Decentralization Discourse and Health:
A Critical Analysis

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CERTIFICATE

This dissertation entitled **"Decentralization Discourse and Health : A Critical Analysis"** is submitted in partial fulfillment of six credits for the degree of Master of Philosophy of this university. This dissertation has not been submitted for any other degree of this university or any other university and is my original work.

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We recommend that this dissertation be placed before the examiners for evaluation.

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I dedicate this work to all those who are genuinely trying to promote and practice decentralization.

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List of Abbreviations and Acronyms

AIDS:	Acquired Immuno-Deficiency Syndrome
Bank:	World Bank
CHC:	Community Health Center
CHW:	Community Health Worker
DALE:	Disability Adjusted Life Expectancy
DALY:	Disability Adjusted Life Years
DoRD:	Department of Rural Development
GATT:	General Agreement on Tariffs and Trade
GBD:	Global Burden of Disease
GoI:	Government of India
GOBI-FFF:	Growth monitoring and promotion; Oral rehydration therapy; Breast feeding and Immunization, combined with Family planning, Female education and Food supplements
GP:	Gram Panchayat
HFA:	Health For All
HSD:	Health system decentralization
HSR:	Health sector reform
IBRD:	International Bank for Reconstruction and Development
ICDS:	Integrated Child Development Services
IDA:	International Development Association
IFC:	International Finance Corporation
IMF:	International Monetary Fund
INGO:	International Non Governmental Organization
IRDP:	Integrated Rural Development Project
JRY:	Jawahar Rozgar Yojna
MCH:	Mother and Child Health
MIGA:	Multilateral Investment Guarantee Agency
MLA:	Member Legislative Assembly
MoHFW:	Ministry of Health and Family Welfare
MP:	Member Parliament
MPW:	Multi-Purpose Worker
NGO:	Non Governmental Organization
NHP:	National Health Policy
NNGO:	National Non Governmental Organization
PHC:	Primary Health Care
PRI:	Panchayat Raj Institution
PS:	Panchayat Samiti
SAP:	Structural Adjustment Program
SC:	Scheduled Caste
SCC:	Short Course Chemotherapy

SHS:	State Health System
SPHC:	Selective Primary Health Care
ST:	Scheduled Tribe
TB:	Tuberculosis
TINP:	Tamil Nadu Integrated Nutrition Project
U.K:	United Kingdom
UNAIDS:	United States Agency for International Development
UNDP:	United Nations Development Program
UNICEF:	United Nations Children's Fund
USA:	United States of America
VHW:	Village Health Worker
WB:	World Bank
WDR:	World Development Report
WHO:	World Health Organization
WHR:	World Health Report
WTO:	World Trade Organization
ZP:	Zilla Parishad

Chapter 1

Introduction

In an evolving paradigm of development there is a new high ground,
a paradigm of people as people. Local, complex, diverse, dynamic and unpredictable, ...
On the new high ground, decentralization, democracy, diversity and dynamism combine.
Multiple local and individual realities are recognized, accepted, enhanced and celebrated.
(Chambers, R., 1997)

The discourse on development and governance has undergone a paradigmatic shift[1]. Top-down governance is out, bottom-up governance is in; welfare of civil society is out, empowerment of civil society is in; standardized central planning is out, diverse area planning in; experts setting national priorities is out, local people setting their priorities is in, centralization is out, decentralization is in.

A global trend towards decentralization and local participation has resulted. Centralized governance resulted in redtapism, corruption, irrelevant standardized programs for diverse population and inequitable development. Decentralized governance is endorsed because it is representative of diverse geographical regions and ethnic groups; is socially just and politically correct; is economical and easy to manage.

The shift from conventional top-down to new bottom-up approach requires a change in ideology and value system. Centralization promotes a culture of distrust where those in power believe that they alone have the capability to formulate policies and implement programs. In direct contrast, decentralization rests on the principle that all human beings are equal, everyone as a matter of right should be empowered to influence the policies and programs that concern them.

[1] Paradigm is used here as per the definition of Chambers (1997) i.e. a coherent system of concepts, values, methods and behavior

However, it is outside the scope of this book to go any further into the ideology or the methodology of participatory approach. It will suffice to note that the challenge posed by this approach is to gradually, but firmly reverse the realities, by putting the first last and the last first. This reversal however is very difficult as participatory ideology demands unlearning the norms and challenging the systems, which support hierarchy and learn a new code of conduct that embraces equality and diversity. In short, it is nothing short of a revolution at personal, social, political and economic levels.

The philosophy of decentralization is not merely limited to governance mechanism but has permeated to sectors like health, education, natural resource management etc. The rapid pace at which the participatory approach and decentralized governance has been adopted has led to dilution of the philosophy of participation; reducing it to mere lip service or passive participation. However, for the purpose of this research our focus shall be on health system decentralization. In this chapter we shall restrict ourselves to defining key concepts, presenting theoretical approaches, elucidating the methodology and describing the organization of the paper.

1.1: Defining Health

Health is conceptualized in various ways[2]. In the early twentieth century a narrow definition was put forth in the biomedical field, which conceived health merely as "absence of disease". This perspective tends to regard ill health as an individual problem, caused by germs and sees the solution of this problem in treatment by the doctors. In the words of John Ryle,

"Thirty years of my life have been spent as a student and teacher of clinical medicine. For thirty years I have watched disease in the ward being studied more and more thoroughly- if not always more thoughtfully- through the high power of the microscope; disease in man being investigated by more and more elaborate techniques and, on the whole, more and more mechanically. Man as a person and a member of a family and of much larger social groups, with his health

[2] An interesting reading for understanding various conceptions of health is Culler, C. and Stacy M., 1986, Concepts of Health, Illness and Disease: A comparative perspective, BERG, Oxford

and sickness intimately bound up with the conditions of his life and work-in the home, the mine, the factory, the shop, at sea, or at land- and with economic opportunity has been inadequately considered in the period by the clinical teacher and hospital research worker" (Ryle, J).

The biomedical conception of health is outdated, negative and simplistic. The other extreme to the medical model is WHO's conception of health. WHO stressed that health should be understood as a state of physiological, emotional and social well being. WHO emphasized that health is a social problem and acknowledged that ill health is brought about by conditions in the wider natural, social, psychological, and political environment and an individual's response to it. They proposed health care services to comprise curative, preventive and promotive care. However, this model is criticized as being idealistic, utopian and immeasurable.

In this section, we shall attempt to identify some of the factors, which underline our conception of health.

1. Health is an individual, family, regional, national and global public good: For any individual health is one of the most precious assets. Absence of health can impact negatively on an individual's social and economic well being. A sick person is a liability because s/he cannot do his/her daily chores and is dependent on others, thereby eating into their productive time and causing mental and emotional agony, especially for family members. Also illness eats into family's resources and in many cases, people have to take debts to pay for health services, medicines, nutrition etc. Similarly at regional and national levels good health promotes development in all other fields and vice versa.

2. Health is socially defined: Health is a state of being that has been subjected to a wide range of individual, social and cultural interpretations[3]. The term health is used in

[3] Castairs (1955) research in Western Rajasthan presents the contrast between western and rural Indian village's conception of cause of illness, role of the healer and the relationship between the healer and the patient. The latter viewed disease as a result of past sins and attributed cure to accurate prognosis and penance by the patient or prayers of his healer. Though the conclusions of Castairs were in a different context yet they are still relevant today. For example, TB and leprosy are still regarded as curse of God. Also certain norms govern people's eating habits during

everyday life to "designate the intensity with which individuals cope with their internal states and their environmental conditions" (Illich, I., 1975). For instance the young consider health as vitality and energy and the old consider it as the ability to cope with life. An academic may perceive health as a state of mental agility and an athlete may regard it as a state of physical fitness. Thus health is not merely absence of disease but a resource for everyday life and is perceived differently by different people. The concept of what constitutes health varies individually, spatially and temporally, and is often incommensurable and irreconcilable between one culture to another.

3. Health is a socially produced natural reality: The factors such as history, culture, social norms, livelihood profiles, distribution of resources combine to determine individual's health and access to health services. For example, a person working in a mine has more chances of contracting respiratory diseases; a person living in unsanitary conditions is more liable to contract skin diseases; a person who is undernourished succumbs to infections more often; and a person who is socially less valued or is poor has more chances of not accessing health services.

4. Health is a multidimensional phenomenon: Health is a multidimensional concept and the factors causing ill health are multiple. The studies conducted by Chadwick and Snow were landmark studies as they demonstrated the correlation of health to sanitation and safe drinking water respectively. Later many other scholars demonstrated the interrelation between health and other sectors. Djurfeldt, G and Lindberg (1975) and Shah, G (1995) conducted research in Tamil Nadu in 1970's and Gujarat[4] in 1990's respectively, demonstrated that the health outcome is rooted in living

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menstruation or pregnancy. The perception of people's health must be utilized for strategizing health care delivery and should be extended to feed into the planning of health services in order to actualize the potentials of decentralized health care (Priya,1995).

[4] Shah studied the 1994 plague in Surat: the impact of plague on different stakeholders, the migration patterns, treatment accessed by different social groups, the response of public and private sectors, and urgent public health needs of the city. He found that the richer strata migrated, the poor formed the majority of those who died, the private

conditions and economic standing. These studies demonstrated that health policies could not succeed by concentrating solely on health service delivery, even if these services were provided free of cost[5]. The health services in addition to providing curative care are now engaged in preventing illness and encouraging institutions, services and behavior that promote good health. These include making provision for proper drainage, clean water supply, good quality food, public distribution system, vaccination camps, toxic waste management, population control, prevention of communicable and chronic diseases, etc.

5. Health should be studied through an interdisciplinary perspective: Health is a multidimensional concept and should be studied through an interdisciplinary approach. Both quantitative and qualitative data should be used. It is also being largely felt that participatory approaches are the best way to understand the needs or the response to an intervention. The point to reinforce here is that interdisciplinary and systemic research in health care systems can yield a wealth of practically relevant information. In the words of Banerjee (1999), "the health policy formulation is a highly complex process requiring optimization of very complex systems. For this purpose, epidemiological, medical and public health, organizational and management issues are visualized in their social, cultural and economic contexts so as to crystallize them in the form of policies based on constitutional and other types of political commitments. The task is even more complicated in the poor non-western countries. Differences in ecology of diseases, availability of resources, cultural meaning of health problems and practices are some other determining factors".

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doctors shut their clinics, the public sector struggled with the epidemic and that disregard for sanitation had led to the emergence of the epidemic.

[5] The discipline of Public Health emerged from the realization that the health status of a population is inextricably linked to socio-cultural, politico-economic and religious context and as such a change in the health status cannot be solely brought about by the curative care. In the nineteenth and early twentieth century it was primarily associated with under-nutrition, over-crowding, contamination of water supplies and the resultant diseases like tuberculosis, infant mortality and respiratory diseases. At the end of twentieth century public health had also embraced the chronic health problems and comprehensive health planning, especially in the developed countries.

6. Health should be studied through an integrated and holistic approach: Health is a component of the socio-economic system and hence should be studied through a holistic approach[6]. It has already been established that health is inextricably related to socio-cultural, polico-economic and historical context. Also health is linked with sectors like sanitation, water supply, education etc.

To sum up, health is socially defined and produced multidimensional resource, which should be studied through an interdisciplinary and holistic perspective. Depending on the conceptualization of health, broadly the interventions in the health sector has been advocated on three grounds:

- Health and Economic Development: Good health is a prerequisite to greater efficiency and economic development.
- Health and Welfare: Health is a vital social good[7] and the state should ensure easily affordable and accessible health services for all, especially the vulnerable. Many religious health care centers were started for welfare and blaming the poor approach misinformed many projects.
- Health and Human Right: Health is basic human right and health interventions should be people-centric. Moreover, people should have the right to determine the content and pace of health interventions.

The community, non-governmental organizations (NGOs), international non-governmental organizations (INGOs) or the state can initiate the health interventions. The next section will describe select approaches on role of the state in the health sector.

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[6] This is best illustrated in the works of Banerjee. Banerjee (1984) identifies five components of health culture. First, health culture should be seen in terms of the dynamics of interactions between causative agents and human host against the background of human ecology. Two, it should be based on the understanding of patients, their families and the community at large. Three, to understand the social and the epidemiological factors. Four, to understand the ecological, biological and the overall cultural conditions. Fifth, to understand forces within society which influence decisions about policies, plans and programs.

[7] The drawback in this approach is that it considers poor as passive recipients of health care. In some cases, the welfare approach regards sick people as ignorant and irresponsible and responsible for contracting illness. The purpose of the intervention for them is to provide them enlightenment in addition to aid.

1.2: Role Of The State In Health: Select Approaches

There are several approaches[8] that describe the appropriate role of the state in health care interventions. The approaches are divided into three[9] main types i.e. that the state should play a major role in health; that the state should play a limited role in health; and that the state should delimit its role but enhance the role of local institutions.

APPROACH I: STATE SHOULD PLAY A MAJOR ROLE IN THE HEALTH SECTOR

- Social Democratic: The social democrats propose to minimize the negative impacts of capitalism within the capitalist system and suggest that the state should take up welfare activities to compensate for the 'dis-welfare' in the capitalist system. They push for collectively funded[10], uniform and comprehensive health services, and an active role of the state for the provision and distribution of these services. The experiences of the United Kingdom, Norway and Denmark suggests that social democratic states have greater social capital and less unemployment and are hence able to tackle externalities better (Navarrado, 1999)

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[8] While it cannot be denied that following an approach provides a perspective, sharpens the focus, guides the choice of the issue to be explored, influences the evidence to be used and analysis to be reached. Yet there are some inherent weaknesses in following an approach. For example, there is a tendency to overlook certain other empirical indicators that are not covered within a certain approach or inadvertently to twist the facts to suit the approach. In such a situation the approach is considered superior than the purpose of inquiry which goes against the ethics of research. Moreover, it has to be recognized that no single approach can give a holistic picture and always falls short of a multi-disciplinary approach.

[9] We have not described Marxist approach to the role of welfare state here. The Marxist believes that the ultimate purpose of the welfare state is to preserve the capitalist social order. The welfare state diverts attention from the causes of suffering and decreases the potential of any class-consciousness. The Marxist suggests a wider role for public health after the overthrow of the capitalistic regime.

[10] The principle of pooling of resources by way of taxation and provision of uniform and comprehensive health care for all was first outlined in the Beveridge report of 1942. This approach has been at its pinnacle after the Second World War when the inequalities in health status were most stark. In Beveridge's model health insurance was obligatory and adequate to satisfy the health needs of the entire nation and based on support by progressive taxation. The model also emphasized the need for full employment and employment insurance.

- Keynesian Approach: Keynes made a theoretical summary of the social and economic crisis during the Great Depression of 1930's and its implications, mainly that *laissez faire* economy goes through slumps and booms. To avoid such a situation Keynes recommended an increasingly large-scale government expenditure on public works. The rationale of state intervention was to enable the market forces in achieving a high level of economic activity and full employment.

- Welfare Pluralist Approach: Welfare pluralists advocate pluralist and decentralized welfare. The role allotted to the state is strategic and regulatory i.e. to facilitate and regulate the development of roles of alternative providers and to ensure that the priorities and the standard of services are maintained. In a stimulating article Renaud (1975) points that there are structural constraints to the intervention of a capitalist state in health care[11].

APPROACH II: STATE SHOULD PLAY A LIMITED ROLE IN THE HEALTH SECTOR

- Neo-classical Approach: Neoclassical approach has a commitment to the *laissez faire* economy, privatization and consumer sovereignty. The paternalists within this approach believe that health has certain unique characteristics and therefore should be provided free by the state. The liberals maintain that the provision of personal health care should be left to the market, they accept that a small percentage of state budgets should be spent on externalities or communicable diseases. They suggest resort to voluntary charitable activity and medical insurance to help the consumers tide over the uncertainty. Liberals use the concept of consumer sovereignty, which is contested by

[11] To illustrate, he states that the state cannot eliminate the artificial opulence created by capitalism but can only point to the benefits of exercising, and refraining from smoking and drinking.

the paternalist on the grounds of inadequate information among consumers and unpredictable nature of illness[12].

- New Right Approach: New Right Perspective had been dominant in many countries in the 80s. The neo liberal approach upholds the advantages of free market, private sector as efficient provider, freedom of choice and counsel for restricting the role of the state to regulation. It encourages individual decision making and contribution to health care by the way of user fees. According to this approach the level of state welfare provided during the post-war period is excessive, inefficient, poorly directed and encourages a dependency syndrome. It however does contend that the state can play a limited role to provide some welfare provision to a small number of vulnerable groups. Means test, age test or some other criterion should be made to select this group. Thus the New Right clearly advocate a residual role for the state as a welfare provider and increased roles for the private sector, families, voluntary sector and the charities. The Medicare/ Medicaid is an example of this approach[13].

APPROACH 3: THE STATE SHOULD DELIMIT ITS ROLE BUT ENHANCE THE ROLE OF LOCAL INSTITUTIONS

- Participatory Approach: This approach tries to resolve the contradictions between neo liberal approach (the state should do less) and neo Fabian approach (the state

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[12] Health care is unique as suppliers have considerable influence on the choice of health care and not the consumer. Paternalists further argue that vaccination, which is a personal heath care, would be advantageous for society and hence its cost should be borne by the state. By the same logic, an unvaccinated person is a danger to society and should pay a price. Further, the health service is not price elastic, for example a patient of appendix cannot get treatment for flu because the latter is affordable. The paternalist rejects the role of medical insurance by pointing to high out of pocket expenses, under-insured or uninsured groups, impoverishment of vulnerable groups etc. The paternalistic demand state intervention in the form of free medical care financed from public revenues because the market intervention in health care is both inefficient and inequitable.

[13] Brown (1985) explores the implementation of Medicare and Medicaid and concludes that Medicare and Medicaid are failing to achieve the desired objectives. He suggests that to improve equity the health programs should be progressively financed, have no distinction in coverage or benefits, include large role for public planning and be administered by public bodies at national, state and local levels.

should play a major role in redistribution). The state should ensure law and order, decentralize governance, provide safety nets for the poor, enable micro perspective to inform policy/ programs and secure transparent governance. The state should remove prohibitions, regulations and controls that harm the interests of the poor.

Thus there are divergent views on the role of the state in health care. These approaches influence the scope of policies and programs to decentralize health services.

1.3: Objectives

This thesis is an attempt to critically study the implications of decentralization of the health sector in India. The specific objectives of this dissertation are:

1. To appreciate the complexities in theorizing or practicing decentralized governance, especially health system decentralization.

2. To explore the influence of the World Health Organization (WHO) and the World Bank on the decentralization discourse and practice.

3. To document the experience of decentralization at national level.

4. To assess the implication of decentralization of health services in India especially in the light of global initiatives such as health sector reforms.

1.4: Methodology

The methodology adopted is largely based on review of existing literature. The intention is to draw together some of the many contributions to discourse on health system decentralization on a relatively small canvas. The review covered the broader literature on decentralization to

the extent it was helpful in understanding decentralization of the health sector but largely focussed on writings on health system decentralization. Broadly, the literature on the following topics was reviewed:

- Concepts of decentralization and health
- Theories on the role of the State
- Ideology and methodology on Participatory Approach
- Experiences of other countries which have undergone health system decentralization
- Ideology and programs of World Bank and WHO on health system decentralization
- Experience of India in Health System Decentralization
- Empirical Studies on Indian States which are currently undergoing decentralization
- Research on health sector reforms adopted by India

For the purpose of this research the following sources were reviewed

- Relevant books,
- Relevant academic journals,
- Annual/ Project Reports of WHO and World Bank,
- Research/ Working Papers,
- Unpublished documents,
- Press Releases,
- Relevant sites on the Internet

In addition, informal discussions with selected individuals who have worked on this issue were also undertaken.

1.5: Chapterization

This dissertation consists of five chapters.

Chapter 1 is an introductory chapter. It defines the key concepts, presents a theoretical overview, describes the objectives and elucidates the methodology and chapterization.

Chapter 2 outlines the concept of decentralization and attempts to present the complexities involved in conceptualizing decentralization. The Chapter describes the evolution of the concept of decentralization, the forms of decentralization, and the potential advantages and disadvantages of decentralization. It also presents an overview of the decentralization process in India.

Chapter 3 focuses on health system decentralization and discusses its ramifications in the global context. The chapter unravels the complexities involved in health system decentralization. It reviews the experiences of twenty-four countries, which had undertaken health system decentralization.

Chapter 4 presents the standpoint of WHO and World Bank on health system decentralization and unravels its impact on the policies of the developing countries.

Chapter 5 is an analytical chapter, which draws on the findings on the previous chapters. It focuses on decentralization in the Indian context. It summarizes the findings of the previous chapters, but focuses on the health sector decentralization undertaken by India. The analysis is made with the backdrop that India is a latecomer in Structural Adjustment Program (SAP), and has initiated SAP with a distinct knowledge of its implications on health system.

Chapter 2

Conceptualizing Decentralization

This chapter is an attempt to conceptualize the philosophy of decentralization, describe its evolution, present its typology, explore the potential advantages and disadvantages of decentralization, and document the decentralization process in India.

2.1 Decentralization: The Concept

"Decentralization" and "Centralization" are theoretical constructs. In reality most societies keep oscillating between the two tangents. Generally, nations decentralize certain sectors or functions and concurrently centralize other sectors; they may re-centralize the functions they had previously decentralized or decentralize the functions that were previously centralized. In other words, decentralization and centralization are continuous and simultaneous processes. The supporters of centralization believe that national identity is built "through powerful instruments of governance, capable of steering the economic sector, compensating for deficiencies in the private sector and assuring equality, as well as a level of well-being amongst the citizens" (Drache, et.al., 1998). Decentralization is desired because it is difficult for the central authorities to conduct public business especially service delivery, as efficiently at the local levels. It is also claimed that decentralizing governance can be one of the best means of promoting participation, efficiency, accountability and transparency. The most important stakeholders in the decentralization process are the local people and decentralization can only be effective when the general public keeps a close watch on local politics and the local institutions are empowered to demand their rights (Mills, 1969).

Despite the ambiguity surrounding decentralization, it is generally accepted that it is a case of decentralization when the national government devolves or delegates a part of its powers, resources and functions to other stakeholders. "Apart from structural and functional

reconstitution, decentralization involves reallocation of resources like finances, information, man power ... and redefinition of authority, methods of implementation of the decision made and mode of accountability" (Dubey, 1998). "Under decentralized planning, plans are formulated independently, either by the local bureaucracy or a locally elected body within the sphere allotted to it, according to its needs and priorities, and are also implemented locally" (Mishra et.al.).

Ideally the local institutions should be functionally and financially autonomous, composed of elected representatives who are sensitive to the needs of the local people. The objective of the local institutions in such an idealistic situation is social transformation wherein there is deepening and sharpening of democracy (Sebasti, 1998) and creation of a community where individual is the end and government is the means towards that end (Kothari in Antia and Bhatia, 1993). However due to various factors, which shall be discussed in greater detail later in the chapter, these high ideals are rarely achieved.

2.2: Decentralization: The Evolution

The first wave of decentralization was in 1950's and 1960's. It was introduced by colonial administration in many parts of the world (Mills, A., 1990), for enabling the colonial governments to efficiently collect taxes from their colonies. The structures proposed and set up were usually on the model of British and French local government but the principles of right of the local people to participate in the governance were not encouraged. The intention was not to instill freedom and democratic values but to dominate and exploit the country.

The second phase had evolved in 1970's and 80's when certain developing countries felt secure to relinquish part of their claims (Mills, A., 1990). Many developing countries did not have a tradition of democratic institutions and were largely under authoritarian or single party rule. The newly independent countries continued governing through highly centralized democratic institutions set up by the colonial rulers. But by the 70's, it was clear that centrifugal tendencies did not lead to sustainable development; and that decentralized

governance and poverty alleviation were indispensable for socio-economic development. During this phase the paradigm of community participation and community empowerment had also gained ground. For instance, community based natural resource management projects in India and Kenya and decentralization of health care in China had proved very successful. Their experiences were highly publicized by the national and international academia, non-governmental organizations and international aid organizations; and the developing countries were forced to reconsider their governance policy. It is notable that in contrast to the experience of the developed countries, decentralization in the developing countries was imposed by the Central government (mostly influenced by external forces), and was not demanded by local communities or institutions.

The third phase was witnessed in late 80's and early 90's when the World Bank propagated structural decentralization. The structural adjustment programs suggest a decentralization-privatization package; decentralizing from the center to peripheral and/or to the private sectors. Privatization in their view is the ideal form of decentralization and de-concentration is the intermediate form. The Bank however recommended strict regulation of sub-national units in order to maximize the gains from decentralization. As Nayar observes: "The recent approach to decentralization, as espoused by SAPS and the reform package has also introduced conceptual ambiguity by reducing it to a managerial paradigm and a corollary of privatization" (Nayar, K.R, 2001)

2.3: Decentralization: The Typology

Decentralization is not easily defined. It takes many forms and has several dimensions. Several variants may be operating simultaneously within a country, and even within a particular sector. Therefore, care must be used in labeling, and labels must be read with care. Nevertheless, for conceptual clarity decentralization can be described as horizontal, vertical and structural.

1. In horizontal decentralization, the powers are dispersed in organization at the same level and in vertical decentralization, the powers are delegated downwards to lower tiers of authority.

2. Vertical decentralization can take many forms. For instance it may be de-concentration, delegation or devolution.

- De-concentration is limited to passing down of administrative discretion, with very little to do with sharing the power and resources. In the context of the health sector this can take two forms i.e. vertical form and integrated form. The former is practiced in Sri Lanka and the latter in Thailand (Mills, et.al, 1990). In the vertical form local level staff is entrusted with certain administrative responsibilities which they have to perform according to the guidelines issued by the Center. The integrated form eventuates when a local representative is appointed, who is accountable to the Central government and carries out certain administrative tasks at the local level. De-concentration may be a way of promoting centralization while giving an illusion of decentralization or it may be the first step towards devolution. Notwithstanding the reasons for initiating de-concentration, de-concentration certainly has the potential to improve efficiency of the public sector. Majorities of the developing countries are at the level of de-concentration[1].
- Delegation involves passing of some authority and decision making to a 'para-statal' organization i.e. an organization that is outside the central government structure but is indirectly controlled by the central government[2]. One or more staff may be appointed with clearly defined discretionary powers, budget and responsibilities. This form of decentralization may have a "principal-agent" problem, i.e. problem in ensuring that

[1] The municipalities of Chile, the villages in Indonesia, the communes in Morocco and the district councils in Zimbabwe have very little decision-making powers and many local appointments are from above (Mills et. al., 1996).

[2] This form of decentralization is practiced in Tanzania where local bodies had legal status and were responsible for planning and implementing development programs, but they did not have political authority or the power to raise revenue. Delegation is also found in some teaching hospitals in Africa and social insurance organizations in Latin America (Joes Luiz, 1997).

local governments (agent) will act in accordance to the wishes of the central government (principal) (Lietak, 1997).

- Devolution implies that sub-national units have clear legal status, recognized geographical boundaries, decision-making powers, and ability to raise financial resources. The local authorities undertake full responsibility for programs under their jurisdiction without any interference from the central government, although they are rarely autonomous[3].

TABLE: 1

CHARACTERISTICS OF

HORIZONTAL, VERTICAL AND STRUCTURAL DECENTRALIZATION

	Horizontal	Deconcentration	Delegation	Devolution	Privatization
Decentralization to	Same strata	Lower levels of government	Parastatal organization	Lower levels of government	Non governmental and private
Decentralization of	Power, finance and/or functions	Administrative Functions	Some powers, finance and functions	Power, finance and functions	Functions
Mode of participation of local people/ institutions	Nil	Nil	Nil	Potential	In so far as customers affect the prices and commodity
Possible advantages	-Standardization	-Better administration and service delivery -Lower levels are better informed	-Center role is reduced to monitoring and planning	-democracy -empowerment -participation -equity -efficiency -need-based -sustainable development	-efficient -market oriented -better quality
Possible Disadvantages	-does not reward special efforts	-more centralization	-conflicting accountability	-local elite seize power -low quality -chaos	-poor and vulnerable suffer

3. Structural decentralization, also called privatization, implies transfer of responsibilities from the government sector to the private or non- governmental sector. In the context of health sector, contraction and cost recovery of health services offered by the public sector is

[3] For example, Papua New Guinea has devolved health services, with the help of locally raised revenue and a local grant (Mills et. al. 1990).

prescribed. In extreme cases the public sector is advised to decentralize all functions except regulation of the private health care providers and industries such as pharmaceuticals. Upholders of this approach argue that privatization leads to democratization as it increases choice for customers who receive services. But the critics of this approach refuse to recognize this shift as decentralization because power is transferred from one power structure to another (Manor, 1995).

However it is important to add that the reality may be overlapping and complex. The situation can be especially convoluted when a country decentralizes certain functions and centralizes others, simultaneously. Thus decentralization is a complex, dynamic and contextual process.

