THE ROLE OF GLOBAL PARTNERS IN HEALTH SYSTEMS STRENGTHENING IN INDIA POST 1990s

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LIST OF ABBREVIATIONS

Abbreviation	Stands For
ANM	Auxiliary Nurse Midwife
AP	Andhra Pradesh
APAC	AIDS Prevention and Control
APER	APER Primary Health Project
APVVP	Andhra Pradesh Vaidya Vidhana Parishad
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homoeopathy
BCG	Bacillus Calmette-Guérin
BMGF	Bill and Melinda Gates Foundation
BPL	Below Poverty Line
CBHI	Community Based Health Insurance
CBO	Community Based Organisations
CHC	Community Health Centre
CHW	Community Health Workers
CIFF	Children's Investment Fund Foundation
COVID-19	Corona Virus
CPS	Country Programme Strategy
CSO	Civil Society Organisation
CSSM	Child Survival and Safe Motherhood
CTF	Common Treatment Facilities
DALY	Disability-Adjusted Life Year's
DANIDA	Danish International Development Agency
DAP	District Action Plans
DDT	Dichlorodiphenyltrichloroethane
DHS	Directorate of Health Services
DMC	District Management Committees
DoHFW	Department of Health and Family Welfare
EC	European Commission
ECOSOC	Economic and Social Council
EMTC	Equipment Maintenance Training Centres
EU	European Union
FAO	Food and Agriculture Organisation of the United Nations
GAIN	Global Alliance for improved nutrition
GATT	General Agreement on Tariffs and Trade
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFATM	Global Fund against AIDS, TB, Malaria

GHE	Government Health Expenditure
GHG	Global Health Governance
GHI	Global Health Initiatives
GIA	Grants-in-aid
GoI	Government of India
GTZ	German Agency for Technical Cooperation
HAC	Hospital Advisory Committees
HEMR	Health Equipment Maintenance and Repair
HFWSD	Health and Family Welfare Development Programme
HLEG	High-Level Expert Group
HNP	Health, Nutrition, and Population
HSR	Health Sector Reforms
HSS	Health Systems Strengthening
HVC	Hospital Visiting Committee
IAVI	International AIDS Vaccine Initiative
IBRD	International Bank for Reconstruction and Development
ICSID	International Centre for Settlement of Investment Disputes
IDA	International Development Association
IEC	Information, Education and Communication
IFC	International Finance Corporation
IFFI	The Vaccine Bonds Programme
IFPS	Innovations in Family Planning Services
IHG	Innovations in Family Planning Services
ILO	International Labour Organisation
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPP	India Population Projects
IR	International Relation
ISR	International Sanitary Regulations
ITSU	Immunisation Technical Support Unit
IUD	Intrauterine device
JH	Jharkhand
JICA	Japan International Cooperation Agency
JSI	John Snow Incorporation
KMDA	Kolkata Metropolitan Development Authority
LMIC	Low- and Middle-income countries
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MDR-TB	Multi-Drug-Resistant Tuberculosis
MDT	Multi-Drug Treatment
MERS	Middle East Respiratory Syndrome

MHCS	Mobile Health Care Services
MIGA	Multilateral Investment Guarantee Agency
MMJRK	Mukhya Mantri Jeevan Raksha Kosh
MoHFW	Ministry of Health and Family Welfare
MP	Madhya Pradesh
MPHSRP	Madhya Pradesh Health Sector Reform Programme
NACO	Health Sector Reform Programme
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NIPI	Norway-India Partnership Initiative
NITI Aayog	National Institution for Transforming India
NORAD	North American Aerospace Defence Command
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, CVDs and Stroke
NPSP	National Polio Surveillance Project
NRHM	National Rural Health Mission
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OED	Operations Evaluation Department
OHSP	Odisha Health Sector Plan
OPEC	Organisation of the Petroleum Exporting Countries
PAHO	Pan American Health Organisation
PDP	Product development partnerships
PEPFAR	President's Emergency Plan for AIDS Relief
PGB	Project governing board
PHC	Primary Health Care
PHSC	Punjab Health System Corporation
PIP	Programme Implementation Plans
PLWHA	People Living with HIV/AIDS
PMC	Project Management Committee
PMI	President's Malaria Initiative
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPP	Private-Public Partnerships
PRI	Panchayati Raj Institutions
RCH	Reproductive and Child Health
RDI	Research Development Institute
RF	Rockefeller Foundation
RI	Routine Immunisation
RIHFW	Regional Institutes of Health and Family Welfare
RKS	Rogi Kalyan Samitis
RSBY	Rashtriya Swasthya Bima Yojana
SACS	State AIDS Control Societies

SAP	State Action Plans
SARS	Severe Acute Respiratory Syndrome
SAST	Suvarna Arogya Suraksha Trust
SC	Strategic Cell
SC	Scheduled Caste
SIDA	Swedish International Development Cooperation Agency
SIFHFW	State Institutes of Health and Family Welfare
SIFPSA	State Innovations in Family Planning Services Project Agency
SPC	Strategic Planning Cell
SPHC	Selective Primary Health Care
SSA	Sarva Shiksha Abhiyan
ST	Scheduled Tribe
STCI	Standards for TB Care in India
SWAP	sector-wide approach
TB	Tuberculosis
THE	Total Health Expenditure
TNC	Trans-national corporations
TNIP	Tamil Nadu Integrated Nutrition project
TOR	Terms of Reference
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
U.K.	Uttarakhand
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organisation
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
UNSDF	United Nations Sustainable Development Framework
UP	Uttar Pradesh
USA	United States of America
USAID	United States Agency for International Development
USD	United States Dollar
VAS	Vajpayee Arogyashree Scheme
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation
WHR	World Health Report
ZSS	Zilla Swasthya Samiti

INTRODUCTION

CONTEXT

The current Corona virus (COVID-19) pandemic has once again (like the other epidemics of Ebola, Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS)) brought the attention to the importance of strong and resilient health systems in managing an unforeseen crisis. Countries with strong health systems have always been able to respond better than countries with fragile health systems in meeting the health needs of the people in routine as well as in times of health emergencies.

With the increasing frequency of epidemics, fast transmission of diseases from one country to another, and the failure of disease-specific initiatives in the past, strengthening of health systems has gained more attention and Health systems strengthening (HSS) has become a buzzword or a one-stop-solution for improving the health status of the populations around the world. As evidenced even during the current pandemic, most solutions to the health crisis are pointed towards building strong and resilient health systems. Though the importance of HSS has been much discussed especially in the last three decades, conceptual clarity about HSS, its meaning, constituents and approaches is still being debated.

Last two decades have seen a growing consensus around the larger goal of HSS to improving health outcomes, however, various socio-economic, political, environmental and demographic determinants of health have not been analysed adequately in terms of their role in HSS. As a result, healthcare or health service systems continue to enjoy the centre place in the HSS domain. So much so that health care or health services systems are often used interchangeably with health systems [1].

India has been no different in following this suit of giving primacy to health services in strengthening health systems, by mere acknowledging but not sufficiently engaging with all

[1] Researcher does not agree with the use of the terms health care system, health service systems synonymously with health systems and treat health systems to be broader social systems but because of the interchangeability of these terms in the literature referred in this study, health systems is used as synonymous with health services systems.

important elements of health. As a result, in the last seventy years since independence, India has made not so impressive gains in impqroving the health of its people. It stands at 191th position out of 201 countries in terms of female to male ratio ("World Population Prospects - Population Division - United Nations," n.d.)[2] and ranks twelfth among fifty-two low- and middle-income countries contributing to the highest Infant Mortality Rate (IMR), witnessing thirty-two infants deaths each year out of every 1000 live births[3] (ICMR et al., 2017 p.1). There are huge interstate differences in health status of the populations which are often masked by the average country wide figures[4].

India's health challenges are growing as it is facing an epidemiological transition, having Non-Communicable Diseases (NCDs) as the leading causes of death[5] (ICMR et al., 2017 p.1). As discussed above, there are several metabolic, environmental and behavioural factors which contribute to the mortality and morbidity burdens in India. Malnutrition, dietary risks and air pollution are top three factors associated with NCDs' disease burden in 2017 (ICMR et al., 2017). These factors confirm that major risk factors fall outside health systems and arise from socio-economic and environment determinants of health.

Major health improvement strategies in India since independence have narrowly focused on improving the health systems with an over-emphasis on health services delivery. Resultantly, major HSS policies in India have focused on increasing resources like finances, infrastructure, drugs, finances for improving health service delivery; and by initiating reforms to maximise the benefit from these resources. Such reforms consisted of decentralisation of health care delivery services; restructuring national health agencies; creation of autonomous health societies under national disease programmes, limiting the role of State in provisioning of services; promotion of

[2] Sex ratio for India fell to 930 women for 1000 men in the year 2013 falling from 972 women for 1000 men in 1901 ("World Population Prospects - Population Division - United Nations," n.d.)

[3] performing worse than Sri Lanka (127), Bangladesh (54), Nepal (50) and Bhutan (60) (Indian Council of Medical Research et al., 2017 p.1).

[4] For example, the India- state-level disease burden study by Indian Council of Medical Research in 2017 noted that the all India figures show an overall improvement in 'Life expectancy at birth' from 59.7 years in 1990 to 70.3 years in 2016 for females, and from 58.3 years to 66.9 years for males, it varies between the range of 66.8 years in Uttar Pradesh to 78.7 years in Kerala for females, and from 63.6 years in Assam to 73.8 years in Kerala for males in 2016. Similarly, the per person disease burden measured as DALY rate dropped by thirty six percent from 1990 to 2016 in India, but there was an almost two-fold difference in this disease burden rate between the states in 2016, with Assam, Uttar Pradesh, and Chhattisgarh having the highest rates, and Kerala and Goa the lowest rates. The under-five mortality rate has reduced substantially from 1990 in all states, but a four-fold difference in this rate was observed being the highest in Assam and Uttar Pradesh as compared with the lowest in Kerala in 2016(Indian Council of Medical Research et al., 2017 p.1).

[5] Comparing the major causes of death in past decade, from 2007-2017, among the NCDs, Ischemic heart disease stood as number one cause of mortality, Chronic Obstructive Pulmonary Disease (COPD) reached to second position from third, stroke has become the third leading cause of death in comparison to it being sixth in 2007.

private sector engagement in public health; and promotion of alternate health financing mechanisms.

Though these health systems policies have been largely shaped by the State, HSS policies like other social policies have been co-produced by a wide range of national and international non-State (not a part of government) and non-health (whose primary interest are not improving health) actors. In the past three decades, with the growing commitment from global health institutions to invest in strengthening health systems in Low- and Middle-income countries (LMICs), India has seen an upsurge in the participation of global institutions in HSS policies in India. These global institutions (also known as global health partners or global health actors) include but are not limited to Multilateral and Bilateral agencies, Development Banks, philanthropies, private foundations, international policy think tanks, universities, research institutions as well as global public-private partnerships. As HSS policies involve different actors, a wide variety of ideas are promoted and negotiated by the range of actors. Development aid agencies (also known as development partners) have been particularly reported to diffuse HSS ideas and interventions to influence and in few cases distort national health priorities by pushing certain diseases and governance reforms on national health agenda (Ollila, 2005) and (Ravishankar et al., 2009).

Though there is clear evidence of global actors' influence in shaping national policies in aid-dependent countries, influence on countries which do not receive a substantial amount of funding from external actors has also been observed (Sridhar and Gomez, 2011). This influence is evident from a number of studies, commissioned from time to time to understand the impact of the HSS interventions supported by these actors globally (Khan et al., 2018),(Okuonzi and Macrae, 1995)and(Rutkowski, 2007). However, these studies have mostly focused on one or more components or functions of health systems like service delivery, human resource, financing, drugs and equipment (Warren et al., 2013) and (Marchal et al., 2009). Issues of coordination and harmonisation between different global actors in strengthening health systems in the aid recipient countries have also been addressed by others (Balabanova et al., 2010). Yet, the involvement of global actors in HSS policies at the country level is under-studied.

In India's case, 1990s marked an important evolution in the involvement of global actors in HSS policies in India. Three major shifts in HSS policy-making in India took place during this period. First was the addition of decentralisation amendments to the Indian Constitution which facilitated

the direct involvement of global actors (which till now was only limited to the federal government) in State-level policy-making. Secondly, there was a sudden decline in Church funding which prompted Christian missionaries to seek funds from other organisations and government. This resulted in increased involvement of Community Based Organisations (CBOs) in policy-making [6] as there was an implied preference of donor community to work with the NGOs. Thirdly and the most importantly this was the period in which the structural adjustment reforms were initiated in India. reforms in India. These reforms were manifested by policy-based funding from the World Bank which gave global actors like Bank an added advantage in steering HSS policies.

The increasing participation of global actors post these reforms have distorted India's national priorities by contributing only 1.6–2% of total health sector financing in India (Sridhar and Gomez, 2011). However, the evidence on the process through which these actors influence in these policies remains weak. Past studies on global actors' engagement in HSS polices is limited in their focus on the 'content' of the policies that is evaluations of projects supported by global actors highlighting the positive and negative implications of specific global health actors' initiatives and engagement. Such studies include one or sometimes more than one health systems project or components of health systems including evaluation of health projects of one global actor (Ravindran, 2007), analysis of patterns of health sector aid in India (Jeffery, 1986), examining extent of utilisation of external funds and problems associated with utilisation (Gupta and Gumber, 2002), and tracing the interests of philanthropies working in India[7] (Gordon, 1997).

The scarcity of country level studies on the role of global actors in health systems strengthening initiatives in India is located in the following methodological challenges in studying health systems strengthening landscape. First and most important challenge is the prevailing ambiguities around defining health systems strengthening and its components (World Health Organisation, 2007; Marchal et al., 2009 ;Reich and Takemi, 2009;Van Olmen et al., 2012; Hafner and Shiffman, 2012; Chee et al., 2013). Given the multiple meanings of health systems strengthening, country wide studies have approached HSS from varied and often asymmetrical dimensions focusing on either selected component(s) or function(s) of health systems often at (State) sub -national or (District) sub-sub national level. Secondly, the involvement of range of stakeholders including State (at

[6] in the 1990s, Indian government quadrupled the amount of money it allocated to NGOs(Keeley, 2012 p.58).

[7] This work is not focused on the role of philanthropies in health sector in India but on a larger (evolving) mandate of these organisations.

national, State and local level) and non-State (national and international) actors in designing and implementing HSS initiatives makes it difficult to hold one actor accountable for the final policy and its impact. Lastly, as the policy-making (and implementation) is dependent on the wider context of policy path dependency[8], socio-economic, political and structural changes taking place in the overall policy domain, it is difficult to delineate the context from the actors and hold actors responsible for policy outcomes and impacts.

STUDY AIM AND RESEARCH QUESTIONS:

This study aims to conduct a 'country level' analysis of global actors' participation in health policy making, post 1990, focusing on understanding the HSS ideas and the process used by global health actors in diffusing and negotiating HSS ideas in the health policy networks. It aims to uncover the range of actors involved in health systems strengthening policies in India, and studies one these actors that is the World Bank in detail, situating the analysis in an overarching network and relation-based health governance framework.

Broad research question guiding this study is:

> Which global actors participate in HSS policies in India? How do they participate in these policies and what contextual factors enable their participation in these policies?

Broad objective of this research is:

> To study the range of global actors engaged in HSS policies, key HSS ideas diffused by these actors, key strategies adopted by these actors for participating in HSS policies and the broad political and economic environment which enables these actors to participate in HSS policies in India post 1990.

This study is designed as a policy research aiming to understand the process of policy formulation by engaging with the four broad questions below.

- Which global actors have participated in HSS policies in India post 1990?
- What HSS ideas have been diffused by global actors in India post 1990?

[8] path dependence is a situation where the present policy choice is constrained or shaped by institutional paths that result from choices made in the past.

— Which political, economic and public administrative contextual factors has enabled global actors' participation in HSS policies in India post 1990?
— What methods and tools are used by global actors to participate in HSS policies in India post 1990?

This study is designed as a policy research and uses Walt and Gilson's 'policy-triangle' framework to analyses the role of global actors in HSS policies. Policy-triangle approach draws from the political economy frameworks of analysis and incorporates four main concepts of policy that is context, process, actors and content (Walt and Gilson, 1994).Case study approach is used as a method for this analysis (Yin, 2009). A landscape analysis of global actors' participation in HSS policies in India is done in the first part of the study followed by an embedded case study on the World Bank focusing on the HSS ideas diffused by the Bank and the processes used by the Bank to participate in HSS policies.

World Bank is chosen as the embedded case for studying the ideas and process of participation of global actors in HSS policies as it emerged as one of the most influential global actors during the landscape analysis of global actors in HSS in India. The following attributes of the World Bank makes it an important actor to be studied in detail. Firstly, it is the only actor involved in giving policy-based funding to India. Secondly, it is one of the oldest donors in India after the philanthropies. Thirdly, it emerged as the largest donor in health sector in India in 1980s and fourthly, it continues to play an important role in health sector governance reforms in India since 1990s.

STRUCTURE OF THE THESIS

Chapter one titled as 'Global actors and Health system strengthening in India', engages with the theoretical aims of this research to examine the concept and different approaches to understand health systems, health systems strengthening and global actors in health. It argues that the existing discourse on HSS fails to adequately capture the most important feature of HSS that is governance. It then proposes governance as the cornerstone of HSS and a useful tool to examine HSS policies. It stresses on the narrow conceptualisation of governance in health systems discourse as a function of health systems and proposes the network-based, relationship-oriented discourse on governance in health systems to examine the role of different actors in shaping HSS policies. This chapter then

reviews various methodological approaches to study global actors and their role in influencing policies and argues that a policy analysis framework which focuses on a process-oriented analysis (than an actor-oriented analysis) is best suited to this study and proposes an embedded case study approach to be applied in this research.

Chapter two 'Research approach and methods' presents the operational HSS framework for this research and discusses the methodological approach to study the role of global actors in HSS policies. This chapter outlines policy-triangle' as the policy analysis framework and elaborates the various components of policy under study including: actors, content, context and processes. Using the proposed governance framework, it then substantiates the focus of this research on 'ideas' and 'process' component of the policy by taking the case of the World Bank. This section concludes with a detailed methodology adopted for this study including a discussion on data collection, analysis, limitations and challenges encountered in carrying out this research.

Chapter three 'Landscape analysis of global actors in health in India' presents a broad overview of global actors' participation in HSS policies in India. It gives a timeline analysis of major actors, dominant ideas of HSS diffused by them and processes used by these actors to diffuse these ideas of HSS. Using the HSS framework it outlines the broad shifts in the prominence of major global actors in the HSS domain, shifts in ideas from mere increase in resources to reforms in HSS processes and highlights that governance mechanisms are inherent in these ideas of HSS. This chapter also outlines the tools and mechanisms used by the different actors and the shifts in these strategies used by global actors over time moving from mere increase in resources to a growing involvement of global actors in processes like administrative reforms, decentralisation, multi-sectoral action, innovative financing, community engagement and integration of health systems.

Chapters four, five and six focus on the embedded case of World Bank and engages with all four objectives of the study.

Chapter four engages with first and second objective of the study which focuses on the 'actor' and 'context' component of the policy analysis. It analyses the World Bank as an institution, outlining its inception, structure, overall philosophy and approach for engaging with health systems globally and in India. Next section of this chapter examines the broad contextual factors which enabled the Bank to participate in HSS policies in India. This section examines the enabling factors for

increased role of Bank in HSS policies including the political and economic context; administrative structures and civil services reforms; and personal interest of key policy stakeholders.

Chapter five engages with the third objective on the 'content' of HSS policy. It examines the major HSS ideas produced, diffused and legitimised by the Bank. Using the HSS analytical framework described in chapter two, this chapter presents the ideas by locating them in Bank's health sector projects and technical assistance work. It analyses HSS ideas under the categories of increasing resources (like drugs, equipment, infrastructure and human resource) and improving processes (like administrative reforms, integration of health services, community engagement and multisectoral action).

Chapter six engages with the fourth objective of the study and analyses the processes used by the Bank for participating in HSS policies. This chapter suggests an analytical framework for studying the role of global actors in shaping HSS policies using a governance framework based on a network-based conceptualisation of governance. It examines these processes at the normative level in shaping macro-level HSS policies for national and international health system reforms and at the operational level of governance in terms of implementation of HSS policies. In examines the Bank's role in health governance by studying governance as a function of the health systems as well as the ways in which governance is co-produced by policy networks.

Last section of this thesis brings different parts of the study together and discusses the implications and contributions of the study. It summarises the major findings of the thesis and discusses the theoretical and the policy implications of the study findings. This section also presents the major contributions of the study and concludes with identifying the areas for future research in this domain.

CHAPTER 1

GLOBAL ACTORS AND HEALTH SYSTEMS STRENGTHENING – A REVIEW OF LITERATURE

INTRODUCTION

Health systems strengthening in the past two decades have gained a lot of attention from the global actors in health (Hafner and Shiffman, 2012). Several Global Health Initiatives are focusing on HSS (Reich and Takemi, 2009), including the specific diseases initiatives like the Global Alliance for Vaccines and Immunisations (GAVI) and the Global Fund for AIDS, tuberculosis and malaria (GFATM) established in 2002 (Warren et al., 2013). Providing Development Aid for Health (DAH)[9] has been one of main channels used by global actors in directing their efforts in the domain of HSS. This chapter will provide a background to the overall participation of global actors in HSS policies. This will be done by reviewing the existing literature on various aspects of involvement of global actors' in HSS policies starting with deconstructing the concept of health systems, health systems strengthening, and outlining the significance of global actors as important stakeholders in health governance. This chapter will conclude with analysing the existing methodological approaches to study global actors' role in HSS policies and highlight key gaps in the literature, which leads to the conceptualisation of this thesis.

1.1 UNDERSTANDING HEALTH SYSTEMS:

The concept of health system has been approached from different disciplines but most of the work on understanding health systems has come from the disciplines of economics and sociology.

[9] Development aid for health is defined as all flows for health from public and private institutions whose primary purpose is to provide development assistance to low-income and middle-income countries (Ravishankar et al., 2009).

1.1.1 Health systems frameworks

McPake et al. (2013) suggests economics is concerned with the allocation of resources between competing demands and an economic framework in health helps in analysing best ways through which health benefits can be achieved within minimum costs. Earlier health systems frameworks developed by economists have conceptualised health system as markets focusing on the financing and payment for health insurance services (Feldstein, et al., 1972)and (Feldstein, and Friedman, 1976), sometimes focusing on human resources (Yett et al., 1972) and other times on financing and fund flow (Hurst, 1991) as two important sub-systems of the health systems. Health system in these frameworks has been conceptualised as health services system and in few cases only restricted to hospital care or insurance.

Evans (1981) and Frenk (1994) give an actor- oriented conceptualisation of health systems. Evans (1981) in his famous 'actors framework' gave the concept of transactors[10] emphasising the transactional relationship between consumer and supplier in health care market. Frenk (1994) builds on this framework and defines health system as set of relationships among five major groups of actors: the health care providers, the population, the State as a collective mediator, the organisations that generate resources, and the other sectors that produce services with health effects.

Sociologists have conceptualised health systems as a sub-system of society (like other sub-systems including education, welfare and communication) discussing health system at a macro sociological level emphasising its evolutionary, dynamic, relevant and comparative characteristics (Field, 1973 p.768). Sociologists have also described health systems a social activity for the provision of health services and cautioned that it does not imply that health services are the only or even the major determinant of an individual's or a population's health (Roemer, 1993).

1.1.2 Governance at the centre of health systems performance

Regardless of the disciplinary affiliation, there has been a constant pursuit for improving the functioning of health systems in the health systems frameworks and in the larger discourse on

[10] The transactors mentioned in this framework were i) consumers, ii) first line providers contacted directly by consumers like hospitals, drug manufacturers, equipment makers etc., iii) second line providers whose output is either used by consumers under direction of first line providers or is supplied as intermediate products to first line or other second line providers , iv) governments and suppliers of insurance or purchasers of risk associated with health care use(Evans, 1981 p.330).

understanding health systems. Comparative studies (comparing the performance of health system in one country with the other) of governance mechanism of health system have in most cases generated the knowledge and suggestions for improving health systems performance around the world till 1990s. Scholars of economics, medicine, and public health though varied slightly in their conceptualisation of health systems, used the strategy of comparing the existing governance mechanisms in different health systems to guide these health systems improvements or strengthening policies.

For example, Roemer, who was a sociologist distinguished three ideal types of health systems: first is a welfare-oriented or mandated health systems where a mandated insurance is imposed on all workers, second is an entrepreneurial health system which relies on the prevalence of the private sector to provide health care insurance and delivery and third is a comprehensive type in which health care coverage takes the form of a universal health insurance that covers all citizens or residents of a country and are financed through progressive taxes (Roemer, 1993 p.696).[11].

Julio Frenk, who was a Mexican physician trained in public health emphasised on the anchoring role of governance in health systems improvements operating at " four policy levels: i) systemic, which deals with the institutional arrangements for regulation, financing, and delivery of services; ii) programmatic, which specifies the priorities of the system, by defining a universal package of health care interventions; iii) organisational, which is concerned with the actual production of services by focusing on issues of quality assurance and technical efficiency; and iv) instrumental, which generates the institutional intelligence for improving system performance through information, research, technological innovation, and human resource development"(Frenk, 1994 p.19[12]).

[11] Referring to 'market intervention' in health systems , Roemer suggested following four types of health system based on the model of governance : entrepreneurial like the American health system, welfare oriented like health system of many Western European countries like Canada, Japan and Australia , comprehensive health systems which cover most of the population like Great Britain and Italy to some extent and many Scandinavian countries and Socialist health system like in the Soviet Union (Roemer, 1993 p.696).

[12]Frenk (1994) presents health systems as a set of relationships among five major groups of actors including: i) health care providers, ii) population, ii) state as a collective mediator), iv) organizations that generate resources, and v) other sectors that produce services with health effects. He highlighted the institutional arrangements and also emphasized the role of level levels in health systems reform process outlining the importance of a) 'programmatic level' in setting priorities, b) 'organizational level' in production of services and c) 'instrumental level' in intelligence generating. He further stressed that the relationships among providers, population, and the state form the basis for a typology of health care modalities (p.19).

Another significant contribution on health systems improvements came around the same time by Cassels[13] (1995) who stressed that "there is no consistently applied, universal package of measures that constitute the health sector reforms" (Cassels, 1995 p.331). He further added that reviewing the performance of existing policies, structures, systems and institutions to deal with the issues of efficiency, access, cost- containment and responsiveness to popular demand can give cues on the agendas of health reforms (Cassels, 1995 p.331). He referred to the earlier work of Frenk (1994) and Roemer (1991) and gave a relationship and network-based framework for health systems improvements. He emphasised that the relationship between the institutional actors serves a basis for characterising health systems and these relationships are the focus of reforms[14] (Cassels, 1995 p.337). Cassels (1995) also stressed on importance of including 'donor agencies' in the analysis of health systems reforms and suggested that a country specific view should be taken to assist recipient government in analysing implications of different reforms (p.343-44).

Attention to donors and their role in health sector reforms till now has been a neglected area in health systems discussions. However, post 1990s, global actors' engagement in giving a direction to improving performance of health system became more explicit. Since the year 2000, health systems strengthening became an popular term as well as an important agenda for the 'donors' (Hafner and Shiffman, 2012). They got more actively involved in shaping the larger discourse on health systems and health systems strengthening and giving country specific advices to the governments for initiating health systems strengthening reforms.

During this period, global health actors developed several frameworks on HSS (discussed in detail in the next section) using the existing understanding of health systems. With these frameworks, the centrality of governance in health systems improvements also witnessed a change.

1.2 UNPACKING HEALTH SYSTEMS STRENGTHENING

[13] Andrew Cassels was working as a Health Systems Development Consultant in Canterbury, Kent, United Kingdom at the time of writing this framework (Cassels, 1995).

With the start of the Twentieth Century, Health system strengthening gained the top position in the health development agendas being regarded as "a 'first-order' goal within 'higher-order' development goals" (Singh, 2006 p.326). Strong and effective health systems started to be recognised as precondition rather than an outcome for reducing the disease burden and achieving the health related development goals (Shakarishvili et al., 2009).

However this priority has been accompanied by issue of lack of clarity on the concept of HSS (World Health Organisation, 2007; Marchal et al., 2009; Reich and Takemi, 2009; Van Olmen et al., 2012; Hafner and Shiffman, 2012; Chee et al., 2013). This concept at one point was regarded as vague or a meaningless "container concept" that was being used to label any health related capacity strengthening activity as HSS (Marchal et al., 2009 p,3).

The sections below discuss multiple meanings of HSS highlighting its different uses, approaches, definitions and constituents.

1.2.1 Three conceptualisations of HSS

Though the usage of the term HSS gained more popularity in the past two decades. The term has been in use for a long-time. It's usage in policy contexts can be traced in the documents of the World Health Organisation (WHO) in 1980s where strengthening district health systems was suggested using the Primary Health Care (PHC) approach (World Health Organisation, 1988).

Major conceptualisations of HSS include its conceptualisation as a concept, a process or strategy and a goal. Being discussed as a process or strategy, it is often used interchangeably with other strategies like improving performance and improving efficiency of the health systems (World Health Organisation, 2007 and Reich and Takemi, 2009); health systems improvement (Frenk, 2010) and (Travis et al., 2004) and permanent health performance improvement (Chee et al., 2013). On one hand, HSS has been discussed as a goal but on the other hand it has been conferred as a process to achieve the same goal. For example Universal Health Coverage (UHC) has been stated as a means for achieving health systems strengthening (Ooms and Hammonds, 2015; Garrett et al., 2009) and has also been advocated as a means to achieve UHC (Kieny et al., 2017).

Three different definitions for HSS by WHO elaborates the above stated observation. The first definition which defines HSS "as any array of initiatives and strategies that improves one or more

of the functions of the health system and that leads to better health through improvements in access, coverage, quality, efficiency" ("WHO | Health Systems Strengthening Glossary," n.d.) encompasses the view of HSS as a concept as it highlights its components. The second definition in which HSS is defined as " the process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges" ("WHO | Health Systems Strengthening Glossary," n.d.) points to its conceptualisation as a process. The World Health Report, 2007 also defines HSS as a process while stating HSS "as improving … six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. It requires both technical and political knowledge "(World Health Organisation, 2007). However, when HSS is mentioned in statements like "…the suggestion… to secure the health-MDGs for lower quintiles must be accompanied by a strategy to strengthen health systems"(Singh, 2006), or When the Director General of the WHO says "…I called for a return to Primary Health Care as an approach to strengthening health systems..."("Address to the 61st World Health Assembly," 2008), it is referred to as a goal which can be achieved through various strategies and not as a strategy itself.

1.2.2 Health Systems Strengthening frameworks

HSS frameworks have evolved in accordance with the evolution of health systems frameworks. Shakarishvili et al. (2009) highlights the existence of more than ten frameworks for defining health systems. These frameworks have further sub-categories but broadly classified under three major categories of i) descriptive models: providing a basic description of the systems outlining its components, ii) analytical models: going beyond descriptions and analyse the aspects of systems and its complex operations and iii) predictive models: trying to answer the questions like, why do some health systems work better than others? and how can policy-makers make a national health system perform better. Most cited example of analytical framework, popularly known as 'six building blocks framework' was given by WHO in World Health Report (WHR),2007 titled "Strengthening health systems to improve health outcomes".

This framework has been derived from the functions of health systems identified in the WHR 2000 after breaking down these functions into a set of six essential building blocks (World Health Organisation, 2007 p.9). The building block framework highlighted that "in order to achieve their

goals, all health systems carry out some basic functions of providing services; developing health workers and other key resources; mobilising and allocating finances and ensuring health system leadership and governance (also known as stewardship)" (World Health Organisation, 2007 p.4). This report also highlighted the dynamic nature of health system by stating that health system "is a set of inter-connected parts that must function together to be effective. Changes in one area have repercussions elsewhere. Improvements in one area cannot be achieved without contributions from the others. Interaction between building blocks is essential for achieving better health outcomes" (World Health Organisation, 2007 p.4).

In the same year in 2007, the World Bank published a report titled 'Healthy development: The World Bank strategy for Health, Nutrition and Population results. This report highlights the role of Health, Nutrition and Population (HNP) in achieving economic development and the role of improved economic growth in enabling improvements in health outcomes, and alleviating poverty. It also suggested that a multisectoral approach is required to achieve the HNP results (World Bank, 2007 p.25). Here health systems are seen as a 'means to ends' system. A predictive framework for HSS is suggested in which the functional and structural components of health systems (called as Control Knobs in the framework) were described as means of change and therefore could influence performance of the health system as the result. The identified Control Knobs are financing, payment, macro-organisation of health care delivery, regulations and persuasion (Hsiao, 2003 p.5). In the section on strengthening health systems, the report notes that well-organised and sustainable health systems are necessary to achieve the results. To achieve sustainable systems, means

> "putting together the right chain of events (financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure equitable access to effective HNP interventions and a continuum of care to save and improve people's lives" (World Bank, 2007 p.19).

This strategy document is intended to inform the decisions of client–country policy-makers, Bank country teams and Bank management, and global partners on country and Region-specific strategies and action plans for achieving HNP results on the ground. It identifies a plan of action and internal functional adjustments for its implementation to bring about essential improvements

in Bank work on HNP. This framework stresses on governance (macro organisation and regulation and persuasion) and financing reforms as key mechanism to improving health systems (Hsiao, 2003 p.5).

1.2.3 Dominant approaches for HSS

When defined as a goal, several approaches have been suggested by national and international actors to achieve HSS. These approaches include but are not limited to PHC approach, diagonal approach, UHC, social capital, community systems strengthening and health sector reforms.

PHC as outlined in the Alma-Ata declaration in 1978 (WHO and UNICEF, 2018) stands as the most widely cited approach to HSS. Many scholars and global health leaders have stressed on the importance of principles of PHC including inter-sectoral collaboration, social justice, community participation as the key to achieve HSS (Walley et al., 2008; Lawn et al., 2008, Kruk et al., 2010).

Diagonal approach, which aims for disease-specific results through improved health systems gained a lot of popularity among global actors focusing on disease-specific initiatives for directing their HSS support (Ooms et al., 2008). Diagonal approach uses explicit "intervention priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance" (Frenk, 2006 p.4).

UHC approach suggests UHC as a means to right to health and ending financial exclusion (Ooms and Hammonds, 2015) and (Garrett et al.,2009) for strengthening health systems. This approach draws the connection between health financing and performance of health systems in terms of achieving its overall goals (Kutzin, 2013).

Building social capital has also been recommended as a means to strengthen health systems as it "…facilitates the systematic and effective inclusion of community voices in the health policy process—strengthening programme effectiveness as well as health system accountability and governance" (Ogden et al., 2014). This approach called for strengthening health systems by connecting communities and by creating a bond among them and other social systems decision makers (Ogden et al., 2014) and (World Health Organisation, 2007).

