix that proposed a scheme, health maintenance organisation, to be piloted in one or two blocks. The report further says that the scheme will be voluntary for the doctors (private) and patients can choose the service provider as per their wishes. The report suggests a detailed proposal for funding consideration under NGO heads with an aim to enhance the quality of care, optimal resource allocation and better referral system (WB AM, November 1998). Thereafter, a study was done under SPC (Networking of Public and Private Mix, 1999 by ORG-MARG Research Limited, Bangalore) which showed that doctors from both the sectors were willing to join HMO (Hospital Management Organisation) for offering quality service in rural Karnataka. The study also reported that doctors from the private sector agreed to the cost/patient tariff, and stressed that infrastructural development including filling up of staff could be geared up for the implementation of public private mix type of health services (KHSDP Office File, 2004). The full study report is not accessible, just the summary of the findings is available in the file. The next appearance of the scheme came on the Bank's MTR, 1999 where the mission visit report notes the *"New opportunities for contracting out of clinical services are being explored through participation of NGOs"* (WB MTR, November 1999, p. 3). It does not mention the opportunities and specification about clinical services. Interestingly, the very next aide-memoire (WB

[91]This researcher met the retired deputy director during the field work, and the information was shared over discussion. He worked in KHSDP.

AM, May 2000) also mentions that *"Contracting out of clinical services is being explored through the participation of NGOs"*. It is to be noted that both the aide-memoires have reported only single line on the contracting out of clinical services through NGOs without mentioning the types of contract and nature of clinical services.

Internal file document has the upkeep of record on the list of PHCs which were outsourced. The outsourcing was started during the time of KHSDP (2002/03 – 30 March 2004), and went even after the official closure of the project, till 17 June 2006. Total of twenty three medical colleges and forty four societies (NGOs) had been allowed to take over PHCs, and accordingly six medical colleges and thirty societies had been given the responsibility to take charge of the PHCs (KHSDP Office File, 2004[92]).

This research finds the process of documenting contracting in of NGOs in government service provisions is misleading and confusing. The Bank's prepared project preparatory document, SAR, already notes this scheme in the project-matrix as one of the key private sector linkage areas. Still the way the entire component is documented in the periodic supervisions of aide-memoires by the Bank shows the hesitation of the Bank as well as the implementers to 'accept on paper' that government facilities are outsourced to the NGOs for operational purposes.

Apart from the reaching out to the NGOs, three notable Public Private Partnerships (PPP) were started for the very first time in Karnataka as per the KHSDP policy recommendations. OPEC funded Raichur super speciality hospital (Rajiv Gandhi Institute of Super Speciality Hospital, or OPEC hospital) had been given to Apollo group, Mudigere hospital to Bapuji Memorial Trust and a block hospital in T. Narasipura outsourced the dietary and ambulance services to a local NGO (WB, 21 September 2004, Annexure-8).

The field visit to OPEC hospital, Raichur exposed the aftermath of the PPP experiment in the public-run tertiary sector (hospital administrative staff personal communication, February 2, 2017).[93] After Apollo group had run the hospital for eleven years (1 July

[92] This research is not sure of the numbers. The number is calculated after reviewing the KHSDP internal file records for the relevant section. The records are not in order and kept loosely.
[93] The information is gathered during the discussion with a member of the senior administrative staff of the hospital. The anonymity is maintained based on the member's request.

2001 to 31 May 2012), the GOK discontinued the service on the ground that patients from BPL community were not treated free of cost by the corporate group. The hospital is now under the GOK's Raichur Institute of Medical Sciences which is situated in the same campus. The current in-charge of the hospital (Designation: Special Officer) is available only for half an hour (between 10:00 AM and 10:30 AM) in a day. The hospital at present has fifteen doctors including the Special Officer. Out of fifteen, ten specialists who usually stay for one hour every day (between 10:00 AM and 11:00 AM), and the rest four are junior doctors, available from 10:00 AM to 1/2:00 PM on an official day. The hospital is run by the technicians (14/15), nurses (30), administrative staff (10), and Group D (35) staff since the doctors are busy in serving duty at private clinics.[94] A visit to the hospital wards shows beds without any patients. In-patient treatment is low. The super speciality hospital has become almost an outdoor clinic.

Interestingly, the private sector engagement is not promoted by the KHSDP alone. GOK's Task Force report also recommends that strategic partnership be developed and *"....government should be able to recognise and appreciate the importance of the voluntary and private sector, to create an atmosphere of trust, and to foster public-private partnership in delivering comprehensive health care"* (GOK - Task Force, 2001, p. 402). In its major recommendations, the report gives emphatic approval to involve the private sector not only in curative care but also in preventive and promotive care. Regarding primary care, it suggests that private practitioners may be recruited on 'ad-hoc' terms in PHCs where doctors are not available and can be allowed to use admission and laboratory facilities on an agreement basis. Government tariff may be applied for the patients availing the PHC facilities through private practitioners. It also encourages the private practitioners to get involved in public health communications.

The Task Force acknowledges the deficiency of specialists in secondary care which could be solved through contractual staffing. It is also in favour of contracting out of non-clinical services in case of economic concern. For in-patient services, the report is very clear on its position that *"tertiary care and super-speciality hospitals may be left to be developed largely by the private sector"* (GOK - Task Force, 2001, p. 397). However, the report is also clear about the need to set accreditation and standardisation practices for ensuring quality. The study conducted by the Task Force (Review of Role

[94] Numerical figures mentioned within the first brackets are the strength of manpower.

of Private Sector in Health Service - Access and Quality by A. F. Ferguson & Co.) reasserts the same. It was found that 46 per cent of IPD and 52 per cent of OPD patients were of the opinion that their service expectation was not met fully in the private sector. The study also observed that the private facilities lacked standardised practice (appointing non-qualified nurses, unsatisfactory diets, and doctors' behaviour) (KHSDP Office File, 2004).

As per the ICR, a total 170 of 204 health facilities in KHSDP had opted for the contracting out of supporting (or non-clinical) services to the private sector (WB, 21 September 2004, p. 5). This component was introduced as a testing point in KHSDP to develop a positive environment for involving the private sector in health service provision. It is imperative that both the KHSDP (led by SPC) and DOHFW/GOK (led by Task Force) acknowledged the need for engaging non-state actors (both private sector and NGOs). However, the suggestion came without any proper guideline or plan of action. Both list out 'what to do' for strategic partnership, but not detailing the 'how to do' question where in fact capacity building was needed. GOK probably was more in need of the answer for 'how' than 'what'. The Bank's own analysis also documents the limitation of implementing this component in ICR. It notes that 'private sector development' was represented ineffectively because of the dearth of initiatives to implement a strategic approach to engage and develop the private health sector. The analysis further says that difficulty in measuring development objectives and performance indicators had made the private sector component assessment more challenging (WB, 21 September 2004, p. 10). This research is unable to find any thorough study regarding the private sector involvement. It is still a question why the KHSDP or the DOHFW did not carry out a detailed policy guideline for private sector's role in health service provision.

6.4.3 KHSDP Objective II

Table 6.6: KHSDP objective II

Objective II: To improve the performance of the health care system in the Project State (Karnataka) through improvements in the quality, effectiveness and coverage of health services at the first referral level and selective coverage at the primary level, so as to improve the health status of the people, especially the poor, by reducing mortality, morbidity and disability.		
M5: Strengthening secondary level/first referral facilities to bring quality, effectiveness and coverage of health services	M5-C11: Upgradation of physical infrastructure at the secondary level of care (civil works in community, sub-divisional and district hospitals and staff quarters)	Strategic
	M5-C12: Upgrading access to facilities, effectiveness and quality of clinical and support services at secondary level of care	Technical
	M5-C13: Improving the referral mechanisms and strengthening linkages with the primary and tertiary health care levels	Technical
M6: Primary level: selective coverage to serve mostly the vulnerable population	M6-C14: Improving access to Primary Health Care in remote and underdeveloped/disadvantaged areas	Tactical

Source: WB Development Credit Agreement, April 18, 1996

The second objective of the project is centred on the population in relation to health service provisions. This is a departure from the first objective where the state (IA and IB) and non-state (IB) actors are taken as an object of modification and change. The project in acknowledgment of the suffering of the community (especially poor) enunciated service improvement oriented actions, especially at the primary and secondary level of care. The underlined assumption was to one the one hand, increase the level of quality and effectiveness to enhance the performance of health service system, and on the other to expand the coverage base of the population served, especially focussing on primary and secondary care to decrease the burden of morbidity, mortality and disability.

Mechanisms are also developed and divided to cater separately to primary and secondary level of care.

M5: Strengthening Secondary Level/First Referral Facilities to Bring Quality, Effectiveness and Coverage of Health Services

This mechanism is taken up to strengthen the capacity and expansion of in-patient services in particular for secondary level facilities. It was an underlined assumption that the strengthening activity would bring in the desired quality and effectiveness, and that expansion would increase the coverage.

The first component was on secondary level/first referral to enhance the quality, effectiveness and coverage (expansion of facilities) of health services for the improvement in service quality, access to and effectiveness of care. The component was also designed to address three key areas (quality, effectiveness and coverage). Coverage was taken up by expanding and restructuring the existing secondary level facilities (community, sub-divisional and district hospitals) and upgradation of staff quarters, though no new health facility was built under this component. Investment on equipment and drugs, staff recruitment, building HMIS, preparing standard treatment protocols, and quality assurance training programmes are made to increase the efficiency, quality and effectiveness of the services. Activity focussing on building a referral system and strengthening linkages between the primary and tertiary levels are performed to ease access to health services.

M5-C11: Upgradation of Physical Infrastructure at the Secondary Level of Care (Civil Works in Community, Sub-divisional and District Hospitals and Staff Quarters)

This component was taken up to renovate and expand the existing secondary level health facilities. It was a huge investment for KHSDP and certainly a boundless help for GOK to address the infrastructural crisis. The major activities were civil works (hospital and staff quarters), procurement of equipment and building maintenance. The project supported renovation/expansion/upgradation works for all 204 hospitals at the secondary level. Also, staff quarters were constructed for all 204 hospitals to ensure availability of doctors during an emergency. This physical infrastructural investment had helped to increase the number of beds (14,858 to 19,206), number of admissions (0.6 to 1.1 million till 2003), number of OPD consultations (12.6 to 21.7 million) and a massive increase in diagnostic tests, surgeries and X-rays in the project facilities (WB, 21 September 2004, p.6).

Markedly, despite a good progress in other hospital level infrastructural activity indicators, the Bed Occupancy Rate (BOR) had not gone up significantly (37 per cent in 1996 to 41.2 per cent in 2003) and Bed Turnover Rate (BTR) too fell short of any

substantial difference (4.55 per cent in 2001 to 4.9 per cent in 2003). BOR and BTR indicate the poor utilisation and productivity of health care facilities respectively. However, the cost effectiveness as well as quality of care indicators, i.e. Average Length of Stay (ALOS), had got reduced from 15 days to 3.5 days in 2003 (WB, 21 September 2004, p. 15). It is important to note that the project took up altogether twenty seven studies (eighteen by SPC and nine by Task Force) but had not considered to conduct a study or end evaluation on the combined utilisation and productivity analysis of hospitals, which could be thought of as impact indicators for the infrastructural activities.

M5-C12: Upgrading Access to Facilities, Effectiveness and Quality of Clinical and Support Services at Secondary Level of Care

This component is an output index for the objective IA, IB and II (only component-C1 of M5). The changes attempted through policy revision (IA), institutional arrangement (IB) and physical infrastructural (II) improvement were supposed to get reflected in this component.

Access to services: The following infrastructural investment had been taken up to make service available and accessible for the people. The hospitals were provided staff, medicine and necessary equipment as per the standard clinical guidelines.

Table 6.7: Infrastructure supported by KHSDP in Karnataka

Type of infrastructure	Number
Secondary level hospital (restructuring)	204
Staff quarter of secondary level hospitals	Constructed for all 204 hospitals as per ICR
District equipment workshop buildings	19
District laboratory buildings	21
Blood bank buildings	27
Trauma care centre	30

Source: WB, 21 September 2004, annexure-8, p. 30

Quality: Training is the project activity which is directly coming under the quality assurance initiative. Apart from that, addressing the gap in human resource and upgrading the facilities through resource stocks (such as availability of drugs and

equipment) had been tried. Altogether, it was thought that proper training, adequate staff and well-equipped facilities would bring in the desired quality in the health service.

Training: Training was considered as the single-most important activity under the project for enhancing the quality of the service. The concerns over software (role of clinicians and paramedics in service provision) were given high priority on the letter issued by the Bank to Principal Secretary Health, GOK for scaling up the service quality and patient satisfaction after the mid-term review happened (Lim, 1 December 1999). Several types of training (mainly management, maintenance and clinical) were imparted. As per the internal file noting, 2,888 doctors (including specialists) and 4,902 paramedical staff (staff nurses, pharmacists, equipment engineers, X-ray technicians and physiotherapists) had undergone training in clinical speciality courses, hospital administration and management resources. Also, forty one senior doctors had been sent for training abroad (KHSDP office file, 2004). Apart from the training programme, 12,994 (13,036 as per internal file noting) doctors and paramedical staff had attended 5,205 (5,235 as per internal file noting) seminars/workshops/conferences (WB, 21 September 2004, p.30). These trainings were made to raise the quality of staff for clinical practice, management of resources, handling of newly added technologies and equipment for quality care. A Task Force study (Training Programmes for Health Personnel and Government Service in Karnataka, 2001 by Manipal Hospital, Bangalore, International Centre for Health Sciences) observes that the development of health manpower was not on par with the sudden expansion of health facility infrastructure that took place in Karnataka (KHSDP Office File, 2004). The recommendation of the study stressed more on the development of grassroot health workers (Female Health Workers-FHW and ANMs- Auxiliary Nurse Midwife). However, it is not found anywhere in the project activities where grassroot health workers were trained or considered for capacity building exposures.

Recruitment: According to the ICR, KHSDP had generated 5,180 medical and paramedical posts. KHSDP was a great help in assessing the need for manpower, especially in underdeveloped districts and lessen the gap by facilitating the recruitment of staff on contract or through transfers (WB, 21 September 2004, p. 30).

Institutional arrangement: Committed decisions had been observed in the increment of budget on drugs/bed (INR 3,790 in FY 1996-97 to INR 7,166 in 2003-04), maintenance (INR 3.04 M in FY 96-97 to INR 55.00 M in FY 2003-04, Source: WB, 21 September 2004, p. 32), collection and retaining of user charges and through the establishment of twenty seven district equipment maintenance wings. Under the supervision of the project, the six district hospitals for blood bank, maternity care and equipment maintenance services had acquired ISO 9002 certificate and along with that, quality assurance programme had been implemented in all 204 secondary hospitals (WB, 21 September 2004, p.30 – 31). The project was keen to see the outcome of the above quality assurance measures. Hence, it decided to initiate patient satisfaction survey in the re-commissioned hospitals by 30 June 2000 (WB AM, May 2000).

Effectiveness: The project addressed the effectiveness through management of health services. The theory was that a mix of changes in service management and institutional arrangement led by policy decisions could scale up the effectiveness into the secondary level of care. Practices of outsourcing non-clinical services (cleanliness, water supply, lighting, gardening etc.) in all the hospitals, need-based supply of ambulances through contractual ambulance drivers, technical training to operate equipment, introduction of waste management system, computerisation of reporting system (HMIS and GIS), collection and retention of user charges to strengthen the referral system were the moves to make the system more efficient.

SPC had conducted studies on patient satisfaction to see the outcome of all these changes in health service management. SPC's in-house study (Pilot Study on Patient Satisfaction by Opinion Poll through Reply Post Cards, 2001 by SPC) found that 28 per cent respondents reported that hospital staff charged money for service and were reluctant to issue receipts after taking the money from the patients. The study raised the issue of health service management which was ineffective and inefficient to provide services to patients in PHCs and hospitals (KHSDP Office File, 2004).Three rounds of surveys on behalf of the SPC (Patient Satisfaction Surveys, 2001, 2003, 2004 by Centre for Research in Health and Social Welfare Management) were conducted on patient satisfaction. The 2001 survey had shown that some of the major reasons for the community to not utilise government health facilities were lack of confidence in doctors/hospitals (72·2 per cent), corrupt practices (11·6 per cent), unavailability of drugs (10·4 per cent) and the distance (11·4 per cent) (KHSDP Office File, 2004). The

table below gives the comparative facts of patient satisfaction indicators as collected over three rounds of survey.[95]

Table 6.8: Three rounds of patient satisfaction surveys during the period of KHSDP

Indicators	% Respondents satisfied with the facilities				% Difference on satisfaction level between rounds		
Satisfaction indicators	I Round	II Round	III Round		Round I & II	Round II & III	Round I & III
Availability of lab facility	74·6	85·3	81·2		10·7	- 4·1	6·6
Availability of X-ray facility	61·8	72·1	79·9		10·3	7·8	18·1
Nursing care in the wards	82·2	90·5	94·9		8·3	4·4	12·7
Privacy during clinical examination	71	78·1	63·3		7·1	-14·8	-7·7
Stability of hospital timings	90·5	96·5	93		6	-3·5	2·5
Availability of linen in the wards	74·4	78·8	86		4·4	7·2	11·6
Cleanliness of the hospital	83·1	94·9	91·3		11·8	-3·6	8·2
Doctor-patient communication on illness	76·5	74·9	89		-1·6	14·1	12·5
Availability of doctor	82·2	76·9	73·3		-5·3	-3·6	-8·9
Availability of clean toilets	48·3	41·5	62·5		-6·8	21	14·2
Proper guidance at the reception desk	85·7	78·4	72·3		-7·3	-6·1	-13·4
Availability of drinking water facility	63	54·7	56·1		-8·3	1·4	-6·9
Proper seating arrangements	89	80·5	83·9		-8·5	3·4	-5·1
Availability of prescribed medicines	73·3	61·2	71·8		-12·1	10·6	-1·5

Source: Patient Satisfaction Surveys, 2001, 2003, 2004 (calculated after figures obtained from KHSDP internal office records (KHSDP Office File, 2004).

[95] Patient Satisfaction Surveys in Selected Hospitals of KHSDP, 2001; Repeat Study on Patient Satisfaction Survey, 2003; Third Round of Patient Satisfaction Survey, 2004; all three were done by Centre for Research in Health and Social Welfare Management.

The result of surveys is not very positive about the changes that actually occurred regarding patient satisfaction. Patient satisfaction was one of the few outcome indexes for KHSDP, though neither SAR (project preparation document) nor ICR (project end evaluation document) did categorise it as an outcome index. Further, the entire findings of the three rounds of surveys are very much in contradiction to the claim made by the evaluation report conducted by the implementation agency, KHSDP project team, (Bank used the borrower terminology) which even got featured in the Bank's official end project evaluation report (ICR). The report observes (WB, 21 September 2004, Borrower's evaluation section, p. 32):

"3 rounds of evaluation and independent patient satisfaction survey indicate increased level of satisfaction in nursing care, cleanliness of the hospital, communication between doctors & patient, drinking water facility, availability of medicine etc., and efforts are being made to overcome deficiencies observed."

This implementation agency's (as per Bank, borrower) evaluation report in ICR does not elaborate the entire findings. Similarly, one of the Bank's last periodical mission supervisory reports also (not directly) points out about the poor performance of the many indicators of patient satisfaction survey. Instead, it registers that *"Overall satisfaction levels have improved between the two surveys; however, significant areas for improvement such as availability of drugs, maintenance of facilities, availability of water and overall cleanliness were identified* (WB AM, 21 – 23 May 2003)."

Many of the indicators scored poorly despite repeated rounds of survey, such as availability of doctor, availability of prescribed medicine, availability of drinking water, privacy during clinical examination, and proper guidance at the reception desk. The poor performance of the indicators of the patient satisfaction survey in all the three rounds shows that both the quality and effectiveness issue remained not addressed fully. It raises the question on the achievement of the project objectives (especially objective no. II).

Medical waste management was taken up as another measure to raise the effectiveness issue. Biomedical Waste (Management & Handling) Rules (July 1998) by the Government of India followed by the rulings from the Supreme Court made it a legal obligation to implement healthcare waste management practices in all the more than fifty-bed facilities in the country (WB MTR, interim report: June 1999). Indian Society

of Hospital Administration was outsourced by the SPC to conduct a 'Study on Clinical Waste Management, 2000'. The draft recommendation came in the line of the State Pollution Control Board to manage the clinical waste in hospitals (note: final report is not received by the SPC as per the internal file's notification) (KHSDP Office File, 2004). The project had managed to provide short and medium term waste management measures to all the 204 project hospitals (AM, 30 May – 02 June 2002). The medical waste management initiative was an example of a relatively successful project activity which increased the efficiency of the hospital in regard to handling hospital waste.

M5-C13: Improving the Referral Mechanisms and Strengthening Linkages with the Primary and Tertiary Health care Levels

This component was devised to discourage patients from directly reporting to tertiary care. The intention of the project was to direct patients to secondary care from PHCs. Hence, the underutilisation of secondary care and over-utilisation of tertiary care could be averted. All necessary operational costs were covered by the project to establish successful referral linkages between primary and secondary care. Referral linkage committees had been formed at block and district levels (WB, 21 September 2004, p. 31).

Initially, Chitradurga district was proposed as a pilot for establishing the referral system and setting up a district referral committee. It is not known why Chitradurga was selected for the pilot while knowing that the conditions of the facilities needed to be upgraded first (WB AM, November 1997). Recognising the limitation existed in Chitradurga, Udupi was selected next where infrastructural upgradation was already underway. However, Udupi was also acknowledged as a difficult place to properly implement the system because of the same challenges. Finally, it was decided to restrict the scheme only to Udupi until 'improved infrastructure and services' would come into existence across the state (WB AM, November 1998). Thereafter again, the change in tactics took place for implementing the referral system in individual facilities during the Bank's Mid-Term Review (MTR) (WB MTR, November 1999) after assessing that a minimum of one year would be required to equip and adequately staff the hospitals throughout the state. However, later on, the Bank's periodical supervision team moved from its earlier tactic and recommended expansion of the referral system across the state, irrespective of the hospital upgradation criterion (WB AM, May 2000).

This move questions the Bank's seriousness about implementing the referral system. It is well planned that upgraded facilities at secondary level would be of help to reduce the burden on the tertiary sector. Hence, improved referral linkages (especially from primary to secondary) were aimed at. The project hurriedly tried to implement the referral system without giving the due time to the steps involved in building the infrastructure. The Bank team did not take the problem of staffing or facility upgradation under consideration, but rather suggested carrying out IEC activities targeting facilities and communities to direct people to go at first to primary care instead of approaching tertiary care (WB MTR, November 1999). However, the issue of staffing came up in 2001 as lack of laboratory and X-ray technicians were identified as the reasons for diagnostic related referrals (WB AM, November 2001).

The logic of implementation of the referral system was based on the assumption that strengthened primary and secondary levels of care would curb the overcrowding at the tertiary sector. Selection of Chitradurga or Udupi without building necessary infrastructure weakened the logic. Thereafter, the Bank's impatience regarding the expansion of the referral system made the situation bad. The project focussed on and ensured the technical aspects of the referral system, like training, format preparation, and maintenance of registers. It even started analysis of referral data by the constituted facility-level referral committees (WB AM, 30 May– 02 June 2002). However, those technical advances were not in match with the progress of the facilities' physical infrastructural lack.

This research observes that the strategic management offered by the Bank worsened the situation. It hardly tried to analyse the actual problem, rather trying options after options. An important strategic shift was reducing the intervention level from district to make it facility specific. The referral system in a resource scarce setting is dependent on coordination management. In a low resource management set-up, introducing a district referral committee would have been a good strategy since it could coordinate among the facilities that existed within and outside the district and offer timely inputs to the facilities regarding referrals.

On the goal of targeted assignment, the Bank struggled to manage the structural challenges (manpower, equipment, facility upgradation) of the facilities and at the same time shifted to facility specific referral committee and management. In that shift, the

system lost the very promise of building an effective coordination body, a district referral committee. The lack of a coordination body in a resource scarce condition caused the referral system to function and be managed inappropriately. Further, KHSDP supported mainly secondary level institutions (for infrastructural expansion), so the entire PHC structure was also out of the referral reach from where many patients directly were referred to tertiary care. It is understood from the project documents that an institution-specific referral system had been developed only in secondary hospitals or even at the PHC level. The Bank supervisory teams did not concentrate on the issue of coordination and its linkage with the structural limitations. One of the project's pre-operational claims was to strengthen the referral system which was interlinked to the success of the overall health service system development. The Bank's end evaluation report admits that the referral system could not be established properly in the HSDP-II (WB, 21 September 2004, p. 6). This research also found that none of the Bank's mission visit reports (except March and November 1997 aide-memoires) did mention about the implementation challenges of the referral system.

M6: Primary Level: Selective Coverage to Serve Mostly the Vulnerable Population

The sixth mechanism was geared to expand the coverage mostly among the vulnerable population through primary level of care. The strategy was adopted to reach out to the population (mainly SC, ST and women) in six backward districts where the existing publicly provided health service was in lack. Annual health check-up camps, finance for additional staffing, maintenance expenses, trainings and information dissemination activities were carried out.

This mechanism was devised to address the challenges faced by the state in delivering services in underdeveloped regions. The mechanism had also two components.

M6 - C14: Improving Access to Primary Health Care in Remote and Underdeveloped/Disadvantaged Areas

This component was designed to reach out to the vulnerable population in the state. Karnataka is infamous for its regional imbalances. The condition of health services has always been poor, especially in the region of North Karnataka. Hence, the aim was to increase the access to primary health care services for SC/ST and women population. KHSDP had taken up biannual health check-up camps at PHCs (headquarters of ANM)

by arranging the supply of medicines, vehicles and conducting IEC activities initially in six backward districts (Gulbarga, Bidar, Bijapur, Raichur, Dharwad and Bellary) of Karnataka. The project had introduced a Yellow Card scheme to offer free health check-up in biannual camps for SC/ST households in rural Karnataka. As per the ICR, the Yellow Card scheme reached 7.67 million people through 52,372 camps from 1997-98 to 2003-04 (WB, 21 September 2004, p.34).

The KHSDP-designed yellow card scheme had earned a good response from the community. A SPC evaluation study (External Evaluation of Yellow Card Scheme, 2001 by ORG-MARG) on the Yellow Card scheme had reported an overwhelming success. It recommended the need for inter-departmental coordination in planning and stressed the role of NGOs for conducting health camps.

The study done under the supervision of the Task Force (Feasibility and Modalities of Application of Principles of Health Promotion and its Integration with Health Education, 2001 by International Union of Health Promotion and Education) reflected on the issues of organisational change needed in health promotion management and activities. For example, the study recommended that 'Health Education Bureau' be made 'Health Promotion and Education Bureau' including the introduction of new staff at taluk/block level. It advised the tapping of the resource of NGOs for health promotion activity due to their proximity to local people and acceptance. It also suggested that the DOHFW Officer needs to be always a qualified (DPH or MD-CM) public health professional (KHSDP Office File, 2004).

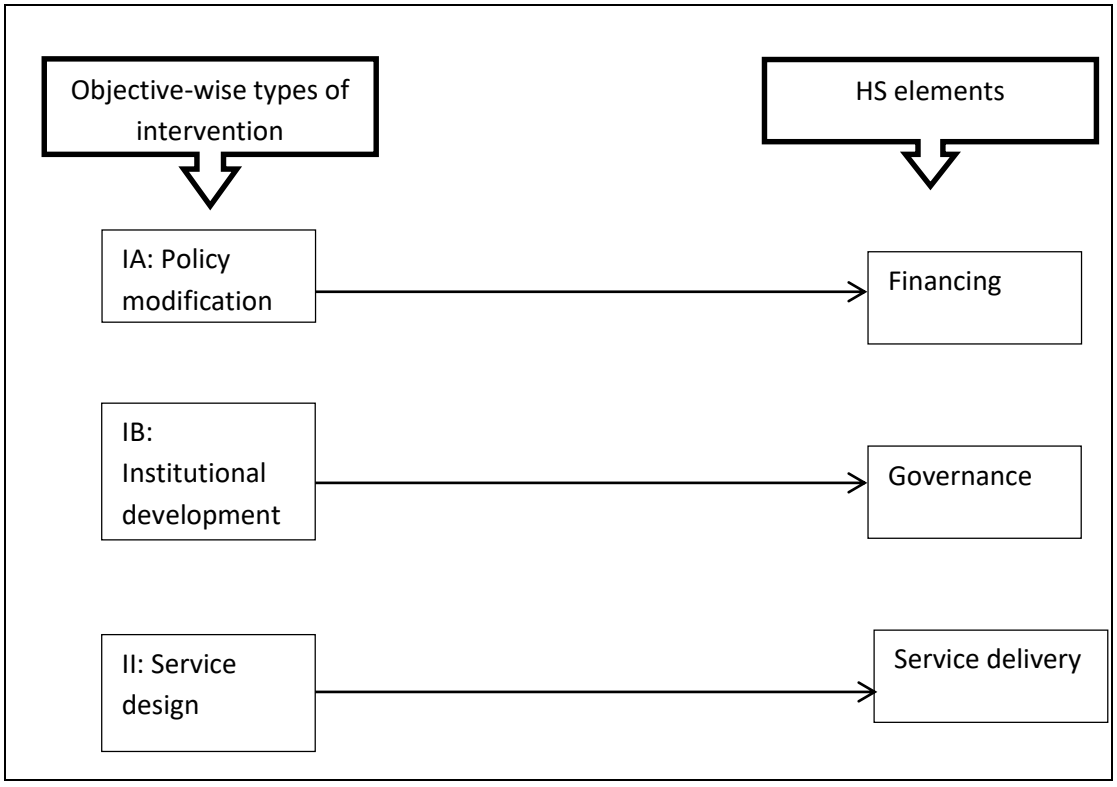
The measures taken under this component were helpful for the people from vulnerable communities located in remote areas. The tactic was drawn to extend outreach support to the community. Though this support was a temporary arrangement, the mechanism did not evolve as a permanent solution for the non-availability of the health services in remote areas.

6.5 Analysis of the project operational design

This section analyses the design of the project, and how the project objectives were linked to the mechanisms. The design of the project accommodates the experiments with both the policy and practice that existed with regard to health system organisation and management in Karnataka. The project was an immediate outcome of the health

sector reform programme as conceived by the World Bank due to the larger macro level factors which are not of interest for this research. In the Indian scenario, the project came in the backdrop of the unfavourable fiscal space condition at the state level to scale up public funding in health sector in the mid-1990s (WB, 21 September 2004, p. 2). Below is the KHSDP design.

Figure 6.2: KHSDP project design



This research, after elaborating the mechanisms and components, arrives at the understanding that the KHSDP design was built based on the three long term strategies: Policy modification, institutional development and service design. The project conceptualised the health system from the aspects of three elements: Financing, governance and service delivery. Policy modification was meant to form a new set of rules to increase and reorganise financing. Institutional development was aimed at to strengthen (for the public system) and reorient (for both public and private) the governance management. Service design was envisaged to make available the selective service packages for the targeted population in specific levels of care to build an efficient health service delivery system. Hence, the programme theory for the KHSDP was that three measures (modified policy, formation of new institutional bodies and effective designing of service delivery) could deliver effective health services by

increasing financing in health and reorganising the governance system. The project objectives as well as mechanisms and components were developed based on the premise of the above illustrated design and formulated in coherence with the stated programme theory.

The project design had set the objectives according to the agenda of the health sector reform, and accordingly either strategised (as long term goal), or employed tactics/techniques (as an immediate measure) to pursue the stated objectives. The first objective was about efficient management of resources. The objective IA (first part of the first objective) was conditional in nature and thus policy driven. The financing input is primarily linked to the budgetary exercise in the public system. Similarly, resource allocation is also a technique for the public institutions to prioritise the financing within the health service. Further, resource mobilisation (through user fee) can also be a tactic of resource allocation or generation to meet the priorities and being independent for a public institution. Hence, political commitment in the form of a policy decision was aspired for to deal with the overall budget to health and intra-health departmental allocation. On the same lines, a policy decision was sought after to rigorously implement the user fee since it had direct political pros and cons.

The second part of the first objective (objective IB) was about the utilisation of health resources. The project brought in the concept of efficiency here. The assumption was that institutional development could bring in the desired efficiency in the utilisation of health resources. The efficiency was strategised in twofold approaches: First, the effort was made to build the capacity of the state (i.e. DOHFW) for doing policy analysis and management of the health service by creating new institutional bodies. Second, the inclusion of the private sector (both for profit and not-for-profit) in the health service provision was created by tactically opening selected positions and service facilities for participation from private entities. The efficiency logic works here also, and thus steps were taken to de-regularise non-clinical service posts to get rid of the nonchalant attitude of the regular staff in terms of performing duties. Similarly, the clinical services (mostly PHC facilities) were handed over to the NGOs/private sector with an aim to improve the service delivery to ensure the availability of clinical staff (doctor), medicine and consumables.

The second objective of the project was very direct and dealt with service provisions in order to cater to the need of the people. It focussed on the three important components (infrastructural development, service upgradation and referral coordination) to strengthen the secondary level of care under the desired parameters of quality, effectiveness and coverage. The project also went for a targeted population approach for making available primary level of care among the poor. The main agenda of the project for this objective was to ensure basic health services at the public facilities and meet the health needs of the most vulnerable.

6.6 Transition period from KHSDP to KHSDRP

The project, KHSDP, closed officially on 30 March 2004. Thereafter, the World Bank followed up with the health system development initiative in Karnataka with another project, titled as Karnataka Health System Development and Reform Project (KHSDRP) started in 2007. The interim period between KHSDP and KHSDRP was funded by IDA support using KHSDP and KHSDRP resources. The support was mostly for staff salary including PA position and not related to any activity. The transition period between KHSDP (ended on the 30 March 2004) and KHSDRP (started on the 11 January 2007) was marked by a shift from the autonomy of the state to the submission of the state. Internal files reveal that a series of events in this regard took place between 2001 and 2004. The following section narrates the events chronologically.

After the formation of the Task Force on Health and Family Welfare and followed by the Task Force report, the government constituted a High Level Interdepartmental Implementation Committee to implement the recommendations of the report. Considering the financial constraints, GOK further set up a Project Preparation Committee (Order No. HFW 415 CGM 2000, Bangalore dated 12 September 2000) to incorporate the findings and recommendations of the Task Force report in a project proposal for practical implementation (GOK KIHN&FWSDP, 2002, Annexure-2, p. 236). Karnataka Integrated Health, Nutrition and Family Welfare Services Development Project (KIHN&FWSDP), prepared by the Community Health Centre - a voluntary community and public health resource group, had been developed on behalf of the GOK for external assistance to reach ‘towards equity and quality in health and health care services’ (GOK KIHN&FWSDP, 2002).

The proposal first went to State Level Coordination Committee (SLCC) for getting 'in principle clearance' and accordingly obtained the same in the 12 March 2001 SLCC meeting. The same meeting also allowed availing of a grant by the Japanese Policy and Human Resource Development (PHRD) to undertake various studies for preparation of the project (SLCC meeting proceedings, 2001). The KIHN&FWSDP proposal had been sent to GOI by GOK on 11 April 2002 and finally forwarded to the World Bank via GOI on 21 April 2003 for five years' funding consideration. The aftermath is… *"In response to a request from Government of India, the World Bank Mission visited Karnataka several times. During discussion it was agreed to revise the whole project proposal"* (KHSDP Office File, 2004). That revision of 'whole project proposal' brought in the KHSDRP in Karnataka.

Interestingly, an internal file document (Information for the Review of Cabinet Sub Committee on KHSDRP) further qualified the last 'verse':

"…..*In response to a request from Government of India, the World Bank Mission visited Karnataka several times and during discussion it was agreed to promote with IDA support a broad, long-term process of reform and development in the health sector to achieve the goal envisaged by the Karnataka Integrated State Health Policy to "provide quality care with equity" (KSIHP 2004). Further was also agreed to revise the Project Proposal giving more priority to service improvement and reform components rather than the infrastructure. Accordingly Project proposal has been revised"* (KHSDP Office File, 2004).

The priority was very clear; furthering of health sector reform was the chosen agenda and not strengthening of PHCs as mooted in the KIHN&FWSDP proposal.

It is important to mention that information from different sources is tracked down to analyse the pre-project exercise in more detail. An internal document on KHSDRP reports that an agreement was signed on 3 January 2002 by the IDA and GOI to execute the PHRD grant (USD 6, 80,000) *"to undertake various studies for preparation of the Karnataka Integrated Health, Nutrition and Family Welfare Services Development Project."* Accordingly, six studies and five assignments were completed before the official closure (31 December 2004) of the PHRD grant (KHSDP Office File, 2004).

This research questions whether those studies and assignments (pre-project) were based on the suggestions made in the KIHN&FWSDP proposal or the project proposal that the Bank developed to change the whole KIHN&FWSDP proposal. It is found in the KIHN&FWSDP proposal that pre-project studies for some components were already recommended for the detail costing and planning exercise of the project. In fact, the KIHN&FWSDP proposal evidently mentions that

"A Technical Assistance (TA) grant from the Government. *of Japan has been approved to support studies that require to be done during the pre project phase to develop detailed requirements for the Project Implementation Plan"* (GOK KIHN&FWSDP, 2002, p. 224-225).

Thus it is clear that PHRD grant (from the Japan government) was approved well before the formation of the KIHN&FWSDP proposal; thus it was identified for executing the KIHN&FWSDP's suggested pre-project studies/assignments. However, after the Bank's intervention, the same PHRD grant seemed to be redirected to be utilised for the pre-project studies of KHSDRP proposal. The intervention from the Bank took time to negotiate and convert the KIHN&FWSDP proposal into KHSDRP proposal. Hence, both the GOK/GOI and the Bank had to wait till 2004 to initiate the contract agreement for the pre-project preparation studies despite the PHRD grant agreement being sanctioned and accordingly approved on 3 January 2002.

This information raises serious questions on the importance of a platform like SLCC. SLCC cleared the PHRD fund requisition at the 12 March 2001 meeting based on the knowledge that the fund would be a technical assistance for preparing pre-project studies of the KIHN&FWSDP proposal (SLCC meeting proceedings, 12 March 2001). The approval was not given for utilising the fund to prepare pre-project studies on behalf of the KHSDRP. The topics of studies proposed by the KIHN&FWSDP as pre-project preparation are also not exactly the same which were undertaken later on by using the PHRD grant. Rather, the study topics of PHRD are matching with the KHSDRP proposal.

The interpretation of the above information is that the World Bank was in disagreement with the KIHN&FWSDP proposal. Hence, it revised the 'whole project proposal' by conducting several studies using PHRD grant. The Bank's end evaluation report (ICR) of KHSDRP also notes that Japanese PHRD grant was used to build the project's

operational plan (WB, 21 September 2004, p. 7). Interestingly, the internal file's document refers to that all the PHRD studies had been executed in the year of 2004 whereas the last SLCC meeting (12 March 2001) advised that all studies should be finalised by October 2001. The SLCC gave the timeline probably keeping in view the closure of the initial timeline of the KHSDP project (March 2002), and the need for a new project to begin with. It is very rare that the decision of the SLCC, the second highest decision-making body of the GOK after Cabinet body, was ever inverted, and the fund originally sanctioned for the preparation of KIHN&FWSDP, had been rerouted to use for the development of KHSDRP. The next section discusses the differences between KIHN&FWSDP and KHSDRP project which may help us to understand the motive of the state and IDA to choose the agenda of reform over strengthening.