2.4: Decentralization: The Rationale

Decentralization is widespread both in the developing and developed countries. Decentralization is introduced due to a variety of reasons:

(i) Political: The change from a centralist political party to one with decentralist orientation, from military rule to democratic rule, and from single party rule to multi-party rule are some of the political factors supporting the advent of decentralization. Decentralization may also be initiated as a response to the pressure from local institutions, to keep centrifugal forces at bay, or responding to the international trend.

(ii) Social: Human rights, social justice, equitable distribution of resources, local participation, local level empowerment, and poverty alleviation, are some of the social factors used for promoting the cause of decentralization. The adoption of decentralization policies for the supporters is tantamount to an attack on poverty, exclusion and ignorance.

(iii) Economic: Integration in the global economy, cost effective programs, allocative efficiency, and privatization are some of the economic factors used to patronize decentralization. In most of the countries adopting SAP, a decentralization and

privatization package is recommended, whose parameters are designed by the Bank but which is finalized by the country in accordance to its context.

(iv) Administrative: The need to serve large and diverse populations, delegate routine jobs, and constraints of time at the central level are some of the administrative factors behind marketing decentralization.

2.5: Decentralization: The Two Sides of It

Decentralization has always attracted extreme views. Some consider decentralization to be a panacea for intra and interregional inequality in terms of political clout, distribution of resources, access to services, sustainable livelihood, environmental conservation, social status and so on. Others regard decentralization as an illusion designed by those in power to hoodwink the have-nots in believing that they are empowered. There are evidences both in favor of and against decentralization. This is because decentralization per se does not bring either benefits or problems. Successful decentralization improves the efficiency of the public sector and enhances the development process while unsuccessful decentralization threatens the economic and political stability of the nation and disrupts the delivery of the public sector (World Bank, 1999).

Received wisdom shows that when it works well, (Manor, 1995) decentralization leads to many benefits (Mills, A., et. al., 1990). In what follows, the advantages of decentralization are divided into political, social, economic and administrative; though these advantages are overlapping and interrelated in reality.

Political: Decentralization is an opportunity for increasing democratic participation, developing political skills at local levels, encouraging community participation and control, facilitating local self-reliance and essentially redistributing power between national and sub-national units. Khemani (2000) studied voter behavior in India between 1960-92 and concluded that voters were more vigilant at state level elections as they re-elected a person only if s/he had performed throughout the tenure. The

national level voting was more influenced by the incidents in the last year of the tenure.

(ii) Social: Decentralization is an opportunity for ushering in social transformation of the society, recognizing the equality of all social groups, accepting the right of all social groups to have equal opportunities and essentially leading the nation into a more equitable socio-economic structure.

(iii) Economic: Decentralization is an opportunity for increasing local entrepreneurial capacity, utilizing resources efficiently, lowering costs, improving services, providing better maintenance and monitoring, and prioritizing efficiently the use of resources. It also has the prospect of generating more resources through collection of taxes, user charges and increasing voluntary contributions (especially in the form of labor) for grassroots developmental projects. In many cases it is observed that the resources are routed towards small-scale endeavors.

(iv) Administrative: Decentralization is an opportunity for overcoming institutional, physical and administrative constraints; improving the flow of information between the government and the general public; ensuring accountability of government officials to the population; and enhancing responsiveness from government[4].

However the above mentioned benefits are possible only if there is genuine decentralization. Some have doubts regarding the very efficacy of decentralization to provide equitable and efficient administration, as it is vulnerable to manipulations to suit diverse political pursuits of various stakeholders (Collins and Green, 1994). A review of literature reveals that multiple factors are responsible for the failure of decentralization to produce the desired benefits, the factors are divided into political, social, economic and administrative

[4] In a district of India decentralization helped in maximizing the number of children receiving free inoculations (Manor, 1995). In another case decentralization yielded early warning system in outlying areas and the government responded to the crisis quickly. In yet another area in India decentralization has helped in reducing absenteeism and corruption amongst the government employees.

(i) Political:

- Decentralization often results in deconcentration because it is not backed by political conviction or certain circumstances may not allow the center to devolve its powers.
- The decentralization process may be subverted by the selfish motives of the bureaucrats and politicians[5].

(ii) Social:

- Decentralization often does not lead to a more democratic society, nor does it reflect local priorities in their programs[6].
- Decentralization may not lead to a more equitable society and may even sharpen the inequities[7]. Sometimes after decentralization of expenditure decisions, a greater share of public resources are spent on services used by the non-poor, and inequities are sharpened. Similarly, decentralization can be misused by introducing user charges and taxes that burden the poor disproportionately[8].
- Moreover, decentralization instead of promoting self-esteem of the local people is often used to reaffirm that the local people do not have the capacity to take care of their affairs. This is detrimental to the spirit of decentralization.

[5] That the conviction of ruling party determines the pace of reforms is demonstrated from the following example: in 1994, when panchayats in most of the states were either non-existent or restricted to routine work, the West Bengal government passed an amendment to empower the gram sansads to evolve local plans for West Bengal (Sujata Rao, 1994). Another illustration of a nexus between a political party's ideology and decentralization is the flourishing of panchayats in West Bengal under the backing of the Left front and dismantling of panchayats in Tripura with the demise of the Left front.

[6] For instance, in Bihar the regional elite were nominated as local representatives for generations and local people did not participate in the working of the panchayats in any way (Kumar, 2001). The issues of inequity were not addressed in such a scenario.

[7] For example, India has a long democratic tradition but the poor and the vulnerable often have little influence on the policies of the government (World Bank, 1996). To take another example, in the Mexican State of Guerreto, decentralization of health services allowed wealthier areas to negotiate better health budgets and in Zambia, transferring some recurrent costs for primary education from the central government to the parents tended to increase interregional inequality [7](Lietek, 1997).

[8] There may be sometimes real constraints on the amount of resources that can be delegated to the decentralized institutions for public expenditure as in the case of countries undergoing SAP.

Economic:

- The benefits of decentralization can be offset by losses in the economy of scale[9].
- Decentralization is unlikely to mobilize local level resources because Central governments generally do not delegate the powers of imposing local taxes to the local government. Also, local leaders are disinclined to impose fresh taxes due to political, social or administrative constraints (Lietek, 1997).
- The contributions of local people in the form of voluntary labor are considered as one of the most important advantage of local government. There are doubts on whether these are really 'voluntary'[10].
- The structural adjustment programs usually favor haphazard budget cuts and centralization of power and this retards the process of decentralization (Banerjee in Rao, 1994: 7).
- The dependence of the local governments on the funds of the central or the state government does not allow decentralization to flourish (Sujata Rao, 1994)

(iv) Administrative:

- Effective decentralization in administration is possible only if there is decentralized pattern of administration
- Sometimes the newly decentralized countries lack the necessary administrative skills as they are asked to perform new functions without adequate training. Decentralized local institutions need to learn self-discipline and obtain support of the central government[11].
- In some cases decentralization also leads to a fall in standards[12] or increase in costs[13].

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[9] For example, in China local power plants were 30% more expensive in terms of capital and 50% more expensive in terms of operational costs (Lietek, 1997).

[10] In India, Indonesia and Nepal, University students are required to "volunteer" to supervise small-scale development projects. In some African countries, including Tanzania, local people are fined or punished if they refuse to work on "self help" projects.

[11] In Ecuador, decentralization of rural public health program meant that there was no effective supervision or logistical support, resulting in severe delays and supply shortages.

TABLE: 2

DECENTRALIZATION AND POTENTIAL ADVANTAGES/DISADVANTAGES

	Advantages	Disadvantages
Political	♦ Redistributing power between national and sub-national units. ♦ Fosters democracy and national unity, diffuses social and political conflict ♦ Promotes political awareness, skills and participation at all levels ♦ Promotes selfgovernance and local self-reliance ♦ Makes government responsive to people ♦ Decentralizes conflicts, pacifies minorities and avoids fragmentation	♦ Reduces central level to a level of non-entity ♦ An exercise of centralization ♦ Initiated to shift the blame to sub-national units ♦ Power usurped by local elite ♦ Shadow politicians ♦ Does not promote democracy or national unity Local taxation can be used as a political weapon ♦ The sub-national entities can jointly rebel against state ♦ Local institution may be vulnerable to external pressures
Social	♦ Economic and social justice ♦ Affirms that local people have the right and capacity for self governance ♦ Improves access of poor to public goods ♦ Provides avenues of political participation for local people	♦ Increases inter and intraregional inequity ♦ Reaffirms that local people do not have the capacity for self governance ♦ Transfers the burdens on the poor in the name of revenue generation ♦ No opportunity for community participation
Economic	♦ Increasing local entrepreneurial capacity ♦ Utilizing resources efficiently and at lower costs ♦ Prioritizing resources in a need based fashion ♦ Generating more resources through collecting stringently, applying user charges and increasing voluntary contributions,	♦ Losses in economy of scale ♦ Local revenue is not mobilized or used as a political instrument ♦ Voluntary labor is coerced ♦ Imbalance between revenue and expenditure ♦ Dependence on center for funds
Administrative	♦ Overcoming institutional, physical and administrative constraints ♦ Improving the flow of information between the government and the general public ♦ Ensuring accountability of government officials to the population ♦ Enhancing responsiveness from government ♦ Overcomes disadvantages of centralized administration ♦ Facilitates adaptability and flexibility in management systems	♦ Fall in standards ♦ Inappropriate supervision ♦ Inadequate administrative skills to handle new responsibilities ♦ Increase in work without corresponding increase in funds or power

[12] In Kenya the schools built by local initiative have under-qualified teachers and the level of achievements of the pupils is also low.

[13] In Mexico and Venezuela, decentralizing the education systems has increased costs because of proliferation at national, regional and local levels (Lietek, 1997).

Thus, decentralization does not automatically produce equity or efficiency. This is because of various factors. First, decentralization is not an end in itself but a means to an end and is intrinsically vulnerable to many manipulations. Second, it is difficult to measure decentralization, as it is intangible and subjective. Third, different stakeholders promote the implementation of decentralization to fulfill different goals and it is hence difficult to establish general patterns of decentralization (Jose Luiz et.al., 1997). Fourth, it is very difficult to predict the pace and outcome of decentralization. This is because decentralization influences and is influenced by a multitude of factors. Fifth, the policy and process of decentralization is based on the political choices made by those in power and hence there is no blueprint for decentralization. Sixth, it is important to understand the historical, cultural, social and political context under which this concept is used and the goals of those advocating this approach because each decentralization episode is unique and context-specific. Finally, decentralization does not imply that there is no role for the central government. Instead decentralization implies a restructuring of roles and responsibilities between the national and the sub-national units. The central authorities have an edge to handle macro issues of national and international importance; monitor, sanction or guide the local institutions; and provide an enabling environment by enforcing general law and order. The local institutions have the first hand knowledge of multiple grassroots realities and are the best guide for policy formulation and implementation. In fact, synchronization between centralizing and decentralizing tendencies is required for successful decentralization

2.6: Decentralization: An Indian Overview

Decentralization is not new to India. India has a long history of local governance through village panchayats. There are many instances of Panchayats in the Vedic periods (Singh, 1998), in the Chola dynasty (1900-1300 AD), in the Mauryan rule (3rd to 2nd Century BC) and

in the times of Gautam Buddha. The panchayats of ancient India were the pivot of administration, justice, economy and custodians of social and cultural norms[14].

The institution of Panchayats had started to lose its importance in the pre- British times, especially between the decline of Mughal rule and the advent of British rule. This was a time of political uncertainty and the Kings were more interested in maintaining their titles than ensuring efficient administration. The panchayat system was further destroyed with the advent of British rule when District Collectorate took over the functions of Panchayat Samiti. Nonetheless, local self-government in India, in the sense of a representative institution accountable to the electorate, was the creation of the British. The underlying objective of the British, in setting up local self-government in India, was twofold: one, to involve an Indian support base in the administration and two, to extend the "tentacles of colonial state into the rural hinterland (Lieten G.K, et. al. 1999). Lord Mayo in 1870's passed a resolution for decentralization of administrative functions. But it was Lord Ripon who revived the concept of decentralization with the Ripon Revolution of 1882. Subsequently District Boards and Taluk Boards came into being which nominated members to look after health, roads and education. In 1907 the Royal Commission for decentralization revised the tenets of Ripon Revolution. By 1948, twenty native states had enacted village panchayat acts. But the marriage between local government and local bureaucracy remained "somewhat inconclusive" (Morris, J., 1971).

With the coming of Independence, Mahatma Gandhi made a plea for decentralized governance[15]. But B.R. Ambedkar was of the view that the elite in the higher castes exploited these 'little republics'! J.P. Narayanan pointed that the panchayats had deteriorated so much that they were no longer custodians of individuals or communities. As a result, Panchayati

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[14] The Rural reconstruction Program, started by Maharaja Sayajirao Gaikwad in 1890 in Baroda, the Rural Reconstruction Centers started by Tagore in 1908 in Bengal, the self help Multi.-Purpose Development Program started by Spencer Hatch of YMCA in 1921 in Travancore are cases in point (Rao, 1994).

[15] In his journal Harijan of 1942 he had written, "My idea of village Swaraj is that it is a complete republic independent of its neighbors for its own vital wants and yet interdependent for many others in which dependence is necessity" (Mathew in Aziz and Arnold).

Raj finds mention in Directive Principles of article 40, which pronounced that the State should take steps to organize village panchayats and endow them with such power and authority as may be necessary to enable them to function as units of self government. Consequently, Panchayats were not accepted as an alternative form of political and economic organization and the Constitution remained largely federal and parliamentary in structure, with a pronounced bias towards centralization. This bias got accentuated over the years.

The first phase of Panchayati Raj started twelve years after independence[16]. Rajasthan was the first state to implement Panchayati Raj Act in 1959; thereafter states like Maharashtra, Gujarat and Andhra Pradesh passed necessary legislation while the others lagged behind. In the few areas where decentralization worked well its impact has been favorable. According to the Report of the Ministry of Community Development of 1964-65, "younger and better leadership was emerging through PRIs and there was a fairly high degree of satisfaction among the people with the working of PRIs". Nevertheless, by and large Panchayati Raj did not fulfill its expectations due to structural inadequacies, limited resources, lack of conceptual clarity, lukewarm attitude of the bureaucrats, vested interests of the rural elite, disinterest of the rural masses and lack of political will to check irregularities.

A series of teams and committees were appointed to advice on promoting decentralization (Table 3). In spite of benevolent policies and commissions to foster decentralized planning the administrative system, India remained highly centralized. The first phase of decentralization was over with the death of Nehru. During the next 13 years i.e. between 1964-1977 panchayats were neglected, elections were not held regularly and little financial resources were made available to implement the programs.

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[16] Before Panchayati Systems could take roots, the community development project was launched in 1952. The community development movement was designed to promote better living for the whole community with the active participation of the community and help from Block Development Officer and village level workers. The movement started with a fanfare with the help of Gandhian volunteers and aid from America. But the project soon fizzled out because "there was neither community nor much development in the community development program (Listen, G.K., et. al., 1999).

TABLE: 3

SELECT COMMITTEES ON DECENTRALIZATION IN INDIA

COMMITTEE	RECOMMENDATIONS/OBSERVATIONS
Balwantrai Mehta team, 1957,	It recommended three tiers decentralized system of administration with sufficient resources, power and authority devolved on the panchayats.
Mudliar Committee, 1961	The Committee observed that health facilities were skewed in favor of urban areas, the PHCs were understaffed and that majority of rural population did not have access to drinking water and adequate sanitation. It is ironical that though the Committee recommended the training of para medical staff it actually gave financial and infrastructural support to medical education. There has been a general dichotomy between stated policy and actual intention and implementation (Anita and Bhatia, 1993).
1969, the Planning Commission	It stressed the need for local involvement in planning at district levels.
Dantwala Committee, 1978,	It emphasized the need for local involvement at the block level planning.
Ashok Mehta Committee (1978)	It stressed the need for planning at district level. It proposed a two tier Panchayat consisting of Zilla Parishad and Mandal Panchayat with direct election in both tiers and reservation of seats for SC, ST, and women. The role conceived for Zilla Parishad was of planning and that for Mandal Panchayats was of implementation.
The Working Group on District Planning (1982).	The working group, under the chairmanship of Hanumantha Rao reiterated that block level planning should be entrusted to District Planning Body comprising representatives from Zilla Parishad, panchayat samiti, municipalities/corporations, MLA, MPs and representatives from banks and entrepreneurs. The concept of decentralized planning outlined in Hanumantha Rao Report was accepted in principle by all the states except Sikkim, Goa and Tripura (Mishra et.al, —).
G.V. Krishnamurthy Rao Committee, 1985,	It was set up to review the administrative arrangement for rural development and poverty alleviation. It recommended that Panchayati Raj at the district level and below take on the role of planning, implementation, and monitoring of rural development programs. It further recommended that a State Development Council should be set up so that district and state plans could be brought into a common framework.
L.M. Singhvi Committee (1986)	It recommended district planning and financial devolution for rural development and nation building. The report advised that every official in public administration should be made to work in Panchayati Raj to sensitize them to the problems of rural India. The Committee felt that training, research and public education inputs would be most productive investment in democratic institution building.
Sarkaria Commission in 1988	This was mainly concerned with Center State relations but within the broader context of decentralization. The Commission reiterated the need for regular elections and devolution of finances, functions and real power to Panchayati Raj institutions.

In 1977, with the election of the Janata Party, the interest in Panchayat was revived and a Committee was formed under Ashok Mehta to review the system. The Ashok Mehta Committee observed that,

"It is wrong to think that Panchayati Raj should be viewed as a God that failed. It has many achievements to its credit, the more important of which may be identified here. Politically speaking it has become a process of democratic seed-drilling in the Indian soil, making an average citizen more conscious of his rights than before. Administratively speaking, it bridges the gulf between the bureaucratic elite and the people, socio-culturally speaking it generated a new leadership which was not

merely relatively young in age but also modernistic and pro-social change in outlook. Finally looked at from the development angle it helped the rural people cultivate a development psyche" (Singh, C.B.P, 1998).

The Ashok Mehta Committee proposed the two-tier approach on the rationale that after the state the next point of decentralization should be at the district level. The major efforts to rejuvenate PRI's on the basis of the Ashok Mehta Committee came from West Bengal, Karnataka and Andhra Pradesh. This new system led to the emergence of high level of perception among rural voters; emergence of a young, literate rural leaders; acquisition of power and resources by local bodies and involvement of political parties in enthusing the villages. But the political backing of the Panchayati Raj was short-lived. In 1979, Congress came back to power and adopted, perhaps somewhat reluctantly, the mandate of PRI but did not give it the political backing it required. Soon the states, which had adopted Panchayati Raj, realized that to function efficiently and effectively they needed adequate constitutional safeguards.

In May 1989, the Rajiv Gandhi administration brought forward the 64th Amendment Bill. The Bill proposed: a three tier system in all states; direct elections for all seats; reservations for SC, ST and women; fixed tenure of 5 years; devolution of power, responsibilities and finances to Panchayats; superintendence of the Election Commission to direct and control elections; and empowerment of the Auditor General to audit the accounts of Panchayats. The Bill was passed in the Lok Sabha but defeated in the Rajya Sabha in October 1989. The major problems that were articulated were non-statutory and financially dependent status of panchayats, uniformity of three-tier system, excessive controls of the Center and negligible role for the State.

The 72nd and 73rd Amendment Bills, introduced in the Lok Sabha in September 1991 and in the Rajya Sabha in December 1992, are described as a watershed in the process of decentralization in the country[17]. The bill makes the three-tier system mandatory; requires all

[17] The 73rd Amendment is not applicable in Jammu and Kashmir, Meghalaya, Mizoram, Nagaland and certain Scheduled areas of some States.

posts to be filled through direct elections; recommends 1/3rd reservation for women and SC/ST, and emphasizes that Panchayats should receive adequate funds from the States. The States were advised to make a state election commission and state finance commission; the responsibility of the former was to oversee local level elections and the latter was to innovate ways in which panchayats could be made financially autonomous. The Bill recommended entrusting to the panchayats the responsibility of formulating, implementing and monitoring the local level development programs for 29 subjects including health, sanitation, housing, drinking water, women and social development, family welfare, welfare of the handicapped and mentally retarded, welfare of the weaker sections, public distribution etc.

With the bill, after forty-three years since the constitution of India was adopted the PRI's were finally given statutory status[18]. Though this bill is applauded by many and is definitely a great leap towards decentralization, yet it does have some drawbacks. Firstly, the Bill made a three-tier system compulsory and the state is not given discretion in deciding on number of tiers, except in some exceptional cases. Secondly Panchayats have been termed as institutions of self-governance but without law and order under their control. Likewise, panchayats do not have legislative or judicial powers. Thirdly, the bill is critiqued because the PRI do not have financial autonomy: resource-raising capacity of the panchayats is limited; and they have a narrow tax base (tax on property, professional income and vehicles). Moreover, there are unfavorable external factors, such as, in most states bureaucracy is not willing to share power with PRI and Zilla Parishads; Similarly MPs and MLAs have been arguing against strengthening or revolutionizing panchayats. Political will is lacking and consequently PRI's are concentrating on one or two schemes. These are mostly development schemes which are centrally sponsored and where staffing and other norms are set by the Central government.

Perhaps the worst drawback in the 73rd Amendment act wherein the State legislatures are given discretionary powers which enables the state government to do away with

[18] It is outside the scope of this paper to analyze the impact of the 73rd Amendment. The general consensus is that the amendment is a start of social transformation but as of yet has not succeeded to make a difference.

representatives who ask for more responsibilities, finance or personnel (Pal, M. 2001). Also, nearly 60% of the provisions of the 73rd Amendment have been left to the state. This makes PRI excessively dependent on the state. In such a situation the power of Gram Sabha is not specified and this can lead to a lot of ambiguity and confusion[19]. This drawback led to the proposal of 87th Constitution Amendment Bill in the Rajya Sabha in December 1999. The Bill proposes that the state should have the discretion to fill all the seats in panchayats at intermediate level and district level by persons elected as chairpersons at the village level panchayats or intermediate level panchayats[20]. This amendment if passed, would be detrimental to the Panchayati Raj envisioned in the 73rd Amendment.

The proposal for 87th Amendment and its country cousin the Andhra Pradesh Ordinance have highlighted once again that decentralization is inherently a political process and is guided by the model of development pursued at a given point of time. Instead of addressing the loopholes in the amendment, the powerbrokers are trying to put a brake on the decentralization process, a process of forward and backward movements continues to characterize the decentralization process in the country. The decentralization process is indeed a political event, some stakeholders, guided both by their own selfish motives and the neo-liberal paradigm, are trying to stop the process of decentralization. Some scholars argue that the 73rd Amendment is not introduced with the view to promote self-government but is to strengthen administrative federalism.

The Panchayats should be given functional and financial autonomy if it they are to serve the vision of local self-government. The Article 249 should be amended to withdraw completely the discretionary powers of the state or restrict it only for certain well-defined extreme

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[19] For instance, in Karnataka, the first state to pass 73rd Amendment, though the bill is well liked by the people, there are transitional difficulties related to personnel issues, and significant confusion in the state about the roles of different segments of the government.

[20] The rationale given for this amendment was that elected members of territorial constituencies of the panchayats at intermediate level and district level have no substantive function to perform and that there is an absence of organic linkage between three levels of panchayats.

situations. One only hopes the acts such as 87th amendment are not passed to dampen the spirit of people at local level. The PRIs should have financial autonomy and not be strangulated with excessive controls in relation to budget, taxation, expenditure, contracts, staff appointments, disposal of assets etc. and so on.

To sum up, this chapter had attempted to demonstrate that decentralization is not just a matter of passing a constitutional amendment and restructuring roles and responsibilities accordingly. It is an extremely complex process, which is affected by and affects a multitude of factors and needs careful implementation to maximize on the advantages. In the words of Lietek (1997),

"Many factors affect both the ideal and the actual form of decentralization adopted in any country for any service at any time. The number of subnational units as well as their absolute and relative sizes and wealth, the distribution of functions, the nature of the institutions, the role and status of the constitution, the technical characteristics and policy objectives of specific public services, and the current political situation. Much of the discussion of decentralization presumes that it is a matter of choice or deliberate design but in the circumstances of many countries it may equally well be either a political necessity. For these and other reasons, "decentralization" often encompasses nuances that can only be understood, analyzed, and—to the extent possible—guided on the basis of thorough local institutional knowledge" (Lietek, 1997).

The next chapter will focus on health system decentralization.

Chapter 3

Health System Decentralization: Theory and Practice

Decentralization is the most common component of health sector reform in the developing countries. This chapter focuses on exploring the complexities of health system decentralization; it defines health system, explores the benefits of health system decentralization, presents the experience of twenty-four countries in health system decentralization and discusses lessons learnt from their cumulative experiences.

3.1: Defining Health System

Health system[1] consists of all activities, actors and agencies that are chiefly involved in promoting health, preventing ill health, or treating and rehabilitating ill people. This includes the entire gamut of medical care system, health care system, public health measures, health education, health policy making, health administration, health economics, health research, and training centers on health issues.

Health system is a dynamic entity that is shaped by the historical, political, demographic, cultural, social, economic, scientific, technical and geographical factors. The tendency in developing countries to centralize policy formulation and resource management derives from historical factors rather than inherent needs of the health system. Likewise political factors effect health systems, countries with capitalist orientation privatize health, those with socialist affiliations regard health as a direct responsibility of the state and those with mixed economy have a combination of both. The population and its density are important factors

[1] A system is a conceptual representation of a set of sub-units, which has a structure and a function and works towards a common objective. Each unit is a sub-system but to study the whole one has to understand the interaction between sub-systems.

for determining the organization of the health system. The cultural determinants[2] of health care systems are complex and ramifying, as they affect the acceptability of the services. The social customs, norms and taboos affect the utility of health services and the health status of the people. The importance of economic factors in the planning of health services is manifest as it influences the levels of provision, the scale and type of services. The source of expenditure (government, private, charitable, international donors) affects the scale and allocation of services and also impacts the sustainability of health sector development. Though each of the above-mentioned factors are extremely important in themselves yet if health interventions are to be successful the health system has to be planned taking all these factors into account. In other words, health system is an integral part of holistic development strategy.

3.2: Rationale of Health System Decentralization

In the context of health care it has been sufficiently demonstrated that decentralized people based health care is desirable (Antia and Bhatia, 1993). Decentralization of health system can range from transfer of limited powers to lower management levels within current health management systems, to extensive reforms in the system. Health sector decentralization is propagated on the grounds of equity, efficiency, accountability and quality of health services. Some of the factors that are used by its advocates are as follows:

1. It would cater to the local priorities and problems. In macro situations the local priorities are sometimes misunderstood. When the local authorities keeping in view the local situations make decisions, it is more likely that the decisions will be in tune with local

[2] Understanding the culture and rationality of the people is a prerequisite for successful health interventions. Marriot's research in a village of Uttar Pradesh demonstrates that "scientific medical practice can divest itself of certain western cultural accretions and clothe itself in the social homespun of the Indian village" (Marriot, M., 1955). His conclusions are relevant today also. Banerjee's (1971) study of national tuberculosis program in India suggests that health behavior of the community cannot be studied in isolation of the health services. A similar story was revealed by Mamdani who studied the reasons of the failure of family planning program. His research in Punjab shows that it is rational for the poor to produce more working hands for the family.

needs. In the best case scenarios the local people may themselves control the planning of health systems and in the worst case scenario the changes do not reflect the local priorities at all.

2. Improved implementation of the health programs because of community participation. Sometimes good policies fail because of improper implementation. This can be avoided with decentralizing the services as local people could ensure that the programs are implemented properly. In case of default they could complain to the concerned authorities. In case of genuine problems they may volunteer to help.
3. Decrease in duplication of services. Different service providers waste a lot of time and money due to duplication of services and unnecessary competition. Decentralization necessarily demands good coordination between all the service providers, with the control in the hands of local authorities and a distinct plan with a predetermined budget. This could decrease unnecessary duplication, confusion and corruption
4. Reduction in costs and better access to the poor. Decentralization of health services may reduce the direct and indirect costs in accessing services. In most known societies social class and gender affects a person's access to health services. After decentralization the services may be more accessible to the vulnerable as health care is nearer, cheaper and targeting of safety nets is easier.
5. Greater integration of activities of different public and private agencies: The decentralization process can also lead to greater integration of public and private agencies. Also the local institutions can decide on the type of services to be privatized, depending on their own unique context.
6. Improved inter-sector coordination, particularly in local government and rural development activities: The health sector can coordinate with other sectors, such as water department or sanitation department, to optimize the health status in their area.

The actual level of decentralization is generally determined by a complex set of factors including the size of the country, its economic situation, the mode of governance, attitude of the civil servants, capacity at the local level to participate, finances at local level, intra and inter

sectoral coordination, obstacles and handling of the same. However, this issue shall be discussed in greater detail towards the end of the chapter.