The importance of community systems strengthening has also been brought forward by Global Health Initiatives for increasing the coverage of health services. Two components including Community-led and community-based response form the core of this approach. Community-led responses refer to initiatives which are managed, governed and implemented by communities themselves and community-based responses are responses are delivered in the community settings that is outside the scope of formal health facilities ("Community Systems Strengthening Framework," 2010).

In addition to the above specific approaches, Health Sector Reforms (HSR) have also been suggested as a medium for strengthening health systems (Senkubuge et a l., 2014). These reforms include radical structural and systemic changes where national health systems take a lead in ensuring that there is an alignment and coherence of policies, an ownership of health systems by national stakeholders and coordination among different partners in health systems (Senkubuge et al., 2014).

1.2.4 What constitutes HSS

Along with the varied uses and approaches for HSS, there are on-going debates on what constitutes HSS. Confusions on constituents of HSS have resulted from the existence of multiple frameworks on health systems. It is argued that the variety of frameworks for health systems (see section 1.1) when used to develop HSS strategies has led to different ideas of HSS and sometimes also created confusion at country level regarding which conceptual model to refer for designing HSS strategies (Shakarishvili et al., 2009).

A significant part of literature has tried to address this confusion on constituents of HSS. The discussions have been around: whether disease-specific initiatives (single-disease, multiple disease or cluster of diseases) should be treated as HSS or not as these are selective in their approach (Marchal et al., 2009). Other concerns suggested differentiating between supporting and strengthening health systems, arguing that 'supporting' includes interventions which improve the system's functioning mainly through increasing inputs. These interventions are short-term and narrowly focused (for example, distributing free condoms or topping up salaries for target staff for a specified period). Whereas 'strengthening' includes interventions which bring "comprehensive

changes to policies and regulations, organisational structures, and relationships across the health system building blocks that motivate changes in behaviour, and/or allow more effective use of resources to improve multiple health services"(Chee et al., 2013 p.85).

It has been cautioned that HSS should be differentiated from 'partial strengthening' that has "been undertaken by several agencies involving directed support for their own activities, support for a limited set of health systems functions necessary for the delivery of their own activities, or integration of their activities into the existing health system" (Balabanova et al., 2010 p.1) . Here strengthening is viewed "as being directed towards the ability of the entire system to collect, pool, and spend the necessary finances to become sustainable and equitable, to deliver effective, appropriate, and equitable care, to generate the necessary resources (such as a trained workforce) to make this happen, and to provide the stewardship to ensure its effective governance"(Balabanova et al., 2010 p.1).

Shakarishvili et al. (2011a) suggests a distinction between activities or investments contributing to health systems strengthening versus those which contribute only towards improving health outcomes has also been suggested (p.3). Placed in the context of tracking donor assistance, he argues that only those activities should be considered as HSS, which make changes to the health system in order to achieve health systems goals, and not all activities that improve health outcomes. He explains this by giving the example of treatment with antiretroviral therapy which improves the health outcomes but not necessarily make any impact on health system (Shakarishvili et al., 2011).

These discussions point to a careful distinction between two aspects of the HSS which can be seen along a continuum. These two aspects include i) increasing the resources like finance, drugs and equipment and human resources resulting in improved health outcomes and ii) improving effective utilisation of these resources in order to achieve overall health systems goals (including better health outcomes).

1.2.5 Governance at the cornerstone of HSS

Governance lies at the cornerstone of both these aspects of HSS of increasing as well effectively utilisation the resources. Fryatt et al. (2017) highlight the direct and indirect ways in which governance impacts health. While alluding to the direct association between governance and health

they cite the example of autocratic governments resulting in adverse events like increased mortality due to famines and explain indirect impacts by using the example of strong governance across different sectors leading to overall improvements in income and health.

Effective functioning of health systems depends broadly on the availability of finances (to ensure availability of infrastructure and equipment), labour (availability of adequate human resources for health) and governance. Though availability of finances and labour impact provisioning of health services and health outcomes, governance is the cornerstone of health systems on which other pillars (that is financing and human resource) depend. As said by Mamdani (2007), governance can blunt or enhance the effects of both capital and labour in the health systems. It is because of this that governance assumes the central role in strengthening health systems (p.1). Governance enables the health system to deal with not just day to day challenges but also with the evolving policies and issues. Greer et al. (2016) suggests that governance ensures the functioning of health systems in a sustainable and efficient way regardless of the quality of top leaders. They elaborate this characteristic of governance by stating that governance "works in the absence of especially good leaders, and is a defence against especially bad leaders" (Greer et al., 2016 p.4).

This view of governance points to a broader understanding of governance which goes beyond the most emphasised concept of 'stewardship' used by global actors while describing the governance function: "Governance in the health sector refers to a wide range of steering and rule-making related functions carried out by governments/decisions makers as they seek to achieve National Health Policy objectives that are conducive to Universal Health Coverage…"("WHO | Governance," n.d.). Aspects of stewardship and leadership are often related with the functions of effective oversights and regulation by health systems. A review of governance frameworks suggests that most of existing governance frameworks focused on the desirable attributes of governance and discuss what should be done and how can it be done (Greer et al., 2016) . Authors identified close to sixty attributes of governance, which they classified into five broad categories of: transparency, accountability, participation, integrity and capacity. They have emphasised that governance is central to policy performance and stressed that "the point of improving governance is to improve policy performance, meaning better formulated and implemented policies." (Greer et al., 2016 p.28).

However, Kickbusch and Gleicher (2013) expand this understanding on governance and argue that "governance is co-produced by a wide range of actors at the level of the State {such as

ministries, parliaments, agencies, authorities and commissions), society (as businesses, citizens, community groups, global media (including networked social media) and foundations} and supra-national organisations (such as the European Union and the United Nations)" (p.7).They elaborate two existing conceptualisations of governance in health systems in relation of health systems strengthening . i) 'health governance' that is governance of the health system including the attempts of governments or other actors to steer communities, countries or groups of countries in the pursuit of health as integral to well-being and ii) governance for health, that refers to as the joint action of health and non-health sectors, of the public and private sectors and of citizens for a common interest. They elaborate this idea by emphasising that governance for health "requires a synergistic set of policies, many of which reside in sectors other than health as well as sectors outside government, which must be supported by structures and mechanisms that enable collaboration"(Kickbusch and Gleicher, 2013 p.4).

The first conceptualisation of governance that is governance of health systems stresses on the function of governance and places governments at the centre of this function. The second conceptualisation of governance that is governance for health systems points to a network-based and relation-based understanding of governance alluding to the role of actors outside government. This understanding is consistent with health governance scholars like Kjær (2004) who points out the problem with governance being synonymously used as government. She expands the understanding of governance by directing to the following three definitions, referring to the works of Rosenau (1995), Rhodes (1997) and Hyden (1999), highlighting the meaning of governance beyond government or the authority of State.

- Governance is conceived to include systems of rule at all levels of human activity - from the family to the international organisation - in which the pursuit of goals through the exercise of control has trans-national repercussions (Rosenau, 1995 cited by Kjaer, 2004)
- Governance refers to self-organising, inter-organisational networks characterised by interdependence, resource-exchange, rules of the game, and significant autonomy from the State (Rhodes, 1997 cited by Kjaer, 2004)

- Governance is the stewardship of formal and informal political rules of the game. It refers to those measures that involve setting the rules for the exercise of power and settling conflicts over such rules (Hyden,1999:185 cited by Kjaer, 2004)

Kjaer (2004) argues that though these definitions are placed in different contexts, they point to a similar understanding about governance in health. According to her, Rhodes (1997) talks about governance in the context of public administration and public policy and discusses the term governance referring to reforming the public sector. Rosenau (1995) discusses governance in context of international relations and refers governance to global political problems requiring global solutions. Hyden (1999) discusses governance in the context of comparative politics and talks about it in relation to theories of development and democratisation in the third world countries (Kjær, 2004 p.4).

According to Rhodes (1997) idea of governance provides interesting insights for developing a nuanced understanding of governance in HSS. According to him, governance means there is no one centre but multiple centres of authority, claiming an absence of "sovereign authority because networks have considerable autonomy" (Rhodes 1997, p. 109 cited by Kjaer, 2011 p.101). In an elaborate account on governance he emphases that "governance signifies a change in the meaning of government, referring to a new process of governing; or a changed condition of ordered rule; or the new method by which society is governed" (Rhodes, 2007, p. 4). He suggests that for "clarity's sake, it is best if the word always has a qualifying adjective… and be called as network-governance" (Rhodes, 2007, p. 4).

This thesis uses his idea of governance, referring to governing with and through networks" which he calls as networks as 'policy networks'[15] defined as:

> "sets of formal and informal institutional linkages between governmental and other actors structured around shared interests in public policymaking and implementation. These

[15] Roderick Arthur William Rhodes was a professor emeritus of government (political science) at the university of Southamptom at the time of writing this paper. His engagement with the study of governance started with his work on *Understanding Governance in 1997*, which was a study on policy networks and British government (Rhodes 1988; Marsh and Rhodes 1992). After ten years, he visited his concepts again through a journal paper titled *Understanding Governance: ten years on* and also answered some of his critics (Rhodes, 2007).

institutions are interdependent. Policies emerge from the bargaining between the networks' members…the other actors commonly include the professions, trade unions and big business. Central departments need their cooperation because … government rarely delivers services itself" (Rhodes, 2007 p.1244).

1.3 GLOBAL ACTORS AS IMPORTANT STAKEHOLDERS IN HSS POLICY PROCESS

Global actors constitute an important part of the policy networks and contribute significantly in shaping HSS policies. Yet they remain as one of the most neglected and under-studied actors in terms of their involvement in shaping policies. Before focusing on the role of global actors as stakeholders in HSS policy-making, it is important to understand the terrain of global actors in health.

1.3.1 Understanding the terrain of Global actors

Global actors are "those groups, institutions or both exercising public authority beyond the State and that with the aim of influencing broader socio-political trans-national space" (Madsen and Christensen, 2016 p.2). They include the trans-national actors that have a primary intent to improve health and the poly-lateral arrangements for governance, finance, and delivery within which these actors operate (Hoffman et al., 2015 p.4). They may operate at the community, national, or global levels, and may include governmental, intergovernmental, private for profit, and/or not for profit entities (Szlezák et al., 2010 p.2).

Birn et al. (2017) in their writing on global health actors and their activities point to a dizzying view of actors operating in the global health arena, with new organisations appearing almost monthly. They further add that in addition to large Multilateral, Bilateral, private, and non-governmental entities, many other health organisations, with far smaller budgets including community action and public- interest NGOs, human rights organisations, and advocacy movements, have emerged in recent decades as important global actors in health. They have grouped these actors (see table 1.1) according to the sources of funding, mission and scope of activities.

Presence of these large number and types of actors leads to a complex health governance landscape creating multiple centres of authority which challenges the State's sovereignty. This complexity in health governance has also been called as 'global health governance' which operates at the intersections of 'global health' and 'health governance'.

Table 1.1- Types of Global Health actors according to funding source, mission and scope of activities

Type	Examples
UN (Multilateral) Agencies	WHO, UNICEF, UNAIDS, UNFPA, UNDP, UNEP, UN Women
International Financial and Economic Institutions	World Bank, International Monetary Fund (IMF), World Trade Organisation (WTO)
Bilateral Aid and Development Agencies	United States Agency for International Development (USAID), Swedish International Development Agency (SIDA), U.K. Department for International Development (DFID)
Military Actors	US Department of Defense, North Atlantic Treaty Organisation (NATO), European Union Force (EUFOR)
South- South Cooperation	BRICS, China South- South Cooperation Fund, Ministerio de Relaciones Exteriores (Cuba)
Contract Providers and Consulting Firms	Management Sciences for Health, John Snow, Health Systems Trust, Abt Associates, FHI 360
Government Technical Agencies and Research Institutions	Centers for Disease Control and Prevention (CDC), Fundação Oswaldo Cruz (Fiocruz), European Centre for Disease Prevention and Control (ECDC)
Regional Organisations and Economic Unions	Organisation for Economic Cooperation and Development (OECD), African Union, European Union (EU), CELAC
Foundations	
The Old Guard	Rockefeller Foundation (RF), Ford Foundation, Wellcome Trust,
The New Guard	Bill and Melinda Gates Foundation (BMGF), Clinton Foundation, Elton John AIDS Foundation
LMIC Foundations	Aga Khan Foundation, Carlos Slim Health Institute
Business Interests	
Private Health Insurance	Aetna
Big Pharma	Merck, Pfizer, GSK
Corporate Foundations and Alliances	Shell, ExxonMobil, Walmart
Public– Private Partnerships (PPPs)	Global Fund, GAVI, the Vaccine Alliance, Stop TB Partnership, Global Alliance for Improved Nutrition (GAIN), Global Polio Eradication Initiative
Emerging Global Financing Approaches	UNITAID
Missionaries and Religious Agencies and Charities	World Vision, Diakonia, Mennonite Central Committee, Islamic Relief Worldwide
Joint Health and Development Initiatives	International Health Partnership Plus+, H8
NGOs	
Large Humanitarian NGOs	Save the Children, CARE, Concern Worldwide, Plan International
Relief Groups	National Societies of the Red Cross & Red Crescent, International Rescue Committee, Gift of the Givers
Social Rights- Oriented/ Service Provision NGOs	Oxfam, Médecins Sans Frontières (MSF), Partners In Health (PIH), Doctors for Global Health (DGH)
Human Rights and Health Groups	Physicians for Human Rights, Amnesty International, Dignitas International, Association for Women's Rights in Development (AWID)
LMIC NGOs	BRAC, Urmul Trust, Jamkhed Comprehensive Rural Health Project
Global Health and Development Think Tanks	Centre for Global Development, Overseas Development Institute, CPATH
Source : (Birn et al., 2017 Table 4- 1 Typology of Global/ International Health Actors and Programmes p.142-143)	

According to Koplan et al. (2009) 'Global health' can be thought of as a notion (the current state of global health), an objective (a world of healthy people, a condition of global health), or a mix of scholarship, research, and practice (with many questions, issues, skills, and competencies)" (p.1993) .They suggest that "global" is also associated with the growing importance of actors beyond governmental or intergovernmental organisations and agencies including the, internationally influential foundations, non-governmental organisations, media and trans-national corporations[16]. Szlezák et.al (2010) suggests global health as the constellation of actors (individuals and/or organisations) "whose primary purpose is to promote, restore or maintain health" and "the persistent and connected sets of rules (formal or informal), that prescribe behavioural roles, constrain activity, and shape expectations among them" (p.2).

According to Buse and Tanaka (2011) the relationships between these Global health actors have evolved over time. They note no significant collaboration between the actors in private and public sectors within the United Nations (UN) or international development system till 1970s and suggest their relationships as often abrasive, with little trust on either side. This began to change post 1980s with the joint action between UN agencies and Non-government actors resulting in ease of the process of link up among different actors like NGOs, industry and the public sector. Reich (2002) note that a large number of global partnerships[17] marked this era of 'Global health'[18]. These partnerships have brought a shift in thinking about the conventional roles of public and private (Buse and Tanaka, 2011).

By 1980s in the context of global economic crisis and weakness of internal structures, the governments were left with the option to attract private capital for economic growth and sustenance. Two strategies for this purpose were persistent during this period. One was to borrow money on their own and the second was to obtain Multilateral assistance and loans from

[16] Koplan et al. (2009) argues that Global health has derived from public health and international health and shares common characteristics with these disciplines including: priority on a population-based and preventive focus; concentration on poorer, vulnerable, and underserved populations and its multidisciplinary nature.

[17] Few examples of these partnerships include : European Partnership Project on Tobacco Dependence, Global Alliance for TB Drug Development, Global Alliance to Eliminate Lymphatic Filariasis, Global Alliance to Eliminate Leprosy, Global Alliance for Vaccines and Immunization, Global Elimination of Blinding Trachoma, Global Fire Fighting Partnership, Global Partnerships for Healthy Aging, Global Polio Eradication Initiative, Global School Health Initiative, Multilateral Initiative on Malaria, Medicines for Malaria Venture, Partnership for Parasite Control, Roll Back Malaria, Stop TB and the UNAIDS/Industry Drug Access Initiative (Reich, 2002).

[18] Brown et al. (2006) suggests that, the terms "international," "intergovernmental," and "global" need not be mutually exclusive and in fact can be understood as complementary. They claim that global health and especially the term "global" has been used well before the 1990s and elaborate this by citing examples of different programmes and initiatives like , "global malaria eradication program" launched by WHO in the mid-1950s. They further add that 'international health' continues to be used by many academic departments and organisations but has expanded to cover a broader range of subjects such as chronic diseases, injuries, and health.

international agencies like IMF or the World Bank[19]. Peabody (1996) argues that it is these public-private partnerships on which the foundation of 'Global health' rests.

1.3.2 Global actors, health governance and HSS

Global actors have played a significant role in health governance at global as well as country levels. Through methods of provisioning of development aid in health, they have gained influential positions in national health policies and have been able to set the larger discourse around HSS in the aid recipient countries like India. In the past two decades, the landscape of global health and global health partnerships has evolved significantly. With the growing number of global health partnerships, more and more global health actors are giving attention to HSS policies in LMICs (Hafner and Shiffman, 2012). Few of these partnerships are also focusing on HSS through vertical health initiatives and disease-specific (Reich and Takemi, 2009). Two of such most popular partnerships include GAVI, established in 2000, the GFATM established in 2002 (Warren et al., 2013). These actors have also signed various agreements and joint statements outlining their increased collective participation in HSS through improving the effectiveness of development aid. For example the First High-Level Forum on Harmonisation which took place in Rome in 2003 committed to improve the management and effectiveness of aid ("Rome Declaration on Harmonisation. 2003.," 2003).

Following this the Declaration known as Paris Declaration that took place during a meeting in Paris in 2005 committed to further the country ownership, harmonisation and alignment of development assistance, managing for development results, and mutual accountability for the use of aid ("Paris Declaration On Aid Effectiveness.," 2005). The Accra High-Level Forum on Aid Effectiveness in 2008 then reviewed progress made against Paris Declaration commitments for improved aid effectiveness (Peters et al., 2013). This was followed by the High-level Dialogue on maximising positive synergies between health systems and Global Health Initiatives, which took

[19] In the early 1980s, the commercial Banks and other private institutions held forty nine percent of the Third World debt and official agencies like the IMF, World Bank, and governments held only thirty five percent but by 1994, this trend had reversed itself, with official agencies holding fifty one of the Third World debt and commercial banks holding only thirty nine percent (World Bank , 1994 cited by Peabody, 1996 p.823). Peabody (1996) notes that this shift happened because it was believed that what these countries were facing was not the debt crisis but larger macroeconomic imbalances and thus the requirement was not only of money but also of guidance and support to address the underlying economic problems. Such guidance was believed to be available only from agencies like IMF and World Bank and not from the private investors. These funds saw a shift from a straightforward economic perspective, such as "austerity" programs to intertemporal terms as "present pain" for "future gain"(Peabody, 1996 p.824).

place in Venice, Italy on June 23rd, 2009 ("Venice Draft Concluding Statement on Maximising Positive Synergies between health systems and Global Health Initiatives," 2009 p.2).

As a result of such developments in the global health governance, India has also seen a growing complexity in health governance landscape. New global health actors are emerging at a fast rate and their participation in HSS policies in India is increasing. Most common channel of their participation is through provisioning of financial aid and providing technical assistance in policy-making processes. Both these routes have created strong pathways for these actors to influence national policy-making.

1.3.3 Global actors diffusing varied ideas of HSS

While participating in HSS policies, these actors have used and promoted varied ideas of HSS in India. These ideas have been shaped by their own ideas and understanding of health systems. For example, global actors GFATM and GAVI have used an analytical framework for HSS that is the WHO's Six Building blocks framework (World Health Organisation, 2007). Whereas the World Bank has used a deterministic framework that is the reforms framework also known as five Control Knobs framework (Hsiao, 2003). As a result, the prescriptions for HSS by GFATM and GAVI are different from those of the World Bank. The former focuses on increasing resources like increase in drugs, equipment and human resource[20], while the later focuses on improving the process of utilisation of resources by bringing governance reforms[21]. Table 1.2 examines the usage of different health systems and HSS definitions and frameworks by different global actors and their objectives and approaches for HSS policies.

[20] The recent focus of GFATM on building Resilient and sustainable systems for health targeting improvements in health systems capacities for managing public health emergencies is also focused on improving the provision of essential services through improvements in data management, supply chains and procurement, community health systems and integrated delivery of services etc. These investments are aimed at accelerating progress toward UHC and helping countries prepare for emerging threats to global health security ("Resilient and Sustainable Systems for Health," n.d.)

[21] World Bank's major objective for HSS is placed in the broader context of poverty alleviation. According to Banks', HSS means "putting together the right chain of events (financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure equitable access …and a continuum of care to save and improve people's lives..." (World Bank, 2007 p.28-29) .World Bank's conceptualization of HSS does not treat it as an outcome or a result but as a process which will lead to health improvements . The following statement from Bank' Health and Nutrition policy paper makes this position clear by stating that, "Strengthening health systems is not a result in itself…without results health system strengthening has no meaning. However, without health system strengthening, there will be no results" (World Bank, 2007 p.28-29)

Table 1.2- Global health actors diffusing varied ideas for Health systems strengthening.				
	WHO	**World Bank**	**GFATM**	**GAVI**
Definition of Health systems	All the activities whose primary purpose is to promote, restore or maintain health). *	In addition to maintaining and improving health, Banks' definition of health systems also focuses on preventing impoverishment as a result of illness. **	Focus is on ensuring the efficient and effective delivery and use of the spectrum of products and information for prevention, treatment, and care and support to people in need of these services.	Defines health systems by its functions as given in six building blocks framework.
Defining health system strengthening	HSS is improving six health system building blocks (that is Health service delivery, Health workers, Logistics and supply systems, Health financing, Health information and monitoring and Leadership and governance) and managing their interactions. It requires both technical and political knowledge and action ***	The role of interactions between different parts of HS is not emphasised rather these parts and functions are suggested to occur in a right chain of events for HSS. **	Six building Blocks.	Six Building Blocks.
Objective for investing in HSS	Focus on achieving more equitable and sustained improvements across health services and health outcomes placing the notions of access and coverage at	Focus on improving health outcomes of the poor and vulnerable, protecting households from impoverishing effects of illness and achieving sustainable financing,	Focus on reduction of infections, illness, and deaths from the three diseases HIV/AIDS, Tuberculosis and Malaria. ****	Focus is on child and maternal health and to achieve and sustain increased immunisation coverage and other health services*****

	the heart of the strategy. ***	improving governance and accountability.		
Approach for HSS	Primary health care, sector-wide approach, integrated systems, Universal Health Coverage.	Inter-sectoral and sector-wide approach, convergence in thinking about aid management with national budgets and public expenditure programmes providing the link between macro-economic policy and the pattern of investment within individual sectors.	Diagonal, cross disease or cross-cutting, taking the desired health outcomes as the starting point for identifying health systems constraints that 'stops' effective scaling up of services. ****	Integrating programme based interventions like immunisation and other disease-based efforts into a more sector-wide approach in one common method.
Major areas of investments	Disease-specific as well as policy level interventions	During the 1970s, the emphasis was on improving access to Family Planning services. From 1980-86, the Bank directly financed health services. From 1990 onwards strove to improve health finance and reform entire health systems.	Five health-system-related risks that directly affect successful implementation of HIV/AIDS, TB and Malaria programmes including procurement and supply chain management, health information systems, health and community workforce, service delivery and financial management. ******	The three main health system barriers for achieving immunisation coverage are including health workforce, health services, drugs, equipment and infrastructure. *****

*Source (World Health Organisation, 2000 p.2)
** Source (World Bank, 2007 p.44)
*** Source (World Health Organisation, 2007 p.4).
**** Source (The Global Fund Strategic Approach to Health Systems Strengthening, 2007).
***** Source (GAVI Alliance, 2007).
****** Source ("Global Fund's investments in health systems strengthening - information note," 2013 p.12)

1.4 METHODOLOGICAL APPROACHES FOR STUDYING THE ROLE OF GLOBAL ACTORS IN SHAPING HEALTH POLICIES

Current literature on studying the role of global actors in HSS is focusing on quantifying fund allocation by global actors to specific health initiatives (Ravishankar et al., 2009), examining the percentage of funds provided by global actors in comparison to the total health expenditure of aid recipient countries (Michaud and Murray, 1994) and assessing the HSS policies supported by global actors in health (Howard, 1983). Few of these studies aim to highlight major trends in global health governance by examining the proportional financial contributions of different global actor's (over time) in provisioning of development aid in health (Clinton and Sridhar, 2017). Others examine the intentions, goals and criteria guiding aid allocation in addition to engaging with the measurements of aid flows in health (Bendavid E, et al., 2017). Other studies examine the challenges in aid- effectiveness (Radelet, 2006).

Relatively small section of research has engaged with questions related to motivation of the development of the global health strategy of one or more countries. For example, Aluttis et al. (2017) have studied Germany's Global Health Strategy by examining Germany's health and foreign policy processes at the national level and Steurs et al. (2017) have examined the commonalities in the vision of global health policies of European Union and its five member States (including France, Germany, United Kingdom, Belgium, and Denmark) through a comparative framing analysis of their global health policy documents. Others have done similar studies on global health strategies of one or more organisations. For example, Lidén, (2014) has done a historical analysis on the changing position of WHO in global health architecture and Brown et al. (2006) has studied WHO's changing role in international and global health over years. Abbasi (1999) has analysed the changing role of the World Bank in World health in 1990s followed by a similar analysis by Ruger (2005a). Studying the overall shifts in global health landscape has been an interest of scholars examining the changing approaches to international health of different global actors including WHO, UNICEF and the World Bank (Banerji, 1999) and (Szlezák et al., 2010).

Global actors' engagement in policy process has also been studied by focusing the analysis on global health actors as 'international organisations as such' and within their institutional environment (Kaasch, 2011). These studies have been carried out largely by the scholars of International Relations (IR) focusing on the linkages between States and International (Kaasch, 2011) taking up the questions of governance, intergovernmental institutions, globalisation, and intellectual property rights (Stoeva, 2016). Koch (2015) argues that the theories in IR draw from the theories of international law and metaphorically describe international organisations as instruments, arenas, actors or more recently as bureaucracies. In conceptualisation of International organisations as actors, he argues that these organisations have the ability to influence the interstate relations and have an impact on State's behaviour[22]. These studies apply the concepts of multilateralism, bilateralism and unilateralism describing these in simple terms of quantity: understanding unilateralism to be based on one State, bilateralism on two, and multilateralism on three or more States (Keohane, 1990).

Other definitions of these concepts also exist. For example, Wedgewood (2002) describes 'unilateralism' as a situation where the powerful State disrespects multilateral norms and adopts a self-centered foreign policy. He further adds that the 'power levels' determine how unilateral a State can be (Wedgwood, 2002 cited by Tago, 2017). Tago (2017) describes Bilateralism, to be based on preferentialism and it changes its goals and priorities on a case-by-case basis[23]. Ruggie (1992) describes multilateralism as "an institutional form which coordinates relations among three or more States on the basis of "generalized" principles of conduct... which specify appropriate conduct for a class of actions, without regard to particularistic interests of the parties …"(p.571). His definition focuses on international organisations as "regimes," or "sets of rules that stipulate the ways in which States should cooperate and compete with each other". He explains that multilateralism requires to possess features like indivisibility, generalised organising principles, and diffuse reciprocity[24] pointing to the organisations like UN, the World Bank, the IMF. He

[22] Koch further adds that this does not challenge the claim that states are key actors of the international system it rather attributes an active role to international organisations beside states (Koch, 2015)

[23] Tago (2017) elaborates this by giving an example of the- collective security system under the UN Charter arguing it to be clearly a product of multilateralism, but the collective defense system (known as collective self-defense) is based on preferentialism by the powerful states (such as the United States of America) and thus is a form of Bilateralism.

[24] Ruggie,(1992) stresses that indivisibility requires multilateralism to be based around socially constructed public good. He further adds that the generalized organizing principles and reciprocity require multilateralism to be opposed to discrimination and preferential bilateralism (p. 11).

further added that the General Agreement on Tariffs and Trade (GATT) which were formed after the Second world war as the core of multilateralism, aiming to include all of the world's States as members(Ruggie, 1992).

Most widely used approach in these studies to understand the relation between International organisations and State has been 'principal- agent approach'. This approach treats States as 'principals' and international organisations as 'agents' and studies how States created these organisations and not only delegates but also enables them to perform tasks as demanded by the States (Lyne et al., 2006). Principal-agent approach has also been applied in studying the relation between citizens and States. Here citizens (taxpayers) are considered as 'principals' and government (State) is considered as an 'agent'. As citizens pay taxes, they expect their State to perform certain activities and if the States fail to do so then the citizens can complain to the government or even change the government during next elections. However Keeley (2012) points out that this scenario does not exist in 'international aid' where the citizens in donor countries pay taxes and expect their agent (governments) to distribute it prudently through aid and the citizens of aid receiving countries have no mechanism of complaining or changing the donor government (Keeley, 2012).

Others have focused on studying the role of international actors by explaining their organisational autonomy and responsiveness to the demands of member governments. They argue that the groups of member governments empower their international organisations agents with real decision-making authority. Nielson and Tierney (2003) take the case of the World Bank to demonstrate the autonomous nature of international organisations as it displays substantial independence from its member governments. They explain the disconnect between the behaviour of international organisations and the interests of member States and also bring forward instruments like staff selection, monitoring, procedural checks, and contracts-through which States regain control over these organisations (Nielson and Tierney, 2003).

The ability of international organisations to affect the behaviour of recipient countries or the influence of global aid actors in aid recipient countries has most commonly been studied through the concept of 'norm diffusion'. Finnemore (1996) suggests that norms make similar behavioural claims on dissimilar actors and coordinated patterns of behaviour which establishes the reasonableness and usefulness of norms as an explanation for behaviour of international actors.

Koch (2015) provides a detailed account of the ability of international organisations to create, diffuse, enforce and monitor certain norms which has consequences for establishing global order.

Svitchy (n.d) stresses that definitions of international organisations are State-centric in character and given the evolving nature of nation-states suggesting that the international relations studies should include relations between nations and new non -State actors. He suggests that the notion of 'global governance' can provide an alternative to keep up with this changing political context. According to Kaasch (2011) the basic features of global governance are mostly marked as a changing fabric of international society (Held and McGrew, 2002b cited by Kaasch, 2011), a new configuration of actors (Hein and Kohlmorgen, 2008 cited by Kaasch , 2011) or a growing complexity (Wilkinson, 2002 cited by Kaasch, 2011) due to diverse agencies and networks with overlapping jurisdictions, power resources and competencies.

Ng and Ruger (2011) argue that there has been a shift in the focus of studies from International health governance which was relevant till 1990s to Global Health Governance (GHG), which is gaining popularity with increasing economic interdependence, globalisation and vast international movements of people and products. They emphasise that GHG is "dramatically more complex than IHG, with a plethora of new actors and the accompanying deluge of uncoordinated activities" (Ng and Ruger, 2011 p.2). Fidler (2010) defines GHG as "the use of formal and informal institutions, rules, and processes by States, intergovernmental organisations, and non-state actors to deal with challenges to health that require cross border collective action to address effectively" (p.3).

Lee and Kamradt-Scott (2014) highlight three ontological variations in GHG scholarship. These include i) the scope of institutional arrangements, ii) strengths and weaknesses of existing institutions, and iii) the ideal form and function of GHG. They highlight three common, yet distinct, emerging meanings of global health governance as "i) globalisation and health governance, ii) global governance and health, and iii) governance for global health" (Lee and Kamradt-Scott, 2014 p.5). Similarly, Kickbusch and Szabo (2014) suggest that "it will be helpful to analyse global health governance along three political spaces in order to fully appreciate the links and the interface between the different institutions and processes involved in global health. According to them GHG refers

> "i) mainly to those institutions and processes of governance which are related to an explicit health mandate, such as the World Health Organisation; ii) global governance for health refers mainly to those institutions and processes of global governance which have a direct and indirect health impact, such as the United Nations, World Trade Organisation or the Human Rights Council; iii) governance for global health refers to the institutions and mechanisms established at the national and regional level to contribute to global health governance and governance for global health such as national global health strategies or regional strategies for global health" (Kickbusch and Szabo, 2014 p.1).

Studies engaging with the global health governance areas (though not explicitly stated) especially those concerned with the mechanisms of exerting influence by the international organisations on the recipient countries have widely used two concepts: 'policy transfer' and 'norm diffusion' to study the process of participation of global actors in policy-making. 'Policy transfer' has initially been an interest area of scholars engaged in comparative policy analysis. Dolowitz and Marsh (2000) defines it as "a process in which knowledge about policies, administrative arrangements, institutions at one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place"(p.344).

They elaborate on two kinds of policy transfer including voluntary and coercive and suggest making a distinction between 'direct coercive transfer' and indirect transfer where certain 'push factors' lead to policy transfer. They argue that it is rare to find direct imposition of policy transfer from one country to the other and highlight the role of supra-national institutions in coercive policy transfer. Taking examples of International Monetary Fund and the World Bank, they demonstrate their role in spreading Western monetary policies to Third World countries (Dolowitz and Marsh, 2000 p.344). Examining the role of The European Union (EU) and the European Court of Justice in driving policy transfer upon member nations, they cite Shapiro (n.d), who showed the process through which EU functioned as a policy-pusher, using its power to issue directives and regulations, while the European Court of Justice has forced governments to adopt policy directives the EU has issued (Shapiro n.d, cited by Dolowitz and Marsh, 2000) .

They also elaborate on the role of Trans-national corporations (TNCs) in forcing governments into policy transfer using the threats of not doing business with them. In cases of indirect coercive transfer, they take examples from the environmental policies elaborating the role of externalities

which result from functional interdependence in pushing governments to work together to solve common problems. For example they cite Hoberg (1991) who demonstrated policy transfer by Canadians from America for drafting their environmental regulation, because of indirect effect of United States' pollutants and regulations on Canadian border. They explain that there are always two or more actors involved in policy transfer and provided six main categories of actors involved in policy transfer: elected official, political parties , bureaucrats/civil servants, pressure groups, policy entrepreneurs/experts and supra-national institutions (Dolowitz and Marsh, 2000 p.345). Citing Rose (1991) they elaborate on the role of supra-national institutions and explain that, "Intergovernmental and international organisations encourage exchanges of ideas between countries . . . The European Community and OECD encourage exchanges among advanced industrial nations . . . and the World Bank and the United Nations agencies focus on programmes of concern to developing countries" (cited by Rose, 1991 Dolowitz and Marsh, 2000 p.345).