The KIHN&FWSDP proposal was mostly about the strengthening of the primary-level health care of the state, focussing on the infrastructural development of the public system. The proposal also planned for some targeted interventions (for example, nutrition, school health, mental health, women's health, and persons with disability and from hill tribes) along with regularisation of the diseases surveillance and referral systems. It also aimed at developing the human resource for primary health care management through professional, technical and managerial training (including training for ANMs), and building a comprehensive HMIS (GOK KIHN&FWSDP, 2002). The KIHN&FWSDP's proposal on the primary-level health care strengthening can be considered as an advanced stage of the KHSDP in which the focus was mostly on the secondary level of care. This proposal was also in another way a continuation of the recommendations of the High Level Interdepartmental Implementation Committee to implement the Task Force report's recommendations. In contrast, the KHSDRP was mostly about management and technical support. This distinction is important to mark that KIHN&FWSDP proposed for another infrastructure-oriented (like a major part of the KHSDP was) project, whereas the KHSDRP went for the software-related support. Needless to say that the GOK chose the latter one ignoring the former which consisted of the recommendations given by its own constituted body. However, it is not possible for this research to comment on what would have happened if KIHN&FWSDP had been implemented instead of KHSDRP.

The revised proposal emerged as the Karnataka Health System Development and Reform Project with an estimated cost of INR 642.35 crores (USD 149 million).

Thereafter it was again placed before SLCC and accordingly obtained clearance on 8 July 2005, followed by Cabinet approval for the implementation of the project in the state on 19 August 2005 (KHSDP Office File, 2004 and Cabinet Note - GOK, 2005).

The reason behind the rejection of KIHN&FWSDP over KHSDRP is not documented very well. The Bank notes that the rejection of the GOK's 2002 KIHN&FWSDP proposal was based on the logic of it not having enough potential to improve the service delivery since the proposal was on primary health care and about infrastructural investment. The Bank considers that coverage and service improvement are systemic issues and cannot be addressed through investment in infrastructure (WB, 15 July 2006, p. 14). The GOK did not officially register any reason for not pursuing the KIHN&FWSDP proposal. One of the persons who were closely involved in the formulation of the KIHN&FWSDP remembers that the World Bank team was not positive about the project proposal (Informant 04). This research finds that a state-led and civil society driven project plan had to be done away with to avert any interruption in the continuation of reform under the guidance of the World Bank. This entire transition process questions the failing autonomy of the state to act on its own as well as the legitimacy of the international economic institute (World Bank) to ignore and suppress the concerns of the state.

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Chapter 7: Karnataka, transitioning towards health system strengthening

Summary of the chapter: The Karnataka Health System Development and Reform Project (KHSDRP) was financed in two phases to augment the health system reform by focussing particularly on organisation development, service delivery, and financing of health care service. The design of the project aimed at achieving MDG through HSS. The significant departure from the KHSDP was the extremely low commitment for infrastructural development (hardware), and instead bankrolled on software. The central plank of the project, organisational development, was symbolised as an appliance of outsourcing governance management in the health care service delivery. The project created room for GOK to try and test various service delivery schemes modelled after PPP. The project remoulded the governance cum service delivery arrangement by introducing strategic purchase model as new financial instrument (assurance/protection) to buy in-patient services for targeted population. The analysis finds that complicating governance is often counter-productive for the management of the governance itself. The Bank has withdrawn itself after two decades of steady assistance, though the shadow of the Bank is much bigger than it appears!

The second project of the World Bank on Health System Strengthening (HSS) is also in line with KHSDP, but more focussed on the software than hardware component. The project had been undergoing several revisions at the concept stages and finally got approved by the Bank on 22 August 2006. The transition period from KHSDP to KHSDRP is already elaborated in the previous chapter which illustrated how KHSDRP came into it.

In the Project Implementation Plan (PIP) analysis of the Karnataka Health System against the backdrop of the KHSDRP, four challenging issues had been listed. The problems ranged from management of the organisation to intervention style. Issues on the accountability and efficiency of government health services, lack of priority for primary and public health activities, scarce financial allocation for health sector and unregulated private health care were identified as system challenges. Keeping those lacunae under consideration, the project had devised mechanisms and components to make government health service more effective and equitable (Project Implementation

Plan [PIP], September 2005). The PIP document ascribes to the very idea of the Bank by acknowledging that the project was "*basically about reforms*" and aimed at "*ensuring basic health service by the state*" (PIP, acknowledgement, September 2005). The Bank has developed the framework of the project in collaboration with the 'State Project Monitoring Unit' (SPMU) and DOHFW officials (PIP, foreword, September 2005).

The project was consistent with the other policy suggestions as put forth by the Bank's Country Assistance Strategy (CAS), Tenth Five Year Plan of GOI, and National Population Policy, 2000. Like HSDP-II of 1990s, the KHSDRP project of the Bank was also the processed policy outcome of its overall country approach. For example, the Bank's Project Appraisal Document (PAD) of the KHSDRP notes that

"*The project is consistent with the strategic principles and the priorities identified by the Country Assistance Strategy (CAS), September 2004 in: (a) focusing on outcomes as a means to improve governance and service delivery; (b) being selective in support of activities that have greatest impact on the poor; and (c) envisaging a strengthened role of the Bank as knowledge provider and generator*" (WB, 15 July 2006, p. 8).

The project had set the outline at the beginning that performance enhancement of the public sector especially for strengthening of targeted basic health care, ensuring the involvement of the private sector in essential health service delivery and introduction of insurance mechanism as a measure of risk protection were key features of the reform programme (WB, 23 November 2003; WB, 24 March 2005; WB, 5 April 2005).

7.1 Funding Arrangement of KHSDRP

The project had come up under the Specific Investment Loan (SIL) to plan, implement and test several innovative service delivery schemes. The Bank's Project Appraisal (WB, 15 July 2006, p. 14) reports that the Sector Adjustment Loan (SECAL) was not considered for KHSDRP since the nature of reform in health sector and the planned innovations for service deliveries were in need of SIL mode of investment. KHSDRP had been executed in two different financing phases. The following table gives details about the loans.

Table 7.1: Loans taken under the KHSDRP

Project No. (KHSDRP)	Loan no.	Signing date	Effectiveness date	Closing date	Amount (in USD million)
P071160	IDA – 42290 (KHSDRP original financing)	16.10.2006	11.01.2007	31.03.2016	141·83
P071160[96]	IDA – 51610 (KHSDRP additional financing)	21.11.2012	22.01.2013	31.03.2017	70·00
P071160	TF – 99435	14.10.2011	14.10.2011	31.08.2014	0·40

Source: Collected from World Bank Implementation Status and Result Report (ISR25318) (WB, 17 October 2016, p.7)

The project (Project no.: P071160) was initially approved for five years with effect from 11 January 2007 to 31 March 2012 (Loan no.: IDA – 42290, approval date: 22 August 2006). The project had further got an extension by five years under the arrangement of Karnataka Health System Additional Financing (KHSAF) (Loan no.: IDA – 51610, approval date: 27 September 2012) (WB, 17 October 2016). For the reference purpose of this research, the first phase of the KHSDRP financing is called as original financing phase and the second phase is named as additional financing phase.

The original financing loan came with the start of the project and closed on 31.03.2016. The Additional Financing loan came on 22.01.2013 and finally ended on 31.03.2017.

The KHSDRP original financing phase was expected to close on the 31 March 2012. The project went for restructuring twice (from 31/03/2012 to 30/09/2012 and later on again from 30/09/2012 to 31/03/2013) during the negotiation of KHSAF loan between the GOI/GOK and the Bank to plan, design and complete the official formalities (ISEC 2017, p. 5). KHSAF finally started on the 31/03/2013 to provide resources for three additional years (till 31/03/2016). However, the KHSAF loan also got extended by one

[96] The KHSAF's Project ID no. is P130395 as per the World Bank's website information for the concerned project page. Though the Bank's periodical supervision visits (Implementation Status and Results Report, available on the Bank's website under the concerned project page) refer to both the original financing and additional financing under the same Project ID number (P071160). This research uses the P071160 as the single Project ID for both the financing phases. (Web-link: http://projects.worldbank.org/P130395/india-karnataka-health-systems-additional-financing?lang=en&tab=details as accessed on 7 May 2018)

year. The KHSDRP (along with the support of the KHSAF loan) finally ended on 31/03/2017.

7.2 Rationale for KHSDRP

The rationale for KHSDRP credit was linked to the changing context of the state as well as the national scenario. At the beginning of the KHSDRP (2005 - 2006), it was thought that the project would be one of the prominent sources of financing in health for public system in the state. However, both the state and central government increased resources (in absolute value) in health from 2006 onwards (WB, 27 August 2012, p. 5). The investment got increased partly because of the arrival of National Rural Health Mission (NRHM). That changing scenario converted the KHSDRP to become a strategic investment within two years of the project, and not considered any more as only financial investment in the government health system. Both the state and the Bank used KHSDRP as a special resource for health sector development. KHSDRP, especially the original financing, was chiefly used by the state as financial support for budgetary consolidation. In contrast, the Bank used KHSDRP as tactical support in the form of technical handholding to reorganise the health service in the state.

The possibility of additional financing was first discussed during the mid-term review discussion. According to the Bank, the needs identified were the continuation of reform and capacity development activities, expansion of successful initiatives in KHSDRP, and experiment of new pilot innovations and their evaluations (WB MTR, July 2010, p. 11). The KHSAF was also in sync with the Bank's 2009 – 2012 CAS strategy to increase the health service delivery's effectiveness by institutional strengthening, capacity development and improving the information system for result-based outcome and private sector engagement (WB, 27 August 2012, p. 5). It is further to be noted that additional financing was not a separate project; rather, it was an additional loan for the extension of KHSDRP.

7.3 Project operation of KHSDRP

This section explains the objectives of the project, its approach and design. As discussed above, the project had two different phases of financing. Hence, the objective of the original financing phase had become changed with some modifications in components and sub-components in the additional financing phase. However, the main agenda of

the project was to get aligned with the state health service and change the approach of health service management.

The objective of the original financing phase of the project was more concentrated towards the health MDGs by taking the initiative to increase the essential health service utilisation, especially in underserved areas for vulnerable groups (WB, 2 December 2010, Annexure-1).

The project implementation of the KHSDRP under original financing had been done in two different approaches: Project and programme approach. Through project, the Bank strategised to support the operational cost of the dedicated project mechanisms and components. The programme approach was a tactic used by the Bank to indirectly influence the state's own health service management and budget planning by offering conditional funding. The technical support and supervision of the Bank was limited to the project approach only. In the mechanism section, the approaches are dealt with in more detail.

The additional financing also operationally retained the same objective with changes in the articulation. The objective especially focussed on the service delivery, PPPs and financing areas to improve the health status of the vulnerable community (WB, 27 August 2012, p. 6). The project objectives from the two phases were instrumental in strengthening the health system by employing various mechanisms, components and sub-components. Below is a table that lists the mechanism, components and sub-components that were used in the project. It also shows the components/sub-components that were continued/dropped/added with regard to the original and additional financing phases.

7.3.1 KHSDRP Mechanisms-Components-Sub-components

The following table lists mechanisms, components, and sub-components of the project to elaborate the detailed execution experience of KHSDRP.

Table 7.2: KHSDRP Mechanisms-Components-Sub-components
(Original and Additional Financing)

Original financing				Additional financing	
Mechanism (M)	Component (C)	Sub-component	Activities	Sub-component	Continued/dropped/added under the additional financing
M1: Strengthening Essential Government Health Programs to Achieve More Effective and Equitable Delivery of Services	M1-C1: Organisational Development		Institutional strengthening		M1-C1: Continued
			Capacity development		M1-C1: Continued
				M1-C1-A: Quality Assurance (scaling up activity)	M1-C1-A: Added
	M1- C2: Improving the effectiveness of primary and secondary health care services				M1- C2: Dropped
M2: Innovation in service delivery and health financing	M2-C3: To provide service delivery through creating/expanding government infrastructure, using PPPs for managing the services and conducting outreach	M2-C3-A: Service Improvement Challenge Fund	Capital investment: Civil work and equipment		M2-C3: Continued M2-C3-A: Continued with modification
			Service delivery (PPP): MHC, Contracting out of PHC, Source in of specialists, CHD, RDL		M2-C3-A: Continued with modification
		M2-C3-B: Public Health Competitive Fund (PHCF)			M2-C3-B: Dropped
				M2-C3-C: Non-communicable disease prevention and control	M2-C3-C: Added

Original financing				Additional financing	
Mechanism (M)	Component (C)	Sub-component	Activities	Sub-component	Continued/dropped/added under the additional financing
				M2-C3-D: Road safety and emergency health services	M2-C3-D: Added
				M2-C3-E: Food safety	M2-C3-E: Added
				M2-C3-F: Health Care Waste Management (HCWM)	M2-C3-F: Added
	M2-C4: Innovations in health financing				M2-C4: Continued
M3: Project management, monitoring and evaluation					M3: Continued

The project retains the three same mechanisms in both phases of financing. The components were also similar except 'improving the effectiveness of primary and secondary health care services' one which got discontinued after the original phase of financing. Hence, there was also no programme approach in additional phase of financing. There were a number of sub-components that had been added in the additional financing in replacement of the Public Health Competitive Fund component in the additional phase.

The section below elaborates the experience of the mechanisms along with their components and sub-components in both the financing phases of the KHSDRP.

M1: Strengthening Essential Government Health Programs to Achieve More Effective and Equitable Delivery of Services

The project's agenda was to focus on the essential government health programmes to make the service delivery more effective and equitable. Through this mechanism, it

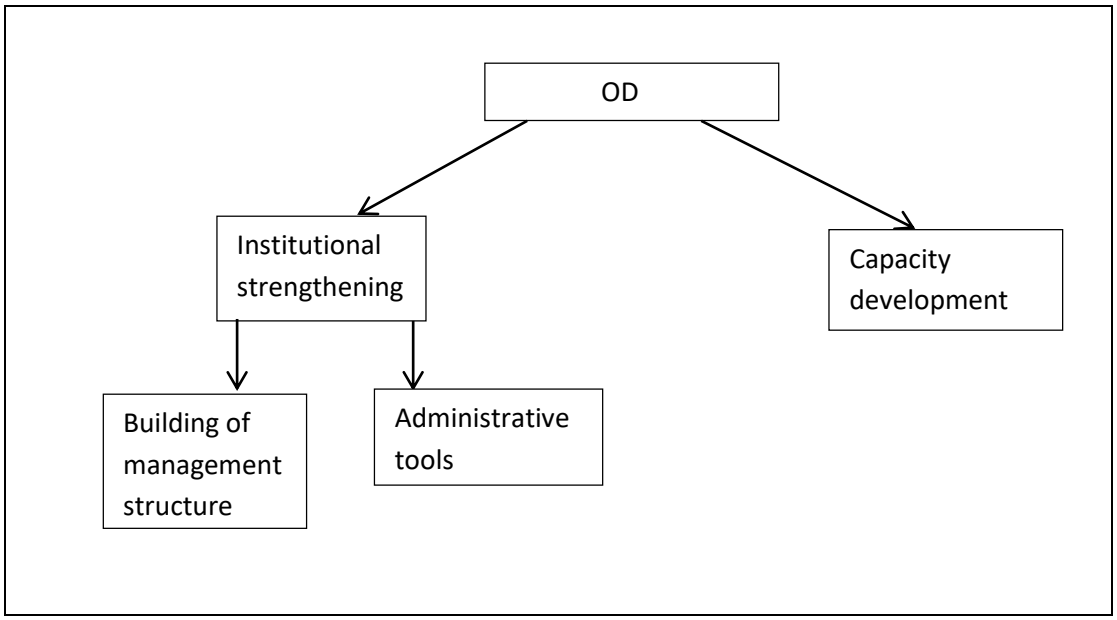
strategises two components: Increase the management capacity (organisational development) of the DOHFW and direct budget support to improve the primary and secondary health care services. This mechanism was devised for the improvement of the public system and to steer health service management. On the one hand, it aims to scale up the management efficiency of the public system through organisational development. On the other hand, it extends support to help the state government to boost its field interventions for the Millennium Development Goal (MDG) drive.

M1-C1: Organisational Development

Organisational Development (OD) was the most important and much envisaged component of the project. The main agenda of the OD component was to aim at reorganising the 'department at every level' and move towards a result-based approach in planning and implementing health care programmes. The success of the entire project was dependent on the OD and thus it was considered as the *"central plank in the reform process"* (WB AM, June 2007, p. 5).

OD as a whole is the only component in the entire KHSDRP which was formulated as a strategic means, designed for tactical cooperation and executed through technical assistance. Below is the schematic diagram of the OD component.

Figure 7.1: Schematic Diagram of Organisational Development (OD) Component in KHSDRP



OD had been assigned as a long-term strategic engagement in the project as it would be linked to institutional reform. The tactical cooperation had been improvised by introducing institutional strengthening measures in one hand, and on the other complementing them with the selected capacity building activities. Both institutional strengthening and capacity development were by nature technical but arranged tactically to cooperate with each other. It is to be noted that institutional reform primarily refers to institutional strengthening (both the management structure and administrative tools). The capacity building activities were the specially premeditated inputs to prepare the workforce for strengthening activities that aimed at involving both the public and private sector. Further, institutional strengthening was divided into two parts: Creating a management structure and developing selective administrative tools. The following sections elaborate the measures of institutional strengthening and capacity development exercises taken under the component.

The management structure was set up to execute the operational plan of the reform, and administrative tools had been formulated to develop the normative plan of the reform. The World Bank's PAD (WB, 15 July 2006, p.10) claims that the series of then proposed administrative tools were on the line of the Task Force on Health's recommendations for organising public health services better. Administrative tools were the support to speed up the institutional reform. Apart from the institutional reform, the project conceived of capacity building activities to fortify both the public and private sector for initiating an accreditation system and successful implementation of PPPs (WB, 15 July 2006, p. 10).

The detailed list of reform agendas is not mentioned in the World Bank PAD, 2006 document. The following were the institutional reforms planned at the beginning of the project as mentioned in the PIP prepared by the state in consultation with the Bank in 2005 (PIP, September 2005, p. 7 – 9):

Management structure

- Project management apparatuses: For execution of the project and to coordinate with the rest of the health service, State Project Management Unit (SPMU), District Project Management Unit (DPMU) and Senior Management Team (SMT) were planned to be formed.

- Setting up a separate Directorate of Public Health to plan, implement and monitor public health activities.
- Reconstitution of State Health Informatics Centre for strengthening of data collection and analysis to help the planning unit.
- Strategic Planning Unit needs to be converted into single planning unit. With regard to the planning unit, the PAD document elaborates that Health Planning Unit (HPU) was conceptualised to support at the state and district level for developing planning mechanisms and policy making inputs. It was planned that HPU would assist the district bodies in preparing Service Improvement Plan (SIP), another project component on capital investment (WB, 15 July 2006, p. 10).
- Revamp of State Health Institute of Family Welfare (SIHFW) to facilitate training as a nodal centre in the state as it had not been developed accordingly to cater to the need of the training. New training components (such as PPP, health insurance and health sector planning) would be introduced to get into the momentum of the new ways of doing things.

Administrative tools

- Human Resource Development: New rules would be proposed after consultation on Cadre and Recruitment Rule to get professionals from IT (Information Technology), finance and management planning areas.
- Enactment of Law: To bring out a model comprehensive Public Health Act by replacing some of the out-dated Acts and Rules in Public Health.
- Regulation: Setting up State-level Healthcare Accreditation and Regulatory Authority to maintain basic standards of treatment among care providers both in public and private.
- Standardisation: Development of a medical and clinical manual to have a uniform practice on clinical protocol and hospital administration.
- Human Resource Management: Preparing of suitable incentives and disincentives to enhance the performance and demotivate the practice of absenteeism.

Keeping in line with the institutional strengthening measures, the capacity building activities were employed as additional technical assistance to set institutional reform on the right path. They were designed to impart the requisite skills among the administrators, legislative representatives and health workers to get them acclimatised with new forms of management structure and build capacity to execute the envisaged administrative tools. Four types of assistance were planned through training activities (WB, 15 July 2006, p. 44 – 46):

Thrust for attitudinal change: Improve the skills of key officials in health department for managing programmes' planning and implementation activities to adopt the desired attitude for *"new ways of doing things"*.

Focus on decentralisation: Gain the confidence of the key stakeholders (especially local government representatives) by orienting them with the KHSDRP for execution of the project to smoothen transition towards reform.

Private sector regulation: Prepare the private sector to provide services with due quality of care by leading-in to the accreditation system for strengthening the regulatory framework.

PPP management: PPP planning was taken as an alternative mode of service provision. Hence, both the government and private facilitators were planned to be trained on PPP management. Government officers (senior and mid-level) were considered to be trained for a skill-building exercise on developing Service Agreement with the private sector. The private sector was aimed to be covered by imparting *"training, technical support on legal and managerial matters, and interaction through professional associations on management issues."* (WB, 15 July 2006, p. 46).

The reason for introducing capacity building seems to be technical to adjust with the alternative mode of service provision. Thus institutional strengthening was the primary agenda for the OD, capacity building was formulated as a supportive technical assistance to ensure the process of reform. For example, attitudinal change was proposed for the key health workers to adjust them with the new model of management for health service provision, i.e. PPP. PPP management and private sector regulation were adopted to enhance the service quality at first and then skill building for both the public and private sector to enter into joint ventures. Similarly, grassroot training for

local governance actors was devised to execute the SIP (Service Improvement Plan) component for infrastructural expansion, because the SIP was set to roll out under the executive function of the existing decentralised governance at ZP level.

This research elaborates the OD planning outline above because of its significance in the project. OD was planned to deal with the structure of the state health service organisation which had been in distress for long. The following segment deals with the implementation process of the components to know the present status of the planned activities.

Institutional strengthening

The project envisaged that the OD component be planted within the department and steer the entire department. The two project management bodies were created (SPMU and DPMU) for this purpose. The plan was that the two bodies would execute the project (respectively at the state and district levels) and also imbibe new values as well as practices to revamp the DOHFW and a few other institutions of the department. The key management bodies for the execution of the project, SPMU and DPMU had been formed (WB AM, June 2007). Joint Director and Deputy Director were given charge component-wise executive powers in SPMU. District Project Managers were recruited in two batches at the beginning of the project to set up full-fledged DPMUs. The technical positions at the SPMU and DPMU were managed by the DOHFW's own cadre who had a minimum qualification of an MBBS (Bachelor of Medicine and Bachelor of Surgery) degree. The SPMU was led by an IAS level cadre as a Project Administrator. Formation of SPMU and DPMU had become strategic resources for the department. These institutional bodies were instrumental to primarily execute the project, and integrate the works between KHSDRP and NRHM/ National Health Mission (NHM) and DOHFW. Similarly, the proposal for the constitution of District Health Society and District Health Mission were also on the lines of merging NRHM and KHSDRP (ISEC 2017, p.17).

The project acknowledged that the restructuring of every department was an immediate need before making attempts to improve the quality of decision making. For OD, an external professional agency was decided to be appointed as technical resource to work with the department to change the work culture for moving towards a result-based approach with regard to planning and implementing programmes (PIP, September

2005; WB, 15 July 2006, p. 44). The department was definitely lacking the capacity to execute the technical specifications involved in OD. Hence, the OD was decided to be executed by contracting an external consulting agency. The scheme was for the consultancy agency to train the department staff for carrying forward the OD activities. However, appointing a consulting agency had always been a problem with the project. Several of the Bank's mission visitors express their anguish over the nonchalant attitude of the project leadership to select a consultancy firm for supervising OD activities (WB AM, June 2007, p.5; WB AM, October 2009, p.8). The project was desperate to look for a consultancy agency which could manage the components. The failure in selecting a consulting firm delayed the operationalisation of the management structure, formation of the administrative tools, and other capacity building activities at the cost of decelerating the very agenda of institutional strengthening.

The aim behind the strengthening of the OD was to shift it to the Directorate for strengthening the management in DOHFW to revamp DOHFW and SIHFW (WB AM, September - November 2008). However, it is surprising that within two years after the start of the project; the component which had been primarily planned to revamp DOHFW and other state institutes was itself termed as "*needs to be revamped*" (WB AM, May 2009, p.7). Knowing the importance of the OD component, the Bank had come up with a tactic to begin with the activities planned for organisational development. The Bank's mission visit advised that instead of channelising the human resource for direct service delivery, the department should go for stewardship functions, *"such as M&E, management of PPP and - moving forward - health insurance, regulation and quality enhancement processes in public and private sectors, health financing, etc."* (WB AM, May 2009, p.8). The introduction of a stewardship style of functioning until then had been never planned or designed in another project.

The Bank's mission further said that *"These functions will become increasingly important, as Government moves away from direct service delivery and towards establishing a more pluralistic delivery system"* (WB AM, May 2009, p.8). Thus, as the same mission observes, the DOHFW was taking initiatives to create "units" or "cells" to build expertise for stewardship activities (WB AM, May 2009, p.8). While it is understood why the tactical improvisation was needed to bring in the concepts of cells, it is dubious to accept the Bank's claim that the DOHFW, which was not even capable enough to run the OD, was taking initiatives on its own to create cells.

The Bank intervened in the execution of the OD component because it was non-performing since the beginning. For instance, the OD training in the additional financing phase is a case of discussion here. This research takes the example of 'Carrier oriented multi-skill based training programme' of the OD component in KHSDRP to elaborate the issue of procurement related challenges how that affects the project deliverables. The company, named ISQT Process & Counselling Services Private Limited, was hired for the said training. The company complained for delayed payment. According to the letter sent to then Minister of Health and Family Welfare (dated 7 February 2017), the company registered its complaint for not getting the payment for the training conducted. The hired company claimed that all the trainings (batches of 160) were completed by 12 March 2016 along with the required details as per the Agreement Contract dated 28 October 2015 (KHSDRP Office File, 2017). This researcher could not get further details on why the payment was delayed for one year. However, from examination of available documents, it was noticed that though the Consultants' capacity was judged before selection based on their previous experience in offering similar trainings, individuals' abilities, crucial as trainers, in the first place were not considered because their individual qualifications and experience were not stipulated in the Request for Proposal. Hence, what were the requisites of such trainers (qualification for job profile), and who were actually deployed are unknown. Thus the quality of such trainings is doubtful as well as questionable. The similar observation was noticed in Bank's aide memoire also, where the concerned training's efficacy refers to as doubtful. Moreover, the same mission visit also points out the poor standard of external evaluation process done even by a reputed institution like IIM – Bangalore (WB AM, June 2014, p.24).

The above example from OD training shows that the inability of the Bank financed project staff (deputation from government) to handle project activities compelled the project to outsource 'all' the institutional strengthening measures (both the management structure and administrative tools). This was done by creating proto-institutions like cells. This is a very important change in the project's operational design. The project did not conceptualise cells at the designing phase. The aim was to develop the capacity of the staff through *"learning by doing"* to strengthen the institutions, hence there was no mention of cells either in PIP or in PAD. The tactical improvisation of creating cells by filling up consultants killed the very spirit of the learning by doing strategy. The

appointment of consultants to take care of the cells balked the process of learning for the government's own staff with regard to acquiring hands-on technical knowledge and competency. Almost all the executive works were done by the contractual consultants as per the operational guidelines drafted by the Bank. On the contrary, the post of DD – Deputy Director (GOK cadre to be in-charge of the various cells) became reduced to the 'signing authority' for receiving (from the Bank) and discharging (to the consultant) instructions. With this tactical move, the Bank converted the OD from the strategic component to the tactical component, and therefore the strategy of 'learning by doing' turned out to be a tactic of 'doing by hiring'.

The periodic aide memoires of the Bank were of the opinion that the project management team was incapable to execute the project components efficiently and also expressed dissatisfaction over the leadership role of the DOHFW (WB AM, February 2008, p.4; WB AM, September – November 2008, p.3). The continuous lagging on the key developments of the project components might convince the Bank to devise the tactic of cells' creation to move the state from direct service delivery to a 'more pluralistic delivery system'. The hindrances with the execution of OD convinced the Bank to go for the cell-type model. These cells were PPP Cell, Health Financing and Accounts Cell (under OD), HMIS/Monitoring and Evaluation Cell (under M&E), Health Care Waste Management Cell, Blood Blank cell, Quality Assurance (QA) Cell and Information Education Communication (IEC) Cell. The motive behind the creation of the cells was to change the management culture in the DOHFW, motivate the officers and lead towards stewardship. These tasks were decided to be executed with the help of OD/management consultant (WB AM, May 2009). The project could not establish all the cells during the original financing phase, and in due course many of the cells had been established later in the additional financing phase of the KHSDRP. As per the 2012 April aide-memoire, the IEC, QA, Health Accounts (integrated with Health Financing) and Health Care Waste Management Cell had been created and accordingly activated. PPP (created but not fully activated), Food Safety, NCD, Road Safety were still then under the planning phase (WB AM, 16 – 20 April 2012). The Food Safety, Non Communicable Disease (NCD), and Road Safety cells were also formed in the additional financing phase; however, they were not part of the OD component anyhow. Similarly, the cells formed during the original financing phase were initiated by the OD

but did not remain with the OD thereafter. Those cells' operational performance was based on the activity of various other components.

The formation of the cells and thereafter their activation were not an easy task for the project. The activation meant the filling-up of the vacant positions of the respective cells by appointing individual consultants. The cells were empty for long because of the unavailability of consultants and delay in the agreement process. The Bank's 2010 aide memoire (WB AM, May 2010, p. 3) observes:

"Progress on strengthening of institutional capacity has been slower due to poor response to the published expressions of interest (EOIs). The project has re-advertised the EOIs with modified Terms of Reference (TORs) and these cells are expected to be fully activated shortly".

This is clearly showing that the unavailability of a desired number of EOIs not only made the project to modify the TORs but probably also pushed it to reduce the consultancy criteria further. This shows that the KHSDRP at first failed to develop the capacity of the government's own human resources because of delay in consultancy selection and then moved to hire compromised resources (by reducing the conditions in TORs) from the market in order to activate the cells and execute the pending tasks. The tactical decision of the formation of cells in fact put the project's original strategy in question.

Below is the detail of the cells' functioning under the OD component. It would further help to give a detailed understanding how much the cells were active and contributed into the project's original goal.

Health Financing and Accounts Cell: The project created Health Accounts Cell in the year of 2009 and accordingly it got integrated with the Health Financing Cell (Government Order, vide No. HFW (PR) 45 WBA 2009, dt. 21-07-2009) (WB AM, October 2009). The cell was given the responsibility to prepare health accounts, analysis and publication of health account reports, policy input to the DOHFW and coordination with the Department of Economics and Statistics for analysis of population level health expenditures to provide policy feedback. The Accounts Cell was created in pursuance to the need for preparation of MTEF (Mid-Term Expenditure Framework) and public expenditure review for DOHFW to comply with the larger

conditions of governance reform (WB AM, February 2008,p.7). It is not clear from the project documents what was the difference between the Health Accounts and Health Finance cells. Comparing several aide-memoires reveals that the same responsibilities were mentioned for both the cells (WB AM, October 2009; WB MTR, July 2010; WB AM, April 2012). It seems that the project integrated/renamed health accounts with health finance just to give an outlook of the changing nature of the health service management where the term 'finance' can be used in diverse management practices, such as purchasing health care from non-public providers. From primary observation of the field, it seems that Health Accounts/Finance cell is responsible for the fund management of KHSDRP. The field survey has failed to obtain any publication information which was generated by the Health Accounts/Finance cell.

The project did not continue with the Health Financing Cell, which was the point of contact between the KHSDRP and Suvarna Arogya Suraksha Trust (SAST, a body for managing health assurance and insurance schemes in Karnataka). With the closure of the Health Financing Cell, the capacity building on health economics, health accounts study and other health financing exercises could not also take off (WB AM, 19 – 23 January 2015, p.10).

Quality Assurance (QA) Cell: Quality assurance was an envisaged OD activity in the project planning. The quality assurance pilot had been initiated under the aegis of the Reproductive and Child Health-II (RCH) programme in 2007 to develop a systematic quality improvement of Maternal and Child Health (MCH) related services at the levels of Sub Centre (SC), PHC and Community Health Centre (CHC). The pilot got replicated to ten districts for broadening the scope to establish a state-wide QA cell.

The Bank's IDA consultant had designed a three-pronged approach to scale up the QA programme after drawing lessons from the QA piloting in order to set up the QA cell: Institutional strengthening at the state level, internal quality assessment mechanism at the facility level (only at SC, PHC, CHC and District Hospital), and three different forms (self/supervisory/external) of monitoring based on the standardised Service Quality Index (SQI) (WB AM, October 2009). The motive behind initiating the quality assurance activity was to standardise the accreditation process. The approach was meant only for primary (SC and PHC) and secondary (CHC and District Hospital) levels of care to ensure quality measures and initiate accreditation processes for both

the public and private facilities (WB AM, May 2009). The facility accreditation activity got modified in later years to obtain National Accreditation Board for Hospitals and Healthcare Providers (NABH) accreditation for thirteen district and two *taluk/*block hospitals (WB AM, 16 – 20 April 2012 AM, p. 24). The important point was that the move towards NABH accreditation meant dropping the earlier plan to set up the state-level accreditation mechanism.

The QA cell was not very effective in the original financing phase of the KHSDRP. The Bank's mission report of May 2010 acknowledges that *"QA Cell has not been activated, and no consultant has yet been hired. We expect, however, that this project will see forward progress in the next phase thanks to the PA's vision and excitement for this topic"* (WB AM, May 2010, p. 34). The cell took time to get fully activated despite being created in 2010 (GO: HFW/KHSDRP/PHCF/QAC/16/2009-10, Bangalore, dated: 15.03.10). The Bank's Mid Term Report (MTR) (WB MTR, July 2010, p. 12) points out that the QA cell was not active because of vacant positions, pending trainings and delay in other operational planning. Because of the delayed start of the QA cell, the quality management service at PHC facilities and accreditation for pilot hospitals also did not take place till May 2012 (WB AM, 16 – 20 April 2012, p. 8). The QA emerged as a sub-component under the OD in the additional financing phase to augment the pending activities.

IEC Cell: The project had facilitated to establish an IEC cell/wing to integrate the activities of disease control programmes, NRHM and KHSDRP vide Government Order (HFW/KHSDRP/OD/IEC Wing/ 59/2009-10, Bangalore, Date: 16.04.2010) in 2010. The IEC wing had been created with the responsibilities to coordinate among various programmes/projects (sponsored by central/state/external assistance), educating the mass, capacity building for departmental staff, liaison with the community, and intra/inter-departmental cooperation. IEC wing consisted of Information and Publication Cell, Field Research Cell, Monitoring and Evaluation Cell, Communication and Publicity Cell, Programme and Capacity Building Cell. The project initially also supported five posts of the IEC wing (WB MTR, July 2010).

The DOHFW already had an existing IEC department, but that was not linked to department-wide programmes. KHSDRP was in need of the dissemination and information body to reach out across the programmes and health facilities for

disseminating the service-related changes brought in by the project. KHSDRP utilised the then existing IEC structure by planning an integrated IEC wing, cutting across the programmes. The IEC wing also, like all other cells, took time to become functional.

Health Care Waste Management (HCWM) Cell: The HCWM cell was established (GO, vide no. HFW (PR) 97/WBA/2009, Bangalore, 21/07/2009) to manage the biomedical waste generated at the health facilities as per the Biomedical Waste Handling Rules 2000 by supervising, training, periodic evaluations and management of MIS. The cell was staffed with one state-level DD, two consultants (solid waste and liquid waste) and district-based environment officers (WB AM, 16 – 20 April 2012). The HCWM was initiated under the Bank's Environment Management Plan (EMP). The Bank's MTR (WB MTR, July 2010) finds less involvement of the SPMU and DPMU in executing the EMP. It also objects to the process and impact of the training conducted for managing biomedical waste. This cell later on got more active in the additional financing phase. This research will discuss about the HCWM cell in the later section.

A PPP cell was also created (GO, vide no. HFW/PR/ 45 WBA 2009. Bangalore, Dated: 21.07.2009) by the project to facilitate a number of public private initiatives under the project. Detailed analysis will be given in the subsequent section under the service management component (of innovative financing).

The institutional strengthening activity was mostly limited to creating project executive bodies and establishing of activity-wise cells. The earlier plan of a separate Directorate for Public Health was dropped. It is not clear how the KHSDRP helped in reconstructing the SHIC (State Health Informatics Centre). The project evaluation report done by an external agency on behalf of the state too points out that there was no documentation with regard to the operationalisation of the very centre (ISEC, 2017, p. 118). The formation of the Health Planning Unit (HPU) is not featured in the project monitoring documents. Instead, the DPMU is established in all the districts for micro level planning and execution of the project. The DOHFW's planning department was given the charge to prepare both the PIP and SIP (WB AM, May 2010, p. 26 – 27).

SIHFW revamp was one of the key institutional strengthening agendas of the KHSDRP planning. However, the aide-memoires and the external evaluation report have very inadequate representation of the SIHFW revamp. The strengthening of SIHFW is mentioned as a planned activity without elaborating in much detail on the design and

operational pathway of the revamp in the 2009 May aide-memoire (WB AM, May 2009). Thereafter, two subsequent aide-memoires (WB AM, October 2009; WB AM, May 2010) note that the OD had been given charge as the Technical Support Group to help in revamping the SIHFW, and also implied that it shall be done once the OD consultancy took charge of the execution. It was the same time when the concept of the cell also started emerging in the project. Thereafter, this research is unable to find from field observation and review of the project documents how the OD tried to revamp SIHFW. The end project evaluation report from the state notes that infrastructure expansion of the SIHFW was done under the project but without giving any further details. The evaluation report mentions that the KHSDRP developed the training materials for the SIHFW to conduct the training (ISEC, 2017). It is not clear how infrastructural expansion could alone revamp the training Institute unless its own capacity development takes place at first for preparing training aids and imparting training in new areas.

Administrative tools

The project tried to embark on several administrative tools as a part of health governance reform. As mentioned in the World Bank PAD (WB, 15 July 2006), the project helped in preparing the following tools.

Enactment of law

The project had a similar stint, like other OD activities, with the revision and finalisation of the new Public Health Act. The October 2009 aide-memoire observes that the study on the revision of the Act was not completed for the last two years (WB AM, October 2009). The draft Act consultancy was first given to the National Law School of India University, Bangalore, and accordingly got it developed (WB AM, June 2007, p. 19). However, information from the field reveals that the contract with the Law School got discontinued after nearly two years due to the problem over the mode of payment on the contracted terms. Thereafter, the project roped in the Karnataka Institute of Law and Parliamentary Affairs for reviewing and finalising the draft Public Health Act for putting it before the Legislature in 2009 – 2010 (WB AM, October 2009). The May 2010 aide-memoire notes that the draft Public Health Act was prepared and scheduled for a wider consultation in September 2010 (WB AM, May 2010). The copy of the draft Act could not be obtained despite repeated attempts made to DD-OD.

The GOK's end project external review report notes that the draft report is prepared and facilitated in the development of the Karnataka Health Policy, 2017 (ISEC, 2017). This research finds the entire process of the draft Act preparation is abstruse. The project team (especially, DD-OD) does not have, as reported, even a copy of the draft Act and information on how the draft assisted in the preparation of the new health policy of the state.

Standardisation of the medical and clinical protocols

As per the project plan, the medical and clinical manual had been prepared under the project. The GOK's end evaluation report finds that a medical manual for PHC Medical Officers was developed and accordingly disseminated to orient them at the time of recruitment. The component also developed a standard treatment guideline as a point of reference to treat common diseases, and subsequently disseminated and trained the doctors in public facilities (ISEC, 2017). The question is how, due to the paucity of the MBBS qualified doctors, most of the PHCs are without doctors or manned by doctors (popularly known as AYUSH doctors) trained in any one of the AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy) systems of medicine. It is not clear how the developed medical manual (based on the biomedical modules) would be of help for the AYUSH doctors to run the PHC.

Regulation and Accreditation system

The OD component could not set up the State-level Healthcare Accreditation and Regulatory Authority (as planned in the PIP, September 2005) or any comprehensive accreditation system (designed in the PAD in WB, 15 July 2006) as envisaged in the beginning of the project. The component rather switched to NABH accreditation facilitation for the health care facilities as elaborated earlier. The dropping of the original accreditation activity made the project to compromise with a very important agenda, expansion of service providers from public to private. Private providers are not directly controlled by the state for quality treatment. The proposal of developing state-owned accreditation (as planned in the PIP 2005) was coupled with the regulation factor. The regulation is a mechanism for the state to control the private sector, whereas the accreditation system is an operative tool for the respective mechanisms to work. The failure in not developing the state-owned accreditation system resulted in an imperfect regulation system.