3.3: Decentralization of the Health Sector in India

The provision of health care was considered a social responsibility even in the pre-colonial times. Hospitals provided free service in the reign of Ashoka and the Mughal Empire. In addition to the state, the rich traders also undertook a social responsibility towards their kinsmen and provided charitable health care in the cities[3]. The majority of private practitioners of that time practiced at an individual level and concentrated on indigenous health care of various types such as vaids, herbal healers, snake bite specialists, birth attendants, abortionists, psychic healers, folk healers etc.

In the colonial times Indian medical systems such as Ayurveda and Unani suffered a huge setback due to lack of patronage, diffusion of western medicine and decline of state economies. While the Portuguese established the first modern hospital in Goa as early as 1510, it was only under the British that modern health care was firmly established in various parts of the country. The reason the British started to invest in hospitals was that they wanted to provide adequate health care to their soldiers (Banerjee, D., 2001). The English East India Company established its first hospital in 1664 at Fort St. George in Madras and subsequently in other areas where English troops were stationed. In 1764 the Indian Medical Service (IMS) was founded, initially as the Bengal Medical services. The medical facilities at the IMS, however, continued to be restricted to the urban areas and that too in the military and civil enclaves of the British, until the Chelmsford reform of 1919. It is only when epidemics started that sanitation and rudimentary health services were provided to the civilian population and by 1914 the health policies had acknowledged the need for travelling dispensaries, disinfecting of wells and other sanitation activities (Qadeer, I., 2001). The rural

[3] Many such hospitals exist even today in Mumbai and other parts of India.

health care started in India only after 1920 when the Rockefeller Foundation started preventive health program in Madras that gradually moved to other areas. However by 1926 only 13% of the population had access to health services and the army achieved a mortality decline of 80% between 1869 and 1910 and the general population achieved a decline of merely 10% during the same period (Qadeer, I., 2001).

Some of the eminent medical professionals like BC Roy, M.A. Ansari, Dr. Khan Saheb, Hakim Ajmal Khan, Dr. Jeevraj Mehta, and Dr. N.M. Jaisoorya occupied leadership positions in the national struggle. They were impressed by the egalitarian health services provided by the welfare state of the United Kingdom and socialist state of the Soviet Union. The Indian National Movement compelled the British to set up the Health Planning and Development Committee in 1944 and the Congress itself set up National Planning Committee. In addition, the Gandhian Plan for Economic Development and People's Plan Committee and Bombay Plan Committee were also set up in 1944. While the Gandhian Plan was of the view that people should have a major role in planning and implementing their health care, the Bombay and the People's Plan stressed the role of doctors, nurses and latest medical equipment.

The British, at the insistence of the nationalist leaders, set up the Bhore Committee in 1943 to make an appraisal of the health services in the country and make recommendations for national health services. The Bhore Committee Report (1946) was the first plan for an Indian National Health Service[4]. The committee recommended that no individual should be denied health services because of inability to pay and the health services should be easily accessible to all - both in the rural and urban areas. The Primary Health Care (PHC) was the basis of an integrated preventive, promotive, and curative health care service. The Committee proposed a 75-bed hospital for each PHC center, catering to the health needs of 20,000 people. The Bhore Committee considered housing, sanitation, drinking water supply, environmental

[4] Perhaps, the drawback of the Bhore Committee was an overemphasis on the western medical system. The recommendations also ignored the most important stakeholder, i.e. the community, in the planning of the health services. It is also notable that the educated, urban, upper class professionals were more concerned with the diseases of the rich and with educating the ignorant poor not to spread disease.

hygiene and economic and infrastructural development to be an integral part of public health. It estimated a time frame of 30-40 years for achieving this target (Antia, N. H., 1993). Subsequently, some of the recommendation's of the committee found place in the planning of Independent India (See Table 4).

The National Health Policy (NHP), issued in 1983, was a landmark in the health planning of the country. The India government has designed a publicly financed and publicly managed system of health services, from PHCs to hospitals, throughout the country. The intention was to have trained traditional attendants and village health guides for every village, multipurpose workers for every few villages, health sub-center for every 3000 population, primary health centers for every 30,000 population and community health centers for one lakh population. The policy recommended correcting the curative and urban bias in health service delivery by 'large scale transfer of knowledge, simple skills and technologies' to health volunteers and making efforts to facilitate effective community participation. The policy emphasizes that curative; preventive, primitive health care should reach remotest areas in the country. In addition, effective secondary and tertiary health care services had also been emphasized as a back up support to primary health services. The NHP gives high priority to control of fertility, infectious diseases of public health importance and preventable causes of maternal and infant mortality. The policy acknowledged interlinkage with employment, education and integrated rural development. The National Policy also recognized the need for the government to co-exist with the private sector.

Though the health services were biased towards the urban areas, yet between 1970 and 1993, life expectancy at birth increased from 50 to 61 years and infant mortality decreased from 137 to 74 per 1000 live births" (World Bank, 1997). However, the distribution of health services witnessed inter and intra regional inequities (Appendix 6 and 7). The acceptance of 72nd and 73rd Amendment in 1993 presented a critical opportunity for the states to intensify health system decentralization.

TABLE: 4

FIVE-YEAR PLANS AND HEALTH SYSTEM DECENTRALIZATION

Plan Period	Relevance to Health System Decentralization
First five-year plan (1951-56)	▪ It recommended formation of PHC and disease specific programs for malaria, small pox, leprosy, tuberculosis and filaria. ▪ In the 1952 the first batch of PHC was set up and community development programs were initiated but decentralization was limited to sectoral programs at panchayat levels (Mishra, et.al, -).
Second five-year plan (1956-61)	▪ It recommended district level plans. By 1959 all the states had passed panchayat acts but this did not have the expected benefits. ▪ The sixties saw a decline in importance of the rural institutions and was favorable towards urban areas, specialized doctors and good hospitals.
Third five-year plan (1961-66)	▪ It launched national goiter control program and Applied nutrition. ▪ On recommendation of Chadda Committee (1963) and Mukherjee Committee (1965) a norm of one basic worker for every 10,000 people was adopted, separate staff for family planning was hired and basic health services were provided at block level.
Fourth five-year Plan (1969-74)	▪ It recommended strengthening the rural health infrastructure and separate allocation for PHCs. In 1972 Kartar Singh committee proposed one health worker per sub-center, one supervisor for four workers, one PHC for every 50,000 people and one sub-center for every 3000 population[5].
Fifth five-year Plan (1974-79)	▪ It stressed reorientation of workers into multipurpose workers. In 1977 population control and family planning was made concurrent subjects. The Srivastava committee recommended to train one male and one female community member's as health assistant for every 5000 people and a strong referral system[6]. ▪ Janata Government in 1977 implemented a number of proposals: expansion of the training of indigenous midwives; expansion of employment of paramedical personnel, retraining of multi-purpose workers, and training and employment of community health workers (Jeffery, R., 1986).
Sixth five-year Plan (1980-85)	▪ It emphasized the development of a community based integrated health system with a built-in graded referral system. A village health guide scheme was started by the central government[7]. The CHC was recommended to be the apex body of interrelated graded health care system dealing with curative, preventive and promotive functions[8]. ▪ The changes suggested by the plan included reducing the budget of family planning program from 22% to 15% of the total health budget and promoting expansion of infrastructural institutions on the lines suggested by PHC approach.
Seventh five-year Plan (1985-90)	▪ The objective of the plan was to eliminate poverty, illiteracy, unemployment, and to provide food, clothing, shelter, water, sanitation facility and health for all by the year 2000. It also proposed to complete the infrastructure on PHC as suggested by the National Health Policy of 1983. ▪ However, it increased the budget of family planning program from 15% to 24.7% of the total health budget, thereby diverting time and resources from the objectives it had set out to achieve.
Eighth five-year Plan (1990-95)	▪ It identified health as one of the six priority areas for investment and emphasized commitment to decentralization of health services, starting with family planning. Evolved a sanitation project with a holistic perspective and involvement of panchayats, NGOs and beneficiaries. ▪ The HSR suggested by the World Bank was detrimental to the decentralization process.
Ninth five-year Plan (1995-2000)	▪ Started on a better footing due to the passage of 73rd and 74th constitutional amendment Acts.

[5] Consultative Committee 1973-74 reported that the expanded rural health services were not utilized due to barriers between doctors and patients and a general lack of referral, drugs, diagnostic, laboratory facilities and funds for general services.

[6] However, in practice community health worker scheme was allowed to die a natural death (Quadeer, 1994).

[7] Though this scheme still exists on paper, in many states it is no longer practiced

[8] But CHC remained non-functional, mini district hospitals remained understaffed and PHCs remained underutilized. The concept of PHC was used to push SPHC and population control (Qadeer, 1994).

Depending on the political will of the state and the capacity of the local institutions, states are in different stages even after eight years of passing the 73rd Amendment. The transfer of power to Panchayats is happening very slowly in some states whereas some have implemented it rapidly. The experience of West Bengal and Kerala was very impressive. The experience in Andra Pradesh, Maharashtra, Punjab, Gujarat and Madhya Pradesh has not been satisfactory. The experience of selected states in presented in the following table.

TABLE 5

AN OVERVIEW OF DECENTRALIZING HEALTH SYSTEMS SELECT STATES

State	Decentralization	Remarks
West Bengal (Dutta, 1993)	▪ The Panchayati Raj Act was enacted in 1956 but it gained momentum in 1978, with the advent of left government. In 1981 government strategy of HFA was incorporated in the state plans but without procuring community participation. ▪ A conceptual lacuna about health and ignorance of preventive, promotive and public health was witnessed. The scheme to incorporate paramedical staff, CHW and MPW did not yield results because of misdirected training and unrealistic expectations. ▪ The state disburses 50% of its funds to ZPs, (Zilla Parishad) which in turn allocates 50% of its funds to GP (Gram Panchayat) though PS (Panchayat Samiti) for their own development projects. The remaining funds are spent by the state where two or more ZPs and PS are involved. The poor have derived rich dividends from this system. ▪ After the adoption of the 73rd Amendment the social and political awareness in the state has been increased manifold and leadership at the periphery has blossomed. ▪ However there are delays in dispersal of funds.	▪ Financial devolution enhances the decentralization process ▪ Decentralization enables political leadership ▪ Decentralization of health system can only be successful if combined with a holistic perspective on health and involve community in health planning.
Kerala (Soman and Panikar, 1993; Nayar, 2001; Menon and Sinha,)	▪ In 1957 administrative reforms were initiated. In 1960 the panchayat act proposed to organize panchayats as units of local self-government with authority to levy certain taxes. In 1979 District Administration Act proposed that administration of health & hygiene[9] should be passed on to the district councils, but it did not yield results because the state retained control on finances. Also, there were frequent changes in political leadership, and each party deleted some of the provisions. Panchayati Raj Bill was passed in 1994 but elections were held in September 1995. ▪ The State has adopted participatory methodologies to map the priorities of the local people. It is interesting to note that the panchayats identified in their work plan, issues such as improving sanitation, promotion of health education and health camps. The panchayats also emphasized traditional medicine systems such as ayurveda and unani.	▪ Adopting participatory methodologies can help the local people propose their priorities. ▪ Decentralization can revive public services ▪ Decentralization in Kerala is characterized by one step forward

[9] Health and hygiene included: establishment and maintenance of hospitals, vaccination campaigns, health education, MCH, family welfare, malaria and filaria eradication, rural water supply, rural drainage and sewerage.

	▪ The decentralization process revived the public health system in Kerala and has ushered in a new system of governance, which may act as a buffer for facing macro-economic crisis.	and two steps backwards.
Andhra Pradesh (Pal, M., 2001)	▪ Jawahar Rojgar Yojana (JRY) is the only program entrusted to PRIs. Another major reason for the failure of PRIs is the absence of linkage between the three tiers of local government and members of territorial constituencies at the intermediate and district level. ▪ Andhra Pradesh Sarpanch Association had appealed to High Court to check the state government from violating the 73rd and 74th amendments and debilitating the PRIs. The Sarpanch Association accused the state government of not releasing funds to panchayats, appropriating their revenue sources, hijacking rural development funds sanctioned by the center (for panchayats) and imposing financial burden on the local bodies ▪ On Feb 5, 2000 the governor of Andhra Pradesh promulgated an ordinance for the administration of Mandal Parishads and Zilla Parishads in the State until the next ordinary elections are held.	▪ Absence of coordination and trust between three tiers is detrimental to decentralization ▪ Decentralization, backed by appropriate legislation, gives space for the local government to appeal against the atrocrcities of the state government
Maharashtra's (Kumar, 2000, Buddhikar, 1996)	▪ The apathy of bureaucrats for poor, monopolization of seats of panchayats by regional elite and centralization of health services was characteristic of Maharashtra since 1960's. In early 1990's attempts to revitalize the panchayats were made. In 1992 Panchayat elections were held after a gap of thirteen years. ▪ Endeavor to revitalize their panchayats also failed and they faced resource crunch and local governments were always dependent on the state.	▪ Financial devolution is essential for effective decentralization
Punjab (P.S. Verma,—)	▪ Passed the required legislation, constituted Election Commission as well as Finance Commission, and the elections in the village panchayats, panchayat samities and Zilla Parishads were held in 1993-94. ▪ Panchayat election, though a major landmark in the restoration of normalcy in the state, has many drawbacks. Many people were not allowed to contest on the pretext of terrorist links and only 60% seats were filled by direct elections; 72% of the elected Panches belonged to one party. The Bill was used to consolidate the position of parties and individuals rather than to strengthen democracy ▪ Subsequently the pace of reforms was very slow and some Panchayati Raj leaders had filed cases in courts to issue directions to the State government to delegate executive, administrative and financial powers[10]. ▪ The fact that substantial proportions of representatives are illiterate, is an impediment in their ability to manage development schemes and activities. Also, the officials deployed in the panchayats are not oriented towards decentralized governance and the common people do not understand the importance of panchayats. Recently the state had diluted the institutional linkage between gram panchayat and panchayat samiti.	▪ Decentralization process can be subverted by the political parties ▪ Illiteracy of the local representatives and the apathy of the officials is an impediment to effective decentralization
Gujarat (Khan, 2000)	▪ The panchayat system in Gujarat is disappointing in spite of it glorious tradition in cooperatives, participatory governance and participatory management of natural resources. ▪ Panchayats are merely treated as agents for implementing local development projects and the privileges of the district council presidents is limited to a bungalow, vehicle and telephone; they are not given an opportunity to participate in development affairs. ▪ The role of the panchayats in health is reported to be vague and confusing	▪ The hierarchical mindset of the doctors and the officials is detrimental to decentralization

[10] The government identified schemes and selected the departments to be transferred to the Panchayati Raj institutions, by the beginning of 1997. The Minister of Rural Development and Panchayats manipulated the Rs. 16 Crores meant for the centrally sponsored JRY schemes, which was to be directly available to the Zilla Parishads and arbitrarily redistributed it. Likewise, the cheques issued by DoRD and Panchayats were not sent to Sarpanch but to the MLAs who in turn handed them over to the payees concerned at the functions organized by Sarpanches.

	and the conflict between the bureaucracy and elected representatives contributes to the ambivalence. ▪ Zilla Parishads have no control on higher levels of health institutions and some of the elected members were unaware of the detailed functioning of PHC or the role they can play in improving performance of PHC[11]. ▪ The class A and B workers (doctors and district officials) are under the control of state health directorate and are posted to ZP on deputation. The class C and D workers (drivers, clerical workers, extension workers, and paramedical workers) are accountable to the Zilla Parishads.	
Madhya Pradesh (Jafry ,2001)	▪ Research suggests that in spite of support from the state government PRI's were not in a strong position. ▪ This is because the district bureaucracies, state legislatures, members of national parliament see panchayat representatives as their competitors.	▪ PRI are seen as competitors
Karnataka (Chandran, 1993; Sivanna, 1999)	▪ Three relevant acts in context of PRI were in 1969, 1983 and 1993. The result of 1983 Act was increased mobilization of local resources for health infrastructure, greater accountability of doctors and nurses and increase in supply to drugs and other public health facilities. First state to pass bill after 73rd Amendment but did not have elections between 1993 and 1995. ▪ The state transfers about 1/3rd of the funds to panchayats; the total transfer to panchayats in 1994-94 was 109.31 crores and transfer to zilla parishad was 86.34 crore which, is approximately 80% of the health budget. In addition the panchayats have power to levy tax on buildings, water, entertainment, vehicles, advertisements, hoardings, bus stands, grazing. ▪ Despite this there is friction between the state government and zilla parishads over issues like recruitment, transfers, overall disciplinary control. The officials at middle and higher levels have not been able to totally appreciate the ideology of decentralization and pachayats are used as implementing agencies rather than development institutions. ▪ Another problem is that regional elite in spite of reservation policy usurps most of the seats at local level.	▪ Despite financial devolution, conflict on personnel and administrative issues ▪ Regional elite usurp power
Uttar Pradesh (Lieten G.K., et al, 1999)	▪ Only six panchayats were able to reverse the power relations; in others the sarpanch was either a traditional leader or his proxy by inheritance. ▪ In some cases panch were nominated by pradhans, some panch were informed about nomination afterwards, some women members still do not know that they are nominated. Panch get some favor such as hand pump at the time of nomination, they do not have any other powers, women members especially are given no powers. ▪ The study also observed leakage of funds in IRDP, JRY and that no financial or bureaucratic changes have come to deliver items listed in the eleventh schedule.	▪ Regional elite usurp power ▪ SC, ST and women presence is mere tokenism. They do not have any power ▪ Corruption is rampant
Bihar (Kumar, 2001)	▪ The gram sabha election of 2001 was after a gap of twenty-three years.	▪
Delhi (Chauhan ,2001)	▪ Delhi is planning to decentralize the management of hospitals, trauma centers and dispensaries at the district level.	▪

[11] For instance, the problem of water contamination in Jhunal village led to diarrhea epidemic and tablets were needed for chlorinating water. "Sarpanch and other panchayat members instead of purchasing the tablets under the panchayat budget had gone to district officials to get permission and approval for the budget" (Khan, 2000). This proves that the panchayat members are not aware of their rights and responsibilities.

The table demonstrates that the states are at varying degrees. However, in what follows, some broad generalizations are drawn.

Political

- The inability of the states to conduct regular and fair election is perhaps the biggest impediment in the process of decentralization. The elected body did not represent all classes and neither ensured the reservation for SC, ST and women.
- The political will of the states is questionable in some states, as there are instances where the states enabled panchayats to function independently
- The frequent changes in parties has generally diluted the zeal for decentralization

Social

- In most of the states, the regional elite usurp the position at panch and sarpanch level
- In most cases, community is not able to appreciate the role of gram sabha and has failed to pressurize the authorities from below or they do not recognize their own capability of instigating change
- The high-handed attitude of the officials is the cause of conflict with elected representatives at the local level, and it hinders the smooth functioning of the local administration

Economic

- The inappropriate devolution of financial resources has been perhaps the most important reason for discontent amongst the panchayats.
- Leakage of funds of development programs have been witnessed in some states

Administrative

- The inapathy of the bureaucracy has been a common feature in most states. Conflict with states on personnel and other administrative issues is very common
- A substantial proportion of panchayat leaders are illiterate or do not have the requisite skills to manage development skills/programs

- In many states, the pachayats function as implementing agencies rather than evolving themselves as development institutions

To sum up, PRIs have not proved to be a big success story but they have certainly made headway. The situation is especially vague in health system decentralization as there is ambivalence regarding the role and responsibilities of all stakeholders in the health sector. In Kerala, Karnataka and West Bengal the panchayats have conducted their business efficiently and also forced the service providers to be efficient. In Kashmir and Bihar the last elections were held after a lapse of twenty-three[12] years (Kumar, 2001; Chowdhry, 2001). The PRIs in Gujarat are disappointing in spite of the fact that Gujarat had a pioneering tradition in co-operatives, community based natural resource projects and adopting panchyati raj (Khan, 2001). The fact that the inefficiencies of the state to deliver the funds have been challenged by the local institution shows that the process of local institution building has been already instigated. The people's newfound interest in panchayat elections in Bihar, panchayat leader's opposing the state in Andhra Pradesh and protest of the masses against inefficient functioning of panchayat's in Punjab certainly does present a ray of hope. The key then is to invest in local people's capacity to handle the pressures of self-government by arming them with knowledge, motivation and requisite skills.

3.4: Lessons from other Countries

It has to be acknowledged at the outset that there are very few well-informed, empirical and comprehensive studies on decentralization of health system and its possible outcomes. It is also useful to note that decentralization of health care is in relatively early stages in most developing countries and its impact on health systems and service delivery has not been comprehensively evaluated. There are some country studies, which have tried to grapple with

[12] The election in Kashmir proved to be a 'paper exercise' because 22 Sarpanch and 295 panch were vacant and many constituencies had unopposed candidate. Moreover the panchayats do not have any credibility in the eyes of the people. Likewise, the decentralization process has not seen a conducive atmosphere in Bihar since the last three decades. The

this issue but most, have not succeeded in developing a clear-cut analytical model. This section attempts to review the experience of decentralization in twenty-three countries and arrive at some broad generalizations.

TABLE: 6

AN OVERVIEW OF DECENTRALIZING HEALTH SYSTEM IN SELECT COUNTRIES

Country	Decentralization Process	Remarks
Botswana (Mills, et.al., 1990)	▪ 1972- District council responsible for clinics and health posts; center responsible for capital grants and supervision of hospitals at district level ▪ 1974- Started formation of regional medical teams (accountable to health ministry) for all districts for guidance, monitoring and evaluation but with no administrative powers for employment and discipline. ▪ 1984:Renamed-district medical team, were seconded to districts because conflicts between district councils and regional teams. ▪ Health Staff worried because of loss of power in the hierarchy and effects on career advancement. They were assured of no loss of benefits. ▪ 1987: Viable district medical teams for all districts and Basic Health Service Coordination Committee, made up from officials at the central and local levels, to oversee the process of decentralization. The Ministry of Health responsible for formulating policies, training personnel and subsiding the health services of the districts.	▪ The administrative system of Botswana was decentralizing since 1965 and this aided the process ▪ A learning approach is required to reach a form of decentralization that is desirable
Brazil (Jose Luiz, 1997; World Bank,-)	▪ Decentralized health policy, with an emphasis on community participation, was adopted after fall of military regime in 1985 on national, state and municipal levels but could achieve only administrative decentralization. ▪ The Central authorities were to provide financial and technical cooperation but in reality were the decision-makers. The states managed all municipal health units because almost all municipalities failed to fulfil requirements to be autonomous. The municipalities were not even allowed to use assigned budgets according to their discretion. ▪ There was no policy to train local officials or empower local politicians for new functions. The national civil servant did not trust local level ability and also feared loss of their financial resources and political influence	▪ Centralist tradition and traditional bureaucracies hamper devolution ▪ A new value-system for officials at all levels and training at the local level is a must ▪ Financial dependence of local bodies is not conducive to devolution
Bolivia (World Bank,-)	▪ In 1994, 311 municipalities were recognized and given the responsibility of health service delivery. But local institutions were weak and could not deliver the expected benefits. ▪ In 1996, 2300 municipalities got local autonomy. ▪ But health budgets were still prepared by the center and local institutions role was mainly maintenance. The health status of the municipalities is changing favorably and equitably.	▪ Health Care Decentralization can be an instrument for democratization. ▪ Devolution of health services can lead to equity.

political heads were nominated and they in turn had passed ordinances to enable the regional elite to run the panchayats. Fortunately the panchayat elections were finally held in April 2001.

Mali (World Bank, 1999b)	▪ The Bank started working with Mali in 1983 to expand the number of health centers and train new staff but the project failed ▪ Late 90's, Bank tied project with a health policy aimed at decentralizing health services an involving community in managing and financing health centers. ▪ The government shifted to generic drugs and later private sector was allowed to import drugs. By 1994 the cost of the drug was ;20% of what it was in 1980's. ▪ By 1998, 300 community health sectors had established one-third of which were financed by Bank and the community. These project had better coverage and quality but difficult to retain staff, especially in poorer areas because salaries paid by community. The health staff prefers parallel government jobs. ▪ But utilization of health services still low and drugs still unaffordable for the poor of Mali.	▪ Health care can be made affordable by shifting to generic drugs ▪ Involvement of community allows better coverage and quality of health care.
China (Tang and Bloom, 2000)	▪ Since early 1970's the policy was to devolve responsibilities to township government. Devolution of health centers began in late 1980s. The township governments were made fully responsible for local health care in accordance with national guidelines issued by county health bureaux. ▪ The health system collapsed and coverage decreased from 90% in late 1970s to less than 10% in early 1990's. Decline was also felt in number of services offered and quality of services. The inequities between rich and poor counties increased especially in terms of trained personnel and medical equipment. Devolution contributed to the increased employment of unskilled personnel to serve the interest of local officials and job insecurity in the health centers. The guidelines were bypassed in many counties and supervision was non-existent. Inability to transfer personnel across counties also led to problems. The skills, knowledge and the initiative at local level were missing.	▪ The devolution process should be gradual and dependent on pre-existing conditions. Devolution of control is questionable if local authority has restricted management capacity and ability to generate revenue. ▪ It is essential to train local bodies
Netherlands (Mills, et.al, 1990)	▪ Due to high cost of private health care and private insurance, overlaps, inequities and inefficiencies of the private sector, decentralization movement started in 1974 and was crystallized in a law in 1982. ▪ Eight regions in the west and south of Netherlands had started experimenting with decentralization by the end of 1980's. Municipalities and provinces worked towards better primary care and containing costs, private insurance retained responsibility of budgeting and financing and private institution of providing care. The finance was also by social insurance and taxation. ▪ Regional health forums consisting of care users, care providers, financiers were supposed to meet other municipalities and committees and work towards information sharing. But except the spokesperson knowledge of decentralization and values of sharing and working in a diverse group was not found in other members. ▪ A health for all policy is adopted in 1986 and eight regions will take up on an experimental basis but they are afraid of chaos. ▪ It is too early to understand the impact of decentralization	▪ There is no blueprint and hence it is futile to search for one. It is better to go with people's priorities and empower them to manage and control their health system ▪ This is a long and tedious process with a long gestation period and hence needs a long term and firm commitment

Mexico (Mills, et. al., 1990; Gonzalez-Block e.al., 1989)	▪ Health service centralization and fragmentation was rampant since 2nd World War. In early eighties Mexico adopted a charter for political reform by devolution and deconcentration and in 1984 a mandate for health protection for all was introduced. ▪ The responsibility of decentralization was delegated to the states, which gave its field offices more planning and budgeting responsibilities. The states that were most successful had a history of implementation of decentralization. ▪ The first state to implement decentralization was Oaxaca and it had to abort its efforts in this direction very soon because of suspicion of the bureaucracy and national level leaders. Interruption and withholding of decentralization was found in 14 out of 20 states. Some states aborted this process because they felt a decline in services and increase in inequities. The rural areas, backward regions and poorer people's access to health services and public health declined. Efforts of decentralization are ongoing in 6 states and have varying degrees of success. ▪ According to Gonzalez-Block (1989) decentralization was a measure to increase central control rather than a democratic principal or pressure from below. The states also did not demand financial autonomy because they did not have the incentive or capacity to deal with it. Financial control from federation offset any attempts to decentralize at peripheral level. ▪ Mills (1990) interpretation of this is that the process is leading to more equitable and relevant health services. They do recognize serious personnel problems and delays in transfers of financial resources. The national health system is however introduced to combat such problems. It comprises decentralization, consolidation of the health sector, administrative modernization, intersectoral coordination and community participation.	▪ Economic policy, interest of the elite and capacity of the local institutions and people shape decentralization process ▪ Decentralization process can be subverted to increase inequity and impoverish the weaker sections and people.
Thailand (Nityarumphong, 1990, Wibulpolprasert, 2001)	▪ In 1966 and 1968, focus was to raise capability of district level health personnel and train volunteers from the community. National PHC program was launched in 1977. A holistic perspective of PHC, adequate financing and delegation of management to district level organization. The focus on training village level health workers and community organizations, introducing community in self-financing and management of health programs and restructuring the health system to ensure better coordination. The initial training of VHV by health workers was not successful, so villagers used as trainers. The PHC was successful until 1987 except lack of two-way communication between peripheral officials and community leaders. ▪ 1988-1977, a period of economic boom saw worsening of health systems due to irrational increase in public expenditure and resultant inequity of health service delivery. Health strategies in 1977, included expansion of health insurance, safety nets, rural doctors, drug management, hospital autonomy, efficient health expenditure, quality health service and empowering society.	▪ Economic situation not directly proportional to health system development. PHC successful in economic recession and unsuccessful in the period of boom. ▪ Strategies like community and NGO involvement, decentralizing planning and management, etc. contributed to success of PHC in a period of crisis.