Rose (1991) also focuses on another similar concept of 'lesson-drawing' and brings in the important role of stakeholders at the receiving end or those responsible for implementing the policies transferred. He explains that lesson-drawing involves examining policies or programmes elsewhere to determine what has been done to solve problems (Rose, 1991). Using the example of United States Freedom of Information Act being utilised in Canada and Britain, Bennett (1991) demonstrates that "there is a natural tendency to look abroad, to see how other States have responded to similar pressures, to share ideas, to draw lessons and to bring foreign evidence to bear within domestic policy-making processes" (p.220). However, Stone (1999) highlights that lesson- drawing is a political process and actors involved in this process have the capability to manipulate this process. Lesson- drawing serves as a shortcut to problem solving dealing with the problem quickly and at lower cost (Stone, 1999 cited by Newmark, 2005).

Other political scientists who have focused on the study of 'Public policy' engaging with influence of global actors on policy-making in recipient countries used the method of 'policy analysis' in their studies. According to Hugh Heclo (1972) the term policy is usually considered to apply to something 'bigger' than particular decisions, but 'smaller' than general social movements' and it should not be narrowly understood in terms of its intentions but also its implementation and its (un)intended results. He suggests that "policy should be operationally identified, not by its goals, but by the actual behaviour attempting to effect the goals" (Hugh Heclo, 1972 p.85). In line with

this idea of ‘policy’, ‘policy analysis’ deals with not just the content of the policy, but also with policy-making process, its implementation and results. It deals with 'approaches, methods, methodologies and techniques for improving discrete policy decisions'(United Nations, 1993). A ‘Public Sector Management and Private Sector Development’ working paper of World Bank defines Policy analysis as “the task of analysing and evaluating public policy options in the context of given goals for choice by policy-makers or other relevant actors”(Paul et al., 1989). They elaborate that “the usefulness of policy analysis is by no means limited to macro-economic management but it is equally relevant to sectoral and programme-related policy issues (Paul et al., 1989 p.1). Others explaine policy analysis as “multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, to understand past policy failures and successes and to plan for future policy implementation” (Walt et al., 2008).

One of the popular framework in policy analysis, best known as public policy framework is the ‘stages heuristic’ which divides the public policy process into four stages: agenda setting, formulation, implementation, and evaluation (Brewer and deLeon 1983 cited by Walt et al. 2008). This framework has informed a large body of studies on public policy analysis; however, the framework has been criticised for presenting a rather linear process of public policy not taking into account the causality and demarcations between the four stages of policy process. The need for development of new theories is emphasised which is based on the integration 'of political scientists' knowledge of specific institutions and policy scholars' attention to policy (Sabatier, 1991).

Walt and Gilson (1994) note that policy analysis work in health has mostly focused on ‘the content of policy’, and neglects the actors involved in policy reform (at the international, national and sub-national levels). They argue that this focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge. Acknowledging that the process of health policy is extremely political and dynamic, they argue that policy analysis merits for an in-depth understanding of health policy process in comparison to approaches which concentrate on the technical aspects of the policy (Walt and Gilson, 1994). They also observe that policy analysts to some extent have also engaged with the ‘context’ exploring the macro and contextual factors that influence policy. However, they have placed the ‘role of State’ as their central concern. Such studies include reviewing relative role of State in policy-making in

comparison to other (Mackintosh, 1992 cited by Walt and Gilson, 1994) , role of State in assisting markets to work better (Streeten, 1993 cited by Walt and Gilson, 1994) and handling the role of State in the functioning of free markets (Perkins and Roemer, 1991 cited by Walt and Gilson, 1994).

They propose an analytical model for policy analysis to be applied for the health sector. This model came to be popularly known as 'policy-triangle' which incorporates four main concepts of i) context which refers the broader systematic factors influencing policy-making including political, economic and social contexts; ii) process which refers to the ways in which policies are formulated and implemented; iii) actors which refers to various organisations, institutions and individuals that are directly or indirectly involved in the policy process including organisations and institutions which are outside the authority of State and whose primary purpose is not to promote health; and iv) content which refers to the main elements of the policy. Content not only covers the actual blueprint of plans and guidelines but also the implementation of the policy under study. They suggest that this model is nearer to political economy approaches and draws on the concepts of several disciplines but have been dominated by economics and politics (Walt and Gilson, 1994) [25].

1.5 GAPS IN LITERATURE

The present review confirms that under the four concepts of policy analysis triangle, a large part of studies on role of global actors in health policy have focused on the 'content' part of the policy. Major part of the literature focuses on what has been introduced in health policy. The quantum, nature, priority areas and motivations of aid have dominated the number of studies in this domain (Michaud and Murray, 1994) (Howard, 1983) , (Clinton and Sridhar, 2017) (Ravishankar et al., 2009)and (Bendavid E, et al., 2017).

[25] A similar policy analysis framework popularly called as 'policy stream framework' as been applied in studies on the process of agenda setting. This framework asserts that convergence of three streams of: i) problem, ii) politics and iii) policy is required for policy making. Problem stream engages with the process of framing and recognizing certain issues as problems whose solutions take priority on the agenda. Political stream deals with the context which (dis)enables those issues to get priority. These (dis)enablers include national mood, consensus among organized forces and changes in government. And the Policy stream involves formation and growth of policy proposals. These proposals are backed by several merits like technical feasibility, public acceptance and reasonable cost. This stream deals with the study of "how policies 'find' a problem to back up and who is behind those policies"(Fischer, 2003).

This is also true for studies done on India's HSS policies. For example, the early work from Jeffery (1986) focuses on 'policy content' as he analyses the patterns of health sector aid in India from 1947 to 1980s, and demonstrates the primacy of USA as primary donor, highlighting the control of communicable diseases and population control as the focus areas of aid. Similarly, Gordon (1997) examines the role of two big American philanthropies namely Rockefeller and Ford Foundation in India[26] by focusing on the 'content' part, including some of the 'context' questions tracing the interests and modes of working of these philanthropies in India .Gupta and Gumber (2002) do a similar exercise by examining external aid in India from 1960s to 2000 and reflect upon the extent of utilisation of the external funds and briefly deal with the problems associated with the externally funded projects. They confirm the earlier arguments made by Jeffery that till 1980s, USA was the most prominent actor providing aid to India and Post mid-1980s, World Bank became the single largest donor of funds marking a change in the passive role of donors in influencing health policies in India to becoming an active participant in policy processes(Gupta and Gumber, 2002).

Others have evaluated one or more projects of global actors in health. For example, Ravindran, (2007) studies nine State health systems development projects of World Bank and highlight the performance gaps against the stated project objectives. She also focuses on the 'content' of the policy focusing her enquiry of the components and outcomes of the projects through end-of project evaluation documents (Ravindran, 2007). These studies do not sufficiently provide a macro-level analysis of the health policy process in India. Being limited to one actor or one area of work of one global actor limits their scope to sufficiently develop a comprehensive understanding of broader process used by global actors in shaping health systems development agendas in India.

This scarcity of country level studies on role of global actors in health systems strengthening initiatives in India is located in the following methodological complexities in studying health systems strengthening landscape. Most important part of this complexity is the prevailing ambiguities around defining health systems strengthening and its components (World Health Organisation, 2007; Marchal et al., 2009 ;Reich and Takemi, 2009;Van Olmen et al., 2012; Hafner and Shiffman, 2012; Chee et al., 2013). Given the multiple meanings of health systems

[26] This work was not focused on the role of philanthropies in health sector in India but on a larger (evolving) mandate of these organisations.

strengthening (discussed in the next chapter), country wide studies have approached HSS from varied and often asymmetrical dimensions focusing on either selected component(s) or function(s) of health systems often at (State) sub -national or (district) sub-sub national level. Secondly, the involvement of range of stakeholders including State (at national, State and local level) and non-State (national and international) actors in designing and implementing HSS initiatives makes it difficult to hold one actor accountable for the final policy and its impact. Thirdly, the policy-making (and implementation) is dependent on the wider context of policy path dependency[27], socio-economic, political and structural changes taking place in the overall policy domain. This makes it challenging to delineate the context from the actors and their interventions and modes of participation making it challenging to hold actors responsible for policy outcomes and impacts.

To address the gaps in evidence on process of global actors' participation in HSS policies, the present study aims to conduct a 'country level' analysis on global actors' participation in health policy making post 1990 focusing on understanding the process used by global actors in diffusing their ideas in the policy process. It aims to uncover the range of actors involved in health systems strengthening in India situating the analysis in an overarching network and relation-based health governance framework. A detailed conceptualisation and methodology for the study is presented in the next chapter.

[27] Path dependence is defined as a situation where the present policy choice is constrained or shaped by institutional paths that result from choices made in the past.

CHAPTER 2

RESEARCH APPROACH AND METHODS

This chapter outlines the research approach and gives an account of the broad logical plan followed for the study. Research design and methods for this study are shaped by the existing context of health governance and HSS policy-making process in India and key research objectives of the study.

2.1 CONCEPTUAL BACKGROUND

Critical review of the debates about the meaning, definition, constituents and uses of HSS, highlight the need for differentiating between three conceptualisations (concept, goal, strategy) of HSS. While HSS has been discussed as a concept and a goal, discussions on HSS as a strategy has dominated the discourse on its meaning.

Conceptualisation of HSS as a strategy has equated it with improving performance or improving efficiency of the health systems. HSS is a continuum including two kinds of interventions that is i) increasing the resources like finance, drugs and equipment and human resources resulting in improved health outcomes and ii) improving processes for effective utilisation of these resources for achieving overall health systems goals (including better health outcomes).

Descriptive frameworks like Six building blocks point to an idea of HSS that is limited to increasing resources and analytical frameworks like Control Knobs framework point to the mechanisms of effective utilisation of these resources helping in understanding and initiating broader behavioural reforms in health systems to improve the processes of allocation and utilisation of resources. However, these widely used and dominant HSS frameworks do not sufficiently focus on the governance ideas inherent to both increasing as well as effectively utilising the resources for achieving health systems goals.

Recognising governance as the cornerstone of both these ideas of HSS though will be useful, the discourse on health governance itself needs to better acknowledge the function of governance operating at the macro policy level health system reforms in addition to the operational aspects of governance (working at different levels of the health systems) in undertaking HSS policy analysis. This needs a shift in discourse on governance in HSS currently dominated by the idea of governance as a function of health systems outlining the desirable attributes of governance to a broader network-based conceptualisation of governance, as one in which governance is co-produced by a range of actors (including the non-State and non-health actors [28]) at different levels (from citizens, communities, regional, sub-national, national and supra-national) of the health system. Network-based and jointly-produced understanding of governance refers to governance beyond government with multiple centres of authority, recognising the process of policy-making as a complex exercise involving negotiations between formal and informal actors, structured around their interests in policy-making and implementation.

This conceptualisation of governance is useful for understanding HSS policies as i) it acknowledges that governance is a 'global' process in which different actors at different levels are interacting with each other outside the authority of the State (for example grassroot community-based organisations directly interacting with the supra-national institutions like World Bank and World Trade organisations) having implications for State sovereignty. ii) it recognises the complexities in policy-making by embracing the role of and negotiations among different factors which influence health systems policies and have implications for blurring the mechanisms of accountability in policy-making and implementation (as the non-State and non-health actors are in most cases not accountable to either governments or communities for improving health).

While many actors (operating at different levels) are involved in the HSS policies, not all actors enjoy the same amount of significance and weight which determines their policy influencing power. National level actors fall under the boundary of State and hence can be held accountable by the State for their policies and actions, but there is no single authority above supra-national or global actors which can hold these actors accountable for their policies and actions. Such lack of authority poses a challenge to regulate the role of global organisations in policy processes in

[28] Non-health actors refer to actors and institutions whose primary objective is not promoting health but they play an important role in health systems and impact the health outcomes. Such actors include multilateral institutions like the UNICEF , the World Bank, and the Regional Development Banks.

different countries. The above proposed conceptualisation of governance is suitable to understand the policy process in a more nuanced way as it helps in analysing the extent of and methods through which different actors participate in policy-making and implementation. The extent of each of global actors' involvement in HSS policy-making vary depending on different parameters (like their financial and normative power), but these actors are all a part of a larger network (of individuals and organisations) continuously interacting with each other in policy formulation.

This study examines global actors as important stakeholders in network-governance. It studies their participation in HSS policies in India using the following research design and analytical framework.

2.2 RESEARCH DESIGN

A research design is a blueprint of research, dealing with at least four problems: what are the questions being addressed by study, what data are relevant, what data to collect, and how to analyse the results (Yin, 2009). A robust research design allows to be sure that the evidence obtained will answer the initial question as clearly as possible.

This study is designed as a policy research. The term 'Policy' has been used in a variety of ways including an expression of general intent, specific decisions made by government, broad guidelines issued by institutions or organisations, broad area or field of work, specific outcomes and outputs of a decision and more. This study uses Hugh Heclo (1972) conceptualisation of policy as "something 'bigger' than particular decisions, but 'smaller' than general social movement"(p.85). According to him, policy "should not be narrowly understood in terms of its intentions but also its implementation and its (un)intended results… should be operationally identified, not by its goals, but by the actual behaviour attempting to effect the goals" (Hugh Heclo, 1972 p.85).

John (1998) refers to two kinds of policy research i) research 'for' policy which he describes is like an evaluative research concerned with the content of the policy and engaging with questions like "what should be done" or what has been the outcomes and impacts of a particular policy. ii) research 'on' policy which is an explanatory research concerned with studying the policy process engaging with the 'how' and 'why' questions (p.1). He elaborates that research on policy "seeks

to understand how the machinery of the State and political actors interact to produce public actions...the main tasks … are to explain how policy-making works and to explore the variety and complexity of the decision-making processes“ (John, 1998 p.1).

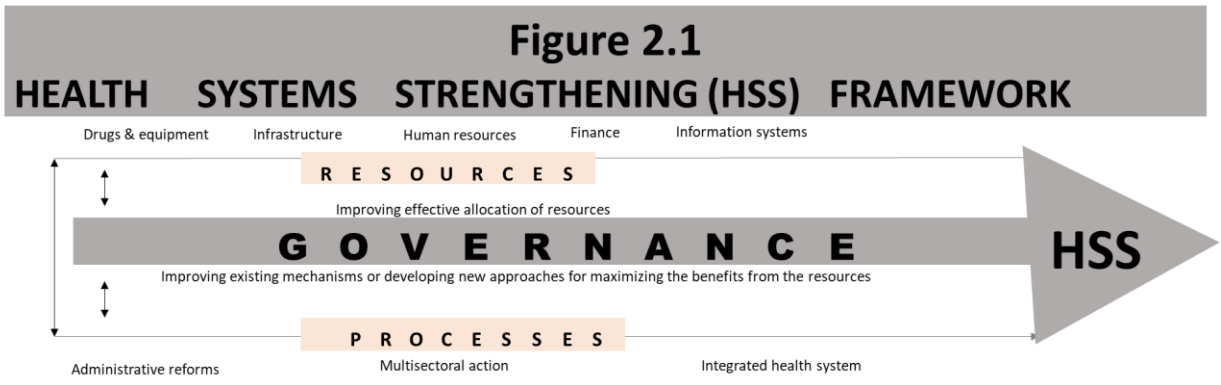
This study is designed as a research on policy aiming to understand the process of HSS policy formulation in India by addressing the following aspects of policy-making.

- ‘Who’- Who are the major global actors involved in the HSS policies in India?
- ‘What’ – What is the nature and extent of the engagement of global actors in HSS policies in India?
- ‘How’- How are global actors participating in the HSS policies in India?

2.3 OPERATIONAL FRAMEWORK

For analytical purpose, this study treats HSS as a continuum of increasing resources to improving existing mechanisms or developing new approaches to maximise the benefits from existing resources for achieving health systems goals of equitable access, quality of care and responsive health systems (see figure 1). Resources include drugs and equipment, infrastructure, human resource, finances and information systems. Processes include mechanisms for effective utilisation of these resources like administrative reforms, multi-sectoral action, integration of health services, community involvement, innovative alternate financing etc.

As shown in the figure 2.1, this conceptualisation of HSS recognises that though increasing resources is a part of HSS, the increase in resources is accompanied by processes and mechanisms for effective utilisation of these resources to achieve HSS. This conceptualisation also stresses that ‘governance’ plays an important role along this continuum of increasing and effective utilisation of resources and thus is the cornerstone of HSS policies. It treats the idea of governance functioning at the macro policy level health system reforms as well as its operational aspects working at institutional (health facilities) and community level (community-based health initiatives and interventions.



Source: adapted from (Berman, 2009)

This study benefits from the frameworks of policy analysis focusing on understanding the 'process of policy-making'. It uses the 'policy-triangle' framework developed by Walt and Gilson (1994) for analysing global actors' engagement in HSS policies in India. According to Walt and Gilson (1994) policy-triangle approach draws from the political economy frameworks of analysis and incorporates four main concepts of policy that is context, process, actors and content.

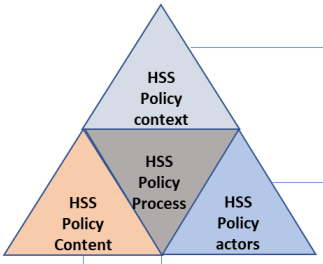
- Context refers to the broader systematic factors influencing policy-making. These include the political, economic and social contexts in which policies emerge. Existing contexts at different levels from local to national and global play a role in policy-making. These include i) situational factors- transient, impermanent conditions which can have an impact on policy (e.g. wars, droughts) ii) structural factors- relatively unchanging elements of society (e.g. the political system, type of economy, demographic features) iii) Cultural factors- religion, ethnicity, gender iv)international or exogenous factors- some policies require cooperation between national, regional or Multilateral organisations.
- Content refers to the main elements of the policy. Content not only covers the actual blueprint of plans and guidelines but also the implementation of the policy under study.
- Actors refer to various organisations, institutions and individuals that are directly or indirectly involved in the policy process. These include organisations and institutions which are outside the authority of State and whose primary purpose is

not to promote health. For example, global financial institutions, civil society organisations, private sector companies.

- Process refers to the way in which policies are formulated and implemented. Process goes beyond the process evaluations to include why and how were the policies made.

2.4 ANALYTICAL FRAMEWORK

Figure 2.2
Framework for data collection
Policy analysis – Global actors' role in health systems strengthening policies in India



Factors enabling the influence of global actors in HSS policies
- Financial crisis
- Political readiness for reforms
- Rigid administrative procedures
- Perceived Knowledge gaps
- Policy stakeholders' interests

Global actors involved in shaping HSS policies
- Bilateral (State government and international agencies working with another state)
- Multilateral (United nations agencies and regional agencies working with multiple states)
- International financial institutions (Global & regional Development Banks)
- Non-governmental organizations, humanitarian and religious agencies
- Global health and development think tanks

Methods and tools for influencing HSS policies

Methods
- Transferring HSS policies from abroad
- Producing, Diffusing and Legitimizing HSS ideas

Tools
- Producing HSS ideas (Policy & strategy papers)
- Diffusing HSS ideas (financial & technical assistance
- Legitimizing HSS ideas (partnering with & support other actors in health system)

HSS ideas diffused by selected global actors

Increase in resources
- Drugs and equipment
- Infrastructure
- Human resource
- Finances
- Information systems

Improvements in processes
- Administrative reforms
- Integration of health system
- Financing reforms
- De-centralised governance
- Multi sectoral action
- Promoting non-state actors
- Enhancing community engagement

Source: adapted from (Walt and Gilson, 1994)

This thesis examines the content, context, actors and process component of HSS policy process focusing on the ideas and process aspect to understand the ways through which global actors participate in HSS policies. As shown in figure 2.2:

- Content aspect of policy in the study engages with exploring the HSS ideas and interventions diffused by global actor(s). These include increase in resources (like drugs and equipment, infrastructure, human resource, finances and information systems) as well

as processes (like administrative and civil services reforms, integration of health systems and multi-sectoral action in health governance).

- Actors aspect of the policy under the study deals with understanding the landscape of various organisations and institutions involved in HSS policy-making focusing on the global actors and studying the extent of involvement and shifts in significance of global actors in HSS policy-making in India over time. Studying the actors was the first logical step followed in this enquiry. After mapping different global organisations in HSS policy-making, one global actor (World Bank) was chosen (reasons for this selection are discussed in the following section) to understand the aspect of 'ideas' and 'process' in detail.

- Context of HSS policy-making engages with understanding the broad political and economic context of policy-making. This includes issues of economic and fiscal situation in India, political context in term of leadership at National and State levels (at both technical and administrative level) that is health and finance ministries as well as National and State-level elected representatives of political parties which encourage global actors to assume a dominant place in policy space.

- Process aspect studies the ways in which HSS policies are formulated and implemented. Using the network-governance conceptualisations of HSS policies, this section engages with studying the methods and tools mechanisms that Bank has used to engage with and influence HSS policies. This includes studying methods i) methods of policy transfer and norm diffusion used by the Bank which includes tools like ii) production (through producing HSS policy and strategy papers), diffusion (through provisioning of financial and technical support to government) and legitimisation (negotiations and relationship with other actors like central and state government departments and other actors including civil society and other development agencies) of specific ideas (or the content) of HSS policies.

2.5 RESEARCH QUESTION AND OBJECTIVES

Broad research question guiding this study is

Which global actors participate in HSS policy process in India? What HSS ideas they promote? How do they participate in these policies and what contextual factors enable their participation in these policies?

Broad Objective

To study the range of global actors engaged in HSS policies, key ideas of HSS diffused by these actors, key strategies adopted by these actors for participating and the broad political and economic environment which enables these actors to participate in HSS policies in India post 1990.

Specific objectives

1. To understand the landscape of global actors' participation in HSS policies in India post 1990.
2. To understand the political, economic and public administrative context which enables global actors to participate in HSS policies in India post 1990.
3. To understand specific HSS ideas diffused by global actors in India post 1990.
4. To understand the methods and tools through which global actors participate in HSS policies in India post 1990.

2.6 RESEARCH METHOD

This study examines global health actors within the broad historical, macro-economic and development assistance context of the health systems development as well as the context of existing governance and service delivery structures in India. It is both exploratory and explanatory and addresses the 'what'(content) as well as 'who' (actors), 'why' (context) and 'how' (process) questions related to policy process. It involves an in-depth understanding of a case (that is global actors) set in the broad real- world context. The boundaries between different elements of policy that is context, content, actors and processes of policy-making are not explicitly marked as these

components are dependent on each other. These elements of this research make a case study method as the best suited research method for carrying out the study.

Yin (2009a) defines 'case study approach' as "an empirical inquiry about a contemporary phenomenon (a "case"), set within its real-world context—especially when the boundaries between phenomenon and context are not clearly evident (p. 18). He describes two broad types of case studies: single and multiple. He adds that, though multiple case studies provide strong and reliable evidence for comparison across different cases (clarifying if the results are valuable or not), single case studies are better for an in-depth understanding of the subject under study (Yin, 2009a).

For a deeper understanding of a particular aspect or actor within the existing single case study, he explains that a researcher can use single case study with an embedded (sub) unit(s) of analysis to explore the subunits located within larger cases (Yin, 2009a). According to Scholz and Tietje (2002) an embedded case study involves more than one unit or object of analysis. It allows for focusing on different salient features of the case under study. They give an example of an embedded case study in an organisational case study noting that the main unit of analysis may be a company as a whole, and the embedded unit of analysis may be the departments or even groups of individuals, such as owners and employees. Bass et al. (2018) suggest that embedded case study approach should be differentiated from multiple case study approach. According to them, in a multiple case study approach, different (multiple) cases are studied in equal detail with aim of either corroborating the evidence or comparing the evidence from multiple studies to complete a holistic understanding of the case. Where as in an embedded case study approach, other cases are the sub-unit(s) of the main case and often the sub-unit(s) are studied in more detail to understand a particular aspect of the main unit or case. They further add that both multiple and embedded case study approach are suitable for a holistic understanding of a case, however while using a multiple case study approach which places equal focus on different cases, there is a potential to sacrifice some level of descriptive richness in each case (as the focus in mainly on making comparisons between cases than understanding an aspect in complete detail).

Considering the above limitation and strengths of both single and multiple case study approaches in providing a deeper understanding of the process of policy-making, a single case study approach with an embedded study of one sub-unit is chosen as the research method for this study. For this purpose, the main unit of analysis are the global health actors which are studied as whole to

answers the objectives of 'content, actors, process and context' of policy process, and World Bank has been chosen as a sub (embedded) unit of analysis to study these policy components in detail with a special emphasis on policy content and process.

2.7 INFORMATION GENERATION PROCESS

2.7.1 Kind of data collected for the study

Case study method permits the use of both qualitative and quantitative forms of data and different sources of information can be used to collect data for different objectives and sub-cases.

This study uses both quantitative and qualitative data to construct a holistic understanding of the global actors' involvement in HSS policies in India. Quantitative data was largely collected to understand the extend of involvement of global actors in HSS by exploring the amounts of aid they have given to India. This data included understanding the grant portfolios, aid commitments and disbursements by different global actors in health in India. Qualitative data was collected to fulfil all four objectives of the study that is: to understand the content of HSS policies diffused by global actors, landscape of different global actors engaged in HSS policies, broader context in which global actors participate in HSS policies and the process or ways in which global actors participate in HSS policies.

2.7.2 Methods of data collection

For the purpose of this study, data has been collected by using two broad methods: i) desk review and ii) field work.

For desk review, primary and secondary information in forms of documents produced by or produced for global actors (which contained relevant information for understanding one or more elements of policy process) were used as the principal source of data. Field work included interviews with key stakeholders involved in policy process to understand their perspectives about all four elements of HSS policies.

2.7.2.1 Desk review

Desk review was done in three phases, first phase focused on reviewing key documents and literature on health systems and health systems strengthening for conceptual clarity on these concepts and developing an operational definition of HSS for the study. After this, (using the operational definition of HSS) the second phase of desk review focused on mapping the landscape and key HSS interventions and ideas of global actors involved in HSS policies in India. This involved studying all four elements of HSS policies and led to the third phase, which focuses on understanding the World Bank's HSS ideas and processes for participating in HSS policies in India.

Documents as primary data

Documents formed the primary sources of data for this study. Both primary and secondary documents were examined in order to understand all four elements of policy process (see table 2.1).

Primary documents included documents which were produced by the global actors. These were used to understand the 'content' of the policy that is the key HSS ideas and interventions diffused by global actors including documents produced by the global actors. As shown in table 2.1, these included i) strategy papers (both theme specific as well as country specific), policy papers (both theme specific as well as country specific) and constitutional documents and ii) reports like internal evaluation reports, project implementation reports, annual reports. These documents were used to understand specific HSS initiatives and interventions supported by global actors in India (as stated by them).

Secondary documents included documents not produced by the global actors themselves but are related to the work of global actors. These documents covered mostly one but sometime more than one global actor. As listed in table 2.1, these included evaluation reports, journal articles, opinion papers (not authored or published by the respective global actor). For example, for the World Bank, the secondary documents included largely evaluations (both project and intervention specific) of Bank's initiatives by researchers (sometimes these researchers were the ex-staff members of the Bank). This set of documents provide information on Bank's history, its composition, changing mandates, key HSS ideas and intervention and helped in triangulating the findings from the primary documents.

Different kinds of documents were used during different phases of the study. For example, during the second phase, which was focused on mapping global actors' engagement in HSS policies in India, documents like annual reports, strategy papers, project evaluations of different actors constituted main source of data. These documents provided a broad overview of the quantum of funds, areas (both geographic and thematic) of work and performance of HSS initiatives of global actors engaged in health. The next phase, which aimed at establishing a deeper understanding of role of World Bank in shaping health systems strengthening policies in India focused more on documents relating to Bank's financial lending (in form of health systems projects) and knowledge production activities. These included strategy papers, policy papers, concept papers and project implementation reports. These documents helped in charting out Bank's theoretical orientation as well as practical prescriptions for HSS policies in India.

Table 2.1- Type of documents used: Key objectives, examples, level and search strategy

Objective	**Type of document**	**Example**	**Level**	**Search strategy**		
				Step 1	**Step 2**	**Step 3**
HSS ideas & approach	Policy papers	Financial policy paper, health sector policy paper	Global & country specific	Website	cross references	Google scholar search
HSS interventions	Strategy papers	Country strategy, country partnership, country assistance,	Global & country specific	Website	cross references	Google scholar search
HSS interventions	Internal evaluations	Detailed implementation reports	Project specific	Website	cross references	
HSS interventions	Project papers	Project implementation reports	Project specific	Website	cross references	
HSS approach & interventions	Annual reports	World development reports, world health reports	Global & country specific	Website	cross references	Google scholar search
HSS interventions	Grant portfolios		Global & country specific	Website	cross references	
HSS approach & interventions	External evaluations	Project evaluations, studies focusing on shifts and motivations of 'development aid in health'		Journal articles, working papers, Books	cross references	

In most of the cases these reports, and documents mentioned that they do not represent the views of the (global) actors but those of the authors. However, i) affiliations of the authors of these documents with the specific organisations, ii) organisation as the publishing authority of these documents and iii) the overall match between the documents and overall policy recommendations of these organisations were considered to draw links between the documents and position or ideas being diffused by the global actors.

Almost all documents were accessed in electronic copies in English language. These documents were identified by a three-step process. The first step was searching relevant literature by using the standard search guide on the websites of global actors using keywords 'health systems strengthening', 'health systems development', 'grants', 'projects', 'strategy', 'approach', 'framework'. After this initial screening of these documents, cross references were used to obtain related documents. After this a google scholar search was made using the same keywords to obtain other relevant documents. Documents were also received by signing up on the global actors' websites for updates about their activities. Few of Bank's documents were obtained through email by submitting an information request form on their website.

Websites as primary data:

Global actors' websites constituted an important source of data during desk review and were considered as primary data as this data was produced by the global actors. Websites provided i) primary documents (like strategy papers, policy papers, research publications, working papers discussed above) and ii) unstructured data in form of webpages. The unstructured data included webpages listing the grant portfolios; history and key intervention areas of specific actors; key partners of these actors, news articles, media coverage and more. These data were used to construct an understanding of the magnitude of involvement of different global actors in HSS policies and the 'content' of HSS policies. At the same time, websites also were studied as the medium of 'exerting influence' by the global actors as they act as a channel for of information dissemination to other stakeholders.

2.7.2.2 Field work

Field work started after completing the desk review and was done in two phases. In the first phase, key stakeholders involved in HSS policy-making (at National and State-level) were identified and interviewed for understanding all four elements of HSS policies. After this phase, key stakeholders involved in diffusing World Bank's HSS policy ideas and interventions were identified and interviewed in the next phase to develop a deeper understanding of the processes and ways in which Bank participates in policy-making. After completing the field work, another round of desk review was done to include key documents and reports suggested by respondents during the interviews. During the field work data was collected through elite interviews. These interviews were conducted to supplement and triangulate data on all four elements of policy process.

Elite interviews belong to the family of qualitative interviews. Stephens (2007)defines elites as those who occupy senior management and Board level positions within organisations. In social science research elite status has been ascribed to certain stakeholders depending on their access to information that can help answer a given research question. For the purpose of this research these stakeholders were treated as 'elite' as they had a role in health policy process and had access to

and ability to produce specific forms of knowledge. As shown in table 2.2, these interviews were done with national, State-level government stakeholders and development professionals working in different development organisations including the World Bank. Interviews formed a significant part of the data in this study as it provided very useful information in terms of perspectives about the ideas, approaches and role of global actors in HSS policy process in India and triangulating the data collected from the documents.

Table 2.2- Interview respondents

		Professional working in development organisations		
	Government officers	Professions working with Global organisations		Professions working with quasi-government organisations
No.of respondents		Other development agencies	World Bank	
	12	11	7	4

Interviews were particularly useful for understanding the 'process' aspect of policy-making especially negotiations and relationship among different global actors involved in policy process. Interviews also provided information about other relevant documents for the analysis and potential respondents were identified through these interviews.

Tool for data collection

A separate interview schedule was prepared for all respondents (see annexure 1) depending on their involvement in health system strengthening policies in India. Each interview lasted between one to three hours. After stating the purpose and potential use of information provided, respondents were asked about their preferences for using their identities and for permission to audio record their responses. Only two out of thirty-four respondents agreed for using their names and current affiliations and four refused to be recorded. Notes were taken for those who refused to be recorded and for others the audio recordings were transcribed in full verbatim.

Selection of respondents and the process of data collection:

Interview respondents were purposively chosen based on their involvement in the HSS policy-making in India. This included government officers (present and retired) and (technical as well as administrative officers) and officials working with global health organisations. As given in table 2.2, a total of thirty-four interviews were done. Respondents were identified from the key documents and reports of the respective global actors, analysed during the desk review. The World Bank officials were identified from the project implementation reports. All respondents were contacted via email for a face to face meeting or a telephonic call. The email included a short description of the study and outlined specific purpose of the proposed interview.

Interviews with these professionals were not difficult to fix as most of them seemed interested in knowing more about the project and were happy to participate in the study. Fourteen interviews with the professionals working with global organisations and State-level government officials were held over skype. Rest twenty interviews were done face to face in Delhi with the respondents from both national government offices and professional working in national offices of development aid

agencies. Government officers interviewed included the administrative staff, the technical heads of National Health Programmes and staff working at quasi – government institutions[29].

2.8 DATA ANALYSIS

Separate methods were used for analysing data collected from desk review and interviews.

Interviews were transcribed in verbatim and thematic analysis for the interviews was done manually. Interview respondents were identified as CG- Central government officers, SG- State government officers, B- professionals working with the World Bank, DP- professionals working with other Development partners and agencies. For quasi government organisations, CG and SG for quasi government organisations at Central and State government level. For analysing documents and websites, the method of document analysis was used.

According to Bowen (2009) document analysis is a qualitative method used in research studies which combines the methods of content and thematic analysis. It is a systematic procedure for reviewing or evaluating documents—both printed and electronic (computer-based and Internet-transmitted) material. But this is not like the review of literature which is review of previous studies. Documents are any written material relevant to the study that may be used for systematic evaluation. As described above, documents were used as the primary source of data in this study. Document analysis involved skimming (superficial examination), reading (thorough examination), and interpretation of the data.