The Bank's PAD design on the comprehensive accreditation system was about an independent body (neither provider nor government) consisting of professional peers to assess the quality and treatment assurance. The PAD's proposal offered a voluntary choice to opt for the accreditation system. That did not compel the hospitals (both public and private) to be accountable to the government, and thus regulation is technically out of the government's ambit. The change in the approach from PIP, 2005 to PAD, 2006 made a distinct difference in the perspective of the GOK's position on hospital accreditation and regulation. The government has become a facilitator or 'motivator' for the hospitals (mostly private) to process accreditation, and not a regulator. The project did not build the capacity of the department to develop the desired skills for assessing accreditation, and instead roped into NABH like an autonomous body. This very tactical move inadvertently turned out to be a competitive condition for the hospitals (public/private) to get an accreditation and not a step towards developing a regulatory mechanism.

Human Resource Development

The project intended to build the public health cadre as recommended by the Task Force on Health, 2001. It was the only recommendation of Task Force that the project showed interest to pursue. As per the GOK's end project evaluation report, the project submitted a report to the DOHFW and based on that, the transfer through counselling mechanism had been evolved (ISEC, 2017). The field research has failed to obtain any document from the OD section (headed by the DD-OD) on the public health cadre formation. The project, especially OD component, had outsourced almost all the technical capacity building activities through consultancy. From an internal file noting, it is found from the Procurement Plan (2007 – 2012) that there was no consultancy service specifically marked for the development of the public health cadre. However, there was a separate consultancy service marked for reviewing the DOHFW's C & R (Cadre and Recruitment) Rules (KHSDRP Office File, 2017). The reviewing of C&R Rules helped the DOHFW in establishing the counselling-based transfer to efficiently manage the human resource allocation (ISEC, 2017).

The above mentioned four administrative tools were necessary for the DOHFW to reorient the health service management. All the tools were interlinked with each other and were collectively responsible to uphold the idea of 'new ways of doing things'. The

initiative of enacting the law and formation of a public health cadre were the examples to strengthen the public system. Similarly, standardisation of care & treatment, and accreditation & regulation system were tried to be initiated mostly for the development of quality care and regulated private health care. The component was meant to create administrative measures for strengthening the public system as well regulating the private system. The inefficient handling of the OD led to failure of the attempt for developing administrative measures. The OD component had tried to outsource the technical work to prepare the administrative tools. The question arises how the capacity of the DOHFW got increased by outsourcing the work.

Capacity building initiatives

The OD component planned to carry out the capacity building exercises by involving various cadres in the government, local representatives and representatives from the private sector for better management of the PPPs. As the project rolled out, the OD component had carried out a comprehensive need assessment study in 2008. The findings of the study suggested five thematic areas that were needed for building capacities: Knowledge management, financial management, human resource management, project management and behavioural change management. These five thematic areas had been processed and developed under two training programmes. The trainings were imparted on 'embedding leadership excellence' (only for doctors) and 'managerial capacity building and attitudinal change' (for paramedical, ministerial staff and Group-D staff) (Indian Institute of Management Bangalore, 2014). A total of 20,875 health personnel were trained under the OD component (ISEC, 2017). In stark contrast to the KHSDP, KHSDRP trainings were mostly behavioural and personality development, and techno-managerial in nature. The OD did not impart any clinical training in the project.

Several agencies were contracted to impart training on the two core training programmes (WB AM, May 2010). The training contents were more or less the same for doctors, paramedical and ministerial staff. The doctors were trained in behavioural changes, workload and team management, multi-tasking, time management, building managerial skills, personal development, stress management and inculcating a positive attitude. Similarly, the paramedical and ministerial staff were trained in developing leadership and management qualities, improving tolerance level, time management,

participation in meetings, promoting effective decision making, improving the ability to delegate the responsibilities, improving team management and improving the understanding of personal roles and responsibilities. Group D (for the posts of sweepers, ambulance drivers, stretcher bearer/ambulance cleaners and other helping staff) cadre were given training for attitudinal changes and etiquette (habits), and clinical cleanliness (hygiene) (ISEC, 2017, p.16).

The KHSDRP conducted two evaluation studies on training. The evaluation conducted by the Deloitte on 'embedding leadership excellence' reports that the training covered 400 doctors in the state. Doctors had reported value addition in their professional as well as personal lives to manoeuvre the PHCs and enhance service quality within the available resources (Deloitte, 2012). IIM Bangalore evaluation also marked a satisfactory rating, and pushed for state-wide training expansion, reorientation of training and filling up of human resource vacancies (Indian Institute of Management Bangalore, 2014). However, it is a matter of operational concern for the project M&E component that the training evaluation was conducted two years after the completion of the activity. That very delay impeded the evaluation assignment from obtaining real-time training related information (Indian Institute of Management Bangalore, 2014).

The project also embarked upon some specialised training activities for health service management. It partnered with the Swasthya Karnataka consortium to initiate techno-managerial training on district health management for block and district levels officers in Tumkur district. The Bank's Mission praised the training and advised that it should continue (WB AM, October 2009; Indian Institute of Management Bangalore, 2014). However, the OD component did not further the partnership despite the Bank's repeated suggestion to the DOHFW KHSDRP team. According to a key informant, the partnership could not be continued even after continuous negotiation with the DOHFW for one and a half years because the concerned agency of the Swasthya Karnataka consortium refused to pay cut money demanded by a corrupt person posted in the Department (Informant 02).

The project also made an effort to send DOHFW's staff in Harvard (twenty one personnel for international short courses) and Asian Institute of Technology, Thailand (eighty nine personnel for hospital management course) to orient the officers on Universal Health Coverage (UHC) and how to provide services in coordination with

the private sector (ISEC, 2017, p.18). Inside the country also, the staff were sent to ASCI in Hyderabad, ESCI, IIHMR and AIIMS for getting trained and to attend workshops (ISEC, 2017, p. 17). The detailed reports regarding these trainings are not available with the project office, as found during the field work.

It is not clear why not the project considered the already established schools of health system studies in India (such as Achuta Menon Centre for Health Science Studies, Tata Institute of Social Sciences, Centre of Social Medicine and Community Health in Jawaharlal Nehru University) for training purpose. For the training abroad, the same logic applies, and the question is why the Asian Institute of Technology, which does not even have any hospital management department till date, was chosen as the training venue.

The training contents raised questions on the objectives and purposes of the training. KHSDRP's main aim was to scale up the utilisation of essential health care services in remote areas and among the vulnerable population by arranging innovative financing and organising new ways of service provisions. Except attitudinal change, no other training themes were pursued in the actual project execution. The training activity dropped two crucial stakeholders as participants of the larger state health service system: Local government representatives and private sector representatives. The absence of these two stakeholders from training activities meant utilisation of a decentralised structure for health service management and collaborative participation for regulation of private sector through accreditation remained unattended. The component was also unable to orient the government and private sector administrators for managing PPP. The distortion of the World Bank's PAD, 2006 recommendation for the training plan confounded the very programme logic of the project which theorised project execution through the utilisation of a decentralisation structure and service expansion by the inclusion of the private sector.

Inclusion of the private sector under the capacity building initiative was a significant planning by the project. However, training for public and private stakeholders for PPP management, building up quality accreditation system, dissemination to all the relevant stakeholders under the OD component were dropped after the restructuring of the project (WB Development Credit Agreement, 16 October, 2006, p.23; WB Restated and Amended Development Credit Agreement, 16 October, 2006, p.22). It is, however,

not clear why private sector capacity building exercise for PPP was dropped after restructuring whereas this was perhaps necessary given the fact that the project wanted to include the private sector for the expansion of service provision. Furthermore, with an attempt to include the private sector, the project might have been in a position to make a direct connection with the private sector.

In the additional financing phase, the OD component furthered the training programmes, such as soft skills, PHC Medical Officers (MO), Standard Treatment Guidelines (STG) and managerial training. The component also continued to extend its support to DOHFW officials for national and international training on diverse areas of health system development topics, including UHC (WB AM, September 2013, p.5). Some of the training activities (like PHC MO training) were slowly transferred to the SIHFW as a part of the sustainability of the training programme. One important finding was that STG training for government doctors in private hospitals had to be dropped because of the non-cooperation from private hospitals (WB AM, 19 – 23 January 2015, p.4). The OD component could not complete the soft-skill training because of the delay in procurement. The training activity was decided to be transferred to the SIHFW (WB AM, 26 September - 04 October 2016, p.4). The project wanted to build the capacity of the DOHFW's human resources through OD, where training was planned to play an important role.

The problem with the implementation of the OD component applied to the training also. Hence, dropping of key stakeholders and themes, and non-completion of the training had occurred. The OD's biggest drawback with regard to the training was the failure of SIHFW's revamp. The project gave infrastructural support to the SIHFW for restoration and renovation work. This research is unable to find any process activity carried out by the OD to enhance the technical capacity of the SIHFW. The KHSDRP span is over; however the question remains that how much SIHFW is capable of to develop the training module and impart the training on its own, especially with regard to the new themes.

M1-C1-A: Quality Assurance (Sub-component in KHSAF)

Quality assurance programme (QAP) was scaled up in the additional financing phase and became an independent sub-component. It started after a piloting conducted in Tumkur district in 2009, and later on expanded to the entire state. Under the additional

financing phase, the QA cell became functional with adequate staffing. The state QA team was active in preparing the service quality index, management manual for quality service, imparting training and data analysis. At the district level, District Quality Assurance Group (DQAG) was formed. DQAG was headed by the Programme Officer (consultant), and filled up with the positions of Block Health Officer and District Health Officer. The group was responsible to train doctors on service quality for PHC, CHC and Block hospitals using Quality Management Service manual (WB AM, September 2013, p. 5 – 6).

The component of quality assurance brought in another yardstick, i.e. NABH accreditation for public hospitals. The project conducted gap analysis for the selected hospitals to list the equipment needed and assess the requirements of civil work/renovation. The project was committed to address those gaps for selected hospitals in order to comply with the NABH accreditation criterion. Four hospitals (K C General Hospital, Bangalore; Tumkur District Hospital, Bijapur District Hospital and Bagalkot District Hospital) were selected for accreditation purpose (WB AM, 26 September – 04 October 2016, p. 9). In the meantime, the NHM (National Health Mission) also started (2015) working on the quality assurance measures in hospitals by implementing the NHSRC (National Health Systems Resource Centre) prescribed quality standards. Hence, the DOHFW, Karnataka decided to obtain entry level NABH accreditation for all the public facilities (WB AM, 19 - 23 January 2015, p. 4). The QA cell later on collaborated with the SHSRC (State Health Systems Resource Centre), Karnataka to prepare the PHC/block hospital/CHC checklists as per the guidelines of the NHM (WB AM, 19 – 23 January 2015, p. 5).

The QA component could not complete the accreditation process for the four selected hospitals. The project outsourced the technical support for accreditation assignment to a consultancy agency (CAHO) based on the logic of work-for-payment mode. However, the contract had to be cancelled mid-way because of the changes that occurred in the implementation of the quality assurance activity (WB AM, 26 September – 04 October 2016, p. 9). At the end of the project, only pre-assessment was done for the selected hospitals. For all other public hospitals, it was decided to accredit them through the Ministry of Health & Family Welfare, GOI's 'Kayakalpa' initiative (WB AM, 26 September – 04 October 2016, p.4). Karnataka later obtained NABH accreditation for two hospitals (ISEC, 2017, p.18).

The original credit of the KHSDRP planned to execute the QA activity through the state level QA cell, though in the additional financing phase, the district-level bodies had to be formed as the accreditation of hospitals became a target for the project. The QA is intrinsically linked to the outcome of service delivery. The entire KHSDRP was mandated by the onus of improving service delivery. Furthermore, the logic to expand the choice of service delivery from public to private was also based on the quality service provision. Still, it is surprising that the project did not carry out any separate evaluation for the QA activity at the end of the project. The QA cell was not integrated into the system; rather, it worked as an independent body that gave support externally.

The above analysis of the OD component presents a grim picture of techno-managerial reform approach. The component aimed to impart management training and handhold on technical specification. The failure of the very component made the project's all other mechanisms and components a challenge.

M1- C2: Improving the Effectiveness of Primary and Secondary Health care Services

As per the World Bank Project Agreement with GOK, the *Panchayati Raj Institution* (PRI) is responsible for this component (WB Project Agreement, 16 October 2006, p. 13 and 14). The second component is a component for the programme approach of the project. Programme approach is the only example where the Bank followed the method of Sector-Wide Approach (SWAp) in implementing the health system project. This component is not a direct support for the project but an additional stimulus for the state's health budget. The Bank earmarked funds of USD 55 million to scale up the state's primary and secondary health care services. The commitment was a direct budget support to the state run programmes and not linked to the KHSDRP implementation financing.

The financing had been carved out from the overall KHSDRP funding under the mode of disburse-in-condition assistance for the government's annual incremental budget support for selected state-sector and district-sector budget line items. The condition was put that the state should increase the budget support more than 5 per cent (after adjusting basic inflation) every year in order to obtain the Bank's financing. The then Mid Term Financial Plan (MTFP) calculated that GOK's annual growth of budget would be 13·45 per cent for the health sector. The project arrived at an estimation that 8·11 per cent of annual budget growth in health would be sufficient for the state to claim the total

commitment reserved by the Bank for programmatic financing support over the five-year period. The fund was planned to be disbursed in 50:50 ratio for the incremented budgetary amount only where both the state and the Bank were expected to contribute equally (WB, 15 July 2006, p.74).

The project restricted the programmatic support to only primary and secondary care services. Also, the fund was not available for Centrally Sponsored Schemes (CSS), Externally Aided Projects (EAP), and tertiary hospitals including medical colleges. In the state health sector budget, PRI system is always given a priority. It drew altogether 35 per cent of the total state's health sector budget in 2007 to manage all the below hundred bed hospitals and other primary health care activities (WB, 15 July 2006, p. 47). Thus indeed the World Bank's programmatic financing support was thought to be a further boost for the state's decentralised governance.

The budget line items which were eligible for programmatic financing kept changing throughout the project period. The number was ten during the design of PIP, 2005 and PAD, 2006. Then it became expanded to forty nine in 2007 (WB AM, June 2007, p. 9). Conversely, the Financial Management Report of KHSDRP (No. IDA 4229/FMR 58/2016-17/September 2016) registers twenty five budget items under the programmatic support for disbursement purpose (KHSDRP Office Information, 2016).

The programmatic support component was a tactic for the Bank to align the KHSDRP with the DOHFW's health policy and service management. According to the Bank's PAD (WB, 15 July 2006, p. 19), the Bank arranged the programmatic support for the state in order to upkeep the Tenth Plan's (2002 – 2007) advice and the positive attitude of the GOI - GOK to increase the health budget for greater coverage of 'public health and primary care services' especially in rural areas. Initially, the project was considered as one of the important sources of funding for the state. However, after the arrival of NRHM (National Rural Health Mission), the funding scenario changed. As per the World Bank's own project document, the KHSDRP got reduced mostly as a support to NRHM (WB, 27 August 2012, p.5). The KHSDRP and NRHM had many common features. The NRHM state-level PIP also acknowledges the same, especially the similarities between Mission Flexible Pool components of NRHM and the SICF component of the KHSDRP. The similarities worked out to strengthen infrastructure, employ manpower, make drugs available and procure equipment support for the state

health service (Karnataka NRHM PIP, 2009). The project's support to the NRHM in Karnataka was an exemplary collaboration in operational management. The M1-C2 component played a crucial tactical role in that operational integration by putting the conditional financing obligation to the state.

The project used the structure of SPMU and DPMU to synchronise the NRHM with the KHSDRP. For example, the District Project Management Officer (DPMO) position was the in-charge of both the NRHM and KHSDRP activity for all the districts (Informant 01). The project head of the NRHM (Mission Director) and KHSDRP (Project Administrator) became the same after the advice of the World Bank mission which took place in December 2006 (WB AM, February 2008, p. 12). District Health Society and later on the District Health Mission were also facilitated as the common bodies to integrate NRHM/NHM with KHSDRP (Informant 01).

The integration between the KHSDRP and NRHM happened at the levels of planning, financing and operation. For example, their integration was of help for to generate additional resources to match the funding contribution from the state side under NRHM and accordingly arrange the financing to plan for the construction of new PHCs/SCs, renovation of CHCs/PHCs/SCs, initiating Mobile Health Clinics (MHC), contracting out PHCs (under the Arogya Bandhu scheme), contracting in specialist and non-clinical services for PHCs (WB AM, February 2008; Karnataka NRHM PIP 2009). From the compilation of several aide-memoires, it is evident that NRHM and KHSDRP shared the responsibility of many service improvement schemes. For example, the funding for a number of MHCs was divided between KHSDRP (fourteen) and NRHM (twelve) in March 2009 (WB AM, May 2009). Similarly, financing of CHDs, strengthening of VHSCs and ARSs were jointly shared by the NRHM and KHSDRP (WB AM, May 2010). For the case of operations, the integration between the two was done through common PIP, such as, the 2009 – 2010 PIP which included service improvement plans for all the districts (WB AM, May 2009, p. 6). At the district level also, SICF's Need Based District Action Plan got merged with the NRHM district PIP to avoid duplication of actions (WB AM, May 2009, p. 14). Therefore the Bank's mission qualifies that over the period, the KHSDRP *"has become part of a larger health system development process under the National Rural Health Mission"* (WB AM, May 2009, p. 3).

The programmatic component was disbursed by 100 per cent of the allocated amount under the KHSDRP (WB AM, January 2013).

The programmatic financing support came with the introduction of administrative measures. The Bank introduced some technical tools to implement as administrative measures in the DOHFW. They were procurement manual, initiation of MTEF and resource envelope, mandatory audit for the district sector and preparation of Financial Management Report (FMR). Those administrative measures were set as preconditions for continuously availing the programmatic financing support during the project years.

Health Sector Procurement Reform Action Plan (HSPRAP): The project initiated the HSPRAP in the department even before the project was finally flagged off. HSPRAP was prepared (on 15 July 2006) for ensuring transparency, competition and efficiency to procure goods, works and services (WB Development Credit Agreement, 16 October, 2006, p. 3). The tools were not easy to implement. For example, several mission visits echoed in the first two years that influencing the Karnataka Drug Logistics and Warehouse Society (KDL&WS) was out of reach for the project. So, the delay was experienced in the development of the Standard Bidding Document (SBD) and procurement manual (based on KTPP Act, 2004), as well as in ensuring drug quality and full functioning of the KDL&WS (WB AM, June 2007; WB AM, February 2008 & WB AM, September – November 2008). However, the Bank made note of those experiences and kept the pressure on to push for the tools to get implemented to ensure transparency in procurement and quality in goods. The conditions put for availing the programmatic support fund made the project get access to the state procurement management system. Both the manual and standard bidding document had been prepared and finally co-opted for drug procurement purpose (ISEC, 2017).

MTEF: The second tool was MTEF to control the DOHFW's budget and expenditure practices. MTEF was introduced to project the overall public sector expenditure (both existing and planned) in health including the budget of DOHFW, Centrally Sponsored Schemes (CSS), and expenditure of some other public entities of the state (WB AM, February 2008). MTEF is the DOHFW's departmental apparatus to coordinate with the MTFP, which is responsible for the overall state budget and fiscal scenario. The MTFP played the role of an innovative apparatus to offer technical guidance for implementing Karnataka's economic reform and at the same time to serve as a performance

monitoring tool for the reform yardsticks. It was introduced by another World Bank project (India - Karnataka Economic Restructuring 1) to overhaul the state's economy (WB, 13 August 2002). The Health Accounts and Financing cell, which was created under the KHSDRP, had become the in-charge of the MTEF activity (WB AM, May 2010).

The MTEF also facilitated devising a mechanism called Resource Envelope. Resource Envelope is a mechanism that trade-offs possible adjustments among the different funds available for health service development, and accordingly prioritises expenditures (WB AM, February 2008). Resource Envelope was a technical improvisation by the Bank to execute the programmatic fund for the common development of health service. As per the funding conditionality, the Bank's programmatic fund was not available for CSS, Externally Aided Projects (EAP) and tertiary care. The co-financing style of health intervention under the NRHM – KHSDRP integration would not have been possible if the Resource Envelope was not in place. The Resource Envelope converted the fund of KHSDRP (only earmarked for programmatic support) to contribution from the state's-side for NRHM (flexible pool) financing requirement. In the initial years of the NRHM, the funding came with 70:30 ratio for the Centre and State respectively. The Bank used programmatic fund to get access to the DOHFW's regular operations by introducing administrative tools as well as secure the opportunity of expanding the reform to get aligned with the NRHM. Concomitantly, the GOK had also got the opportunity to generate additional resources for the state's side of financing under the NRHM. MTEF driven Resource Envelope is an example of the NRHM – KHSDRP coordination at the level of GOK-World Bank planning.

The project also made the DOHFW to initiate mandatory auditing for all the activities conducted by the ZP. The audit certification was regularly done by the Auditor's General Office (WB MTR, July 2010, p. 29). KHSDRP initiated the procurement audit also for the KWDL&WS.

KHSDRP used the programmatic fund support in two ways. First, it made a tactical move to get aligned with the NRHM. Second, the introduction of administrative tools was technical in nature to strengthen the DOHFW's operational management. NRHM's Mission Flexible Financing and KHSDRP's SICF components in many ways were complementing each other as shown earlier. The coordination of NRHM with KHSDRP

was necessary for the project to implement new types of service provisions. KHSDRP introduced a lot of new management practices, an example being the experiment with various models of the PPPs to strengthen the service deliveries. For the KHSDRP, NRHM was the reference point to introduce strengthening measures. That tactic had delivered two benefits for the project. First, the project got access to the core planning and management of the DOHFW by introducing technical (and administrative) tools. Second, the NRHM as well as the DOHFW adopted many innovative practices from the project to expand them further. Hence, the opportunity of the financing from the Bank's side under the programmatic support acted as a bridge between NRHM and KHSDRP for the state.

The programmatic support was not a compulsion for the project to appease the state with an opportunity of meeting the financing shortage, but rather tactically devised to fit in with the project's larger goal. The project was instrumental to reform the health governance and for overall sector development, for which the programmatic support component was a necessity. The Project Development Objectives (PDO) indicators were developed in accordance with the programmatic support which was aiming at overall sector development as envisaged under the MDG. Interestingly, NRHM was launched with a similar view of the achieving health-related MDGs through sector development. Therefore, PDO indicators became the implementation level tracking system for the progress of MDG and NRHM and contribution to the sector development. Thus the *"Achievement of the PDOs is [dependent] not just on project activities but on the sector development program as a whole – to which the project contributes."*(WB AM, May 2010, p.7). This gives the justification why the project initiated programmatic support.

M2: Innovation in Service Delivery and Health Financing

The second mechanism of the project consists of the basics of the project, i.e. reorganisation of the health service for provisions and financing. It had two components. The component M2-C3, service delivery component was looking at the infrastructural and management strengthening for better service provisions (access to and availability of service), and M2-C4 on the innovative way of healthcare financing (affordability).

Three tactics were adopted as approaches to address the targeted population: Infrastructural expansion through capital investment, innovative service delivery schemes through PPPs for both curative and non-curative services and protection from catastrophic health expenditure by introducing health insurance. Interestingly, except capital investment, the other two approaches needed technical inputs to implement the approaches. This is the only mechanism through which the project could directly interact with the beneficiaries/community members. It is important to note that the project theoretically designed these components for delivering the service to the targeted population; however, the techniques (PPPs, insurance) were intended to be introduced for not only delivering the service but also to overhaul the entire health service management. The tactical approaches with technical inputs were the common characteristics of both the components. The components were the first in kind to experiment with innovative service deliveries and financing arrangement in Karnataka.

The M2-C3 component had several sub-components. The service delivery component was designed based on the Vulnerable Community Health Plan (VCHP). Under the erstwhile Karnataka Health System Development Project, a social assessment study took place in 2004. The study was a preliminary step towards the development of the KHSDRP proposal. The study categorised the economically backward, ST and SC population in general, and gave special attention to the women and adolescent girls as vulnerable community.

The assessment report observed that few NGOs were working well in Chamarjanagara and Mysore districts. The 'strategies' practiced by those NGOs had been proposed to replicate in KHSDRP, such as tribal ANM, mobile dispensary unit, stringent monitoring, setting up of local groups and Voluntary Counselling and Testing Centres. For example, Vivekananda Girijana Kalyana Kendra (VGKK) developed and implemented a scheme of preparing adolescent girls for ANM training in tribal and modern medicine, and conducting outreach through mobile dispensary units. The assessment report arrived at three 'strategies' for the practical implementation in KHSDRP which were evolved after conducting a lot of deliberations with the DOHFW and the Bank. They were Tribal ANM training, MHC and nutritional support (IIHMR Bangalore, 2004).

Component three for the KHSDRP was a strategy to reach out to the targeted population. The Vulnerable Communities Health Plan (VCHP) had mapped the guideline to execute the strategy of reaching out to the target population. For example, blocks having more than 25 per cent of SC/ST (Scheduled Casts or Scheduled Tribes) population were selected for Mobile Heath Clinic (MHC) intervention. According to the KHSDRP's VCHP under the Bank's social safeguard plan, the same three strategies of the social assessment report were adopted. Tribal ANM and MHC were designed under the SICF sub-component (M2-C3-A) of service delivery component, and nutritional support was taken under the consideration of PHCF sub-component (M2-C3-B) where district-based NGOs were to participate in a competitive bidding for innovative public health intervention (VCHP, 2005).

M2-C3: To Provide Service Delivery Through Creating/Expanding Government Infrastructure, Using PPPs for Managing the Services and Conducting Outreach

This was the only component which directly dealt with service management in the field. The agenda was to improve the primary care and public health services through developing innovative approaches (WB, 15 July 2006, p. 11). This component had two sub-components. Service Improvement Challenge Fund (SICF), M2-C3-A, was about infrastructural strengthening and service delivery for curative services. Public Health Competitive Fund (PHCF), M2-C3-B, was meant to address the non-curative needs of the communities.

M2-C3-A: Service Improvement Challenge Fund (SICF)

This sub-component had the special fund for service improvement on capital investment and service delivery. The fund arrangement was made available to strengthen the infrastructure of the facilities as well as service improvement for primary care at the districts. The special fund was proposed to be disbursed by embarking on a periodical operational plan document at the block level, named as Service Improvement Plan (SIP). SIP was envisaged as a planning and implementation guidance to ensure the result-based framework. It was in fact thought that SIP preparation would be carried out in consultation with the decentralised structure (*Gram Panchayat* – GPs and ZPs). Thus the Bank's PAD planned it as an initiative of bottom-up approach starting from block level and culminating into the district, state and further integrated with the overall state health sector budget (WB, 15 July 2006, p. 50).

SICF was a financial impetus for planning and implementing the infrastructural expansion and nurturing innovations in service delivery for primary care and public health services. SIP was formulated under the SICF as an operational tactic to make the district technically sound in planning and implementation. It was proposed to be executed in three different phases. In the first phase, all the districts were eligible to propose for infrastructural need, but only a few districts could be selected to start innovative service delivery schemes. The SIP and performance target were planned to be introduced with proper orientation during the first phase of SICF. The second phase was conceptualised as formalisation of SIP in the district planning and implementation operation. All the districts were supposed to include both the infrastructure and innovative service delivery plan in the SIP. In the third phase, the idea was that the districts should have built the capacity to plan their activity not only for KHSDRP but overall district activities to claim the SICF fund. It was decided that the districts that performed well in the first and second phases would be given importance for eligibility of awarding SICF fund in the third phase (WB, 15 July 2006, p. 52 – 53).

The entire SICF fund was planned to be introduced in a phased manner, to formalise and regularise the SIP. The SIP exercise was not limited to KHSDRP, but rather for the entire district health services. It was a technical exercise to pilot innovative models of service delivery for the DOHFW's health service system. Concomitantly, it was an opportunity for all district-level health officers to enhance their skills for planning and implementing activities.

The SIP was operationally linked more to the KHSDRP's programmatic support than the KHSDRP's project activities. It was intended to capture the overall district's planning and implementation scheme where both the programmatic contribution from the KHSDRP and NRHM activities were ongoing. Thus that might be the operational reason why the Bank's mission visit team many a times prodded for integration of SIP with the district NRHM PIP to avoid duplication of activity and fund (WB AM, June 2007 AM & WB AM, February 2008). The SIP was merged with the NRHM PIP under the tool of Need Based Action Planning using the template of NRHM (WB AM, May 2009). All the districts were accordingly trained by contracting outside agencies to prepare the SIP for an integrated KHSDRP – NRHM district action plan (WB MTR, July 2010, p. 30).

Initially, the Bank did not show much interest to accept the NRHM format as a common district action plan template due to the vagueness on the areas of linkage between NRHM template and KHSDRP SIP. The Mission visit team of February 2008 was very clear that *"What should take precedence is not the development of a plan, as an end in of itself, but rather the plan should be understood as a means to improved service delivery"* (WB AM, February 2008, p. 9). Hence, the design of SIP was meant to provide a technical exercise of the implementation and monitoring activities to track the outcomes of intermediary/process/service delivery indicators (WB AM, February 2008, p. 7 – 9). The project turned the SIP to become a supportive tool to coordinate with NRHM and thus lost the operational importance of conducting a technical assessment.

The preparation of SIP was supposed to be considered as the most important 'process activity' in the project since it indirectly became an assessment tool of the system's capacity in planning and execution. The Bank's aide-memoires (except February 2008) and other project documents did not pay the required attention to monitor and evaluate the phase-wise advancement of SIP as designed at the beginning of the project. The project was more keen to merge the SIP with the NRHM PIP without giving due importance to the agenda intended behind the introduction of SIP, i.e. build up an efficient district health planning and implementation resource guidance through the bottoms-up approach. This research is unable to find any independent review of the SIP activity conducted by the project. Furthermore, the KHSDRP Office in Bangalore does not have a single copy of any previous district SIPs. KHSDRP made the SIP orientation another outsourced operational activity, and not a 'means' of system development activity for upgrading technical skills and an 'ends' of system outcome for improved service delivery. Following were the activities performed under the service improvement challenge fund sub-component.

I) Capital investment

SICF was primarily meant for capital investment in infrastructure. Civil works and equipment were the areas for SICF to promote capital investment at the district level. The fund was planned to be used largely for the backward blocks as per the categorisation of Dr. Nanjundappa Committee to build up the infrastructure for the relatively underserved areas (PIP September 2005, p. 13).

Civil works: In the original financing of the KHSDRP, a total of 340 civil works (out of that, 35 PHCs and 152 SCs had been newly constructed) were undertaken. Fifty repair and renovation works were done exclusively for 24x7 model PHCs. Similarly, during the additional financing period, total twenty four civil works (repairs and renovations) were carried out. It is found that Sub Centre (SC) construction took place more in the surplus districts where the requirement was nil and less in the deficit districts. For the case of Primary Health Centre also, more PHCs were constructed in South Karnataka (revenue division, Bangalore - 14 and Mysore - 9) than in North Karnataka region (revenue division, Belgaum - 8 and Gulbarga - 4) (ISEC, 2017).

Table 7.3: Percentage of expenditure for civil work in the original phase of financing in KHSDRP

KHSDRP's Original financing (% of expenditure for civil work)	
Bangalore	30 %
Mysore	23 %
Belgaum	24 %
Gulbarga	23 %

Source: ISEC, 2017

The above table shows the expenditure-wise sharing of civil work construction in the four different revenue divisions in the original period of financing. Gulbarga as a backward revenue division received the lowest expenditure sharing in KHSDRP. Bangalore as a most advanced revenue division attracted the highest percentage (30 per cent) of expenditure sharing (ISEC, 2017). The civil work activity information shows that Dr. Nanjundappa Committee's recommendation was not followed by the project, and it rather went against the logic of addressing regional imbalance by investing more in the developed region. The scarcity of PHC and SC are creating more challenges for the primary level service provider. The AYUSH doctor in-charge of Gurgunta PHC (Lingsugur block of Raichur district) complains that the PHC is catering to a population of 42,000, and its SCs are also covering 10,000 -12,000 population (Dr. Vikram, personal communication, February 9, 2017).

In the additional financing period, the civil work activity was renamed as investment in primary and maternal health care services. The renovation work was mostly about

transforming PHCs into full-time (24x7) Emergency Medical Obstetric Care (EMOC). The project tried to implement monitoring and verification of the construction by contracting an agency though it found that regular monitoring was extremely critical to pursue (WB AM, 19 - 23 January 2015, p.5).

The civil work is the only area where capital investment was made by the project. The disproportionate expenditure for the four revenue divisions shows the unplanned nature of the project execution. In the additional financing period, the project decided to go for a health infrastructure assessment study, but finally dropped the plan due to lack of time for finishing the task (WB AM, 26 September - 04 October 2016, p. 16). A health infrastructure assessment study was probably the first requirement for directing the fund disbursement for civil works, but the project management tried to pursue that at the fag-end of the project. In the additional financing, the project also began with the idea of a green technology model for the renovated/constructed buildings, but finally did not implement the model despite it being designed by the consultancy agency (ISEC, 2017, p.39). The field experience tells us that the civil works department (engineering branch) was not fully integrated with the project, and always served as an external outfit within the department of the DOHFW. The engineering section had been used only as an executive unit for civil work construction and never considered for planning and designing the health infrastructure development in the state.

Equipment

The project through SICF procured equipment for a Drug Testing Laboratory (for the Drug Control department), Food Testing Laboratory (for FSSAI, Karnataka) and Intermediate Regional Laboratory (for the RNTCP). SICF also provided 1,133 computers, UPS and printers to the PHCs (ISEC 2017). The supply of the equipment under the project contributed in the technological upgradation of the health service operations.

This research finds that the KHSDRP team was not adequately responsive to the actual health service system's need for equipment. While it is not denied that the above three laboratories' hardware did have a positive contribution in the service organisation, the project could have reallocated further resources for installation of equipment, especially in the backward areas. Raichur, being a backward district, should have been given a more strategic concentration for capital investment. The Devadurga block (one of the

two most backward blocks in Karnataka) and Lingsugur block (one of the two UHC piloted districts in Karnataka) hospitals of Raichur did not have any USG (ultrasonography) facility at the time of the field visit (Dr. Banadesh – THO Devadurga block hospital, personal communication, February 4, 2017; Dr. Nandakumar – THO Lingsur block hospital, personal communication, February 9, 2017). These block hospitals are the First Referral Units (FRU) and often utilised for pregnancy cases. KHSDRP could have been reallocated the fund saved from PHCF discontinuation to upgrade those facilities serving in the remote areas. These instances question not only the investment rationale, but also the capacity of the project's leadership in planning and management activities.

II) Service delivery (Public Private Partnership models)

The service delivery activity was improvised as innovative service delivery schemes. The activity focussed on the primary and secondary care services to advance towards the health related MDGs, especially in backward blocks. The various innovative service delivery models had the agenda of gaining access to and ensuring availability of the services, especially in remote areas and amongst the vulnerable community.

Under the activity of service delivery, the sub-component (M2-C3-A) planned the following innovative schemes in the beginning of the project (WB, 15 July 2006, p. 11):

a- Continuation of Mobile Health Clinic (MHC) through NGO in underdeveloped blocks
b- Arogya Bandhu (contracting out of *"primary ambulatory care"* (PHC) to private sector)
c- Contracting of specialists in government facilities
d- Private sector engagement for service and support services in public health facilities
e- Launching of Tribal ANM schemes for SC/ST population
f- Incentivisation of physicians and paramedics for retaining government staff in rural areas

The first four activities were linked to the inclusion of the private sector in the service provisions and the last two were tactics were to increase the representation of a skilled workforce in public sector. The contracting of support services was decided to be

implemented through NRHM and thus dropped from the KHSDRP activities (WB AM, June 2007, p. 4). The project adopted a few new innovative activities apart from the planned service delivery activities.

g- Citizen Help Desk (CHD) at the facilities
h- Regional Diagnostic Lab (RDL)

This research attempts to understand the implementation practice of those innovative models of service deliveries. The section below provides details of the innovative models taken up by the project under service delivery activity.

Arogya Bandhu: The practice of contracting out of PHCs had been continued from KHSDP to KHSDRP. KHSDRP continued the scheme as one of the innovative project activities. Contracting out of NGOs to run PHCs started in 2008 under KHSDRP and was taken over by the DOHFW in 2010 to launch as Arogya Bandhu scheme (IIHMR, Bangalore, 2013).

It was a PPP model where the PHCs were contracted out to the private parties to manage the establishment and cater the basic services (enlisted by the government) to the demarcated population. From the very beginning of the KHSDRP, the PPP model of the PHC had been in turmoil. The Bank's initial mission visit notes that the ZPs were hostile to continue with the PPP model of PHC because of poor service delivery and failure of some of the contracted out PHCs. So, the mission assured that rigorous monitoring, an increase of the operational cost reimbursement by the government from 75 per cent to 100 per cent, and competitive selection of the private representatives would address the ZPs' concerns (WB AM, June 2007, p.4).

The Bank was more interested to implement the PPP model of PHCs rather than the DOHFW. The Bank made suggestions time and again during several mission visits to 'reactivate' the PPP model of PHCs. The Bank pointed out that the pre-project preparation design (competitive bidding, agreement based on performance-based partnership and a stringent monitoring framework) needed to be followed for rolling out of PPP on PHCs. It observed in one of the aide-memoires:

"In 2003 – 04 DOHFW contracted out an initial batch of PHCs in an arbitrary manner, with no attention to performance, paying contracted out PHCs 75 percent of the total given to Government PHCs" (WB AM, February 2008, p. 8).

The Bank lamented that due to non-compliance with the preparatory design, the DOHFW developed a "general wisdom" that contracted out PHCs were not efficient enough and therefore not required to be continued. Hence, there were a number of occasions where the Bank pushed for a PPP model in PHC and tried to convince the DOHFW to adhere to the technicalities for a better service outcome (WB AM, June 2007, p.4; WB AM, May 2009, p. 12 & WB AM, May 2010, p. 3).

The government's reluctance might be coming from anxiety over the so called privatisation of the PHCs. One of the Bank aide-memoires clarified that contracting out is not privatisation, which was in fact in practice beforehand, rather it was tapping private resources to work under a performance-based agreement for providing universal free access to primary care services (WB AM, February 2008, p. 8). However, the Bank ultimately decided to stop financing of contracting out of PHCs after the Mid-Term Review in 2010 because of unwillingness of the GOK and reluctance from the PRIs. Nonetheless, in the Bank's opinion, the PPP model did not work since the contracted NGOs were somewhat not provided with adequate management autonomy and flexibility (WB MTR, July 2010, p. 23). This interprets that the DOHFW or specifically the project team at the DOHFW were unable to provide technical assistance to the PPP partners.

Interestingly, the DOHFW took over the scheme in 2010 after the Bank stopped funding the very PPP and launched it as Arogya Bandhu scheme. All the contracted out PHCs (Arogya Bandhu PHC) under the KHSDRP were taken up by the NRHM in association with the DOHFW (WB MTR, July 2010, p. 9 – 11). The evaluation report of the Arogya Bandhu scheme finds that 17.4 per cent of Arogya Bandhu run PHCs' MO-IC (Medical Officer In-charge) were Bachelor of Homeopathic Medicine and Surgery (BHMS)/ Bachelor of Ayurveda, Medicine and Surgery (BAMS) graduates and not MBBS qualified. The report also mentions that Arogya Bandhu pay structure was lower than the average pay structure for all the staff categories in the government set-up. The report finds that government run PHCs' performance was better than that of Arogya Bandhu run PHCs (IIHMR Bangalore, 2013).