Croatia (Oreskovic, S., 1995)	▪ Health reform is a part of government's stabilization project and includes cost containment, privatization, health insurance, health education, high quality health services and decentralization of administrative and budgetary decision making in governmental health institutions. The Central institutions play their role in coordination of all reforms in the health system. ▪ The number of private practitioners increased by 33% (635-954) between 1992-1993. Croatia is on top of the WHO list of successful health systems because it has followed a very slow-paced privatization in primary health ▪ In Croatia 65% of the physicians are specialists and only 17.4% are general practitioners. It wants to redress this imbalance. It also propose to invest in raising the health management capacity of the staff to perform according to the logic of integral market and intends to provide incentives to the doctors for work in poor areas. ▪ The ideal for health reformers in Croatia is "market oriented, efficient, professionally high quality and social solidarity based health system in Germany".	▪ Devolution and privatization are adapted simultaneously if government plays a central role in coordination ▪ Slow pace of privatization is good for a country where there is a dearth of privatized services
Spain (Mills, et. al, 1990)	▪ Devolution and decentralization is enshrined in the 1978 Constitution. Each autonomous community was given a government council and legislative assembly. All hospitals, health centers and all functions in public health were passed to autonomous communities, which they have to perform in accordance with rules specified by the state. The state uses individual plans of community to draw a national plan but communities have some discretion. Conferences were organized to foster mutual coordination for the autonomous communities. Each community has an advisory council board of professionals, users, managers and trade union representatives. The financial support of health system is made of social insurance, state transfers, taxes for certain services and contributions of autonomous communities ▪ The results are largely positive and seventeen autonomous communities are providing services but decentralization in curative care is partial in fifteen. A revised Health law was passed in 1986 but it will take time in implementation. There have been difficulties like ambiguity on distribution of financial resources among communities, opposition by the civil servants, limitation of the autonomous communities and diversity of laws implemented by all communities.	▪ Decentralization process should be undertaken gradually. First legal approval must be given and then services should be transferred gradually. ▪ Holistic decentralization is a prerequisite for successful health system decentralization.
Turkey (Tatar and Tatar, 1997)	▪ Committed to PHC in 1978, stated reform package in 1980 but little action till 1990, when reemphasized commitment to PHC. The MoH stopped providing health services and restricted to formulating policies. ▪ But the resources favor urban over rural, curative over preventive and did not focus on ameliorating inequity in health care. MoH emphasized the importance of intersectoral action but left it as rhetoric. The term community participation was at best restricted to educating the people about government's decisions though community financing was acceptable. The community rejected the CHW scheme.	▪ Sometimes decentralization is merely lip service as the basic tenets-such as community participation and decentralization of responsibilities are ignored.

Uganda (Jeppsson et. al, 2000,)	▪ Health system decentralization is a part of overall decentralization and it uses administrative policy structures. The objective is to empower local communities and health is not the focus. New Health policy was adopted in 1999. Heavily dependent on external resources. ▪ The Center has devolved most functions on districts, which are further decentralized to sub-district level. The MoH has been reduced from 800 to 400 posts and is only responsible for formulating policy, ensuring quality, providing training, developing guidelines, evaluating progress and responding to epidemics. The center still has power over finances in practice. The sub district is responsible for all development plans including health on the general guidelines issued by MoH ▪ District office's supervisory role has increased. Hospital boards are formed on general guidelines issued by MoH. Local leaders elect all health committees. All staff except national and regional offices are transferred to district but their salary is low and subject to delays. Procurement through district health boards are delayed. Monitoring is through benchmark indicators. ▪ NGO and private sector are getting more funds from the government but funding from international sources has declined and there is a general resource crunch. ▪ Transparent planning and budgeting based on regulations that apply to all sectors. But computerized and complicated method. User fee is negligible but used at source. Government has been weak in design of user fee, lacking in skills and information and capacity to regulate and enable private sector ▪ No major improvement in quantity or quality of health care or sanitary services provided or utilized. Paradoxically vertical program on immunization was still implemented but it saw a decline though resources for this program were increased.	▪ The ease of management and probability of sustainability is more in holistic health system decentralization but there is also a danger of not giving due importance to health sector ▪ Holistic decentralization includes many issues which are at various stages of decentralization ▪ Holistic decentralization is not necessarily successful ▪ The government cannot be expected to adopt radically new roles. They need to be trained to develop skills to regulate
Zambia (Jeppsson et. al, 2000)	▪ Health sector is decentralized and new structures are formed specifically for this and the district health systems were established in 1995. Sustainability precarious because heavily dependent on external funds. ▪ MoH split into purchaser and provider agents and reduced in size from 9 to 4 offices and 220 to 66 employees. A Central Board of Health (CBOH) was created which in turn commissioned a network of hospital and district health boards. There is not much scope for district councils to participate as CBOH approves work plans for all district and health boards. Neighborhood committees are formed but they do not play a vital role. ▪ Health boards and District boards responsible for management of services. Minister appoints and dissolves hospital boards. ▪ NGO'S are funded to a considerable extent and private practitioners are also given some commission-based tasks ▪ Budgeting by NGO's and a few donors but method for selection of minimum package is widely understood and applied. User fee is high and is remitted to the districts. Procurement through health boards and personnel salary through boards. Monitoring through data collected by health personnel at different levels. ▪ Only one year has passed but no major improvement in quantity or quality of health care provided or utilized.	▪ Sectoral decentralization highlights health issues, but potentially less sustainable. ▪ Participation or control of community is much more difficult in such situations as emphasis is more on health system delivery and cost recovery. ▪ Vertical programs are incompatible with holistic or vertical decentralization process.

Papua New Guinea (Mills, 1990)	▪ Papua New Guinea (PNG) is mostly an egalitarian society and decentralization fitted well with social and cultural practices. A constitutional law was passed in 1976. ▪ Conferences and seminars were held on decentralization for public servants and provincial politicians. But there was reluctance on the part of senior staff to devolve their authority to provincial staff or to be transferred to provinces for implementing a program. ▪ Provinces were given full authority to select their health advisers and managers. The national department of health developed health plans, ensured that health guidelines are followed in the country and gave the new recruits in-service training if they so desired. ▪ Budgets of provinces were decided in consultation with Department of Finance and provinces had discretion to administer their health programs with little interference from the center. The pharmaceutical services remained centralized but provinces had funds to purchase extra equipment and goods. Some allowances and salaries were also paid to church supported health care systems. ▪ At provincial level results have been varied depending on leadership. While in some provinces decentralization permitted greater local control over the health services, in others it opened up avenues for local politics and corruption. In some cases centralization occurred within provinces but in some other cases power was decentralized to the district level. But at the national level, decentralization has enabled the Department of health to be revitalized and become technically competent. Local community participation was still very difficult to obtain.	▪ Egalitarian societies adopt decentralization much more easily. ▪ Decentralization at national level could be accompanied by centralization at peripheral levels. ▪ Pace and impact of decentralization in all the districts is not the same.
Indonesia (Bossert, T, 1990)	▪ A project called Comprehensive Health Improvement Program Province Specific (CHIPPS) is partially responsible for promoting decentralization to the provincial and local levels in Indonesian MoH. Improving Problem solving skills, negotiating capacity at the local levels and national adoption of local initiatives were the benchmarks for this project. CHIPPS was supported by USAID and was implemented between 1981 to 1989. ▪ Indonesian MoH had a highly centralized bureaucracy and is fifth largest country in the world. CHIPPS achieved some of its objectives. It strengthened technical, managerial and planning capacities in each province. All three provinces could negotiate more resources and get acceptance for relevant innovative programs for themselves. This is partly because CHIPPS provinces had access to data, which even the central authorities did not have, and hence they could challenge them. ▪ However the provinces selected were considered better in planning and management of health activities. They understood the epidemiological or problem solving approach. Provinces were not always able to convince center of their innovative programs.	▪ Though CHIPPS was moderately effective it is over ambitious for a single, relatively modest, foreign funded project to encourage a process of decentralization in a system as large and centralized as administrative structure of Indonesia. ▪ The key to change power relations between center and the periphery is better information of the latter

Norway (Elstad, J.I., 1990)	▪ Decentralized governance started in 1970's. The 1984 Act Norwegian Municipal Health Act allocated the responsibility of primary health care to the municipalities. The goal of central health workers was to make health care more relevant, left government to promote democracy, right government to give freedom to people to select their doctors, local politicians to increase local political control over health services, health administrators to disperse conflict over health services. The physiotherapists opposed the reform but put forth-certain economic demands. ▪ The center allocated a grant to each municipality according to population size and composition. This grant composes 30% of the total health expenditure of the municipalities. National Insurance reimbursed fee to contract doctors and physiotherapists and the fees was reduced. All primary health workers were municipal employees. 40% of general practitioners and 10% of the physiotherapists were absorbed as municipal employees in 1986. Home nursing and public health nursing was free. The 1984-88 data shows that the primary health service personnel have increased considerably both in overstaffed and understaffed municipalities. The distribution of services is highly inequitable, as new service was dependent on the revenue generated. People have little role to play though there is some scope for them to comment on draft of policies. Thus their participation is indirect though the local politicians who have many formal powers. They rely on the health sector officers because they are supposed to have professional competence.	▪ Different stakeholders have different goals for the reform. Stakeholders of diverging interests reach an agreement because their particular interest is served.
Chile (Mills, et. al., 1990)	▪ State involvement in health care dates back to 1810. In 1924 a National Social security institute to provide health care for blue collar workers and preventive medicine law for white collar workers ▪ In 1970's attempt was made to create a more unified national health service that would benefit the poor. In the 1980's the emphasis had been on increasing individual choice by promoting the private sector. State still maintained responsibility of blue collar workers and unemployed ▪ The decentralization entrusted MoH with health policy, health planning, budgeting, human resources, environmental health and evaluating. The responsibility for provision of curative and preventive health care was delegated to 13 regional and 27 semi autonomous area health services. The responsibility of some urban and rural primary health care clinics was entrusted to the universities. ▪ Due to economic recession the overall burden on the state increased because of larger number of poor and unemployed ▪ There is more local autonomy and administrative decentralization with staff matters, promotion, new project planning and management, maintenance etc. dealt by area health services. But transfer of primary care clinics to municipalities has not resulted in greater coverage or improvement in services largely because of lack of professional supervision and poor health planning by area health services.	▪ The decentralization of health services is in keeping with the political and economic beliefs of the government that individual rather than state should pay for the health coverage. It is also a reaction against centralist tradition ▪ Proper monitoring and training is a must for new peripheral organizations.

Sri Lanka (Mills, et.al., 1990; Attanyake, N. in Qadeer, et. al., 2001)	▪ In 1949, the government commissioned a study on reorganization of health sector. The study suggested decentralization, which was adopted in Health Service Act 1952. ▪ In 1952, twenty decentralized units were given the certain powers regarding appointment, transfer, promotion and sanction of local employees; administration and maintenance of all health units and preparing draft of accounts. In 1954 the financial, administrative and disciplinary powers were further increased. But there were manpower problems and concentration of authority at the center ▪ In 1972, district political authority system was established whereby all functions were devolved to the districts. In 1984 function of mobilizing community resources, ensuring inter-sectoral coordination and community participation was devolved to district. ▪ With the 13th Amendment in 1987- devolution of maintenance of hospitals and dispensaries; provision of health services; formulation of health development plans etc. ▪ 1992 saw decentralization of administrative functions but lack of skills in planning and management led to a rebound of re-centralization. Need to regulate the quality of care, collect information methodologically and staff motivation were identified. ▪ Annatanye (2001) concludes that the motivation for decentralization was due to external pressure and that decision had now been taken to re-launch decentralization process to bring purposive change in the health sector. Mills, et al (1990) claims that decentralization is giving positive results especially after 1972 - in terms of community participation although there are problems like training, health behavior patterns etc.	▪ Decentralization process can take decades and even then there are problems ▪ There are differences in interpretation of impact of decentralization between Attanyake (2001) and Mills (1990). ▪ Holistic decentralization may give an impetus to health system decentralization ▪ Internal desire to change and not external pressure leads to sustainable changes.
Yugoslavia (Mills, et. al. 1990)	▪ During 1945 to 1952, organizational and legislative steps were taken to unite private practice, state health services and health insurance schemes and exercising central control over the distribution of finances and personnel for the whole country ▪ 1953-1972 was characterized by decentralization, loosening of federal control and development of self-management/ financing of all the health institutions. Between 1972-1976 a series of acts were passed to integrate both health care users and health care providers into the management and control of health services. ▪ Sociopolitical goals have been met to the extent that health care is equally accessible to all levels of the population and makes the users of health systems active subjects of the system, empowering them and making them responsible for decisions concerning their own health and health of their broader community. The health services and resources have also seen a steady growth since 1971. ▪ Some mechanisms for monitoring such as adequate health information system, realistic norms and standards, other instruments for regulating and measuring work and quality could not be established.	▪ Health system is a dynamic system and any changes should come in a gradual fashion taking into account external factors ▪ Sequencing of reforms very important

Philippines (Furtado, 2001)	▪ In 1991 responsibility for delivery of health services was passed to 1700 local governmental units. A primary research, in 1999, demonstrated that devolution led to deterioration of services in the poorer municipalities. Some Filipinos were unaware that health care was decentralized. ▪ Local health officials cannot intervene if funds intended for health care were spent elsewhere by elected officials. The poorer districts experienced resource crunch and VHW left because of meager payment. The decentralization was not based on local realities and insufficient attention on managerial and administrative issues.	▪ Decentralization is an opportunity and a risk ▪ It is essential to have clear legal, fiscal, administrative, management guidelines ▪ Capacity building essential
Senegal (Mills, et. al., 1990)	▪ In 1972, Senegal - a socialist country- carried out a reform of regional and local administration based on the principles of decentralization, devolution and participation. ▪ The decentralization of Public Health started in 1978. In 1980 the forms of community involvement in public health were systematized and implemented in several trial projects. In 1982, an order establishing the regional public health services was signed and Senegal produced its first public health plan. Health structures ranged from five levels: health huts at village level; health posts at chief locality of a rural area; health centers at department capitals, regional hospitals, and national hospitals. ▪ The opposition to decentralization includes opposition by health personnel, lack of qualified personnel to implement reforms, inability of members of management committees to ensure good management of primary health program; scarcity of resources and lack of flexibility in the law on rural communities. ▪ Communities have greater avenues for participation, increased powers of decision-making; and management of resources. The private and non-governmental sector has been better-integrated in public health activities of the state.	▪ If the political will of the government to decentralize is matched by the zeal of the people to accept it -the process will be successful ▪ To encounter opposition and hurdles in this process is normal.
New Zealand (Mills et.al., 1990)	▪ Until 1985 a tripartite system with Department of Health with its 18 district offices; 29 elected hospital boards and private and voluntary services with government funding. It was realized that this system increased costs and inequities and reduced coordination and local participation ▪ The recommendation was to have area health boards. Coordination between service and planning should be achieved though the appointment of health service organization. Each service should be planned and coordinated through its service development group consisting of representatives from state, private and voluntary sectors. Area health boards and standing committees were established for guidance and advice. ▪ There was a lack of national framework or guidelines. However there has been a shift from deconcentration to delegation and the movement is towards devolution	▪ Central policy making and strategic planning is necessary in order to provide operational framework to the peripheral organizations

Cameroon (Essomba, et al, 1993)	▪ Committed to PHC approach in 1978 but adopted national policy of PHC in 1982 and there were favorable changes till 1987. The reason for stagnation were over-emphasis on vertical programs, lack of referral system, absence of integrated approach, no follow up training of CHW and that the community did not accept the health system in that form. ▪ Program to reorient PHC, (decentralize health system, integrate all PHC activities and empowering community) was initiated in 1989. However the impediments included inadequate legal framework, incompatibility between political structure and health structure, incompatibility between new health policy and organizational chart of MoH, lack of trained health personnel, inadequate health information system, inability to control prices of medicines, highly centralized management, and slow pace of extension of PHC coverage.	▪ Careful preparation and research should be done before planning health reform package.

3.5: DISCUSSION

As evident from the tabulations, it is very important to be cautious about making any generalizations about decentralization process and its outcomes. This is because the impact of decentralization has been varied. "One can prove, or disprove, almost any proposition one cares to make about decentralization by throwing together some cases and/or numbers to demonstrate whatever one wants to demonstrate" (Lietek, 1997). However, with the help of the case studies we will try to draw some factors that may lead to or impede successful decentralization. These factors are divided into political, social, economic and administrative; though they are often overlapping and interrelated in reality.

POLITICAL

- Each episode of decentralization is unique and context specific. There is no blueprint on pace or design of successful decentralization and the best policy is to go with people's priorities and empower them to control their health systems (Netherlands).
- The initiation of decentralization in a country can be project based, sectoral or holistic. Though there are evidences to prove that holistic decentralization aides the process of sectoral decentralization (Botswana); there are also cases where sectoral decentralization promotes holistic decentralization (Bolivia) or a single donor funded

decentralization project has encouraged holistic decentralization (Indonesia). However, it is generally accepted that decentralization of the health sector is easier to manage and more sustainable in case of holistic decentralization (Uganda, Spain). Sectoral decentralization may put health on the forefront but it is cumbersome and discouraging to work in a hostile environment (Zambia). The probability of a lone, especially foreign funded, project to usher sustainable development is the least (Indonesia).

- The traditional mode of governance also seems to have an impact on the ease with which the country adopts a decentralized mode of functioning. It is therefore not surprising that countries with centralist tradition have many transitional and ideological problems that slow the pace of decentralization (Brazil, Mexico). Alternatively countries with a non-centralist tradition finds it easier to embark on a full-fledged decentralized mode of governance (Papua New Guinea).

- Decentralization is a long and tedious process, with a long gestation period, and therefore needs long term and firm political commitment (Netherlands, India). It is notable that the nation's desire for decentralization cannot be substituted by adopting decentralization due to external pressures (Sri Lanka).

- Sequencing of reforms is essential. It is better to start with legislation and move on gradually keeping in mind the institutional constraints and the threat to the decentralization process (Yugoslavia, Spain). As mentioned earlier by a method of trial and error and appropriate changes/ training an optimum situation could be reached.

- The actual impact of decentralization on health systems varies in different times, contexts or also within sub-national units of one nation. Decentralization at the national level can be accompanied by centralization at the peripheral levels (Papua New Guinea). The form and pace of various sub-units or sub-sectors within a country may differ. Thus the

policies should be flexible and diverse so as to serve the needs of all the peripheral units.

SOCIAL

- A country, which is heterogeneous with large pockets of poverty (India and Mali), finds it difficult to decentralize smoothly, as the transition to decentralization is fraught with many bottlenecks created by the elite. Decentralization is easier to be achieved in relatively homogeneous countries (Papua New Guinea) or in countries where the political will to decentralize is matched by the grassroots zeal to decentralize (Senegal).

- It has to be realized that the various stakeholders in a country have their own reasons to decentralize or not to decentralize. That a number of people are in favor of decentralizing a country or a sector does not automatically imply that they have the same interest or stake in the decentralization of the country. Stakeholders of diverging interest reach an agreement to decentralize when their particular interest is met (Norway[13]) and once the process of decentralization is started each tries to further their goal. In case decentralization conflicts with interests of any particular social group, they are either pacified (as in case of health staff or bureaucrats in most countries) or coerced into supporting the process. Ideally, decentralization, like any other development intervention, is more sustainable if it has implicit or explicit support of all the relevant stakeholders.

- Decentralization is a means to an end. The ends are defined by a multitude of factors including the political will, the capacity of the ruling class, the influence of external

13 In Norway, the goals of central health workers was to make health care more relevant, left government to promote democracy, right government to give freedom to people to select their doctors, local politicians to increase local political control over health services, health administrators to fragment conflict over health services. The physiotherapist opposed the reform but put forth certain economic demands and when these were fulfilled they extended their support for the process of decentralization.

actors and agencies. Therefore, decentralization can be subverted to cause inequity (Mexico) and deconcentration can be enabled to cause equity (Bolivia). In some cases even though decentralization is attempted (Uganda, Turkey) yet it has not been able to avail the expected benefits due to a host of reasons, including inadequate preliminary research (Cameroon).

- Decentralization process has more probability of being successful if it is demanded or welcomed by the people. Communities must be encouraged to develop skills for supervising the public services and understand that all public services are accountable to them. The successful cases should be widely disseminated, as it can be an effective source of raising awareness and motivation of the communities. Moreover, the communities should be given avenues to influence the national level health policies or they may be involved in health service delivery (Mali). Cross learning from community managed natural resources must be encouraged as civil society building is essential for effective decentralization and sustainable development.

- Measures that made health care more affordable must be explored such as shifting to generic drugs (Mali).

- Vertical programs are incompatible with decentralization process (Zambia, Uganda, Cameroon, India). Vertical programs are essentially centralist in their orientation and approach and therefore are anti-thesis of decentralization. Unfortunately vertical disease control projects are followed simultaneously with decentralizing the health system thereby unwittingly subverting the process of decentralization.

- The health system decentralization cannot bring desired changes without addressing the issues such as poverty, unemployment, racism, castiesm and lack of nutrition, house, sanitation, water supply etc. Efforts must be made for poverty alleviation and economic development and safety nets need to be innovated to ensure that the basic

services are availed by the poor. Caution must be exercised to ensure that the resources are not squandered or amassed by the rich

ECONOMIC

- The periods of economic growth and health system decentralization do not necessarily coincide. In fact, PHC may flourish in economic recession and decay in economic boom (Thailand).

- Financial dependence of local bodies is not conducive to devolution (Brazil) and offsets previous gains of decentralization (Mexico). Adequate financing, clear delineation of financial flow mechanism, sufficient power, well defined geographical boundaries and proper role demarcation is essential for the working of decentralized health care systems (Brazil, Spain).

- There must be coordination between policymaking, service planning, budget allocating, and outcome monitoring at the national and sub-national levels. The local level systems should be allotted sufficient funds and encouraged to generate their own funds.

- New systems of transparent planning and budgeting have to be evolved (Uganda, Zambia).

ADMINISTRATIVE

- Successful decentralization is a gradual process of trial and error (Botswana, Spain, Srilanka, Yugoslavia, Croatia). Each country or sector has to make their own niche by building on the pre-existing supportive factors, nurturing new alliances and effectively handling the bottlenecks. To encounter bottlenecks in the process of decentralization is

normal (Senegal). Thus the key to successful decentralization is to have a flexible, open minded and learning approach.

- Since decentralization implies a new ideological, institutional, political, administrative, management system, and information system; training of personnel at the central, intermediate and local levels is very important before, during and after the decentralization process (Botswana, Brazil, China, India). Very often the peripheral organizations refuse to accept devolution of responsibilities and resources because they do not have the requisite skills to handle the new portfolio (Mexico, Bolivia, Philippines). It is sometimes found that the officials at the national level lack strategic vision and tend to tackle reforms in a piecemeal fashion. It is very common for the health staff and civil servants to view decentralization as a threat to their power and career (Botswana, Brazil, India). The capacity of the personnel to perform in a decentralized scenario, both in terms of requisite skills and value system should be continuously evaluated and gaps rectified.

- The role of the center to formulate policies, provide guidelines, and monitor is invaluable for successful decentralization (New Zealand) and the absence of such a support in the initial phase may result in a fall in standard of service delivery (Chile, China). Decentralization does not imply that the center does not have any role. Decentralization is a restructuring of roles, responsibilities and power relations between national and sub-national units of governance. Effective decentralization rests on continuous communication and performance of roles at all the levels of the government.

- The key to change between Center and the Periphery is better information to the latter (Indonesia).

To sum up, the road to health sector decentralization is not a smooth one. The factors, which may retard or accelerate decentralization, have been discussed in this chapter. The next chapter will focus on perspective of international organizations on decentralization of the health sector.

Chapter 4

Decentralization and International Discourse

"Anyone seeking to understand the genesis of errors in development policy would do well to start in Washington. For it is there that power to propagate economic and social policies in countries of the South has become increasingly located, in the Government of United States, the IMF and the World Bank" (Chambers, 1997).

The object of this chapter is to explore the impact of health policy prescriptions of the World Bank (WB) and the World Health Organization (WHO) on the decentralization discourse and practice. It should be noted that other organizations, such as UNICEF[1], have contributed immensely to the health sector development but due to the constraint of time we will restrict ourselves to the study of the World Bank and WHO. The reason for choosing World Bank and WHO for an in-depth analysis is that they are in a very strong position to influence policies and practices in health sector development, at the national and international levels. The Bank is the single largest financier of health projects in developing countries and WHO has the global mandate of promoting the international health on behalf of the United Nations. In fact the Bretton Wood Institutions i.e. IMF, World Bank and WTO have taken over the mandate of health sector reform from United Nations. In recent decades, WHO and other agencies of United Nations were playing a marginal role in health sector development, but these organizations still have the potential to influence the health sector reform, and WHO is reemerging as an important institution in the health sector.

The chapter is divided into three sections. The first section examines the shifts in the perspectives of the WHO and its influence on decentralization discourse and the second section presents similar issues on the World Bank. The third section presents some conclusions.

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1 In 1970s UNICEF, the co-sponsor of Alma Ata Conference, which advocated a multisectoral approach in health but since the 1980s has emphasized selective approaches to primary health care (GOBI-FFF) and building alliances for children's health. UNICEF's greatest contribution is pointing out the drawbacks of SAP on health (Cornea, 1987).

4.1. World Health Organization

4.1.1: The Mandate and Organizational Composition of WHO

WHO was formed in the 1948 as an international health organization with the objective of attaining the highest possible level of health for all people in the world. WHO has regional organizations in America, Europe, Eastern Mediterranean, Africa, South East Asia and Western Pacific. The membership of the WHO is open to all states and WHO has 191 members at present. The organization has a democratic system and each member state has one vote (Koivusalo, 1997).

The democratic system is complicated by the fact that its funding structure is disproportionately dependent on the donations of a few members. The budget of WHO comprises a regular fund and extra budgetary fund. The regular fund is of $822 million, which is actually less than one per cent of WHO's expenditure on health in the developing countries. The majority of contribution for this budget comes through five developed countries: USA (25%), Japan (11.7%), Germany (9.18%), France (6.13%) and U.K. (4.77%). The extra-budgetary fund consist of donations from governments (major donors are USA, Sweden U.K, Netherlands, Norway, Denmark, Japan, Canada, Italy and Switzerland), UN agencies and private sector, with the contribution of 79%, 6% and 15% respectively. The extra-budgetary fund has continued to grow and in recent years has been estimated to about half of the total budget of WHO (Koivusalo, 1997). By 1996 more than half of the budget was used by less developed countries. The international aid experience shows that such funding structure usually favors the ideology of the donors and restricts the decision-making power of the recipients.

The constitutional mandate of WHO is to act as the directing and coordinating authority on international health work and strive for highest standards of Health For All. The

responsibilities of WHO include: to assist governments (upon request) in strengthening health services; to establish and maintain administrative, technical, epidemiological and statistical services; to provide information, counsel or assistance in the field of health; to stimulate the eradication of epidemics; to promote improved nutrition, housing, sanitation, working conditions and other aspects of environmental hygiene; to promote cooperation among scientific and professional groups which contribute to the enhancement of health; to propose international conventions and agreements on health matters; to promote and conduct research in the field of health; to develop international standards for food, biological and pharmaceutical products; and to assist in developing an informed public opinion among all peoples on matters of health.

4.1.2: The Golden Period of WHO

Till 1978 WHO was dominated by medical professionals and guided by the medical model (Koivusalo, et. al., 1997). Moreover, it was WHO's policy to steer clear of political and policy issues and focus on strictly technical matters (Roemer, 1986). It was evident in 1960's that most countries aggrandized specialized services[2] (especially in urban areas) and almost ignored elementary preventive and treatment services (especially in rural areas) and this resulted in stark inter and intra-regional inequity of health status. That this approach was not the panacea for health problems in the world was accepted by many. Illich's (1975) research claimed that excessive medical expenditure is wasteful and harmful and Chinese experience (Song et. al., 1991) demonstrated that local volunteers, with appropriate training in basic preventive and curative care, can be trained to tackle a large number of primary health needs of the people using simple technologies.

Within WHO, in 1968 the malaria eradication project was declared a failure but WHO could not find the reasons for its failure within the medical model. Though WHO yielded that there were technical drawbacks in the program yet they found the inaccessibility of the

health service system to majority of the people and inadequate back up of public health initiatives as the major obstacle. The solution was to recommend a health service system, which provided basic services and is within the reach of all the people at all times.

The WHO commissioned a study to identify the factors for promoting basic health services. This report (WHO, 1975) was highly appreciated because it concluded that health system, in its present form, was a failure. Moreover, it covered issues such as inequity between countries and regions; inefficiency and irrelevance of costly and technocentric health intervention; and dissatisfaction of the people with the quantity, quality and ideology of services provided (Newell, K.W, 1988).