Content analysis is the process of organising information into categories related to the central questions of the research. Content analysis is described a set of analytic approaches ranging from impressionistic, intuitive, interpretive analyses to systematic, strict textual analyses (Rosengren, 1981 cited by Hsieh and Shannon, 2005). The specific type of content analysis approach chosen by a researcher varies with the theoretical and substantive interests of the researcher and the problem being studied (Weber, 1990 cited by Hsieh and Shannon, 2005). Current applications of content analysis show three distinct approaches: conventional, directed, or summative. In

[29] Quasi government institutions are government technical support units which have been set up by the government and provide technical support to the government but are autonomous in their administrative capacities.

conventional content analysis, coding categories are derived directly from the text data. With a directed approach, analysis starts with a theory or relevant research findings as guidance for initial codes. A summative content analysis involves counting and comparisons, usually of keywords or content, followed by the interpretation of the underlying context.This study followed a conventional content analysis of data obtained from documents and interviews(Hsieh and Shannon, 2005)

As a first step in documentation analysis, abstracts and executive summaries of all documents was scrutinised to see if they are relevant for the study. Relevance was checked to see if they contain information on one or more of the elements (content, actors, context and process) of the policy process. This was done by coding specific sections in the documents which could be used for understanding HSS policies. Same process was followed for analysing data from global actors' website. As a first step, all webpages sections on websites were scrutinised to check their relevance for the study. Useful data was then copied on a word document with date and author if available. This was followed by coding sections on the documents which could be used for understanding HSS policy process. In the second stage, data from documents and websites were combined and selected sections in these documents were coded as per the objectives and elements of policy process (that is actors, content, context and process). Data for 'context' and 'process' was more difficult to obtain from the documents in comparison to data on 'content' and 'actors' as bulk of the documents provided direct information on 'content 'followed by information about 'actors. For analysing the interviews, as the first step, all interviews were transcribed in full verbatim using the audio recordings. Cases where recordings were not available, hand written notes were used to transcribe the interview. This was followed by reading and coding the interviews under four aspects of policy process that is content, actors, context and process.

After this stage, codes on aspects of policy process was individually sub-coded to highlight key words. For example, for the content aspect, key words like focus on health services, promoting user charges, promoting private sector participation, improving institutional capacities were used. For the process part, codes like key partners, conditions for granting loans, process of granting loans, support provided by Bank to States for writing loan proposal, strategies used by Bank to offer technical assistance work were used. In the last stage, these codes were then analysed and grouped under broad themes. Codes and themes were developed manually without help of any software.

2.9 ETHICAL CONSIDERATIONS

An ethical clearance for this study was obtained from the University's Ethical clearance board before starting field work (see annexure 2). No major ethical issues were witnessed while using documents.

For interviews, as most interviews were scheduled via email, the introduction email gave details about the researcher and her institutional affiliations, broad purpose of the study and potential use of information. While conducting interviews (both face to face and virtually), respondents were once again told the purpose of interviews and potential use of data. They were assured of maintaining complete anonymity.

After the introduction, researcher asked for permission to audio record the discussion. Before starting the interview, respondents were asked about their preference for preferred identity to be used while quoting them. Most respondents said they would like to tell their identity part after completion of the interview. Only two respondents agreed to use their name and institutional affiliation for quoting them. Four respondents refused to audio record the discussion.

2.10 LIMITATIONS AND CONSTRAINTS OF THE STUDY

Challenges in data collection

- As all aspects of policy process are interdependent and inter-related. Dividing data as per specific heads of content, actor, context and process was later realised to be not very helpful. In few cases, same quotes were coded twice to be included under two or more aspects of policy process.

- Obtaining data from websites of international organisation was challenging for maintaining data consistency as the websites were often updated in the course of data collection. Updating website involved reorganisation of material on the website, addition of new documents and removal of older documents. This was found to be particularly challenging

in case of accessing World Bank's website as the search criteria for projects were updated and the project categories also reflected change. Global Fund's website also rearranged their grant portfolios during the course of data collection.

- Another challenge faced while obtaining data in terms of quantum of funds disbursed by global actors to India was the change in currency rates. For example, WHO's reports on total official aid given by different donors to recipient countries was calculated at the current price of US dollar at the point of report preparation (for ten years). The current price by the virtue of its nature is not static and this resulted in inconsistent figures on the same indicator in different reports. It posed a challenge to compare these figures across decades.

CHAPTER – 3

LANDSCAPE ANALYSIS OF GLOBAL PARTNERS' PARTICIPATION IN HEALTH SYSTEMS STRENGTHENING POLICIES IN INDIA

INTRODUCTION

As discussed in the previous chapter, a number of global health actors (also called as international or external actors or partners) participate in shaping various health policies. These actors include philanthropic organisations, Bilateral agencies which channel assistance directly from one country to another, Multilateral agencies where donors provide aid indirectly by pooling resources together from many donors, International financial and economic institutions, regional organisations and economic unions, public-private partnership and NGOs. Table 3.1 presents a comprehensive list of all international actors involved in health.

The landscape of global actors in health in India witnessed changes in the magnitude, prominence,

Table 3.1- Types of international health organisations	
Type of international organisations	Examples
UN (Multilateral) agencies	WHO, UNICEF, UNAIDS, UNFPA, UNDP, UNEP
International financial and economic institutions	World Bank, IMF, WTO
Bilateral aid and Development agencies	USAID, SIDA, DFID, JAICA, DANIDA, NORAD
Regional Organisation and Economic Unions	OECD, Africa Union, European Union
Private foundations	Rockefeller Foundation, Ford foundations, Welcome trust, BMGF, Clinton foundation
Public-Private Partnerships	Global Fund, GAVI, GAIN, Stop TB partnership
NGOs	CARE, PATH international, Save the Children
Source: adapted from (Birn et al., 2017 p.142-43) Typology of Global/ International Health Actors and Programmes	

and strategies used by these actors for participating in HSS policies in the last forty years. These

shifts were observed along the establishment and later prominence of newer international organisations in health which also brought in novel mechanisms and ideas for health systems strengthening in India.

This Chapter aims to provide a broad timeline overview of major global actors engaged in health systems development in India. Using the analytical framework (figure 2.2, chapter 2), it addresses all four objectives of this research and analyse four components of HSS policy-triangle. These shifts are discussed in five phases and the chapter is divided in five parts covering the time period from 1940s to the present decade starting in 2010. Each phase is further divided to discuss the i) HSS actors : examining the prominence of major global health actors such as Bilateral and UN Multilateral agencies, international financial institutions and philanthropic foundations ; ii) HSS ideas : examining ideas promoted by global health actors under two broad rubrics of a) increase in resources like infrastructure, drug and equipment supplies, human resource and financing and b) improvements in processes like administrative reforms, integrated health systems development and multi-sectoral action in health, iii) process of exerting influence including the methods and tools used by global health actors to participate in HSS policies constituting direct provisioning of services, financial support and technical assistance and iv) overall context including broader economic, political and social context which enables the participation of global actors in HSS policies in India.

3.1 1940s-60s: AGE OF PHILANTHROPIC POWER AND BEGININGS OF INSTITUTIONALISATION OF INTERNATIONAL HEALTH

Actors

1950s and 60s marked the years of significant political change and development of newly independent countries like India. Provisioning of development aid became an important channel for achieving these development goals. According to Gordon (1997) two decades following the independence are considered as ‘ golden age of American involvement’ in India as America was the key source of foreign assistance for India, providing a net worth of $107 million to India

between 1950 to 1973. The earliest support from America came in the form of missions and philanthropic organisations which were associated with Christianity.

Christian missionaries and philanthropic organisations like the Rockefeller Foundation and the Ford Foundation were the first ones to provide support to India. Christian missionaries started their work in the early nineteenth century India with the aim of spreading Christianity. They tried to show 'Christianity as a spiritual path to freedom' for Indians but it was not much successful, so they shifted their focus towards education, agriculture and health. Gordon (1997) argues that most of the Christian missionaries' work was funded by the American and Indian Christians but they also received funds from private philanthropic foundations especially the Rockefeller Foundation. Apart from the Christian missionaries, other global actors involved in health systems development aid in India in this period included private philanthropies, Bilateral agencies and Multilateral organisations.

Period till 1960s was also marked by setting up of various Multilateral United Nations institutions including WHO which was tasked with coordination of international health work; UNICEF which was tasked with assistance to children in Europe's war-ravaged areas; and World Bank which was charged with reconstruction and development of Europe's war-ravaged areas. India was a member of these institutions and received development assistance from these institutions post-independence. WHO and UNICEF were the most significant Multilateral actors in HSS in India during this period. Between 1947 to 1979, UNICEF contributed almost three times the funds provided by WHO to India and the funding from UNICEF to India rose five times from 1955-59 to 1975-79 (Jeffery, 1988 p.194).

HSS ideas

These earlier philanthropies like the Rockefeller Foundation, were set up primarily " as a way to shield some of their income from taxation but also as a way to garner prestige and influence in the US and world affairs" (Martens and Seitz, 2015). However, the ideologies of these foundation greatly influenced the shaping of health systems agenda in their recipient countries. For example, Rockefeller Foundation's aid was largely based on the idea of Frederick Gates who believed that advances in medical science is the only way to overcome disease. He later became the principal

adviser of John D. Rockefeller Senior, the founder of the Rockefeller Foundation. The foundation in coming years adopted a bio-medical approach to public health and focused on targeting the control of hookworm or yellow fever as its first intervention area. In line with their disease-specific orientation and ideas for HSS, Rockefeller Foundation's support was mainly extended towards combating Malaria and other communicable diseases (Gordon, 1997).

Other than setting a disease- specific discourse on improving health and building health systems; the health systems development ideas diffused by these philanthropic organisations during this period were focused on increase in health systems resources. Two main resources which dominated the ideas of HSS in this period constituted infrastructure development and adequate supply of drugs and equipment. For example, the earliest involvement of Rockefeller Foundation in HSS in India included setting up of (first) medical college in Vellore which was followed by setting up various other Christian women colleges. This was in continuation with Rockefeller Foundation's engagement with infrastructure development in India in pre-independence times, it had formed its first chair in India in 1916 in school of Tropical medicine in Calcutta which later developed into an All India School of Hygiene and tropical medicine in 1932. In 1935, the foundation has established their office in New Delhi to oversee their activities in medicine, agriculture and humanities, which was functional for more than thirty years. The foundation continued to support most of its disease-specific initiatives through Vellore medical college and its other institutes established in India (Gordon, 1997).

In addition to the philanthropies, newly formed international agencies like WHO and UNICEF also centred their support towards disease control efforts and in large parts focusing on resources by directly supplying chemicals and drugs for national disease control programmes. For example, when India launched its first National Malaria eradication programme in 1953, global actors including a Technical Cooperation Mission of the USA, WHO and UNICEF ensured the regular supply of pesticide called Dichlorodiphenyltrichloroethane (DDT) which was used to prevent Malaria transmission acting as a spatial repellent. Similarly, the Tuberculosis control programme which involved vaccination with Bacillus Calmette-Guérin(BCG) ,relied heavily on international agencies like UNICEF, WHO and the Rockefeller Foundation for supplies of the vaccines (Duggal, 2001).

This disease-specific orientation to HSS continued after the Multilateral institutionalisation of international health. Almost all disease control programme in India during this period were rolled out in partnership with international Multilateral agencies. For example, for combating Tuberculosis, Government of India had entered into an agreement with the UNICEF and WHO to carry out a countrywide BCG programme. For venereal disease, Government of India have sanctioned an antigen production unit in collaboration with the WWHO and UNICEF and concluded an agreement with the WHO for the upgrading the Madras Medical College to provide training facilities in venereal diseases (Planning Commission , Government of India, 1951).

Handling Nutrition and Maternal and child health concerns also shaped the earlier health systems development ideas in India. International actors were involved in shaping nutritional and MCH policies from early 1950s and 60s. For example, India's Applied Nutrition Programme was launched with support from WHO, UNICEF and FAO. This programme was rolled out in 1963 in Orissa and later expanded to Uttar Pradesh and Tamil Nadu and then to the rest of the country. Similarly, for MCH programmes, UNICEF supported India to expand the department of Maternity and Child Health of the All India Institute of Hygiene and Public Health in Calcutta as a Centre for post-graduate training for maternity and child health doctors and for public health nurses. Rural and urban training fields for nurses and midwives in the Delhi area and paediatric training centres in Madras, Bombay and Patna were also developed by the Government with support from WHO and UNICEF. However, the support was largely in form of infrastructure development and capacity building initiatives (Planning Commission , Government of India, 1951).

Few interventions by international organisations targeted at improvement in processes of resources and directly influencing administrative processes in India. Banerjee (1973) elaborates the influence of a UN advisory mission visiting India in 1961, asking for, the directorate (health and Family Planning) to be relieved from other responsibilities of maternal , child health and nutrition and focus only on Family Planning which was later adopted by the government (UN Advisory Mission 1961 cited by Banerji, 1973). He highlights this influence by discussing the endorsement of this strategy by the government as it constituted a 'Special committee to Review the Staffing Pattern and Financial Provision under Family Planning' (Mukherjee Committee). This committee indicated the failure of existing camp approach in Family Planning and created a ground for introduction of IUCD (loop). Other recommendations of this committee included introduction of

fixed targets, user incentives in the form of cash payments and reforming Family Planning programmes as a vertical programmes like other disease control programmes (Mukherjee Committee, 1966, cited by Banerji, 1973).

Attempts by international agencies were also made for strengthening India's indigenous capacity for drug production. The first national five-year plan acknowledges that setting up of a DDT factory was proposed during this period with the assistance of the WHO and the UNICEF for increasing the production of DDT from 700 tonnes to 1,400 tonnes. Government of India also entered into an agreement with the UNICEF to set up a factory for the manufacture of penicillin and other antibiotics during this period (Planning Commission , Government of India, 1951).

Processes

Direct provisioning of goods and equipment constituted an important tool for participation by international actors in HSS policies in India. In addition to these, global health actors also used the provisioning of fellowships and consultants as strategies to participate in HSS policies in India. Both Rockefeller and Ford Foundations deployed a large number of experts in India who were trained in American institutes. These experts were deployed under fellowships in the institutions set up under the grants by these foundations. Indians were also selected and trained in America to gain 'American knowledge' and then were deployed in Indian health institutions. This method of training Indians abroad and placing international experts in Indian institutions played a primary role in transfer of 'knowledge from America' to India. For example, Ford Foundation which was established in India in 1951, reportedly had more than hundred experts placed in India in 1968. From 1951-1995, the foundation granted around 2500 grants. Similarly by 1966, Rockefeller Foundations had fifteen of its personnel placed in India to oversee different health related activities (Gordon, 1997). These experts learnt in India about the development issues by overseeing various grants given by the foundations.

Context

The overall context in which international actors were participating in HSS policies in India constituted the economic and political situation of newly independent States who were charting plans and policies for their future health systems. In the immediate post-independence years, India was still dependent on the British legacies to not just continue with the overall bio-medical

orientation of the health systems but also the administrative structures of organising the health systems.

Post-colonial period was also marked by the moral obligation felt by the rich and imperialist powers to assist the new nation States develop. As noted by Radelet (2006) 'Foreign policy' and 'Political relationships' constituted the prime reasons for provisioning of 'development aid[30] by the rich countries[31] (Alesina and Dollar, 2000 cited by Radelet, 2006). According to him, " many donors "tie" portions of their aid by requiring that certain goods and services be purchased from firms in the donor's home country, or that it be used for specific purposes that support groups in the donor countries (such as universities or business consulting firms)" (Radelet, 2006 p.6).

This was the period when the World Council of Churches proposed compensation to the developing countries by the donor countries in form of a (one) percentage of their wealth. Developing countries demanded 0.75% of Gross National Income (GNI) of the developed nations and this idea was endorsed by the Pearson Commission which was the was the first international commission on international development. In 1970s, most of the major donors adopted this target and started providing assistance to developing countries (Keeley, 2012 p.16).

India was one of the major recipients of this development aid.1940 and 50s saw the setting up of various international institutions including WHO which was tasked with providing a direction and coordination of international health work. It was asked to provide technical assistance, emergency aid and normative work for promoting and advocating for better health (Clift et al., 2013 p.19-20). The earliest task taken up by WHO of replacing the old sanitary conventions by drawing up the new International Sanitary Regulations (ISRs) in 1952 was one of the important references to setting the role of international organisation in health and disease control with an explicit focus on protecting the Europe and North America from the spread of disease from Asian and Middle East countries.

[30] The other motivations highlighted by Radelet (2006) for provisioning of aid by the donors can be classified under four broad rubrics which include Philanthropy, compensation, investment and geographical influence.

[31] He gives examples of United States and the Soviet Union using aid during the Cold War for gaining support of developing countries. U.S. providing financial support to Egypt to back the 1979 Camp David peace agreement[31]; China and Taiwan using aid for attempting to gain support for their governments from countries around the world, retaining their political influence in former colonies (Alesina and Dollar, 2000 cited by Radelet, 2006).

Asian and Middle east region were considered to be the prime source of infection and focus for interventions. For example, the annexes of ISR adopted by WHO in 1951 had nearly forty-one articles addressing the annual pilgrimages to Mecca. This was a continuation from the Sanitary conventions of early 1900s where the diseases under surveillance like Cholera, Plague and Yellow fever were called Asiatic disease. Not one of the infectious disease common in Europe was added to the surveillance list till 1926 when typhus and small pox was included (Fidler, 2005 p.331).

Regarding philanthropic organisations, Radelet (2006) notes that these organisations started with the idea of mere charity but soon it became a 'moral obligation towards the well-being of fellow human beings which nested in the concern of natural justice sometimes to correct past wrongs, such as colonialism, or to ensure a fairer distribution of the earth's resources. In the case of aid provided to India in the beginning of 1950s and 60s, the Christian missionaries and the philanthropies like the Rockefeller and Ford Foundations which were mainly providing aid in terms of service provision and capacity building of health care staff gradually became instrumental in shaping health systems development concepts and policies.

The role of Ford Foundation in influencing India's health policy by advocating a camp approach has been well documented (Gupta and Gumber, 2002) . The first president of the Ford Foundation, Paul Hoffman believed that foundations investments in India would help in alleviating poverty which would eventually include India in the 'western camp and further democratic rights', he said that "assistance to India would demonstrate what free men with wealth could do to help other men to follow them down the same or similar path to development" (Gordon, 1997 p.111).

3.2 1970s -1990s: RISE OF BILATERALS AND EXPERIMENTS WITH BASIC HEALTH SERVICES MODELS

Actors

Period from 1970s to 1990s was marked by the growing prominence of Bilateral agencies and Multilateral UN agencies. Apart from the support in 1960s-70s from UNICEF and WHO , FAO, few Bilateral agencies including ODA (UK), DANIDA, SIDA, NORAD also assisted India's

health sector development through various disease control and Family Planning initiatives and nutrition improvement efforts (Gupta and Gumber, 2002).Though Bilateral aid from government of United States, Sweden, Japan, and Denmark started in 1967-68, their prominence grew in coming decades starting from 1970s to 1990s. As shown in table 3.2, position of the US government remained the most prominent in the area of HSS in 1970s contributing to 57.4 per cent of the total external assistance to the health sector.

Table 3.2- External Funding for India during 1970s			
S.no	Agency	Amount funded ($ million)	% to total
1	US government	493	57.4
2	UNICEF	134	15.6
3	WHO	53	6.3
4	UNFPA	42	4.9
5	World Bank	91	10.7
6	Ford Foundation	10	1.3
7	Rockefeller Foundation	5	0.6
8	Swedish IDA	11	1.4
9	Norwegian IDA	9	1.0
10	U.K. (ODA)	6	0.8
	Total	859	100
Source: (Gupta and Gumber, 2002)			

As early 1970s was dominated by a strong focus on population control efforts, almost all Bilateral agencies of Sweden, Denmark and Norway were involved in supporting population programmes in India. For example, as per Bank's first population project in India, SIDA was one of the main partners in that project contributing a grant of US $10.6 million. Denmark has provided 10,000 pieces of IUD (antigon) in 1969-70 for clinical trials and financed a new building for the National Family Planning Institute for an amount of Rs 6.2 million (US $0.8 million). Norway signed an agreement in 1972 worth US $5.2 million for the expansion of the postpartum programme. In June 1970, USAID signed an agreement for US $20 million for program support. Under a 1968 agreement, Sweden has offered assistance in equipment and materials of US $2 million (Bank, 1972). A Bilateral agreement was signed between Government of India (GoI) and Government of Denmark in 1970, where DANIDA agreed to support strengthening of Family Welfare services in seven districts in Madhya Pradesh. This agreement got into effect in 1980 and in 1981 launched 'area development' projects in two districts of Tamil Nadu and eight districts in Madhya Pradesh(Bank, 1972).

In addition to the Bilateral agencies, Multilateral aid agencies like United Nations Fund for Population Activities (UNFPA) granted about US $5.0 million to GoI for new projects. UNICEF supported the building of ANM schools in Uttar Pradesh and Bihar for which it provided Rs 4-million. In early 80s, India witnessed support from various international organisations including WHO, UNICEF, Rockefeller Foundation and DANIDA in reorienting the health systems according to PHC principles (Gupta and Gumber, 2002 p.7). Another Multilateral institution which began assuming a prominent position as a global health actor in India during this period was the World Bank. The World Bank's position got stronger in late 70s with the launch of a series of nine India Population Projects (IPP) focusing on different geographical locations and varied population groups. The Bank replaced UNICEF in the span of a year in 1989-90 (World Bank, 1992 p.3). As far as other Bilateral aid during this period is concerned, their contribution was very small. The World Bank became the single largest provider of external assistance to the health sector (from about 33 per cent in 1985–86 to 66 per cent in 1989–90) (Gupta and Gumber, 2002). Other major donors during this period were UNICEF, USAID, and UK.

This was also the period of inception of a large number of international organisations. It has been noted that in total fifty-one such organisations were created from the year 1970 -1990, out of which twenty-eight were founded in 1970-1979 (Hoffman et al., 2015 p.11).

HSS ideas

Early 1970s saw population control getting a stronger focus in India's health systems priorities in comparison to communicable disease control and improvements in rural health services. The heavy emphasis on population control in India was due to the influence of various developed countries, but especially the USA (Banerji, 1973). A range of global actors participated in shaping this agenda. For example, the first ones to focus on Family Planning in India were the Ford Foundation and the Christian missionaries assisting in population control initiatives, Catholic relief services provided nearly two million dollars of medical supplies which included supplies for population control. Population control as the priority for HSS was further legitimised with the launch of the first stand-alone project on population control in 1973 with support from the World Bank and SIDA. Other Bilateral agencies of government of Denmark and Norway also contributed to these population control efforts.

Besides participating at the national level for population control efforts, Multilateral and Bilateral agencies UNFPA, DANIDA, and ODA (UK) extended support for disease control initiatives. For example, UNFPA participated in Leprosy control efforts in MP and Tamil Nadu (TN) and SIDA assisted in TB programme. In the second half of the 1980s DANIDA and ODA (UK) supported Blindness Control Programme for which DANIDA provided DK 126.56 million. The support was a mix of resources and suggestions for policy reforms. For example, WHO's support to family welfare programmes comprised of increase resources by ensuring general medical supplies, equipment as well as investments in training and research. Similarly, during 1985–90, UNICEF's support for immunisation programme in 1985-90 comprised the supply of Oral Rehydration Therapy (ORT) as well as support for PHC initiatives. Bilateral agencies like NORAD and USAID were active in supporting population control measures like supporting a Post-Partum Programme and developing a Contraceptive Marketing Organisation(Gupta and Gumber, 2002).

Parallel to this in 1970s, the idea of 'basic health services' for health system development was also being supported by global actors. For example, the much acknowledged work of an Indian couple Drs Mabelle and Rajanikant Arole providing basic community health care in Jamkhed, a rural State in Maharashtra in 1970 was supported by the Christian Medical Commission in the form of providing financial assistance for setting up a health centre(Litsios, 2004). This experiment by the doctors couple was to provide a comprehensive community health care to the 40,000 people in the surrounding villages. A report of this project was submitted to the WHO and UNICEF Joint Committee on Health Policy which was looking for examples of 'provisioning of basic health care to at least eighty per cent of the target population at a cost per head which even a country of very limited resources could afford'[32]. This experiment founded the basis for advocating for basic health services which later found its mention in a cumulative effort of Primary Health Care declaration in 1978, a landmark event in the development of Primary Health Care.

PHC with its Health for All' agenda defined an obligation for every nation — including developing countries to provide health services for their whole population. It "located health in a human rights agenda, claiming it as a condition for human well-being in harmony with other human needs, thus balancing efficiency and effectiveness, and with the objective to stimulate people's autonomy and

[32] Similar evidence had come from countries like Bangladesh, China, Cuba, Niger, Nigeria, Tanzania, Venezuela and Yugoslavia highlighting interventions woven into the social and economic environment and had the capacity of being scaled up

participation in the long-term" (Van Olmen et al., 2012 p.3). WHO and UNICEF were the main global health actors and prime movers of the 'Health for All' agenda. The core principles of this declaration were — universal access, equity, participation and inter-sectoral action.

India was a signatory to PHC. During the next five-year plan in 1980-85, India adopted the policy of 'Health for all by 2000 AD' enunciated in Alma-Ata declaration in 1978. Though population stabilisation and disease control remained at the core of health systems development priorities, reorienting health systems in accordance with the recommendations of PHC got (short-lived) attention in this period. This sixth five-year plan gave a clear direction towards shifting emphasis from development of city based curative service's and super-specialties to tackling rural health problems; training of health volunteer chosen by the community; strengthening the hospital referral system; coordination of various national programmes; creation and training of additional human resources for health; involving people in their health problems and empowering communities to participate in health programmes to eventually supervise and manage their own health programmes.

The first National Health Policy of India announced in 1983, reflected that "the contours of the National Health Policy have to be evolved within a fully integrated planning framework which seeks to provide universal, comprehensive Primary Health Care services; relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the Health sector" ("National Health Policy," 1983 p.3). In early 1980s, India witnessed support from various international organisation including WHO, UNICEF, Rockefeller Foundation and DANIDA in reorienting the health systems according to PHC principles and these actors played a larger role in financing health sector in India (Gupta and Gumber, 2002 p.7). But very soon, the criticism of Alma-Ata declaration started appearing globally and the focus immediately shifted to identification of the most cost-effective health strategies for meeting the health needs of the population.

Concerned with this need, the Rockefeller Foundation sponsored in 1979 a small conference entitled "Health and Population in Development" at its Bellagio Conference Centre in Italy. The conference was based on a published paper by Julia Walsh and Kenneth S. Warren entitled

"Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries" and sought specific causes of death, paying special attention to the most common diseases of infants in developing countries such as diarrhoea and diseases produced by lack of immunisation. The authors did not openly criticise the Alma-Ata declaration but presented an "interim" strategy for developing basic health services (Walsh and Warren, 1979). In their paper and at the meeting, Selective Primary Health Care (SPHC) was introduced as the name of a new perspective for meeting health related goals. The term meant a package of low-cost technical interventions to tackle main disease problems of poor countries. At first, the content of the package was not completely clear. For example, in the original paper, a number of different interventions were recommended, including the administration of antimalarial drugs for children (something that later disappeared from all proposals). However, in the following years, these interventions were reduced to four and were best known as GOBI, which stood for growth monitoring, oral rehydration techniques, breastfeeding, and immunisation. In response to the development of SPHC approaches for strengthening systems, Multilateral institutions like WHO and UNICEF and Bilateral agencies like DANIDA, SIDA started to provide support to India in targeted Selective Primary Health Care approaches.

Process

There was a shift in the tools of participation in HSS policies with the entry of Bilateral aid agencies of United States, Sweden and Denmark. The new tools included direct provisioning of funds, while the tools of provisioning of commodities and consultants continued much like the philanthropic organisation. Provisioning of supplies continued to remain the main tool of engagement from the global actors till 1970s with expansion in their support in 1980s. For example, supplies constituted the dominant contribution of UNICEF till 1970s and in 1985–90, it provided support to the tune of US$ 29 million for STDs, ORT and PHC, besides contributing towards training, vehicles, vaccines, Tuberculosis, Leprosy, and Malaria Control Programmes (see Table 3.3). SIDA started to routes its support via WHO to procure various materials and equipment required for Tuberculosis, Malaria and Leprosy programme which till 1970s was mostly in form of direct provisioning of equipment and materials (including X-ray units, film rolls, drugs, jeeps). WHO provided US$ 30 million as assistance towards provision of general medical supplies, equipment, training, and research during 1984-87.

Table 3.3- UNICEF Assistance to India 1947-76- US dollars							
	1947-49	1950-54`	1955-59	1960-64	1965-69	1970-74	1975-79
Supplies	300	6755	9600	18995	24599	-	-
Fellowships	20	60	98	458	1068	-	-
Project Personnel	-	286	172	243	528	-	-
Other	-	488	262	144	63	-	-
Total	320	7589	10132	19840	26258	40000	50000
Source: (Jeffery, 1986 table 3, p.128)							

Other methods of participation in HSS policies by global actors was through supporting the development of infrastructure and providing technical support in form of provisioning of consultants and research support. For example, the major area projects support by global actors in Tamil Nadu, Orissa and five other States by DANIDA, ODA (UK) and USAID in 1980s focused heavily on constructions (see table 3.4). Norway supported the infrasrture expansion of the postpartum program and US supported construction of a new building for the National Family Planning Institute (Bank, 1972 p.8). Likewise, DANIDA gave support to Leprosy programme and area projects in Tamil Nadu and Madhya Pradesh. USAID assisted in strengthening the private and voluntary sector for improving preventive care and Family Planning and nutrition programmes along with developing contraceptive marketing and area projects in Punjab, Haryana, Himachal Pradesh and Maharashtra (Bank, 1989 p.60). Late 1980s saw the launching of the Blindness Control Programme with the support from DANIDA. ODA (UK) also extended support to the programme in the form of technical assistance for research and consultancy and the visits of experts from abroad. During the Blindness Control Programme, DANIDA provided funds to the extent of DK 126.56 million US dollars. The decade of 1980–90 also saw launching of the Tamil Nadu Integrated Nutrition Programme with an IDA credit of US$ 32 million with a focus on health and nutrition.

The support provided by these global actors was fragmented, non-coordinated and largely focused on population and diseases control efforts. Under the support for diseases, major part of assistance was in form of supplies and equipment which reflects a complete deviation from the principles of Primary Health care.

Table 3.4- Comparison of Area Development Project Proposals			
	Tamil Nadu	Five States	Orissa
Administration	5	1	2
Construction	25	54	39
Maintenance and utilities	12	*	4
Supplies, equipment, and drugs	12		16
Transport	A	3	6
Additional staff salaries	14	23	27
Nutrition	4	A	1
Communication and media	4	2	1
Community Fund, innovations, etc.	11	4	1
Source (Jeffery, 1986 table 10 p.137) * Categories are not separately recorded.			

Context

The resurgence of Malaria had brought attention to the growing evidence of ineffectiveness of disease (targeted at disease agent in particular) specific approaches to improve health. This has generated momentum towards understanding the significance of social and environmental roots of health and illness. This was further translated into the search for alternative ways for providing basic health services to mass population. Few of these ideas culminated into the adoption of a Primary Health care approach in 1978 adopting the slogan of 'health for all by 2000'. PHC emphasised the principles of universal care, inter-sectoral action, community participation and appropriate technology (Tarimo et al., 1994).

These ideas became important for HSS in the coming decades. However, late 1980s was marked by deep economic crisis in India which resulted in creating financial imbalances to the extent that India's international creditworthiness was beginning to be doubted. This crisis was so profound that the eight five-year plan was pushed forward by two years. The financial difficulties faced by India created a ground for expanded role of international donors in HSS and adoption of new market-oriented macro-economic policies which gave way to realign the role of State and market and create more space for the private sector.

A targeted and selective approach in HSS thinking as outlined by the SPHC approach (Walsh and Warren, 1979) became more prominent at all levels starting from broad policy direction to micro strategies for disease and infection control or Family Planning or nutrition interventions. For

example, the Eighth Five-Year Plan chose a new slogan of Health for the Underprivileged instead of Health for All by 2000 AD (Duggal, 2002).

In 1980s, debates on contradictions in the meaning and strategies of international health success started emerging. Some of these are still unresolved. These contradictions were of vertical versus horizontal, technical versus social, centrally driven versus locally defined, disease-based versus health-based, individually versus collectively-oriented, doctor-centered versus community-centered(Litsios, 2002) and (Birn, 2009). However, there was not much change in the overall orientation and HSS thinking in this period but more of a continuation of the disease-specific resource-oriented ideas dominating the past three decades post-independence.

3.3 1990s-2000: RISE OF WORLD BANK AND FALL OF BILATERALS

Actors

The global health actor landscape in India began to look more complex post 1990s as the range of actors engaging in health system policies expanded during this period. However, in comparison to the twenty-first century, the numbers of external actors were still limited, and they often knew what the other is doing. With the growing economic crisis and increase in policy-based lending, World Bank's participation in health systems development in India started increasing at a great pace and magnitude during this period. For example, "It was mutually decided between the government and Bank that from 1990 onwards, the Bank will support one project every year (Ridker and Musgrove, 1999). The Bank expanded its support from population and disease control projects to stand-alone State health systems development projects in India (see chapter 5 for details).

Along with the increased assistance from the World Bank, the existing Multilateral UN agencies like the WHO , UNICEF and UNFPA continued their support to a range of health systems initiatives (Dash and Mishra, n.d.). With regards to involvement of Bilateral actors in HSS, new Bilateral aid agencies like those of Japan, Netherland, Canada, European Union and Germany

entered India during this period and the existing ones like DANIDA and DFID continued to grow to prominence. These agencies participated in HSS policies by supporting various State-level disease-specific and population projects having components of cross-cutting health systems issues.

Sundaraman described the decade of 1990, especially the years between 1993 to 2004 as a period in which the "development partners had an absolute and free control over health systems development agenda in India" (Sundaraman, New Delhi, 2018). Alluding to the role of Bilateral agencies, he emphasised that "though there were significant 'big actors' engaged in the health systems development work in India in 1990s, there were also a number of 'smaller players' and interestingly, the smaller ones had more to do with HSS than the bigger ones because the bigger ones had their funding tied-up completely to vertical and mostly RCH programmes". According to him, the important 'smaller actors' included DFID, DANIDA and European Union.

DFID has consistently been one of the largest Bilateral donors to India because of its historic ties with India (Straw and Glennie, 2013). It has engaged in a range of health systems development initiatives including disease-specific, RCH and population projects during this period. At the State-level, Orissa has been the oldest of DFID's interventions States in India. Their partnership dates back to late 1980s, with support and contributions for infrastructure, equipment, supplies and training. Post 1990s, DFID claimed to have focused on strengthening health systems with the aim of providing priority services to poor people and contributing to the reproductive health services in addition to the communicable disease control such as Tuberculosis, child health, and HIV/AIDS. It also worked in partnership with other Multilateral agencies such as the World Bank, European

Union, and the UN agencies such as WHO and UNAIDS to strengthen their mandate to improve access to reproductive health services, communicable disease control[33].