It remains unclear why while the Bank stopped the funding for contracting out of PHCs on the ground of DOHFW's objection, the DOHFW again started the scheme on its own. The success of the scheme was contested and widely debated, including in the

popular media. The GOK cancelled the contracts of Arogya Bandhu run PHCs in the first quarter of 2016, citing the reasons of misappropriation of funds, lack of service etcetera. The community perception was also against the scheme as Arogya Bandhu PHCs reported lack of patient satisfaction and service quality compare to the government run PHCs (IIHMR Bangalore, 2013). On the contrary, one of the implementers of the scheme said that the funding was over from the KHSDRP, hence it got stopped. The respondent further informs us that the scheme did not get the government's backing since the earlier Health Minister did not favour Arogya Bandhu. However, the present Health Minister lent it the necessary political support to restart the scheme (Informant 03). Arogya Bandhu was a much-hyped model of PPP not only in Karnataka but also in the entire country. The model was replicated in many other states later on under NRHM. The contestation in regard to the Arogya Bandhu-type model has been going on in the public sphere regarding the efficiency and viability of such a scheme. At the time of the field work, it was found that an internal office memo was being circulated to revive the contracting out of PHC scheme (Arogya Bandhu). With new guidelines, the department has decentralised the scheme at the level of ZP for sanction and approval of the NGO to take over the PHC (Informant 03).

Mobile Health Clinic (MHC): The concept of MHC is bringing primary level of care at the doorstep to the targeted population. It is an outreach based scheme to make the service available and accessible to the vulnerable population in remote, under-served and unreached areas. The scheme was meant for supplementary, preventive, promotive, curative and referral health services for the targeted population (KHSDRP Office File, 2017). It was operational six days in a week. Each unit was ideally staffed with a Medical Officer (MO), ANM, pharmacist and driver to give ambulatory care and execute minor surgery.

MHC service was launched in June 2008 and implemented in a phase-wise expansion till June 2014. The scheme was expanded in five phases. NRHM also joined with the KHSDRP to support the service expansion for two consecutive phases (phase II and III) (KHSDRP Office File, 2017). Mobile Health Clinics (MHC) scheme became the common activity for both the KHSDRP and NRHM by sharing the financing responsibility of MHCs to cover district-wise blocks (WB AM, May 2009, p. 11). The monitoring was done by the taluk/Block Health Officer (THO) and DPMO for block and district levels respectively.

The MHC service had to be stopped because of the legal intervention over the outrage from the NGOs against the reduction of the number of MHC units from 107 to 35 and particularly dropping of the MHC unit in Naragund block (of Gadag district) (Verma, 2015). The scheme was not flawless. The field visit to Raichur district (especially in Lingsugur block) of Karnataka revealed that in many places, MHC was running without doctors and paramedics and even money was asked against services. The two different evaluation reports point out that financial allocation in regard to the staff salary and maintenance expenditure for running the MHC (vehicle, fuel consumption, drugs procurement) were not comparable to the public system (Verma, 2015; IIHMR Bangalore, 2010). That might be one of the causes of concern over the irregularities found during field visits with regard to the functioning of the MHC in the district.

The MHC scheme was no doubt noble and beneficial for the community. The question comes about the implementation of the scheme. The concept behind MHC was to make the service available to the remote/under-served population until any permanent set-up (per se, SC or PHC) was made. The project did not come up with any such transitional plan to replace the MHC service with permanent public facilities accessible to unreached areas. The monitoring of the MHCs was also poor from the project side. In all the five phases of MHC under the KHSDRP (including phase II and III of the NRHM), the service was accessible to only 56 per cent of the population from SC, ST and minorities, and out of that, 36 per cent and 27 per cent were women and children respectively (Verma, 2015). The service was designed for the under-served and unreached population, and almost half of its beneficiaries were from non-backward section. The distribution of MHC units across the four divisions in the state also raises serious field-level operational questions.

Table 7.4: Revenue Division-wise Number of Blocks Covered by MHCs in KHSDRP

Division	No. of Blocks covered by MHCs
Gulbarga	25
Belgaum	37
Mysore	18
Bangalore	27

Source: KHSDRP Office File, 2017

MHC units covered more number of blocks (27) in Bangalore than in Gulbarga (25) division, though North Karnataka had more number of blocks (62) than South Karnataka (45) that were covered by the MHC units. However, percentage-wise, South Karnataka (42 per cent) had a sizable share of the total number of blocks covered by the MHC units compared to North Karnataka (58 per cent). The implementation logic seems not to match the initial planning of the scheme which designed the activity as a stopgap arrangement until the infrastructure got ready to accelerate MDGs by providing basic services for the vulnerable population of under-developed/unreached regions. The distribution of MHC units was uneven and arguably biased too. KHSDRP carried forward the MHC activity in the additional financing, but had to forego it because of the legal challenges after contract signing was deferred several times (WB AM, 19 – 23 January 2015, p.5).

Regional Diagnostic Laboratories (RDL): The project also came up with the proposal of another PPP model to run the seven RDLs, and accordingly got approval from the Bank's mission team during the supervision visit (WB AM, June 2007, p.4). The seven RDLs were formed through the KHSDRP fund and accordingly three of them (Tumkur, Chittradurga and Bagalkot) were planned to contract out to private entities (WB AM, May 2009, p. 12). Four of them were contracted out under the NRHM; however, the Bank's Mid Term Review, 2010 notes that RDLs had become well equipped but lack of specialists made them remain non-functional (WB MTR, July 2010, p.33). The RDL experiment also did not work well. The DOHFW decided not to continue with the contracting out of the RDLs after reviewing the evaluation of two RDLs, and instead shifted the operational responsibility to the District Surgeons (WB AM, September 2013, p. 8).

Citizen Help Desk (CHD): The CHD scheme of PPP came after the commencement of the project. It came as a part of the NRHM activity with an aim to enhance the accessibility of the service by empowering patients' rights and a body of communication to the Arogya Raksha Committee. The initiative was started to assist the patients, mostly from rural areas, where curative service in the 150 and above bed hospitals/ district hospitals was a hindrance for the community to avail. The scheme was rolled out to sensitise the hospital staff to behave well with the patients and investigate complaints received from the patient/patient party regarding any negative issue with the services (WB AM, May 2009, p. 11). CHDs were run by the private

health agencies/NGOs under PPP initiative in two phases from March 2009 to June 2014 (Verma, 2015). The funding assistance was jointly shared by NRHM (for eighteen CHDs) and KHSDRP (for nineteen CHDs) for a total thirty seven CHDs (KHSDRP Office File, 2017). KHSDRP carried forward the CHD activity as a public-private contracting in the additional financing period, but again had to abandon the scheme because of the legal challenges (WB AM, 19 – 23 January 2015, p.5).

The CHD evaluation report shows that the initiative was beneficial for the patients. Nevertheless, the evaluation was not sure about the contribution of the CHD in increasing utilisation of the hospital services since no baseline was done. The evaluation report also validates the finding from the field that lack of trust and coordination between the hospital authorities and CHD indicates that the full confidence of the hospital authority (Super and Medical Doctors) was not obtained at the planning stage. One striking fact is that despite the initiative of CHD, the patients (80 per cent outpatients and 21 per cent inpatients) reported paying money to avail certain services (Ma Foi, 2011). Another end evaluation report highlights that the project monitoring activity never measured the measurable indicators (service improvement related) recommended in the CHD operational guideline to find the effectiveness of the CHDs (Verma, 2015).

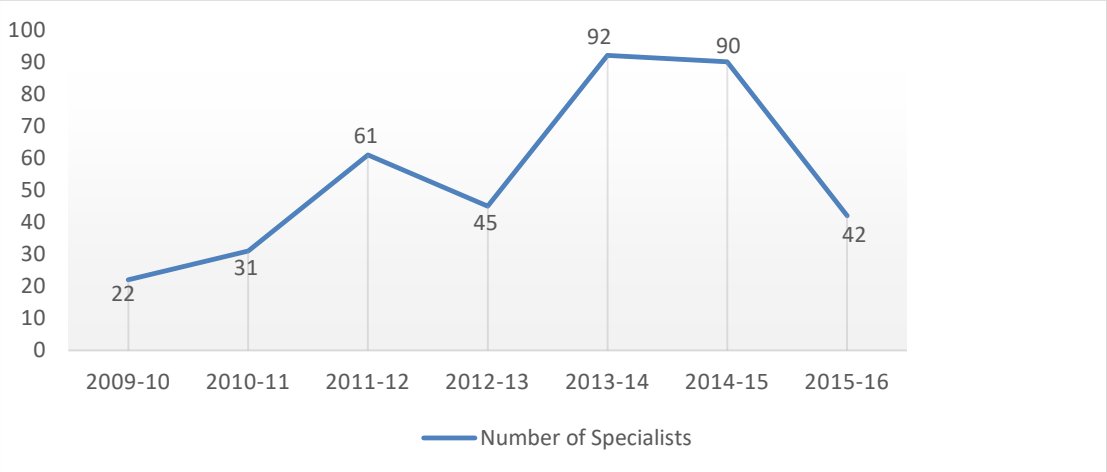
The scheme has drawn ire even from its implementers in the area of programme management. One of the past implementers shared the view that despite the scheme being noble in idea, the operation part was full of challenges because of corruption (such as CHD staffers failing to prevent hospital staff from asking money for services) and lack of coordination from KHSDRP. The KHSDP was just a financer of the scheme; the scheme was operationally interacting with the hospital administration, per se District Surgeon in the case of District Hospital which was often found non-responsive. Hence, the challenges were not addressed either by the KHSDRP or the hospital management (Informant 02). The CHD initiatives, like MHC, had also got stopped because of legal intervention. The project also did not have any transition plan at that point of time to integrate the activity on the lines of DOHFW (Verma, 2015). The scheme was promising to act as a bridge between patients' need and hospital services. The operational challenges (due to poor monitoring) and programmatic obstacles (legal issues, ineffective skill in contract agreement procedure) faced by the

scheme gave scope for further process evaluation to understand how and why such type of PPP model failed to integrate with the government services.

Specialists: Karnataka, like other states in India, has been facing medical human resource crunch for long. Insourcing of specialists was one of the tactical moves (apart from doctors in contract and retainership) to mitigate the challenge of skilled medical resources, especially in rural areas. The project supported the health facilities with sourcing in of non-MCH service related specialists (GO No. HFW/KHSDRP/sect-43/2007-08, dated 2 April, 2008).

The MCH related services (Gynaecology, Anaesthesia and Paediatrics) were covered under NRHM. Under KHSDRP, the non-MCH related specialists were appointed from 2008. The sourcing in of the specialist scheme continued from 2009 to 2016 mostly at the district and block level hospitals and CHCs. The number of specialists varied from year to year (ISEC, 2017). The insourcing study shows that contract in of specialist was extremely helpful. The project did face the crisis of a high attrition rate and often before the end of contract. One interesting finding from the study is that 94 per cent of the contractual appointments were done because of the vacancy of the posts for long (KHSDRP Internal Report, Not Available). This is an example of how government sanctioned posts is not being filled up in the DOHFW and instead converted into contractual positions.

Graph 7.1: No. of specialists financed by the KHSDRP



Source: ISEC, 2017 and KHSDRP Office data base

The table above shows that KHSDRP (both in the original and the additional financing period) supported the specialists from 2009 – 10 to 2015 – 16. The support for

specialists got increased every year, however, the reverse trend is found from 2013 – 14 onwards. The sourcing in of specialists' support had finally been withdrawn after the 2015 – 16 project year.

The above schemes are the innovative experiments carried out under the KHSDRP. Apart from them, KHSDRP also supported the *thai bhagya* scheme of the *chiranjeevi* model for a certain period of time. Under the scheme, both private and public hospitals were given INR 300,000 and INR 150,000 respectively for conducting institutional deliveries (one hundred) of the BPL community (WB AM, May 2009, p. 12).

The project made an amendment to the contract agreement and merged the SICF phase II and III. The service delivery (SICF) activity budget got revised (from 17.8 USD million to 10.8 USD million) because many of the planned activities (many MHCs and all the contracting out PHCs) under the KHSDRP had been shifted to the NRHM (WB MTR, July 2010, p. 9 – 11). This research is unable to find any information regarding the incentivisation of the medical and paramedics, and Tribal ANM initiatives under the project.

A discussion on the status of PPPs

The component M2-C3 had a special operative motive to implement its sub-components. The operational design might use different approaches, but the technique utilised was PPP to organise the service delivery. The service delivery innovation schemes under the SICF had been tried and tested in the PPP mode for gaining hands-on experience. This section gives special importance to the PPP activity carried out in the project.

The innovative service delivery schemes were designed to comply with the agenda of engaging the private sector (under PPP) to enhance essential service deliveries for strengthening rural and remote areas' outreach services (WB, 15 July 2006). PPP played an important part in the SICF as most of the activities were executed using the PPP model. The PPP cell was expected to handle the innovative service delivery schemes (MHC, CHD for district hospitals, sourcing in of specialists, Arogya Bandhu for PHCs, Regional Diagnostic Laboratory etcetera) along with the identification of new PPP opportunities, critical analysis of the existing PPPs, preparing service

agreements, implementation and monitoring of PPPs and the concerns of private sector (WB AM, May 2009, p. 35 – 36).

The creation of PPP cell within the SPMU was extremely vital for the project to get on the new mode of service management. "*The KHSDRP aims at a gradual reorientation of the government's role from one of prime implementer of primary and secondary care, to one of a governing an integrated system with multiple providers delivering care in line with agreed standards and objectives of the services* (WB AM, May 2009, p. 11)."

The strategy behind the PPP cell was to include the private sector in service delivery and prepare the public system for developing regulatory skills. The Bank criticised the delay in creating a PPP cell, which also affected the implementation, monitoring and evaluation of the PPP activities. The problem identified for the delay was that the project was not using the contract agreement document properly for the several PPP models (WB AM, October 2009, p. 5). Apart from the problem with the contract agreement mode, one respondent involved in the KHSDRP mentioned that most of the PPP funding came with 100 per cent support; instead, the costing should have been divided between the government and the PPP implementers in order to generate accountability and responsibility among the private partners (Informant 05).

The entire project's central agenda for health service management was to introduce PPP and make the department familiar with the PPP management. The late establishment of the PPP cell gave an opportunity to raise complaints against the procurement procedure for contracting NGOs to operate schemes like MHC and CHD. The Bank's Mission noted that despite several initiatives running on PPP models, the project was not technically capable to execute the PPP life cycle (planning – procurement – implement - contract management) (WB AM, September 2013, p. 7 – 8). It is surprising that despite holding central importance, the PPP cell was established in 2012, and even thereafter also, the cell took further time to become fully operational (WB AM, September 2013, p. 7). Though it was established in 2012, the cell was facing the problem of unavailability of staff and skilled expertise. Hence, the Bank decided to reactivate the PPP cell by recruiting contractual staff, organising workshops and properly transferred the cell to the DOHFW for larger integration with the department (WB AM, September 2013, p. 7 – 8). However, the difficulty with the PPP cell continued, as neither was it transferred to the department nor properly activated within the project system to

function. The Bank's mission team in 2015 once again voiced the opinion that KHSDRP should initiate a dialogue with the DOHFW in order to reactivate the PPP cell by organising trainings followed by the handing-over of the cell to the DOHFW (WB AM, 19 – 23 January 2015, p. 6).

The KHSDRP was not able to organise and operate the PPP cell as desired. It is clear that after a struggling and unsuccessful time with the PPP cell, the Bank/KHSDRP just wanted to transfer the cell to the DOHFW. PPP cell was anyhow required to shift to the DOHFW because the KHSDRP tenure was near its end, and as per the project's design, all the cells were required to transfer to DOHFW. The transfer of the PPP cell decision was questionable because the cell was sick since the beginning of the project, so what was the point to transfer a 'sick cell' to the department. PPP was a strategic operational instrument of the project with a long term agenda to expand the types of service providers (from public to private). The failure of operationalising the PPP cell and lack of planning on the PPP management had in fact resulted in unsuccessful PPP-based innovative schemes.

M2-C3-B: Public Health Competitive Fund (PHCF)

The second sub-component is another quota of fund which was created for non-curative, public health activities. The fund was open for any government bodies, NGOs or private organisations to work on preventive and promotive health activities in the community, especially belonging to economically backward and underserved areas. The idea was that the fund should be given in a project manner and available to any pertinent public health issue which needed urgent address by involving the community in the district. The fund was not available for any curative services (WB, 15 July 2006, p. 11 – 12). The theory behind the PHCF sub-projects was that the district/block based projects would involve the community in tackling the unaddressed public health activities. The government intervention was already catering to the needs of the preventive and curative aspects of basic health services. The PHCF opportunity was expected to enable the community to improve its capacity in disease prevention and changing social behaviour.

Like all other components, the PHCF sub-components also got a delayed start in the project because of the tardy process of RFP finalisation (WB AM, June 2007, p. 5& WB AM, February 2008, p. 8). The project was unable to rope in the qualified NGOs

which would carry forward the PHCF activities. For example, only two out of 166 NGOs were selected for PHCF works in June 2008 as others were found technically inefficient (WB AM, October 2009, p. 15). The delay in the PHCF contracting made the project leadership to formulate different way-outs to utilise the fund as well as carry forward the intended activities. Three new tactics were adopted: Replacing the process of NGO bidding with district based Anchor NGO selection, allocation of block-wise untied fund, and training support to VHSC and ARS committees.

PHCF switched to the selection based Anchor NGO concept because of the non-availability of technically sound NGOs for competitive bidding. One NGO from each district as Anchor NGO had been identified to work with the District Project Management Unit (within the budget cap of twenty lakhs) to design and implement public health activities (WB AM, October 2009, p. 15). PHCF also extended support by allocating 1.5 lakh as untied fund for each block to organise public health activities in line with the District Action Plan (WB AM, May 2009, p. 16). PHCF also managed to mobilise resources from the project fund to support the NRHM activities by agreeing to co-finance (for some select districts) the training activity for Village Health and Sanitation Committees (VHSC) and PHC based *Arogya Surakshan Samiti* (ARS). The activity was carried out jointly by NRHM and KHSDRP and given to the twenty four NGOs (eight through KHSDRP and sixteen through NRHM) for twenty four districts to strengthen the capacity of VHSCs (total number of capacity built 28,121) and ARSs for efficiently fulfilling their monitoring responsibilities (WB MTR, July 2010, p. 7 and 34). This research finds that training activity of VHSC and ARS is an example of the project's situation-demand adaptability trait. After the scrapping of PHCF sub-projects, the KHSDRP had unspent account on that line, through which the project accommodated the capacity building activity for VHSC and ARS. From the interview, it was found that the actual proposal of training came from the Advisory Group for Community Action (AGCA), NRHM. The AGCA already did a pilot on the capacity building of VHSC and ARS, and pursued the department for scaling up. The KHSDRP came in support by using the PHCF's unspent account route (Informant 03).

The PHCF activity was not successful from the beginning. The competitive tendering of NGOs was not possible, and instead only two contracts were awarded in phase-I of PHCF. The deviation from the original plan was inevitable as the allocated fund was anyhow needed to be utilised and also required to retain the broad intervention outline

(addressing public health needs) drawn during the project preparatory phase. After revising the tactics, the sub-component awarded one-time contracts to forty two NGOs in March 2010 (PHCF phase-II) without any further plan to expand or renew thereafter (WB MTR, July 2010, p. 7 and 12).

The outcome of the PHCF sub-component raised a number of questions regarding the design of the sub-component and then existing capacity of private sector (especially NGOs) to involve in the service delivery at primary level of care. PHCF's design was about fostering innovations through competitions, but after revising the tactics of the sub-components, the agendas of innovations and competitions were lost to the obligation of fund utilisation. The Bank's mission team for KHSDRP initially was not supportive of the very idea of Anchor NGO since it would bypass the original idea of having a competition among the civil society organisations to design innovative public health projects. However, finally, the Bank gave in because of the non-availability of qualified NGOs to implement PHCF activities (WB AM, October 2009, p. 15). The Bank pointed out that the low capacity of 'non-public' sector to fill the gaps in public health service delivery, and ineffective monitoring for measuring performance as well as impact, were a few of the important reasons behind the failure of PHCF (WB MTR, July 2010, p. 34).

The PHCF sub-component was planned to initiate another form of PPP model which was meant to be involved in the primary level of care. The design of the PHCF sub-component was based on the assumption that the private sector would be able to identify and address the gap/challenge through innovations and accordingly contribute in service delivery. The PHCF did not do any need-based district/block-wise profiling of public health challenges; rather, it expected the prospective implementers to take the lead. The project design neither bothered to do the capacity assessment of the private sector at the district/block level nor the gap analysis of public health activities. This flaw in design made the NGOs to duplicate the then ongoing public health intervention run by the DOHFW. This point was once reported in the Bank's Mid Term Review (WB MTR, July 2010, p. 34).

One of the former KHSDP staff during the interview termed PHCF as "*politically benefitted schemes*". The interviewee recounted that a sub-project on the issue of Maternal Mortality Ratio (MMR) reduction under PHCF was granted in such a district

where MMR had always been low in the state. Those sub-projects were available for the NGOs only because of the political network and influence (Informant 01). This information shows that the very tactic of replacing the process of competitive bidding among NGOs with the idea of district-based Anchor NGO selection, in fact, let the 'scheme' to become politically beneficial. This research comes to an understanding that many PHCF projects were awarded as political favours without due consideration of accountability to KHSDRP.

The sub-projects which were financed by the PHCF are similar to the government intervention. The sub-projects were identified by the district authority to address behavioural change and health promotion issues. Following were the issues covered under the PHCF for a total forty four sub-projects (two in phase-I and forty two in phase-II).

Table 7.5: Public health issues addressed through PHCF funding in KHSDRP

Public health Issues (non-curative)	No. of projects
ANC care	7
Control of vector borne diseases, TB, water borne diseases	1
Immunisation service (included with institutional delivery for one project)	9
Malaria, TB and Chikungunya	1
MCH services	7
Primary Health Care Services	12
RCH (included with child nutrition issue for two projects)	4
Reduction in MMR	1
RNTCP	1
TB, HIV, Immunisation and Eye care project	1
Theme-wise project distribution information prepared from the KHSDRP office's softcopy database. Source: Information obtained from the KHSDRP Office during the field work.	

The study is unable to find any meaningful justification from the KHSDRP officials regarding the need of repetitive public health intervention. The above public health issues had been selected without any epidemiological base. Moreover, the PHCF sub-

projects were in line with the government intervention and did not act as gap intervention. For example, Mandya district's MMR is one of the lowest in Karnataka, but still it was selected for the MMR reduction project (Informant 01). Similarly, Shimoga district was selected for ANC issue over Kyasanur Forest Disease (KFD) which has always been a perennial public health challenge and cause of high cases of fatality. The PHCF sub-projects acted as additional, and not supplementary, activities for government-run interventions. The rationale behind the identification of public health issues for contracted out sub-projects also is not clear. The project did not conduct any evaluation for the PHCF sub-projects. The total financial outlay for forty four PHCF sub-projects was INR 816·78 lakhs (WB MTR, July 2010, p. 34). The PHCF sub-projects neither mobilised the community to involve itself in the health service planning nor addressed the original need of the district/block public health services to fill in the gap.

After the Mid-Term Review, the Bank decided to curtail the funding for both the SICF and PHCF. The capital investment (27·6 to 38·5 USD million) activity of SICF was sanctioned to expand further, but not the service delivery (17·8 to 10·8 USD million) part. Many of the PPP schemes (MHC, Arogya Bandhu) under SICF were taken up either partially or fully by the NRHM. Similarly, the PHCF had also been stopped from any further expansion (8·7 USD million to 4·6 USD million) (WB MTR, July 2010, p. 10). The fund, saved from the discontinuation/transfer of the PPP model of various service delivery schemes, and closure of PHCF activities, was reallocated to the capital investment (SICF – civil works) and in the capacity building of organisational development and quality assurance activities (WB MTR, July 2010, p. 9, 10 &12). The project decided to carry out only the then existing SICF service delivery schemes and PHCF sub-projects without any further consideration of expansion.

The KHSDRP's additional financing period had conceptualised four new sub-components under the innovation in service delivery component; Non-Communicable Disease (NCD), road safety and emergency, food safety regulation and health care waste management (WB AM, 16 – 20 April 2012). The health care waste management under the Bank's environmental safeguard plan was initiated under the PHCF sub-component (WB MTR, July 2010, p. 34). However, the HCWM became a separate cell and had an independent in-charge for its activities.

M2-C3-C: Non-communicable Disease Prevention and Control

Keeping the changing disease profile in the background due to the rapid economic growth and urbanisation led lifestyle changes, the NCD component was specially formulated in the additional financing period. It had been designed as a pilot for the prevention, diagnosis and treatment of diabetes, hypertension and cervical cancer. The pilot was done in two districts (Davangere and Dakshina Kannada) at the level of PHCs and CHCs, which were supported with necessary staff and other administrative requirements (WB AM, January 2013, p. 4). Two medical colleges were contracted for imparting training on the implementation part of the component. The operational guidelines included Accredited Social Health Activist (ASHA) incentives, referral pathways, quality assurance and training manuals (WB AM, 19 – 23 January 2015, p. 6).

The pilot had experimented many tactics to make NCD component a success. For example, the project utilised the resource of AYUSH doctors in NCD prevention and control by imparting training and building up referral practices (WB AM, 19 – 23 January 2015, p. 6 – 7). The reason behind this was that the PHCs and CHCs had always been lacking MBBS qualified doctors and thus AYUSH doctors were introduced as in-charge of those facilities on 'against-MBBS' post. Hence, the project wanted to tap the AYUSH resource for screening and testing of NCDs. The sub-component also made efforts to modify the then existing HMIS to incorporate NCD information. The sub-component meant to link the NCD with the Suvarna Arogya Suraksha Trust (SAST) for establishing referral linkages to facilitate the need for care (WB AM, 19 – 23 January 2015, p. 6 – 7).

At the end of the KHSDRP, it was found that the number of screenings for hypertension, diabetes and cervical cancer (CaCx) got increased (WB AM, 27 February – 04 March 2017, p. 4). The pilot was designed to intensify the number of screening and testing. The hiring of IEC agency for awareness generation, incentivisation of ASHA for encouraging households (enumerated) to go for screening are examples of the effort to reach out to the community for screening and testing. The mission team notes during the supervisory visit that incentivisation of ASHA helped in increasing the number of the screenings (WB AM, 26 September – 04 October 2016, p.5).

Community mobilisation through ASHA for enhancing the screening number is an important tactical move by the NCD component. The mission visit report notes that incentivisation practice would be continued with the support of the NHM funding. The last supervisory mission visit notes that the National Program for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS), a component of NHM, was expected to roll-out as a state-wide pilot under the NHM. Hence, it was decided to hand over the resources as well as share the experience of the NCD component with the planned NPCDCS pilot (WB AM, 27 February – 04 March 2017, p.4).

M2-C3-D: Road Safety and Emergency Health Services

The growing burden of road traffic injuries made the project to devise a road safety component in the additional financing period. KHSDRP in coordination with the Karnataka State Highways Improvement Project (KSHIP, a World Bank funded project) planned to pilot two highway corridors (Maddur to Mysore and Belgaum to Hunagund) for creating safe corridor strategies to address the emergency of road fatalities and injuries (WB AM, January 2013, p. 3). The component mostly worked on the pre-hospital (urgent attention and transportation), during hospital (facility upgradation of trauma care and skill building of the existing and appointed workforce) and post-hospital (rehabilitation) services (ISEC, 2017, p. 87). The sub-component helped in the procurement of 150 ambulances under the project's Arogya Kavacha scheme (PGB meeting proceedings, 2017, p.7).

The commencement of the road safety sub-component was very slow in the project for the initial two years (2012 – 13 and 2013 – 14) (WB AM, September 2013, p. 9 &WB AM, June 2014, p. 10). The component prepared 'Essential Standards for Trauma Care' for various levels of hospitals and imparted training on advanced and basic trauma care. The road safety component was tried to be linked with the SAST for financing of care for the road traffic accident victims under the government's sponsored trauma care services (supported by the KHSDRP) and for including into the information management system. This research has failed to understand what form of coordination the KHSDRP had aspired for and finally what actually materialised with the KSHIP. At the time of its conceptualisation in 2012, the coordination between the KHSDRP and KSHIP was envisaged as the support from KSHIP on road design, police

management and communication campaigns (WB AM, 16 – 20 April 2012, p. 4). The coordination was tried with the KSHIP for carrying out the civil works (preparing the state highway) in one of the agreed safety corridors. The KHSDRP mission team notes that the coordination with the KSHIP was difficult and because of that, civil works became pending (WB AM, 19 – 23 January 2015, p. 8 – 9). This research did not get any reliable information regarding the completion of the pending work and any tangible achievement of the coordination. The road safety cell was created by the transport department after the closure of the project, and DD – Road Safety in KHSDRP was co-opted from the DOHFW (WB, 19 January 2018, p. 19).

The entire emergency medical service in Karnataka was run in PPP mode since 2008 when the GOK entered into an agreement with GVK-EMRI (Yasmeen, 2017). The World Bank end evaluation report claimed that the PPP was supported by the KHSDRP and noted as a successful initiative of private sector mobilisation (WB, 19 January 2018, p.25). Though the DOHFW, GOK terminated the PPP contract in the end of 2017 citing the incapacity of the GVK-EMRI to fulfil the management technicalities as mentioned in the MOU, and also intentionally taking the patients to private hospitals instead of public facilities even when the treatment was available in the case of the latter. The DD –EMRI even accused the GVK-EMRI for submitting spurious claims (Yasmeen, 2017). The DOHFW is currently running the 108 service (emergency response) on its own.

This research has observed the handling of one emergency case in the Lingsugur block hospital of Raichur district during the field visit. Following is the case summary:

Box No. 7.1: RTA Emergency Health Service

Emergency Patient ID No.: 593314
Caller No.:8123751537
Date: 9 February 2017
Hospital: Lingsugur Block Hospital, Raichur
Case's reporting to the hospital: 4:30 PM
Doctors arrived: 5:15 PM
EMRI received the call: 5:21 PM
108 ambulance arrived at the hospital premises: 5:33 PM
Ambulance left the hospital premises with the patient: 5:45 PM
Referred to: Raichur Institute of Medical Science

The above road traffic accident case proves that emergency service and hospital medical service is required to be in coordination. The 108 ambulance service is running in the entire Karnataka since 2008, but despite that, the communication took 51 minutes to reach emergency service operator. Similarly, it is the utter failure of the hospital management that an emergency case was deprived from getting doctor's service for about forty five minutes. The staff nurse and OT boys attended the patient first. The question is why the doctor was late, and what the other hospital staff were doing even after seeing the emergency case screaming helplessly inside the emergency ward.[97] The Bank's pilot on the emergency service sub-component did little to understand and address the coordination gap between the emergency service team and the medical service team in hospital.

The piloting of road safety is probably the poorest sub-component executed ever in KHSDRP. The pilot took almost two years to start and thereafter, it faced the closure of the project within a year. Once the Bank's aide-memoire mentions that the international experience shows a system approach is needed to address the road emergencies. For example, it requires planning and management, improved infrastructure, safer vehicles, improved law enforcement, road user behaviour change, and post-accident emergency health care service (WB AM, 16 – 20 April 2012, p. 4). This research is unable to track from any primary and secondary documents how the system approach was followed to address the road safety concerns.

The pilot initiative was mostly about equipped the medical care system by providing ambulance, upgrading the OT in tertiary set-up, and making the skilled resources available. So, the initiative was about emergency health service and not road safety. Road safety needs public health approach by taking a multidisciplinary perspective from amendment of motor vehicle act to constitution of up-to-date traffic management board (Gopalakrishnan, 2012, p.149). Instead of taking any public health approach, the pilot implementation was done to repeat the traditional understanding where human error is identified as cause. The piloting did not work on the preparation of strategies for the prevention of road traffic accidents. This research is unsure whether the sub-

[97] This researcher came to know about the emergency case while he was in a meeting with the THO at the THO office, and reached the emergency ward at around 5:00 PM. The information details gathered from discussion with the hospital staff, other patient party, researcher's own observation and the GVK-EMRI ambulance manager (Mr. Nagraj).

component was introduced to test the efficacy of the pilot or oblige the compulsion of fund utilisation.

The KHSDRP prepared Environment Management Plan (EMP) at the beginning of the project along with the minimum standards for the construction of new PHCs (EMP, 2005). Health Care Waste Management (HCWM) was considered as an important component for the project in the original credit agreement of the KHSDRP. In addition, the food safety component was also included under the environmental safeguard during the additional financing phase. These two components are different from other piloting components developed in the additional financing. They were designed as full-scale intervention components for strengthening the system.

M2-C3-E: Food Safety

The food safety sub-component was planned at the beginning of 2012. Like all other project components, its full operation also got delayed. The food safety cell was established in 2013, and became fully functional in 2014 after filling up the vacant positions. Food safety cell was established within the Public Health Institute in DOHFW. The sub-component was designed to be implemented with two different approaches for urban and rural areas. Baseline survey for mapping food business units and food safety environment in eight municipalities were planned to be undertaken with the support of the urban local bodies. The VHSCs were decided to be utilised as a resource for ensuring food safety in rural areas (WB AM, January 2013, p. 5).

The sub-component helped in establishing and restoring four State Food Safety Laboratories (Bangalore, Mysore, Gulbarga and Belgaum) with equipment support and skilled human resources (WB AM, September 2013, p. 11 &WB AM, June 2014, p. 12). The component also facilitated the capacity building of the technical as well as administrative resources (ISEC, 2017, p. 32).

Food safety was not a typical pilot testing component like the other innovative components which were implemented in the additional financing period. The component was an effort to expand the health service system boundary by involving the food safety measures. It became an important tool to strengthen the Food Safety and Standards Act, 2006 and the Food Safety Rules and Regulations, 2011. It was also an

example how the KHSDRP extended (especially in the additional financing period) its support for intersectoral collaboration. The food safety cell is now under the DOHFW.

The agenda behind the creation of the food safety cell was to mainstream the food safety in DOHFW and strengthen the public health measures. Hence, it was expected that the sub-component would be strong enough in coordinating with the other departments (like civic bodies) and establish linkages. The sub-component failed to complete the baseline survey in municipalities for mapping business units and the food safety environment (WB AM, 19 – 23 January 2015, p.10). The sub-component also did not take any measure or design any plan for ensuring food safety standards in rural areas. Local bodies (municipalities/panchayats) or community collectives (VHSC) are the most important stakeholders to implement food safety measures. The dropping of the baseline survey or not involving VHSCs meant that the project (and DOHFW) had lost the opportunity to build up intersectorality with the local administrative bodies or was unable to utilise the grass-root health bodies (VHSC).

The sub-component also failed to negotiate with the government in terms of fulfilling the vacancies for food safety officers. The state had 164 vacancies of food safety officers in 2014, and the number got reduced to just 155 in 2016 (WB AM, June 2014, p. 28 & ISEC, 2017, p. 32). The food safety cell was a technical requirement for the DOHFW, especially after the enactment of Food Safety and Standards Act, 2006 and the Food Safety Rules and Regulations, 2011. The food safety sub-component was indeed a help by offering one-time infrastructural related support. But ensuring food safety measures needs a continuous coordination and technically enhanced resource network. The component did not fulfil its role to uplift intersectorality.

M2-C3-F: Health Care Waste Management (HCWM)

HCWM was designed and started operating for implementation during the original credit of the KHSDRP. It is important to note that though the KHSDRP designed the EMP at the beginning of the project, still the project failed to comply with the basic requirements (appointing key personnel, training and external audit) for the initial two years in order to implement the EMP. In view of that, the Bank's mission team decided to activate a HCWM cell in the Directorate (WB AM, May 2009, p.23). The fully functional HCWM cell was the result of an ardent desire to comply with the EMP, but

the slow execution of the component made the EMP remain a not-so-active plan in the original period of financing in KHSDRP.

The HCWM plan was executed in different levels of health facilities by appointing a State Nodal Environmental Officer (one) along with District Nodal Environmental Officers (thirty) to implement solid bio-medical waste (disposing wastes into the deep burial pit and a sharp pit at the hospital, and also contracting with a private firm for Common Treatment Facilities - CTF) and liquid biomedical waste (construction of disinfection unit inside the facilities) management (KHSDRP Office File, 2017).

The HCWM cell was established by the project with the responsibilities to supervise all government facilities to comply with the Biomedical Waste Management Handling Rules 2000, and implementing biomedical waste management in all the facilities (DH/BH/CHC/PHC/SC). The cell was expected to impart training, conduct evaluations and maintain MIS about HCWM for all the facilities (WB AM, 16 – 20 April 2012, p.23).

The project had initiated a quarterly trend analysis of the Health Care Facilities on HCWM to track the improvement of the HCWM, and the result was positive. The project, in association with the NRHM, effectively installed a solid and liquid biomedical waste management system for all the PHCs (2185) and the District Hospitals (17), and for most of the Block Hospitals (146 for liquid waste and 142 for solid waste) and Community Health Centres (182 for liquid waste and 173 for solid waste) (WB AM, September 2013, p. 26). A total 2,325 doctors, 6,646 staff nurses/pharmacists/ANM/health assistants and 3,274 Group D staff were imparted the HCWM training (WB AM, September 2013, p. 10). The component also helped in procuring mercury-free equipment (less hazardous) and personal protective equipment for Group D workers to provide safety from hazardous health care wastes (WB AM, 26 September – 04 October 2016, p. 12). Karnataka has become the first state to practice mercury-free equipment and the setting up of Liquid Disinfection Unit across all levels of the facilities (WB AM, 27 February – 04 March 2017, p.5).

As per the suggestion of the Bank's Mission (WB AM October 2016, pp. 7), the HCWM cell had been transferred to the DOHFW at the end of the project for mainstreaming in the DOHFW.

M2-C4: Innovations in Health Financing

The M2-C4 component of mechanism two was experimenting with the health financing approach to protect the poor from catastrophic health expenditure. The project had planned to implement a health insurance pilot in line with the GOI's Universal Health Insurance Scheme (UHIS) that was launched in 2003. Karnataka, at that point of time, was running small-scale health coverage schemes (if not, they were fully demarcated as health insurance). Among them, noticeably, were Yeshashvini (for members of milk cooperatives) and a few other schemes involving NGOs, societies and private hospitals. The KHSDRP decided to design a health insurance pilot primarily for the rural population to effectively reach out to the poor and make the scheme financially viable and sustainable (WB, 15 July 2006, p. 55 – 56).

The initial project design as per the project contract envisaged the pilot as a stepping stone to test the insurance approaches (different packages, subsidies), document the practice, monitor and evaluate the success of the piloting (WB Development Credit Agreement, 16 October, 2006, p. 24). The KHSDRP, under the technical and financial support of the Bank, had established the Suvarna Arogya Suraksha Trust (SAST) in 2009 (vide GO No. HFW 216 CGE 2008, Bangalore dated 20 February 2009). Accordingly, the KHSDRP contract agreement had been amended in 2010 after conducting the Mid Term Review. The amended project document for the first time outlined the role of the SAST, which was to manage the innovative health financing component (WB Restated and Amended Development Credit Agreement, 16 October, 2006, p. 16). SAST was formed as a special purpose vehicle to implement the Suvarna Arogya Suraksha Health scheme. The formation cost of the SAST, health insurance pilot and initial two years of office expenditure were decided to be funded by the KHSDRP (WB AM, October 2009, p. 7).

The component commenced with the contract initiation with a consultancy firm to carry out the household needs assessment and provider facilities' survey. Simultaneously, the Bank offered technical assistance for initiating a health insurance pilot proposal (WB AM, June 2007, p. 6). Like all other activities, the Bank's aide-memoire notes that except a household survey on health insurance, all other activities got stopped from August 2007 because of the change in the Project Administrator's viewpoint (WB AM, February 2008, p. 9). The Bank had a special stake in SAST since additional resources

(manpower and funds) had been invested using the M2-C4 component from the beginning. Initially, the GOK wanted to expand the insurance by building on the then existing Yeshaswini scheme instead of starting any other independent scheme. However, the Bank was not interested to pursue the idea because of the Yeshaswini's low financial protection and limited disease coverage. Furthermore, the Bank's mission was in favour of the insurance company model since the independent trust (like Yeshawini) based operative model carries the risk of a high level of financial liability for the government (WB AM, February 2008, p. 9 – 10).