In 1975, WHO and UNICEF prepared a document (Djukanovic and Mach, 1975) to identify an alternative health service system. It was based on case studies of health services to rural population in ten countries. The alternative system was called PHC system and the paper was presented in World Health Assembly in 1975. A broader interpretation between health development and community participation was explored and this led to the formal signing Alma-Ata Declaration in 1978, with the aim to provide health to all by the year 2000. The model adopted by them was of Primary Health Care (PHC)[3] which, was envisaged as total health systems[4], fulfilling comprehensive health needs of the community, backed by mutually supportive referral systems, supported by community health workers and informed by active participation of the local people in the health system. Each member state was

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[2] The discoveries in bacteriology, organ pathology and anesthesia led to excessive focus on the medical model

[3] PHC has been given various meanings. Some view it as the primary level of health care and others were concerned about the political issues such as power of the local people to control their health services. But PHC is a political issue as it stresses the importance of participation of the people to determine their own priorities and encourages equity in health care delivery and access, universally accessible services, affordable and socially acceptable technology. Qadeer (2001) describes PHC as the product of most critical advances in public health as it reaffirms the interrelation between human health and social, economic, political, physical and biological factors.

[4] The interrelation of health system with all other sectors and aspects of national and community development is stressed. PHC includes education concerning prevailing health problems; methods of preventing them; promotion of food supply and adequate nutrition; an adequate supply of drinking water and basic sanitation, MCH, family planning, immunization against the major infectious diseases; prevention and control of locally endemic diseases; against major infectious diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

advised to develop comprehensive national health care systems, of which PHC should be an integral part. However, each country was to interpret PHC within its own context. The intention was to tackle the problem of inequity in the accessibility of health services and acknowledging the complex and multitude causes of ill health such as poverty, deprivation and environmental abuse (Newell, K.W., 1988).

Armed with the PHC approach, WHO pledged to endeavor for a world where health is a fundamental human right and defined health as complete physical, mental and emotional well being, not just absence of disease and infirmity. WHO considered poverty to be the greatest disease and advised to redirect the resources towards vulnerable sections of population (WHR, 1995). WHO saw decentralization as a means of achieving greater coordination of health service sector, promoting community development and delivering responsive health services. Moreover, decentralization has been seen as an instrument for achieving Health for All (HFA). Until the latter half on 1980's WHO executed its health mandate in the larger political context, especially as regards advocacy and promotion.

4.1.3: The Downfall

Though the importance of PHC was established[5] in 1978 yet WHO reverted to vertical or selective primary health care (SPHC) programs within a year of signing the Alma Ata Declaration. WHO reported, that progress towards HFA has been hampered because of slow socioeconomic development; lack of political commitment; failure to achieve equity in access to all PHC elements; inappropriate allocation of resources; difficulty in achieving intersectoral action for health; unbalanced distribution of human resources; and the persistently low status of women. Other important factors included the inability to assist, guide and supervise the community health workers (Roemer, 1986), economic instability, globalization, and privatization.

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[5] WHO criticized Alma-Ata model for ignoring "demand" and presuming "needs" thereby largely ignoring private health service sector.

The rationale offered for this shift was that SPHC was a more efficient[6] and cost-effective method of promoting health and well being. Consequently, WHO spends almost 50% of its funds on ten major diseases. WHO describes this as "new universalism" whereby high quality essential care is delivered to all instead of all possible care for the whole population or basic care for the poor[7]. Perhaps one of the reasons for this was because the extra budgetary funding was available for certain diseases only. These innovations glorified the technological or biomedical approach and this trend continued for the most part of directorship of Hiroshi Nakajima i.e. between 1988 to 1998 (Koivusalo, 1997).

The detour towards SPHC was antithesis of the PHC model signed at the Alma Ata Conference (Newell, K.W., 1988). SPHC erodes communities right in decisions that concern them; disregards social, political and economic realities in which people live; and detracts from equity, social justice and the need for long term social, economic and political change. It focuses solely on the medical model and cost-efficiency of interventions (Emmel, 1998). Kenneth, N.W. (1988) describes the clash between PHC and SPHC as real. In his own words,

"PHC advocates feel that, even if the list of actions and interventions put forward by SPHC are applied to a total population, the health system may still be classed as a failure. If what results is still an oppression, does not deal with that society's priorities, and is inconsistent with the way of life and dignity of that population, then it is not successful. Such a statement can be reversed to say that PHC system can still be classed as successful even if some of the

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[6] It was argued that resources have been spent to train community health workers (CHW) but funding, equipment, training and time available for community outreach and preventive activities was inadequate.

[7] Banerjee criticizes WHO for lacking in surveillance and providing un-substantiated estimates to support their claim and describes their solutions as prefabricated, technocratic, unscientific, and homogenous. For instance, methods such as DOTS make the treatment process extremely costly and thus forfeits the values of equity (Rao, 1999). The WHO experts ignored the fact that in most developing countries, the health service system could never effectively deliver chemotherapy because of its own inadequacies such as non-availability of drugs, apathy of doctors and non-functioning peripheral institutions. Banerjee questions the basis for treating T.B. as a global emergency and asserts that resurgence of TB in North America and its association with AIDS has prompted WHO to take this step. Qadeer in a study elsewhere had pointed out that even the stress on reproductive health in India is misplaced as it is not based on epidemiological data and death due to such diseases constitute a small proportion of deaths. WHO spends majority of its budget on aids despite evidence that it is not epidemiolgical evidence of its futility in the Indian context (Ritu Priya,)

illness and deaths targeted by SPHC continue to occur, if that society truly had a choice but decides to take up other priorities knowing the implications" (Kenneth, N.W., 1988).

Moreover, SPHC programs were imposed in a vertical approach. Past experiences show that vertical programs are neither sustainable nor self-serving in the long run. They neither give importance to regional priorities nor do they acknowledge the importance of central coordination. Hence, vertical programs are not decentralization but diversification of health services in response to the whims of the markets and international donors (Qadeer, et. al., 2001). Also notable is the fact that when western countries are moving towards herbal medicines and alternative medicine systems, scope for similar interventions are not found in SPHC approach. This suggests that the ulterior motive of the WHO is not to enhance the health status of these countries but to give an impetus to the pharmaceutical companies and serve the interest of the elite.

In response to its declining popularity the WHO started publishing World Health Reports (WHR) from 1995, and perhaps also re-analyzing their work. The table below illustrates the key issues raised in these reports. A close scrutiny of WHR 1995-1998 reflects the change in the perception of health for WHO- Removal of poverty was advised to promote good health in the 1995 and treating non-communicable diseases with the help of latest technology was recommended to promote good health in 1998. WHO HFA strategy of 21st century is based on the so-called scientific evidence provided by DALY[8]. Amartya Sen points out that DALY would prioritize the able bodied over the disabled. It is in fact a narrow cost benefit approach to health planning and excludes consideration of equity in health care provision. The position of the WHO has been reduced to a specialized agency on biomedical and clinical issues.

[8] DALY or Disability adjusted life years is one figure which combines the number of years of life lost to disease through premature death and number of years of healthy life lost to disabling condition. DALY ignores the social, political and economic factors by reducing health to a mere number churned up by an expert thereby reinvigorating the medical model of disease. It depends on value judgements of a group of experts.

TABLE: 7

KEY ISSUES RAISED IN WORLD HEALTH REPORTS 1995-2001

Year and Name of WHR	Key Issues
WHR 1995, Bridging the Gaps	-Poverty as the greatest cause of suffering and ill health. -It recommended redirecting resources towards vulnerable sections
WDR 1996, Fighting Disease, Fostering Development	-Eradicating and eliminating diseases like tuberculosis and malaria; -Treating old diseases in new environments such as resistance to drugs and pesticides, -Tackling new non-communicable diseases such as cancer.
WHO 1997- Conquering Suffering Enriching Humanity	-Integration of disease specific interventions into comprehensive chronic disease control package incorporating prevention, diagnosis, treatment, rehabilitation and improved training of health professionals.
WHR 1998, Life in 21st Century- A vision for all-	- Removing poverty. - Sharing of knowledge, expertise from the developed to the developing countries for mutual interest. - Preventing and reducing premature mortality, morbidity and disability.
WDR 1999- Making a Difference-	- WHO will assume the role of global leadership in health care - Malaria and Tabacoo free world. - Objectives: improving health outcomes, supporting health system development, concentrating on impact oriented works and innovating influential outcomes. - Willingness of WHO to work with other development organizations and develop common policy position in key sectoral issue. - The government should retain the responsibility for creating appropriate regulatory environment.
WDR 2000- Health Systems Improving Performance	- Government should carefully monitor private sector. Donors and citizens should help the government - User fee is efficient not for the poor. Some pre-payment, which subsidizes the poor, must be adopted. - DALE replaces DALY

In the nineties the role of the WHO had been steadily decreasing, with a corresponding increase in the role of the World Bank which ultimately adopted leadership on global health issues. At the International Conference on Harmonization WHO had resigned itself to the status of an observer regardless of its constitutional mandate (Decon, 1999). WHO has to be criticized for shrinking from the responsibility of providing global leadership in international health and gradually downsizing its sphere of influence to narrow disease focus. WHO should have been at the center stage when the GATT/WTO negotiated rather than helping Health Minister afterwards (Deacon et.al, 1999). In a nutshell, WHO as a specialized agency of United Nations in spite of its various achievements in the field of health care has failed to provide appropriate leadership in guiding the world to a state of -

physical, social and mental well being- for one and all. WHO approach prioritizes efficiency over equity, market over social justice, expert with a magic bullet over integrated and inter sectoral health care provision, curative care over social economic and political development (Emmel, 1998). The donors were unhappy with WHO's approach and some countries shifted their donations to other countries; Sweden transferred its resources to UNAIDS.

4.1.4: The Revival?

With the change in leadership and Dr. Gro Harlem Brundland, assuming the directorship of WHO, revitalization of services is expected. WHO has declared in 1999 that it will resume its role of global leader on health issues. At the turn of the century WHO maintained that HFA still remains the comerstone of WHO's institutional vision, but they intended to update it with the new socio-economic, technological and epidemiological realities. To work towards this end WHO has identified four objectives: improving health outcomes; supporting health system development; concentrating on impact oriented work and innovating in creating influential outcomes. WHO is willing to work with other development organizations and develop common policy positions.

WHO defines health system as all "activities whose primary purpose is to promote, restore or maintain health" (WHO, 2000). This includes home care; traditional healing; western medical services (curative, preventive promotive); public health interventions; formulating health policies; financing for health services, providing health education, and so on. This broad conceptualization of health system is commendable as it covers home care, traditional healing and almost any and every agency/ function whose business is to promote health. However during the course of the report, WHO mentions that certain international organizations have a great potential/role in influencing the health policies and practices in the developing countries. Thus implicitly it recognizes the role of these organizations within its conceptualization of the health systems, but it does not explicitly put the departments of health in all such international aid organizations in its composition of

health systems. It is also notable that during the course of the report WHO concentrated on the issues of curative, preventive and promotive services provided by the public and private sector and not to that of home care, traditional medical care centers and so on. This makes one wonder that why did it define such a broad scope of analysis, if it did not intend to explore all the components?

WHO identified three-fold objectives of health system i.e. improving health of the population they serve; responding to people's expectations and providing financial protection against the costs of ill health. Achieving these goals depends on performance of four main functions: service provision, resource generation, financing and stewardship[9].

- Service provision: WHO identified three generations of overlapping health system reform. The 1940's to 60's saw national health systems; 1960's to 80's saw primary[10] health care approach, which changed from universal to selective care; 1980's till date saw health sector privatization but the 90's the provision of safety nets was promoted. The WHO is of the view that there is no one best way to proceed in this direction. WHO finds PHC's unrealistic, hierarchical bureaucracies inefficient and health sector reforms inequitable. WHO considers a system, wherein there is a flexible integration of autonomous or semi-autonomous health care providers, to be the most appropriate.

[9] In World Health Assembly 2000 (WHO 2000, b) discussion was along the lines of these issues. Ministers identified the many difficulties in fulfilling the stewardship role: external interference in policy formulation and health planning; conditions imposed by donors that conflict with national priorities; lack of reliable health information systems; and, lack of accountability of each component of the health system for performing to consistently high standards. The Ministers noted that introduction of a pre-payment schemes could face a number of obstacles including: lack of the required experience or managerial capacity, lack of political will, potential conflict with government policies being implemented in other sectors, opposition by health providers and the public. Concerns were raised that competition amongst service providers might block improved health system performance. Decentralization of service provision, was identified as a key factor in increasing access of the population to health care. The Ministers identified ways in which WHO could support the development of health systems. At a global level, WHO should support poverty reduction initiatives, promote the exchange of experiences in health system development, advise countries on the best models of health care financing, develop models for managing health systems after decentralization, reaffirm the benefit of health as an investment in development, and continue dialogue with other international agencies. At a national level, WHO should: strengthen the stewardship role of MoH and support MoH in co-ordinating the actions of external partners.

[10] There is no one model of primary health care because it has been used in the technical sense to mean first contact or in the political sense to indicate the community participation and control.

- Resource Generation and Financing: The essence of good health system is that "poverty should not be a disadvantage and wealth should not be an advantage. ... The way health care is financed is perfect if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status or their use of health systems" (WHO, 2000). The worst form of payment is via regressive fee, i.e. those who are able to contribute least paying proportionately more than the better off. It is almost impossible to make the user fee progressive. The best way according to them is by the way of pre-payment; large-scale risk pooling empowered by cross subsidies- from low to high health risk and high to low income; and strategic purchasing. WHO is of the view that a health system should strive for both horizontal and vertical equity- treating alike all those who face the same health need and treating preferentially those with greatest needs. Whether it is possible to have a private health care center, even with the cross-subsidized prepayment plan, where poverty is not a disadvantage and wealth is not an advantage, is a matter of further inquiry. WHO should study such projects and give evidence on the feasibility of such systems. Also, if and till, such a system is operationalized what is WHO's recommendation for making health care accessible for the vulnerable group?
- Stewardship: WHO is of the view that health system is fundamentally different than other service systems and hence cannot be left completely to the whims of the market. WHO is of the view that ministries of health must take on a large part of stewardship of the health system at all levels. Stewardship encompasses the tasks of defining the long-term vision and direction of health policy; ensuring its implementation by strict regulation, example, dialogue, and advocacy; and promoting efficiency of health system. It also includes collecting and using information to assess whether the health status of the people is improving, whether health system is responding to the legitimate expectations of the people and whether the distribution of health services is equitable. Where inputs are purchased directly from the public fund the stewardship role of the ministries is to ensure relevance, quality and efficiency. The role of stewardship in systems with a great deal of decentralized spending authority is to set

the rules and regulations. At the personal level individuals should ensure maximum health care for their spending. At the international level, stewardship means influencing global research and production to meet global health goals. WHO is of the view that international aid organizations with their technical expertise should support the aid receiving governments to recognize the importance of stewardship and improve their capacity in this regard. In addition, WHO warns the donors against behaving in a semi-autonomous way or overshadowing the government. On the contrary, WHO advises the international aid organizations should guide the member countries to continuously improve the performance of their health systems.

WHO has come up with a new measure for measuring achievement i.e. disability adjusted life expectancy (DALE). DALE has the advantage of being directly comparable to life expectancy estimated from mortality alone and is readily comparable across populations. DALE is estimated from three kinds of information: the fraction of the population surviving to each age, calculated from birth and death rates; the prevalence of each type of disability at each age; and the weight assigned to each type of disability, which may or may not vary with age. Survival at each age is adjusted downward by the sum of all the disability effects, each of which is the product of weight and the complement of prevalence. These adjusted survival shares are then divided by the initial population, before any mortality occurred, to give the average number of equivalent healthy life years that a new born member of the population could expect to live. One important difference between DALYs and DALE is that the latter does not distinguish the contribution of each disease to overall result. DALE has the advantage that it does not require as many choices of parameters for the calculation and it is directly comparable to the more familiar notion of life expectancy without adjustment. In addition, WHO has also developed a five points system to demarcate between what most could be expected of a particular health system and what least can be demanded from it.

It is still not clear whether WHO is in the process of revival. Is the WHR 2000 full of tall claims and WHO is basically in harmony with World Bank's essential package as suggested by Qadeer (Qadeer et. al., 2001) or is WHO slowly but surely moving in the direction of finding its own space in the discourse of health sector development. The kind of projects they are financing and the kind of health advocacy they would undertake in near future would demonstrate what they want to achieve[11]. As of now there is a slight change in their views about health sector reforms undertaken by the World Bank and the potential of health system decentralization in improving the health status. Of course it is still not advocating bold reforms like PHC but they have started critiquing user fee, and a limited role of the government in regulating health services and ensuring equitable distribution of health care. WHO has accepted that regulation of the health sector is a serious responsibility and the government needs to invest in their capacity to render effective regulation. They have indicated it to the international organizations that they should not act in an autonomous way but work within the scope provided by the government.

4.2: World Bank

4.2.1: The Mandate and Organizational Composition of World Bank

World Bank encompasses two legally and financially distinct identities: International Bank for Reconstruction and Development (IBRD) and International Development Association (IDA). IBRD loans are more favorable than from commercial banks and IDA loans are interest free and have a longer repayment period. Two private sectors affiliate i.e. International Finance Corporation (IFC) and Multilateral Investment Guarantee Agency

[11] In a meeting with organization active in working on disease programs, WHO director said that in fighting malaria, TB, or AIDS, the organizations are actually fighting poverty in a concrete, result oriented fashion (WHO, 2000 c.). Press releases such as these makes one doubt on whether WHO wants to move beyond vertical disease programs or is it just old wine in new bottles. But the fact that this statement is made with organizations working in the field makes it unethical to use it to judge WHO. Also this statement may have been made in a specific context. In another meeting the director referred to sanitary waste disposal and safe drinking water as human rights issue. Thus an in-depth analysis of the activities that the WHO will undertake is necessary.

(MIGA) were initiated in 1956 and 1988 respectively. IFC supports private enterprises through loan and equity financing and MIGA provides political risk insurance to private direct investors. MIGA and IFC help the Bank to play a larger role in attracting, maintaining and managing private capital. In 1997 the World Bank had 180 member countries that operate worldwide. The share of voting is determined by the amount of funding, with ten richest countries having over 50% of voting powers. Thus World Bank is run by ten richest countries of the world and works all over the world, especially in the poor countries.

The Bank describes its mandate to provide loans, economic advice and technical assistance in priority development operations and assist the developing member countries to further their economic and social progress (World Bank, 1997). The Structural Adjustment Program (SAP) aims to restructure the economy by making certain institutional reforms that will enable free play of markets and integrate the country with the rest of the world. The package proposed by the Bank includes a change in macro-economic policies such as exchange rate devaluation, curtailment in government expenditure and increased government revenue.

Privatization is the central thrust of Bank's overall assistance and has sweeped through commercial companies, infrastructure facilities and social services as education, health and social insurance (Torres and Mathur, 1996). However the degree to which privatization has been achieved has varied in different countries and different sector, depending upon the political will of the government, vested stakes of those in power and the acceptance by the society. The proponents of this policy believed that decentralization would not only create conditions that will increase economic growth but also achieve equity in resource allocation (Deacon et. al., 1999). The privatization proposed for the infrastructural facilities and social sector is not outright sale of public assets but a gradual process of private management, private financing, private ownership or any combination of the three depending on the context and the socio-cultural meliu (Torres and Mathur, 1996). The Bank now acknowledges that as these programs are made so that the country no longer

lives beyond its means, the program will be painful in the short run, and the cost of the programs will be borne mainly by the poor and the vulnerable sections of the society. However, they feel that all adjustment policies are more efficient (less fall in economic activity), more equitable (smaller increases in poverty), more flexible (less red-tapism) than non-adjusting countries.

Towards the middle of the 1980's, the critics[12] expressed doubts about the efficacy of this package to deliver on its promises. In the 80's the Bank was subjected to a number of criticisms including its neglect of the social issues (Cornea et. al, 1993). Broadly speaking these criticisms can be differentiated into four, i.e., macro-economic (is liberalization the best way to achieve economic growth?); ideological (is this neo-colonialism?); social (does it further marginalize the vulnerable sections of society?) and feminist (is it "male biased"?).

The total outstanding loan-term debt of developing countries stood at approximately US$62 billion 1970 to $481 billion in 1980 (sevenfold increase) to $2trillion in 1996 (32 fold increase). Deacon (1997) described the welfare provided by the Bank as an investment for its own sustenance. The World Bank is also critiqued for hiring economist with neo-liberal values and ignoring the view of social scientists. The strategy adopted in the name of structural adjustment programs is to expand the markets for developed countries by destroying domestic productive base on the one hand and capturing the cheap labor on the other. The Bank ignores the context, experiences and realities of various countries and applies structural adjustment reforms to them. Bank is often criticized for widening the gap within and between countries; poor, vulnerable and women are worst hit by inflation, unemployment and regression in public services.

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12 Though the Bank responded to these criticisms with the counter argument such as inability to forecast the counterfactual events; overtime it has softened its policies and has started providing a part of the loans for social sector development.

4.2.2: The World Bank and Health

The health budget of the World Bank is the largest source of external financing in the world and larger than the total budget of WHO! World Bank's funding in the areas of health, nutrition and population increased rapidly in the last decade and the number of professional staff in the sector rose to 300 in 1997(Koivusalo, 1997). The number of health projects increased from 26 in 1981 to 124 in 1997(Jailley, 1999) and the funding increased from $100 million (1.5%) in 1981 to $500 million (8.7%) in 1997. The Bank's funding in the health sector, like its overall funding, is not limited to provide finance but also to help the borrowing countries to realign its resources to make it cost-effective and efficient. Bank's interest in the health sector has emerged as a response to concern over human costs of structural adjustment policies and furthering its objective of maximizing the macro-economic efficiency of the nation.

Initially the funding of the Bank in this sector was limited to the issue of population. President McNamara had suggested exploring a policy in health in 1970 but was met with severe resistance. In 1975 it was recognized that Bank's projects lead to negative impacts on the health of the people and thus the Bank included limited interventions on health within their development projects. Thereafter, the document "Health Policy for the Future" was published in 1975. The policy paper lacked originality and basically adopted WHO's objectives. It should be noted that the Bank had refrained from investing in basic health services around this time and did not have any clear strategy on the health sector. It was in 1980 that the Bank came up with a Health Policy and in 1987, as a response to criticisms on its adjustment programs, a document called 'Financing in Health Care' was published to explain the strategy of the Bank.

The key issues raised in some of the important documents of the Bank are enlisted in the box below and the reactions to a few documents are discussed thereafter.

TABLE: 8

KEY ISSUES RAISED IN SELECT WORLD BANK DOCUMENTS

Key Issues Raised in World Bank Documents

1975, Health Policy for Future

Key Issues:- The policy paper adopted WHO's objectives of improving access to basic health systems, complementing traditional healers and ensuring responsiveness of system to the needs of the community.

-It argued for ceasing building large urban hospitals or enlarging existing ones.

1980, Health Policy Paper

Key Issues: - Three-tier scheme with workers from the community, trained for six months, at the primary level and rural, urban or district health centers, equipped with latest technology, at the secondary and referral hospitals.

-Support of the Bank was available for development of basic infrastructure, training of CHW and professional staff, strengthening of logistics and the supply of essential drugs and provision of family planning and disease control programs.

1987, Financing in the Health Sector

Key Issues: As a response to the criticism of health sector reforms, the Bank published this document which discussed on the benefits of the user fee.

1993, Investing in Health

Key Issues: -The report places responsibility for health on individuals, minimizes corporate responsibilities and health risks caused by industries, and contributes indirectly to unleashing of market forces in health sector.

-The role of the state was limited to regulation and provision of health services for which cost effective solutions were not available. A universal package of essential clinical services and cost recovery is proposed.

- It claims that only 8% of global burden of disease (GBD) is amenable to essential public health services as against 24% of GBD dependent on essential clinical services

-Introduces DALY- disability adjusted life year

1993: Health Sector Financing in India: Coping with Adjustments and Opportunities for Reform

Key issues: - Socialist countries such as Romania and Hungary are inefficient health care providers

-PHC should restrict itself to the prevention of communicable diseases and family welfare, reform at the secondary level of care and severe cutback on tertiary level.

-User fee for all services provided by the public sector and privatization of all other services especially curative care.

-Ministry should seek loan from Bank for Vertical programs

-Adjustment will lead to an increase in efficiency and equity. Endorsed by senior health sector personnel in India

1997, Sector Strategy on health, nutrition and Population

Key issues: -importance of engaging the state in regulation of private sector and arrest the market failure in health service delivery.

-Only some communicable diseases and family welfare services should be left to the public sector and all other services should either be based on cost recovery or be privatized.

- To enhance the performance of health care system

-Help in attaining broad based risk pooling mechanisms.

-The Bank advises on cost effectiveness on the basis of their costs and impact on disability adjusted life years (DALYs). According to them reallocating public funds with DALY enhances equity as well as efficiency of interventions.

-Criticized public sector as inefficient provider of health care in terms of cost, quality and accessibility- especially for the vulnerable groups.

-The State is allowed to invest in preventive services at the primary level while curative services are largely left to the private sector.

- The 1993 report is perhaps the most often cited and critiqued document of the Bank. This report is criticized both for its content and methodology. The document uses a

narrow definition of health and proposed a universal set of strategies for the developing world! In doing this, the Bank de-contextualizes the public health and delinks the curative aspects of public health from preventive, promotive and rehabilitative aspects (Qadeer, 1994). Besides, their mantra for handling poverty and disease is SAP and vertical disease control programs, although it had been pointed out that SAP promotes poverty (Cornia et. al., 1987) and vertical programs are unable to singularly arrest the spread of disease. Furthermore, the document is critiqued for using DALY as a methodological tool. DALY is critiqued because it does not capture the difference between temporary and permanent functional loss and fails to reveal whether disease is concentrated in certain sector of population and hence does not inform policymakers on ways to enhance equity (Paalman et. al, 1998). Moreover, it does not give people any say in evaluation or planning for their health care and ignores factors outside the health sector such as female education, income distribution, access to water and sanitation etc.

- The Bank invited select officers from the health ministries and brought out a document on financing strategies in the health sector in India. However, majority of the invitees did not understand the complexities of public health in India and the document did not refer to public health and health policy literature undertaken by scholars since independence and largely ignored important sociological, political, administrative, technological, epidemiological and historical factors (Banerjee, 1993). Secondly, the Bank criticizes the public sector as inefficient provider of health care in terms of cost, quality and accessibility but does not attempt to understand the causes for the same. They ignore that 2/3 of total health budget in India goes to the private sector and 85% of the PHC budget in India goes in salaries; with very little left to provide adequate care (Antia, N.H., 1993). Its claims that PHC is not utilized in Kerala are far from the truth. Thirdly, the Bank criticizes government's overspending on expensive branded drugs and cost ineffective treatment for non-communicable diseases in the public sector but does nothing to encourage switching to generic drugs. In fact the Bank has tried to

resist Bangladesh's attempt to switch to generic drugs (Antia,N.H., 1993). Fourthly, the Bank does not criticize the government for providing subsidies for the profit oriented private health sector. Fifthly, the Bank recommends user fee in the public sector with a way to cushion the vulnerable groups but does not explain the way to proceed. Sixthly, the Bank criticizes centralized structures in health delivery system and advises more of the same in the form of vertical programs even though there is sufficient literature which points towards the drawbacks of vertical and target oriented programs. Seventhly, the Bank criticizes government colleges for not taking adequate fees but does not comment on the ever-increasing number of private medical colleges, which take excessive fee but do not provide adequate training or instill the right values in the doctors. Eighthly, the Bank warns about the dangers of tobacco but do not oppose its entry in new markets in India. Moreover, this document completely disregards the need of participation of people in the management of their health and has inadequate public health inputs.

Beyer (2000) points out that the Bank is changing its stand on health issues. Typically most of the funding is soft money and grant component is approximately 80% and most projects have funds from government and other multilateral and bilateral donors. He also claims that numerous projects are directed towards vulnerable groups such as the Indian Slums Family Welfare Project pays private organizations or practitioners to provide services in slums and to train 21,000 urban health workers and local leaders. The Bank also describes itself as a learning organization and this has been reflected (to some degree) in the shifts in its approach. Even in early 70's the Bank had commissioned a study to assess the opportunities on working for mutual benefit of the 'north' and the 'south' block. By 1992, eighteen out of thirty-two adjustment loans contained explicit poverty focus[13] (World Bank, 1993). In 1997 the Bank started a renewal program to revitalize itself. It has planned to improve its services; broaden its development agenda to include social and environmental

[13] The success of "Asian Tigers" to boost their economy in spite of state expenditure in health and education also proved to be a case in point to convince the Bank of macro-economic rationality of investing in social sectors.

concerns; decentralize greater authority and functions to its local offices; provide training to its staff on complex development issues; and refine their information database and research methodologies to continuously monitor itself. The above mentioned instances proved that the Bank does try to find better solutions. The advocates of the Bank take this as an example of experimental and a learning organization (Beyer, et. al, 2000) yet the critics of the Bank point out that the cost of this experiment is not borne entirely or partly by the Bank (Baru et.al, 2000).