DANIDA started supporting India as early as in 1962 in various disease control efforts spread out in many parts of India with a variety of projects. DANIDA's total aid volume in 1991–2006 amounted to USD 430 million of which one-fourth was allocated to the health sector (Groot et al., 2008). It supported four national disease control programmes that is Blindness, Leprosy, Tuberculosis and Polio. In 1980s, its assistance got concentrated in four focus States of Karnataka, Tamil Nadu, Madhya Pradesh and Orissa. In 1998, however, the cooperation was paused due to the decision to phase out aid in response to the series of nuclear test conducted by India. As outlined in the exit strategy report, DANIDA started to implemented its exit plan from India, in late 1990s but in the year 2000 it developed a new country strategy named 'Lex India', which focused on health, human rights and private sector support (Groot et al., 2008). The 1994 cooperation agreement signed between EU and India took EU's Bilateral relations beyond merely trade and economic cooperation in India. This marked the entry of EC in health sector in India and in the coming decades it became a prominent actor among existing Bilateral and Multilateral actors

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Table 8: Recent External Assistance for Health to India from DFID India

Location	Value	Start Date	End Date	Partner
National	£0.8 Million	Sept. 1997	November 2000	GOI and partner states
National	£6.14 Million	March 1997	Mar-00	GOI and NGO
National	£1.1 Million	Sept. 1999	30th September 2000	Ministry of Health and Family Welfare, Ministry of Broadcasting
Orissa	£2.5 Million	June 1997	Jun-00	Government Of Orissa
Orissa	£5.00 Million	1st April 1997	Mar-03	Implementing NGO Orissa
Other States	£31.74 Million	Mar-96	Apr-04	States AIDS Cell – Kerala, Gujarat, AP and Orissa
National	£47.91 Million	Dec-95	Mar-00	Government of India
Andhra Pradesh	£20.2 Million	Apr-98	Mar-04	Government of Andhra Pradesh
Other States	£4.6 Million	Apr-95	Jun-00	GOI, NMEP, GOG, LSHTM and some institutions.
National	£0.72 Million	Dec-94	Mar-00	WHO
West Bengal	£3.97 Million	Apr-95	Mar-00	GoWB & NGOs
National	£0.8 Million	1994	Dec-99	GOI and ASCI

Source: DFIDI website and micro documents.

Source:(Gupta and Gumber, 2002 table 8 p.21)

supporting two major social sector programmes: Sarva Shiksha Abhiyan (SSA) and the National Rural Health Mission (NRHM).

With this complexity in the actor landscape, private philanthropies like the Rockefeller Foundation had modified their ways of functioning as these foundations got involved in creating innovative institutional frameworks to address global health challenges. Few of these innovations included new Product development partnerships (PDPs) like the Children's Vaccine Initiative (established in 1990), the International AIDS Vaccine Initiative (IAVI) (1994) and the TB Alliance (2000). These partnerships aimed at bringing international organisations, governments, pharmaceutical companies, NGOs and other philanthropic foundations, particularly the Ford Foundation together to work for a common cause of drug and vaccine development (Keeley, 2012). Though there were newer actors which were coming in, the older ones like the Christian Aid were reported to have assumed the role of a coordinator for other global agencies by managing their interventions.

HSS ideas

In terms of health systems strengthening ideas promoted by global health in India, 1990s saw a gradual departure from the' increase in resources' approaches for HSS to approaches stressing on improvements in processes. However, the focus of interventions got more prominent on disease-specific issues in comparison to the previous decade of experimenting with cross-cutting sector-wide approaches and community led initiatives. Idea of economic orientation to HSS got firmer with the growing influence of the World Bank in HSS policies at macro-level national health policies and plans and micro level at health facilities planning and functioning.

The World Bank was the one of the most influential global health actor shaping HSS ideas in 1990s as its 1993 World Development Report: Investing in Health proved to be one of the most persuasive report in health policy stakeholders in India. HSS ideas emphasised in this report created a radical departure from the 'Health for All' roadmap laid in India's first health policy announced in the late 1980. Most influential HSS idea pushed by this report was of the administrative reforms calling for a reduced role of State and growing role of non-State (private for profit and not for profit) actors in health services planning and provisioning. In addition to this, the report advocated for promoting user charges in the health facilities as a tool for health financing and strongly favoured selective disease control approaches prioritising investments in health issues on the basis on economic efficiency gains(World Bank, 1993).

For this purpose, the concept of DALYs (Disability-Adjusted Life Year's) was introduced which was a tool for priority setting in health planning. According to Duggal (2001) this move towards investing resources as per gain in DALYs meant "… committing increasing resources in favor of health priorities where gains in terms of efficiency override the severity of the health care problems, questions of equity and social justice". He adds that this influence of the World Bank also pushed WHO to change its position on Alma-Ata declaration as WHO also supported the selected disease control programme ignoring its promises for equity and social justice(Duggal, 2001).

While the Bank was influencing India's health systems development agenda in the above direction, attempts towards establishing an integrated health system were parallelly being made in this period. Reproductive child health (RCH) programme of the Government of India presents an important case highlighting the steps in the direction of integrating different National Health Programmes. Launched in 1997, the first phase of RCH programme was a consolidation of existing child survival and safe motherhood (CSSM) efforts, population control and Family Welfare initiatives, and Maternal and Child Health (MCH) programmes incorporating two additional components of sexually transmitted diseases and reproductive tract infections. Another significant shift which took place under this programme with respect to health systems development approach was the emphasis on a 'goal centred approach' making a departure from the 'target approach' to health service delivery. This had significance for defining the performance measurement of programmes towards improving quality of interventions than merely meeting qualitative targets to demonstrate good performance. The goal centred approach also included community participation and focused on the needs of the client or community. A range of global actors including DFID, EC, UNFPA, USAID and the World Bank were actively supporting the RCH programmes and they shifted programme approaches for achieving broader systems level gains (Bank, 1995).

Though the Bilateral and Multilateral actors were contributing to integrated RCH programme, they continued to fund various disease-specific projects at the State-level. Few of these State-level projects had cross-cutting health systems issues but mostly focused on specific diseases. Like the 80s, funding from Bilateral actors focused on a mix of support for health systems resources like infrastructure and drugs and equipment and improving processes like community engagement,

administrative reforms, decentralised governance and promoting the role of non-State actors. For example, DFID continued its contributions to infrastructure development, equipment and medical supplies to Orissa under various health projects in 1990s. However, there was a shift in moving towards a 'geographically dispersed' approach in comparison to a 'sector-driven' and 'project-centred' approach of the 1980s emphasising on four 'Focus States': Andhra Pradesh, Madhya Pradesh, Orissa, and West Bengal (DFID, 2012). Whereas EC expanded its supported from the disease-specific and RCH-related initiatives in to support general health sector through the Health and Family Welfare Development Programme (HFWSD)[34]. The HFWSD programme was designed on the principle of sector-wide approach and aimed at enhancing the capacities of central, State and District level bodies to implement the Family Welfare system policy reform and the target-free approach. As per EC's own reports, this programme improved decentralised health planning by developing organisational capacity for planning through the development of independent agencies at the that State and District level to undertake decentralised planning through developing State Action Plans (SAPs) and District Action Plans (DAPs) (European Commission, 2007). In the area of financing reforms, EC promoted the idea of performance-based funding as development of State and District level health plans was guided by setting up of targets for receiving funding from untied EC funds. This model of financing resulted in an enormous change in the planning and implementation practice, which had previously been expenditure focused. Promoting the role of non-State actors was another HSS idea advocated by EC as it piloted various public-private initiatives including short-term contracting of medical specialists to carry out part-time tasks in public facilities and contracting private providers take care of obstetric emergencies (European Commission, 2007).

All these ideas for HSS were well reflected in the seventh five-year plan (1985-1990) which laid emphasis on development of specialties and super-specialties in both public and the private sectors. The emphasis on AIDS, cancer, and coronary heart diseases and the booming industry of diagnostics and corporate hospitals in India was a clear reflection of the priorities of different partnerships and alliances anchored by the international agencies mentioned above.

[34] It was and functioned in twenty-four States, four cities and seventy-three districts.

Process

Examining the methods used by global actors to engage in the health systems development policies in India in 1990s reveal two important and simultaneous developments. First method was to create evidence on effectiveness of their health system strengthening ideas by financially and technically experimenting these ideas at National and State-level policies. Second method was the creation of innovative partnerships and networks which were used for legitimising their ideas in collaboration with other actors in the policy networks. These approaches were used by both Bilateral and Multilateral actors.

An officer who had worked with multiple donor organisation explained that "each of these donors come with their own ideas of the issues in the country, they all have a set budget for assistance, and they see within that limited budget what all can be done…they form a consortium where the funding agencies select some States where they think they will do some interventions and then tell the government that they can do this at the national level" (DP 2). Gupta and Gumber (2002) also note that health systems development ideas like decentralisation approach through setting up of societies to overcome financial issues, and the adoption of target-free approach had their roots in the experiments done by donor agencies in different States and at national level in India. An official who worked with the European Commission in the earlier 1990s said that, "like most of these global actors experimenting with new ideas for developing health systems in India, European Commission selected five consultants in India for experimentation to find out the scalable strategies for developing health systems. These consultants tried different ideas on field and came up with innovative approaches for strengthening health systems. One such idea was the bottoms-up approach". He further elaborated that it is through these experimentations that the process of 'bottoms up' approach for planning processes was designed in the country at national level (CG 2). The second process largely involved demonstrating the effectiveness of the identified approaches. For example, with the help of consultants' effectiveness of 'bottom up' approach was demonstrated by the donor agencies to the central and state government, through initiatives like KHOJ[35] which involved training local people to identify their needs and manage their problems.

[35] KHOJ was an experiment where the people decided what their needs are and then the planners took into account their needs. They trained local people and built their capacity to manage their problems.

These ideas are then diffused to the States for their adoption, "we had a meeting in Kufri in 1996/97, health secretaries of all States were invited to this meeting and eleven States agreed to experiment this approach … after that the Central government was convinced that we can try the bottom up approach" (CG2). Bottom up planning approach then became an important component of national policy for health systems development under NRHM launched in 2005.

As noted in the HSS ideas section, the process of participation by these actors though expanded to policy reforms targeted at improving health systems processes but the emphasis on increasing resources by directly supplying these resources or financing it continued. For example, DFID embarked on the integrated health systems development approach through its contributions to 'area projects' under a 'sector-driven' approach in Orissa in 1990s, but it was simultaneously involved in infrastructure development and medical supplies (see table 3.4). It provided financial assistance to State budgets and technical support through capacity building and strengthening of financial management and improvements in service quality and procurement systems (DFID, 2012). Similarly, DANIDA was also involved in a both kinds of interventions. It was involved in supporting the resource-oriented ideas like infrastructure development including setting up of Primary Health Care facilities; as well as developing district Blindness control societies for promoting decentralised services focusing on community participation and inter-sectoral coordination (AF Ferguson & Co, n.d.) . Its Tamil Nadu project was based on a comprehensive approach placing inter-sectoral coordination and community participation as its founding principles, focusing on enhancement of skills and creation of community demand for health services grew stronger in the concluding phase[36]. Denmark and Dutch governments also supported sector-wide approaches in India. World Bank launched a seri es of State health systems development projects though IDA loans and this gave Bank an added opportunity to experiment at the State-level and influence health systems development trajectories in States while easily

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Share of Actual expenditure across Phases and components of the project			
% share of actuals	Phase 1	Phase 2	Phase 3
Infrastructure	75%	63%	31%
IEC	2%	2%	5%
Training	13%	11%	17%
Management of Health Services	-	-	26%
Drug supply	-	3%	7%
Others	10%	21%	14%
Source:(AF Ferguson & Co, n.d. p.6)			

bypassing the Central government. Most of the HSS ideas recommended in WDR 1993, such as cost-effective intervention, private sector participation, user fees, setting up pf autonomous societies under projects were implemented in the health systems and disease-specific projects supported by the Bank.

Context

Early 1990s marked a central period in the history of international aid and health sector globally and also in India. In India three major changes in the role of international organisation's participation in HSS policies took place simultaneously during this time. First was a decline in Church funding which prompted Christian missionaries to seek funds from the Government of India and elsewhere. Secondly, decentralisation amendments were added to the Indian Constitution facilitating the direct relationship between international organisations and State Government (till now the working of international organisations was only limited to the Central government). This gave entry to new Bilateral agencies in HSS and gave rise to an increased participation of NGOs in delivering health services in India as there was implied preference of donor community to work with the NGOs. Third and the most important change was the initiation of structural reforms with policy-based funding from the World Bank in order to manage the economic crisis. In July 1991, the newly elected Congress Party coalition responded to the financial crisis by introducing a comprehensive programme of stabilisation and structural reforms. This was the time when on one side, India was facing great financial difficulties and was ready for adopting neoliberal reforms and on the other hand there was a change in leadership in Ministry of Health at the federal level. This gave space to the international development agencies supposedly equipped with technical and financial means to support the health systems strengthening policy to pave way for reforms which were guided by their interests and expertise.

The end of 1990s and the collapse of the Soviet bloc had important ramifications for the development world and the real net ODA fell by nearly a third across the decade, having risen in real terms throughout much of the 1980s. As a result, needs of the former Soviet Union pushed the traditional aid recipient regions like Africa and Latin America on the side and in Latin America and Asia, much of the loss was countered by a rise in private investment (Keeley, 2012).

1990s was also the period in which problems arising due to fragmented activities of different global actors engaged in health were coming to the fore. As a result, bringing the ownership of health

systems development to the national governments was gaining popularity in the international health discourse. At a 1997 meeting in Copenhagen hosted by the Danish Ministry of Foreign Affairs and the World Bank, the term "sector-wide approach" (SWAP) was coined and developed to overcome problems of disintegration of programmes and overly prescriptive donor assistance (University of Washington and Institute for Health Metrics and Evaluation, 2010 p.37). It aimed at enabling national governments to articulate and manage government-led sectoral policies and expenditure frameworks, build local institutional capacity and serve way for building effective relationships between governments and donor agencies (Peters et al., 2013).

Another simultaneous change in development thinking happening during this time was a growing attention for placing 'people at the centre' of development. UNDP's Human development Report and Index in 1990s and the World Bank's Development report on poverty tried to bring the focus on people as the wealth of the nation. However, as noted by Keeley (2012) along with this change in development thinking, the development aid atmosphere in late 1990s witnessed a 'donor-fatigue' and a critique arguing that 'development aid does not work'.

These donor-fatigue trends were also observed in India. For example, the quantum of external assistance reached a plateau since late 1990s which till 1980s was showing a rising trend reaching its peak in 1988–89, and then a plateau. This sudden drop in external assistance during 1998–99, has been cautioned by scholars to be presumably because of the donor community's reaction to India's nuclear tests (Gupta and Gumber, 2002 p.2). India's nuclear test in 1998 marked an important shift in India's positioning and the resultant development assistance landscape as the Bilateral agencies of the Nordic countries reacted strongly to this and decided to freeze or phase out their support to India. For example, Denmark and Norway decided on a phase out in 1990s and Sweden decided unilaterally to withdraw from its Bilateral agreement with India that was signed in 1997 (Groot et al., 2008).

3.4 2000- 2010: RISE OF GLOBAL HEALTH PARTNERSHIPS AND CONSOLIDATION OF DONOR FUNDS

Actors

The decade of 2000 came to be known as the decade of global health partnerships and global health goals. The criticisms of ineffectiveness of aid resulted in consolidation of global health community and setting up targets for 'development'. This shift was motivated by the idea of testing if development aid in health is working and if so, then how is it working. Setting of global targets marked this important phase in global health functioning.

While the global health partnerships were emerging as dominant actors in health globally, the Indian government reviewed its policy of development cooperation in 2003 and decided to only accept government-to-government aid from five donor countries (U.K., Germany, Japan, Russia and USA) and Multilateral cooperation (including cooperation from EC).This was significant with respect to the participation of existing Bilateral actors in HSS in India as the countries outside G8 were restricted for providing direct assistance only if they commit a minimum annual development assistance of US $ 25 million. As a result, support from Bilateral actors decreased significantly and these agencies started co-financing and implementing their support via a Multilateral agency and global health partnerships (World Health Organisation, 2011) in addition to continuing working on their respective existing initiatives.

For example, DANIDA started to implement its exit plan from India in 1998 and completed most projects by 2003-2005. Dutch Bilateral aid disbursements also phased out rapidly starting in 2004 and completing in 2007. When the Dutch announced their exit in June 2003, the development programme comprised a total of sixty projects and aid disbursements reduced to USD 44.3 million in 2004 and further to USD 11.2 million in 2006(Groot et al., 2008). The share of aid to India from larger Bilateral actors like DFID, Norway and EU increased substantially since 2003. Data for 2009-10 showed that nearly half of DFID's total contributions to India went to the health sector (Straw and Glennie, 2013). The Norwegian contribution under Norway-India Partnership Initiative (NIPI) expanded to focus achieving the UN Millennium Development Goal 4 (reduction in child mortality). Around USD 80 million aid was announced for five years and was expected to continue for five more years. EU too broadened and deepened the relations with India in 2004 and decided to now cooperate on issues related to foreign and security policy, trade and investment, climate change, sustainable development, research and sectoral partnerships. EU grew to be an important

actor in this decade through its support to the NRHM. However, it gradually phased out in 2014, following India's graduation to becoming a middle-income country.

The most important development of 2000 was the establishment of eight time-bound Millennium Development Goals following the Millennium Summit of the United Nations in the year 2000, focusing on combating poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women by 2015. While most of the MDGs were related to health, eight goal called for global health partnerships which emphasised the importance of collaborative action from all international institutions (especially the rich governments) for strengthening health systems and manage the issues impacting developing countries.

A series of global health partnerships were created in this period for health. Two of the most important of such partnerships: GAVI and the GFATM created in 2002 and 2003 respectively came to become dominant global health actors in this decade. This was followed by the creation of two other significant funding initiatives by the US: The President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI) created in 2003 and 2005 respectively to invest in selected diseases.

India was not PMI's focus country but GFATM and GAVI became significant actors in India immediately after they started functioning. GFATM was established in 2002 to achieve substantial reduction in the global burden due to the three killer diseases that are AIDS, Tuberculosis and Malaria. It was designed as an innovative financing mechanism and a partnership between developed countries, developing countries, the private sector, civil society and affected communities. It started its operations in India in 2003 and had granted around thirty-six grants by September 2019 and soon replaced the World Bank and many other Multilateral and Bilateral actors in development aid community in terms of provisioning of grants to India. It provides countrywide support for HIV and multi-drug-resistant Tuberculosis (MDR-TB), with support to the TB and Malaria programmes.

GAVI alliance on the other hand is a partnership arrangement between the major global players in the area of immunisation with the key UN agencies, leaders of the vaccine industry, representatives of Bilateral aid agencies and major foundations. It was formed as a Global Alliance for Vaccines and Immunisation with initial funding from the Bill and Melinda Gates Foundation and brought together other global actors in health like WHO, UNICEF, World Bank, donor governments,

international development and finance organisations, pharmaceutical industry and representatives from developing countries with the aim of influencing market mechanisms for vaccine development and procurement (Muraskin, 2005 cited by Storeng, 2014)). Though the initial focus of GAVI was on provisioning of Vaccines, from early 2005 the GAVI Board started to widen GAVI support to HSS (Hill, 2011; Naimoli, 2009).

GAVI started its work in India in 2001 mainly in the area of supporting the provisioning of existing vaccines and providing grants for introduction of new vaccines, Injection safety support and by 2013 it started providing grants specifically for HSS. The first round of grants for HSS[37] grants (US$ 107 million) aimed to address the main causes of coverage and equity deficits of the immunisation system [38] by supporting an innovative Public-private partnership called 'The Vaccine Bonds Programme (IFFI) and Matching Fund' which encourages corporate sector to commit resources to HSS (Kenney and Glassman, 2019). In the second phase of HSS support, India asked for assistance focused on routine immunisation strengthening through four

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Gavi support for India

Type of support	Approvals 2001-2023 (US$) (2 Jul 2019)	Commitments 2001-2023 (US$) (2 Jul 2019)	Disbursements 2000-2019 (US$) (2 Jul 2019)	% Disbursed (2 Jul 2019)	2002	2003	2005	2006	2007	2009	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Health system strengthening (HSS 1)	$107,000,000	$107,000,000	$107,000,000	100%									■		■	■					
Health system strengthening (HSS 2)	$90,751,628	$102,217,256	$53,979,703	59%													■	■	■	■	■
HepB mono (NVS)	$26,486,033	$26,486,033	$26,486,033	100%	■	■	■	■	■	■											
Injection safety support (INS)	$18,427,489	$18,427,489	$18,427,489	100%			■	■	■												
IPV (NVS)	$59,652,799	$59,652,799	$26,081,161	44%											■	■			■	■	
Measles-Rubella (NVS)	$127,341,015	$127,341,015	$127,335,531	100%													■				
MR - Operational costs (OPC)	$8,508,020	$8,508,020	$8,508,020	100%														■	■		
Penta (NVS)	$264,904,036	$264,904,036	$264,904,712	100%							■	■	■	■	■						
Pneumo (NVS)	$180,000,000	$180,000,000	$175,385,633	97%													■	■	■		
Rotavirus (NVS)	$55,944,000	$65,000,000	$27,251,701	49%														■	■	■	
Vaccine Introduction Grant (VIG)	$415,523	$415,523	$415,523	100%	■				■												
Total	**$939,430,543**	**$959,952,171**	**$835,775,506**																		

■ Red line on table indicates duration of support based on commitments.
Commitments: Multi-year programme budgets endorsed in principle by the Gavi Board. These become financial commitments upon approval each year for the following calendar year.
Approvals: Total Approved for funding

38 These included: Objective 1: Strengthening of cold chain management in poor performing states through improved human resources capacity, institutional strengthening and supporting supervision (led by UNICEF) Objective 2: Design and implement an eVIN (electronics Vaccine Intelligence Network) that will enable real time information on cold chain temperatures and vaccine stocks and flows (led by UNDP) Objective 3: Increase demand for RI through a national Behavioral Change and Communication (BCC) strategy, develop, broadcast and communicate immunisation messages (led by UNICEF) Objective 4: Strengthen the evidence base for improved policy-making (at all levels) on programmatic areas through a well developed and implemented national M&E plan and research framework (led by UNDP) Objective 5: Leverage the success of the National Polio Surveillance Project to strengthen RI service delivery and VPD surveillance in 8 priority states (Led by WHO).

implementing fartners, UNDP, WHO, John Snow Inc (JSI) and UNICEF. This grant started to disburse funds in 2017 and is planned to function till 2021.

This decade saw entry of new private foundations in India. Most important of these has been the Bill & Melinda Gates Foundation. Gates foundations support to health systems in India started with a focus on HIV/AIDS control with the launch of AVHAAN project in 2003 but soon expanded to the control of neglected tropical diseases and strengthening Maternal and Child Health services in some States. The Clinton Foundation and the Children's Investment Fund Foundation (CIFF) were also established in this decade in India and soon engaged in a range of disease-specific and child health initiatives.

In addition to this, in mid-2000s, with the growing State-initiated health sector reforms, global actors transitioned their role more towards technical assistance and continued to provide technical support to a health sector reforms including National Rural Health Mission (NRHM)and Rashtriya Swasthya Bima Yojana (RSBY). Between 2005-06 and 2011-12, sixty-three percent of total central health spending was on NRHM and nearly seventy percent of total NRHM funds were for RCH-related activities. Three years following the launch of NRHM, a national health insurance scheme called RSBY was launched by the Ministry of Labour and Employment, GoI. This scheme was primarily funded by the GoI paying around seventy-five percent of the funds and rest were contributed by the respective State Government. Two major global actors: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and the World Bank were involved in designing and implementing this scheme. Ministry of Health was not involved in the schemes till few years of its functioning and it was operated by the Ministry of Labour (Swarup, 2019).

Post 2008, the WHO, World Bank and even Bilateral donors- USAID, DFID and other OECD nations had stepped back and WHO and UN agencies became dependent financially on Global Health Initiatives and corporate fund and had a limited role in the health systems development arena. Global Health Initiatives: GAVI, Global Alliance for improved nutrition (GAIN) and GFATM captured the space previous occupied by Multilateral and Bilateral institutions and emerged as main global health players.

HSS ideas

Key HSS ideas which dominated this decade were swinging more towards integrated and collaborative approaches for HSS on paper but were getting more fragmented and disease oriented in practice. In this decade 'HSS' became the buzzword for addressing health challenges. The term HSS found its place in many strategy documents and policies as it received a lot of attention from global health actors. This was also a period which saw growing debate about clarity in the meaning and approaches for HSS stressing the importance of differentiating health systems support from health systems strengthening (see context section below). This decade also witnessed the SARS pandemic, following which the focus on HSS grew stronger and HSS was repositioned as building health systems resilience which enables health systems which can respond to health emergencies and emerging threats to global health security.

Two important health systems strengthening frameworks that is six building block's framework and Control Knobs framework (see section 1.1 HSS) provided more clarity on the concept of HSS and its application for improving health systems performance. More specifically in India, two strands of thinking on HSS was promoted by the global actors. One strand directed to an integrated, community-centred participatory health systems which were steered by India in a mission mode through the launch of NRHM and other was a fragmented, disease-oriented idea of HSS focusing on increase in resources and cross-cutting HSS interventions targeted at improved coverage of services for specific diseases (mainly of HIV/AIDS, Malaria, Tuberculosis and immunisation coverage) as was practiced by global health partnerships like GFATM, GAVI and PEPFAR.

These two opposite and simultaneously existing strands in HSS ideas can be ascertained from the series of policy processes which took place in India in this period. These can be viewed as a fast wave which touched India in early 2000, starting from announcement of a population policy, followed by National Health Policy, followed by the launch of NRHM on one side. And increasing focus towards the MDGs and support from global health partnerships like GFATM and GAVI to meet the disease-specific targets and later the launch of RSBY targeted to meet the health needs of the vulnerable population on the other side.

In terms of specific HSS ideas under increase in resources and improvements in processes, a combination of ideas from both these strands was promoted by global actors. There was an increasing focus on ensuring availability of critical health systems resources like drugs, equipment,

infrastructure as much as there was a focus on improving processes like improved public sector administration, integration of health systems, inter-sectoral action and community participation. For example, RCH programme supported by a wide range of global actors shifted its focus from a narrow Family Planning approach to a need based, demand driven, high quality integrated Reproductive and Child health care services in the year 2000. Simultaneously, the issue of "Health for All" as outlined in PHC approach was being emphasised by the Peoples Health Movements pushing for adopting the Peoples Health Charter in India.

These developments as followed by National Health Policy 2002 reflected the vertical and selective concerns of MDGs which focused on HIV/AIDS, TB, Malaria and charted a complete departure from the earlier health policy failing to include the recommendation of the first policy towards 'health for all' goals and calling for completely revamping and reorienting the existing health systems. However, the launch of NRHM emphasised improving the condition of health care delivery systems in India through decentralisation, community participation, organisational structural reforms, inter-sectoral convergence, public-private partnerships, mainstreaming Indian system of medicines under Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) and induction of management and financial personnel into health care management and delivery system ("NRHM- Framework for Implementation," 2005).

A mix of these ideas was also promoted by the Bilateral and Multilateral actors in India through their existing projects in the States. For example, DFID's projects focused on HSS ideas including community engagement, integrated care and private sector participation. During the extended phase of DFID's support from 2007- 2015, it laid focus on developing a comprehensive approach to integrating health, nutrition, water and sanitation services by supporting to three government departments for their respective areas [39]. Its Health Sector Reform Programme (MPHSRP) in Madhya Pradesh, had major components of community-based approaches and district level engagement. Multilateral actors like Bank also continued to push its HSS ideas of cost-effectiveness, enhanced role of private sector and decentralised planning and delivery of service through its disease-specific and State health systems development projects in different States (see chapter 5)

[39]Department of Health & Family Welfare (DHFW) for health (FA and TA); Department of Women and Child Development (DWCD) for nutrition (FA and TA); and Department of Rural Development (DRD) for water and sanitation. The support in the first phase, according to the project memorandum, included a package of £50 million (£47.5 million FA and £2.5 million TA) and an additional £50 million was allocated later, making the total investment equal to approximately £100 million

On the other hand, global partnership like GFATM and GAVI were also engaged in HSS interventions targeted at reducing the health system constraints to achieving outcomes related to Malaria, TB, or HIV/AIDS and immunisation. GFTAM promoted the idea of HSS aiming to address health system weaknesses through a ‘‘cross disease approach’’ and benefit more than one of the three focus disease of the fund (Global Fund, 2007). Components of HSS have been parts of nearly all proposals made by India to GFATM. Some grants had comparatively direct focus on improvement of processes for HSS like strengthening human and institutional capacities of the national health system, improving procurement and supply chain systems and information systems while others included an increase in resources like health workforce recruitment and training (Global Fund, n.d.). GAVI's ideas of HSS mainly focused on supporting the provisioning of existing vaccine and introduction of new vaccines and injection safety support.

Process

Same methods of creation of evidence on effectiveness of health system strengthening ideas by financially and technically experimenting these ideas and legitimising these ideas through creation of innovative partnerships and networks in collaboration with other actors in the policy networks continued in this decade. However, the second tool that is collaboratively legitimising ideas got stronger with the expanding nature of policy networks in the context of increased role of global health partnerships post 2000. With the growing partnership, new actors especially from private and civil society sector entered the policy networks as global partnerships like GFATM, GAVI and PEPFAR preferred working with private sector and CSOs. Their partnership with these CSOs and private sector served as important tools for diffusing and legitimising their ideas as these organisation were given contracts under various projects which made them financially dependent on global actors.

While non-State actors were gaining more space in the HSS policy networks, the role of Bilateral actors was shrinking after 1998 nuclear tests. Few of the Bilateral agencies like SIDA formed partnerships with Multilateral organisations and Indian NGOs, private sector and universities and channeled its support through these partnerships. NIPI partnered with UNICEF and WHO routing its funds through the United Nations Office for Project Services (UNOPS) for providing support to NRHM in Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh)(Groot et al., 2008).

After the decentralisation amendments in 1990s and easing of procedures for providing assistance to NGOs in 2000, partnerships became a norm and the most important tool for almost all global actors for diffusing and legitimising their ideas. Most of the programmes of the government during this period had more than one global actor involved in designing and delivery of the programme and not just in providing financial support. For example, under the RCH programme partnership were pursued with a range of actors and for a variety of purposes ranging from partnership with global organisations like WHO, UNICEF, World Bank, DFID, International NGOs etc for designing of programme interventions and financing those interventions at one and. And on the other hand, with local CSOs and private organisations and individuals for provisioning of services at the facility level by outsourcing, contracting in staff and contracting out the management of hospital facilities, franchising and social marketing of contraceptives, accreditation of private facility for institutional delivery.

In 2000, it almost became an upspoken policy that different Bilateral actors invested in and supported few selected States in which they have been involved from few years. DFID decided to focus on three priority States that is Bihar, Orissa and Madhya Pradesh. NIPI 's focus States included Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh. DANIDA supported Karnataka, Tamil Nadu, Madhya Pradesh and Orissa. Netherlands focused its support to Uttar Pradesh, Andhra Pradesh, Gujarat and Kerala. In each of their focus State, their involvement in shaping States' HSS policies deepened in decade of 2000. For example, DFID played a critical role in drafting the Odisha Health Sector Plan (OHSP) 2005-10. It conducted a strategic review of the Odisha health sector in the late 1990s and produced a policy document in 2003 titled 'Health Vision 2010' which aimed to "improve people's health status with their participation, and to make health care equitable, accessible and affordable through partnerships between the public, voluntary and private actors"(e-Pact consortium, 2015). Similarly, DFID's was involved in health sector reforms in Madhya Pradesh starting in 2004, through financially and technically supporting a District Health Management and Sector Reform Programme which spilled into two phases.

In 2005, with the launch of NRHM, the health plans claimed a reduced role of global actors in HSS policies. However, this was not true in entirety. Though NRHM was mainly a centrally sponsored health mission, global actors participated in NRHM execution in various technical capacities. For example, NRHM Task Forces were set up with experts from various Bilateral and

Multilateral agencies. These agencies (commonly referred to as development partners in GoI documents) were consulted to provide written feedback on the State Plan(s) (PIPS). Their involvement in providing financial and technical assistance to the Mission in the concerned States formed the most significant part of their participation in NRHM. These actors were also involved in the creation and functioning of National and State health systems resource centres which were created to provide technical assistance to Ministry of Health and Family Welfare (MoHFW). Most consultants who worked in these agencies were funded by development partners and they helped in augmenting human resource capacities at the national, state and district levels and also act as carriers of HSS ideas promoted by these actors.

Participation from Bilateral and Multilateral actors was actively solicited in NRHM by the GoI, for example for coordinating the assistance, monitoring and evaluation arrangements, data requirements and procurement rules for the development partners under an integrated framework of State Health Plan joint annual reviews were held with the State. These actors duly authorised by the MoH&FW from time to time, to undertake field visits in any part of the State and have access to necessary information for measuring the progress of the mission (World Bank, 2006a)..

Participation of these actors in NRHM was closely linked with their participation in RCH programme. The second phase of RCH programme also known as RCH II was signed off in July 2005. It was largely financed by GoI with support from development partners, including DFID, World Bank, UNFPA, UNICEF, WHO, EC, USAID, NIPI and JICA. Two prong approach was adopted by the Development Partners to support the RCH programme. It was co-financed by DFID, UNFPA, and IDA as pooling partners, and other global actors including EU, USAID, UNICEF, WHO, USAID, NIPI and JICA provided their financial and technical assistance from outside the pool (World Bank, 2006a). This pooling of funds was partly a consequence of the global agreements and joint statements by the global actors in health and the ministers of developing countries aiming at aid effectiveness and harmonisation. In India too funds received from UNICEF and other agencies were mixed up under NRHM fund account. Outside NRHM and RCH, Multilateral institutions like Bank and global partnerships like GFATM, GAVI and PEPFAR continued supporting the disease-specific, nutrition, and State health systems development projects using the tools of financial and technical support and partnerships for legitimising their ideas of HSS. Under RSBY, technical role of global actors became more

dominant as both GIZ and World Bank got involved in assisting States in designing and implementing the insurance schemes. Technical inputs like designing of service packages, development of smart cards for beneficiaries, developing data and information systems and monitoring and evaluating the scheme were all driven with the support from these two actors.

Context

The decade of 2000 marked important shifts in the prominence of global actors in HSS and HSS ideas globally as well as in India. Van Olmen et al. (2012) argue that during this period, health systems thinking was shaped by three major and intrinsically connected developments. First was the dramatically changing landscape of actors in global health as the private foundations and Global Health Initiatives (GHIs) emerged as major global health actors. Second was the shift in attention of WHO shifting towards the performance of health systems. Third was the increasing complexity of health systems which was beginning to be recognised by the health systems research community (p.5).

'Health systems strengthening' became a buzzword and gained a lot of attention from international actors in this period (Hafner and Shiffman, 2012). For example, the 2000 World Health Report focused on health systems performance, World Bank trained approximately 20,000 individuals on improving health system performance under its flagship programmes on Health Sector Reforms and Sustainable Financing (Shaw and Samaha, 2009 cited by Hafner and Shiffman, 2012 p.44). and then prioritised HSS in the revised Health, Nutrition and Population strategy of the year 2007.