The health insurance scheme first started in the entire Gulbarga division (the small piloting was also done there) in a phased manner in 2010. It developed the service package and costing for a total 402 procedures (WB AM, May 2010, p.37). The scheme was named as Vajpayee Arogyashree Scheme (VAS), and based on the model of Andhra Pradesh's Rajiv Arogyashree Scheme, though the financing terms were different for both the schemes. Rajiv Arogyashree is an insurance-based premium model whereas VAS is an assurance based purchasing model. In this regard, the Bank's supervisory mission visit cautioned that SAST had to be well prepared and technically capable enough to handle such a scheme since the Rajiv Arogyashree outsources the risk and administrative tasks to the insurer, but SAST on behalf of the VAS is bearing all the responsibility and controls the operational management (WB AM, May 2010, p. 37). Hence, the VAS like scheme was designed to operate under the assistance of SAST. It is necessary to mention that SAST was (and is) the nodal agency for strategic purchase model of service delivery. KHSDRP utilised SAST to mediate the service provisions of VAS cases. Though SAST was (and is) a service delivery instrument, as argued in the chapter three, in this section both SAST and VAS (as a financing tool) are discussed together since both of them were referred under same financing component (M2-C2) in Bank's aide memoires and other official documents.

The VAS like scheme has been designed to move the state towards an insurance arrangement for service provision. The move got both political and policy support. The state political leadership was enthused by the popularity of the Arogayshree scheme in Andhra Pradesh, and wanted a replication (WB MTR, July 2010, p. 40). The GOK's most influential budgetary tool, MTFP for the Financial Years of 2007 – 2011, encouraged the government to introspect the prospect of an insurance-based health care financing since that alternative model of service delivery, especially for the poor, has

the potential to bring competition in between public and private hospitals and enhance service quality (GOK Finance MTFP, 2007, p. 18).

The VAS is a health protection scheme available to the BPL households for tertiary care. It is the biggest health assurance scheme at this time in Karnataka, and was started under the support of KHSDRP. The scheme covered at the time of launch 400 procedures for seven major diseases (cardiovascular, cancer, neurosurgery, renal, burns, pediatric surgery, and polytrauma) with fixed package prices (WB MTR, July 2010, p. 7 – 8). The services are purchased and arranged through empanelled private hospitals. The government hospitals also participate in offering treatment to the VAS patients, though the patient turnout in government hospitals is usually very low.

The Bank wanted to establish an insurance-based health protection scheme through this component. The Bank's MTR (WB MTR, July 2010, p. 38 – 39) notes that the changes in the political, project and Bank leadership between 2007 and 2009/10 modified the preliminary concept of the insurance pilot and also led to an operational interruption. The operative model of the insurance got changed into an assurance-based scheme. SAST, from the beginning, has always been running the VAS on an assurance mode without the pooling of any premium, the core of insurance logic. However, the Bank still considered SAST as an "*insurance agency*" of the government for managing the VAS (WB AM, May 2010, p. 4). The Bank justified the operative changes by claiming that the component was still part of the 'project' funding and not a 'programmatic' support. It also cited that the component's activity was primarily the activity of health insurance since the SAST, and not the government, is reimbursing the empanelled hospitals (WB MTR, July 2010, p. 40).

The Bank used the component not only for initiating VAS; rather, VAS was a secondary operative agenda for the KHSDRP. The component's primary task was to set up a system that can execute the insurance model of health care financing as well as service provision in the long run. The Bank has set-up milestones in order to establish and fully functionalise the SAST. A total of seven milestones were there. The milestones were linked to the fund disbursement. Each milestone had dedicated tasks. The milestones were designed to build the SAST administrative and executive capacity to handle the VAS like schemes. Milestones' tasks were staff recruitment, vendor selection, installation of software system, carry out impact assessment etcetera (WB MTR, July

2010, p. 41 – 42). The milestone specific fund release was tactically a good move as it outlined the preparation details in advance for SAST to meet the compliances. In the additional phase of financing (KHSAF) also, the milestone specific fund disbursement tactic continued. The component had got an extension for the additional financing period in KHSDRP. In the additional financing period, the component provided claim-based reimbursement support, which was again linked to the milestone specific implementation activities (WB AM, 16 – 20 April 2012, p. 4).

VAS has been operational by the SAST since 2010, but on a low scale during the original credit period. The additional period accelerated the component by introducing "P4R" (Pay for Results) tactic. The World Bank set the target for non-negotiable Tranche Milestones for SAST to achieve the designated milestone results. In turn, the SAST was paid for the reimbursement of claims to the network hospital up to a certain extent (SAST, 2016). The P4R was used as a tool with an aim to uphold SAST as a model institute for effectively managing the health assurance scheme.

In the additional financing period, a total eleven tranche milestones were set to be executed over three phases. For the first and second phases, the tranches were institutional building, stakeholder capacity enhancement, efficient IT system, standardising the quality treatment protocols and implementing STGs, cardiac follow-up care, grievance redressal mechanism, and incentivising government hospitals for participating in the 'strategic PPP'. In the third phase, tranches were linked to the GOK's Good Samaritan Road Traffic Accident Scheme to identify and strengthen emergency care services (SAST, 2016).These tranche-based milestones were the conditional financing from the Bank's side. This was the only financing pattern where the project followed result-based financing in the additional financing period. The World Bank was reimbursing the claims of VAS beneficiaries only, so in that way the KHSDRP never had any legal programmatic leverage on the SAST. SAST has always been a technical agency of the GOK. The KHSDRP had utilised the VAS financing as a tactical opportunity to influence the SAST whereas tranche-based milestones were improvised as techniques to strengthen and make SAST sustainable. Both the tactics and techniques were performed under the clause of conditional funding. The World Bank wanted to build the SAST as an effective operating model for running a health

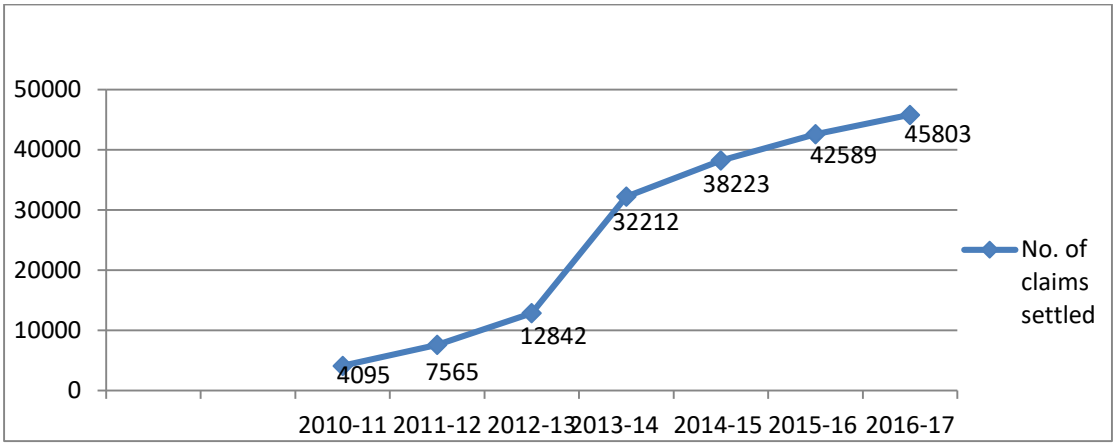
insurance/assurance scheme and showcased "….*as a testimony for other states to follow*" (SAST, 2016).

Under the additional financing period, the VAS scheme gradually expanded to the entire state and health camps also were made bimonthly. The core KHSDRP team had little to do with the VAS implementation. The project was linked to the VAS only through the Health Financing and Accounting Cell (WB AM, January 2013, p. 6). The KHSDRP was a point of contact for VAS to only settle the claim reimbursements. The VAS scheme has always been fully operated and supervised by the SAST. The operational activity of SAST got speeded up after the commencement of the additional financing period. In fact, the SAST, at one point of time in 2013, was implementing different tranches (third and fourth tranches of original credit and first tranche of additional financing) simultaneously from both the original and additional financing period respectively (WB AM, September 2013, p. 12).

The health financing component had primarily acted upon the SAST to strengthen the institutional mechanism for achieving sustainability, and the reimbursement of the VAS claims was secondary from the project side. Apart from the VAS operation, two other state-funded schemes (Rajiv Arogya Bhagya for APL population and Jyoti Sanjeevani for government employees) had been added to the SAST in the years of 2014 – 15 and 2015 – 16. With the addition of the two other schemes, the Bank mission in 2015 claimed that the state had stepped into the provision of universal coverage to the entire state for identified diseases (WB AM, 19 – 23 January 2015, p. 10). SAST also successfully empanelled the hospitals for providing emergency services to road traffic accident cases (WB AM, 26 September – 04 October 2016, p.6).

Till the end of the project, the KHSDRP supported a total 183,329 claims for reimbursement under the VAS. In the year of 2010 - 11, the number of claims was 4,095. The number got increased by every year. In the last year of the project, the number of claims escalated to 45,803.

Graph 7.2: No. of claims settled in VAS through KHSDRP



Source: SAST Office (Shathinagar, Bangalore), primary data collected on 15.05.2017

The project made the SAST to almost be on target in terms of achieving the tranche-based milestones during the additional financing period. At the end of the project, the SAST has become the sole implementation agency for all the government sponsored health insurance schemes, and that makes it a possibility for the schemes to get consolidated in future. SAST had also been given the responsibility to assist the union government and other states in operationalising the then proposed pan-India National Health Protection Scheme (NHPS)/ *Pradhan Mantri Jan Arogya Yojana* (PMPJAY) of Ayushman Bharat (WB AM, 27 February – 04 March 2017, p. 1 – 2). The NHPS is rechristened as

M3: Project Management, Monitoring and Evaluation

The third mechanism was a support to strengthen the project's technical competency and efficiency. The mechanism was expected to help in the formation and execution of SPMU, DPMUs and other institutional bodies under the project. This was the only mechanism which directly served as a component also. This mechanism was responsible for strengthening the efficiency of all other components (and sub-components) in the project. It was planned for management, Monitoring and Evaluation (M&E) of the project's on going activities.

The mechanism was in charge of setting up the project management resources (such as recruitment, purchasing assets etcetera). The SPMU and DPMUs were technically part of this mechanism. The mechanism had a special task to form a State Health Informatics Centre (SHIC) and develop a new Health Information Management System (HMIS),

especially to focus on public health, primary and secondary care services. SHIC and HMIS were two important monitoring tools the project planned to introduce. Apart from the creation of the information architectural system and institutional bodies, the mechanisms were also supposed to deal with technical issues like conducting evaluation (baseline, mid-line and end-line) for household and facility survey, managing procurement and financial execution, human resource management, office equipment and incremental operating costs (WB, 15 July 2006, p. 57). The project had so much of technical specifications that a dedicated management, monitoring and evaluation mechanism was perhaps the need. It was indeed a good strategy for the project to conceptualise the very mechanism.

The project planning gave HMIS a special importance for strengthening the referral system between the three levels of care, and cover both the field-based programmes and facility specific information at the district level. The initial planning of HMIS was indeed holistic to supply both the field and facility information. The HMIS information is not only meant for regular monitoring purpose. *"The project was to establish a new integrated HMIS for the department and undertake population level surveys to assess effectiveness and impact of sector investments."* (WB MTR, July 2010, p. 24). The HMIS design was conceptualised at first as a district-based pilot in phases to scale up further for the entire state. The then existing disease-specific monitoring system and other IT systems were also planned to integrate with the HMIS (WB, 15 July 2006, p. 58).

The project execution got halted and delayed for several reasons. The commencement of the project was late by six months and thus the establishment of the SMPU and DPMUs also got delayed. The HMIS activity had to face many administrative snags too. For example, despite the creation of a separate Task Force on HMIS, the project could not follow the recommendations of the Task Force due to the ignorance of the then project leadership. In consequence, the HMIS development got stuck in 2007. The HMIS development plan became an important factor after the change in the then current leadership (PA- KHSDRP) in 2008 (WB AM, February 2008, p. 11).

HMIS remained the central agenda of the mechanism number three. By the first half of 2009, the hospital-based information of HMIS switched to a web-based application system where all the district hospitals and CHCs started uploading the data. Meanwhile,

the DOHFW adopted the District Health Information System (DHIS, version: II) to report all field-based activities including those under NRHM. However, the Bank mission notes that despite the HMIS and DHIS being rolled out, the system's outcome was not very effective to make decisions because of a lack of quality data and the validity issue (WB AM, May 2009, p. 9). The original plan of developing an integrated field and facility based HMIS finally got divided into hospital-based MIS and DIHS-II database for field information. Both the information systems were web-based. The National Informatics Centre helped in developing the hospital-based MIS (WB AM, October 2009, p.5). The HMIS wing was finally merged with the M&E cell of the DOH&FW (Demography department) (WB AM, May 2010, p. 27). The HMIS became the DOHFW's own management assessing tool for planning and data mining activity. On the other hand, the support for the State Health Informatics Centre (SHIC) was not followed up by the project since the state received financial support from other sources to set up the SHIC (WB, 19 January 2018, p. 13).

In the additional financing period, the project continued with the funding of the state and district level management units, and other planned evaluation activities. The additional financing period also planned to implement Information Communication and Technology (ICT) and mobile application (mHealth) for other innovative components through this mechanism (WB AM, 16 – 20 April 2012, p. 4 – 5). The ICT was a new introduction into the system strengthening efforts till then. The proposal was developed for piloting ICT on the initiatives (run by the department) of mother and child tracking system, beneficiary verification, incentive payment system and facility monitoring etcetera. Another technical group was formed to look at the possible engagement of the ICT (WB AM, January 2013, p. 6). The ICT experiment had also faced delay for two years, and the mission team in 2015 raised doubts about the timely completion of the pilot. Finally, the activity was dropped from the project because GOK had already taken up a comprehensive IT development initiative for all of its departments (WB AM, 19 – 23 January 2015, p.11). Still, it is not clear whether it was the lack of time or GOK's IT initiative which actually made the project leadership/the Bank's mission team to get convinced about dropping the activity.

The M&E design of the project was aimed at centralising the evidence generation activity by progressively introducing SHIC and HMIS. It was different from the then existing data collection mechanism which was desegregated and under-financed (WB,

15 July 2006, p. 15). The SHIC was conceptualised as a prospective tool for regular project monitoring activity and periodic policy decisions. The initial monitoring design was planned to depend on the HMIS for facility specific information and on the SHIC for the overall state programmatic outcome. The facility specific or programmatic information was not adequate to measure the output of the people's health status, which was the main goal of the project. Also, both the SHIC and HMIS were meant to be for public sector, whereas the private sector too was a part of the health service provisions (WB, 15 July 2006, p. 15). Thus the surveys (baseline, mid-line and end-line) were considered to be the perfect exercise to measure the health status of the population, determinants (social) of health status and the preference as well as reasons for using different health care providers. The mechanism experienced challenges in conducting the evaluation also.

The project design did not give adequate attention to this mechanism. The mechanism was given the charge of strengthening the project system. This mechanism was expected to coordinate with the other components of the project and accordingly execute the task. The problem was that the other project components were equally challenged in implementation. This research does not find any collaboration process, apart from some joint review meetings, between the project management, M&E mechanism and other implementing components. The lack of coordination between the third mechanism and other components pose questions on the operational design as well as operational management of the project. As per the project design, SPMU and DPMUs were coming under the M3. Nevertheless, both the SPMU and DPMUs were pursuing the activities as planned and/or prescribed under the respective components with dedicated responsibilities. These management units technically fell under the M3 but administratively worked with all other tactical/technical components.

This research finds also that this mechanism did not forge any collaboration with NRHM/NHM. This research in the field visit at Tumkur district's Pavagada block hospital has found the KHSDRP's M&E section did not have any coordination with the District/City Level Vigilance and Monitoring Committee, which is active under NRHM/NHM. KHSDRP's DPMU had an operational link with the district monitoring mechanism, but that link never permitted it to act as a bridge between KHSDRP's M&E section and NHM's district-level monitoring activities.

The M&E mechanism faced further problems in the project, probably because of the absence of well-defined indicators. The project had broad Project Development Objective (PDO) indicators and intermediate result indicators. Both the sets of indicators were very general in nature and could not be linked directly to the project performance. In fact, the Bank's own end evaluation report shares the same concern (WB, 19 January 2018, p. 27 – 28). This research has further carried this scrutiny into the analysis section. The mechanism three was supposed to be the coordinator among all mechanisms/components/sub-components, but instead it became a division of developing and managing HMIS, and conducting studies and evaluation.

7.4 Analysis of the project's operational design

This section is planned to discuss the objective, PDOs and intermediate indicators of the KHSDRP in order to analyse the role of the Bank and the GOK in health system strengthening in Karnataka. The section is divided into the original and additional financing period. Though the objectives of the KHSDRP were mentioned earlier, still this research further analyses them to draw an analogy between objectives, PDOs and intermediate indicators. That analogy would help us to understand the challenges experienced in the implementation of the project.

The objective of the KHSDRP's original financing was different in the IDA's Development Credit Agreement (DCA) made with the Indian government and in the operational guideline of the PAD, 2006 prepared (by the World Bank) for the GOK. The objective mentioned in the DCA was:

"[t]o support the Program and to assist Karnataka in improving the utilization of essential curative and public health services, particularly in the underserved areas and amongst vulnerable groups" (WB Development Credit Agreement, April 18, 1996).

As per the PAD's, 2006, the objective was:

"*[I]ncrease utilization of essential health services (curative, preventive and public health), particularly in underserved areas and among vulnerable groups, to accelerate achievement of the health-related MDGs"* (WB, 15 July 2006, annexure: 3, p. 31).

The difference in the wordings between the two objectives made an enormous impact on the project implementation. This research analyses that the difference in the

wordings came with two different agendas. The DCA (Credit No. 4229 – IN) was between the International Development Association (IDA), the Bank's lending unit, and Government of India for the KHSDRP. DCA is a legal document and applicable to the concerned parties, i.e. IDA and GOI (as a guarantor to the loan amount). The PAD is a project operational guideline document, and mostly applicable for the implementation organisation, in this case the Government of Karnataka or specifically the DOHFW's KHSDRP team.

The Bank' DCA considered the KHSDRP as a theory of health system for the overall strengthening (programming) of the health sector (including public, for-profit private and non-profit private) of the Karnataka. Hence, the word *'Program'* is mentioned in relation to the entire state scenario. The PAD's objective was more operative in nature. PAD, 2006 drops the word Program and Karnataka, and instead clearly mentions about the aim to achieve health MDGs. This research considers this difference is an important distinction between the agenda of the Bank and the target of the DOHFW, Karnataka. The programmatic strengthening for the overall health sector was a theoretical objective for the Bank, whereas attaining health MDGs became an operational objective for the GOK. So, it can be said that with regard to the project objective, the understanding of the implementer (GOK) was different from the financer (the World Bank).

Considering both the legal and operational documents, the objectives are almost semi-identical where the stated ends were different (program strengthening versus MDG) but the means (mechanisms and components) were the same. KHSDRP was clearly on the line of Health System Strengthening (HSS) to achieve the targets for MDGs related to health. The HSS was theorised as an 'agenda' by the Bank (theoretical objective) and the health MDGs was made as an 'aim' for the GOK (operational objective). The uniqueness of the KHSDRP is that it accommodated both the agenda and the aim in one goal, i.e. MDG through HSS. It is very clear from the objective that the nature of service was selective, catering of population was protective (vulnerable groups), and focus of the system was on output (increase the utilisation of service).

The distinction between the two different forms of objective is further getting cleared from the selection of the indicators to measure the success of the project. The project design (of original financing) selected altogether nine Project Development Objective (PDO) indicators to track and monitor the progress of the project. PDOs were important

M&E tools both for the KHSDRP M&E team and the Bank's supervisory team (conducted through mission visits). The PDO indicators were developed in relation to the health MDGs. Following are the PDOs.

Table 7.6: Links between PDO indicator and health MDGs in KHSDRP original financing

Sl. No.	PDO Indicators (Original Financing Period)	MDG (four health MDGs)
1	Percentage of safe deliveries	MDG 4 & 5
2	Percentage of institutional deliveries	MDG 4 & 5
3	Percentage of mothers and new-born children visited within 2 weeks of delivery by a trained community level health provider	MDG 4 & 5
4	Percentage of children fully immunised	MDG 4 & 6b
5	Percentage outpatient attendance	No link
6	Percentage inpatient attendance	No link
7	100- Annual prevalence index of malaria (% (100 – API))	MDG 6b
8	% number of women receiving HIV/AIDS during pre natal/post natal or family planning visits (% cent HIV)	MDG 6b
9	% TB cure rate	MDG 6a

The PDO indicators (or tracer indicators as mentioned in the PAD, 2006, pp. 30) chosen were the representatives of the outcome of the essential health service provisions. Out of nine PDOs, seven (except percentage inpatient and outpatient attendance) were linked to the health MDGs as aimed at in the operative objective. The project design did not link the PDOs with the process activities of the mechanisms and components/sub-components of the project except on one occasion. The component devised for the programmatic financial support (M1-C2: Improving the effectiveness of primary and secondary health care services) was the only component that could be directly linked to the PDOs. The M1- C2 component (programmatic approach) was a direct budgetary support for the overall health service development, and not any technical/physical investment from the project end. Thus all the chosen PDO indicators were developed for the operational purpose, and not linked to the theoretical objective. This research does not find any merit on the logic why none of the PDOs directly reflect upon the performance of the project mechanisms/components.

The project also formulated sixteen priority performance indicators to track the 'impact' of the project for moving towards achieving MDGs. The indicators were limited to maternal services (three), ANC (five) and child services (eight) (WB, 15 July 2006, table-11, p. 36). The targets were set and accordingly monitored. The point is neither PDO nor the priority performance indicators were directly linked to the project process implementation activities. In fact, the KHSDRP did prepare indicators for implementation plan for intermediate result monitoring (process indicators) (WB, 15 July 2006, p. 37 – 42). However, this research could not find the continuous tracking of the process indicators for progress verification/reporting in the Bank's periodic aide-memoires or any other evaluation documents. The process indicators were very important for the project, since they were linked to the project implementation mechanism/component/sub-components. The Bank's supervisory mission visits which were conducted periodically for the purpose of monitoring and handholding used to report, as captured in the aide-memoires, the mechanism/component-wise update, and not the progress of process indicators. The omission of the process indicators in the monitoring exercise made the DOHFW's KHSDRP team probably more nonchalant about the successful implementation of the mechanism/component.

The project's objective had been changed for the project received additional financing for further extension. The restructuring was done on 27 September 2012 for changing the PDO and results framework to match with the requirements of additional financing (WB, 19 January 2018, p. 14). The objective of the Karnataka Health System Additional Financing (KHSAF) period, as per the project document and financial agreement, was "*to improve health service delivery, public-private collaboration, and financing, particularly for the benefit of underserved and vulnerable groups in Karnataka"* (WB, 27 August 2012, p. 6).

The objective of the additional financing was extremely important in the discourse of the KHSDRP. The additional financing period's objective carries a different articulation compared to the operational objective of the original financing. However, both the phases' objectives in practice represent the same idea of the Bank's theoretical objective, i.e. strengthening the health system. The revised objective did not put MDG achievement as a target; rather, it made very clear what needed to be done to strengthen the health service. It clearly stated that improvement in the areas of service delivery, collaboration between public and private, and financing (innovative, i.e. insurance) are

the key to reach out to underserved and vulnerable groups. Thus the objective emphasises that service delivery, governance (using PPPs) and financing are the only key elements for strengthening the health system.

The revised objective was more straight-forward and direct in nature. The additional financing's objective mentions PPPs and financing which were in fact the most distinct features of the entire KHSDRP. The revised objective also resonated, unlike the original credit, with the concepts and practices of the mechanism and components. One important change is under additional financing period, the project shifted its focus to the NCD intervention from the performance indicators of Communicable Disease. The process was also started in 2010 when restructuring was done to change the PDOs in order to drop malaria, HIV and TB from the result framework (WB, 19 January 2018, p. 10). The project also changed the PDOs during the additional financing period. The number of the PDOs got reduced to six to capture the project's progress performance.

Table 7.7: PDO Indicators under additional financing in KHSDRP

Sl. No.	PDO Indicators
1	Per cent of institutional deliveries
2	Per cent of institutional deliveries among the poor
3	Per cent of outpatient attendance in government facilities in 7 less-developed districts (Category C districts) (population-weighted average)
4	Number of claims paid by health insurance pilot programme benefiting BPL households
5	Number of women screened for cervical cancer in pilot districts
6	Per cent change in number of road traffic accident patients transported by 108 ambulance system who receive emergency care at government health facilities in pilot districts

Under the additional financing, the first three PDOs were more general and linked to the overall outcomes of the health service. It is difficult to attribute the progress of those indicators solely to the KHSDRP because of the existence of other confounding factors as mentioned earlier. The last three PDOs were directly connected to the project components; health insurance claims, cervical cancer screening, and emergency

response to road traffic accident cases were the outcome indicators of the project components/sub-components for the additional financing phase.

The project also had altogether nineteen intermediate results indicators over different periods of time to track the progress of the project. The indicators were part of the practice of addition and deletion as and when needed to adjust with the project's changing result framework. Some of the PDO indicators had also been shifted to the intermediate results indicators. Below is the list of the total nineteen intermediate results indicators that were used in the project (both original and additional financing period) over different times.

Table 7.8: Intermediate Results Indicators in Additional Financing under KHSDRP

Sl. No.	Intermediate Results Indicators	Direct (D)/Indirect (I)
1	Health personnel receiving training	D (under various component)
2	Per cent of mothers and newborn children visited within 2 weeks of delivery by a trained community level health provider	I
3	Per cent of inpatient attendance in government facilities	I
4	Per cent of pregnant women receiving HIV/AIDS counselling at government ICTCs	I
5	Per cent of TB cure rate	I
6	Number of Taluks (Blocks) with Annual Prevalence Index (API) for malaria < 2	I
7	Births (deliveries) attended by skilled health personnel (number)	I
8	Health facilities constructed, renovated, and/or equipped (number)	D (under civil work and equipment)
9	Number of mobile health clinics operational	I
10	Per cent of government Primary Health Centres (PHCs) with no stock-out of Vitamin A in the previous month	I
11	Per cent of government Primary Health Centres (PHCs) where a doctor is available at the time of survey	I

Sl. No.	Intermediate Results Indicators	Direct (D)/Indirect (I)
12	Per cent government Primary Health Centres (PHCs) with a functional labor room	I
13	Per cent of government Primary Health Centres (PHCs) providing round-the-clock services	I
14	Training materials on non-communicable disease activities for clinical staff are developed	D (NCD component)
15	Guidelines and standards for trauma care services developed	D (Road safety and emergency)
16	Information and communication technology (ICT) pilot starts implementation	D (ICT under M&E)
17	Number of claims paid to private sector hospitals by the government health insurance programme supported by the project (cumulative)	D (innovative health financing)
18	Number of private hospitals empanelled by Suvarna Arogya Suraksha Trust (SAST) that have submitted at least 100 claims (cumulative)	D (innovative health financing)
19	Number of hospitals empanelled to provide care to road accident victims under the government programme (cumulative).	D (innovative health financing)

Source: Collected from various World Bank Implementation Status & Results Reports of KHSDRP

The above table shows the direct and indirect link of the project with the intermediate results indicators. It is found that only eight out of nineteen indicators were directly linked to the project performance, and the rest (eleven) of the indicators had indirect association with the project's process implementation performance. Some indicators' performance had contribution from the NRHM also despite being implemented as activities under the KHSDRP, such as 'number of mobile health clinics'. The KHSDRP used various data-sets (national disease surveillance, national survey etcetera) to track the indirect indicators for intermediate results. The question is if most of the PDO and intermediate indicators consisted of non-project progress activities, then how the project's process implementation performance was measured.

The project had a restructuring in 2010 and thereafter revised the PDOs and intermediate results indicators to match them according to the project logic (WB, 19 January 2018, p. 28). Accordingly, three PDOs and eight intermediate results indicators were directly linked to the project performance. The additional financing project

document also acknowledges that lack of interconnectedness between the indicators and project mechanisms/components made the project to drop some of the PDO and intermediate indicators, because *"The project contributes to overall improvement in health services, of which this is an indicator. However, planned project activities will not have a direct impact on this service"* (WB, 27 August 2012, p. 18).

The KHSDRP team in DOHFW already had to face a lot of implementation challenges because of various technical/managerial/political/institutional reasons; afterwards, the lack of interconnectedness between the key indicators and project activities had impacted it in two ways. Firstly, the inaccurately developed indicators made the project decision-making bodies (specifically PSC and PGB) defocused about the core project activities. Secondly, the choice of key indicators indirectly affected the KHSDRP project management bodies (SPMU and DPMUs) by not aiming to prioritise the project process implementation activities. This research opines that implementation challenges and performances could have been handled efficiently if the project had given adequate importance to the system variables (process indicators) and not the system outcomes in monitoring and supervision exercises.

The project design interconnected the project performance with the outcome and impact of the overall health status related indicators which might be considered as system outcomes. The project mechanisms/components were instrumental to reorganise the system by offering technical (and some physical) inputs. The project design chose to select outcome/impact indicators (system outcome) instead of process and output indicators (system processes or known as system variables).

This is an irony of the KHSDRP that the project operation-wise worked with the system-level inputs and processes, but measured the performance at the level of system outcomes and impacts. The challenges with the implementation of the components/sub-components should be additionally attributed to the choice of selection of system outcome/impact indicators. This research considers the entire KHSDRP (both the original and additional financing) as a process of HSS. In that process, the original financing of the KHSDRP was not different from the additional financing, rather the latter was built on the structure of the former.

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Chapter 8: Banking on HSS for operationalisation of governance

Summary of the chapter: This chapter advances the analysis of World Bank's health system intervention at the operational level by taking reference from the Karnataka projects as discussed in last three chapters. It argues that overemphasis on activities in the Bank's project design weakens the scope to analyse the role of actors in the Bank's health system policy implementation and operation stages. To address this gap, this research the role of the Bank and Government of Karnataka (GOK) as main implementing agencies, and along with that critically engages with the linkages between health system intervention and private sector and community. The analytical exercise shows that the Bank engaged with the intervention to ensure the completion of the activities without taking much care of quality of the activities performed. This particular practice compromised the 'process-of-change' principle that any reform intervention desired for. On the other side, the role of GOK was to extend political, policy and operational support to the Bank's ideas (if not projects alone!) for developing as well as strengthening health system. On the linkages with private sector, the project worked as a communicator to engage the private entities in service delivery, and also made room for private sector to become partner in governance. With regards to community, the health system projects did not understand the role of community in the organisation of health care service delivery. This drawback is attributed to the theoretical formulation of HSS approach which does not consider community as one of the health system elements. Finally the chapter goes into the operational function of HSS, and contests that HSS is not strengthening the health system, rather strengthening certain elements of health system. In this way, HSS is diffusing a governmental behaviour to operationalise a hypothesis that publicly financed and privately managed – run health care service delivery is possible in semi-advanced or not-so-advanced liberal society.

The World Bank financed projects' process evaluation analytically describes how implementation and operation stages were executed by the Bank and the Government of Karnataka (GOK). In this process, the projects as representative of the Bank's health system policy (or especially Health System Strengthening/HSS approach) had also

interacted with two other important actors of the health system; the private sector and the community. While the presence of the Bank and GOK in the projects' execution process was loud, projects' relationships with the private sector and the community were relatively silent. It is because the programmatic articulation (design-wise) of the Bank financed projects is always functionalist, as argued in chapter three, where activities are generally the key concern at the cost of undermining the role of actors. The role of the actors is necessary to understand the Bank's health system intervention to not only know the efficiency of implementing agencies (Bank and GOK), but also to understand how the project interventions (as representative of government as well as inter-governmental organisation) build and/or shape the two other key actors in the organisation of health system. This chapter on one hand analyses the role of the main actors in the Bank financed projects, and on the other side examines the interlinkages of the projects with private sector and community. The following objective and research questions are being addressed in this analytical examination.

Objective:

- To understand the role of the actors (World Bank and Government of Karnataka) in the execution of health system projects, and the projects' relationships with the private sector and the community.

Research questions:

- How do the Government of Karnataka and the World Bank complement each other in the projects' execution?
- What were the relationships of the projects with the private sector and the community?

The Bank and the GOK's as projects implementing actors had formed a triad with the health system projects which in turn form relationships with other two actors. In the following sections, this research at first analyses the role of the Bank and the GOK in the execution of the projects. Thereafter it traces projects' relationships with the private sector and the community.

8.1 The role of the World Bank

The 2007 Bank second HNP sector strategy acknowledges, as mentioned in chapter three also, that the Bank is less efficient in handling micro level organisation of health care service delivery (WB, 2007, p. 51). Nevertheless, this limitation hardly deterred the Bank to not get involved in real time project implementation as evident form the lending portfolio of the Bank's health system intervention in India since the first half of 1990s. With regards to implementation of project, many Bank professionals have argued to this researcher that the Bank's role in health system intervention is not an implementer, rather financer of those projects. This research from the field experience has found that argument is unfounded. An interviewee having an in-depth knowledge of the Bank's health system project execution at the ground level also downplayed the claim by saying that for the Bank "*the idea is [whether] the component getting implemented in a satisfactory manner*" or not. The interviewee further clarifies that implementation of the overall project depends on the supervision, and by conducting the supervisions the Bank automatically gets into implementation (Informant 08). Irrespective of the claims and counterclaims, this research opines that the Bank is always a part and parcel of health system projects' implementation-operation exercise.

The role of the Bank was very important for both the Karnataka Health System Development Project (KHSDP) and the Karnataka Health System Reform and Development Project (KHSDRP). To know the operation of the Bank in both KHSDP and KHSDRP, the *modus operandi* of the Bank's project execution is needed to know. This research has taken example from KHSDRP to explain how the Bank operates in the project execution from the proposal formation to end evaluation. At the beginning, the Bank usually finalises Project Appraisal Document (PAD) based on the agreed proposal by both the state government and the Bank. The base of the proposal for obvious reason has to be within the broad understanding of the Bank's health system approach, i.e. HSR/HSD/HSS. In the PAD only the operative plan is usually outlined where the Bank concentrates on its implementation role. For example, the KHSDRP design was supported by three important operative plans: Component-wise milestones, year-wise implementation plan for intermediate results monitoring, and results framework (target for Project Development Objectives and intermediate indicators) (WB, 15 July 2006). In order to follow up with the operative plan, the Bank constitutes

a Task Team headed by a Task Team leader to oversee the project execution, and also deputes one operation officer from the team for regular management activity. The operation officer is the point of contact from the Bank to the state government's project management team (like KHSDRP team of DOHFW, GOK). The Task Team is a technical team consisting of the Bank's employed specialists (domain expert, i.e. health/e-governance) and hired consultants (mechanism/component expert, i.e. Public Private Partnership/PPP, insurance, road safety, Non-Communicable Disease/NCD etcetera). Task Team in consultation with operation officer conducts half yearly monitoring and supervision visits to the state for assessing the progress as per the outline of operative plans. For record, it is found from the Bank's end evaluation report that during the entire KHSDRP period, a total thirty supervision visits were made by the Bank's missions (WB, 19 January 2018, p. 31).

The Bank has two types of monitoring tools to capture and assess the project's performance during the supervision visits; Implementation Status and Results (ISR) and aide-memoire. ISR is a declassified information fact-sheet and is publicly available on the Bank's website under the respective project information pages. It is a project dashboard that features status of indicators (PDO and intermediate results), disbursement of finance, and implementation ratings. The practice of ISR update after every supervisory visit was not there in KHSDP; it started from KHSDRP period. Another one is aide-memoire, not available in the public domain, which is a technical supervision document and gives a thorough account of the performance of the project mechanism and components. Certainly the aide-memoires give a more elaborative reflection of the project's periodical performance. Apart from these two regular monitoring tools, the Bank's end evaluation document (known as Implementation and Completion Report) for KHSDRP, which is available in the public domain (World Bank website), too highlights the performance of PDO/tracer and intermediate indicators. As analysed in the process evaluation of the projects, the Bank's monitoring and evaluation activity was extremely inadequate, and that hampered the projects' deliverables. Neither monitoring tool (aide-memoire) nor evaluation report (ICR) captured the finer details of the challenges faced by the mechanisms/components during the process of project execution.

This research draws example from KHSDRP's NCD sub-component to explain how the aide-memoires as monitoring tool was not utilised properly to tackle the operational

challenges. The NCD pilot was commissioned in March 2014, but effective implementation started only in July 2015. The evaluation report submitted to the Project Governing Body (PGB) acknowledges that 'full-scale operation' for NCD pilot began not before July 2016, and thus shouted for an extension to "*ensure project is effectively implemented and monitored*" (PGB meeting proceedings, 2016, p. 5, 12 and 25). The NCD pilot wasted initially one year due to administrative snag at the directorate over the procurement of semi auto analyser for laboratory services (Dr. Padma – former Deputy Director/DD NCD of KHSDRP, personal communication, December 3, 2018). The delay changed the operational modality of the pilot. The Bank's mission instead of dealing with procurement bottleneck chose to suggest for outsourcing of diagnostic services. As a result, Kasturba Medical College in Dakshina Kannada and JJM Medical College in Devangere districts (both were NCD piloting districts) were contracted out for laboratory testing of NCDs.

On another occasion, the abnormal delay construed to reduce the PDO target for cervical cancer screening from 60,000 to 1,000 (WB, 19 January 2018, p. 11). On being asked the question, then DD-NCD explained that main reason for scaling down of target was the incapacity of staff nurses in conducting the cervical cancer screening. The nurses were mostly fresh and hardly had any experience in cervical cancer screening. They were outsourced by a third party agency contract. The KHSDRP's contracting agreement with the agency did not have any specific criterion to appoint experienced nurses especially in NCD screening. All these challenges pushed the actual operation for NCD pilot to commence only at the end of the project and lasted for three to four months (Dr. Padma – former DD NCD of KHSDRP, personal communication, December 3, 2018).

It is deplorable that no internal monitoring tool or evaluation report captured and diagnosed the reasons behind the failure of NCD pilot. Total six aide-memoires have been reviewed from January 2013 to March 2017 (January 2013, September 2013, June 2014, January 2015, October 2016, and March 2017), which happened to be the NCD piloting period; none of them notes about real-time operational challenges of NCD sub-component. Like the aide-memoires, evaluation reports (the Bank prepared ICR, and the external evaluation conducted by the DOHFW, GOK through Institute of Social and Economic Change) are completely silent on the real obstacles. The 'tactical adoption of new ways' as mentioned in the NCD sub-component section (in chapter seven) were

attempts at bypassing the obstacles temporarily in order to complete the piloting and exhaust funds. The NCD example shows why the Bank's advice did not bring any permanent solution or addressed operational challenges in most of the cases as analysed in the process evaluation of the projects.

Apart from the supportive supervision, the Bank also utilises monitoring instrument through funding modalities. The Bank's result-based funding approach is about fulfilling the milestone/tranche-based milestones; they are set for the mechanisms and not closely associated with the PDOs or intermediate indicators. The formulation and development of Suvarna Arogya Suraksha Trust (SAST) as a strategic purchase trust based institute in KHSDRP was an example of result-based funding. The other direct project monitoring instrument is indicators. Indicators featured in the Bank's ISR are general in nature and performance-wise often being influenced by many factors. These give advantages to the project to choose the indicators which are target-wise safe to meet since apart from the concerned health system project several other factors are also contributing. For example, KHSDRP through the 'Improving the Effectiveness of Primary and Secondary Health Care Services' component indirectly financed state side of NRHM interventions also, as described in chapter seven, where indicators in many occasions for both KHSDRP and NRHM were identical. Technically, the failure of those indicators is in fact very rare since the incremental progress is almost certain given the effort of investment (both financial and technical) made from multiple sources. In this regard, the example of KHSDRP again can be taken where the Bank's ICR (end evaluation report) claims success based on the achievement of those indicators; however, it remains indifferent to acknowledge as well as analyse the failure of the mechanisms implemented and component operationalised. The Bank used the ISR as a public advocacy tool to showcase that the KHSDRP was on the path of success in order to achieve health MDGs. The project had a programmatic convergence with NRHM under the overarching goal of achieving health MDGs, which paved the way to share the PDOs with NRHM objectives.