While the efforts of the Bank to change have to be acknowledged, broadly the approach of the Bank is definitive, inward looking and top-down as it does not invite participation or feedback from other stakeholders, especially those whom they influence. This approach is against the primary health approach of the Alma Ata Declaration. It ignores the importance of integrated approach and the link between socio-economic development and health outcomes. Moreover, evidence suggest that WB policies are instrumental in increasing poverty and inadvertently has negative implications for health (Baru et. al., 2000). The structural adjustment policy has taken precedence over the Health sector development strategy (Kanji, N. et.al, 1991). The Bank has entered the health sector to promote structural adjustment rather than vice versa.

4.2.3: World Bank's Perspective on Decentralization of Health System

Decentralization implies a redistribution of resources from the center to the periphery. This has implications for political stability, economic growth, resource generation, resource distribution, and institutional reforms. Decentralization is in tune with the Bank's claims that centralization leads to inefficient, inappropriate and inequitable distribution of public services. The Bank is of the view that peripheral governments recognize the importance of generating user fee and are better placed to target services to the vulnerable groups. However, the Bank recommends diffusing responsibilities to the private and non-governmental sector. It is of the view that decentralization and private sector development

have an interdependent relationship whereby the former enables the latter, and the latter strengthens the former. Bank claims that private institutions are relatively more cost-effective, efficient, flexible than public institutions and that they provide better services, while leaving the government with more resources and time to target the vulnerable groups (Torres and Mathur, 1996). The Bank considers the ultimate form of decentralization as privatization. Moreover, the Bank recognizes that decentralization can impact all aspects of development and may even lead to macro-economic, political or national instability and this makes decentralization an important intervention for the Bank to monitor and influence (Appendix 5).

The Bank conceptualizes decentralization as a multidimensional entity with three distinct but interrelated components i.e. fiscal, political, and administrative. Fiscal decentralization includes information on resource generation and distribution. Political decentralization is concerned with the degree of decentralization. Administrative decentralization as the name suggests is concerned with decentralization of the administrative tasks. The Bank considers political, constitutional and legal changes in favor of decentralization as internal matters. Therefore, the Bank endeavors to restrict its interventions to financial and institutional aspects such as finance mechanisms, allocative efficiency, good governance, institution capacity, transparency, accountability, sustainability (World Bank, 1994).

A major theme in Bank's lending is decentralization but the attention to decentralization varies according to regions and sectors (World Bank, 1994). Many programs to strengthen the municipal and the provincial government have been taken up in Brazil, Chile, Columbia, Mexico, and Venezuela. In South Asia the reforms for decentralization are underway in India, Bangladesh and Nepal but Banks involvement in them is only peripheral. The focus of Bank in the South Asian countries is to support innovative community based projects and to promote financial accountability of the public sectors. In East Asia the progress in this regard is varied. In China decentralization of decision making to lower levels is proceeding very fast and the Bank is supporting the local government development in many provinces.

In the other transitional economies the decentralization process has been less pronounced and there have been reversals. In Africa the focus of the Bank has been to raise the standard of financial accountability. In Europe and Central Asia, Banks work on decentralization has been concentrated in the Eastern and Central Europe. In the other parts it is concentrating on raising accountability. In Middle East and North Africa the work on decentralization is limited to few projects. Twelve percent of Bank's projects completed between 1993-1997 involved decentralizing responsibilities to lower levels of government (Litvack, J. et, al,) and 43% urban, 27% health, 26% social funds, 16% environment, 13% water, 11% agriculture, 10% transport and 9% education projects during this period had decentralization components.

Even in 1970's, the Bank provided small-scale loans for initiatives undertaken at the level of sub-national government. These loans were in the form of small-scale initiatives called social funds[14] or were provided for raising the capacity of the local governments to handle the new responsibilities. As Parker and Serrano (2000) point out, social funds and decentralization often contradict each other. The communities may have 'social funds' for local expenditure without being accountable to the local institution, thereby weakening the very institution that it wanted to strengthen. The Bank's experience shows that social funds enhance local governance when key decentralization policy reforms are in place and social funds are in alignment with them.

Of late, the Bank has started a new policy of allowing sub-national borrowing. This is applauded by some on the grounds of promoting participation and equity but there are also many caveats. The Bank's experience has shown that maintaining budget constraints on sub-national governments is both essential and difficult. To achieve this they apply limits to

[14] By 1987 there were about 100 social fund projects worth $3.4 million in sixty countries. The funds generally have a limited menu from which the local people can prioritize. But this has been manipulated by many; professional engineers in Peru and Honduras made standardized designs for a few project types and asked people to choose. These funds were sometimes instrumental in introducing procedures for community participation as in Honduras and Malawai but in Bolivia the existing statuary process was found satisfactory for the introduction of social fund projects

such borrowing on some criterion, have transparent fiscal reporting, periodic reviews and stringent regulation or ask for prior approval of central government and they are very selective in choosing these sub-national governments. The transfer of funds to the sub-national government are either lump sum (in some cases based on certain conditionalities) and matching grants with sub-national government's own funds. But the practice of giving matching grants may distort sub-national priorities; Bolivia provided 10% matching grant for a rural development project and 50% matching grant for a world Bank funded education project and this distorted the sub-national priorities in favor of the education project (Parker and Serrano, 2000). Some countries have however issued formal notices that center is not being responsible for sub-national borrowing.

The Bank's staff is engaged in exploring the impact of promoting decentralization on development of their client. This is demonstrated through large number of publications and research reports on the issue of decentralization. One of the Bank's collective action projects in the Himalayas demonstrated that socially heterogeneous communities have poorly maintained projects and community inequality has a U shaped relation with the maintenance i.e. those who benefit most maintain least and vice versa (Kwaja, A.I., 2000). Recently the Bank carried out a review of Bank's experience in urban service delivery (Dillinger, W., 1994). They concluded that strengthening the working of the local government alone would not bring any meaningful change. Banks experience shows that making political decisions and holding elections are the easiest part of decentralization.

"What is slow and difficult is working through of new regulatory relationships between central government and local government; the conversion of what had been annual budgetary transfers within central government into intergovernmental transfers that are transparent and predictable, and the development of credible local political systems. Many of the problems associated with the current wave of decentralization arise from the failure to match the pace of political decentralization to the pace of regulatory and other organizational reforms" (Dillinger, W., 1994).

The failure to match the pace of political decentralization to the capacity of the local institutions leads to various problems such as wastage of resources (in cases where

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(Parker and Serrano, 2000). The statuary planning was generally about holding local institutions accountable for the planned dispersal of the funds.

resources are in excess of responsibilities) or frustration (in cases where resources are scare in relation to responsibilities) (Lietek, 1997). Even if both sides of the budget are decentralized in a balanced fashion, it is often feared that local governments may not have adequate administrative or technical capacity to carry out their new functions efficiently.

The Bank's experience in Pakistan and Latin America shows the projects handled by local governments are demand driven, target the poor, encourage community contribution and avoid red tapism. But, instead of training preceding decentralization, the Bank suggests a more dynamic approach where the staff is trained according to the requirements. Bank identifies weak institutions as one of the main factor for failure of decentralization in the developing countries and therefore aims to compensate for weak institutions in designing decentralization policy in the short run, while focusing government planners on the priority areas for institutional strengthening. In some cases the bank suggests that the institutional development should precede decentralization and to start with decentralization in the areas where institutions are strong and work on weak institutions before embarking on a holistic decentralization program. Thus, the Bank applauds asymmetrical decentralization. This implies decentralizing some and not all responsibilities, to some and not all areas (depending on capacity) or to decentralize directly to private sector[15]. Thus asymmetrical decentralization essentially means decentralizing where it is feasible rather than all or nothing approach.

The World Bank recommends that local government's freedom to adapt to local conditions should be balanced by a common vision about the goals of health sector. The Bank was not appreciative of a situation in Philippines when a province banned a donor funded family planning project in spite of the fact that it was a national priority (World Bank, ----). In the Bank's view the program design of issues of national priority is best handled by the center

[15] Decentralizing only to those who have the capacity to handle raises many sensitive issues. Some countries have identified a set of criterions, which have to be fulfilled before a sub-national unit can be given autonomy. But this is also used as an excuse for not forgoing the central control. A more common practice is to pass certain functions to the sub-national units; both public and private.

and the local government's role in this must be that of service delivery. The local government obviously had the autonomy to decide on local priorities. The Bank also suggests that the Center should be responsible for taxes on mobile factors such as income and any other sensitive central government concern. The local governments should tax immobile factors such as land and also impose user fee and other local priorities. Thus the Bank suggests that, "the key to designing good policy is a clear understanding of what outcomes are important for the central government, and what outcomes can be determined by the local government. The central government should retain control (either by directly providing services itself, or by creating incentives for local governments to act according to central preferences) of those functions for which certain outcomes are desired by the center (e.g. family planning), and should relinquish control only on issues where local divergence in priorities is not very important to the center " (Litvack, J., et .al. ——).

The Bank is of the view that adequate financing for local institutions must be ensured but the local freedom to allocate funding should be tempered with nationally set minimum standards. For instance, in Papua New Guinea the nursing schools declined from 13 to 3 in two years because of many provinces did not invest in this area (World Bank, ----). The Center should be responsible for the transfer of resources to the local level and formulating guidelines on its use in expenditure, maintenance and training. The financial responsibility of the local government consists of executing finances according to center's guidelines and independently deciding on the user fee to be charged for service delivery (World Bank, ----).

To sum up, though the Bank has benevolent programs for promoting decentralization yet it's chief concern is to ensure that local institutions do not override central concerns and do not undo the efforts of the center to decentralize.

4.3: DISCUSSION

Though one cannot deny the benefits of international partnerships and cooperation in arresting the spread of disease (especially infectious) and promoting good health, yet past

experiences have shown that these partnerships are rarely equal and are usually for the benefit of the politically and economically dominant sections of the population.

This is especially true for the World Bank. The Bank aims to eradicate poverty and is the single largest source of external financing for environmental, health, education, and nutrition projects (World Bank, 1997). In addition the Bank also invests in raising the capacity of member countries by supporting training, skill enhancing, modernizing institutions and streamlining procedures and systems. The total outstanding loan-term debt of developing countries stood at approximately US$62 billion 1970 to $481 billion in 1980 (sevenfold increase) to $2trillion in 1996 (32 fold increase). The strategy adopted in the name of structural adjustment programs is to expand the markets for developed countries by destroying domestic productive base on the one hand and capturing the cheap labor on the other.

The World Bank does not have a mandate in health policy formulation and has entered in this arena to facilitate health sector reforms. Koivusalo (1997), Deacon (1999), and Baru et. al. (2000) point out that the structure and objectives of the Bank are not suitable for its increasing involvement in policy-based funding in the health and social sector. "The cost consciousness of the organization in terms of input of staff time in relation to the amount of loan, slow disbursement in comparison to quick disbursing infrastructure projects makes Bank a inappropriate leader. The Bank ignores the context, experiences and epidemiological realities of various countries and applies health reforms to them. The internal evaluations of the Bank show that they are most successful in developing infrastructure and least successful in engaging in a planned intervention leading to development [16]. In their own evaluation only one out of three health projects is a success.

16 Jailley (1999) uses the Bank's data to show that only 17% of the projects have contributed substantially to development. The Bank is also criticized for unrealistic project objectives, inadequate monitoring and lack of country commitment. In terms of economic analysis: only 18% of the projects depicts future projections, most do not have a market or substitution analysis and only 10% of the projects contrain a cost effective analysis. The section on risk analysis was short and only less than 10% of the projects examined specific strategies to reach the poor. Only 40% of

Pavignani (2000) calls for leaner and flexible procedures, decentralized management, and openness to the wider world from the World Bank. The author also criticized the Bank for being overbearing to the extent that the previous clients have been reduced to dependents of the Bank. She argues that global partnerships in which everyone is equal can only be effective and bilateral and multilateral organizations in its present form are essentially unfit for leading international health.

Perhaps one of the reasons for this undisputed international leadership status of the Bank on health is because WHO had been largely ineffective in influencing the international health policies and refused to respond to the new challenges that the developing countries were facing. This is not to say that all WHO strategies have been in the interest of the poor and the vulnerable. However, there is certainly a shift in value system. The issue of universal and comprehensive health has got shelved under the discourse of finding the most efficient and equitable public private mix (Baru, 2000). The Bank views health neither as a right not as a consumption but as an economic commodity (Buse et. al, 2000) to be bought and sold in the market. The shift of leadership from the WHO to the World Bank, took the responsibility of providing health from the government to the individual. The World Bank advocates a system whereby the private sector caters to the needs of the rich and the public sector funds the health services of the poor. But the Bank overlooks the long-term impact of such a targeted approach. The American experience has shown that targeted programs do not continue to receive attention for a long time and this ultimately contributes to increasing inequities in the health status (Brown, 1984). An over-emphasis on privatization and unrestricted entry of the corporate sector in the health sector would further transform the health service sector to an hazardous industry.

However, this tendency to place organizations like WHO on a pedestal is also simplistic. The WHO, like almost all other development organizations, have to look after their own

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the projects provide information on consumer satisfaction only 2% estimate consumer response to planned intervention. Only 4 out of 224 projects mentor participation by beneficiaries in project planning.

sustainability, pacify their donors and meet their costs. Though WHO is a democratic organization yet five or six rich countries fund a major share of its budget. However, another possibility is that WHO has itself engineered the SPHC project itself. It should be noted, that WHO was guided by a bio-medical model until it started analyzing the reasons for failure of malaria program (Roemer, 1986). It is possible that once the WHO was applauded for coming up with the health for all strategy it developed cold feet because it did not have the requisite funds, skills, staff or ideology to render the HFA in the PHC mode. They thus reverted to something they were good at i.e. the SPHC approach, which was guided by the biomedical model. Thus the HFA approach wherein a comprehensive and universal approach to health care was advocated was reduced to rhetoric. In the context of environment, the eco-development concept coined in the Stockholm Conference, which called for satisfaction of basic needs and self reliance-, was largely reduced to rhetoric. The primary health care approach was diluted by reducing it to selective primary health approach and the eco development concept was limited to micro projects only (Nayar, 1991). The dilution of these approaches had rendered them useless as discussed in the previous section. This dilution happens because these approaches are against the interest of the ruling classes and challenge the hierarchical society. Consequently, these concepts are portrayed as highly expensive or idealistic and part solutions are found for these complex problems. As a result the whole concept gets subverted as the part which is taken away is the one which challenges the hierarchical structure and what is remaining is not identical to the original concept. The primary factor behind these changes is the inegalitarian socio-economic system. The international agencies, which are the product of the hierarchical society and are funded by the politically and economically dominant sections, play their role by portraying a mirage of the original concepts as champions in social and economic development.

The international institutions tend to favor the interest of the dominant section and are partly governed by their own agenda and internal politics. As mentioned before, the members of the World Bank get votes according to their funding capacity and ten richest

countries appropriates 50% of the votes. Though WHO has a democratic set up in which each member gets a single vote yet the developing countries have taken loans from the developed countries and in practice the relation between them is essentially unequal. The rich, industrialized developed countries bear a major portion of the regular and the extra budgetary budget of WHO and thus have a strong bargaining power vis a vis the non-funding members of WHO. The problem is made more complex because other international agencies such as UNDP is soliciting funds from global corporations with tarnished records on human rights, labor and environment (Karliner et. al., 1999). It is surprising that development agencies ask the local NGOs to plan their interventions in a sustainable fashion, recognizing that foreign funds will not be available to them indefinitely and likewise they cannot support the areas in which they work endlessly. Ironically the international agencies do not apply the logic of exit policies to themselves. This clearly illustrates the hypocritical tendencies in these organizations; that they exist to benefit their benefactor at the expense of their clients. It has to be accepted that international initiatives cannot promote national self-reliance. What is worse is that this farce is carried out under the name of development and poverty alleviation.

In sum, the perspectives of two of the most important international development organizations, in the context of health sector, is favorable towards decentralization of the health system and overall governance mechanisms. Both WHO and the Bank advocate decentralization of services. WHO sees decentralization as a means of achieving greater coordination of health service sector and responsiveness to local needs through delegation of responsibility, authority and resources to the community to intermediate levels. Generally decentralization has been seen as an instrument for achieving Health for ALL (HFA) as described in the Alma Ata Conference. The model adopted by them initially was of Primary Health Care (PHC) but later on they started focussing on the selective primary health care (SPHC) model. They have again started concentrating on the issue of health system decentralization but not with the model of PHC. The Bank holds that excessive centralization increases economic and social costs and is a source of political disturbance.

They also propose decentralization of the health services but the model of decentralization suggested by them is of privatization. They propose that the govemment should restrict its role to formulating guidelines, assuring quality, regulating private and non-governmental sector and cushioning the vulnerable sector and that the public heath services should be curtailed and user fee should be charged. They are in favor of large-scale decentralization of services to the subnational level but with series of regulations to ensure that the larger "national" priorities are not compromised and privatization of health services is promoted. Bank's enthusiasm for decentralization has been dampened when some adjusting countries risked macro-economic stability and reversed the gains on the pretext of decentralization. Bank is not open to this sort of experimentation and cautions the decentralizing countries to move gradually and maintain a balance wherein the local interest do not hamper the national goals. Indeed, one cannot find fault with this suggestion of the Bank until one notices that this cautionary attitude is recommended only when the decisions are taken against the Bank vision of development. The Bank has never hesitated to recommend the adjusting countries to experiment with health sector reforms[17] which affect cost-recovery mechanisms such as user fee despite the fact that there are ample evidences that these may impact negatively on the poor and the vulnerable. Thus it is important to see who is promoting decentralization and what are the motives behind espousing decentralization. It has to be recognized that international organizations come with their histories, policies, mandates and aims and that determines their approach and their direction in engineering health policies and perception of health.

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17 Kolko (1999) who studied the impact of IMF policies on countries which had undertaken Enhanced Structural Adjustment Policy successfully illustrates that the benefits of additional investment in health care bypass the poor and are appropriated by the rich17. Banerjee (1999) shows that health reforms have managed to give a deadly blow to Chinese commune system and increased the IMR among the poor. Gross neglect of health care of the poor was witnessed in Malaysia, Indonesia, Thailand and Philippines. Health sector reform further increases women's deprivation by reducing their access to medical services (by increasing costs) and employment (by reducing nurse employment and retrenchment in the public sector) on one hand, and burdening them with additional domestic duties (unpaid nursing at home) and dangerous technologies (like amniocentesis and Norplant) on the other. In Ghana three years after introduction of user fee the rural sector noted a decline in utilization of services especially among the female users. Similarly Zimbabwe saw a decline in maternal and child health and the number of women who were brought to the hospital for delivery. The maternal death increased by 56% and number of deliveries in hospital declined by 46% in Zaire region of Nigeria even after five years of reform (Standing, H., 1997)

Chapter 5
SUMMARY & CONCLUSIONS

'Sustainability does not emerge from quick stabs at the symptoms of major problems.
Instead it requires long-term commitments that build on experience
And apply steadily increasing pressure on the cause of the problem'
(Font, A.L, 1995)

The objective of this dissertation is, to unravel the complexities at the conceptual and practical level in decentralizing governance, especially of the health system; to assess the influence of WHO and World Bank on the decentralization discourse and practice; and to analyze the implications of decentralization of health services in India. This concluding chapter summarizes the findings of the study and explores the implications of decentralization of health sector in India, especially in the light of health sector reforms proposed by the World Bank. This chapter is divided into five sections[1]. Section 5.1 and 5.2 present the complexities in decentralized governance and health system decentralization respectively. Section 5.3 presents the position of the WHO and the World Bank in the decentralization debates. Section 5.4 assesses the implications of the decentralization of health services in India, with the backdrop that India is attempting to adopt health sector reforms simultaneously. Section 5.5 identifies areas of further research.

5.1: DECENTRALIZATION IS COMPLEX AND CONTEXUAL

It has been established in the previous chapters that decentralization is not just a matter of passing a constitutional amendment and restructuring roles and responsibilities. It is an extremely complex process, which is affected by and affects a multitude of factors, including the historical, cultural, social and political factors. The pattern of decentralization is

[1] It must be mentioned that section 5.1, 5.2 and 5.3 present summaries of conclusion reached in chapter 2, 3 and 4. For a detailed analysis of the conclusion reached therein reference to the relevant chapters is necessary.

determined by political choices made by the countries. Successful decentralization is a gradual process of trial and error. Each country or sector has to make their own niche by building on the pre-existing supportive factors, nurturing new alliances and effectively handling all the bottlenecks. Decentralization therefore needs careful implementation to maximize on the advantages; adequate financing, clear delineation of financial flow mechanism, sufficient power, well-defined geographical boundaries and proper role demarcation are essential for the working of decentralized systems. Successful decentralization requires the center to formulate policies, provide guidelines, and monitor that there is coordination between policymaking, service planning, budget allocating, and outcome monitoring at the national and sub-national levels.

5.2: HEALTH SYSTEM DECENTRALIZATION IS CONTEXTUAL

Health system consists of all activities, actors and agencies that are chiefly involved in promoting health, preventing ill health, or treatment and rehabilitation of ill people. A review of experiences of twenty-four countries undergoing health system decentralization demonstrated that health system is a dynamic entity that is shaped by the historical, cultural, social, economic, political, demographic, scientific, technical and geographical factors of a country. Decentralization of health system can range from transfer of limited powers to lower management levels within current health management systems to extensive reforms in the system. A holistic conception of health is essential for effectively decentralizing the health systems. Vertical disease programs were found incompatible with health system decentralization process as they impose pre-determined, universal packages. The health system decentralization cannot bring desired changes without addressing the issues such as poverty, unemployment, racism, castiesm and lack of nutrition, housing, sanitation, water supply etc.

There are always forces inimical to decentralization. Generally there is tremendous pressure from technocrats and bureaucrats who are against decentralizing health system.

This is because they view decentralization as a threat to their jobs and work culture. The decentralized governance also hurts the ego of the professionals who do not want to be supervised by less educated or illiterate people at the village level. Training of health personnel at the central, intermediate and local levels is very important before, during and after the decentralization process, since decentralization implies a new ideological, administrative, management and information system. Alliance with communities should be especially encouraged. Communities must be encouraged to develop skills for monitoring the public and private health services. Moreover, the communities should be given avenues to influence the national level health policies.

5.3: WHO and WORLD BANK MANIPULATE THE PROCESS OF DECENTRALIZATION

Though one cannot deny the benefits of international cooperation in arresting the spread of disease and promoting good health yet past experiences have shown that these partnerships are rarely equal and are usually for the benefit of the politically and economically dominant sections of the population.

WHO saw decentralization as an instrument for achieving Health for ALL (HFA) as described in the Alma Ata Conference. The model adopted by them initially was of Primary Health Care (PHC) but later on they started focussing on the selective primary health care (SPHC) model. SPHC erodes community's right in decisions that concern them, disregards social, political and economic realities in which people live and detracts from equity, social justice and the need for long term social, economic and political change. SPHC can only lead to deconcentration or delegation but not to genuine devolution. This is because they are given a pre-determined package and not given a free hand to identify their health priorities within the constraints of finance, technology, manpower etc. The primary concern behind this shift from PHC to SPHC is the promotion of an inegalitarian economic order. The international agencies, which are the product of the hierarchical society and are funded

by the politically and economically dominant sections, play their role by diluting the original concept of PHC. WHO like almost all other development organization have to look after their own sustainability, pacify their donors and meet their costs. It is also possible that WHO developed cold feet because they did not have the requisite funds, skills, staff or ideology to render the HFA in the PHC mode.

With a change in leadership, WHO has declared in 1999 that it will resume its role of global leader on health issues. It is still not clear whether WHO is in the process of revival. The kind of projects they support and the health advocacy that they will undertake in near future would demonstrate what they want to achieve. As of now, WHO is not advocating bold policies like PHC and neither is it explicitly criticizing health sector reforms promoted by the World Bank. But WHO has started critiquing user fee and a limited role of the government in regulation of the health sector.

Wold Bank is not really interested in transfer of power to sub-national governments yet decentralization in that form also has implications for all aspects of development. Therefore the Bank finds it imperative to monitor and influence the decentralization process in their client country. The model of decentralization proposed by the Bank is that of privatization. They see decentralization as an opportunity for privatization and claim that both decentralization and privatization strengthen each other. This is reflected in their claim that privatization is the extreme form of decentralization. The World Bank suggests that the government should restrict its role to formulating guidelines, assuring quality, regulating private and non-governmental sector and cushioning the vulnerable sector and that the public heath services should be curtailed and user fee should be charged. In case of devolution to sub-national units, the Bank supports decentralization but with a series of regulations to ensure that the larger "national" priorities are not compromised. The 'national' priority here is defined by the Bank's vision of development. It is notable that, the World Bank has never hesitated to recommend the adjusting countries to experiment with health sector reforms which affect cost-recovery mechanisms such as user fee despite the

fact that there is ample evidence that these may impact negatively on the poor and the vulnerable. Thus, the World Bank has manipulated the decentralization model to suit its development strategy of globalization, liberalization and privatization

5.4: IMPLICATIONS OF DECENTRALIZATION OF HEALTH SERVICES IN INDIA

With the coming of Independence, despite a glorious history of decentralized administration, the panchayats did not get sufficient importance in the constitution. Panchayati Raj finds mention in the Directive Principles of article 40 but is not accepted as an alternative mode of governance; the governance in the country remained largely federal and centralized. Thereafter, a series of committees were formed to formulate strategies for promoting decentralization. However, by and large Panchayati Raj did not fulfill its expectations due to structural inadequacies, limited resources, lack of conceptual clarity, lukewarm attitude of the bureaucrats, vested interests of the rural elite, disinterest of the rural masses and lack of political will to check irregularities.

The 73rd Amendment Bill[2] introduced in the Lok Sabha in September 1991 and in Rajya Sabha in December 1992 is described as a watershed in the process of decentralization in the country because it made panchayats statutory. Depending on the political will of the state and the capacity of the local institutions different states are in different stages even after eight years of passing the 73rd Amendment. The transfer of power to Panchayats is happening very slowly in some states whereas some have implemented it successfully. The experience of West Bengal, Kerala and Karnataka is impressive. The experience in Andhra Pradesh, Maharashtra, Madhya Pradesh, Bihar, Uttar Pradesh, Punjab and Gujarat has not been satisfactory.

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[2] The bill makes the three tier system mandatory; all posts to be filled with direct elections; gram sabha to vote; 1/3rd reservation for women and seats reserved for SC/ST and Panchayats to receive adequate funds from the States. The States are requested to innovate ways in which panchayats can be made financially viable. Perhaps the biggest step

The National Health Policy (1983) is being revised. The draft of the revised policy proposes user charges for public health services on people living above the poverty line. A standard percentage is not indicated in the draft but there is the incentive for the local governments to charge user fee as the revenue generated would be used for the maintenance of the PHC. It also proposes to double (HT, 2001) the public outlay in health services from approximately, 1% of the GDP to 2.5% of the GDP (i.e. from 17,000 crore to 40,000 crore), with 50% for primary health care, 35% for secondary and 15% for tertiary care (Nagi, S, 2001). The policy also intends to formulate Drugs and Cosmetic Act and register all private hospitals and diagnostic centers to ensure accountability. The Center has advised the states to follow a policy of coercive 'incentive-disincentive' for arresting the growth of population.

While the government was formulating ways to decentralize the governance system, it was also working towards absorbing the Bank's recommendations. The Bank recommends curtailment of public spending and public services in health care, cost recovery of essential services that are provided in public health centers, privatization of curative sector especially at the secondary and tertiary level, and reinvestment of revenues gained through user fee into maintenance. "The government has introduced budget cuts, a new drug policy with decontrols, privatization of medical care and is exploring cost recovery schemes such as introduction of user fee and health insurance" (Qadeer, 1994).

Between 1972 and 1988 the Bank had supported five population projects. Overall, the projects have met their objectives, which was mainly to support the government to expand their population and mother and child projects. But none of these projects made significant contribution[3]. The Population project one and two could not have any systemic impact on

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towards local governance is taken by entrusting to the panchayats the responsibility of formulating, implementing and monitoring the local level development programs for 29 subjects including health, sanitation, housing, drinking water etc.

[3] The Bank's experience in the PHN projects in India have led them to the conclude that the Indian government are inattentive in management aspects; slow in implementation; weak in supervision; poor in maintenance; untimely in flow of funds, poor in procurement for services and insensitive to qualitative aspects. The Bank also disapproved the fact that the outcome of any project in India depends on the personalities who are involved in the project.

family welfare program; population three had favorable outcomes in Kerala but not in Karnataka and Project four appears to have accomplished its objective of increasing contraceptive prevalence and reducing infant mortality.