This was the period when the criticisms of ineffectiveness of aid had resulted in setting up targets for 'development' for the global aid community to show if development aid is working and if so, then how is it working. These goals were set to be achieved by 2015 and came to be known as Millennium Development Goals (MDGs). Marten (2019) notes that from 2000–2015, the eight MDGs[40] provided the framework for global development efforts. Three out of these eight goals related directly to health and the other five goals focused on critical determinants of health and thus represented a new 'super norm' dominating the global development agenda (Fukuda-Parr &

[40] to eradicate extreme poverty and hunger; to achieve universal primary education; to promote gender equality and empower women; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria, and other diseases; to ensure environmental sustainability; and to develop a global partnership for development.

Hulme, 2011 cited by Marten, 2019). However, Shiffman (2007) claims that the issues included in the MDGs agenda like HIV/AIDS, gained disproportionate attention and displaced funds and attention from other health issues[41].

Though there was a purported shift in thinking about health systems disease focused approaches between 1990s to 2000 towards the overall health systems development approaches promoted by new initiatives, most of this shift was a rhetoric and in practice actually legitimised the disease-specific focus. For example, the Okinawa Infectious Disease Initiative, announced by Japan at the G8 summit in 2000, led to strengthened global efforts on several diseases, in particular HIV/AIDS, Tuberculosis, and Malaria, but also poliomyelitis, parasitic diseases, and other neglected tropical diseases (Hafner and Shiffman, 2012). With the coming of new HSS initiatives under Global Fund & GAVI, this disease-specific approach to HSS got further legitimised.

Internationally, the role of UN agencies shrunk as Global Fund, GAVI and the Gates Foundation became important channels of funding in health. WHO attempted to position itself as the central actor in health by focusing on a Bank's model of working and emphasising on stronger partnership with member States and improving the quality of work at country level and supporting health sector development (Ruger, 2005). The Bilateral programmes of Sweden, Spain, Japan, and Germany remained nearly constant over the period. But the programmes of the Joint UN Programme on HIV/AIDS (UNAIDS), the Pan American Health Organisation (PAHO), US non-governmental organisations, the Asian and Inter-American development Banks, and the Bilateral programmes of France and Italy showed real declines (Murray et al., 2011).

In India as a result of the freeze in aid in 1998, the number of Bilateral projects decreased from eleven in the beginning of 1999 to four projects in 2002. Most Bilateral organisations started channelling their support through Multilateral organisations, NGOs and civil society but with smaller amounts. In 2003, the Indian government, announced its reoriented aid policy to only accept government-to-government aid from five donor countries (UK, Germany, Japan, Russia and USA) and Multilateral aid (including the EC's). Countries outside G8 were restricted to direct assistance only if they commit a minimum annual development assistance of US $ 25 million. In

[41] Similarly issues not included within the MDG agenda, like noncommunicable diseases received reduced interest, attention and resources within the field of global health. By 2014, roughly $23 billion out of a total of $36 billion of Development Assistance for Health (DAH) was directed towards MDGs Four, Five, and Six whereas only $611 million was directed towards NCDs (Dieleman, Murray, & Haakenstad, 2015). Moreover, since 1990 DAH associated with the MDGs increased more than any other areas (Dieleman et al., 2016). While this was not necessarily the case for every goal and target within the MDGs, it was the case that if a health challenge was not a MDG goal or target, it was more difficult to raise support and awareness for this issue in the MDG era. (Marten, 2019).

2005, Indian government modified the channel of routing of aid money to India. Earlier for receiving foreign money, agreements are made with Department of Economic Affairs, Ministry of Finance, who received funds that are paid into the foreign currency reserves. The Central government in New Delhi used to receive the monies in foreign currency and channelled the equivalent amounts in Rupees to the individual States at a ratio of seventy percent loan and thirty percent grant. This modified the rule to permit to pass the external assistance to the states on the same terms and conditions under it was received by the centre. The new arrangement was meant to expedite the utilisation of Bilateral and Multilateral assistance received by the States for undertaking fiscal and structural reforms (Groot et al., 2008).

There were attempts of consolidating funds from donor organisation and pooling of funds in this period. It was partly a consequence of the global agreements and joint statements by the global actors in health and the ministers of developing countries aiming at aid effectiveness and harmonisation. For example the First High-Level Forum on Harmonisation which took place in Rome in 2003 committed to improve the management and effectiveness of aid ("Rome Declaration on Harmonisation. 2003.," 2003) and following this the Paris Declaration that took place during a meeting in Paris in 2005 committed to further the country ownership, harmonisation and alignment of development assistance, managing for development results, and mutual accountability for the use of aid ("Paris Declaration On Aid Effectiveness.," 2005). The Accra High-Level Forum on Aid Effectiveness in 2008 then reviewed progress made against Paris Declaration commitments for improved aid effectiveness (Peters et al., 2013) . This was followed by the High-level Dialogue on maximising positive synergies between health systems and Global Health Initiatives, which took place in Venice, Italy on June 23rd, 2009.("Venice Draft Concluding Statement on Maximising Positive Synergies between health systems and Global Health Initiatives," 2009 p.2).

The donor decisions on phasing out in the 1990s were political decisions, while the same was true for the decisions to phase in again. Groot et al. (2008) note that aid administrators and advisers in the field at both sides of the donor as well as India often did not agree with the phase out decisions. The planning of the phase out was in most cases left to the aid administrators, but the margins for manoeuvre varied from one case to another. While GoI has subsequently allowed the conditional return of some of the smaller Bilateral donors and G8 members, it has nevertheless maintained its medium- to long-term ambition of gradually phasing out dependence on foreign aid. However, aid

in form of provisioning of State of art evidence, methodological inspirations and high-level support in decision-making, technical assistance programmes aimed at enhancing the knowledge and skills of Indian national were decided to be welcomed (World Health Organisation, 2011). Coinciding with this emphasis on minimising aid dependence, was the increasing emphasis on the issue of "Health for All" by the Peoples Health Movements and a push for adopting the Peoples Health Charter culminating into the launch of the launch of NRHM in 2005.

3.5 2010 ONWARDS: CIRCLING BACK TO PHILANTHROPIC POWER

Actors

Post India's development cooperation strategy changes in 2003-04, the decade of 2010 saw a shift in terms of landscape of global actors involved in HSS to be limited to large actors like Multilateral organisations, United Nations agencies, large global health partnerships, private philanthropies and few dominant Bilateral actors. As noted in WHO Country Cooperation Strategy of 2012-17, the total support from donors contributed to less than one percent of total health expenditure (World Health Organisation, 2011).

Among the Bilateral actors, UK was the largest provider of Grant Assistance to India through the United Kingdom Department for International Development (DFID). DFID's major support was given to national programmes including Reproductive and child Health and AIDS Control Programme in Andhra Pradesh, Bihar, Madhya Pradesh, Orissa and West Bengal. It also provided assistance to civil society organisations and Multilateral organisations like UNICEF, World Bank, Asian Development Bank and WHO. Another important Bilateral actor during this period was the USAID which focused on RCH, infectious diseases and health systems improvements. The "Innovations in Family Planning Services" (IFPS) project of USAID initiated in 1992, ran for almost twenty years in UP and nearly eight years in Jharkhand (JH) and Uttarakhand (UK). The "AIDS Prevention and Control" (APAC) programme of USAID in Tamil Nadu and Pondicherry was another important project which provide support worth US$ 47.25 million. EU continued to

support the sector social policy support through joined funding to NRHM and second phase of RCH. EC committed €470 million to the Health and Education MDGs in 2007-13 and of this €110 million (€99 million as sector support plus €11 million as services) were allocated to these programmes (World Health Organisation, 2011).

Regarding the Multilateral actors and United Nations agencies, UNICEF and WHO continued to be important actors involved in health systems development. WHO continued its work on the core programme clusters in the areas of specific communicable and Non-Communicable Diseases and disease surveillance, MCH and immunisation including vaccine development and more directly on Health Systems Development. It also had a dedicated programme cluster on Health Action in Crisis including emergency and humanitarian action. WHO's major involvement with HSS included strengthening of national surveillance systems, which were built under the National Polio Surveillance Project (NPSP) and Integrated Disease Surveillance Project. It was also involved in responding to communicable diseases like HIV/AIDS, Leprosy Elimination and had an active role in supporting the National Vector Borne Disease Control Programme, Integrated Prevention and Control of NCDs, Tobacco Free Initiative, National Programme for Prevention and Control of Cancer, Diabetes, CVDs and Stroke, National Mental Health Programme and Elimination of Lymphatic filariasis. However, during the latter part of the decade of 2010, WHO transitioned to support the implementation of GoI's flagship programme Ayushman Bharat. It emphasised on strengthening comprehensive Primary Health Care component under Ayushman Bharat which focused on Health and wellness centres. It also committed to assist and guide policy discussions and designing, testing and evaluating the implementation of the Pradhan Mantri Jan Arogya Yojana (PMJAY) hospital insurance programme (World Health Organisation, 2011).

UNICEF remained another important actor in health operating in collaboration with the Ministry of Women and Child Development and the Ministry of Rural Development. It had presence at sub-national levels with various projects and programme operational at State-level and in collaboration with other Multilateral and Bilateral agencies. For example, it has worked in partnership with WHO (supported by the NIPI) in routine immunisation strengthening, RCH and polio eradication (UNICEF, 2012). The World Bank continued to support the Central government's national disease control programmes including HIV/AIDS, TB and Malaria; RCH programmes and State health systems development projects. The World Bank's Country Strategy 2009–2012 allocated US$ 14

billion loan focusing on the above components. It also played a crucial role in India's efforts towards UHC by assisting at National and State-level on the designing and implementation of health insurance schemes (World Bank, 2008a).

Simultaneously, global health partnerships became significant actors in health sector in India. These included GFATM, GAVI, Roll Back Malaria and Stop TB partnership. The main focus of these partnerships has been to control specific infectious diseases, but they have also claimed to contribute to HSS directly. For example, GAVI extended a two-phase HSS project in India with the aim to increase immunisation coverage and strengthen health system for immunisation in the country through a support of USD 107 million for three years (2014-16), followed by USD 100 million for the second phase from (2017-21). The project was targeted to support GoI's intensified efforts focusing on overall health system improvements through targeted support to strengthen RI and accelerate new vaccine introduction (GAVI Alliance, 2012). This project was implemented through partnerships with a range of other global actors participating as project implementers namely UNDP, UNICEF, WHO and JSI and other partners (USAID, BMGF and CSOs) (GAVI Alliance, 2012). With regards to GFATM, India has been one of the largest implementers of Global Fund grants. Since 2003 and as of September 2019, the Global Fund has disbursed more than US$2.1 billion in grants to India for programmes to fight HIV, Tuberculosis and Malaria between and allocated US$500 million for 2017-2019. It continued to provide grants to health systems development directly and indirectly through giving grants to projects focusing HIV/AIDS,TB and Malaria (Global Fund, 2019).

This decade saw an increasing role of private foundations in India. They entered in 2000 and by 2010 gained a prominent role. Bill & Melinda Gates Foundation which started with its HIV/AIDS focused project in 2003 but had a presence in all health systems development areas including MCH, nutrition, vaccines and routine immunisation, Family Planning, and control of selected infectious diseases by 2010. Similarly, the CIFF provided technical support to a number of programmes including the GOI's school-based deworming programme and other State-level intervention in a range of health systems issues. It invested in Rajasthan in the area of malnutrition and adolescent girls focusing on Family Planning. CIFF's work has been mostly focused on children' health targeted on reducing child mortality including initiates for improving the quality of care in child birth focusing on quality improvements in the labour rooms and introduction of

the Safe Childbirth practices. It gradually expanded to work through government-sponsored health insurance in Andhra Pradesh and Telangana to save maternal and neonatal and also assisted the prevention and control of paediatric HIV/AIDS and mother to child transmission of HIV/AIDS(CIFF, 2016).

Ideas

Most dominant ideas of HSS in the decade of 2010 was the ideas of Universal Health Coverage. This move towards UHC was a successor to the commitment in 2005 World health assembly which legitimised achieving UHC as one of the key goals under United Nations' Sustainable Development Goals launched in 2015. The 2005 World health assembly urged member States to pursue UHC, ensuring equitable distribution of quality health care infrastructure and human resources, to protect individuals seeking care against catastrophic health care expenditure and possible impoverishment (WHO, 2005). The idea of UHC was also rooted in the idea of 'Right to health'. Over last many years, India has signed various international treaties, agreements and declarations specifically undertaking to provide right to health including but not limited to: Universal Declaration of Human Rights (UDHR).

The GoI defined UHC as "Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services" (National Health Portal Of India," n.d.) . Formulation of UHC plans has been guided by ten principles including i) universality, ii) equity, iii) non-exclusion and non-discrimination, iv) comprehensive care that is rational and of good quality, v) financial protection, vi) protection of patients' rights (that guarantee appropriateness of care, patient choice, portability and continuity of care), vii) consolidated and strengthened public health provisioning, viii) accountability and transparency, ix) community participation x) putting health in people's hands (National Health Portal Of India," n.d.).

In India the focus on UHC was asserted by the constitution of a High-Level Expert Group (HLEG) on UHC in October 2010 by the Planning commission of India. HLEG was given the mandate of

developing a framework for providing easily accessible and affordable health care to all Indians with the primary aim of providing financial protection. DFID and Rockefeller Foundation supported the activities of the HLEG and compiled a UHC report in 2011. Thirty-two international consultants were consulted for the report out of which eight were from the Bank, three from the WHO, and two from the UNICEF and two from the DIFD. Availability of adequate healthcare infrastructure, health human resource and skilled and access to affordable drugs and technologies were recognised as essential requisites for achieving universal coverage in this report (K.Srinath Reddy et al., 2011).

The twelfth five-year plan emphasised on moving towards UHC to assure access to a "defined essential range of medicines and treatment at an affordable price, which should be entirely free for a large percentage of the population. The main idea for meeting the goal for UHC included i) an expansion and strengthening of the public sector health care system. ii) a substantial increase in health sector expenditure by the Centre and States and iii) enhanced cooperation between the public and private sector including contracting in of services and effectively regulating PPPs (Government of India, 2017). Reforming in RSBY was suggested for enabling access to a continuum of comprehensive primary, secondary and tertiary care and to cover the entire population below the poverty line. "Strategic purchasing" was recognised as the key idea for filling in the critical gaps in public health services through building synergy with "not for profit" organisations and private sector to provide health services as per predefined norms.

In addition to RSBY, insurance schemes and health care packages, Public-Private Partnerships became a key idea for HSS in this period. Twelfth plan emphasised that PPPs would play an important supplementary function to the development and strengthening of the public health function. It stressed that PPPs would supplement and not substitute existing public health systems and would bring in fresh investment. Private sector was promoted by incentivising it through inter alia (i) reimbursement or fees (ii) preferential treatment to collaborating private hospitals and institutes for Central Government Health Scheme (CGHS) empanelment and in proposed strategic purchase by Government (iii) Non-financial incentives like recognition and skill upgradation to the private sector hospitals and practitioners for providing public health services and for partnering with the Government of India and State Governments in health care delivery and (iv) through

preferential purchase by Government health facilities from domestic manufacturers (Government of India, 2017).

Simultaneously, GAVI continued to promote the diagonal approach for HSS through supporting grants which aimed at improving the quality and level of immunisation coverage and prepare for the adoption of new antigens by catalysing the development of immunisation programme. These ideas of HSS focused on improving both the supply and demand side of routine immunisation and policy-making and guiding programmatic improvements and expansion of the Universal Immunisation Programme. HSS ideas supported under GFATM grants mostly included strengthening human and institutional capacities of the national health system focusing on health workforce recruitment and training, improving procurement and supply chain systems, improving information systems etc. Funds have also been granted to provide access to health care; supplementary nutrition and health information, access to education through formal and informal education and vocational skills-based training for older children; and psychosocial support for children and family members affected by AIDS (Grant Portfolio, India," n.d.).

World Bank Country Strategy 2009–2012 (with a US$ 14 billion loan) focused on fast-tracking the development of infrastructure, supporting the seven poorest States and responding to the financial crisis. Loan assistance tops Government outlays in several centrally sponsored national disease control programmes (e.g. TB, Malaria and HIV/AIDS); sectoral programmes (e.g. Reproductive and Child health) and health systems components (e.g. integrated disease surveillance). It also provides assistance on health systems development to specific States (e.g. Tamil Nadu, Andhra Pradesh and Rajasthan) (World Bank, 2008a).

Process

By 2010, the technical assistance work and partnerships became the main process of participation of global actors in HSS polices. Partnerships became central to all health systems work promoted by global health actors. Ranging from the governments programmes in which other global health actors were partners to the independent projects and initiatives of respective global actors, partnerships were used as the key to legitimise HSS ideas. These partnerships existed in the designing as well as the implementation phase of the health systems projects. For example, GoI's Ayushman Bharat and PMJAY solicited partnerships with global actors in designing of the programmes and partnerships with local private sector hospitals for implementing the scheme.

Nearly all disease-specific projects and mainly HIV/AIDS, TB and Malaria projects involved a range of global partners varying in their involvement in terms of financing and technical support to the government for programme implementation. Similarly, for sector programmes like RCH and nutrition a host of partners participated in different aspects of programme designing and implementation. These partnerships extended to a large extent to the private sector industry and civil society organisation. This mode of partnering with the non-State actor by sub-contracting them party became a key tool for legitimisation of HSS ideas of donor agencies.

Most global health actors were involved in providing technical support to India's journey towards UHC. For example, Under PMJAY and Ayushman Bharat WHO committed to support in development of a methodology for defining, coding and pricing of benefit packages under UHC based on local and global evidence. WHO was also involved in supporting the Department of Health Research in conducting health technology assessments. It committed to setting up of linkages between primary care facilities and higher levels of care to ensure continuum of care, identify and document successful models of service delivery and best practices (World Health Organisation, 2012).

Bank supported knowledge exchange function through assistance in functioning of Government-Sponsored Health Insurance Forum in India. This forum was launched in 2011, designed as a practitioner-to-practitioner learning opportunity to bring together the policy-makers and practitioners from across India to discuss the "how-to" of implementing tax-funded health insurance programmes. For instance, during these forums, States shared the learning from their insurance schemes which have the potential to be replicated such as the costing of health services (first undertaken in Andhra Pradesh and Kerala and later by Chhattisgarh, Karnataka and Meghalaya, each building on the lessons of the others), as well as the collective work on fraud control (identifying red flags and triggers in claims data to prompt follow-up action by the insurer). The Forum has continued to grow, and almost twenty Indian States participated in New Delhi, with the central MoHFW playing host in 2018 (Smith, 2018).

Other mechanisms of involvement in HSS by major Multilateral like WHO, UNICEF and Bank continued as the previous decade. For example, WHO continued to support capacity building of frontline health workers and mid-level health care providers, including AYUSH practitioners, in the prevention, promotion, diagnosis and management of NCDs and roll-out of a population-based

screening programme. UNICEF continued to work in partnership with WHO and NIPI in supporting routine immunisation, polio eradication and other RCH initiatives. Bank continued to grant loans for health sector projects and influenced National and State health policies through financing it. In 2010 Bank had granted loans to nearly fifteen new projects including State health systems development, disease-specific projects like TB, HIV/AIDS as well as sectoral projects like nutrition.

Context

The decade of 2010 was marked by the idea of UHC. Since the release of the 2010 World Health Report, the global momentum for UHC has continued to grow. At the 2012 World Health Assembly, Margaret Chan, the then Director-General of WHO announced that, "following publication of the 2010 World Health Report on health system financing, more than sixty countries have approached WHO seeking technical support for their plans to move towards universal coverage...UHC is the single most powerful concept that public health has to offer"(Chan, 2012).

2010 was also the decade in which Non-Communicable Diseases got more attention by global actors in comparison to the previous decades. The General Assembly of the United Nations (UN) voted in 2010 to hold a High-Level Meeting on Non-Communicable Diseases in September 2011(United Nations, 2011) to put NCDs, including cancer, diabetes mellitus, cardiovascular disease, stroke, and chronic respiratory disease, on the global health and development agenda. The focus on NCDs called for a multisectoral approach and a coordinated global response. These goals were viewed by many as the world's development and public health agenda (Partridge et al., 2011).

A collective action to health was further recognised through the adoption of Sustainable Development Goals (SDGs) in 2012. United Nations Member States adopted the SDGs as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030. These seventeen SDGs replaced MDGs and emphasised that "action in one area will affect outcomes in others, and that development must balance social, economic and environmental sustainability". SDGs stressed on the importance of partnerships and collective action of governments, private sector, civil society and citizens to achieve the goals. These goals were led by UN development agency, UNDP and was to be implemented through UNDPs work in 170 countries and territories (UNDP, n.d.)

Goal three of the SDG focused to ensure healthy lives and promote well-being for all ages and target 3.8 under this goal was to achieve UHC, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all. India was a signatory to the SDGs and in India (as noted above), the focus on UHC was asserted by constituting a High-Level Expert Group on UHC in October 2010 followed by UHC being stated as an overarching means for health systems improvement in the twelfth five-year plan in 2012 , National Health Policy in 2017 and then the GoI's flagship programme Ayushman Bharat and PMJAY.

HLEG proposed the creation of the Integrated National Health System in India through provision of universal health insurance, establishment of autonomous organisations to enable accountable and evidence-based good quality health care practices and development of appropriately trained human resources, the restructuring of health governance to make it coordinated and decentralised, and legislation of health entitlement for all Indian people (K.Srinath Reddy et al., 2011). However, the idea of UHC in India has largely been translated to mean assuring health services to people through provisioning of a package of health services to the vulnerable populations by the States under various health insurance schemes (in many cases funded by the State).

Simultaneously, most of the activities from the global actors were consolidated under large plans as there was a growing recognition of the ineffectiveness of the fragmented approaches of donor agencies. For example, in 2018, Government of India and United Nations signed a United Nations Sustainable Development Framework (UNSDF) for the period 2018-2022. UNSDF is a framework of cooperation between Government of India and UN bodies including UNDP, UNFPA, UNOPS, UNICEF, UNIDO, UNESCO, ILO, UNODC, WHO, UNAIDS, WFP, UN-Habitat and FAO guiding the achievement of national priorities. It has been developed in consultation with National Institution for Transforming India (NITI) Aayog and its three-year Action Agenda (2017-2020) including other policy initiatives planned for the coming years. All major UN actors involved in health committed to support India under this framework (UNDP, 2018).

CONCLUSION

Global actors have been an active participant in shaping health systems strengthening policies in India from pre-independence times. These actors have entered at different points in time and

experimented with different ideas of health systems strengthening (such as disease-specific inputs, Primary Health care and sector-wide approaches, decentralised planning etc.) in India through providing financial and technical support to the health sector.

The prominence of global actors over time in India can be understood as a circle. The early independence years were marked by prominence of American private philanthropic foundations followed by few Bilateral and UN Multilateral agencies till 1980s. World Bank remained the most significant actor till the early 2000 and was taken over by global health partnerships like GFATM and GAVI in the following decades. This prominence of partnerships was soon again taken over by American private foundations such as BMGF.

Both ideas of HSS that is increase in resources and improvements in processes have been a focus on global actors' interventions. The participation of global actors in HSS in early decades till 1990s was mostly around increase in resources mainly concerned with provisioning of medical supplies, infrastructure development and recruitment of human resources. Influence on processes till 1990s included knowledge transfers through training of Indian experts abroad and deployment of international experts in India. Post 1990s, there was shift towards a skewed focus on improving processes or health sector reforms like reducing the role of State and promoting the participation of private sector in health care provisioning, administrative and management reforms like decentralised planning and community involvement in health care planning and implementation. As the global actors were allowed to work directly with the States, they could by-pass the Central government to diffuse their ideas directly to the States.

The areas of work and HSS interventions of global actors have been varied and inconsistent over time. Consequentially, the ideas for HSS promoted by global actors is seen as pendulum like motion swinging between vertical to horizontal and again to vertical approaches. Global actors like EC, DANIDA, DFID which experimented with decentralisation through society routes of functions, carried bottoms up planning, promoted community participation and developed integrated systems got attention during 1990s but soon got hijacked by international agendas of MDGs. These components for HSS were again incorporated in NRHM but again got replaced by larger global partnerships like GFATM and GAVI as they had more money to pump in. The changes in India's foreign cooperation policy in 2003 resulted in a changed landscape of global actors dominated by the presence of large Multilateral and global health partnerships.

The HSS ideas of these partnerships are still narrow, selective and disease-specific and skewing the health agenda towards vertical disease-specific approaches for HSS. Though the quantum of funds, areas of investments, prominence of certain actors against others, motivations of providing aid establishes the role of global actors in health systems strengthening arena in India but to minimise their disproportionate and negative influence it is important to understand the process through which global actors exert their influence in this area. Few of these questions will be addressed in the next chapters focusing on role of one actor (World Bank) in HSS policies in India.

CHAPTER 4

WORLD BANK AND HEALTH SYSTEMS STRENGTHENING POLICIES IN INDIA: ANALYSING THE ACTOR AND CONTEXT

INTRODUCTION

This chapter focuses on the embedded case of the World Bank. The World Bank has been one of the key players among these different actors and has been the single most important global health actor in India from late 1980s to early 2000. Starting from 1960s till 2019, the Bank has provided nearly seventy project loans to India. Almost all of these projects have been funded by IDA except two which have been granted after 2018 when India graduated to middle-income countries status and could only ask for IBRD loans. This chapter will address the first and second objective of the thesis and is divided into two parts focusing on understanding the World Bank as a global health actor in health systems strengthening policy network and the political, economic and public administrative context which enables global actors to influence HSS policy process in India.

As noted in chapter one, different ideas of HSS are being promoted by different global actors (see table 1.2). These ideas are in turn shaped by the history, constitution, mandate and the understanding of health systems by respective actors. This makes it important to understand the origins and composition of different global health actors for understanding the ideas of HSS promoted by them as well as the process used by them to promote these ideas. In this context, first section of this chapter will examine the history, composition, mandate and evolving priorities of the World Bank to understand the origins and basis of the HSS ideas promoted by the Bank in India.

The underlying inherent values of actors and their behaviour are shaped by the broad social, political and economic context in which these actors operate, at both macro government policy level and micro institutional functions level. Therefore, for a complete understanding of

functioning of actors, it is important to study the context in which the actors are working. In this context, the second section of this chapter will examine the context including the overall political, economic and social background in which the World Bank participates in HSS policies in India. This section will study the relationship between Bank and India over few decades and will discuss the factors that enabled the functioning of Bank in India

4.1 WORLD BANK AS A GOBAL HEALTH ACTOR

4.1.1 Inception of the World Bank

The experience from interwar period in 1930s had established that economic cooperation was the only way to peace and prosperity, at home and abroad. Officials like Franklin D. Roosevelt, the then President and Cordell Hull the then Secretary of United States of America were of the belief that free trade promoted international prosperity and international peace. The Atlantic Charter issued by Roosevelt and British Prime Minister Winston Churchill in August 1941 first articulated this vision. The charter called for a commitment for collaboration between all nations in the economic field. In around 1942, the United States of America and the Great Britain drafted plans for organisations that would provide financial assistance to countries experiencing short-term deficits in their balance of payments. For about two years that is from 1942-44, a series of Bilateral and Multilateral meetings of allied financial experts were held to agree on a common approach for the assistance. On April 21, 1944, a Joint Statement by allied leaders and experts was released calling for the establishment of an International Monetary system. This statement provided the basis for the negotiations at the upcoming conference at the Bretton Woods, New Hampshire.

In July 1944, delegates from forty-four nations had met for a three-week discussion in Bretton Woods to agree upon the new rules for the aforesaid monetary system. This gathering later came to be commonly known as the United Nations Monetary and Financial Conference and as also Bretton Woods conference. One of the major accomplishments of this conference was the creation of IBRD along with its sister institution the IMF. The IMF was charged with the maintenance of a system of fixed exchange rates centred on the US dollar and gold and the IBRD was the 'first Multilateral Bank' made responsible for providing financial assistance for the reconstruction of

war-ravaged nations and the economic development of less developed countries (Department Of State, the Office of Electronic Information, 2008). The Bank provided interest bearing and interest-free loans, credits, grants, and technical assistance to war-damaged and economically developing countries that could not afford to borrow money in international markets. It initially raised funds through private financial markets and received donations on a regular basis from the world's wealthiest countries.

4.1.2 World Bank and the hegemony of United States

As most of the Europe was devastated postwar. It was only the United States of America which was still economically productive and in a State to financial support other countries. At the time of inception of World Bank, United States had the highest shares (37%) in it. Design of both the institutions of IBRD and IMF were purely drafted by the officials of US government with the help of British delegation to the Bretton Woods conference. The charter for IBRD required that "the principal office of the Bank shall be located in the territory of the member holding the greatest number of shares" and hence its headquarters was decided to be located in the USA. British economist Lord Keynes was of the opinion that the World Bank and IMF should work as autonomous institutions and should not be influenced by the national politics but the one of the implicit earliest victories of United states to control the World Bank was the choice of Washington D.C. over New York city as headquarters of World Bank (India economic overview, n.d.). Kapur et al. (1997) note that the Americans had a secure enough lead in the Bank throughout the half century as it chose the president of the Bank (p.4).

One of the biggest factors which contributed to the homogenising role of the World Bank and grew gradually over time was "economics". Economics became the Bank's hallmark scholarly discipline, and the economists heavily shaped Bank's operations. Kapur and colleagues (1997) note that "to a large degree, however, they were the product of the graduate economics departments of English-speaking, but especially American, universities" (p.4). This fact, as it played into the Bank's consulting, research, technical assistance, and agenda setting, enhanced the role of United States in the Bank beyond the apparatus of formal governance. As will be discussed in chapter 5, the most influential health governance tools developed by Bank for measuring health status and

prioritising health problems have economic concerns at its centre and have been developed with the idea of containing costs (for example cost-effectiveness, DALYS, disease burden metrics).

4.1.3 Five institutions of World Bank Group

In addition to IBRD, the present-day World Bank Group comprises four other institutions known as the International Centre for Settlement of Investment Disputes (ICSID), the Multilateral Investment Guarantee Agency (MIGA), the International Finance Corporation (IFC), and the International Development Association (IDA). ICSID, established in 1966 provides international facilities for conciliation and arbitration of investment disputes. MIGA, created in 1988 promotes foreign direct investment into developing countries to support economic growth, reduce poverty, and improve people's lives. It fulfils this mandate by offering political risk insurance (guarantees) to investors and lenders. IDA, established in 1960 provides interest-free loans also called credits and grants to governments of the poorest countries. Together, IBRD and IDA make up the World Bank. The IBRD provides long-term loans to low- and middle-income member countries with annual average per capita incomes less than $5445 at interest rates in line with market values. Countries with an average annual per capita income of $1505 or less—are eligible for interest-free IDA credits. Creditworthiness and economic performance also influence the type of loan offered. Small island economies, for example, have higher annual average per capita incomes than the cut off but their lack of creditworthiness makes them eligible for IDA loans. Some countries are deemed to be eligible for both types of loan(Abbasi, 1999a).

IBRD was a created as a public sector institution as public affairs at that point tended to be more highlighted in social discourse than private affairs. But this public institution was peculiarly linked to the private sector and private resources (Kapur et al., 1997 p.2) . Originally, its loans helped rebuild countries devastated by World War II, but gradually its focus shifted from reconstruction to development, with a heavy emphasis on infrastructure such as dams, electrical grids, irrigation systems, and roads. Slowly, it asserted its main objective as 'worldwide poverty alleviation' and to connect global financial resources to the needs of developing countries. Consequentially, though it was established to finance European reconstruction after World War II, Bank today is a considerable force in the health, nutrition, and population sector in developing countries.

The World Bank describes itself as a cooperative with membership of 189 countries. A Board of Governors represent each of these countries. The Board of Executive directors together with the Board of governors are responsible for decision-making at the Bank. Each country's voting power is proportional to the size of its economy relative to the world economy. Hence the United States wields seventeen percent of the votes, effectively giving it the power of veto to any changes in the Bank's capital base and articles of agreement, for which eight five percent of the vote is needed. The G7 countries (Canada, France, Germany, Italy, Japan, United Kingdom, and United States) control forty-five percent of the total votes. Loan approvals are passed by a majority decision.

4.1.4 India's membership in World Bank

India is a member of four of the five constituents of the World Bank Group viz., International Bank for Reconstruction and Development (IBRD), International Development Association (IDA), International Finance Corporation (IFC) and Multilateral Investment Guarantee Agency (MIGA) and has been accessing funds from the World Bank (mainly through IBRD and IDA) for various development projects. India has a voting percentage of three percent in the IBRD in comparison to the fifteen percent for United States. In IDA India has three percent of voting power in comparison to about ten percent of United States.

India's involvement with the World Bank dates back to its earliest days. India was one of the seventeen countries which met in Atlantic City, USA in June 1944 to prepare the agenda for the Bretton Woods conference, and one of the forty-four countries which signed the final agreement that established the Bank. India is one of the founder members of IBRD, IDA and IFC. On 27th December 1945, The IBRD Articles of Agreement become effective in Washington, upon signatures of twenty-eight governments including India. The name "International Bank for Reconstruction and Development" was first suggested by India to the drafting committee[42] (India economic overview, n.d.).

India' first project approval by the Bank for Agricultural Machinery in 1948 marked the beginning of World Bank funding in India. World Bank resident mission was established in India in 1957 and in August 1958, the first meeting of the Aid India Consortium was held at Washington D.C. under the aegis of the World Bank. First investment of IFC in India took place in 1959 with US$

[42] The Indian delegation was led by Sir Jeremy Raisman, Finance Member of the Government of India and included C. D. Deshmukh (Governor of the Reserve Bank of India, later to become India's Finance Minister), Theodore Gregory (the first Economic Advisor to the Government of India), R.K. Shanmukhan Chetty (later independent India's first Finance Minister), Mr. A.D. Shroff (one of the architects of the Bombay Plan) and Mr B.K. Madan (later India's Executive Director in IMF).

1.5 million. India became a member of MIGA in January 1994. India has been on the Board of Directors of IBRD, IFC, IDA and MIGA.

India remains one of the largest borrowers of the Bank since its inception. The Bank has been one of the India's largest source of external capital, providing almost a third of all long-term gross in flows in the 1980s and, by the end of the 1990s, was supplying more than a fifth. Bank disbursements, which were about 5.5 percent of gross domestic public investment during 1980s, rose to about eight percent in the early 1990s. As per the 2011-12 estimates of the Department of Economic, in 2011-12, India purchased 5757 shares from IBRD and became the 7th largest shareholder in IBRD. India has 573,783 votes in IDA comprising 3.16% votes. However, as a constituency (comprising of four countries - India, Bangladesh, Sri Lanka and Bhutan), India comprises 4.44% of the total votes. For MIGA, India has 5,371 shares with a voting power of 2.56 % and for IFC a voting power of 3.38% (India economic overview, n.d.).