The Bank played a supervisory role in both the projects. It did not get directly involved with the regular project execution. Rather, the periodical mission visits of the Bank tried to ensure that the progress of the defined mechanisms/components were on the right path. The mission visits were more about checking the project progress on the agreed activities than understanding and analysing the execution hurdles. For example,

the Bank's periodical aide-memoires of KHSDP, prepared during the mission visit, contradicted with the Bank's end evaluation ICR finding on referral system. ICR did not find any proof that the referral system got improved in KHSDP (WB, 21 September 2004, p. 6). In comparison to that, not a single aide-memoire (except the initial March and November 1997 aide-memoires) mentioned any observatory note on the problem of implementation challenges faced by the referral system component in KHSDP. Rather, the Bank's supervisory visits always praised the operational management to complete the activities performed under the referral system in KHSDP. The lack of courage to accept or being ignorant of the implementation-operation related challenges is the biggest drawback of the Bank's support at the ground level in both KHSDP and KHSDRP.

With an exception, PhD research has also found that for a particular period in KHSDRP the Bank's supervision had high impact on the project performance. The aide-memoires prepared during the time of Dr. Paolo Belli (the first Task Team leader of KHSDRP) are still carrying the evidence of fair reporting and good performance. Those aide-memoires were detailed with both objective and subjective analysis, and contextually consulted. The SAST financing vehicle – the architect of UHC, despite all the odds took place as discussed in chapter seven, was constituted during that time only. The researcher during the field work had received positive feedback about the Bank's handholding support to KHSDRP till 2009 from several DDs, Bank appointed consultant, and from civil society actors also who are critical of project agenda. The leadership of Dr. Belli in the early phase of KHSDRP exemplifies effective supportive supervision (through monitoring and evaluation activities) is necessary from the donor agency in handling health system like complicated projects.

The KHSDP/KHSDRP team at DOHFW, GOK was always struggling with the deficiency in capacity. The Bank's technical handholding was also limited to diagnose actual problem, but instead it was resort to shortcut by forming new tactic to complete the activity. In this tactical improvisation, the original value of the activity got lost on most of the occasions. Those values were meant to achieve system integration (creating link between the elements) and improvement (better coordination among the elements). In any system intervention, the process activity is linked to the outcome of the system development/strengthening. The mere fulfilling of the activity cannot guarantee the accomplishment of the envisaged outcome except ticking the boxes of activity check

list. The Bank fails to understand this dichotomy in project implementation-operation, thus was busy in completing the activity instead of achieving the activity in its essence!

8.2 The role of the Government of Karnataka

The Government of Karnataka was involved in facilitating KHSDP and KHSDRP in three different ways: Political support, policy support and operational support. The Bank assisted projects were in need of a larger consensus in favour of policy reform across the state's political spectrum since they were involved in changing the state – society interaction. The introduction of user fees or de-regularisation of posts were the examples for which the KHSDP needed political confidence in order to deal with any unwanted political unrest. Policy commitment was another arena where the project seeks the government's uninterrupted support. For example, the budget increment and involvement of the private sector in public service delivery needed the government's steadfast attitude to accommodate the changes within the state policy framework. Finally, the government had to facilitate an executive structure to operationalise the project's designed mechanisms and components. The various management decision-making bodies (PGB, Project Steering Committee/PSC) and the project management team (KHSDP and KHSDRP respectively) were constituted under the umbrella of DOHFW. In a project executive structure, those bodies and teams were working 'on behalf' of the GOK, but technically representing the ideas of the Bank. This was possible for the Bank because of the complementary operational support extended by the DOHFW on behalf of GOK.

The research has found that both KHSDP and KHSDRP managed to get enormous political support due to the favourable condition of a pro-reform political economy context in the state. The effect of macro-economic changes in 1991 at the national-level impacted on the economic and governance arrangement at the state level too. The policy of fiscal space management and continued lack of public investment in health convinced the political class of Karnataka to adhere to the Bank's prescription on reform. Chapter five has already discussed that this Bank guided reform process in Karnataka was based on 'fiscalised development model'. In the process of Karnataka's politico-economic governance, the Bank's fiscalised development model (to spearhead growth) got adjusted within the state's own developmental politics (to ensure decentralisation), and formed a 'reformed model of development'. The health system

projects (both KHSDP and KHSDRP) were implemented on the premise of that reformed model of development. The incorporation of the Bank's fiscalised development model within the state's own development model was possible because of support from the state's political class. This political support of the GOK with regards to health system reform was manifested in the availing of KHSDRP loan from the Bank in 2006. From the position of revenue and budget surplus, the state's fiscal health was considerably much better during the KHSDRP loan negotiation years (from 2004 to 2006) than the late 1990s or immediate years of 2000s. For example, chapter five has already showed by analysing the state general accounts data, that Karnataka was officially out of debt trap (primary deficit in state account was positive) for consecutive two years (2004 – 05 and 2005 – 06) for the first time since 1960 – 61. Despite having the positive fiscal health, going for external loan (such as, KHSDRP) meaning with regards to decision on reform, the state's political leadership was not always compelled by resource crunch situation rather motivated for reform based solution.

In the pro-reform political ambience, the Bank's funding came with pre-agreed terms on the implementation of certain policy measures (such as user fee, referral system in KHSDP, and programmatic fund support, health insurance/assurance in KHSDRP etcetera). So in other way policy support had been assured by the GOK before the projects officially commenced. Apart from supporting the projects' policy-based mechanism/component, it is found that the overall state's health policy also provides adequate policy support in order to promote the projects' goals. For example, the goals of the state's first ever health policy, i.e. Karnataka State Integrated Health Policy (KSIHP), 2004 were to make the health service robust and adequately responsive in order to meet the demand of the community by providing quality health care with equity, and promote enabling environment for development of the health sector (GOK, 2004, p. 9 and 10). The adoption of development of health sector was on line with KHSDP suggestion where private sector development was a strategy since the beginning. Similarly, the last submitted draft Karnataka health policy (Karnataka Integrated Public Health Policy, 2017) has affirmed that the goal is to attain highest possible level of health and wellbeing through universal access to quality and affordable healthcare services to all, and inclusion of health in all development policy (KJA, 2017, p. 12). Needless to say, this proposed policy is again linked to the main thrust of KHSDRP, i.e. Universal Health Coverage.

The operational support was actual interface between the Bank's technical know-how and the GOK's administrative robustness. The projects encountered the maximum challenges at this level. The decision-making bodies are mostly filled up by the bureaucrats (usually IAS). Conversely, the operational teams are run by the technocrats (doctors with/without Public Health background). Projects like KHSDP/KHSDRP needed technical support for being operative and administrative backing for being persuasive. However, the research finds one critical flaw in the project's human resource management. The project lead, Project Administrator, was a bureaucrat (an IAS cadre) and not a technocrat. PA was the point of coordination between the decision-making bodies and operational management team. Hence, that position is supposed to be technically sound and administratively experienced. In the total span of twenty one years of the health system intervention, the projects experienced altogether twenty nine bureaucrats who played the role of the PA to lead the projects.[98] The average time for a PA in office was seven months.

The bureaucrats are administrative personnel and technically less qualified to understand the project theory that involved PPP, financing, referral system and many more. At the same time, the technocrats (or the doctors) are usually from MBBS background. Thus doctors too are not qualified enough to handle the operational demands of the projects that required public health driven health system operation knowledge. This gap in knowledge made the project to recruit so many consultants and create cells to implement the technicalities of the project.

The role of the DOHFW, GOK in the health system projects may be described as facilitator. The DOHFW had given a platform to the projects wherein the Bank invisibly operated. The KHSDRP project is closed, and finally the Bank's health system intervention is also over. The department had started many new initiatives which were originally initiated by the projects. Those initiatives after being deviated from the original value as showed in the process evaluation have now become part and parcel of GOK's health service system management. The question remains how much the capacity of the department gets increased. The Bank's end evaluation report of KHSDRP mentions that the DOHFW accepted all the findings and had no comments on the draft ICR shared with on the 16 January 2018 (WB, 19 January 2018, p. 52). It

[98] The information was obtained from the KHSDRP office in Bangalore during the field work.

is interesting that after implementing a project (KHSDRP) for eleven years, the main implementation agency does not have any comment on the draft project evaluation report prepared by its financer. It is argued that the GOK including DOHFW as an implementing agency had offered favourable political support, active policy support and subjugated operational support to the Bank to comply with the projects' implementation-operation criteria.

8.3 Private sector mobilisation

The Bank financed projects through their mechanism and components had developed a relationship with private sector. For instance, the case of KHSDRP can be recalled. It is a remarkable project in the history of private sector mobilisation in Karnataka. The project did not have an overtly dedicated mechanism or component for private sector engagement in health care service. However, that cannot undermine the role of the project in engaging and strengthening the private sector in the health care service provisions. Two types of private entities were chosen, for profit and not-for-profit, to provide the health care services in PPP model. The services ranged from the primary (Mobile Health Clinic/MHC, Arogya Bandhu) to secondary (Citizen Help Desk/CHD, diagnostic) to tertiary (assurance/insurance) levels. The PPP model was followed also in referral services for emergency ambulance care.

The biggest private sector engagement strategy of the KHSDRP was establishing a state-wide health insurance scheme by extending technical and financial support (WB, 19 January 2018, p. 25). However, this research is unable to find how much private sector investment was assured through that engagement strategy in terms of investing in health care sector. The Bank's own end evaluation report also acknowledges its inability to calculate the same (WB, 19 January 2018, p.25). The contribution of the KHSDRP is that the project, through its mechanisms, made fundamental changes in the government's administrative arrangement and service management to engage private sector. In the Bank's own words, *"the project helped the Government to create enabling policies for private sector engagement and introduce results based contracting and transparent provider payment mechanisms"* (WB, 19 January 2018, p.25).

The private sector engagement was a tactical as well as strategic operation done by the KHSDRP. For example, the decision to engage the private sector (mostly not for-profit)

for selective areas to run MHC under the primary level care was tactical because of the poor health infrastructure. Concomitantly, the invitation to the private sector (profit-based) to provide tertiary care support under the Vajpayee Arogyashree Scheme (VAS) scheme was strategic. The government investment had been positively discriminated towards the primary and secondary levels as guided by at first the KHSDP and thereafter KHSDRP. Thus the scarcity of public investment in tertiary care created the opportunity for the private sector to get involved with tertiary care services. The VAS scheme was particularly of help in this case. The purchase of care (strategic purchase model) for the VAS beneficiaries from the private sector hospitals by the SAST (through the KHSDRP fund) helped the private sector to grow. The project's keenness to develop the private sector at the tertiary level also got reflected in two of the targeted intermediate results indicators (number of claims paid to the private sector and number of private sector hospitals empanelled), which were formulated to monitor the progress of the private sector development. In this regard, the field visit in Gulbarga district of North Karnataka found that number of VAS related claims (number of patients treated under VAS) made by Patil nursing home was 103 in Financial Year (FY) 2011-12. The same nursing home's number of claims under VAS was rose to 1514 in FY 2015-16 (Nursing home administration staff, personal communication over email, February 13, 2017).[99] This exponential increase in number of claims interprets that the small nursing home leapfrogged 1470 per cent growth under VAS just in the gap of five years.

The strategic purchase model of health care service delivery is certainly a real booster (argued in chapter four also) for the private sector. The researcher has analysed the data regarding number of patients treated by hospitals under the Bank financed VAS during the scheme's entire execution period in KHSDRP. It is found that from 2010 – 11 (effective year of commencement of purchase of care) to 2016 – 17 in every financial year, the first ten hospitals in terms of treating VAS patients were always from the private sector, except the Kidwai Memorial Institute of Oncology (an autonomous cancer care hospital of GOK) which found place regularly among the first ten from the financial years of 2013 – 14 to 2016 – 17 (SAST Office, Bangalore: Monitoring and Verification Unit, May 15, 2017). This particular example shows how over the years

[99] Financial Year in India is from 1 April to 31 March. The data was collected during the field visit made to Patil nursing home in Gulbarga on 13 February 2017.

the Bank financed KHSDRP inducted the private health care service delivery within the public service provision, which is by now a regular practice for GOK.

The Bank projects' not only facilitated the private sector inclusion directly in the publicly financed service delivery scheme ranging from Arogya Bandhu to VAS, they also created a policy reference for the GOK (and Government of India) to inherit the values from projects' practices. These values get manifested in state's own policy position as described in the previous section while discussing the role of GOK in policy support. The policy expression has two sides. The above discussion on private sector is only one side of the coin where the service delivery (both clinical and non-clinical) support from private sector is taken by the public system. The flip side is also there. While the private sector development in the state is quite impressive over last two decades, the facility accreditation and standardisation of medical practices remain daunting tasks, which results into commercialisation of health care services among corporate hospitals. This research opines that KHSDRP must take the responsibility for this setback. The project's failure in establishing any regulation and accreditation system, as described in chapter seven, within the public system had paved the way for commercialisation of health care services. Thus it is argued that the unrest over the amendment of Karnataka Private Medical Establishment Act to regulate cost of private facilities in 2017 was directly linked to the failure of KHSDRP to develop regulation and accreditation system. It is an irony that the project failed to build the capacity of the government to regulate private sector, but succeeded to establish a mechanism to link the government with private sector for outsourcing service delivery.

The presence of private sector is not only limited to a city, it has been mushrooming to all over the state. The growing number of private facilities is not a concern as such, but the unregulated growing number of facilities is definitely a severe cause of concern. A Staff Nurse in the Galag PHC (Devdurga block of Raichur district) lamented during field visit that the entire block does not have any USG (Ultrasonography machine), hence pregnant women are bound to visit private clinics (namely R K Hospital, Ashwini clinic, Lellabati clinic) for the same and helplessly spend INR 1000 per scanning (Staff Nurse of Galag PHC, personal communication, February 4, 2017). This is the reality that even the most backward block in the state has the presence of private sector, but not an adequately equipped public system facility. It is to be questioned whether the

negative financing in public system especially in secondary and tertiary levels of care also is not helping in the development of the private sector.

Small scale private health care services have become an industry in rural Karnataka. KHSDRP did not ask the government to not buy equipment or postpone the recruitment of technicians in government facilities, or advise the public system to develop a small scale health care industry. It is the execution process of the KHSDRP that failed to identify this parallel development of the small scale private sector, and the programmatic logic of the project which did not consider the importance of primary health care development in Karnataka's public system. The disproportionate region-wise investment in infrastructure and equipment, shortsightedness in reallocation of money across the spectrum of care (primary to secondary to tertiary), and unnecessary wastage of fund on Public Health Challenge Fund (PHCF) like initiatives instead of creating sound state owned regulatory mechanism were translated into the unregulated growth of the private sector in rural areas.

Apart from service delivery, the Bank project especially KHSDRP developed association with private sector at the governance level also. The KHSDRP created Suvarna Arogya Suraksha Trust's (SAST) board of trustee consists of members from government, non-government organisation and for-profit private sector (like, Dr. Devi Shetty of Narayana Hrudayalaya, Bangalore). This is an example of collaborative form of governance. The chapter five already showed that under the reformed model of development the representation from outside the government in governance body is not new. In KHSDP period also, the first Task Force on Health was constituted mostly by the civil society members. However, in the KHSDRP led collaborative governance, the significant change is the inclusion of for-profit private sector in the governance decision making body.

In an interview with this researcher, a private sector representative opined that both the private sector and government should trust each other. The mutual trust is not only required to work together, but also to help the population to be served together (Informant 06). This research is of opinion that serving together to population is the articulated position of present-day health system's collaborative governance. Because crunch of resource or inefficiency of service provision can legitimise the inclusion of private sector in service delivery, but can not be a justification to include private sector

in governance exercise. Hence, serving the population is the needed justification for the government to include private sector in public policy making exercise. The presence of private sector in governance forum means the presence of private interest in public policy. This is a new form of governance emerging in health system, which should be a matter of further study.

8.4 Community management

The Bank financed projects in total twenty-one year of intervention experience did not involve much with community. Still, this research thinks an analysis on community should be needed to find the cords of interaction between the Bank's health system projects and community. The analysis of projects – community interaction can shed light that how present-day HSS or even the earlier health system approaches (HSR or HSD) conceptualise and utilise the actor called community in the health system organisation. This research from its field experience has found that community in an operational health system refers to a management resource category for health care service delivery. This operative definition interprets that community is a part of health system's service delivery management force. It should not be (or at least in this research) considered as a unit of beneficiary of services. Through community management the beneficiaries are reached out for service delivery. Hence, as per the field understanding community is represented by the concerned service delivery instrument (community leader and Community Health Workers) of health system.

In Naglapur Community Health Centre (CHC) locality, a community consultation was carried out to understand the challenges of the community in terms of access to health care services. All the participants in the consultation unequivocally shared their disappointment with the existing facilities at the Naglapur CHC and Lingsur block hospital. At the time of the field visit, there was no permanent doctor in the nearby Naglapur CHC, often doctors at the Lingsur block hospital ask the villagers to go to private clinics for safe delivery and better post-operative care. Despite having a CHC in the vicinity, villagers usually report to uncertified community-based Rural Medical Practitioners (RMP) (total three in that locality) at first for any physical discomfort because of the unavailability of a doctor in the public system. Like the health care service delivery, community members were equally disenchanted with the community leaders, especially the elected body members at the GP, *Taluk Panchayat, zila*

panchayat levels. The community leaders, as the consultation opined, prioritise self-interest over community interest (Mallesh Madiwar Land Development site, Naglapur; block: Lingsur, district: Raichur dated 8 February 2017). The experience from the consultation informs that neither the service delivery system at the facility nor their democratically chosen representative is very responsive to the actual need of the community. In order to cater to the need, the community management as a grass root planning mechanism is active.

The WHO also lists community health services as a management activity in health care service delivery.[100] There are two functions that community performs in that management of service delivery; monitoring and participation. The Mission Group on Public Health constituted by the *Karnataka Jnana AAyoga/KJA* (Karnataka Knowledge Commission) of GOK even mentions 'communitisation' as one of the values (in public health governance) that should be made through participation and monitoring (KJA, 2013). This research also considers that communitisation as a governance value should be practiced by monitoring and participation like management processes. The community monitoring and participation are usually conceived in health intervention as tools of community empowerment. The micro-level bodies of *Arogya Surakshan Samiti* (ARS)/*Rugi Kalyan Samithi* (RKS), Village Health and Sanitation Committee (VHSC) are the examples where community leaders are inducted in the health care service delivery to *monitor* the services provided in public facilities and among village population. On the other hand, the Accredited Social Health Activist (ASHA), Auxiliary Nurse-Midwife (ANM), *Anganwadi* Worker (AWW) – collectively known as Community Health Workers (CHW) are playing the role of grass root workers to reach out the community members for their *participation* in health care service delivery. In this health care service delivery, the community is represented by community leaders (for monitoring) and CHWs (for participation) as community-centric service delivery instrument in health system.

Community monitoring-

At present in Karnataka (like elsewhere in India), the ARS/RKS (facility based, from Primary Health Centre to District Hospital) and VHSC (village based) are the

[100] More information on the community management is available in the WHO link. https://www.who.int/management/community/assessment/en/ Accessed on 25 May 2019.

decentralised bodies existing at the ground level to involve community in management of health care service delivery. The decentralised bodies at first were envisaged in National Rural Health Mission (NRHM) strategy framework to ensure community participation in the welfare management of patients (KHSRC & CBPS, 2012, p.5). The capacity building of these bodies was carried out in KHSDRP also as discussed in the chapter seven. In these bodies, the presence of politically elected representatives (*Panchayat* to Legislative members in Assembly house) and other key leaders (such as, school teacher, post master etcetera) are considered as representatives of the community. However, the actual representation of the community in health care service delivery is always under doubt. In fact, at the beginning of the formation of these bodies under NRHM, the 2009 report on assessment of the community planning and monitoring in Karnataka opined that VHCS members were difficult to identify since the committees were formed only on paper (Sudarshan, Bhojani, Madhav, Prabha, January 2009, p. 47). Since then the VHSC like community monitoring bodies have come across a long way, and now become a part of health care service delivery.

This research from its field visit has found that these grass root bodies hardly have any place in current HSS approach to health system, and function often against the spirit of community empowerment. The visit made in Arkera Community Health Centre/CHC (block: Devadurga, district: Raichur dated 4 February 2017) found that only five ARS meetings took place between November 2013 and January 2017. The ARS meetings are supposed to be chaired (at the capacity of President) by the local Member of Legislative Assembly (MLA). Though in practice, the MO (Medical Officer), in-charge of the CHC, conducts the meeting, and thereafter one of the facility staffer usually visit the MLA house/office to get the legislative member's signature. The sole purpose of the meetings, according to facility staff, is to release the fund for the facility maintenance.

In another visit to the Galag PHC (block: Devadurga, district: Raichur dated 4 February 2017), a group meeting was organised with the CHWs to understand their field-level challenges. The workers unequivocally complained about the non-cooperation of *Panchayat* members in several VHSCs in Galag PHC. The anguish is over the *Panchayat* members' greed for 'cut money' to sign the VHSC cheques on untied grant (INR 1000/annum). To avoid this kind of demand, Echanal PHC (block: Lingsur, district: Raichur dated 9 February 2017) amended the facility's ARS constitution in

2015 to empower MO and LHV (Lady Health Volunteer) as signing authority for ARS untied grant cheque. However, the respective GP member was found to be in the ARS committee at the time of field visit, but not anymore as a signing authority. The field experience reiterates the findings of contextual analysis done for Karnataka in chapter five, the political decentralisation in the state is indeed a success, but still that decentralisation is yet to come out of traditional power monopolies (caste, class, and gender). The *gram panchayat* members have the audacity to ask for cut money because the political decentralisation in the state has the audacity to not de-concentrate the power fully among the people.

The presence of those bodies definitely has positive contribution. For example, the 2012's joint study conducted by Karnataka State Health Resource Centre – Centre for Budget and Policy Studies found positive link between the utilisation of untied funds and the readiness of infrastructure and equipment (KHSRC & CBPS, March 2012, p.82). The present health care service delivery operation restricts these bodies to their executive function which is only about utilisation of three types of untied funds (RKS/ARS corpus, Annual General Maintenance, and untied grant). The fund utilisation depends on the physical need of the infrastructure, but that is not the only purpose of these micro-level bodies. The spirit of setting up RKS/ARS and VHSC like bodies at the bottom of the health care service delivery was to make sure that community takes the ownership of the service delivery at the ground. It was envisaged that the ownership would help the health care service delivery mechanism to be more just, non-discriminatory, and community-centric.

The situation experienced in Devadurga block is not different from other blocks of North Karnataka. The situation in South Karnataka is relatively good, though the conversation with DHO (of Mandya district) and RCHO (of Tumkur district) did not offer any satisfactory view on the role of micro-level bodies in those two districts (District Health Officer, Mandya District Health Office, personal communication, January 30, 2017; Dr. Keshavaraj, RCHO Tumkur, personal communication, April 30, 2017). The practice of asking for commission on untied grant may be less, but their role (executive function; presiding meeting and signing cheque) is very much designed from the top with little chance of planning at the bottom. It has been observed that presence of political and key community representatives is helpful for the local health authority in block and district (Block Health Office and District Health Office respectively) to

run the health service facilities without any hitch. This was definitely not the objective of the initiation of those bodies in health care service delivery.

KHSDRP supported these bodies in its project lifetime by giving untied fund to the blocks and organising training for VHSC and ARS. It is not at all surprising that the project failed to understand the challenges of community monitoring. Chapter seven already clarified that KHSDRP lent the support to community monitoring activity not because of its project design, rather to clear the unspent account from the sudden closure of PHCF sub-component. This is the importance of community monitoring activity in a health system intervention project or *per se* in an operative health system of the state. With this analysis, this research wants to opine that these bodies have become another co-opted institutionalised management extension of health care service delivery. KHSDRP had the opportunity to utilise the resource of community through its state-wide institutionalised base at the district-level (District Project Management Offices), but the concept as well as design of HSS approach does not consider any role of community in the health system. Thus despite getting the sudden opportunity to support community monitoring activity, the project utilised it as fund exhausting option. This research argues that these micro bodies are actually serving the interest of the present design of health care service delivery than the community's own interest. Community management at present is functioning as micro-level management bodies for ensuring decentralisation principle on health policy document and proclaiming community empowerment structure in health policy workshop.

Community participation-

The role of CHWs at the grass root is to achieve the target of threshold coverage (ranges 70 to 99 per cent of the total population) for immunisation, ANC check-up, completion of DOTs and active case detection of TB, timely collection of blood smears for malaria control intervention and many other preventive and promotive health activities. The present health system policy documents consider CHWs under human resource element. The flaw is that considering CHWs as HRH (health in human resource) mean ignoring their exact purpose in the health service system. The CHWs are part of health service mechanism because they are considered as community members. That identity gives them the advantage to mobilise the community for health promotion and prevention activities. The CHWs are managing the community to participate in the

preventive and promotive activities based on their identity. Here, the community participation is a management process between the CHWs and the targeted community (often expressed as vulnerable community). The problem is that policy and planning guidelines completely miss this aspect, and rather theorise that CHWs are managing preventive and promotive services. This misrepresentation is taking a heavy toll on the entire community participation process. This is further elaborated through the following illustration.

The Revised National Tuberculosis Control Programme (RNTCP) field workers in the DOTS programme primarily needs to build rapport with the patients to ensure their participation in the programme. The handling of Isoniazid or Rifampicin (as first line TB drugs) comes as secondary responsibility. The service delivery operation is practicing exactly the opposite. ANMs are given responsibility to meet the polio immunisation target. The fact is in order to meet the target, ANMs at first need to mobilise the community by organising camp or household visit. After the mobilisation only, can they ensure the administration of polio vaccine and reach the target.

Another example is ASHA in health care service delivery, modelled after the *mitanin* initiative of Chhattisgarh. The embodiment of ASHA in health care service delivery entails that it should be a village representative of the community (in particular women) to improve the maternal and child health scenario of the concerned community. However, over the period, ASHA has been gradually inducted into the health care service delivery management by bringing them under pay for performance policy. Field experience apprises that incentives are offered under the government programmes for institutional delivery, completion of immunisation, and in-fact at the time of field visit ASHA was also considered to be potential link for strategic purchase schemes as a point of referral. Last but not the least KHSDRP's NCD sub-component officially endorsed the incentivisation of ASHA, as discussed in chapter seven, by paying them incentives for improving the screening percentage. This incentivisation of ASHA has converted the embedded spirit of community 'Activism' into the service delivery logic of 'Assistance'. The field information from all the four visited districts has exposed the fact that small scale hospital/nursing home are roping in ASHAs by offering them cash incentive to supply patients and pregnant women for various health care seeking behaviour. The present mode of health care service delivery has converted ASHA from

activist to assistant in public system, and to establish as link to private health care industry.

It is required to understand that CHWs are not delivering the health care services; they are primarily managing the community to make the services be reached as well as delivered. The present health system considers CHWs as provider of health care service delivery. In reality, CHWs are the coordinator of health care service delivery. The role of CHWs in health system policy document is usually most neglected space, because they are health care workers and not community managers. The Bank financed health system projects' also conceptualised the role of CHWs within the dominant care-worker model framework. In the entire twenty one years, the Bank projects' never had any training/capacity building initiatives for CHWs. KHSDP mechanism for primary level care was to go for selective coverage of vulnerable population, in line with the principle of bottom forty per cent. The activities performed under the very mechanism were only related to infrastructure and supply commitments as mentioned in chapter six. The assumption was infrastructure and supply were the only assistance required to reach out to the community, since the rationale was to provide the services to needy, but not to develop the coordination with needy.

The similar logic prevailed in KHSDRP also, thus the Tribal ANM initiative could not see the day light. As health system intervention, it was a big limitation of the projects to not address the grass root level health worker's challenges. The group meeting organised with CHWs in Galag PHC revealed their stressed work life under target bound dateline, where most of the time they occupied with reporting in order to comply with documentation to report target status. In the same meeting ANMs complained that they are bound to cater to population size of 11000 – 12000 under their respective Sub-Centre (SC) since the number of SCs are abnormally low in the North Karnataka region (block: Lingsur, district: Raichur dated 4 February 2017). KHSDRP did not find any suitable reason to consider these problems as problems of health system, thus it did not have any problem to construct more SCs in the surplus districts and less in the deficit districts as described in chapter seven under capital investment of service improvement challenge fund. It is surprising that most of the generic population-level indicators (from institutional delivery to maternal and child health status) of both KHSDP and KHSDRP were linked with the performance of community participation, still the projects did not take any initiative to strengthen CHWs. Further, in the case of

KHSDRP a community participation strategy was devised through PHCF sub-component where district-based NGOs were given contract to replicate the national programmes. There is no point to reiterate what was the outcome of that strategy. Altogether projects' handling of community participation again shows the paucity of HSS approach (including HSR and HSD also) that fails to recognise community as a health system element within the boundary of health system.

The above analysis is carried out to show that how much the role of actors is pertinent in health system. Despite that the Bank financed health system projects' interacted with private sector and community, they were not considered in the theorisation of project design. This limitation of the project design ultimately restricted the projects to not efficiently utilise their resources in private sector mobilisation and community management. It is important to understand that in the relationship between the project and the private sector, the project interacted with private sector but private sector interacted with government. It is because the Bank financed project interacted with the private sector on behalf of the government. Hence, the failure of project's activity over the time translated into the failure of government's policy. For instance, KHSDRP's inability to develop the capacity in handling PPPs and unsuccessful attempts to run a full-fledged PPP cell led to the failure of all the PPPs (except source in of specialist) in the state, and not the project alone. Similarly, the projects' inability to understand the importance of community management in health system gets reflected in the failure of PHCF sub-component and also into the overall policy and planning exercise of DOHFW, GOK.

The analysis raises many questions regarding the role of the Bank and the GOK as implementing agencies. The questions range from the issues of integrity to efficiency to ownership. It is acknowledged that field-level complexity compelled the implementing agencies to frequently change the means to achieve desired activity. Still, it is a matter of self-introspection for both the agencies that how appropriate, convincing and effective those means were. It is to argue further that if the implementing agencies are facing challenges to implement the project then concept, theory and design behind the project should be reconsidered.

8.5 Health system: Development and Strengthening

The World Bank's intervention in health system through KHSDP and KHSDRP were made over two different approaches. Both the projects might have a similar style of functioning, but the operational methods were different. The first intervention (KHSDP) was on line with HSR approach of the Bank's health system policy where care-based reform was theorised by minimising allocation for tertiary care and maximising allocation for primary and secondary levels of care. Overall the policy modification of budget allocation for various components was an important dimension of KHSDP. The project had also the tenets of HSD approach where various proto-institutions (such as, cells, bodies etcetera) were created or strengthened to ensure quality, efficiency, effectiveness and so on by upholding value-based reform. The introduction of proto-institutions was an advocated statement that building up those institutions would deliver 'justice' in health care service delivery. Apart from introducing the HSR and HSD approaches, KHSDP also extended support for high volume of capital investment and direct service delivery at the primary level of care for vulnerable population. The support on the fronts of capital intensive initiatives and primary level health care need of vulnerable community can be considered as motivational factors for the state to accept the Bank's health system approaches for reform.

The second intervention under the execution of KHSDRP was based on HSS approach. It was implemented on the road built by the KHSDP (WB, 19 January 2018, p. 31). The official arrival of HSS approach may be in the year of 2007, but KHSDRP typified the creeds of HSS approach since the beginning of the project in 2006. Like KHSDP, KHSDRP also created many proto-institutions and SAST like institution, but along with that project also introduced a range of new functions with an expectation to take them over by the department in future.

In the distinction to KHSDP from KHSDRP, KHSDP was a project to improve the public system infrastructure in health as evident in the fund allocation concentration. Seventy five per cent of the project's cost was invested in civil work construction (only at secondary level) and equipment (infrastructural) expenses (Cabinet Note - GOK, 2005). The infrastructural investment was the mainstay of the KHSDP intervention. The KHSDRP, on the other hand, was on the line of health system's element support.

The project in opposition to the KHSDP had allocated only twenty per cent for infrastructural (civil works and equipment) investment (Cabinet Note – GOK, 2005). The entire project was instrumental to build the capacity of the public system in developing stewardship in order to manage private sector for arranging service delivery.

The Bank through its projects' interventions made Karnataka a social laboratory for health system reform experiments. The methodology of reform got changed from HSR-HSD to HSS, but the agenda of reform remains the same, increase the role of the market by reducing the role of the state. Then the question is what is new in HSS, how is it different from earlier approaches? HSS is also addressing the reform. The importance of HSS can not be narrowed down to reform, it is linked to larger governance to oversee UHC movement as elaborated in chapter three and four. In the end of this analysis, a brief discussion on HSS is necessary to understand the operative governance of HSS.

8.6 Governing operation through HSS

This research has already argued in chapter three that HSS is a governance framework for every level of policy system (macro to meso to micro). At the micro level where actual health system is in operation, the HSS is active to govern the implementation of UHC. The Bank financed KHSDRP was instrumental in implementing UHC through HSS. However, KHSDRP was not a hundred per cent HSS based health system intervention, in fact no Bank's health system intervention is fully based on the Bank's health system approach. It is because in any lending project the 'idea (i.e. health system approach propounded by the Bank) always gets exchanged with money' as explained in chapter four. The persuasion of idea is the interest of the Bank, and the inflow of money in the state treasury is the requirement of government. Thus in any health system intervention both the Bank and the government (in this case is GOK) need to strike a chord between the idea and the money. KHSDRP was also a product of that idea-money balance negotiation. Hence, the task is to separate the money from the ideas in order to understand what is HSS!

In the Bank's policy description, HSS is a chain of events as mentioned in chapter three. However, in project intervention this chain of events formula is invalid because the project comes as an aid assistance to strengthen the elements of health system (such as, financing, governance etcetera), and not to form any chain of events. Though one can

argue that through KHSDRP, the HSS approach tries to create the right chain of events. Even in that case, the primary task is to know what activities that KHSDRP introduced were with regards to HSS in particular. It is better to acknowledge that theoretical or practical guideline to identify HSS activities in health system intervention is academically inconspicuous. It is due to the Bank's inability to not have any management framework for health system intervention from where the activities of HSS could be distinguished. Chee and colleagues give a following broad outline to distinguish the activities that strengthen health system from the ones which support health system (Chee, Pielemeier, Lion & Connor, 2013, p. 86):

"*Supporting the health system can include any activity that improves services, from upgrading facilities and equipment to distributing mosquito nets to promoting healthy behaviors. These activities improve the system's functionality primarily by increasing inputs and can be short term and narrowly focused (for example, distributing free condoms or topping up salaries for target staff for a specified period). In contrast, strengthening the health system is accomplished by more comprehensive changes to policies and regulations, organizational structures, and relationships across the health system building blocks that motivate changes in behavior, and/or allow more effective use of resources to improve multiple health services. Both supporting and strengthening are important and necessary, and the balance must be driven by the country context.*"

The above understanding suggests that HSS approach led strengthening activities for health system should address the long term goals by improving the capacity of the state from policy preparation to management of service delivery. Hence, technical assistance is the single most criterion to identify activities associated with HSS in any intervention. Technical assistance can range from policy guidance to training to creation of proto-institutions to piloting of new schemes and a few others. It may be a relevant point that a piloting scheme (for example, NCD screening KHSDRP) can be a technical assistance. KHSDRP assisted NCD/road safety like sub-component by offering equipment purchase, staff salary, training, and pilot design support. While the hardware support, such as, equipment/hospital infrastructure/salary support within the NCD pilot may be considered as supporting activities, this research argues that those hardware support were provided to motivate the DOHFW to incorporate the scheme in its future service delivery mechanism. All the schemes and PPPs were introduced in KHSDP and KHSDRP in order to 'produce knowledge' for 'best practice' in health system

organisation and performance. Therefore all the assistance are usually carried out keeping in mind the long term change in the health system organisation and performance.

Going by the above discussed operative understanding, not only KHSDRP but many components of KHSDP also can be qualified for addressing strengthening activities. It is accepted that in KHSDP period the focal approach to health system was not HSS, but is it possible to deny that the strengthening activities in the forms of technical assistance were not there. Both KHSDP and KHSDRP had the components that directly applied the activities to strengthen the health system. The tables below identify the activities which were carried out to strengthen the health system both in KHSDP and KHSDRP.

Table 8.1: World Bank on strengthening health system through HSR-HSD approach (KHSDP experience)

KHSDP		Activities addressing strengthening of health system or supporting of health system
Mechanism	Component	Strengthening
M1: Increase Financing and Improve Resource Allocation for the Health Sector	M1-C1: Adequate Budgetary Allocations to the Health Sector	Strengthening
	M1-C2: Increasing the Share of Health Sector Resources to the Primary and First Referral Levels	Strengthening
	M1-C3: Increase the Allocation in the Operations and Maintenance Heads for the Secondary Health care	Strengthening
M2: Cost Recovery through User Charges Policy	M2-C4: Implementing Existing User Charges More Rigorously	Strengthening
	M2-C5: Retention and Use of Revenue Collected	Strengthening
	M2-C6: Exemption of Poor from User Charges	Strengthening
M3: Capacity building of the state for health Sector Analysis and Management	M3-C7: Creating special unit/cell for health sector analysis within the government	Strengthening
	M3-C8: Enhancing the Role of the state in administrative management	Strengthening
M4: Enhance the Role of the Private and Voluntary Sectors in the Delivery and	M4-C9: Contracting-out Selected Services	Strengthening
	M4-C10: Linkages with the Private and NGO Sectors	Strengthening

KHSDP		Activities addressing strengthening of health system or supporting of health system
Mechanism	Component	Strengthening
Management of Health Services		
M5: Strengthening secondary level/first referral facilities to bring quality, effectiveness and coverage of health services	M5-C11: Upgradation of physical infrastructure at the secondary level of care (civil works in community, sub-divisional and district hospitals and staff quarters)	Supporting
	M5-C12: Upgrading access to facilities, effectiveness and quality of clinical and support services at secondary level of care	Supporting
	M5-C13: Improving the referral mechanisms and strengthening linkages with the primary and tertiary health care levels	Strengthening
M6: Primary level: Selective coverage to serve mostly the vulnerable population	M6-C14: Improving Access to Primary Health Care in Remote and underdeveloped/disadvantaged Areas	Supporting

Table 8.2: World Bank on strengthening health system through HSS approach (KHSDRP experience from original financing)

KHSDRP original financing				Activities addressing strengthening of health system or supporting of health system
Mechanism (M)	Component (C)	Sub-component	Activities	
M1: Strengthening Essential Government Health Programs to Achieve More Effective and Equitable Delivery of Services	M1-C1: Organisational Development		Institutional strengthening	Strengthening
			Capacity development	Strengthening
	M1- C2: Improving the effectiveness of primary and secondary health care services			Supporting
M2: Innovation in service delivery and health financing	M2-C3: To provide service delivery through creating/expanding government infrastructure, using PPPs for managing the services and	M2-C3-A: Service Improvement Challenge Fund	Capital investment: Civil work and equipment	Supporting
			Service delivery (PPP): MHC, Contracting out of PHC, Source	Strengthening: MHC, CHD, and RDL, contracting out of PHC

KHSDRP original financing				Activities addressing strengthening of health system or supporting of health system
Mechanism (M)	Component (C)	Sub-component	Activities	
	conducting outreach		in of specialists, CHD, RDL	Supporting: Source in of specialists
		M2-C3-B: Public Health Competitive Fund (PHCF)		Supporting
	M2-C4: Innovations in health financing			Strengthening
M3: Project management, monitoring and evaluation			Project operations	Strengthening

Table 8.3: World Bank on strengthening health system through HSS approach (KHSDRP experience from additional financing)

KHSDRP additional financing		Activities addressing strengthening of health system or supporting of health system
Mechanism (M)	Sub-component (only the sub-components newly added during additional financing)	
M1: Strengthening Essential Government Health Programs to Achieve More Effective and Equitable Delivery of Services	M1-C1-A: Quality Assurance (scaling up activity)	Strengthening
M2: Innovation in service delivery and health financing	M2-C3-C: Non-communicable disease prevention and control	Strengthening
	M2-C3-D: Road safety and emergency health services	Strengthening
	M2-C3-E: Food safety	Strengthening
	M2-C3-F: Health Care Waste Management (HCWM)	Strengthening

From the above three tables, the stunning finding is that the Bank financed projects in terms of strengthening the health system employed more activities (derived from components) through HSR-HSD approach (total eleven in KHSDP) than HSS approach

(total ten considering both original and additional financing in KHSDRP).[101] The supporting activities (or 'money') have always been less in the Bank's reform-based health system approaches as found in KHSDP (three supporting activities), KHSDRP original financing (four supporting activities) and KHSDRP additional financing (no activity at all) periods. Altogether strengthening activities in the entire twenty one years were more in number and represented the 'ideas' of the Bank. In terms of investment on technical assistance, KHSDRP (80 per cent of total project allocation) was much ahead of KHSDP (25 per cent of total project expenditure). So, it is a riddle that where the number of strengthening activities was comparatively more the investment in technical assistance was less (HSR-HSD approach in KHSDP), and oppositely where the investment on technical assistance was more the number of strengthening activities was less (HSS approach in KHSDRP). This research argues that solving this riddle is the gateway to know what HSS is!