In January 1987, India and the Bank agreed to a five-point sector strategy: increased emphasis on outreach, temporary methods of contraception, MCH, enhancing quality of health services (especially services in urban slums, backward and high fertility states) and fewer project resources for expansion of system. The change in the approach of the Bank in its health care interventions was a result of change in its larger approach i.e. the Bank started involving the government in designing its programs and local consultants in the execution of the programs (World Bank, 1999). In recent projects the Bank has started performance based budgeting and hopes that it will be also make the government more accountable (World Bank, 1997).

Thereafter the Bank supported Tamil Nadu Integrated Nutrition Project (TINP) and Integrated Child Development Services (ICDS). The Government of India did not show any interest in continuing its TINP project despite its partial success. So the Bank has restricted its support to ICDS program though the Bank is disappointed with its outcome.

Since 1991, the Bank has significantly increased its emphasis on health sector development in India and has been engaged in a dialogue with the Ministry of Health. Earlier the projects were mainly supply- oriented with no effort from the Bank to reform the institutional capacity or the health policies of India. But it was increasingly becoming evident by the end of 1980's that the earlier approach was not working, also the government was more receptive to Bank's 'advice' for the lure of getting more finances in a period of economic crisis. The Bank on its part wanted to help India with what it considered to be the right approach in service delivery[4].

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[4] The Bank is highly critical of the administrative and financial administration of the health system in the country (World Bank, 1997). First they critiqued government's health care strategy for being based on population size rather than the specific health needs at the community level which can vary from area to area. Second, criticism leveled against

The perspective of the World Bank (World Bank, 1997) on decentralization of health sector in India is that decentralized governance can contribute to improving health systems in India. This is because the plans would reflect the local priorities and would be supervised by local institutions and local people i.e. those who are effected by it. But in order to deliver services to the best of its capacity the role of PRIs should be enhanced in the field of revenue raising, policy making, regulating and supervising, personnel management, resource procurement, resource allocation and overall planning. In addition opportunities for intersectoral collaboration, interagency collaboration and training should be encouraged. On the basis of research undertaken by the Bank (World Bank, 1995 and World Bank, 1997) by reviewing five states of the India, the bank suggests the following ways to strengthen policy and finance strategies at primary level:

- The States and the Center should increase health spending on primary health from current 0.65% to 1.0% by relocation of existing resources and allocation of new resources.
- The public sector should provide enhanced support to a basic package of public health measures and clinical services that will reduce the burden of disease in a cost -effective manner. To make the services more cost effective, full cost recovery from private and government insurance schemes, reducing subsidies in medical education and user fee should be charged at secondary and tertiary levels.
- The public funds should be targeted on poor people and the center should increase funding to needy states.

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government health service system is that the government duplicates services in some areas, do not reach some areas and use outdated technical paradigms such as the latest drugs are not used to a large extent. Third drawback pointed out by the Bank is in the field of personnel management. The government does not provide sufficient incentives to the doctors to serve in rural areas, do not focus on in-service training of doctors, neglects the shortage of trained nurses and that quality of basic medical education is being deteriorated. Fourth, the government is also criticized for not clarifying the role of private sector in its overall health strategy and in failing to encourage the private sector to invest in preventive and promotive aspects of health care. Fifth, the budgeting and accounting procedures of health system are considered complex and cumbersome. Sixth, they critiqued the financial decision made by the health system that make them spend beyond their scope and skews resources in favor of tertiary sectors. Seven, the Bank critiqued the government for inefficient systems for collecting user fee, lack of appropriate mechanism to review user charges, targeting poor and retaining revenue at the levels of collection. Eighth, the Bank describes the analytical capacity for health care planning at central and state level as limited and health care management as weak.

- The Ministries of Finance and Health and Family Welfare should jointly review the fiscal structure and develop fiscal tools to enable resource reallocation (between center, state and local government), decentralized financing, cost recovery, financial incentives to NGOs and private providers, and monitoring.
- The government should contract out service to the private sector and encourage private provision of health care especially in preventive and promotive care. It should raise its capacity to register, certify, regulate and monitor private health care and ensure minimum standards by providing appropriate guidelines.
- The other suggestions include: to improve referral system; to promote planning and analysis capacity of Government of India/ Ministry Of Health and Family Welfare; to initiate community awareness of health related issues and encourage participation in existing health education program.

The Bank's involvement from 1987 to 1996 has not yielded significant improvements in terms of increase in access to primary health care, decentralization of budgetary and planning power to the local institutions or involvement of the non-government organizations (World Bank, 1999). The Bank has identified a three pronged approach. One, to reduce the burden of most significant diseases; two, to strengthen performance of state health systems and three, to strengthen essential functions such as food and drug administration capacity.

1. To address the first issue, the Bank supports five disease control projects (Malaria, Tuberculosis, AIDS, Leprosy and cataract blindness) and fourteen Population, Health and Nutrition projects ongoing (World Bank, 1996 & 1997). The health and nutrition projects are mainly aimed to bring a systemic impact on family welfare program, contraceptive prevalence in selected areas, and child survival and safe motherhood. Recently a school health program and immunization project has also been started. Program to reduce consumption of tobacco, alcohol and drugs has also been attempted.
2. To tackle the second issue Bank has initiated state system project in four states of India. The state systems projects are comparatively new and give banks more leverage to

influence public health and health service systems in the State and this will be dealt at length in what follows.

3. For the third issue, the government of India is preparing a project for Capacity Building for Food and Drug and Quality Control. Since this project has not yet started we will not focus on this.

The state health system project was started in Punjab, West Bengal, Karnataka and Andhra Pradesh in 1995 (Appendix 3). These states were selected because they captured heterogeneity in the country in terms of epidemiological profiles, levels of economic development, health service development and political will. This is a pilot project and would be applied on a broader range if it works well. The loan is about $350 million, repayable at 12% p.a. over the period of 35 years. The following reforms were suggested to the four states (World Bank, 1997):

- Reorient health strategy: Integrate population size base approach with a need approach; rationalize service norms and update technical paradigms; and create incentive for staff and provide training.
- Coordinate Public and Private sectors roles: Encourage private sector participation; increase opportunity for contracting out ancillary services, strengthen linkage between government and non-governmental organizations and expand capacity to monitor and certify.
- Strengthen State Financing arrangements for health care: Review fiscal structures and procedures at health and family welfare sectors including role of central, state and local government financing; develop tools for the state and central levels for monitoring; develop fiscal tools for experimentation with state financing and enhance central transfers to the state
- Enhance and prioritize state expenditure on Health: Improve overall state finance and increase allocation to health within the overall budget; reorient at least 75 percent of resources to primary and secondary levels; and increase allocations for non-salary recurrent costs.

- Implement Cost Recovery mechanism: Institutionalize mechanisms for periodic review of user charges and pricing policy; strengthen collection mechanism with the objective of increasing cost recovery from 3% to 15-20% in three to five years; strategize ways to exempt vulnerable groups from exemptions; retain the revenues at the point of collection and utilize it for non-salary recurrent expenditure such as drugs, essential supplies and record keeping.
- Improve the analytical capacity for decision making: undertake analysis of burden of disease at regional and community level; review cost-effectiveness of key health interventions by using cost-effective analysis
- Strengthen Public sector management of heath care: strengthen overall management authority; enhance capacity of PRIs by giving them more power in the areas of budget allocation, resource use, revenue raising planning, policy making, supervision, maintenance and training; and increase coordination between the three tiers of PRIs and between PRIs and the state.

The four states decided to invest in primary care; upgrade community, sub-divisional and district hospitals; improve referral mechanism; cutback on secondary and tertiary care; contract out ancillary services to private sector; decentralize government health programs; raise capacity of the government for sector analysis and management; pass regulations to enhance participation of private and voluntary sectors; implement existing user fee effectively; and levy fee at the secondary and tertiary levels for those who can afford to pay;. The user charges are to be increased in a phased manner and matched with better quality services and use resources generated to enhance selective interventions at primary level (World Bank, 1996). Karnataka, Punjab and West Bengal are investing maximum funds on civil works, which are mostly contracted to private firms (Baru, 2001). Other important investment items are medical equipment, vehicles, medicines and studies[5].

[5] It is notable that the Bank is aware that the private bed capacity exceeds the public bed capacity in Andhra Pradesh and Karnataka and medical manpower is skewed towards private institutions in West Bengal (World Bank, 1995). The Bank recognizes the risk that the state may not be able to maintain the investments but is hopeful that this may not happen.

Though, the World Bank has proposed to strengthen the powers at the primary level in terms of planning, resource generation, resource allocation, budgeting, especially through its SHS Project, yet there are doubts whether their efforts will lead to decentralized health care. This is because of the following reasons:

1. It has been seen that the central grants towards health have been progressively declining[6]. The World Bank restored some of these cutbacks in 1992-93 but most of them were for vertical programs like AIDS, tuberculosis, family planning etc. The national and the international experiences have sufficiently demonstrated that vertical disease and population control programs take away the attention and resources from the public health endeavors and reverse the progress made by the PHC approach. Furthermore, not all diseases selected by them are epidemiologically sound and nor are they backed by cost effective strategies (Qadeer, 1995). Though malaria and tuberculosis are national concerns, leprosy, AIDS and cataract blindness do not require projects of such a large scale. Secondly, while supporting tuberculosis and leprosy the Bank has opted for very costly drugs [7] which are not necessarily the best in the Indian scenario.
2. The State Health Systems (SHS) started by the Bank advocates the cause of decentralization and raising institutional capacity, besides many other factors. But the PRIs are flooded with funds that may not be available in future. This may impact the sustainability of not only the tangible goods but also non-tangible items such as

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Moreover, the SHS project is investing on the institutional mechanism to cope with any such disaster, but in case of an eventuality the Bank is prepared to help the state to tide over the crisis.

[6] The share of medical and public health in the total plan outlays (excluding family welfare (dropped from 3% in first plan to 2% in sixth plan to 1.75% in the eight plan and there has been no significant re-targeting of the expenditure towards components that benefit the poor both at the state and central level (Prabhu and Radha, 1995).

[7] For instance in the case of tuberculosis WHO and the World Bank recommended expensive short course chemotherapy (SCC) program instead of the standard regime (SR) that was adopted by the country. Qadeer (1995) observes that, " for Rs. 12,500, a hundred cases treated by the cheaper standard regimes compare to 20 cases by SCC. With a cure rate of 86% for SR and 95% for SCC, patients treated will be 86 and 17 respectively". She has also pointed out that the chances SCC attains that much success rests on two very dubious assumptions; one that India has infrastructure for direct supervision of 6.5 million tuberculosis patients and two, that the patients have the time to visit PHC for direct supervision.

institutional strength. The intention of the Bank to directly fund the states and panchayats raises a doubt on whether this is done because it is easier to influence the vulnerable and inexperienced peripheral institutions.

3. The Bank also encourages the concept of user fee in public hospitals. In the context of SHS project, doubts[8] have been raised about the sufficiency of the user-fee to sustain the maintenance of the investment made. Besides, the levying of user charges at the secondary and tertiary level would affect negatively the quality of 'free' or primary health care (Qadeer, 1997). This would also impact the relationship and the coordination between the primary, secondary and tertiary levels of care, which is vital for functioning of health service system.
4. Another proposition of the SHS project is to gradually pass on the tertiary and secondary health services to private sectors. Without the tertiary and secondary sectors the utility of the PHC would be restrictive (Qadeer, 2001). Without the continuos referral system at primary, secondary and tertiary level the purposes of equity is defeated.
5. The Bank recommends that safety nets should be innovated for the poor but there are doubts on the quantity and quality of secondary and tertiary services that would be available for the poor in the changed scenario.
6. The Bank proposes to train officials at the state level in cost effective and DALY methodology. The use of the above-mentioned technologies is questionable[9] to enable the officials to plan effectively in decentralized health care system. In fact, training in cost effective methodology and DALY may be detrimental to the cause of decentralization.
7. The Bank recommends the strategy of selective decentralization i.e. decentralization when it suits the purposes of the Bank. It warns the nation to regulate the peripheral institutions

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[8] Baru (2001) rightly points out that sustainability of these investments must be a matter of concern for all states (Appendix 4). Prabhu and Radha (1995) observes that the recovery of public health declined from 6.4% in 1975-76to 1.6% in 1988-89 to 2.74% in 1987-88. Moreover, Baru (2001) points out that with the plan of limiting user charges to the upper and middle class, cost recovery is bound to be lower. "In Karnataka and West Bengal, where of the top 20 percent, 62 percent and 80 percent respectively utilize public hospitals from rural areas, there is some possibility of cost recovery through user charges. al., 2001). However, in Punjab and Andhra Pradesh, only 33 percent and 24 percent respectively, of the top 20 percent use public hospitals" (Baru., 2001) and cost recovery is not very likely. In case the Bank again helps the Panchayats they will get used to being dependent on external resources and may collapse the help is no longer available.

[9] The criticisms leveled against the above mentioned methodologies have been discussed in Chapter 4.

so that they do not oppose the national priorities like family planning or create a situation where there is a macro-economic destabilization. At the same time the Bank encourages the nation to experiment with cost recovery and user charges.

8. To encourage private health sector is an integral part of the Bank's strategy of health care development. But decentralization and privatization are antithetical to each other (Collins and Green, 1994). Though both decentralization and privatization are opposites of centralization yet the two are very different. Decentralization is done with the aim to increase intra-sectoral coordination whereas privatization encourages fragmentation of health services. Decentralization aims to deliver public services in accordance with public needs and privatization want to make public services responsive to the market economy. Decentralization aims to reach the health services to people who cannot reach the health services themselves whereas privatization aims to reach the services to those who can pay for them. Decentralization has a social development element in it whereas privatization has a business development element, which may not always be the best attitude in service delivery.
9. Moreover, the accessibility of the poor to the health services is dependent on issues that may lie outside the scope of health service system but not outside the scope of public health interventions and equitable socio-economic development. The need-based intersectoral approach on the PHC principles is the only way to reach the ideal of achieving health for all.

To sum up, India is adopting two distinct approaches, health system decentralization (HSD) and health sector reforms (HSR), which are at cross-purposes to each other. The participation of people is the backbone of the decentralization program[10]. The HSD model recommends devolving the responsibility of managing the health sectors to the local institutions. In the HSR

[10] China has demonstrated that a disease like schistosomasis can be eradicated with the participation of the people (Antia, 1993). The barefoot doctors scheme in China has also proved very successful. It has demonstrated in our own country that community involvement even in sector of environment or education. The NGO experiences in Maharashtra (Jamkhed and Mandwa), Gujarat (SEVA), Andra Pradesh (AWARE), Uttar Pradesh (Banwasi Ashram) and Kerala (Munnar) have proved successful at the level of primary, secondary and tertiary care (Antia, 1993).

model also decentralization is suggested, but it is recommended that the local institutions should not be given the freedom of surpassing the national objectives. Obviously, such a system cannot provide enough space for the participation of people at all levels. They can allow people to participate in top down program but cannot allow them to make plans according to their own priorities because of the fear of macro-economic instability.

The focus on HSR being anti-thesis of decentralization does not imply that the World Bank is the only impediment in the process of decentralization in India. It should be noted that the objective of local governance was espoused since the 1940's when PRI were sanctioned in the Directive principles of the country. Thereafter a series of committees recommended various policies and programs to enable effective decentralization; but the implementation always fell short of the goals espoused. Regional elites, bureaucrats and politicians subverted the process of decentralization.

With the 73rd and 74th constitutional amendments a genuine opportunity was presented to decentralize governance and entrust the responsibility of managing 29 subjects to the local level government. Though some states did make headway in the direction of decentralization, most of the states tried to take advantage of the loopholes in the constitutional amendments. The delay in local level elections, dispersal of funds, delegation of responsibilities, devolution of power to the local level government has been very common. Also the inability of innovating methods of making states financially viable and ensuring a fair play in local level elections has been witnessed. Some are of the view that decentralization is a hoax; the regional elite and political parties use it to further their own interests and the priorities and problems of the local people remain unadvised. Moreover, it has been reported that technocrats and bureaucrats are against decentralizing health system. This is because they view decentralization as a threat to their jobs and work culture and do not want to be supervised by less educated or illiterate people at the village level.

The challenge now is to implement the benevolent guidelines of the amendment by undertaking the following activities:

Political:

1. Ensure regular elections at panchayat level

Most of the states in India are infamous for not holding the elections regularly, and even postponing them for decades, one of the foremost tasks for the nation is to ensure regular elections in all panchayats, irrespective of the ideology of the political leadership.

2. Ensure fair elections and appropriate reservations

Another characteristic in panchayats in most states is that regional elite disproportionately monopolizes it. The states should accept the challenge of promoting an atmosphere, which is conducive for all sections of the population to come forward fearlessly and contest elections. It should also be ensured that elections are fair, voters are not coerced and the panchayats abide by the guidelines of 73rd Amendment about the reservation of seats for scheduled castes, scheduled tribes and women.

3. Ensure that states do not misuse their discretionary powers

The central government should also ensure that the states do not take undue advantage of its discretionary powers and devolve the responsibilities and resources in accordance with the guidelines. For this purpose, the government may consider to modify Article 249 of the 73rd Constitutional amendment.

4. Collaborate with INGO's to facilitate PHC

It has already been established that the HSR and the World Bank further complicates the process of decentralization in the country. India cannot just wish away the existence of the Bank but India should not accept inappropriate policies for the lure of resources, which may be much needed in the situation of economic crunch. It has to be noted that the increase in

resources when not backed by appropriate policy, leads to wastage of resources paid for not by the Bank but the country and its citizens. The solution lies in being selective in taking what we want. In the context of health sector development, India should only accept the programs and strategies, which promote health system decentralization on the principles of PHC and public health. The Bank could suggest how these ends could be realized, without diluting, in a cost-effective manner. For instance, budget for raising the analytical and management skills of health personnel and policy makers can be used on motivating and sensitizing personnel on the gains of public health, the integrated nature of health, primary health care approach and participatory approach to development. The responsibility of the training could be given to institutes, which specializes, in the field of participatory approaches, decentralization of health service management, behavioral changes etc. Besides, the Bank could facilitate in raising the capacity of local institutions for effective decentralization of health care and public health interventions.

5. Take inputs from all stakeholders in the new health policy

The government should seriously reconsider the draft of the new health policy. The health policy should be tested for technological, managerial, financial, epidemiological, sociological, public health, community health and specialists from all fields must be invited to contribute to the policy. Most important it should be based on people's priorities. After more than fifty years of independence, as a country who is striving to pursue self governance at local levels, shouldn't India discuss policy changes at various avenues to enable the people at all levels and in all regions to give their views about the health policy of the Nation? It has been twenty-four years since the demand for people's health in people's hands has been made. Even by the standards of slow pace of India's infamous bureaucracy, isn't it time that people should finally get a chance to control and determine their health policy and have a role in monitoring of the health programs?

Social:

6. Challenge the hierarchical value system at national, international and local levels

Decentralization is an extremely complex endeavor and it involves sharing of power, resources and status with people who are generally regarded as local, ignorant, backward and less capable. Only in a society where equality of human beings is the preferred social value and leading towards equitable society the social norm can, genuine decentralization take place. Decentralization is nothing short of a revolution; upper's and lower's, have's and havenot's, rich and poor, powerful and powerless, educated and uneducated have to change their value system and contribute towards this revolution. It has been seen time and again that those in power try to keep the decision-making powers and purse strings in their control. To justify the inequitable distribution of resources, on the one hand they did not let the so called lowers to move up in the hierarchy and on the other fabricated stories on the lowers being lazy, irresponsible, incapable, weak and corrupt. This strategy of victim blaming has been used time and again. Nowadays the same strategy is polished and sugarcoated and used by some international aid organizations to justify their reform packages. Likewise the same rationalization is used to promote centrifugal tendencies by the Center. To usher in decentralized governance, the hierarchical systems (at national, international and local levels), which have been crystallized over the centuries, have to be challenged and the value system which these systems have promoted have to be denounced.

7. Collaborate with NGO's and INGO to empower local people

The government, non-governmental organizations[11] and international aid organizations should get together to promote such initiatives and enable the local people[12] to monitor the health services and pressurize the health centers to be responsive to their needs. The following table depicts the possible roles for participation of the local people.

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[11] The national NGO's of Bangladesh have made exemplary contribution to public health in Bangladesh by supporting the government in its initiatives, developing new options for health care in remote villages and training considerable number of health care staff in community-oriented health care (Streefland and Chowdhry, 1990). The efforts of non-governmental organizations have made common people aware of the importance of PRI in Bihar (Kumar, 2001).

[12] However it has to be acknowledged that local community is heterogeneous and dynamic, with competing interests and entitlements, and this may impact on any development intervention (Ahluwalia,M., 1997).

TABLE: 9

LEVELS OF PARTICIPATION OF THE LOCAL PEOPLE

Participation	Characteristics
Electoral	Local people's participation is restricted to electing their representatives.
Enlightened	Local people are informed about the policies and programs of health
Endorsement	Local people are asked to endorse the pre-determined plans on development
Advisor	Local people are asked to contribute to plans made by higher authorities
Designer	Local people are asked to make their own plans
Self Government	Local people control and monitor the health services in the area

Majorities of the states in India are at the level of electoral, enlightenment, endorsement or advisor participation. The objective is to move to the level of designer and self-government. An example of the designer approach is found in Kerala where the local institutions use participatory methodologies to depict their priorities. To illustrate self-government, a WHO supported project, 'Empowerment of rural poor for better health', a local non-government organization enabled the common people of Dahanu, (Thane district of Maharashtra) to take to streets and protest against lacunae in public and private health services. They pressurized the doctors to display rate list, increase availability of medicines, curb illegal charges, refrain from over-charging, not to give unnecessary injections and to ascertain that ANM makes the scheduled visits and publicly displays her schedule for the month (Shukla and Phadke, 2000).

Economic:

8. Ensure adequate flow of funds to panchayats

It has been demonstrated through this research that inadequate flow of funds strangulates the panchayats. Appropriate devolution of funds has been already witnessed in some states, the center should ensure that other states should also devolve appropriate funds to their panchayats.

9. Ensure that panchayats or local health centers are not over-funded

Providing funds to panchayats, which is beyond their management capacity, should be avoided. Also there must be synchronization between the resources and responsibilities. It has been noticed that the health centers under the State health system project of the World Bank are given huge funds. These funds will not be available to them beyond the project period and it will be difficult for them to sustain the institutions that have been created.

10. Scrutinize if the panchayats are ready to take loans directly for the World Bank:

The World Bank is contemplating to fund the local institutions directly. Assuming that the Bank will choose to fund only those local institutions which have the requisite capacity, the government on its part should support these institutions specifically by training them to handle the new responsibility.

11. Provide safety nets for backward regions and people

Since decentralization is adapted concurrently with the SAP, the government should take measure to enable the poor regions and people to be on a level playing ground. However, it should be stringent lest those who do not need them use these benefits.

Administrative:

12. Undertake training programs for government employees

Moreover, India should undertake large-scale training of health personnel, civil servants and politicians at the central, state and local levels. The training should address the ideological, administrative, management and other relevant issues essential for rendering their services effectively. In a different context, PRA training for bureaucrats and rural people has been very effective in questioning the biases of the bureaucrats about the ability of rural people. Such exercises could be taken up to dispute the hierarchical value systems at different levels and promoting active participation among the community. Training sessions should address practical issues like demarcating the responsibilities of central, state, district and local level organizations; identifying the sectors in which each level of organizations can contribute;

locating area's on which they need training or support; exploring ways in which they can coordinate and contributing towards development of their area and people. Furthermore, specialized training programs for different sectors (health, education, sanitation, and drinking water) should be undertaken. Moreover, training should be intensive, of high quality and recurrent.

13. Reduce bottlenecks and ensure smooth procedures

The Government of India is infamous for red-tapism and corruption and these characteristics have enhanced in some states after the adoption of decentralization. The center should reduce corruption and ensure smooth procedures.

5.5: Key Issues for Further Research

- Has constitutional amendments ushered in health system decentralization in India? Is the decentralization process thwarted by the elite and manipulated according to the wishes of the international development organization? Which are the states/regions who are succeeding in decentralizing and where have the efforts to decentralize failed? What are the factors that have contributed to the success and failure in both cases?

- How to make all stakeholders agreeable to decentralization? What is the motivation of the various stakeholders for decentralization? What are the central, state and local government's perspective on their role? What is the perspective of external actors such as the international donors and the local non-governmental organizations? What is the community's perspective on decentralization? What are the perspectives of relevant social groups or strata towards decentralization? Who are the social groups that are against decentralization? How are their grievances tackled? How far should decentralization go?

- What is the institutional capacity of organizations at various levels to influence decentralization and how can their capacity be strengthened? What is the capacity of the local people to influence local institutions? What is the capacity of local institutions in terms of implementing the decentralization process? What is the capacity of the central institutions in terms of planning and monitoring the decentralization process? What is the capacity of international organizations influencing the central and local government to accept their mandate? Do institutions at all levels genuinely participate in planning and implementing development projects? Are efforts made to raise the capacities of all the stakeholders to perform in a decentralized scenario? How can one maintain conceptual unity of the system while promoting decentralization? How to achieve coordination between the institutions at central, intermediate and peripheral levels? How can realistic standards and norms and adequate information systems established for proper monitoring and evaluation? How can evaluation be made a participatory process?

- What are the factors that disable or enable the community to participate effectively in local institutions? What is the implication of their participation on accessibility, affordability, quality and appropriateness of services provided? How can representations of the interest of all the stakeholders within the community be ensured? How can the public institutions and services be made accountable to the local people? How can self-esteem of the community be developed? How can the knowledge and skills of the community be raised to enable them to demand their rights? How can usurpation of power and resources by local elite be prevented? What are the decisions that should be left to the professionals and which should be under the community?

By way of conclusion, it has to be reiterated that the hierarchical systems (at national, international and local levels), which have been crystallized over the centuries, have to be challenged and the value system, which these systems have promoted, have to be denounced. Politically, regular free and fair elections have to be ensured; economically, appropriate devolution of resources has to be ascertained; Socially, inequities at international,

national and local level should be reduced; Culturally, the value system that favors hierarchy has to be denounced; Administratively, the benevolent policies should be implemented. Moreover, the local institutions and people have to be empowered to demand as a matter of right, access to education, health, power, resources, and social status. This has already been witnessed, to some extent, in Kerala and the challenge is to intensify and expand it to the entire nation.

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Appendix I

Health System in India

Through the years India has built an extensive health service system and has a network of institutions i.e. institutions for providing curative, preventive, promotive and rehabilitative services of various kinds; institutions for education and training of different categories of personal; institutions for generation of knowledge for basic research; institutions for formulation policies, plans and programs and their monitoring and evaluation; and institutions for financing the health service system.

Health is primarily a state responsibility. Center is responsible for health care in the Union Territories and jointly responsible for programs listed under the concurrent list. Center also has an important role in formulation and implementing a variety of disease control programs and the family welfare program. At the central level, there are two wings in the administrative structure i.e. Ministry of Health and Family Welfare. The former is an administrative wing and the latter is a technical wing. Both wings have the same status and report directly to the health Ministry. The administration of the Union Ministry of Health and Family Welfare is headed by a Secretary who is a generalist administrator and usually belong to the IAS. A specialist called Director General of health service helps the secretary. The office of DGHS is called an attached office of the ministry. The secretariat is responsible for the key functions of policy formulation, planning, personnel and financial administration. The Departments under him include Department of family welfare, Department of Health and Department of Indigenous system of medicine and homeopathy. Department of Reproductive and Child Health, area project, research, training, supplies and infrastructure development fall under the jurisdiction of department of family welfare. Department of health has two distinct wings, one is dealing with fourteen diseases, medical and nursing staff and their training and the second is concentrating solely by National Aids Control. Both the wings are headed by and Additional Secretary, who is assisted by other generalist administrators occupying different positions in the hierarchy- Joint Secretary, Directors, Deputy Secretaries, Under Secretaries and so on. The department of Family Welfare is distinguished by the fact that unlike the Department of Health, it does not have a separate office of specialist officers trained in various fields of family welfare. The specialist is placed under the direct control of the Additional Secretary, who is also designated as the Commissioner of Family Welfare. In addition to health care systems at national level there are health service systems at the state, district and the village level.

The same structure is found at state level. At the state level under the ministry of health and family welfare there is one technical directorate functioning under the director of health services, and one executive wing headed by Health Secretary, who is the overall administrative head. Facilities at district level include community health center, primary health care center and sub-centers. The secretaries of all the state comprise a Central Council of Health and Family Welfare Program (CCHFW), which is the primary advisory and policy making body for the health care in the country. The Central government's Planning Commission also has a health cell that supports CCHFW and also prepares plan-financed scheme for health care. At the level of each district within every state, there is a Chief Medical Officer (CMO) in charge of the rural non-hospital facilities; a District Medical Superintendent (DMS) in charge of the district hospital; and a District

Collector (DC) who is the overall head of the civil services in the region. Village guides and trained traditional birth attendants are perhaps the last link between the health service system and the community.