4.1.5 World Bank's involvement in health

For a long-time, it was thought to be unwise for the Bank to intervene and support the issues related to health. Eugene Black, the then president of the Bank for example categorically told his counterparts in the Economic and Social Council in an address in 1961, that health and in particular population control, was not a field in which international agencies (could) do much. This started to change in the 1980s. According to Abbasi (1999b) Dr Richard Feachem who was the then director of health, nutrition, and population at the World Bank from 1995-99 hints to three main reasons for this shift. The first one he stated was that the health sector has been a major part of the GDP of most of the countries and the World Bank's interest in macro-economic policy drew it towards the health sector investments. Second, the interest of the World Bank was growing in sectors like health, education and environment as 'in these sectors free market cannot work without governments involvement'. Third there was a growing consensus among economists that investments in people and the formation of "human capital" are essential prerequisites for sustained economic growth and social development. The investments in health were deemed to be crucial to the overall Bank's mandate of promoting sustained economic growth and alleviating poverty. On being asked, 'why did Bank take so long to develop this thinking about investing in health', Feachem said that "The Bank was simply moving with the global tide of ideas. Sometimes the Bank can be two or three years behind the global cutting edge, sometimes the bank can be a

little way ahead, but it is always there" (Abbasi, 1999b p. 1207). Feachem added that "If you go back to the '50s, '60s, and '70s you find that development economists in general were not stressing human capital formation, and the significance of, for example, girls' education and improving health were not as well recognised as they are today. The evidence that we have today that links good education and good health with good development outcomes was not as clear cut" (Abbasi, 1999b p. 1206-07).

Jennifer Prah Ruger who was economist in health, nutrition, and population sector (1998-2000) and a speechwriter to James D. Wolfensohn, former president of the World Bank, confirmed Feachem's ideas in her writings on the changing role of World Bank in global health. She notes that new theories and evidence have deepened and transformed the international development debate and have influenced Bank's development practices and policy decisions. Bank's focus on large investments in infrastructure and physical capital in the 1950s and 60s was based on the existing evidence that economic growth was the key to development. The shift in the development theory started to happen in the 1960s through to the 80s to include the 'basic needs' of individuals and according to Ruger, this approach appealed to Bank staff and especially to Robert McNamara, the then president of the Bank which led to a slow shift in Bank's focus towards investments in Family Planning, nutrition, health, and education (Ruger, 2005a).

Since then, the Bank has invested extensively in health. Following the Alma-Ata declaration in 1978, the Bank attempted to reorient its policies towards Primary health care approach to improve health gains for the poor. In 1979, the Bank established its health department. It devised its health policy which aimed at funding stand-alone health projects, as well as health components in other projects. This was also the period when McNamara was endorsing 'basic needs' approach for poverty reduction. 1980 turned out to be a significant year for the Bank's participation in health and nutrition sector in developing countries. This started with the Bank launching its health sector policy paper in 1980 and hence formally announced its commitment to direct lending in the health sector. The policy paper recognised the importance of providing services to the poorest groups in the society and drew a tighter link between health sector activities, poverty alleviation, and Family Planning. During this period, Bank claimed to commit itself to broaden access to cost-effective health care services and the need for basic health services, especially in rural areas (Fair, 2012).

The WDR 1980 also maintained the twin objectives of development as: to accelerate economic growth and to reduce poverty. It emphasised that "growth is vital for poverty reduction, but it is not enough", stressing on the role of human development and required investments in health and education. For a period of about six years that is from 1980 -86, the Bank remained committed to the idea that social sector policy was highly relevant to financial sustainability and growth. This phase was marked by its inclination towards PHC and nutrition projects which were seen to work as catalysts to bring policy attention to the issue, and to reinforce efforts in the sector as they contribute to the development of Primary Health Care and Family Planning programmes (Berg, 1987).

4.2 FACTORS ENABLING WORLD BANK'S PARTICIPATION IN HSS POLICIES IN INDIA:

As noted in chapter 1, governance lies at the centre of public policies. Examining the policy processes from the governance standpoint, highlights the centrality of co-creation of policies though constant negotiations taking place among a network of policy stakeholders including the State and non-sate actors. Rhodes (2007) has called these networks as policy networks defined as

> "sets of formal and informal institutional linkages between governmental and other actors structured around shared interests in public policy-making and implementation. These institutions are interdependent. Policies emerge from the bargaining between the networks' members…the other actors commonly include the professions, trade unions and big business. Central departments need their cooperation because … government rarely delivers services itself…" (Rhodes, 2007)

India's long history of accepting international aid in health affirm the existence and functioning of HSS policy networks in India. Though in the initial years private philanthropies and Bilateral organisations were the leading actors in these networks, but 1980s marked the World Bank's dominant role in supporting health systems in India by replacing other Multilateral and Bilateral organisations. Health sector has not always been an area of focus for the World Bank investments in India. For almost thirty years post-independence, only a small fraction of projects of the Bank

in India involved health. However, by 2018, out of total 783 projects of the World Bank in India, sixty-six (around twelve percent) were in the health sector. Bank's position as a significant actor in health in India was reinforced in 2003 as India revised its development cooperation strategy and refused to accept aid from several Bilateral organisation.

Various such developments and interests of different actors in policy networks shaped the HSS polices in India over the years. The role of global actors including Bilateral and Multilateral agencies, UN organisation and philanthropies in the HSS policy networks has been discussed in chapter three. This section will examine the relationship and negotiations between two such policy actors in the health systems policy network in India that is the State (Indian government at both Central and state-level) and the World Bank in more detail (and will give reference to other actors where applicable).

Findings presented here have arrived through analysis of primary data collected during the field work. Data was collected through thirty-four elite interviews with national, State-level government stakeholders and development professionals working in different development organisations including the World Bank (for details see table 2.2). This analysis reflects the perception of the stakeholders interviewed and is supported by secondary literature. Data was analysed and themed under five broad factors including i) low health care budget, ii) knowledge gaps, iii) structural or administrative rigidity, iv) interests of policy stakeholders and v) foreign policy and diplomatic relations.

4.2.1 Low health care budget

Financial difficulties faced by India constitute the most significant reason which enables Bank to engage in health systems development policies in India. Public health expenditure in India has always been grossly inadequate (see table 4.1). India spends close to one percent of its GDP on health. The most recent data on Government Health Expenditure (GHE) including capital expenditure has been reported to be 30.6 % of Total Health Expenditure (THE)[43] and 1.18% of the GDP. This financial crisis is a chronic problem to public health systems in India and the need to

[43] Total Health Expenditure (THE) of a state/ UT includes health expenditure by all government agencies (Union/State/Local Bodies including quasi-governmental organizations and donors in case funds are channeled through government organizations), all household health expenditures, all expenditures by Enterprises, Not for Profit Institutions Serving Households (NPISH/NGO) and external donors.

increase this spending has been advocated since 1940s but barely reached two percent[44]. The interstate gaps in these contribution to expenditure are also huge (National Health Systems Resource Centre, 2018).

Table 4.1- India's Total Expenditure on health in US million dollars (at then current price)											
	2000	2001	2003	2003	2004	2005	2006	2007	2008	2009	2010
Total health Expenditure	19.57	20.92	21.06	23.66	26.44	30.62	33.08	40.4	43.12	44.33	54.25
Government expenditure	26	24	23	23	23	24	25	26	28	30	29
Private expenditure	74	76	77	77	77	76	75	74	72	70	52

Source (World Health Organisation, 2012)

Though the total aid from external actors in India has always been nearly 1-2 % of the total expenditure on health (Sridhar and Gomez, 2011) but in the context of chronic scarcity of funds, any kind of financial support obtained from any source is extremely valued by the national and sub-national stakeholders.

Interviews respondents from both government departments and those working with international aid organisations believed that even though the amount of money received through international aid is insignificant, these funds are seen as not just "extra" money but also "quite huge" in actual amount. Dr. Mahopatra, who was one of the key government officials involved in preparing proposal for first health systems development project from the World Bank in Andhra Pradesh (AP) said that

> "most of the times, the money required to run public health systems effectively is way less than the capacity of the government to provide". He explained that the amount of money which was needed for setting up new hospitals in AP, certainly could not be approved by

[44] A large part of health expenditure in India is Household's out of pocket expenditure. National Health accounts latest report in 2018 stated that Household's Out of Pocket Expenditure on health is 60.6% of Total Health expenditure (THE).

the Planning Commission through regular planning cycle of the government" (Mahopatra telephonic interview, 2019).

"We were proposing to double the existing bed strength to 8500 beds in our hospitals and the government had the capacity to support less than 500-600 beds". After making a presentation to the Planning Commission regarding our proposal, I was told by the then Principal Secretary that, though our demand is genuine and I have supported it with enough evidence but there is a huge mismatch between our demand and the resource allocation envelope of the government" (Mahopatra telephonic interview, 2019).

"I was told that, that the scope of our planning is limited to 800 crores and this needs 1000-1500 crores… then I realised that the only way for our proposal to receive its due allocation is to propose for World Bank funding" (Mahopatra telephonic interview, 2019).

Another respondent who is a national level government official said that the lack of funds is more severe than what it appears in national budget allocation figures. He said that whatever funds are allocated to the health systems by the government, most of it is tied to salaries of health care staff which leaves very little funds for other activities.

"it only looks like we are spending so much on health, even in this one percent that we are spending – most of it is spent on giving salaries to the staff. After spending for salaries, you will see that there are actually no funds for public health systems" (CG1 New Delhi, 2019).

The Bank's Uttar Pradesh (UP) State health system development project implementation report also notes that about seventy-seven percent of the total allocated health budgets in the State were consumed by salaries, leaving the non-salary recurrent costs chronically under-funded (Bank, 2011).

Another respondent who was involved in Nutrition projects at the State Government level, stated that "we were not as keen to demand for loans but once received, loan money was found to be of great monetary value to support programme activities" (SG3 telephonic interview, 2019).

On the other hand, the Bank perceives that the value of these funds is not so much related to the actual money it provides but more about the 'value' of interventions supported by the Bank under its projects. One of the officials from the Bank who was involved in a few State health systems development projects said that the, "money involved in digitisation of records for the health personnel as a part of the Health systems development project in Uttar Pradesh is insignificant but the value of the digitising these records is quite high" (B1 New Delhi, 2019).

According to him, the low monetary value of funds allocated through these projects to the States is well recognised by the State as well as the Bank. However, the interest of the Bank to support health systems projects is not in providing extra money but to support health systems reforms from which the States will reap benefits for a long-time.

> "When we first started working in UP, they didn't know how many doctors', nurses and other health workers they employ and suspected that they have ghost workers, overlaps and duplicates. So, one of the things that the project helped them to do was to digitise these records of workers and establish personnel systems to detect anomalies and then they also started paying electronically and on time… So, this does not cost a lot of money but it means the half a billion that they are spending on salaries can be spent more effectively" (B1 New Delhi, 2019)

4.2.2 Perceived lack of technical knowledge and skills in national health officials

Not just the Bank but also the government perceives that the technical knowledge and skills which the Bank brings along with its projects is much advanced than those existing at the national or sub-national level. Government technical officers involved in Bank's projects like project managers and medical staff working at the State and Central level shared that the technological solutions, especially the digital and information systems solutions supported by the Bank are extremely valuable. One of the national level administrative services officer while describing Bank's technical contributions stated that "We didn't know programme management before these donors came and taught us how to do it. Their tools of line-by-line item expenditure were far more

sophisticated than what we were using, they really helped us reform our outdated systems of programme management" (CG2 New Delhi 2019).

Similar perceptions were shared by the Bank staff positioned in Bank's headquarters and in India office. One of Bank's staff at global headquarters office (who was earlier working in India) said that

> "the financial help is nothing… it is about the systems that Bank comes with like the procurement systems, information systems, Quality assurance systems e … it is our rigour of design, systematic monitoring, evidence-based approach, accessibility to global knowledge because of which States ask for loans from us" (B2 telephonic interview, 2019).

Giving an example of the Uttar Pradesh State health systems development project, another technical officer from Bank's India office said that "150 million dollars over five years when the State budget is 2 billion dollars might be little but the reforms we support are more efficient than the total health budget spent by the State of Uttar Pradesh" (B1 New Delhi, 2019).

Even the States with apparently better public health systems like Tamil Nadu and Karnataka have requested for Bank's support for health systems development. As told by one of the Bank staff stationed in the headquarters (earlier worked in India), the well performing' States in India perceive the technical advice given by the Bank to be extremely valuable for improving their State health systems. Elaborating this claim, she added that

> "After the detailed implementation review in 2007-2008 the government got really upset and a meeting was called where all States were asked if they need finances from Bank and everyone said no, it was only Tamil Nadu which said yes we need assistance because with it comes the 'long-term technical knowledge' and technical assistance to put together systems" (B3 telephonic interview, 2019).

While the Bank uses India for diffusing its technical knowledge and HSS ideas, India uses the advanced knowledge tools of the Bank for piloting innovations in health sector, which otherwise are not possible given the low and restricted budgets and also the (perceived) lack of knowledge and skills at the national and sub-national level. One of the officers working at the Bank said that

Bank is roped in "for trying out new things or different approaches and things which no one else is supporting" (B4 telephonic interview, 2019).

National stakeholders steering the national disease-specific programmes confirmed the technical knowledge as a reason for involving Bank in national policies. He stated that though receiving monetary support used to be the prime reason for demanding aid in the early 1970s till late 1980s, but it is not so anymore. Another government officer at the national level while referring to the population and early nutrition projects said that

> "if you look at our national budgets of that time- we hardly had any money for health, so there were all the justified reasons for demanding aid. But today we have sufficient means to run our health systems, why we apply for Bank loans today is not-for money but for their technical support" (CG4 New Delhi, 2019).

4.2.3 Administrative rigidity

In addition to the financial support and technical assistance reasons mentioned above, the 'flexibility' that came with the Bank's loan money is perceived to be quite advantageous by the National and State-level stakeholders. This money is often disbursed in instalments and based on submission of appropriate expenditure certificates by the recipient organisations.

"Loans are flexible money over and above State and centre budgets" (DP1 telephonic interview, 2019). The implementers (the government officers at sub-national and national level) found this un-tied characteristic of money (unlike the government money) to be extremely valuable as it created a special worth among the government officials to use it.

State-level stakeholders also associated a feeling of 'flexibility' with the money coming under projects financed by the Bank as they had the opportunity to use these funds in the areas where they find they cannot spend under the routine budget allocations. A sentiment of 'ownership' of the money received under the Bank projects has also been shared by the government officials at the State-level, as they feel that this money raised through loans is the money that the State raised and hence the State has the right to spend it in a way they feel is appropriate without being answerable to the Central government.

> "Of course the State and Central government have their own health budgets but these finances are mainly tied-up expenditures against rigid line items requiring submission of numerous certificates of expenditures. However, money procured through the Bank is State's own money which can be spent in areas they wish, without asking for permission from the Central government and without following the cumbersome administrative procedures" (CG5 New Delhi, 2019).

However, one of the government officers who handled Bank's projects said that the "Bank's processes are more beaurocratic than the government systems, we have to produce payment slips for even the biscuits we offer during meetings and if we can't produce those bills, the funds are not disbursed" (CG6 New Delhi, 2019).

One of the Bank officials noted that "Bank's duality of working with both States and Central government is to make sure that States get an opportunity to finance their own development and they do not have to depend on central governments funds" (B2 telephonic interview, 2019). Similar thoughts were shared by other national level government officers. Taking the example of (supposedly) well-performing and progressive States, one of these respondents stated that progressive States see the loan money from the Bank as an opportunity to spend in areas which they feel are not priority areas for the State government and the government cannot afford it under regular budget allocation

> "you see, if Tamil Nadu wants to buy 'moped' for the frontline health workers, they know they will not get it approved under NHM and can only do it through donor money or if they have to hire a specialist but that the salary of that specialist is way higher than the highest medical officer in the government hospital, they have to ask the donors to hire the specialist for them" (DP2 telephonic interview, 2019)

Regardless of the organisational and programmatic affiliations of the respondents, most respondents mentioned the rigidity of administrative procedures (like giving tenders to the lowest bids, preferring partnerships with government organisations for initiating innovations, permissions and procedures for hiring and incentivising human resource) hampering fast processing of innovations in public sector pushes the States to ask for money from the Bank. One of the national

level respondents said that “It is only with the donor arrangement that the States can give tenders to the agency they feel without abiding the lowest quoted applicant which is a standard rule” (CG5 New Delhi, 2019). Another officer added that “simple things like hiring consultants for day to day work in health departments is not possible under the government rules, these are things which are done through donors”(CG7 telephonic interview, 2019).

International visits for attending workshops and trainings also have to undergo a cumbersome process to get approvals from the government departments and thus officials use donor money for these purposes. An officer who worked at the national level in health department said

> “who do you think is funding all the foreign trips for the government officials, it is the donors” and “how do you think, the entry of retired beaurocrats in the leadership positions at various donor organisations happen? it is through accepting aid and helping the sustainability of these donors in respective countries” (CG7 telephonic interview 2019)

4.2.4 Interests of policy stakeholders

Personal and professional interest of stakeholders on both sides (government and Bank) also play a key role in encouraging Bank’s involvement in India’s health systems policies. On one side, officers in the Bank pursue their interests in pushing their ideas in health sector reforms in India and on the other, National and State-level stakeholders use Bank to implement the reforms they wish to pursue.

Dr. Mahopatra, from Andhra Pradesh who was the president of Andhra Pradesh Vaidya Vidhana Parishad (a divisions of Health, Medical and Family Welfare Department of Andhra Pradesh Government which deals with middle level hospitals of bed strengths ranging from 30 to 350) was for a long-time working on getting the focus on secondary level health facilities to increase their numbers and improve functioning. He found an opportunity to do this with the prospect to avail money from the Bank. He, with help of other government administrators wrote a proposal to get funding from the Bank to bring those reforms. Similarly, the HIV/AIDS control project is reported to have given an opportunity to demonstrate the much-admired leadership skills of K. Sujata Rao[45] who was Secretary National AIDS Control Organisation (NACO), to effectively

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steer donor organisation and achieve quick results in reduction in disease morbidity and mortality. From Bank's side, one of the officers (name not disclosed) has been reported by many respondents to have promoted the cause of tax- based health insurance schemes in India. One of the respondents who has worked with multiple development sector organisations said that

> "it was her personal and professional interest in health insurance shaped by her previous professional experience which motivated her to introduce and support the implementation of these schemes in different States. She saw this as an opportunity to legitimise her ideas as a policy entrepreneur in the domain of health financing and health insurance" (DP3 telephonic interview, 2019).

Other negotiations that happen between that Bank and Indian government includes motivation of the States to legitimise their ideas by routing them through Bank showing that these ideas are being co-produced with partners coming from advanced health systems context "working with the Bank gives States a chance to appear as advanced and progressive…by getting Bank projects, States gain visibility for not only the beaurocrats but also the politicians" (DP4 telephonic interview, 2019).

Like in the case of Andhra Pradesh, the then Chief Minister was instrumental in bringing Bank's money to the State. As told by a national level officer, the Chief Minister firmly believed that "Bank's global expertise in working in nearly all areas of health systems brings legitimacy to the efforts of the State Governments" (CG7 telephonic interview, 2019). While others added that the prime reason for legitimacy attached with Bank's projects is its Multilateral composition. One State-level stakeholder said that "working with Multilateral organisations like the Bank, one is sure of not being a victim of the agenda of one particular country like it is with DFID or USAID" (DP5 telephonic interview, 2019).

4.2.5 Foreign policy and diplomatic relations

Most respondents from both sides stated that the high-level decisions on which agency and actors lend money to India are hardly taken in consultation with the State-level or National level health

Kanuru Sujatha Rao was the Secretary, Department of AIDS Control and Director General of the National AIDS Control Organization (NACO) from 2006-2009 and later health secretary from October 2009 till 2010 . She was instrumental in establishing systems and building up NACO with a capacity to implement programs with a five-fold budget increase. She has represented India on boards of the WHO, Global Fund and UNAIDS.

departments. Respondents reported that decisions like boycotting aid from one agency but not from the other are not dependent on the philosophies and ideas promoted by these donors but are largely a part of maintaining geo-political and strategic interests of both the recipient and the donor countries. As stated by a national level stakeholder "especially after NRHM, we hardly need the financial support from donors, but we still seek these funds because we are obliged under international trade agreements to accept aid" (CG8 New Delhi, 2019). Another national level officer working in one of the disease-specific programme said that "you think, the people in health ministry have a say in getting these projects? these are high-level decisions taken under the compulsions of maintaining international relations" (CG10 New Delhi, 2019).

However, once the high-level decisions about accepting aid are taken by the government, National as well as State partners see a lot of value in applying to the available kitty of funds for which they are eligible.

CONCLUSION

The World Bank is a significant actor in Health system strengthening policy network in India especially from 1980s till 2000. Its history and composition reflect the dominance of US, starting from its role in the creation of the Bank to having maximum number of shares and voting powers in the Bank and the continued leadership of American origin till the present time. Bank's overall economic orientation to systems strengthening policies can be understood by the dominance of its staff trained in economic disciple (mostly from the American schools). Bank's entry in the health systems strengthening policies started with mere project funding to National Health Programmes like population and nutrition in late 1970s with not much involvement in making suggestions to the project contents. However, soon after the its reorganisation and economic crisis and decentralisation amendments in India, it got directly engaged in policy processes at national and state level.

The growing role of Bank in the policy network has been in response to capturing the space created by issues plaguing the public health systems in India including the low and inflexible healthcare budgets and perceived lack of technical knowledge and interests of policy stakeholders. While

India used Bank for filling few of these (perceived) gaps in health systems in India, Bank used India to experiment with and legitimise its HSS ideas in India through funding and technically supporting various innovation under Bank sponsored health projects.

There has been an overall decrease in prominence of Bank in India with the emergence of global health partnerships and philanthropies. However, Bank continues to retain an important place in health systems governance because of its continued long-time association with various other actors in the policy networks including other Multilateral organisations and private sector. The next chapter will discuss the HSS policy ideas diffused by the Bank in more detail.

CHAPTER 5

WORLD BANK AND HEALTH SYSTEMS STRENGTHENING POLICIES IN INDIA: ANALYSING THE IDEAS

INTRODUCTION

This Chapter will address the third objective of this study through the embedded case study on the World Bank and will discuss specific HSS ideas diffused by the Bank in India. As discussed in the previous chapter, World Bank's organisational composition, its relatively powerful position (in comparison to other global health actors) and varied political, economic and administrative factors enables the Bank to diffuse specific ideas about health system strengthening in India. Using the HSS analytical framework described in chapter two, this chapter will locate these HSS ideas in Bank's health sector projects and technical assistance work. The chapter is divided into two parts based on two broad HSS ideas of increasing resources (like drugs, equipment, infrastructure and human resource) and improving processes (like administrative reforms, integration of health services, community engagement and multisectoral action). These ideas will be analysed by identifying their diffusion through Bank's health system projects (including population, nutrition, stand-alone disease-specific and State health systems development projects). Data was obtained from the project evaluation reports available at Bank's website. Project documents were screened and analysed with the aim of understanding their systems strengthening components as per the analytical framework under two broad themes of increasing resources and improving processes.

5.1 INCREASING RESOURCES

5.1.1 Infrastructure development and supply of goods and equipment

The idea of infrastructure development as a key for health systems development has been promoted by the World Bank in India since the early 1970s. Infrastructure development remained the most important idea for HSS before 1990s till the Bank's role in the policy advice sphere got more prominent. The focus on infrastructure development started with the Bank's series of nine India Population Projects (IPPs)[46] which spanned over a period of more than two decades (1972-94)[47] supporting the national programmes at Central government level. The first five projects (1972-1988) focused on increasing the demand and improving the delivery of Family Welfare services which mainly involved infrastructure development including upgrading and expanding the facilities and providing equipment and supplies for delivering Family Planning services. The first project spent almost half of its budget on infrastructure development and nearly twelve percent on meeting procurement costs of goods such as vehicles, furniture, equipment etc (World Bank, 1989).

These projects established a large network of training infrastructure comprising of State Institutes of Health and Family Welfare (SIHFWs), Regional Institutes of Health and Family Welfare (RIHFWs) under the Indian Family Welfare Programme (FWP) (World Bank, 1999). It was soon noted that earlier population projects focusing on

> "rapid expansion of the FWP during the 1980s had eroded service quality. Large numbers of outreach workers and their supervisors… provided services largely from sub-centres

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India Population Projects (IPPs)		
Title	Year	States
First Population Project	1972-1980	Five districts Mysore, Six districts Uttar Pradesh
Second Population Project	1980-1988	Six districts of Uttar Pradesh and three districts of Andhra Pradesh
Third Population Project	1984-1992	Six districts of Karnataka and four districts of Kerala
Fourth Population Project	1985-1994	Four districts of West Bengal
Sixth (First National Family Welfare Training and Systems Development) Population Project	1989-1997	Uttar Pradesh, Andhra Pradesh and Madhya Pradesh
Seventh Population project (training)	1990-1998	Rural areas of Bihar, Gujarat, Haryana, Jammu, Kashmir and Punjab,
Family Welfare (Urban Slums) Project (Population VIII) Year of Approval 1991	1991-2001	Urban slum populations of Andhra Pradesh, Karnataka, West Bengal and Delhi.
Family Welfare Project (Population IX)	1994-2001	Assam, Rajasthan and Karnataka

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> located on premises which had no basic amenities such as water supply or furniture and poor communication with higher levels of the service delivery system" (Bank, 1989 p.3).

In an attempt to address these gaps, the next projects aimed at improving State-wide training systems and the environment in which the trained worker would operate. In the Seventh population project, in 1990 the GoI and the Bank placed 'expanded access' and 'quality of care' at the centre of the all programme strategies. This project was rolled out in five States Gujarat, Haryana and Punjab, Bihar, and Jammu and Kashmir and few centrally administered components were implemented nationally. However, it succeeded only in infrastructure development. Other components like improving the performance and quality of the training program , strengthening of MCH and Information, Education and Communication (IEC) components and shifts in promoting a contraceptive remained weak (World Bank, 1999).

Similarly, infrastructure development and goods and equipment supplies constituted an integral part of the disease-specific projects among other components including training of community health workers, improving the supply and logistics of essential drugs (World Bank, 1980a). The Blindness control project involved private sector to procure large volumes of consumables. The increased involvement of the private sector was seen in the area of infrastructure development as well. Post 1990s, strengthening of private sector infrastructure assumed greater importance in nearly all of the Bank supported disease-specific projects. While the disease-specific projects were diffusing the idea of strengthening the private sector infrastructure through public sector funds, the State health systems development projects placed a specific focus on improving health infrastructure in public facilities.

State health systems development projects, especially the first five projects allocated a large part of funds to enhancing quality of services under which the infrastructure development and goods and equipment supplied constituted a major part. As shown in table 5.1, civil works received nearly half of the project amount in nearly all projects. The activities under civil works included major demolition, construction, renovation and upgradation of health facilities. Combined allocation to civil works and equipment constituted to a range starting from half to as high as eighty-five percent of the total project costs (see table 5.1).

Table- 5.1- Expenditure on civil works and goods and equipment as a percentage of total project cost			
State	Expenditure on civil works as a % of total project cost	Expenditure on goods and equipment as a % of total project cost	Combined expenditure on civil work and good and equipment as a % of total project cost
Andhra Pradesh	45	24	69
Karnataka, Punjab, West Bengal	49	27	76
Orissa*	39	15	54
Maharashtra	61	25	85
Uttar Pradesh **	44	24	69
Rajasthan***	45	32	77
Source: compiled from project implementation reports *Approximate figures calculated by converting INR to US$ ** Amount given in INR *** Amount given in SDR			

5.1.2 Human resource

As noted in chapter three, human resource development has gained attention as a key idea of HSS since the early foreign assistance years. Global actors like philanthropic organisations and Bilateral agencies of the governments of the United States, Sweden, Japan, and Denmark till 1970s, supported human resource development in the form of fellowships and consultants and trainings.

Likewise, the Human resource development constituted an integral component of Bank's health systems projects. However, the focus has been not so much on hiring new resources but training the existing human resources as per the needs and specific requirement of different projects. The focus on building the capacities of existing human resources got stronger with the dissatisfactory performance of initial population projects. The low performance of these projects initiated a series of sector studies undertaken by the Bank during late 1980s to 1990s, aiming to understand the performance barriers[48]. These studies helped in expanding Bank's health sector work in India and guided future operations of the Bank in India.

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After the initiation of the long-term strategy for the Bank with regards to its role in Family Planning starting with the sixth population project in 1989, Bank started to focus on strengthening human resource in health. This shift happened after Bank's report on the earlier population projects noted that, "rapid expansion of the FWP during the 1980s had eroded service quality. Large numbers of outreach workers and their supervisors, rapidly trained through training programmes of questionable quality…" (Bank, 1989 p.3).

In an attempt to address these gaps, the next project launched in Andhra Pradesh, Madhya Pradesh and Uttar Pradesh aimed at improving State-wide training systems and the environment in which the trained worker would operate. 'Training' was listed as a sub-system and as a component of systems development in this project and continued as an essential component of all later health projects under population, nutrition, disease-specific and State health systems development projects.

The population projects had specific component of training human resources and established a large network of training infrastructure comprising of State Institutes of Health and Family Welfare, Regional Institutes of Health and Family Welfare (World Bank, 1999). Nutrition projects laid a special focus on training of human resources as training constituted to be an integral component for the performance of the projects. For example, the significance of 'planned job-oriented training' was identified as one of the key reasons (along with realistic workloads and worker to client ratios, quality supervisory support and well designed and implemented monitoring and information system) for the success of the first stand-alone nutrition project that is the Tamil Nadu Integrated Nutrition project (TNIP) (Shekar, 1991). Shortages of resources and training were found to be the reasons for the dissatisfactory performance of later nutrition projects under ICDS. Following the observation that the workers were inadequately trained, overextended and "the focus

World Bank health sector studies 1988-98

- Family Welfare strategy in India: Changing the Signals, 1989
- Strengthening the role of Non- Government Organisations in Health and Family Welfare Programme in India, 1990
- Population and the World Bank: A review of activities and impacts from eight case studies, 1991
- India: health sector financing coping with adjustment – opportunities and reform, 1992
- India: policy and finance strategies for strengthening primary health care services, 1995
- Improving women's health in India, 1996
- India's Family welfare programme: Towards a reproductive and child health approach, 1996
- India: New directions in health sector development at state level: an operational perspective, 1997
- India: wasting away, the crisis of Malnutrition in India, 1998

Source:(Ridker and Musgrove, 1999)

by the government on quantity rather quality has been a major concern for low performance", the next projects laid special attention to the quality of the training of health workers (Shekar, 1991).

In the disease-specific projects like Tuberculosis, capacity building and skills enhancement were listed as core project components and various level of trainings (ranging from medical officers, IEC officers, programme managers, data manager, procurement and drug logistics, laboratory technician and DOTS implementers[49]) were done under the project. The program developed the training for the volunteers including private practitioners, NGOs, teachers, postmen, unqualified private practitioners, women members of self-help groups and nurses. Training were used as incentives to NGOs and private practitioners for adopting the Revised National Tuberculosis Control Program (RNTCP) strategy and agreeing to report cases to the Government. Private companies were also trained, and few reported to have initiated management of TB in the workplace. Similarly, under the HIV/AIDS project a huge number (7500) of private sector physicians were trained in technical skill enhancement. State AIDS control Organisation (SACS) organised training of paramedics, nurses and doctors. The projects also trained Primary Health Care physicians and 10,000 private health care providers in STD syndromic case management through the Indian Medical Association. Indian Medical Association also provided training under the Leprosy project to private practitioners to increase programme coverage. The Blindness control project involved an intensive training programme of ophthalmic surgeons in doing Intraocular lens (IOL) surgery and extensive improvements of equipment and infrastructure

5.1.3 Finances

Increase in finances has been at the core of HSS ideas promoted by the Bank. The initial State health systems projects focused on increasing the public sector allocations in health budgets. This idea was accompanied by two more ideas for increasing finances that is enhancing the collection of User fees (in the initial five HSS projects) and supporting the State funded health insurance schemes (in more recent projects).

[49] The Tuberculosis project report noted the completion of training for master trainers from Gujarat and Maharashtra on DOTS-Plus activities, 25 IEC officers, 285 Program Managers, 130 staff, 334 personnel and master trainers (DTOs, STOs, State TB and Demonstration Center (STDC) directors and faculty from medical colleges) , 108 DOTS-plus implementers, 39 medical officers, data managers, 800 national PMDT 800 officials.

5.1.3.1 Increased budget allocations to health

Early ideas for improving health finances included the push for maintaining the overall proportional allocation to health in State budgets and to increase resource allocation to primary and secondary health care. These were listed as core objectives of the initial State health systems development projects. However, both these objectives were not met successfully. The overall State health budgets allocation actually declined in few States (see table 5.2) and this objective got lost by the sixth HSS project starting with Uttar Pradesh in the year 2000. As shown in table 5.3, the resource allocation to primary and secondary health care did not see a significant increase (declined in one State) given the total increase in annual health budgets.