The technical assistance in KHSDP was mostly revolved around governance decision-making arena where policy guidance (budget and resource), institutional building (proto-institutions), and experiment over service delivery (for contracting out of PHCs and non-clinical services) were addressed. On the other hand, in KHSDRP (both in original and additional financing periods) the technical assistance was mostly addressing the management operations of service delivery except the Organisational Development (OD) component (to build the management capacity of the department). The investment on technical assistance in KHSDP was less because decision-making is always a governance related activities where the requirement of choice is primary and capital is secondary. Conversely, KHSDRP's service delivery operation was full of operational management activities where capital is always a necessity to organise/produce/purchase services. For example, SAST was formed under the principle of accountability to provide in-patient care for the needed population. The decision to form SAST for GOK was governance related choice given by the Bank. The regular purchase of service from private and public hospitals under the VAS was an operational management assistance offered by the Bank. The example is self-

[101] Service delivery (PPP) activity (M2-C3-A: Service improvement challenge fund) in KHSDRP's original financing had both strengthening and supporting inputs, since the source in of specialists was the short term support to state government to address human resource crisis.

explanatory to solve the riddle why the money was more required in KHSDRP's technical assistance.

HSR-HSD in KHSDP was more about governance related changes on policy and institutional management that also included capacity building on the new style of managing service delivery. HSS in both the financing periods of KHSDRP (original and additional) addressed directly the management operation of service delivery. That management operation of service delivery came with innovations ranging from PPPs to strategic purchase. Thus KHSDRP had invested aid in the form of technical assistance to operate the management of innovative service deliveries. That management was involved of everything about the operation (recruiting, capacity building, contracting, and purchasing etcetera) of various service delivery schemes. The important point is while the HSS-HSD was more active in the decision-making process (governance level), the HSS of KHSDRP was instrumental on the functional process (management level) of health system. In other words, HSR-HSD got aligned with decision-making body of health system, and present-day HSS engages with the functional body of health system. The OD component (the only non-service delivery component) in KHSDRP was also fundamentally linked to the function of health system. It was introduced to bring the change in the attitude of leadership in order to make the leadership familiar with new 'attitude of service delivery'.

The above analysis reveals that technical assistance in HSS means providing operational management assistance for introducing innovative service deliveries. Technical assistance does not literally mean strengthening the health system, for programme intervention one can be discrete to the strengthening activities, but that discretion does not necessarily mean strengthening the health system. Strengthening activities mean through technical capacity strengthening of a particular system element, for instance building proto-institutions (as an activity) for governance and leadership (as an element), piloting innovative schemes (as an activity) for financing or service delivery (as an element). Thus the strengthening of health system depends on the quality of technical assistance provides for any activity, more specifically the impact of activity performed through technical assistance. Through the activity, HSS approach intends to strengthen the concern element of health system. The performance of those activities is the deciding factor to make the elements optimally *function* to strengthen the health system. In brief, HSS approach at the micro level of policy system focuses on the

functions that strengthen the capacity of health system elements by performing certain activities through technical assistance.

With this operative definition of HSS, this research wants to argue that if the function-based reform is about strengthening the health system elements, then how the strengthening of the health system itself is happening. Strengthening of the health system is subject to a successful interaction the health system elements have with each other. In that case, the functions of HSS approach through the strengthening of health system elements need to create a successful interaction (i.e. relationship) among the elements to strengthen the health system. For example, if the goal of the health system is UHC then in any health system intervention the HSS approach may introduce activity like empanelment of hospitals with an assumption to strengthen the service delivery element through strategic purchase. Similarly, insurance (social/mandated/employee based and so on) and OD training activities are also required to take up to strengthen financing, and governance and leadership elements respectively. Also there are other health system elements (like, community/population, information and knowledge etcetera) equally important to strengthen and participate in that particular interaction process. Now all these strengthened health system elements have to successfully interact to produce relationship then only strengthening of the health system can happen in order to achieve UHC.

From the above analysis, two important system relationships are found; first the functioning capacity of the element is depending on the performance of the activity completed for the strengthening of respective element in the health system intervention, second the theoretical rigour of the function determines the employability of the function as system lever. For the first relationship, the process evaluation done in chapter six and seven have already analysed as well as deliberated about how well those activities had been executed and thus performed in the Bank financed health system intervention. Regarding the second relationship, the theoretical formula of those functions are determined at the stage of policy formation where international economic governance interacts with international health governance as described in chapter three. Hence, there is almost zero reflection by the HSS approach on the assessment of local context where health system is actually in operation. Moreover in order to condition the local context, the Bank either brings its own reformed model of development in and/or

utilise state's existing development model to make the model accommodative towards the HSS's implementable functions.

The HSS approach in the operative health system is bringing a set pattern of functions to govern the health system's service delivery element. The intervention sites for the Bank's health system project may be different from Karnataka to Uttar Pradesh to Andhra Pradesh, but all the activities and subsequent functions are indistinguishable. Albeit the project execution experience must be different in all these sites, but the operational method is same. This 'method' is creating a pattern to streamline and uniform the health system to adopt behaviour – governmental behaviour, i.e. publicly financed and privately managed and run health service. This research argues that this governmental behaviour for state like Karnataka or country like India or economy like developing or less developed countries is a hypothesis. The hypothesis or the 'observed hypothesis' is publicly financed and privately managed – run health care service delivery is possible in semi-advanced or not-so-advanced liberal society. India will achieve universal health coverage or not that time will tell, but pursuing Bank's HSS approach further will definitely make India nearer to achieve universal health system – the Bank's HSS driven hypothesised health system!

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Chapter 9: Discussion

Summary of the chapter: The discussion chapter is the overall analysis of this research. This chapter develops a mental model to analyse that how HSS approach gets formed and thereafter engaged in as different models of HSS in the three levels of policy system; international, national, and state levels. This research argues that health system exists in the form of conceptual, theoretical and operational health system, and in international, national, and state levels respectively. The HSS approach acts as a descriptive model in the conceptual form of health system, analytical model in the theoretical form of health system, and finally as a deterministic model in the operation form of health system. With these three different models HSS approach promotes agenda, policy, and practices in order to govern the health system as the way Bank wants. This approach is more about engineering the Bank's own idea of health system rather than contributing into the goal of health for all.

The analysis of policy process shows how the World Bank's health system approach gets formed and formulated in the macro system (international arena), adopted and modified in the meso system (national scenario, India), and finally implemented and operated in the micro system (Karnataka is the case in this). Chapter three delineates how political economy of international governance as well as cultivation of knowledge factored in to the formation and formulation of the Bank's health system policy evolution since 1969 in macro system. Similarly, chapter four illustrates how mediation tactic of policy tool (Country Assistance Strategy/CAS) and validation practice of policy instruments (research and lending) are carried out in order to adopt and modify the policy respectively in the meso system. While the stages of policy adoption and modification involve in building normative alliance (through policy alignment and convergence) with Government of India's policy and planning outlook to implement and operate the policy at the state-level, chapter five argues that these normative alliances incredibly fail to study the contextual determinants of the Bank's policy intervention site (Karnataka). At the end, chapter six and seven analytically describes the mechanisms and components through which the Bank's health system policy approaches had been implemented and operated in the micro level of policy system from 1996 to 2017 in Karnataka. Finally, chapter eight argues why Health System Strengthening (HSS) is not strengthening the health system rather strengthening the health system elements in order to govern any operational health system.

In the entire policy analysis, this research has so far systematically mapped actors, agendas, interests, knowledge innovations, technical feasibilities, economic compulsions, political rationalities, epidemiological reasoning, governance practices and management executions. They have been studied to understand the present health system approach of the Bank namely HSS. In this discussion chapter the role of health system or especially the present approach of health system (i.e. HSS) is intended to be deliberated upon to understand how the HSS approach is performing throughout the policy pathway from formation to operation. HSS is the central theme of discussion!

The replacement of epidemiological reasoning with economic reasoning had changed the Bank's health system policy structure permanently as argued in chapter three. Since then the Bank has introduced three health system approaches; Health System Reform (HSR), Health System Development (HSD), and HSS. Needless to say, all these approaches adhere to the path of reform; from care-based to value-based to function-based. In the path of reform, these approaches tend to reconfigure the health system that already exists. This chapter intercepts at this reconfiguration process to assess the performance of the Bank's health system approach in reconfiguring the health system.

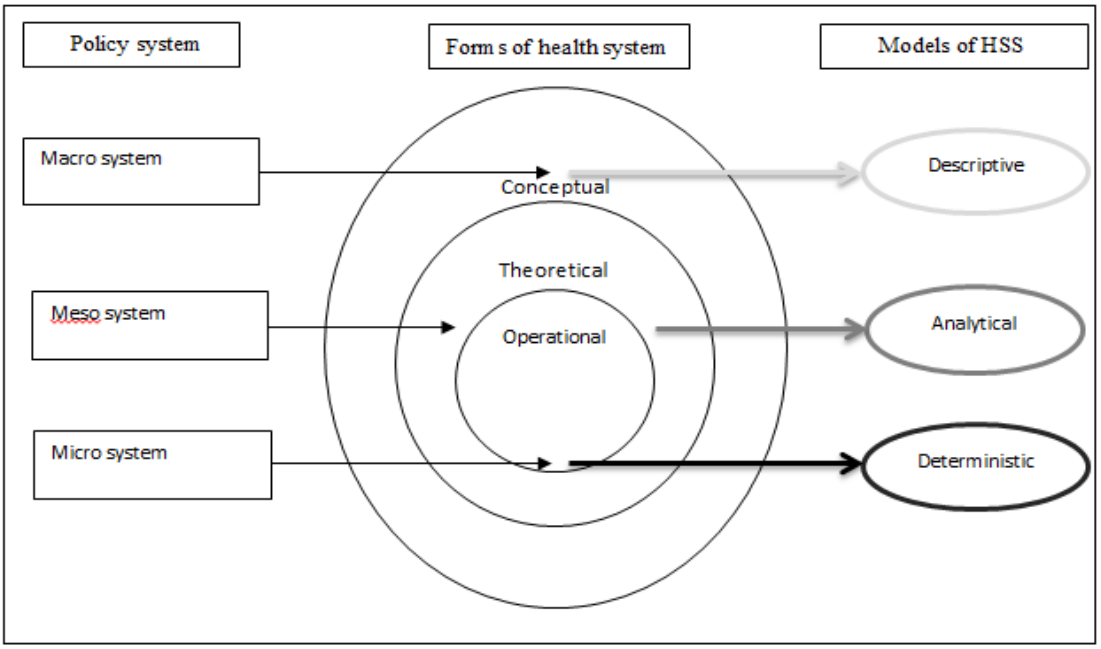
The reconfiguration is linked to the Bank's health system policy agenda, and performed at the behest of the Bank's health system approach. For example, in HSR and HSD the reconfigurations were attributed to reform and development of health system respectively. In the HSS approach the reconfiguration is about strengthening the health system. As per the policy process analysis, the reconfiguration of health system occurs at every level of the policy system conceptualised in the international (macro system), national (meso system) and state (micro system) levels. The analytical challenge is that while the health system approach is known to be active at all the three levels (macro-meso-micro) of policy system, the forms of health system coexist which in these three levels of policy system are not clear. In this regard, all the available health system frameworks for intellectual reference describe health system as a set of elements, such as goal, governance, financing, service delivery etcetera.[102] However, these elements are active only at the operational level (which happens to be the micro system for the Bank's policy) to interact with each other for organising/arranging/producing health

[102] Almost all the frameworks address the functions of health system (like goal, financing, service delivery) as components. However, this research uses 'element' as terminology to address the health system functions.

care services. Nevertheless, at the same time the Bank's health system approach is also active at the macro and meso levels to reconfigure the health system. Then the question is how the Bank's health system approach engages with the health system at macro and meso levels of the system.

This research attempts to overcome the above identified challenge by introducing a mental model of the health system. This model is cerebrated during the analysis of policy process for this research. It was found that in each level of policy, the Bank's health system approach does not only engage with actors (for example, international health actors, state government etcetera), it engages with certain forms of coordinated networks. Those networks consist of thoughts (expressed through goal/value), actors (leadership from both state and non-state), processes (such as, payment mechanism), and functions (like service delivery). Form the policy analysis perspective, they collectively represent the *form* called health system. Therefore, according to the mental model, health system is a *form* that constitutes of various system elements, whereas the Bank's health system approach is a system method to engage with the very health system to reconfigure the *form*. The diagram below illustrates the mental modelling of HSS's engagement, as health system approach, with forms of health system exists in the three levels of policy system.

Figure 9.1: Mental modelling of health system in the Bank's HSS approach



The mental model represents health system in conceptual, theoretical and operational forms. The contribution of the Bank's health system approach is required to analyse all these three forms (conceptual, theoretical and operative) of health system. The operative form of health system for HSR and HSD approaches is not possible to look at as they are the things of past. Thus HSS being the latest and most importantly current approach becomes the automatic choice in this case.

The outermost circle as a conceptual form of health system exists at the international level where the policy related to health system gets formed and formulated. The Bank's health system policy at its nascent stage through its macro level of policy system engages with this form of health system to develop a descriptive model of health system approach and subsequently formulate the approach (i.e. HSS, in this case). The model describes HSS by characterising its goals, principles, values and the likes. In the intermediate circle of national scenario, a theoretical form of health system subsists. This form of health system is the place where the abstract model of policy turns into a concrete one to articulate the policy. The Bank's HSS approach engages with this form of health system at the level of meso system. This engagement results into the construction of an analytical model of HSS. In result, this model of HSS serves as analytical base to prioritise the needed health system elements to be focused for an operative health system organisation. This analytical exercise is theorised based on the Bank's HSS formula developed at the macro system.

The inner most circle depicts the real-time interactions of health system elements with each other that organise/produce/arrange health care services. This form of health system exemplifies an operative health system. The Bank's HSS at the micro level of policy system further engages with this form of health system to execute a deterministic model of HSS. This model is by nature definite, visible and in fact countable through policy action.

These three forms of health system are independent entities and self-organised. Every form of health system has its own organisation process. The Bank, like any other actor, is just a part of those organisation processes. The policy analysis points out that the Bank's HSS approach through policy system engages with all the forms of health system exist in macro, meso and micro levels. Over these engagements, the HSS approach formulates, constructs and executes descriptive, analytical and deterministic

models of HSS respectively. The next three sections discuss the performance of the Bank's HSS approach as three distinct models in the process of reconfiguration for all the three forms of health system by drawing resources from all the previously analysed policy stages in this research, i.e. formation and formulation of macro system (chapter three), adoption and modification of meso system (chapter four), and implementation and operation of micro system (chapter five, six and seven).

9.1 Conceptualisation of descriptive HSS model

The conceptual form of health system holds a general idea about the health system which exists at the international level, which is neither specific nor conclusive. This form of health system on behalf of the International Health Governance (IHG) provides a descriptive idea that serves as a conceptual reference to primarily develop a health system model. In that concept, the wide-ranging nature of health system is expressed, such as what should be the main focus of health system in terms of goal, value positions and principles. The boundary for conceptual health system is the events that occur in International Economic Governance (IEG), interest of several international health actors, finance of development assistance, and the leadership of UN and other international-level health actors. Noticeably, this form of health system does not provide any rigid guideline about how any health system approach (*per se* HSS) strengthens a health system, instead offers which are the elements that could be considered to strengthen a health system.

In brief, this conceptual form of health system is an abstract form of system which is active as a policy development network in IHG. In this abstract form, the health system has several frameworks that represent diverse interests of actors. Those frameworks are hands-on conceptual reference for IHG to develop health system model and finally health system approach. The Bank's policy system comes in contact with the conceptual form of health system only at this point in order to develop the descriptive model of HSS by selecting the appropriate framework available. Subsequently, the selection of health system framework within the Bank's policy structure paves the way to formulate HSS approach at the macro level. It should be noted that at the conceptual form of health system, at first the Bank's health system policy reconfigures the very form of health system by developing the descriptive model of HSS. Thereafter, the Bank based

on the overarching frame of descriptive model of HSS formulates HSS approach within the health system policy structure. Below is the case discussion of the same.

The Bank's health system policy after 2000 was in need of update because of the reorganisation in IHG. Though it was not only the Bank alone, health system became an epicenter of discussion for entire IHG. The example of WHO convened Montreux meeting in 2006 on health system action agenda was one such earlier initiative. The thrust on health system was given in order to legitimate the finance and participation of Global Health Institutions (GHI) in Global Health Partnership (GHP) as discussed in chapter three. The GHP was the need of the hour especially for disease-based intervention to meet the health Millennium Development Goals. Hence, the Bank as an influential actor in IHG had to rope into a framework for its own health system policy which would support its continuous reform programme, and at the same time comply with the larger consensus on GHP. In other word, the Bank was in need of a framework that would give a practical outline of reform through horizontal intervention, and also extend the support to the vertical intervention made by GHIs. This research lists the available health system frameworks in the box below to discuss the rationale behind the Bank's choice for a particular framework.

Box 9.1.: Multiple Health system frameworks

Pre 2000
1981 (Evans): Actors frameworks
1991 (Hurst): Fund flows and payment framework
1995 (Cassels): Demand-supply framework

Post 2000
2000 (WHO): Performance framework
2003 (Hsiao): Control knobs framework
2004 (Roberts, Hsiao, Berman, & Reich): Reforms framework
2004 (Khaleghian & Das Gupta): Public management framework
2006 (Mills, Rasheed, & Tollman): Capacity framework
2007 (WHO): Building blocks framework
2008 (WHO): Primary healthcare framework
2008 (PAHO): Essential public health functions framework
2008 (Atun): Systems framework
2012 (ITM): Health system dynamics framework

Adapted from Atun, Berman, & Hsiao (2009, p. 4) paper. ITM, 2012 framework is an addition to the list.

The GHP in IHG bolstered the focus towards health system as evident in the growing number of health system frameworks after 2000. The above frameworks depict that there is three broad categories of elements that design health system organisation; process led, actor led, and function led. Design-wise, these categories either singlehandedly or collectively constitute the health system. From the perspective of the Bank, it needed an economics-based framework in order to address the macro as well as microeconomics of health system to restructure the health sector economy and reorient the health governance system, since the Bank's perennial agenda of health system intervention is always reform. It is already presented in chapter five while discussing contextual determinants of Karnataka state that reform, especially the Bank's model of reform, is at all times a set of processes. So in order to continue the reform agenda, the Bank's health system approach had to be based on an economics framework and driven by process led elements.

Out of above mentioned thirteen health system frameworks, control knobs fulfills both the criteria. This economics-based framework is the Bank's enduring process-led health system approach to 'control' the reform processes, which otherwise is not possible through elements like actors or functions. Actors have diverse interest, and to mobilise them collectively for reform require political engagement. For an economics framework, it is difficult to devise a political mobilisation strategy because of contextual specificity and ever evolving power relationships. Similarly in the case of functions, they are determined by actors and discharged by processes. In order to control the functions, the economics framework has to operate like a monitoring and verification tool which again a difficult job considering the operational complexity of reform. Therefore process led health system approach can address the reform best as they proffer a set of replicable recommendations and guidelines, and appear as technical requisite for reform. The Bank's adoption of process led economics-based health system framework (control knobs) developed the descriptive model of HSS, which generalises the concept that health system can be strengthened by following the reform processes.

In descriptive model of HSS, control knobs as a framework primarily represent as a collection of certain concepts (or knobs). However, within the framework the concepts are propounded as process of financing and institutional organisation, payments, regulations, macro-organisation of service delivery, and persuasion (Hsiao, 2003, p. 12 – 19). Later on politics, and ethics and values have also been added as listed on the World Bank's website.[103] The theorisation of the framework is important to understand to know how HSS approach from control knobs framework got formulated. Control knobs theoretically defines health system in policy and economic research as "*a set of relationships in which the means (i.e. structural components) are causally connected to the ends (i.e. goals.)*" (Hsiao, 2003, p. 4). In these relationships, the goals of health system are, improving health, financial protection and pubic satisfaction, whereas the means are above mentioned five processes (or concepts). The hypothesis behind these relationships is that means of the system can influence or moderate the behavior of individuals (beneficiaries/consumers) and firms (providers and purchasers of health care service), which in turn determine the outcomes (or goals) (Hsiao, 2003, p. 3 – 4).

From the above understanding, the conclusion can be drawn that "*health system is a means to an end*" (Hsiao, 2003, p. 3). It interprets that health system is theorised as means to achieve the health system goal as end! Here, health system symbolises 'relationships of processes or *structural components*'. So the postulate is strengthening the processes strengthens the relationship, which in turn strengthen the health system goal. This strengthening of health system processes is nothing but health system means, and strengthening of health system goal is nothing but health system end. The Bank formulates this 'strengthening of health system processes' (or health system means) as "*right chain of events*" as discussed in chapter three (WB, 2007, p. 5). In order to set the right chain of events, the processes have to be strengthened – the health system has to be strengthened! Within the framework of controls knob, this strengthening process is the HSS approach that the Bank has formulated as a means of health system. With regards to goal of health system, control knobs in line with IHG emblematically articulate the crux of UHC – financial protection.

[103] The detail on control knobs can be found on World Bank's Flagship Program on Health Sector Reform and Sustainable Financing . (http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:22346748~menuPK:376811~pagePK:148956~piPK:216618~theSitePK:376793~isCURL:Y,00.html. Accessed on 15 June 2019)

The above discussion makes it now clear as described in chapter three as to why the Bank in 2007 HNP second sector strategy conceived HSS as means and not as an objective, and also explains the rationale made behind financial protection (later epitomised as UHC) as key health system goal. The Bank's adoption of control knobs framework has reoriented the conceptual form of health system to develop the descriptive model of HSS. Within the descriptive model of HSS, the Bank with the help of economics-based process led health system elements has formulated HSS approach for theoretical and operational advancement of HSS approach. On one hand, the Bank through descriptive model of HSS promotes the goal of UHC through HSS, and on the other side through control knobs theory, the Bank formulates HSS approach as means to achieve UHC.

9.2 Theorisation of analytical HSS model

The theoretical form of health system represents the national scenario where the national health policy and planning related to health system are developed. This form of health system is concrete in nature and objective-wise more specific. It is also theory based and more definite in nature. The boundary for this form of health system is mostly limited to actors (both state and non-state) and their interests, aid assistance (or coordination) of IHG, and in rare occasions any specific public health event (like Ebola virus disease, Middle East Respiratory Syndrome/MERS or Severe Acute Respiratory Syndrome/SARS like diseases outbreaks or epidemics) potential to pose internal or cross-border threat. It is important to note unlike conceptual form of health system, theoretical form of health system is hardly influenced, except in budget allocation, by the macroeconomics events hovering around at the national level. This is due to policy orientation (both economic and health) of nation-state like India which is predominantly determined by the events of international macroeconomics factors as argued in chapter four.

Compared to other two forms of health system, theoretical form of health system has limited role in terms of developing or executing health system policy. The national health system policy or planning exercises should not be typically considered as policy development event, they are rather policy decisions to articulate or direction policy. The exercise of policy decision is the crossroad between the Bank's policy system and theoretical health system. The Bank's HSS approach in the meso level of policy system

becomes decisive for making inroad into national policy and planning map. Here, HSS approach engages with theoretical form of health system not because to develop any national health system policy, rather serve as a theoretical referent in the construction of national health system policy decisions. In this process of theoretical construction, the HSS approach intermingles with the country's theoretical form of HSS in order to perform as analytical model of HSS to apply its formula. Thus HSS formula in the descriptive model of HSS is the concept, but in analytical model of HSS is the theory. This is the difference of general (descriptive) vs. definite (analytical) nature of health system. The theoretical reference can be found, as explained in chapter four, in India's 2017 National Health Policy or *Pradhan Mantri Jan Arogya Yojana* (PMJAY) of Ayushman Bharat programme where UHC is articulated as policy decision.

In this definite nature, how the theoretical form of health system is intervened by the Bank's HSS approach is a point of discussion. Though the HSS formula (*right chain of events*) gets developed in the macro system of policy, however, the conceptual form of health system does not provide the opportunity to apply the formula at the international level as discussed in chapter four. The Bank's HSS approach as analytical model of HSS applies the formula in the process of engagement (through the policy instruments like research and lending) with the theoretical form of health system to shape/contribute into national health system policy decisions. In this process, the analytical model of HSS classifies the 'chain of nine key functions', as formulated in HSS, in four broad categories of health system functions (service provision, service inputs, stewardship, and financing) as elaborated in chapter three (WB, 2007, p. 174). These effective health system functions of analytical model of HSS theorise that strengthening of these functions through HSS approach strengthens the health system for achieving UHC. So according to the theory, "*the failure of any of the nine key functions may compromise overall health system performance"*, thus the Bank's analytical model of HSS is inevitably a reference point in the articulation of national health system policy and planning decisions (WB, 2007, p. 80).

In the theoretical form of health system, the performance of analytical model of HSS is linked to the acceptance or reflection of the theory in the national health system policy and planning decisions. All the theory driven functions' *modus operandi* is same, to continue the reform in health system. However, in this continuation of reform the

technique to pursue reform in the analytical model of HSS is different form descriptive model of HSS. While the descriptive model of HSS is conceptualised on process led health system elements, the analytical model of HSS is theorised on function-based health system elements. The functions stem from the processes of descriptive model of HSS only, but similarly these functions also represent the same economics framework (control knobs). Thus in contrast to the descriptive model of HSS the analytical model of HSS overrules the complexity of operational challenge in reform intervention as previously argued.

The choice of function-based health system elements over process led health system elements at the theoretical form of health system definitely gives the Bank advantage in the designing of reform policy. Because in terms of execution of health system intervention, nominating function against each process is more feasible for operational accuracy. For example, financing as one of the reform processes gives only a broad idea that in health system source of financing may be tax based, insurance, co-payment etcetera. However, until and unless the tax based financing is overhauled the process of health care financing reform can not be addressed. Hence, risk pooling (through insurance, taxation or copayment and so on) as a function has to be bought in to reform the tax-based financing. Similarly, from the process of macro organisation of service delivery strategic purchase is strategised as function in the analytical model of HSS to split between provider and purchaser in the health care service delivery reform.

This analytical model of HSS through its theory of function-based element driven health system brings some concrete changes. It makes the theoretical form of health system more objective oriented. This model of HSS is also top down in approach since the functions are discharged by the processes, and of course determined by the Bank only. This top down design of HSS as analytical model justifies why contextual determinants get less priority in the Bank's heath system reform intervention. The analytical model of HSS concretises and objectivises the Bank's health system policy in order to execute it at the operational level.

9.3 Operationalisation of deterministic HSS model

The operational form of health system is the place where health system is organised and performed in reality. In this form of health system, all the health system elements

participate and interact with each other to provide health care services. The uninterrupted and quality provision of health care services is the goal of any operative health system. Health being a state subject is obviously falling in the domain of Indian provincial states like Karnataka where operational form of health system is active. The Bank engages with this form of health system at the micro level of policy system through its health system projects by operationalisng a deterministic model of HSS. This deterministic model of HSS is the end model of HSS approach that engineers the functional aspect of an operative health system. To discuss the interaction between the Bank's deterministic model of HSS and the operative health system, what is an operational form of health system is required to be discussed at first.

The multiple frameworks of health system provide references that how the selection of elements determine the nature and boundary of health system. The actors in the health system as per their agenda and interest choose the frameworks based on their types of elements. The Bank's control knobs or WHO's building blocks are the references of this kind of choice to design and run health system intervention. The point is these frameworks driven health system is not a true reflection of an operative health system. They are the representatives of different actors' idealised position on the 'means' to improve health system operation and performance. The operative health system has its own boundary, and nature-wise also it has its distinct originality which varies from context to context. Thus an operative health system is not necessarily to be (in fact, can not be) the prototype of any framework designed health system. This researcher during the seven months' field visit in Karnataka had to relearn the health system frameworks exist in policy documents – the imagined health system – to learn the form of health system that exists in reality – the operative health system! The Bank's engagement with the operative health system is actually the engagement with the reality to operationalise its own theorised (or imagined) health system. Below is the discussion in brief as to what an operational form of health system in reality is.

It is to clarify at the beginning that operational form of health system discusses about the form of health system at the operational level, and not the operative health system (in this case is Karnataka) in specific. The operational form of health system covers the boundary of both upstream (goal, context, governance and leadership) and downstream (finance, service delivery, infrastructure and supply etcetera) of system, and an

arrangement of process, actor and function-based elements. Karnataka's operative health system boundary-wise spreads from policy decisions (upstream interactions) to policy actions (downstream interactions). Similarly, the operative health system possesses multiple types of elements (process, function and actors) because of presence of various actors, directions of various policies, and introduction of innovative practices. From this understanding, it is an uphill task to identify which existing framework can even closely resemble with the operational form of health system. This research after lot of mental simulation identifies that among the available frameworks the ITM's health system dynamics framework, which consists of ten different system elements, could be a reference of an operational form of health system as mentioned in the chapter two on methodology (van Olmen, J. V. et al., 2012).

The ITM framework entails an idea that what constitutes a health system in terms of boundary and nature. Because of the multiple types of elements, the framework covers broader spectrum of health system. However the elements are just the prescribed units of health system's operative function, the actual operation depends on how the elements are coordinated with each other. This is the limitation of all the frameworks, they prescribe a set of elements that constitutes health system, but they hardly have any guideline to tell how the elements are interacting and thus producing relationship for operationalising health system to be studied. This is because the operative health system is very much context driven, and moreover academic and policy references in this regard are also inconspicuous. The academic and policy research are mostly involved in studying element-wise (financing/service delivery/supply etcetera) performance, and not the entire health system's organisation and performance. It is a matter of concern that from 1996 (since the birth of WHO Alliance for HPSR) till date, there is hardly any system analysis of operative health system involving the relationship produced by the elements. Hence, it is known what constitutes the health system (the elements), but how the health system is constituted remains unknown (relationships of elements). This research opines that owing to this particular limitation all the existing health system frameworks (including ITM) offer an anatomy of health system to study, invest, and intervene. This anatomical health system helps to identify and understand the structure of the system that consists of elements. The dissent is this anatomy can not complement the physiology of the health system. The physiological health system holds the surface wherein the structural determinants (elements) interplay through their functions and

processes. The anatomical health system is concealed in the health system frameworks' incognito, and thus the operation of physiological health system is also not appearing on the surface.

The physiology of health system is an important facet to understand operational form of health system. The health system is complex and dynamic (Atun, 2012), but why does any health system pose these characteristics. Actually it is not any health system; only an operative health system in its physiological state carries those traits because of the multidirectional interactions produced by actors, policies, and practices. At the same time, Karnataka's operative health system over the period has become adaptive to some dynamic complexities since the anatomical structure of health system has got adapted to those practices (which are dynamic and complex) occurred in the physiological state. Hence, until and unless the interrelation between anatomy and physiology of health system is accurately clear, it is difficult to understand that why the Bank's deterministic model of HSS aims to be an "*effective adoption and diffusion of innovations in health*" (Atun, 2012, p. iv7).

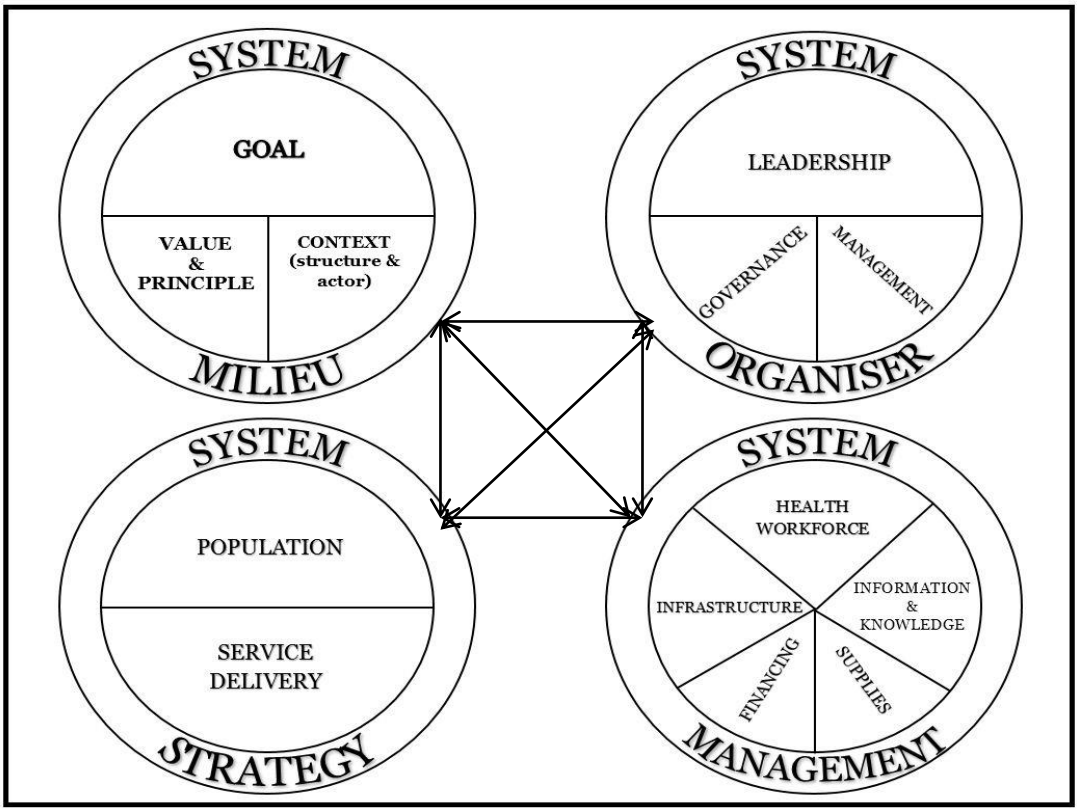
The analytical problem is because of absence of any distinction between anatomy and physiology of health system, all the present health system frameworks address only anatomy of health system (element-based) at the operational level. The assumption is that these elements would interact with each other in order to perform the health system goals. It means that the functional properties of those elements active in the physiological state are incomprehensible to those frameworks. Elements are not functioned on their own, they are driven by their properties. During the field work it was observed that many elements hold similar properties, but their degrees of influence on those properties are not same. For instance, administration can be considered as a functional property of three different elements (leadership, governance and management); but does that mean administrative leadership, administrative governance, and administrative management have equal role in the fulfillment of any particular health system function? For example, covering all the secondary heath care facilities through Hospital Management Information System (HMIS) depend on the foresightedness of administrative leadership, decision of administrative governance, and supervision of administrative management. The three elements are involved (through interaction) in the same activity (HMIS network), but their quality of

involvement (relationship) with the activity is moderated by the nature of administrative function (property) they employ. This is the difference between anatomical understanding and physiological understanding of health system. The three elements are required to interact for the HMIS activity, but the accomplishment of the activity depends on how much those interactions are producing successful relationship. The production of successful relationship rests on the functional properties of the elements. The existing frameworks through their anatomical understanding profess that concerned elements are required to interact with each other, but the challenge is to capture these elements along with their functional properties that produce relationship in the physiological state of the system.

To overcome the above mentioned challenge, this research has embarked upon the dimension analysis technique. The dimensional technique is adopted to analyse the value laden health system elements' functional properties in any operative health system.[104] Dimension analysis categorises the elements in four groups as per the operative dimensions of health system. These dimensions bring the physiological state of an operative health system by classifying the role of the elements in each dimension, so that their properties can be tracked. In this process, this research from its field experience has further modified the ITM's ten health system elements to include (i.e. management) and detach some of the joined elements (for example, leadership and governance are listed separately and not together). This modification of elements demonstrates the dimension aspect more clearly. The picture below depicts the modified version of dimension-led complex adaptive health system dynamics framework.

[104] Dimension in Physical Science is a measure of physical variables which are not factored by any numerical values. The health system elements have the properties which are measurable (though not quantifiable all the time) and observable. After the field visit, the primary understanding of this researcher is that those health system elements' properties are actually physical properties. It is not proposed, discussed and elaborated further since it is a different theorisation and analytical path of enquiry, and not in the immediate scope for this research. Regarding the physical properties Mark Burgin's Theory of Knowledge: Structure and Processes can be consulted especially the Theory of Abstract Property (p. 500 – 518) section (Burgin, 2017).

Figure 9.2: Health system dimension framework



The picture above illustrates that how the health system elements are classified as per the dimension of an operative health system. This health system dimension framework gives an idea of an operational form of health system through which an operative health system in reality can be understood. There are total four dimensions and thirteen elements active in an operative health system. All the four dimensions are discussed in the table below.

Table 9.1: Dimensions of health system

System milieu: Goal, value and principle, context	The milieu means some conditioned socio-physical set-up which serves as a base for the development of some structure/elements/events. The goal, value and principle, and context are the necessary elements that are in dynamic interactions to form the very structure of health system. This structure (i.e. system milieu) is in-fact the subterranean level for the rest of system elements. In this level, the system elements have bidirectional interaction with social, political, and economic arrangements both outside and inside the health system. This is chiefly the terrain of health system policy decision domain.