Central and the State governments together account for 20% of the total national health spending. Of this 75% is financed by the state and 25%[1] by the center. State finances primary health care facilities, hospitals, disease control programs and insurance. The center is largely concerned with family welfare program and also education and research. The budgets for the health sector are made during the planning of five-year plans. Budget has plan budget and unplanned budget and in the case of State it also has grants from the central government for the vertical programs which sometimes is based on the principle of matching grants, as in the case of malaria eradication program. Plan budget refers to all expenditures, both capital and recurrent, initiated for programs and schemes as designed n the five-year plans. Non-plan budget refers to salaries and other recurrent inputs. About 65% of the central health spending and 99% of FW spending is in the plan budget, whereas 86% of the state health spending is in the non-plan budget. This gives the MOHFW relatively more flexibility in designing their programs. In the nineties the center had to decrease the untied budget of the plan grants that it gives to the state and has further reduced the flexibility of the states. In the eighth plan a certain amount is given to the center to pay off the debts to the state for their inability to pay for the family welfare program. Local bodies did not have any financial authority and were mainly dependent on pre-determined specific purpose grants. One of the major program for the expansion of rural PHC within the state budget is that of a National Minimum Needs Program (NMNP). But due financial constraints it declined from 83% in the sixth plan (1980-85) to 73% in the seventh plan (1985-90). This would create problems in financing the recurrent cost of facilities already created and would impact the quantity and quality of care delivered by PHC. Private sector expenditure is India is estimated about 75% of total health spending. About 2/3rd is spend on ambulatory and outpatient services and 1/3rd on inpatient services. . Household expenditure accounts for 82% of curative primary care and 27% of the preventive/promotive care. The outlay of expenditure for secondary/tertiary/inpatient care by the center, state, third party and the private households is 2%, 22%, 6.4% and 70% respectively.

Total health spending (public and private) in India is 6% of their GDP and this amongst the highest levels in the developing countries. Out of this 47% is on curative care, 30% for preventive and promotive services, 7% for insurance for central government employees (ESIS) and organized industrial workers (CGHS); 9% for research, education and training; and 6.4% for physical infrastructure. Further, salaries and wages account for 62% of government health spending, non-salary maintenance for 20%, capital investments for 7% and transfer to local bodies (which also has salary components) is 11%. Primary health care services account for 58.7%, secondary/ tertiary for 38.8%and non-service for 2.5% of the total national spending (private and public). Of the total spending for primary health care, 85% is for curative care services. The outlays of the center, state and center for the preventive/promotive services are 44%, 29% and 15% respectively

[1] This could be one of the interest of the World Bank to have health system project at the state level. Also, the success of the project at the central level depend on the implementation in the state and sometimes also matching grants by the state.

Appendix- II

A NOTE ON PRIVATE HEALTH SECTOR IN INDIA

The private sector plays an important role in health care service system of India. The private health sector consists of non-profit sector (NGO and trust) and profit sector (individuals, clinics, nursing homes, hospitals, corporate hospitals etc). There is no firm data on number or private practitioners. The origins of private sector in India can be traced to seventeenth century when British private practitioners came for British and native gentlemen and the British have therafter encouraged the role of private sector (Baru., 1995). Though post independence the state have been ambiguous about its view on the private practice and had also not clarified how the private sector would be monitored, yet implicitly the state had tolerated, if not supported the growth of private sector. A couple of times when State tried to ban the private practice in some states but was rebuffed by the doctors (Baru, 1995). The state supports the private enterprises by maintaining law and order, special assistance on tariffs, fiscal concessions and other such incidences. The state provides subsidies in setting up private practice, hospitals, diagnostic centers, pharmaceutical manufacture, in terms of soft loans, subsidies, tax and custom duty waivers, income tax benefits etc. In addition the state finances majority of the medical education of the doctor, nurses and paramedical staff. Only recently the private sector has entered this domain. In the last budget the state has waived all duties on the import of medical technology and equipment. Concessions are also given to this sector to purchase land. In return the government expects the corporate hospitals to provide 25% free care to the economically weak section of society. In sum, the state is providing a lot of facilities and concessions to the private health sector with the view that this sector would provide social service to the people of the nation. A study undertaken by Dr Duggal on the bases of indirect extrapolations has estimated that " 11,25,000 practitioners registered with the medical councils in the country, and of these 125,000 are in government service". Though the actual figures may be debatable yet it is clear that private health care plays an important role in India despite the fact that large infrastructure and human resources are in the public domain. The number of private hospitals has increased rapidly from 14% in mid-seventies to 58% in 1993 and this period coincides with increasing number of medical technologies and specialist (Duggal, 1996). Moreover, the private health sector in India is expected to grow at the rate of 13 per cent in the next five years.

(A) Social Background of the Doctors: Many studies show that the doctors belong to upper and middle classes. A survey undertaken among 108 private doctors in Ahemdabad revealed that 46% of the health providers do not borrow to finance their capital investment, 19% use moderate debts and 35% use heavy debts.

(B) Brain Drain from the Public Sector: There is evidence to suggest that more than three-forth of the medical graduates join private institute or migrate abroad. The migration of doctors and a trend towards private practices has increased further in the post liberation years.

(C) Location of Health Services : As in 1996, 84% of the hospital beds in a survey were found in the urban areas (Bhat, R., Baru, 2000). Nadraj's (1996) sample of Satara district in Maharashtra also reveals that 83.87% of the private health practitioners in economically developed areas and 13.64% of the practitioners in the economically backward areas were based in urban sector.

(D) Quality of Health Care: Phadke in 1995 examined the use of irrational drugs and injections amongst doctors in the private sector and found that out of 633 prescriptions carried out form private clinics 28.5% were of irrational drugs, 9.6% of hazardous drugs, 45.7% were unnecessary drugs and 26.5% were unnecessary injections. A study undertaken by Ramesh Bhatt reported over-prescription of drugs or diagnosis, fee-splitting practices and inadequate measures for disposal of waste as the most prevalent unethical practices found in the private sector.

(E) Human Resources in Private Sector: Nagraj and Duggal (1996) also analysed the hospitals in terms of human resource. 39% of the hospitals were functioning without either a full-time or a visiting consultant. Out of the 19% of the hospitals that were run by doctor-owner alone, 29% of the hospitals were being run by doctors trained in other systems and in 10% they were operating alone. Besides 19 owner-doctors, only 27 doctors were available for full time basis i.e. no full time doctor was available on a shift basis. Only two hospitals had three qualified nurses between them, 14 hospitals did not have either qualified or unqualified nurses (Nagraj and Duggal, 1996). In a forthcoming study Baru et. al are exploring these issues and also the remuneration provided to nurses and para professionals in corporate hospitals and the initial findings have indicated that the situation is dismal (pers.com). This is because most of the private sector prefer to take up nurses who are trained as auxiliaries or train them on the job (Duggal, 1996). In yet another study it is evident that the doctors avoid hiring sufficient paramedical staff and hire untrained staff (Bhatt, R., 1999). Recent study in Hydrabad and Chennai being undertaken by Dr. Baru suggested that the CGHS referrals consists mainly of corporate sector and this scheme is exploited by the private sector which gives CGHS patients a lower priority, recommends unnecessary tests and do not keep proper records of the CGHS patients (Duggal et. al, 1996). This suggests for a need for private practitioners and hospitals to invest in accounting personnel.

(F) Facilities and Equipment: Nagraj and Duggal (1996) also analyzed hospitals in terms of hospital facilities. It was found that 82% of the hospitals were located near market place and the noise levels in 55% were disturbing. In 27% of the hospitals had a place for dispensary but the space provided was inadequate. The consulting room was found adequate only in 28% of the cases. Only 59% of them had washbasin and 49% did not have any water available in them. 65% of the hospitals did not have a screen or a curtain. The situation of the wards was even worse. It was found that the walls of the wards were bad, with insufficient light, ventilation, screens, cleanliness and most of the wards were highly congested. In 575 of the hospitals the distance between the two beds was less than 3 ft and 50% of the bed sheets and pillows were found to be dirty. Out of 49 hospitals only 36% was having facility of OT. In 13 hospitals there was no facilities for a labor room, the OT was used as labor room. In four hospitals facilities were present of only of labor room and were providing other medical services. In 11% of those who had facilities of OT the conditions were inadequate in terms of minimum requirement of space, proper OT table, shadowless lighting, cleanliness and organization. The finding reveal that basic equipment was not found in almost 50% of the hospitals. ECG monitor (which is a must for all hospitals) was found in only 10% of the cases, steriliser was available in 65%, oxygen cylinder in 52%, labor table in 74%. Some hospitals did not even have sufficient number of smaller

instruments such as needles, thermometer, dressing material, kidney trays, scalpel etc. Moreover basic cleanliness was not maintained with regard to equipment and instruments.

(G) Social Responsibility in Health Care: Dr. Shah studied the epidemic of plague of Surat in 1994 and analyzed who were the victims of plague, who got infected, who died and who got cured. He also analyzed the response to the crisis by private and public sector. Dr. Shah's study illustrates the lack of medical ethics amongst the private practitioners in the area. Majority of private practitioners and many doctors attached to the charitable public hospitals fled from the city. Amongst the private doctors who remained in the city, some kept their clinic closed for the first five days of the epidemic and the rest sent the patient to NCH without making preliminary examinations. Only five or six of the private practitioners conducted normal business. In contrast the doctors in public hospitals carried their duties with moral conviction and worked round the clock. It was observed that during a time of crisis neither the government nor the medical associations could prevent the private practitioners from closing shop, moving out from the city or report all deaths from their clinics. Dr. Shah's study also refers to the constraints within the public system to handle a crisis situation but this is of course beyond the scope of this paper.

(F) Corporate Private Health Care Sector: Heath services, especially in urban areas, are moving towards completely corporate, high technology driven, profit motivated corporate hospitals, popularly called five star health care corporations. It is pertinent to add that most of the promoters of these hospitals are from landed aristocracy and have other commercial interests in the country (Baru, 2000). The Indian government provides subsidies to corporate also and this is in addition to numerous financial concessions in terms of subsidized sale of land, reduced import duties and tax concessions for medical research. The government expects these hospitals to serve a certain number of in-patients and out-patient free of charge but like most of the areas non-compliance is rampant in this sector also (Baru, 2000). Such concessions seem meaningless because corporates charge at least double of that of nursing homes or trusts. With these rising costs and new conception of 'good health care' this has the potential for business for private insurance companies.

(I) Medical Technology and Pharmaceutical Industry: The pharmaceutical industry in India is very large and is able to cater to not only almost the entire demand for drugs in the country but is also emerging as a major exporter at the global level. The demand for high tech equipment from abroad is growing quickly. There was a steep rise in mid eighties, a slump in the nineties and sharp increase in 1997-98. The recent announcement of the government to slash the import duties on medical equipment may further increase the demand for imported technology. Many multinationals have already set up units for production of medical equipment and many others have collaborated with Indian countries to do the same. This can only be reversed when regulatory bodies become active and committed to the cause of quality and standards of care.

(J) Regulation of the Private Sector: The central and state governments have promulgated several legislations to regulate the private medical sector. These include Pharmacy Act, Drugs and Cosmetic Act, Drugs Control Act, Drugs Price order, Poisons Act, Consumer Protection Act, Indian Medical Council Act, Medical Termination of Pregnancy Act, Sex Determination Act, Nurses, Midwives and Health Visitors Act,

Public Nuisance Act, Minimum Wage Act etc. However most private doctors are not aware of the existence of all these acts and still fewer are aware of their objectives and abide by them (Bhatt, 1999).

The private sector is unregulated, unplanned and not accountable. The range of private service providers varies from unqualified or semi qualified quacks to highly qualified practitioners of different systems of medicine, many of who also indulge in quackery. The IMA should actively monitor the private practitioners and grade the clinics, nursing homes and hospitals. Doctors who are unqualified and practiced should be penalized and debarred from practice. The registration of the doctors should be renewed annually. Incentives and Disincentive should be evolved to send private sectors to under-served areas. More nurses and para-medical staff should be trained. Corporate Hospitals should be treated as industries and required to pay income tax or they should comply with the government orders for social service and should be rigorously monitored. It should be made mandatory for private practitioners and hospitals to maintain proper records. Importing medical technology should be made expensive for the private sector. Clear guidelines on physical structure, human resources, medical facilities and equipment should be issued, circulated and monitored by the state and heavy fines should be imposed on the defaulters. In sum, the private sector should be turned into a service industry and state should find ways to regulate it and work with it.

Appendix: 3

Box 1 : Heath Status in India and the Four States					
	India	**Andhra Pradesh**	**Karnataka**	**Punjab**	**West Bengal**
Population (millions in 1995)	919	66.5	47.9	20.3	72.4
Annual Growth Rate of Population	2.1	2.2	1.9	2.1	2.2
Crude Birth Rate	28.7	24.2	25.9	25.0	25.5
Infant Mortality Rate	78.5	70.4	65.4	53.7	75.3
Expectation of Life at Birth	60.6	59.1	62.1	66.6	62.0
Percentage of Currently Married Women 13-49 Using any Contraceptive Method	40.6	47.0	49.1	58.7	57.4
Pregnant Mothers Receiving Ante-natal Care	78.1	86.0	84.0	85.1	80.0

Source: World Bank, 1997, India: New Directions in Health Sector Development at State Level: An Operational Perspective, South Asian Department, pp 10

Appendix: 4

Cost Recovery in Medical and Public Health Services (Non-ESIS)
(in percent)

State	1975-76	1980-81	1984-85	1988-89	Average
15 Major States	6.4	4.1	3.04	1.6	3.8
Andhra Pradesh	2.9	3.4	3.8	0.8	2.7
Assam	3.9	3.5	-	1.6	2.2
Bihar	17.0	8.5	3.3	-	7.2
Gujarat	3.7	5.0	1.9	2.6	3.3
Haryana	6.4	3.9	7.7	1.5	4.9
Karnataka	11.0	3.2	2.7	6.6	5.9
Kerala	3.8	4.1	3.7	1.6	3.3
Madhya Pradesh	4.9	2.4	6.4	2.4	4.0
Maharashtra	12.9	3.5	1.7	1.7	5.0
Orissa	2.6	3.0	4.3	1.1	2.8
Punjab	15.6	5.6	4.3	5.4	7.7
Rajasthan	4.0	3.9	2.5	0.8	2.8
Tamil Nadu	4.0	9.5	3.2	1.6	4.6
Uttar Pradesh	5.3	1.9	1.3	0.5	2.3
West Bengal	2.2	2.1	2.1	-0.8	1.4

Source : Tulasidhar, 1992; p.85 cited in World Bank, 1997, India: New Directions in Health Sector Development at State Level: An Operational Perspective, South Asian Department

Appendix: 5

Decentralization Matrix - Scope for Change in Grassroots Administration in the Health Sector

Areas and Scope of Decentralization	Current Scenario	Proposed Scenario
Legislation	-	
Revenue raising	Limited in most states/dependent on state grants	Scope should be expanded
Policy making	Very little at the moment	Scope should be expanded
Regulation/Supervision	Varies from one state to another - at present weak to average	Large scope
Planning	Process has been set in motion - particularly in choice of location and construction of SC/PHCs	Should be given greater scope in some selected areas
Resource allocation	In some states, this is being done as part of the district planning exercise	Should have more freedom
Management - Personnel	Except recruitment, transfers outside districts, and punishment, PRIs are exercising control over the line dept. personnel	For effective implementation, vast powers to PRIs are needed for personnel related matters
Budget allocation	Most PRIs doing it	More needs to be done
Supplies/Equipment	Limited operations	Greater involvement/freedom to order (local procurement is more cost effective)
Property maintenance	Hardly any funds - thus limited operations	More funds - greater scope - PRIs to put more effort.
Intersectoral collaboration	At present very limited	Much greater need for best results
Interagency Collaboration	Reasonably good	Greater scope
Training	No sustained effort	Highly desirable

Source: World Bank, 1997, India: New Directions in Health Sector Development at State Level: An Operational Perspective, South Asian Department

Appendix: 6

State-wise Indicators of Health Infrastructure, Revenue Expenditure and Attainment : 1988-91

State	No. of Hospitals	No. of Hospital Beds	No. of Dispensaries	No. of Primary Health Centres	No. of Doctors	No. of Nursing Personnel	No. of Hospitals	No. of Dispensaries	No. of Primary Health Centres	Real per Capita expenditure on health	Infant Mortality Rate (1988-90)	Life Expectancy
	Per 1 lakh population					Per 100 sq. km.						(Years)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Andhra Pradesh	0.93	55.76	1.2	1.93	44.1	59.64	0.22	0.29	0.47	34.01	78	60.64
Assam	0.91	62.79	1.42	1.97	44.04	31.71	0.26	0.41	0.56	44.65	89	55.47
Bihar	0.35	32.43	0.49	2.32	27.16	26.83	0.17	0.25	1.15	18.71	88	57.63
Gujarat	3.8	123.86	14.23	1.71	46.57	42.79	0.8	2.99	0.36	37.24	83	59.86
Haryana	0.47	49.03	1.31	2.24	0.39	45.23	0.17	0.48	0.82	40.18	80	60.3
Karnataka	0.64	78.11	2.31	2.53	59.64	82.96	0.15	0.54	0.59	34.53	75	60.6
Madhya Pradesh	0.55	33.26	0.55	1.79	12.89	51.71	0.08	0.08	0.27	36.16	116	55.5
Maharashtra	2.39	120.64	11.6	2.09	52.11	101.93	0.61	2.97	0.53	43.70	62	63.11
Orissa	0.91	44.43	0.63	2.93	31.31	24.91	0.18	0.13	0.59	28.67	122	56.15
Punjab	1.31	108.96	7.76	10.08	121.91	240.26	0.53	3.11	4.04	51.71	61	65.46
Rajasthan	0.61	50.14	2.2	2.39	26.46	49.04	0.08	0.28	0.31	42.81	94	58.22
Tamil Nadu	0.73	88.07	0.92	2.49	71.93	127.25	0.31	0.39	1.07	44.11	70	60.83
Uttar Pradesh	0.53	38.12	1.26	2.23	21.13	25.47	0.25	0.59	1.05	28.17	113	52.03
West Bengal	0.6	79.43	0.81	2.26	56.98	56.57	0.46	0.62	1.73	33.44	70	59.75

Source: Prabhu, K.S., and Radha, A, 1995, Recent trends in Heath Financing in India, AISSI, Vol. 14, No. 1 & 2: PP 52

Appendix: 7

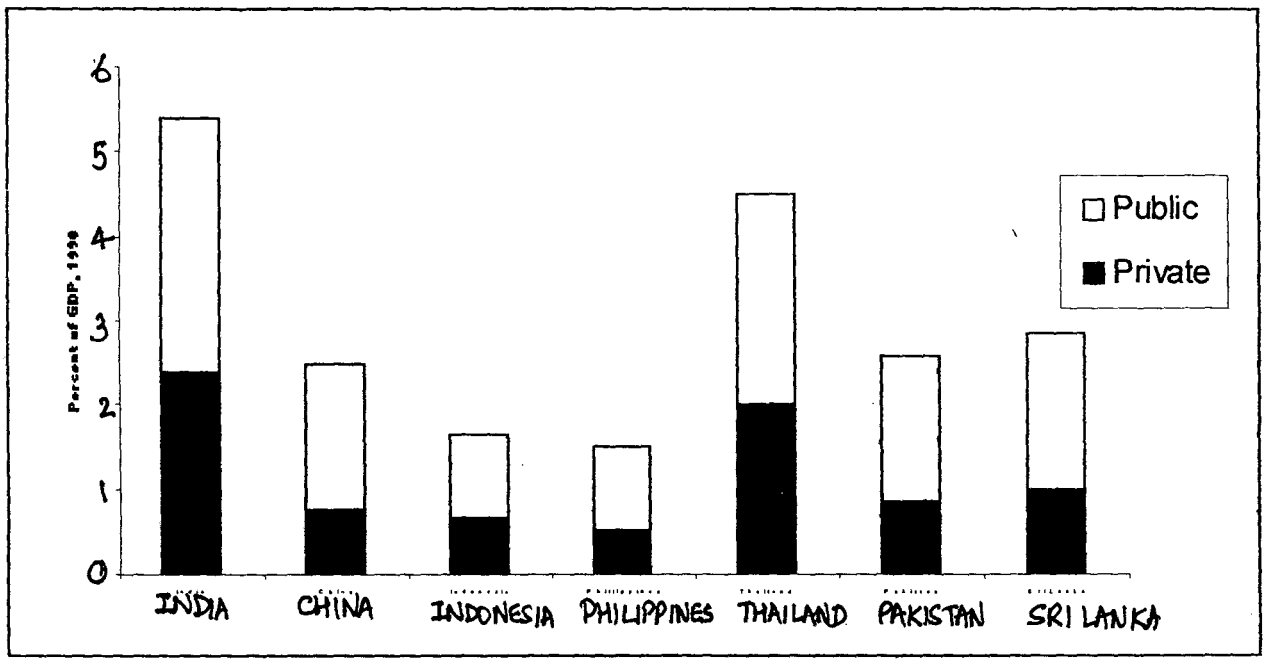
Statewise Details of Budgetary Subsidies in Health Sector : 1987-88

States	Share of Total Subsidy (%)	Recovery Rate (%)	Per Capita Subsidy (Rs.)
Andhra Pradesh	9.73	1.37	112.08
Bihar	9.08	1.99	96.76
Gujarat	7.05	3.73	149.28
Haryana	8.16	1.16	144.32
Karnataka	10.53	2.38	132.24
Kerala	11.61	2.81	178.13
Madhya Pradesh	9.21	3.74	88.65
Maharashtra	11.39	1.72	147.13
Orissa	9.12	0.41	98.23
Punjab	9.28	2.30	176.40
Rajasthan	9.06	0.76	116.33
Tamil Nadu	8.56	8.87	121.66
Uttar Pradesh	10.91	3.21	74.42
West Bengal	11.84	1.27	116.32
All States	9.83	2.74	

Source : Tulasidhar, 1996

Appendix: 8

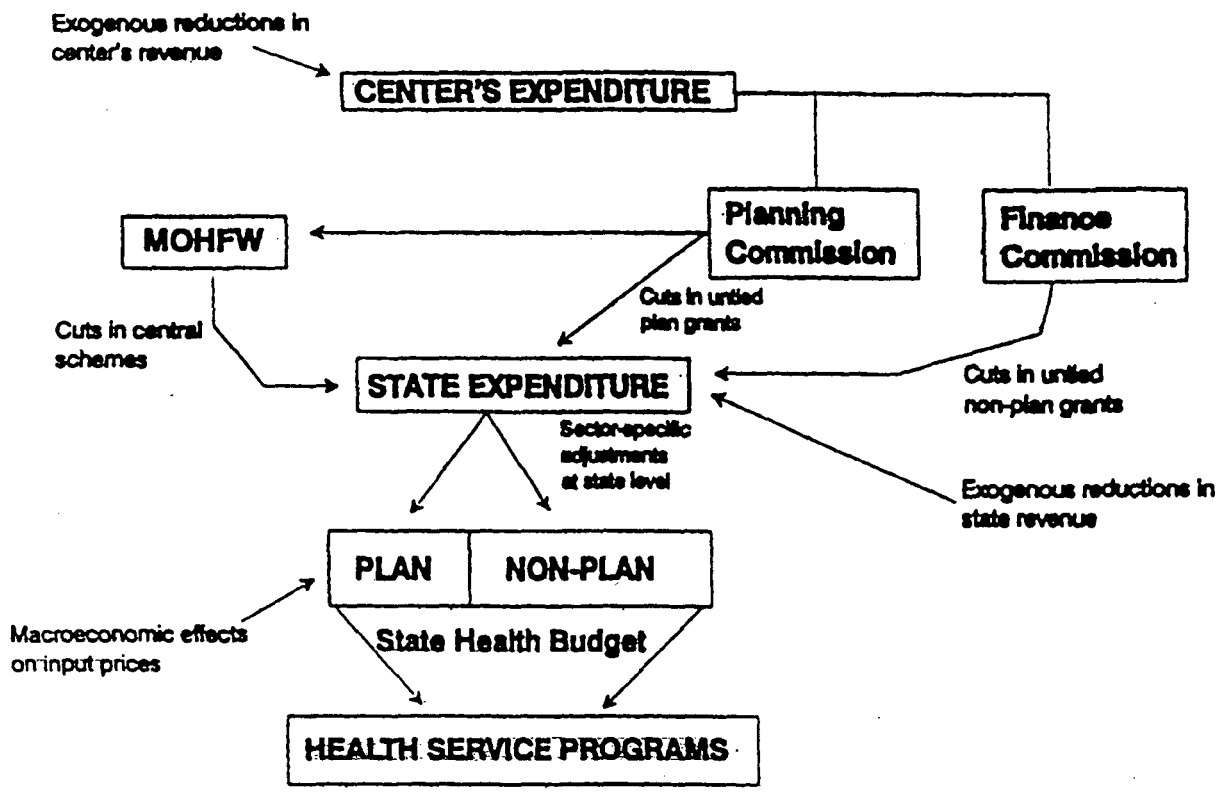
Health Expenditure as a Percent of GDP : Asian Countries (1990)



Source : WDR 1993, Table A 9

Appendix: 9

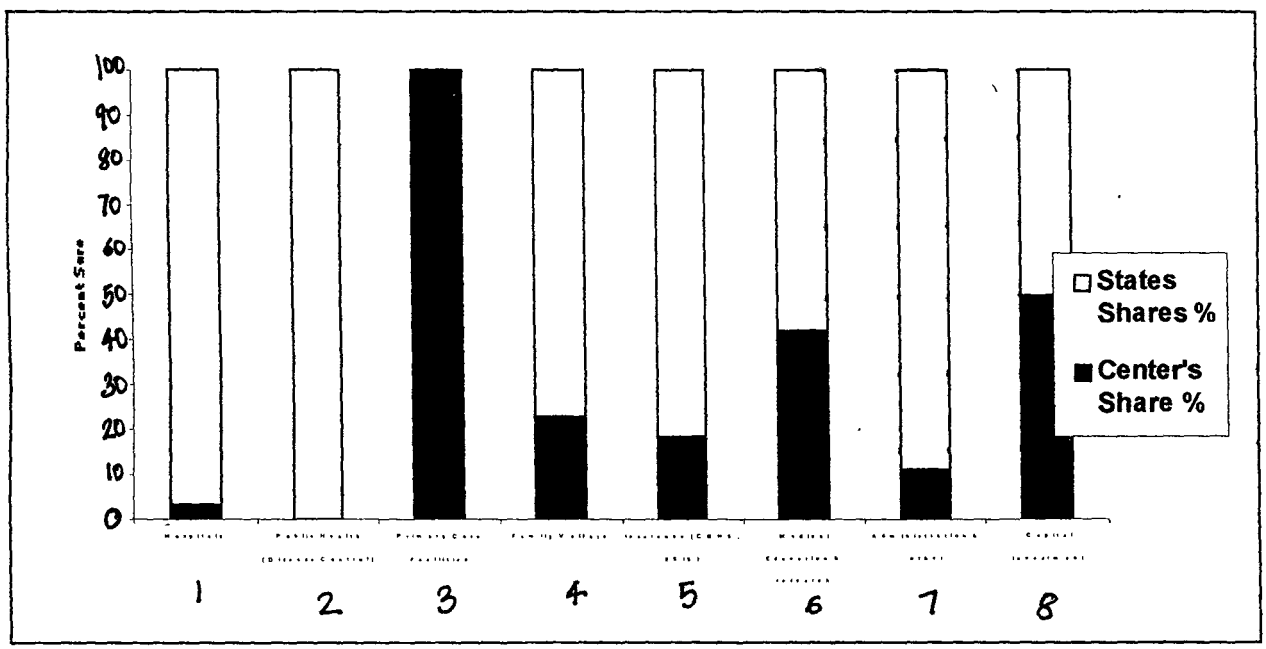
Channels Through Which Structural Adjustment Affects Health Spending



Source: *World Bank, 1995,* India: Policy and Finance Strategies for Strengthening Primary Health Care Services, *Report No. 1304-IN, Washington D.C., World Bank*

Appendix: 10

Center and State Shares in Different Components of Government Health Budget (1991-92)



	Center's Share %	States' Share %
1 Hospitals	3.1	96.9
2 Public Health (Disease Control)	0	100
3 Primary Care Facilities	99.7	0.3
4 Family Welfare	22.6	77.4
5 Insurance (CGHS, ESIS)	18.2	81.8
6 Medical Education & research	41.7	58.3
7 Administration & other	11	89
8 Capital Investment	49.7	50.3

Source: World Bank, 1995, **India: Policy and Finance Strategies for Strengthening Primary Health Care Services**, Report No. 1304-IN, Washington D.C., World Bank

Appendix: 11

The Structure of Government Health Financing

Source: World Bank, 1995, India: Policy and Finance Strategies for Strengthening Primary Health Care Services, *Report No. 1304-IN, Washington D.C., World Bank*