System organiser: Leadership, governance, and management	In the next dimension, system organiser considers leadership as *medium* of influence, governance as *forms* of power and authority, and management as *means* of tactic and technique in pursuing health system goals. The influence of leadership acts as 'medium' in the link between policy upstream and policy downstream to set the health system goals. The 'forms' is about restructuring the institutions by using the power and authority of governance. The 'means' refers to employability of functions through arts (tactic) and science (technique) of management. The medium, forms and means are properties of leadership, governance, and management, which are determined by influence, power and authority, and tactic and technique respectively. Over the interactions of elements, these properties synchronise with each other. This synchronisation is needed to produce relationship among the three elements for organising health system. In other words, leadership, governance and management are the organs of any health system. In the process of reform, a committed pro-reform state-level political leadership may approve the reorganisation of the state from the role of provider to purchaser. However, the governance mechanism would also be needed to be equally well-equipped in order to restructure the institutions towards reform. Similarly, the management machinery needs to be well fortified to reconfigure the institutional activities to ensure the reform. Thus this research considers leadership, governance, and management as separate but synchronised elements under the dimension of system organisation.
System manager: Financing, health workforce, infrastructure, supply, and information and knowledge	Like any system, health system also requires input in order to function. These inputs are generally the hardware of the system. However, the introduction of information and knowledge as one of the system inputs especially after 2010 shows that the evolving health system is in need of software also. All the mentioned four elements are necessary to manage the performance of the health system. The infrastructure and supply are detached to make them two separate elements, because infrastructure is a direct physical input whereas supply is a combination of procurement skill and physical input.[105] The relationships produced from the elements' internal coordination keeps the system functioning. For instance, the incentive payment (financing) is linked to the performance of doctor or ASHA worker (health workforce). Further, in this dimension the interaction with other dimensions are also very frequent. For instance, information and knowledge is intermittently linked to governance and management elements (of system

[105] It is to be noted that supply is considered as not only supply of medicine, vaccine, and medical appliances, but also supply of care (and even management services) from individual and organisational sources. Hence, sourcing in of medical personnel and PPP or strategic purchase, non-clinical as well as consultancy services from different types of organisations should come under supply. Further, procurement is an essential part of supply as it determines the quality of the product. In the present mode of service delivery, the role of procurement is becoming very important, which otherwise has minimal presence in thinking of health system organisation and performance.

	organiser) for decision making and operational activities. In all the PPP schemes or even strategic purchase, financing and service delivery are in continuous interaction with each other.
System strategy: population and service delivery	Population and service delivery are operative health system's conjoined strategy to maximum utilisation of available resources. The division of population based on socio-economic and geospatial category to serve vulnerable population is the estimation strategy to reduce the universe of population. This is in the same line of Bank prescribed 'bottom forty' per cent (poverty groups) of total population formula. On the other side, the service delivery is divided by levels of care (primary, secondary and tertiary), types of package (selective/comprehensive), and natures of provision (public, PPP, and private purchase). These different modes of care, package, and provision are because of strategising cost-effective treatment. In resource crunch economy comprehensive health care for all is not feasible, so population and service delivery are always strategised together for optimal utilisation of health system inputs and maximum benefit of population. These two always interact in an operative health system. The elements from other dimensions can not interact with population or service delivery individually; they interact collectively with both of them. The example can be infrastructural expansion which not only depends as per the demand for service (levels of care) but also on the need of population in the catchment area.

The above deliberation on dimension framework of health system was needed to be discussed for developing an understanding on the operational form of health system that consists both anatomy and physiology of the system. In each dimension, elements primarily interact with other elements in order to produce relationship within the same dimension. Based on the quality of the relationship generated from the primary interaction they go for secondary interaction with elements from other dimensions. Hence, primary interaction sets-up intra-dimension relationship and secondary interaction constitutes inter-dimension relationship. It is to further clarify that without having intra-dimension relationship is not possible to have inter-dimension relationship. A hypothetical example can be taken from *Pradhan Mantri Jan Arogya Yojana* (PMJAY) scheme of Ayushman Bharat programme to discuss how such strategic purchase model of service delivery may be organised within system

thinking.[106] In the dimension of system milieu, the health system goal is conceived as UHC, and in order to meet that goal system milieu holds relationship with system strategy where bottom forty per cent of Indian population is aimed to cover through strategic purchase model of service delivery. Correspondingly all three elements in system organiser grow intra-dimension relationship to plan (by leadership), establish (through governance) and operationalise (by management) National Health Authority/NHA (an autonomous society) to implement PMJAY. The success of NHA depends on the inter-dimensional relationship of system organiser with system manager where system inputs (elements) are primarily forming intra-dimension relationship by allocating finance, building infrastructure including IT (Information Technology) infrastructure, and ensure empanelment of hospitals through supply to make the NHA functional.

It is important to note that in the above example of PMJAY, none of the element forming any of the dimensions goes for one-on-one interaction with element from another dimension. It is always the element at first develops relationship within the dimension, and then through the concerned dimension they interact with elements from other dimension in order to establish inter-dimension relationship. These two types of relationships determine the outcome of health system by knowing the behaviour of the system. The system behaviour is necessary to assess by studying the two types of dimension relationships since an operative health system's outcome can not be assessed through impact indicators, as critiqued in chapter six and seven. In this chapter, this delineation on dimensional analysis of an operative health system was needed to articulate what is an operational form of health system. The Bank engages with the operational form of health system in the micro level of policy through its deterministic model of HSS (by financing health system projects) in order to condition the organic nature of the operative health system (like in the case of Karnataka) by executing function-based elements and redrawing the boundary.

The deterministic model of HSS is the direct interface between the Bank and the concerned operative health system like Karnataka. The Bank through its health system project comes in contact with the health system's elements that exist at the operational

[106] It is a scheme led by the Government of India and running in a co-financing manner with the state governments as discussed in chapter four. In this case, the scheme is considered as an example from operative health system.

level in Karnataka. The project (such as, KHSDRP) brings in some specific activities to perform certain functions, which are formulated by the descriptive model of HSS and theorised by the analytical model of HSS. Noticeably, not the functions but the activities are the means in the deterministic model to operationalise HSS approach. From the project/programme management perspective, activity specific execution is more feasible for policy implementation and operation stages since they are observable as well as countable.

In the operational form of health system, there are two types of activities the deterministic model of HSS performs; reform driven and the activities that support the state to meet its budget expenditure. Though the deterministic model of HSS actually executes only the reform driven activities, but still the support to budget expenditure was a part of KHSDRP due to compulsion of lending negotiation. From HSR to HSD to HSS, in any project lending at the micro level of policy the Bank has always been taking responsibility to partially support state government's budget expenditure in order to implement its own idea of reform as explained in chapter four. In the case of Karnataka, the Bank through KHSDRP supported the state government's budget expenditure by investing in civil works and equipment (in both original and additional financing period), and source in specialists, and also offered direct budget support to the state treasury in the original financing period. However, apart from these usual budget support expenditure, the deterministic model of HSS in KHSDRP also financed care on behalf of the state government to purchase services. This is a new type of budget expenditure support that deterministic model of HSS has introduced.

In the operational form of health system, the deterministic model of HSS does not converse with all the elements of an operative health system. It is selectively working with only those elements which could potentially change the health system's organisation with regards to service delivery. The deterministic model in KHSDRP apart from service delivery worked specifically with management (through training activities for technocrats under Organisational Development/OD component), governance (by creating various cells), and information and knowledge (for creating IT infrastructure in SAST and facility-based HMIS) elements.[107] Further, arguably it can

[107] The activities which were supporting state budget expenditure are not included here.

be said that KHSDRP interacted with supply element also for Public Private Partnerships (PPP) contract and hospital empanelment procedure.

The point is while the deterministic model worked with these three elements, it did not try to understand the interaction of these elements with other system elements. For example, PPP schemes were introduced under KHSDRP to address the service delivery innovations, but PPP contracting is falling under supply element, which is the activity of procurement. The project did not have much activity to enhance the procurement skill. Another example is failure of establishment of various cells (or proto-institutions). Creation of cells (such as, PPP, quality assurance, health financing etcetera) in KHSDRP was attempted to address the governance element, but activation as well as sustainability of those cells depend on the willingness of the leadership and availability of skilled staff (financing, management and health workforce elements). Since the project could not obtain the confidence of the political and administrative leadership, the skilled staff remained unavailable under budget support and thus the cells were outsourced to consultants during the project period, and thereafter left to exist only on paper. This is the problem of existing health system frameworks, which in practice tend to address elements directly located at the health system's anatomical structure. The properties of the elements in the physiological state are not addressed (and also well understood), thus the programmatic understanding to build interactions between elements remain abstruse to the deterministic model of HSS.

The Bank's operational outlay through deterministic model only focuses in executing activities because the activities carry the Bank's idea of *innovations* in health. The innovations are the priority as they represent the latest form of reform, i.e. function-based. In Bank's HSS approach reform and innovation are same, therefore it is served as the means. For instance, the KHSDRP-introduced mechanism number two 'innovation in service delivery and financing' was all about reform. Thus innovation is an operative means through which the deterministic model of HSS employs activities in order to determine the function of the element. This is the main role of the deterministic model. The example can be service delivery as an element wherein the activities like hospital empanelment and development of an autonomous body (SAST/NHA) are executed to perform the function called strategic purchase. Similarly, financing as an element could be executed through insurance to fulfil the risk pooling (function) criterion. In those examples, the interesting insight is the innovations are

strategic purchase and risk pooling. This is the strategy of deterministic model of HSS where both the function and innovation are same, meaning if function needs to be addressed then innovation has to be operated – meaning reform is inevitable.

The innovation strategy of the deterministic model of HSS makes the intervention more focussed about the function. Thus investing on interaction to produce successful relationship as principle of system organisation is ignored in project operation. Innovations (or activities) are already formulated (macro level of policy/conceptual form of health system) as well as theorised (meso level of policy/theoretical form of health system) from the above, and lack in contextual understanding. Hence, the activities designed for executing innovations in KHSDRP had unfavourable operational experience, and as a result innovations were often out of sync with the real time interactions among the elements in order to produce relationships in the operative health system. It is already discussed in the operational form of health system that how intra and inter dimension relationships hypothetically may ensure the PMJAY scheme to become operative. Here is an example from the KHSDRP's VAS scheme to demonstrate how the deterministic model undermined the need to improve the interactions of elements, and instead focussed only in the fulfilment of strategic purchase function. The Bank in KHSDRP did not introduce any policy recommendation or execute any activity to address poor status of government's health expenditure, rather through the activity of assurance approach had ring fenced the financing allocation for strategic purchase of care.

The ring fencing of finance is an example how the deterministic model of HSS in order to prioritise a particular function (for example, strategic purchase) ignores the need for enhancing the public expenditure on health in Karnataka. Prioritisation of strategic purchase may strengthen the functional property of service delivery element, but not the overall operative health system. It is evident in the Government of India's (GOI) 2019 – 20 interim health budget in which National Health Mission had to experience cut due to prioritisation of PMJAY strategic purchase model of service delivery as discussed in chapter four. The idea of innovations (top down) and prioritisation of function (single-focussed) in the operation makes the deterministic model of HSS a vertical intervention in health system. These innovations are similar to targeted approach to include private sector in public service delivery from primary to secondary to tertiary levels of care. That is why the deterministic model of HSS is taking activity

specific reform approach to conduct the functions that provide service deliveries. Through activity specific reform, the deterministic model is instrumental to mobilise the operative health system towards health system innovations. This health system innovation is active to establish the hypothesis that publicly financed and privately managed and run health care service delivery is possible in a country like India.

9.4 Metamorphosis of health system strengthening

Metamorphosis in the discipline of Biology refers to animal's physical growth after hatching or birth. The advancement of HSS policy from descriptive to analytical to deterministic model bear a resemblance to the kind of growth in which the models developed on their own as they circumvent each form of health system (conceptual, theoretical, and operational respectively) to operationalise the HSS approach on the ground. The Bank's theorisation as well as formulation of HSS approach prepares it to serves different purposes in the different levels (or forms) of health system. HSS as descriptive model is persuasive in the international level to generate consensus among the IHG actors for valuing health system within the agenda of public-private mix model of health care service delivery. The analytical model of HSS is instrumental in the national-level to change the health system policy of the nation-state according to the agenda set in the international level. Finally the deterministic model of HSS is active to change the health system practices in the state-level. Hence, HSS approach represents conceptually an agenda, theoretically a policy, and operationally a set of practices.

The HSS approach is just changing from one model to another model from international to national to state level in order to engage with the respective form of health system for governing the very form of health system. The Bank through HSS approach (or with earlier health system approach) claims to work for the goal of health for all, however in practice it develops a format to govern the concerned health system. The absence of conceptual rigour, epidemiological understanding, and programmatic framework has made HSS another governance mechanism like the Bank's earlier health system approaches. The overemphasis on 'global partnership-based' development targets (from MDG to SDG) has changed the goalpost from health for all to UHC. This research argues that whether it is the health for all or the UHC, the means to achieve them is health system. The Bank and other international organisation need to understand contextual complexity at first before promoting any governance model. The last section

of this thesis gives a small outline to entail the ideal role to be played by the Bank and implementing agencies for strengthening the health system.

9.5 System must be defended

The UHC is based on the governance framework of HSS. The UHC movement across the world creates opportunity for the international actor (such as, World Bank), implementer (like, Karnataka as state), and private sector (contract in facilitator for service delivery) to work in collaboration. HSS like projects are the practice models of this collaboration. The research outlines some recommendations for a better HSS policy application.

In health sector, the Bank has already declared its goal, i.e. achieving UHC. HSS projects are the means to achieve UHC. The Bank should invest its resources to build a genuine consensus between the actors. One way to attain this is to understand the context of the project implementation side, and accordingly develop the project plan. The social and environment impact assessment in the Bank's project preparation exercise are very important tools, but often they are outsourced to local agencies. These tools should be exercised by the Bank's own staff located in the country office instead of being carried out by any outsourced agency. The political component is also needed to introduce in the social and environmental impact assessment. The KHSDRP project suffered a lot for not understanding the local dynamics of the government employees, and non-governmental actors. Rigorous exercise on impact assessment would have helped the Bank to deal with those shortcomings.

The state government is an implementer, but they are working based on the direction of the Bank staff. It is found that often Bank staff leaves the project activities to the government, and they only concern themselves of deliverables. The Bank needs to get into the process monitoring instead of periodic evaluation. The Bank too has ownership in the reform projects; it's not the state government who is responsible for every odd.

The role of the state government (Karnataka government in this case) is two folded in HSS projects; the coordination with the Bank, and collaboration with private sector. The government needs to understand that these projects are for governance reform where the capacity building of bureaucrats and technocrats are the deciding factors. The project should not be implemented just to complete the activities and exhaust the fund.

Skill building and self-dependency are the two key outcomes from HSS type of intervention. The design of HSS or its product UHC already embodies private sector in service delivery. The outsourcing of administrative and management tasks mean outsourcing the execution of governance. Therefore the state – market interaction is replaced with quasi-state – market interaction. This is nothing but complicating the governance further. Thus outsourcing of administrative and management tasks are required to be shunned away as early as possible. Similarly, the projects' training and evaluation activities should be done by government bodies, such as SHI&FW, SHSRC etcetera.

The Government of India too has some role in HSS project. It should form a centralised but autonomous evaluation unit for end evaluation of various externally aided projects. The government constituted independent evaluation body needs to have an interdisciplinary team, and capable of apprising both the assembly and parliament about the impact of such project.

The role of private sector is undeniable in the present form of HSS policy and its designed projects. The agenda of HSS policy as well as project is to develop a partnership model in health care service delivery. It is understood that self-regulation of individual behaviour for private sector operator is difficult to achieve because of the very nature of market competitiveness. Hence, the onus is on the Bank and state government with regards to dealing with private sector. HSS project has extreme importance on such occasion. The project should not be limited just to develop/mobilise private sector for service delivery purpose. The way HSS project created many institutions within the state structure; similarly it is recommended that project should create bodies in the market side also. Those bodies should not be so-called autonomous but completely state supervised, and not a constituent body of public and private representatives. Those bodies may be envisaged as collaborative platforms on behalf of the private sector to participate in health care service delivery. The strategy is to infuse 'public' values in 'private' sphere. The public system should be capable of regulating private sector through legislation, information architecture, and administrative ruling. The HSS policy needs to conceptualise mechanism as well component to regulate private sector and not only develop private sector.

The existing political economy is favouring HSS agenda of the international actors. The findings of this research are questioning the policy implementation process of HSS. HSS appeared as a technological fix to deliver UHC, but in spirit it has political value, i.e. health for all. Government is the political office of the state, thus capacity building of government side is the priority. It is not the partnership, but primacy of the state should be considered as key strategy of HSS policy theorisation, formulation and implementation in order to defend the system for achieving health for all!

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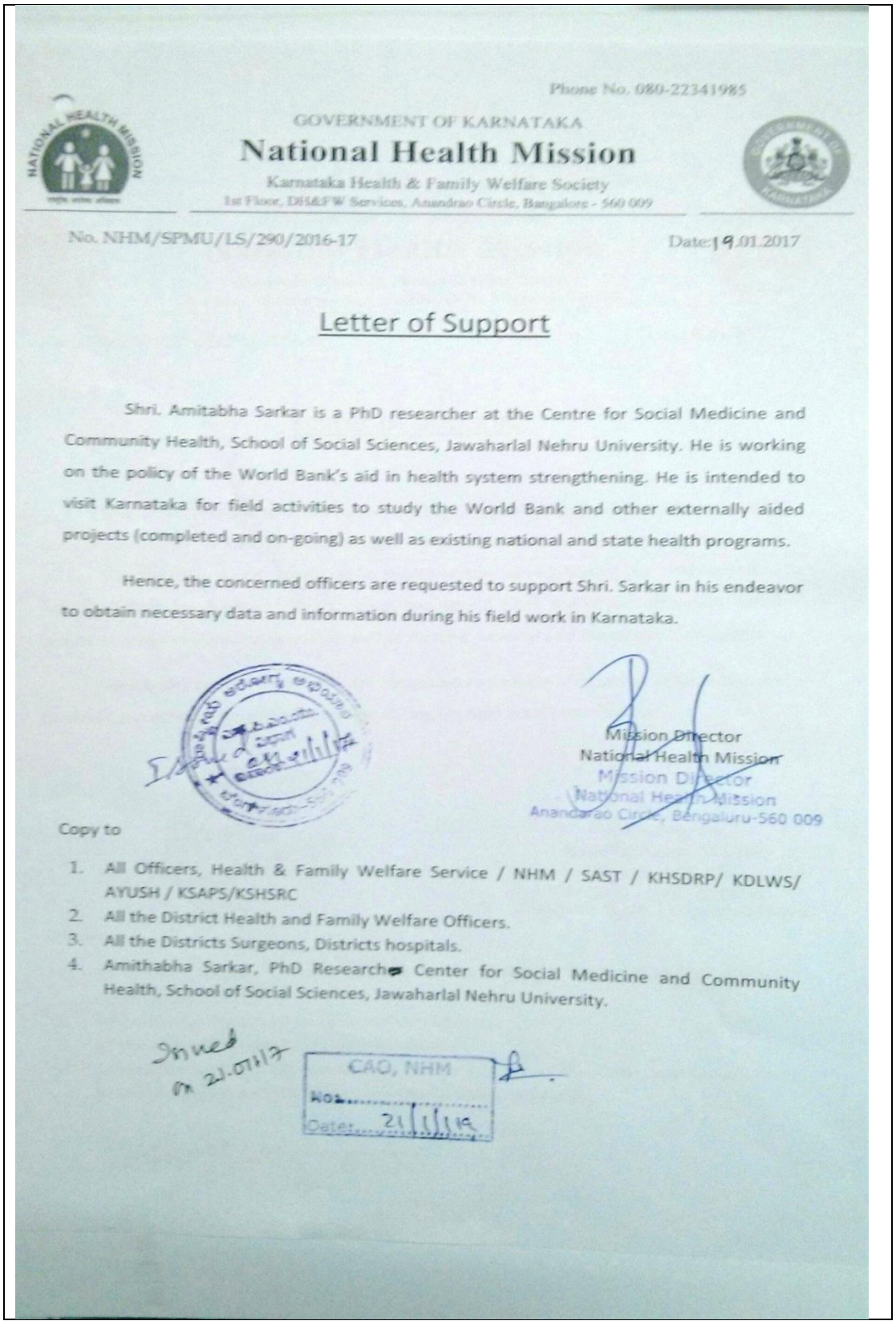
Annexation 1: Letter of support from the National Health Mission, Government of Karnataka



Phone No. 080-22341985

GOVERNMENT OF KARNATAKA

National Health Mission

Karnataka Health & Family Welfare Society

1st Floor, DH&FW Services, Anandrao Circle, Bangalore - 560 009

No. NHM/SPMU/LS/290/2016-17 Date: 19.01.2017

Letter of Support

Shri. Amitabha Sarkar is a PhD researcher at the Centre for Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University. He is working on the policy of the World Bank's aid in health system strengthening. He is intended to visit Karnataka for field activities to study the World Bank and other externally aided projects (completed and on-going) as well as existing national and state health programs.

Hence, the concerned officers are requested to support Shri. Sarkar in his endeavor to obtain necessary data and information during his field work in Karnataka.

Mission Director
National Health Mission

Mission Director
National Health Mission
Anandarao Circle, Bengaluru-560 009

Copy to

1. All Officers, Health & Family Welfare Service / NHM / SAST / KHSDRP/ KDLWS/ AYUSH / KSAPS/KSHSRC
2. All the District Health and Family Welfare Officers.
3. All the Districts Surgeons, Districts hospitals.
4. Amithabha Sarkar, PhD Research Center for Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University.

Signed on 21.07.17

CAO, NHM
No:
Date: 21/1/17

Annexation 2: Observations from field work in Karnataka

Ref. No.: NHM/SPMU/LS/290/2016 dt. 19.01.2017

Submitted to the Mission Director - National Health Mission, GOK
Submitted over email: 16 May 2016
Submitted in person to the Office of MD NHM, GOK: 16 May 2016

This note of observations is made from the field work done in Karnataka, and prepared at the request of MD, NHM (Government of Karnataka). The field work has been carried out as a part of PhD research on the "World Bank's Aid in Health System Strengthening: A Policy Analysis". The support of DOHFW, GOK, especially Dr. Ratan Khelkar, is very much appreciated for giving access to various internal documents/studies and data bank to review. The PhD research is also thankful to the staff of various departmental units and several district and *taluk* health offices and other micro level health institutions for their cordial support and collaboration during the field work.

This note is to be considered as a preliminary observation and not any derived study findings. These observations need a number of academic contestations and discussions to reach into the processed analysis.

This field work is about the study of the health system of Karnataka. The policy suggestions from KHSDP/KHSDRP are often interlinked with the DOHFW's own decision making process. These preliminary observations are in general related to the health service organisation of the DOHFW, GOK and not specifically meant for any Externally Funded Projects (EAP). KHSDP/KHSDRP specifics are not featuring here, they need more time and thinking.

A. Capacity Building

A1: More intensive, structured and planned training are required to handle new aspects of service management (for example, PPP, quality assurance etcetera). The department is running many PPPs which are being implemented even at the level of PHCs. These types of techno-managerial training are better to organise for various levels of staff with different needs and approaches, starting from implementation (PHC) to planning (Directorate).

A2: SIH&FW's resource is almost not explored in KHSDRP and instead the training events are outsourced to external organisations. This is the missed opportunity for the capacity development of the Ministry's own unit.

A3: Similarly, all the studies and evaluations had been outsourced to external agencies. KHSRC was not considered for such exercises in KHSDRP. Also, it is always better to conduct the internal or periodical evaluation/study by the department staff only (who are on permanent pay scale). It enhances the capacity of the department.

A4: The department may think how to develop the skill of the DDs and JDs in managing the health services. Using of consultants on each occasion is a very shortlived strategy and temporary solution. The department is probably not getting any long term benefit from consultant-driven output. The examples are ample; the cells created under KHSDRP are almost inactive at present as the consultants left after the project was over. Those cells or any existing/future new additions (like, scheme/pilot) to the department may be tested upon the

commitment and capacity of the DD/JD. It will not only increase the accountability but also the skills (and finally knowledge through experience) of the department's own technocrats.

B. Management and Organisation

B1: The post of MD/PA is a combination of technical as well as administrative executive. Frequent change of MD/PA in NHM/EAPs is not a very good example for the programme/project's consistency. However, the Directorate probably does not have any role in this decision. Still, this feedback from the Directorate may be helpful in sensitising the appropriate authority to take more informed decisions.

B2: The posts of DD and JD are overburdened, the Directorate is fully aware of that for sure, with the charges of multiple departments/schemes/units. This entire distribution of resource management is unjust and also creates obstacles from having the desired outcome. Incentivisation (not output-based but position-based) of these posts may be of help to attract more experienced and committed doctors into the health administration.

B3: The knowledge and approach of Public Health have changed a lot in the last two decades in India because of macro-economic scenario. The demand for Public Health Cadre is not new in Karnataka, first opined by the 2001 Task Force report. The adoption of PH Cadre will not only strengthen the department but also reduce the dependency on external aid and consultant-based practice.

B4: Doctors' scarcity in this state is well known. DOHFW is administratively unable to handle this crisis on its own. The policy issue is to discuss and scrutinise the relevance of having a separate Ministry for Health and Family Welfare and Medical Education at the present time. The DOHFW may look at it from the perspectives of coordination, integration and implementation to voice its opinion in appropriate spaces.

B5: District Health Officers are becoming more of administrators because of the natural demands of the job. The technical collaboration and cooperation among several programmes remain wanting. Post KHSDRP (especially after December 2016), the post of DPMO is also not existing. Hence, there may be a need of a technical coordinator who collaborates between the programmes and schemes.

B6: The strategic decision to train MBBS doctors in a one-year Public Health course is a good move as the progress in skills and approaches were quite evident in several official conversations during the district visits. This selective approach may be expanded mandatorily for the THO (Taluk Health Officer) level since strategically this is the most important post. In practice, THO post is an implementer of programmes at the block level as well as first hand community level service providers (clinical) since in reality many PHCs and CHCs are almost 'unmanned' by the MBBS doctors. The carrier progress of THO is also towards health administration. Thus it will be of good use to orient this post with Public Health skills, ethics and values from the beginning.

B7: The department may need to build a dedicated Health Planning and Management Unit. The present planning unit at the Directorate is not capable enough to identify, analyse and suggest policy inputs. This is a priority unit for the DOHFW while the department is itself under transition with regard to governance arrangement. Some structural changes are needed to reform this unit. For example, only Public Health professionals (both from MBBS and non-MBBS) on permanent pay roll can be considered for this unit. The weakening of this unit is linked to the crisis of much mismanagement, such as Arogya Bandhu scheme which was launched in 2010 (started under KHSDRP at first).

B8: In continuation of the above pointer, the plannng unit may be conceptualised as an in-house technical and knowledge producing unit (which was the original thought of KHSDP in 1998 through SPC). It can guide other units and also EAPs to handle complex health service arrangement issues. The DOHFW may not properly utilise the knowledge resource of the World Bank in KHSDRP as was evident on many occasions: The untimely closure of several PPPs (Citizen Help Desk, Mobile Health Clinic etc.). CHD and MHC were two of the very effective and beneficial community service PPP models in Karnataka. The question comes why these PPPs were under court scrutiny. They had to be stopped and finally dropped by the KHSDRP because of intervention from the court. World Bank gives an overall outline of project guidelines and implementation, but the state is responsible to efficiently handle it. A strong and effective planning body inside the department may guide the EAP project team or others also in the management of complex service delivery models.

B9: The DOHFW may urgently go for a situation analysis of the condition of grassroot health workers in Karnataka. The workers are becoming unionised because of their distress condition and ever increasing job pressure. The recent strategy of third party recruitment makes the situation worse since the workers are not given pay in time and also the third party agency keeps a considerable amount of the salary as a processing fee. The situation is going to be volatile.

B10: Corruption is a part and parcel of the Karnataka health service as observed by the Karnataka Lokayukta. Neither the research objective nor the researcher's capacity (both knowledge and skill wise) allow us to assess the issue of corruption in health service management and organisation. However, the field experience shows there are good people in the system and most importantly, they are 'accountable' to the system which is indeed very rare. The DOHFW does not have any mechanism to protect these people for the good of the system. Awards and other forms of appreciation may be a good strategy to boost their morale and uphold the public health ethics. Also, the department can allow special paid leave for higher study (PhD level only) to those employees who are committed to the system. This strategy can indirectly protect and promote the Public Health morale, ethics and values and motivate them to act against corrupt practices.

C. SAST

C1: The VAS scheme is very much beneficial for the poor people and instrumental in reducing exorbitant costs. The VAS is the underpinned theory of the UHC in this state. UHC is based on financing and coverage. The coverage expansion of VAS got increased by 10 times in the last five years. There is no financing model designed so far that ensures or throws light on the sustainability of the scheme. The fast growth of VAS is expected to clash with the budget provisions in coming years (probably after three to four years) if it expands at the same growth rate; at least the internal budget allocation practices indicate the same. SAST may conduct a study by appointing any acclaimed scholar (and not corporate agency) of UHC to suggest or simulate the possible financing model/s to make the VAS as well as SAST sustainable initiatives in the long run.

C2: The M&V (Monitoring and Verification) process is not up to the mark. It is just giving information related to the distribution of patients, hospital claims and procedures performed. This style of CMIS (Computerised Management Information System) is only useful to monitor the success of any newly launched scheme as maintained at the initial time. The purpose is different at present. The monitoring system is required to upgrade to monitor the processes (instead of only outcomes) of the schemes' internal functioning, i.e. follow-up on STG checklist for pre-authorisation, cross matching between pre-authorisation observations and the claim settlement findings, conducting periodical audits etc.

C3: It is needed to ensure the presence of government doctors in every health camp where primary screening is done for further referral. The SAMCO dependency is not very satisfactory in the pre-authorisation phase. It is better to make patients (those who directly approach the facility) to visit the government hospitals first for primary screening and diagnosis (if possible) and accordingly the patients can be referred, if need be, to any empanelled hospitals as per their choice. The in-house mechanism needs to be built for the pre-authorisation team to strictly follow the STG while approving the procedure.

C4: The research requests the competitive authority to carry out a clinical and quality audit on an urgent basis on the sampled hospitals. There is as such no monitoring mechanism at present that routinely follows up with the empanelled hospitals to ensure clinical standards and quality control. These two audits are usually a part of monitoring and supervision activity under the strategic purchase contract.

C5: The research is of the opinion that there are highly possible chances of duplication of schemes by the empanelled hospitals, especially between VAS and Yashaswini. During the district visit, the SAST empanelled hospitals were also covered on some occasions. In Gulbarga, out of the three empanelled hospitals, only one hospital has made the SAST data available to the researcher because of the intervention from the respective DHO, though the same hospital did not share its Yashaswini and other small insurance schemes' data even after repeated requests by the researcher and DHO office. The Gulbarga DHO office knows the name of the hospitals including the two who did not share any information to the researcher despite several requests from the DHO himself. This point also indicates the state of KPME in Karnataka and its effectiveness. The M&V mechanism of the SAST needs to understand this evolving nature of monitoring and cross verification requirements.

D. Decision making

D1: The role of the DOHFW is becoming very important in governance arrangement and management. The DOHFW may take a strategic position to lobby for more public health specialists/professionals/scholars in various decision-making bodies. It is observed that public health representation is becoming skewed in key decision-making forums. For example, the composition of the second Task Force Committee (main body) shows only two (apart from the government's own representation) public health experts are in the body. This decision-making spaces are important since the larger policy level decisions have a bearing on the service organisation and management which is solely the area of DOHFW.

D2: There is an urgent need to strengthen KHSRC, SHI&FW and Planning sections at the Directorate. These units should be consulted in advance before implementing any new technical and managerial approaches in service management.

These observations are reflections of the researcher based on the preliminary assessment of the findings. The more nuanced and composite analysis can be available only after the final and detailed assessment of the field study information.

Annexation 3: Consent form for Interviewee

Nomoskar! I, Amitabha Sarkar, am a PhD researcher at the Centre for Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, India. My PhD research is on the policy of the World Bank aid in health system strengthening in India. The research aims to describe and analyse the role of the World Bank, Government of India and selected State governments (especially Karnataka) in the implementation of health system strengthening policies, for example, HSDP (Health System Development Project) in India. The research focuses at three different levels of policy; international, national and regional to follow the entire process of policy formulation-modification-implementation. A key part of the research will be interviews of key informants who were/are involved and/or familiar with the development, adoption and implementation of the World Bank's policy in health system strengthening. The interviews will seek to understand the perception of the informants on the role of the World Bank policies vis-à-vis its interaction with the government units.

I would like to request an interview with you to know how you have been associated in this policy discourse, what are your perceptions on the policy formulation/implementation process of health system strengthening by the World Bank and other government units. The research will be benefited from your thoughtful interpretation on the role of the actors, contextual factors, adopted mechanisms for policy implementation and followed by the reflection on policy outcomes.

You are requested to give one to one and half hour for the interview. This is completely a voluntary participation. You may choose not to answer any question without explanation, and even end the interview at any time. You will be requested to allow taping the interview, and in case of permission denial, the conversations rely on note taking. You are completely free to amend or retract any conversation at the end of the interview or later on. As an interviewer, I need to make notes to recollect the interview proceedings. The request for off the record statement or no note to be taken will be acknowledged.

The research is committed to respect and follow the recommendation issued by the Institutional Ethics Review Board (IERB) of Jawaharlal Nehru University for conducting interviews. The interview information will be valued as highly confidential. The case of anonymity (name and other identifying information) will be maintained always upon request. The interview sources (organisation/agencies/institutions/forums) will be featured in the annexation and you can be opted to ask to not list your organisation. The prior permission will be obtained in case of using any of the interview conversation/statement in the PhD thesis. The interview proceedings, recorded version, hand-written notes will be kept securely. A copy of PhD thesis can be shared upon request.

Please feel free to contact me via email at sarkarjnu@yahoo.com or by telephone at (+91) 2670 4420 (Office landline of CSM&CH, JNU) in case of any clarification.

With this above background, I would like to invite you to participate in the interview and add value to this academic research. Kindly sign this consent from if you are willing to be interviewed.

Consenter's portion

I give my consent to participate in the interview as per the terms mentioned above after fully understanding the purpose of the study and of the interview.

Place_____ Date_____

Signature_____

Name in block letter_____

Designation:

Organisation/agency/forum/institute:

Annexation 4: Institutional and Ethics Review Board (IERB) Certificate

INSTITUTIONAL ETHICS REVIEW BOARD
Jawaharlal Nehru University
New Delhi-110067

Name of the Ethics Committee: IERB-JNU — IERB Ref. No.2016/Student/90

Title of the Project Proposal: **"World Bank's Aid in Health System Strengthening in India: A Policy Analysis"**

Principal Investigator: Mr. Amitabha Sarkar (Ph. D Student) — C/o Prof. Mohan Rao (Supervisor)

CSM&CH/SSS/JNU — Sponser: NA

Telephone: +91 9874665999 — Email: **sarkarjnu@yahoo.com**

Collaborators' Name:

FOR OFFICIAL USE

The proposal was reviewed in a meeting held on 17th February, 2016 at 4:30 PM.
The following members were present:

1. Professor Shiv K. Sarin, Chairperson
2. Prof. S. C. Malik, Member
3. Prof. Ramesh C. Juyal, Member
4. Advocate Rukhsana Chaoudhary , Member
5. Advocate Omika Dubey, Member
6. Prof. Sangeeta Bansal, Member
7. Dr. Sushil Kumar Jha, Member
8. Dr. Madhav Govind, Member
9. Prof. Amita Singh, Member Secretary

The committee resolved to

[ ] Approve - indicating that the proposal is approved as submitted;
[✓] Approve – after clarifications – indicating that the proposal is approved if the clarifications Requested are provided to the satisfaction of designated committee members;
[ ] Approve after amendment/s – indicating that the proposal is approved subject to the incorporation of the specified amendments verified by designated committee members;
[ ] Defer – indicating that the proposal is not approved as submitted but it can be reassessed after revision to address the specified reason/s for deferment;
[ ] Disapprove – indicating that the proposal is not approved for the reason specified.

Comments:

Member Secretary,
IERB, Ethics Committee

Date of Approval: 23.03.2016
*(1st part to be filled in by PI and presented at the time of Review (Periodic, Continuing, Interim)).

Prof. Amita Singh
Member-Secretary
Institutional Ethics Review Board
Jawaharlal Nehru University
New Delhi - 110067

Annexation 5: List of publication out of this PhD research

- Working paper entitled "World Bank's Reformed Model of Development in Karnataka", published in Institute for Social and Economic Change (Working paper No. 408, April 2018) (http://www.isec.ac.in/WP%20408%20-%20Amitabha%20Sarkar%20-%20Final.pdf)

- Commentary entitled 'Methodological Critique from an Epidemiological Perspective on 'Transitions in Health Financing and Policies for Universal Health Coverage', published in Indian Journal of Hygiene and Public Health (Vol. - 2, December 2016, ISSN: 2455-1813), by All India Institute of Hygiene and Public Health. (http://www.ijhph.co.in/current_issue/Dec2016/PDF/Commentary.pdf)

- Article abstract entitled 'The World Bank and health systems strengthening: experiences from four Indian states', published in BMJ Global Health (vol. 1 no. Suppl 1 A30-A31), (DOI: https://doi.org/10.1136/bmjgh-2016-EPHPabstracts.40 published on July 7, 2016)

Newspaper Op-Eds

- In Bengali: *স্বাস্থ্যনীতির চিকিৎসা চাই* (on India's Health Budget of 2019 – 20), Anandabazar Patrika, March 12, 2019 (https://www.anandabazar.com/editorial/ayushman-bharat-scheme-may-actually-a-step-for-privatization-of-health-policies-1.965233)

- People over Profit: National Health Assembly, Deccan Herald, October 23, 2018 (https://www.deccanherald.com/opinion/main-article/people-over-profit-699470.html)

- Wealth is not health (on the distinctions between Alma-Ata and Ayushman Bharat), The Telegraph, October 1, 2018 (https://www.telegraphindia.com/opinion/spot-the-changes/cid/1670610)

- Regulating Private Healthcare: What should Karnataka do?, Deccan Herald, June 6, 2017 (http://www.deccanherald.com/content/615657/regulating-private-healthcare-should-ktaka.html)

- In Bengali: *সদিচ্ছার প্রশ্ন, মতাদর্শের নয়* (Health services provision is the matter of willingness, not ideology), Anandabazar Patrika, March 29, 2017 (http://www.anandabazar.com/editorial/health-services-provision-is-the-matter-of-willingness-not-ideology-1.587980?ref=editorial-new-stry)

- Health first (on the National Health Policy 2017), The Telegraph, March 23, 2017 (https://www.telegraphindia.com/1170323/jsp/opinion/story_142067.jsp#.WNdcLGf-tLN)

Annexation 6: List of World Bank projects on health system in India

Project Name	Website link
Andhra Pradesh Health Systems Strengthening Project	http://projects.worldbank.org/P167581/?lang=en&tab=financial
Tamil Nadu Health System Reform Program	http://projects.worldbank.org/P166373/?lang=en&tab=overview
Uttarakhand Health Systems Development Project	http://projects.worldbank.org/P148531/?lang=en&tab=overview
Nagaland Health Project	http://projects.worldbank.org/P149340/?lang=en&tab=overview
Karnataka Health Systems Additional Financing	http://projects.worldbank.org/P130395/india-karnataka-health-systems-additional-financing?lang=en&tab=overview
Uttar Pradesh Health Systems Strengthening Project (UPHSSP)	http://projects.worldbank.org/P100304/second-uttar-pradesh-health-systems-strengthening-project-uphssp?lang=en&tab=overview
Tamil Nadu Health Additional Financing	http://projects.worldbank.org/P118830/tamil-nadu-health-additional-financing?lang=en&tab=overview
Karnataka Health System Development and Reform Project	http://projects.worldbank.org/P071160/karnataka-health-systems?lang=en&tab=details
Tamil Nadu Health Systems Project	http://projects.worldbank.org/P075058/tamil-nadu-health-systems-project?lang=en&tab=details
Rajasthan Health Systems Development Project	http://projects.worldbank.org/P050655/rajasthan-health-systems-development-project?lang=en&tab=details
Uttar Pradesh Health Systems Development Project	http://projects.worldbank.org/P050657/uttar-pradesh-health-systems-development-project?lang=en&tab=overview
Maharashtra Health System Development Project	http://projects.worldbank.org/P050651/maharashtra-health-systems-development-project?lang=en&tab=details
Orissa Health Systems Development Project	http://projects.worldbank.org/P010496/orissa-health-systems-development-project?lang=en&tab=overview
State Health Systems Development Project (02)	http://projects.worldbank.org/P035825/state-health-systems-development-project-02?lang=en&tab=overview
Andhra Pradesh First Referral Health System Project	http://projects.worldbank.org/P010489/andhra-pradesh-first-referral-health-system-project?lang=en&tab=overview