5.1.3.2 User fee

Along with the increase in budgets, increasing financial resources through charging user fees was another HSS idea promoted by the Bank till 1990s (withdraw in early 2000 after the emergence of evidence on its negative implications for access to health services). Banks' 1992 document for titled 'India- coping with adjustment' under the problems for health sector in India noted the negligible role of User Fees in the public system in India. It outlined the low and declining cost recovery levels in the health sector for fifteen States from 6.4 percent in 1975/76 to 1.6 percent in 1989 and noted that there has been a

> "tremendous loss of a resource for the health sector: the ability to charge patients, who can afford them, for services which have few or no externalities. Cost recovery will become much more important in the health sector if efforts are successful to reallocate public spending to programmes with high externalities. Hospitals and clinics can prosper under such a reallocation if they are allowed to raise their own funds and are provided the independence to do so, while maintaining publicly subsidised access for the poor" (World Bank, 1992 p.34)

Charging user fee from middle- and high-income group was recommended as an immediate measure under the adjustment for cost recovery for facilitating the fiscal pressures on communicable disease control programmes and protecting Primary Health Care budget from the demands of hospitals. These ideas were implemented in the health systems development projects in States. The first project in Andhra Pradesh noted similar issues and emphasised the need to "enhance the overall size of the health budget, redress the imbalance in public spending between

Table 5.2- Change in overall allocation to health in State budgets at health system project completion			
State	Percentage overall allocation to health in State budgets at the start of project	Percentage overall allocation to health in State budgets at the end of project	Percentage Increase
Andhra Pradesh	4.3 (1997)	4.5(2001)	0.2%
Karnataka	6 (1997)	4.3 (2004)	**-1.7%**
Punjab	7.2% (1994)	3.8 % (2003)	**-3.4%**
West Bengal	5.3% (1996)	6.4 % (2001)	1.1%
Orissa	2.7% (1998)	2.8% (2006)	0.1%
Maharashtra	3.2% (1999)	3.4% (2006)	0.2%
Uttar Pradesh	4.8% (2000)	6.4(2008)	1.6%
Rajasthan	4.5% (2004)	-	-
Tamil Nadu	4.6% (2006)	4.5% (2016)	**-0.1%**
Source: compiled from project implementation reports			

the secondary and tertiary levels of health care, enhance user charges, increase contracting of non-

Table 5.3- Change in allocation to primary and secondary care at project completion			
State	Percentage overall allocation to primary and secondary care in State health budgets at the start of the project	Percentage overall allocation to primary and secondary care in State health budgets at the end of project	Percentage Increase
Andhra Pradesh	68.0 (1994)	71.0 (2001)	3%
Karnataka	57.5 (1996)	90.1 (2003)	**32.6%**
Punjab	55.0 (1996)	64.3 (2003)	**9.3%**
West Bengal	84.3 (1996)	80.8 (2003)	**-4.3%**
Orissa	83.0 (1999)	85.0 (2003)	2%
Maharashtra	79.8 (1999)	80.0 (2006)	0.2%
Tamil Nadu	-	-	15 %
Source: compiled from project implementation reports			

clinical services, safeguard the operations and maintenance component, and address workforce issues"(Bank, 2002 p.2).

The policy for implementation of user charges during the Andhra Pradesh project was delayed at first because of the lack of clarity on including the health facilities at the tertiary level in the project. The fees were collected from the beneficiaries falling below the poverty line at all

hospitals. An increase in total collection in user fees of around 18 million was noted from 1995 to 2001 (April-December). The funds were reserved at the health facilities and were utilised for minor repair and maintenance. With the upgradation of health facilities, collection of user fees was reported to have increased substantially. Hospital Advisory Committees (HAC) were created at health facilities and were given the authority to collect and retain user charges at the facility. These funds were used for procuring consumables, drugs, improvement of sanitation, electricity, water and drainage facilities and repairs of essential equipment.

These ideas of user fees were carried forward to the second project that was in Karnataka, West Bengal and Punjab. During this project, user charges were applied to all the health facilities under project. The charges were collected for out-patient departments (OPD) services, surgeries, beds and diagnostic tests. All the health facilities retained the collected charges (except West Bengal) and utilised for equipment maintenance (15%), purchasing essential drugs (45%), building maintenance (15%) and for patient's facilities (25%) (World Bank, 2004 p.44). The project implementation report though does not provide any supporting evidence to this claim but noted that " Financial sustainability of the hospitals was thought to be further aided by user charges and the collection of users charges / fee has enhanced the expectation of the beneficiary / public and thus facilitate in improving the quality of service" (World Bank, 2004 p.36).

User fee was suggested to be used for strengthening the referral system by "establishing an incentive system with differentiated user fees for users and non-users and allowing patients to by-pass waiting lines when they carry a referral slip" (World Bank, 2004 p.39). It was suggested that the money raised through these user charges would be used for financing vehicles, for local training, MIS and IEC materials, for hiring consultants, providing fellowships, holding workshops and managing the operational expenses(World Bank, 2004 p.39).

The Odisha project also saw an increase in user charges collected at District Hospitals. These charges increased with the creation of patient welfare committees called Rogi Kalyan Samitis at the facility level. The Zilla Swasthya Samiti (ZSS) collected user fees in the districts which was used for contracting out of non-clinical services including ambulance services and cleaning services. During this project, user fee collections increased by 601.6% in real terms, rising from Rs. 3.8 million in 1999 to Rs. 30.4 million in 2006 (World Bank, 2006c p.17). The money collected through user charges was reported to have provided extra budgets for non-recurrent expenditure

having a positive impact on the quality of health services. However, there were still no clear guidelines on how to use the collected user charges (World Bank, 2006b).

Similar observations were made for the Maharashtra project which reported that user charges revenue had increased non-salary recurrent expenditures. There was a dramatic increase in user charges from Rs. 14.9 million in FY99-00 to Rs. 281.9 million in FY04-05 in this project (World Bank, 2006b p.6). The funds were reported to have been applied towards upkeeping of the buildings and equipment and transportation of poor patients.

By this time, the negative consequences of user charges on utilisation of the services has started emerging but the project report noted that no such evidence was found under this project. An external review of the project found that the monthly use by paying patients increased from 0.17 million to 0.21 million (22.5% increase) after the rate increase in 2001; and overall there was a small increase in use by exempted patients from sixteen percent to eighteen percent (World Bank, 2006b p.6).

The policy on user charges was changed with the start of the UP project. During this project, user charges were drastically reduced in 2003. It was noted the reduction in charges has led to a huge increase in utilisation of project facilities. The project report highlighted that since the increase in health services utilisation could not be credited completely to the project and slashing of user fees, the utilisation numbers were standardised to correct for the impact of reduced user charges. It was found that

> "User fees do contribute vital resources towards non-salary recurrent costs … However, stipulating annual recurrent increases in user fees to the point of making them prohibitively high is counter to project objectives. Especially when mechanisms to exempt the poor are not in place, the user fee policy needs to be carefully monitored to ensure that it does not become a further barrier to access to services for the poor" (World Bank, 2009 p.21).

This project onwards, the idea of user fees did not find a mention in later projects.

5.1.3.3 Health insurance

Health insurance as a means for financing health services and protecting the poor from the health care expenditures has been another significant idea for HSS that has been promoted by the Bank. Health insurance found its mention in the second HSS project. However, this idea was promoted in the frame of comparative advantage of engaging the private sector for provisioning of services to the poor than the strengthening of public health infrastructure. The project report noted that

> "before decisions are made about upgrading infrastructure, an analysis should be conducted to determine if the most efficient route is to expand and improve the delivery of services through the public sector, or to take advantage of existing private sector investments and use public monies to finance delivery of private services for the poor and thereby to stimulate improvement in the quality of private services. Financing health services for the poor regardless of who will provide services (such as through health insurance) could be a good example" (World Bank, 2004 p.13).

The Odisha project pushed the idea of insurance under the strategy of private sector involvement. It noted that

> "the project did not address … key issues outlined in sector work, such as private sector involvement… community financing and health insurance…that enough attention has not been paid by the project to the components of health insurance as a means to improve health services" (World Bank, 2006c p.29).

This project suggested the Bank's role in assisting the State to develop these ideas and recommended that "Technical assistance should be provided by the Bank for in specific areas like insurance and PPPs, if required"(World Bank, 2006c p.29)

From UP project onwards, Bank got involved in activities covering the health services for the poor through one or the other forms of insurance mechanisms. For example, under the UP project, Bank had implemented the reimbursement of basic health services provided to Below Poverty Line (BPL) patients. Under an initiative of 'BPL Health Cards and Reimbursement', a plan was prepared for 621,000 BPL Health Cards for BPL households which was distributed to each block Primary Health Care Centre to enable reimbursement of cost of treatment to them. For sustaining

and mainstreaming this idea with the Directorate, it was scaled up by the state government in their planned introduction of a Health Insurance Scheme (World Bank, 2009 p.25).

In other projects, Bank carried studies and pilots of community-based health insurance schemes to create evidence for developing the State-level insurance plans by the government. For example, in the Rajasthan project, Bank carried out an analysis of community-based health insurance (CBHI) schemes in India and did a baseline survey for community-based health insurance in three districts of the State. A pilot of CBHI was implemented based upon a study done by Research Development Institute (RDI), in one of the districts in Rajasthan that is Ganganagar. The findings of this pilot were fed into the development of the State-level health insurance scheme called Mukhya Mantri Jeevan Raksha Kosh (MMJRK) which was launched in 2009 in a PPP mode having additional assistance for the poor population (World Bank, 2012 p.46).

Similarly, community-based health insurance pilot was planned under the Tamil Nadu (TN) project to understand the viability of insurance schemes. However, it was dropped because a new Health Insurance Scheme by the Chief Minister of TN was being launched in the State and the project instead provided technical assistance with regards to complete administration and management of the scheme in 2012. As noted in the project report, the coverage of health insurance scheme increased from only four percent of households in 2005 to over sixty-four percent in 2015. During this project, the Bank supported the convening of an International Conference on Health Systems Financing in 2010, attended by government officials of different States across India, international and Bilateral development partners to share experiences and discuss implementation issues.

In Karnataka, designing and implementation of a similar health insurance scheme was planned. In this project, Bank committed to provide the technical assistance for the designing, implementing, and evaluating the insurance pilot. The Bank also provided monetary support for extra premium subsidies to the Below Poverty Line families enrolled in the scheme along with the Government of India and government of Karnataka. However, as noted in the project implementation report, the analysis of national insurance schemes was dropped, and the Bank supported institutional development of the State Government's initiative to scale up the Vajpayee Arogyashree Scheme (VAS). It financed claims for hospital services based on achievement of institutional development milestones such as strengthening the verification and follow-up systems, undertaking a cost

analysis of benefit packages and prices, and establishment of a grievance redressal system, amongst others (World Bank, 2018).

5.2 IMPROVING PROCESSES

5.2.1 Administrative and civil services reforms

Government capacity as an obstacle to development became a central concern for the Bank in late 1970s and early 1980s. Improving the institutional capability of borrowers, thus became the focus of the Bank. Bank devoted significant share of resources and technical expertise on improving the overall conduct of government functions (World Bank, 2008b). Major public sector reform ideas for HSS focused on reforming the i) size, ii) role and iii) efficiency of the State.

As outlined in Bank's documents, cost-containment measures constituted an important part of the short-term civil services reform. Under these reforms, improving personnel management and competence of public agencies were given more attention in the medium term. Key strategies included

> "rationalising the size of the public enterprise sector; privatise, restructure, or liquidate public companies, as appropriate; improve the competitiveness of the policy environment; and clarify the relationship between the Central government and public enterprises with a view to increasing the returns on the government's investment in the sector" (Bank, 1992 p.12-13).

In India, the Bank diffused these ideas for administrative shifts through initiation of the structural adjustment reforms suggesting adoption of the market-oriented macro-economic policies. These ideas were first outlined in the report of Bank's first Health Sector Finance Study in 1992 titled 'India: Health care financing: Coping with adjustment- opportunities for reform' (World Bank, 1992a). The suggested reforms included a reduced role of the State in provisioning of health services, stressing that

> "the years of expanding the health system to reach to the village level, educating personnel to operate the system, establishing a logistics system to support it, and simultaneously

> funding both hospitals and traditional communicable disease programmes is a phase that is completed...a new phase of consolidation and adequate support of recurrent costs is called for" (World Bank, 1992a p.7).

Provision of only a set package of selected services and levying user charges at the point of service delivery was recommended which was contrary to India's effort of universal provision of healthcare services to all irrespective of their ability to pay. These ideas were further re-enforced in the World Development Report 'Investing in health' in 1993 outlining development strategies for health sector in 'low-income economies' (World Bank, 1993).

5.2.1.1 Decentralisation

Intend for decentralisation of health care has been a part of health systems development discourse in India much before the direct involvement of the World Bank. India's first health policy in 1983 had suggested a decentralised health care system, which was based on low cost of care, deprofessionalisation (use of volunteers and paramedics of health services), and community participation (Duggal, 2001 p.33). However, post 1990s financial crisis, liberalisation and India signing World Bank's Structural Adjustment Programmes, decentralisation reforms gained momentum and became the focus for development reforms.

In 1992, the parliament passed the 73rd and 74th constitutional amendments. These amendments introduced the functioning of local self-governance in India and made the Panchayats and Municipalities as "institutions of self-government". The actual shift towards decentralised approach in health care in India began around this time with the National Reproductive and Child Health Programme after the International Conference on Population Development in 1994 (Kaur et al., 2012). This period was particularly significant for decentralisation reforms as the above-mentioned constitutional amendment gave World Bank the opportunity to work directly with the States. Bank's 1992 document for India on coping with adjustment found that the local government bodies in rural areas like Panchayati Raj Institutions (PRIs) play a small role in provisioning of health services. It noted that the PRIs play a small role in implementation of State funded health programmes and have little financing autonomy in comparison to the urban areas where local government bodies like municipalities are the main agents for provision of government funded

public health services. An enhanced role of these local bodies was recommended in this document for better use of health resources.

Under the rubric of public sector management and civil service reforms, decentralisation occupied a special space for the Bank's work in reforming the public sector and overall governance reforms. Bank has used decentralisation in reference to a range of alternative institutional structures but differentiated between three main kinds of decentralisation that is deconcentrating[50], delegation[51] and devolution[52]. Major forms of decentralisation which happened through Bank's support and in partnership with Indian state has been limited to 'delegation'. These decentralisation reforms could not reach the State of 'devolution' in the truest sense though most of these reforms were aimed at devolution of authority at the lowest level of governance by giving people the flexibility to take decisions about their own health (Duggal, 2001).

The World Bank's support to decentralisation reforms in India essentially aimed at improving public sector efficiency and Bank's main approach for this relied severely on financial mechanism constituting cost recovery for municipal services (Bank, 1992 p.22). The first child survival and safe motherhood project which started in 1992 and functioned till 1997 notes in its evaluation report that the project did not effectively decentralised operations of the project activities like delivery of treatment services for ARI, diarrhoea and immunisation services (World Bank, 1997).The following project of Family Welfare in urban slums in 1994-2002 placed a special emphasis on enhancing local ownership through decentralisation. Resultantly, project activities were institutionalised and integrated with the project city's urban Family Welfare bureaus and municipal corporations. In one of the project sites in the city of Kolkata, management of project activities were delegated to local urban bodies with technical oversight from Kolkata Metropolitan Development Authority (KMDA). Facility level Health Development Fund Kolkata was set up using the contributions from the user fees and the community. This example was followed in other

[50] Deconcentration or Branch Office Model involves assigning of specific functions to subnational units within sector ministries or other sector-specific national agencies. Here, governments do not exist as discrete entities; least with respect to the specific functions for which central government ministries are responsible. Government exists at local levels in the form of discrete ministry offices; without any mechanism at the local level for mandatory horizontal integration. The impact of such a structure is to centralize power within central government (World Bank, n.d).

[51] Delegation: Independent Subsidiary Model involves parastatals and other semi-autonomous government agencies being assigned responsibility for implementing or maintaining sector investments. the establishment of independent project management units has also been employed within the national headquarters of sector ministries in other sectors (World Bank, n.d).

[52] Devolution: Discretionary Authority Model involves responsibilities for a range of operations encompassing more than one sector are assigned to local governments. To the extent that local governments have discretionary authority, they can do essentially what they decide to do; bound only by: (1) broad national policy guidelines; (2) their own financial, human, and material capacities; and (3) the physical environment within which they must operate (World Bank, n.d).

cities, where the project teams started to explore the opportunities to create additional resources through partnering with local communities, elected members of municipalities and NGOs (World Bank, 2002b). These ideas were taken to inform the components of the later projects.

5.2.1.2 Creation of Quasi-government bodies

In the later project, World Bank pushed the idea of decentralisation in the form of delegation by parastatal and semi-autonomous agencies taking the responsibility for implementing and maintaining sector-wide investments. For example, the first disease-specific HIV/AIDS project had a major component on creation of an autonomous NACO which was given the charge for implementing the HIV/AIDS control efforts. It was believed that NACO's autonomy with the status of quasi-government organisation would lead to an effective and efficient implementation. In addition to this national level organisation, at the State-level also, State AIDS Control Cells were formed for facilitating decentralisation of project activities receiving money directly from NACO. This shift in mass scale creation of societies in nearly all States was done justifying that " existing cells under Ministries of Health encountered serious funding bottlenecks... and creation of autonomous bodies will help to more easily receive and disburse funds without cumbersome government processes" (World Bank, 2006a p.3).

As in the case of justifications for private sector involvement, creation of quasi-government institutions was also justified by stating that the nature of functioning of government (beaurocracy) was a barrier in smooth functioning of public health systems. However surprisingly, creation of new structures and involvement of new players were sought as solutions for HSS than improving the existing structures. This in turn fragmented the health systems and made governance structures more complex.

Formation of quasi-government autonomous bodies was not only limited to the HIV/AIDS project, but it was an inbuilt component of nearly all of the Bank's projects. Other disease-specific and health systems projects supported by Bank like the Leprosy elimination project in 1994 and Tuberculosis control project in 1997 also established state and district Leprosy and Tuberculosis societies. The funds were further channelled through the State societies to the societies at the district level. As a result, the role of State in these different projects got diluted. This growing confusion in the role of States was noted in the project implementation completion report of the Tuberculosis project stating:

> "The States' role in the project design …was unclear - on the one hand they were seen as responsible for many aspects of project implementation. While on the other hand, the practice of releasing funds from the Central government to the districts had the effect of reducing the authority on the States and providing them with a limited role to implement and monitor the programme. The States also received minimal funds or other support for strengthening their own management capacity. This resulted in the States effectively not "owning" the Revised National Tuberculosis Control Program (RNTCP) strategy and the project as part of it" (World Bank, 2002a).

5.2.2.3 Public sector management reforms

Apart from establishment of the semi-autonomous government societies in the disease-specific projects, various other similar societies were established under the different State health systems development projects for strengthening public sector management efficiency in programme implementation. For instance, during the first health systems development project in Andhra Pradesh, an autonomous agency called' Andhra Pradesh Vaidya Vidhana Parishad (APVVP)' which was created in 1986 through a legislative act. The purpose of this agency was to improve the working of health care facilities at the secondary level of care. This agency was purely autonomous and the Commissioner of APVVP was first given the responsibility of the project coordinator. The Commissioner of the agency was the Chairman of APVVP's Governing Council and could affect the required changes in policy for supporting the project. The director of the project was the Secretary of the Health Department and hence could work closely with the Finance and Health and Family Welfare and Departments to get required clearances timely (World Bank, 2002a).

At the regional level, Engineering Wings were set up to facilitate the implementation of civil works. Health Equipment Maintenance and Repair (HEMR) workshops were set up to assist with the timely installation and commissioning of equipment provided under the project. A Strategic Management Board and a Public-Private Forum were formed under the projects to contribute to policy development. Similarly, a Strategic Support Group was constituted in Uttar Pradesh project to address key policy issues. In the area of quality control, quality assurance groups were created in District and Area Hospitals for improving the functioning of the wing responsible for the

maintenance of the equipment wing, consequently, Equipment Maintenance Training Centres (EMTC) were formed. A separate secretariat wing was created to streamline governments' communications and processes for ensuring communication issues related to the project such as timeliness in issuance of orders and circulars. However, for want of adequate technical support, these bodies were reported in the project implementation reports to have not turned out to be as effective as was envisaged (World Bank, 2002 p.5).

At the State-level, during the second HSS project, strategic planning cells were created in all states. Project governing board (PGB) and Strategic Cell (SC) were set up to provide autonomy in decision-making as well as for better flow of funds for project activities. The Project Management Committee (PMC) was set up with the intention that it would implement the project, in close partnership with the Directorate of Health Services (DHS). In all three States, a Strategic Planning Cell (SPC) was formed for examining health sector critical issues related to the health sector including monitoring the progress of the project and providing technical support for developing Health Sector Policy and plans. State-Level Coordination Committee were established for coordination of the project activities with other programmes and projects of the Bank in the health sector. The project implementation reports noted that

> "The government's move for health reforms has resulted in decentralisation of administration and autonomy to hospitals for collection of user charges and also its use"(World Bank, 2004).
>
> "… decentralised drug purchase mechanism… resulted in greater transparency in procurement and a more cost efficient system, capable of procuring large volumes of drugs in a timely manner"(World Bank, 2006c)

At the district level, District Project Management Units were set up with the key staff for project implementation. District Management Committees (DMC) were formed under the leadership of the Collector of the district and were given primary responsibility for tracking and filling vacancies of key staff. District health committees were created under the oversight of CEO of the Zilla Panchayat to monitor the regular functions of the hospitals. In Karnataka, the government shifted the ownership and management of health facilities under hundred beds to Zilla Panchayats. Health facilities which were attached to the teaching hospitals were handed over Medical Education department. At the level of health facility, Hospital management committees (also called as

Hospital Advisory Committees or Hospital Visiting Committee (HVC)) were formed to monitor quality of care and provider behaviour. Similar to previous projects, a secretariat wing, led by the administrator of the project was formed for streamlining the communications and procedures of the government.

The above-mentioned agencies, bodies and societies were created as quasi-government autonomous bodies justifying their creation as a means to make working in government more efficient and effective. For example, the project implementation completion report of the first health systems development project in Andhra Pradesh noted that

"In the Andhra Pradesh First Referral Health System Project (APFRHSP), decentralisation to the district level and establishing and strengthening District Referral Committees have facilitated quick decision-making within the government structure in the State… empowering Hospital Advisory Committees has strengthened reforms…advisory and development committees with administrative powers and accountability to manage user fees collected at facilities… has enhanced local ownership and participation in project development activities … autonomous corporation, such as APVVP in Andhra Pradesh, has helped in the implementation of reforms" (World Bank, 2002 p.12).

However, no evaluations or data was cited in the reports to validate the above-mentioned claims made in the project evaluation reports. In the subsequent disease-specific projects like the Malaria eradication project it was noted that preparation of state and district annual plans was one of the major accomplishments of the project under the domain of decentralisation of planning. However, a significant inconsistency in the quality and completeness of these plans especially at the level of the district level was also noted (World Bank, 2006e).

5.2.2 Verticalisation of health system

Another significant idea for HSS diffused by the Bank was the vertcalisation of health systems. As defined in World Bank's own reports,

> "verticalisation is as duplication of key function of the health system functions and support systems, each parallelly handling the needs of exclusive single-disease programmes. Verticalisation is noted to have create alterations leading up to the sapping of resources

and making countries missing out an opportunities for spill-over of financing for priority–disease into reforms as a systemic level for making positive contributions to other diseases" (World Bank, 2007 p.197).

Contrary to this approach is the integrated or horizontal programmes and approaches aiming to manage the health issues at a broader level, wider front and sustained basis by establishing a system of permanent institutions or the 'general health services (Gonzalez n.d cited by Mills, 2004). This approach is "a process where disease control activities are functionally merged or tightly coordinated with multifunctional health care delivery" (Unger et al., 2003). By horizontal delivery, publicly financed health systems services deliver health services by a comprehensive primary care approach (WHO, 1978). Horizontal programmes derived from Primary Health Care approach, having origins in the Alma-Ata declaration in 1978 (WHO, 1978).

The Bank had claimed to push an integrated approach for health systems development in India. However, in practice it has diffused the selective and verticalised development of health systems. Some form of functional integration has been achieved in the projects supported by the Bank, but the structural integration has been completely ignored. It has promoted a vertical health system at three levels. First and most dominant of these is through supporting a number of stand-alone population and disease-specific projects. Second is by focusing on one (secondary) level of care versus an integrated model of care and third is by creating parallel stand-alone State health systems development projects which were not entirely integrated with the State health system plans.

5.2.2.1 Stand-alone vertical disease-specific projects

The Bank's support to disease-specific health systems development projects started with HIV/AIDS project (1992), Leprosy (1993), Cataract blindness (1994) followed by Tuberculosis (1997) and Malaria (1997). This support has continued till date by financing second and third phases of these projects. The first disease-specific project HIV/AIDS project amounted to a loan from IDA credit of 84.0 million US dollars with a contribution of 2.2 million dollars from the WHO and 27.5 million dollars from the GoI. Because of the huge contribution from the GoI, the project has been extensively criticised for reducing the allocation by the Central government to other important health related issues. The skewed budgets of the Central government for health with one-fourth of its outlay going for AIDS further weakened the integrated general health

services which were responsible for bearing the major burden of HIV testing and case management (Priya, 1994, p. 11).

According to Ridker and Musgrove (1999) the irrational distribution of national budget to diseases without epidemiological basis occurred in deference to Banks' stress on communicable diseases. In the year 1994-95, Leprosy control programme (22.5%) and Malaria eradication programme (22%) constituted almost half the health budget and AIDS control organisation comprised 19.8% of the public health budget.

For Leprosy control project, two new and enhanced vertical interventions for Leprosy elimination were added as additional objectives to the project after mid-term review. Main component of the project, the expansion of delivery of Multi-drug therapy through a vertical structure increased from sixty-two percent to nearly universal availability. However, this vertical structure of service delivery was reported to be of inadequate value in detection of cases. The project aimed to fully integrate the Leprosy services with the primary health services, but it did not occur and was left to be addressed by the second project. The second phase of the project particularly aimed to integrate Leprosy services into the general health services and to phase out central funding to staff and institutions under a vertical program. This target in terms of functional integration was stated to be partially achieved as seventy-five percent of the regular staff working on Leprosy were reported to be either integrated with general health services or retrenched in all States. The structural integration was reported to be a difficult process due to issues relating to differences in status, salaries and benefits of the cadres involved and was left to individual States to resolve. The project implementation report noted that Leprosy treatment was provided through general OPD and general health services workers were oriented towards Leprosy work and were involved in the diagnosis and treatment of Leprosy (varying in different States). However, the Leprosy work was still managed under the vertical programme and done by one person. An exception to this was the involvement of the Auxiliary Nurse Midwife (ANM), contributing to case detection, treatment and follow-up.

Regarding the Tuberculosis programme, component three of the first project focused on expanding the integration of public TB services with the Primary Health Care system (US$22 million). This component supported the RNTCP's efforts to expand and improve public sector TB services and its integration with government Primary Health Care system. By the second phase of TB project,

the NRHM has been launched and national TB programme was integrated with the NRHM. TB programme accounted for only two percent of the NRHM budget as the delivery of this programme was well integrated with the management of general health services. However, this form of structural integration was noted to be inefficient as it was "causing delays relating to financial disbursements, audits, in payment of salaries, and in filling currently va cant posts" (World Bank, 2012 p.12). To improve project efficiency, creation of "TB -societies" (discussed above in the administrative reforms section) was suggested. The implementation report noted that the "TB programmes integration was causing difficulties such as high turnover rates among staff associated with increased workload as state and district officials are charged with several tasks of general health services besides TB…" (World Bank, 2012 p.12).The weak fiduciary and management capacities at the state and district levels were reported as challenges and the program integration within the NRHM structures was reported to have negatively affected the progress in program implementation.

One form of integration which was witnessed in TB project with general health services was additional resources like lab technicians, stores, laboratories and the engagement of Accredited Social Health Activists as DOTS providers. Another area of integration included the development of National Framework for collaborative activities for TB and HIV. This aimed at coordination between the two-disease-specific project through creation of committees and technical working, training of field staff and officials on management of both diseases, intensified case finding for TB, and cross- referral of TB and HIV patients. An 'Intensified TB/HIV Package' of services was rolled out in twenty-nine States- under this framework for referral, recording and reporting of all cases. Posts for DOTS-Plus supervisor were established along with the formation of a Technical Working Group at the national level working for a Joint TB/HIV framework in fourteen high HIV prevalence States.

5.2.2.2 Creating parallel health systems development ideas

Health systems strengthening projects today constitute a major component of the World Bank's health sector work in India. Till date eleven health systems development projects have been supported by the Bank in India. Few of these projects continued to the second phase as well. Three of the projects are still active in the States of Uttar Pradesh, Nagaland and Uttarakhand and eight projects have completed till 2017. These eight projects were implemented for a duration of

approximately eight to ten years in the States of Andhra Pradesh (1995-2002), Punjab- Karnataka-West Bengal (1996-2004), Orissa (1998-2006), Maharashtra (1995-2005), Uttar Pradesh (2000-2008), Rajasthan (2004-2011), Tamil Nadu (2005-2015) and Karnataka (2007-2017). A total of 1177 million US dollars have been disbursed as loans for the Health systems development projects by the IDA (see table 5.4). Heavy contributions have been made by the respective State Government's health departments and other international donors in case of few projects. Regarding the IDA loans till 2018, 365 million US dollars have been repaid and a total of 180 million US dollars interest has been accumulated (see table 5.4).

Table 5.4- World Bank's State Health systems development projects credits and repayments

		Disbursements US millions $	Repayments US millions $	Interests US millions $
1995-2002	Andhra Pradesh	113	56	24
1996-2004	KR,PB,WB	305	127	63
1998-2006	Orissa	75	30	14
1999-2005	Maharashtra	97	34	19
2000-2008	Uttar Pradesh	83.33	27.89	15.63
2004-2011	Rajasthan	80.44	16.71	12.57
2005-2015	Tamil Nadu	210.09	38.07	18.68
2007-2017	Karnataka	213.53	35.09	13.55
	Total	**1177.39**	**364.76**	**180.43**

Source: compiled from project implementation report

These projects have created a parallel narrative and plan for health systems development in these States narrowly focusing on two broad objectives. The first objective is to improve efficiency in allocation and utilisation of health resources through policy and institutional development; and the second is to improve systems performance by improvements in the quality, effectiveness and coverage of health services at the secondary level (to better serve the neediest sections of society). The objective, design and priorities of these projects have diverted efforts towards an integrated and holistic approach to health systems development. For example, all of the eight projects constituted two or three components for achieving the above-mentioned objectives (see table 5.5). There were mainly two components till the first four projects that is: (i) Management Development and Institutional Strengthening and (ii) Improving Service Quality, Access and Effectiveness at the Secondary Level.

These two components formed the basis of all projects and an additional component of innovative scheme was added from the Maharashtra project. This innovative scheme component in the Maharashtra project included renovation and upgradation of CHCs; improving referral mechanisms between primary, secondary and tertiary levels of the health systems and with private health care; promotion of health services for the disables populations and in the tribal areas; and developing a super-specialty hospital as an innovation model to develop close collaboration between the private-public and sectors. The next project in Rajasthan the innovative scheme aimed to improve the access (including geographical, financial and social access) of disadvantaged populations (namely SC, ST and BPL populations) to secondary health care. This was to be achieved through the targeted operationalisation of an IEC strategy, outreach camps, leveraging traditional systems of care for provision of essential medical services, and piloting various initiatives designed to improve access to care.

Table 5.5- Major components of State Health Systems Development projects				
State	Component 1	Component 2	Component 3	Component 4
AP 1995-2002	Institutional Strengthening (3%)	Improve Quality, Access and Effectiveness at District Hospitals (40%)	Improve Quality, Access and Effectiveness at Community Hospitals (57%)	-
KR, PB, WB 1996-2004	Management Development & Institutional Strengthening (7%)	Improving Service Quality and Effectiveness at District, Sub-divisional, Community/Rural Hospitals (86%)	Improving Access to Primary Health Care in Remote and Under-developed Areas (7%)	-
Orissa 1998-2006	Management Development & Institutional Strengthening (11%)	Improving Service Quality, Access and Effectiveness at Secondary Level (58%)	Improving Access to Basic Health Services at the Community Level (31%)	-
Maharashtra 1999-2005	Management Development and Institutional Strengthening (9%)	Improving Service Quality and Effectiveness District Hospitals Sub-Divisional Hospitals (74%)	Improving Access and Innovative Schemes (CHC, Super-specialty, tribal, referral) (17%)	-
UP 2000-2008	Policy Reform, Management Development and Institutional Strengthening (24%)	Improving Health Service Quality and Access (Clinical, Public health, innovations for disadvantaged) (76%)	-	-
Rajasthan 2004-2011	Project management, policy development and capacity building (19%)	Development of Primary and Secondary Health Care Services in the Public Sector Only 2 PHC for primary (50 %)	Health Care Innovations for the Disadvantaged (31%)	-
TN 2005-2015	Increasing Access to and Utilisation of Services (35%)	Combat NCDs & Accidents (5%)	Oversight & Management of the Health System (20%)	Improving the Effectiveness and Efficiency of Public Sector to Deliver Essential Services (40%)
KR 2007-2017	Strengthening existing Government health programmes towards the achievement of more effective and equitable delivery of services (44%)	Innovations in Service Delivery and Health Financing (45%)	Project Management, Monitoring and Evaluation (10)%	-

The distribution of funds to these components for the first five projects focused heavily on improving service delivery through enhancing quality of services. The secondary level services received more attention in comparison to the primary care services. For example, in first project, as high as ninety-seven percent and in second project, as high as eighty-nine percent of the total loan amount was dedicated to improving service delivery. It is around the fourth project, that the policy reforms including management capacity development and institutional strengthening components started to get more than twenty percent of the total amount of loan. The distribution was highly skewed towards the component of improving service quality (see table-5.6).

Table 5.6- Distribution of project amount to different components

State	% funds for institutional strengthening	% funds for improving quality, effectiveness secondary level hospital	% funds for improving primary care	% funds for innovative schemes	% funds diverted to other areas
Andhra Pradesh	3.0	97.0	0.0	0.0	-
Karnataka, Punjab, West Bengal	7.1	88.4	4.5	0.0	-
Orissa	4.5	46.5	24.0	0.0	25.0
Maharashtra	9.9	79.7	0.0	10.3	0.0
Uttar Pradesh	21.0	79.0	-	-	-
Rajasthan	19.3	50.0*	-	30.6	-

*This component was to support the strengthening of twenty-eight District Hospitals, twenty-three sub-District Hospitals, 185 community health centres, two block-level primary health centres.

Further, (as discussed in section 5.1) the component of civil works received nearly half of the project amount. The activities under civil works included major infrastructure development including activities like demolition, construction, renovation and upgradation of health facilities. Civil works and equipment together constituted near to half to eighty-five percent of the total project costs (see table 5.1).

The systems strengthening component in all these projects largely included development of management systems like setting up of strategic planning units, digitisation of disease surveillance and information systems, waste management systems. Setting up of quality assurance cells and financial management systems were also included in the last two projects in Tamil Nadu and Karnataka. However, not much details about the functioning of these systems are provided in the project implementation report. One of the main objectives related to these components was to sustain the overall proportional budget allocation to health and to increase the allocation of resources to primary and secondary level of health care. Both these objectives were not met successfully. As discussed in section 5.1, the overall budget allocation to health actually declined in few States (see table 5.2) and the allocated to primary and secondary care also did not see a significant increase (declined in one State) given the total increase in annual health budgets (see table 5.3)

In the HSS projects, the first project in AP aimed to integrate project activities with RCH, PHC and several disease control programmes. A tribal strategy which was claimed to be fully integrated with the Primary Health Project constituted an important part of the project. Strengthening of referral systems was emphasised for integrating different levels of care. The project implementation report states that 8,500 community health workers (CHW), were made familiar with the available facilities at APVVP hospitals for strengthening the referral linkages "among the in-patients using project facilities, 18% belong to scheduled castes and tribes. Access to tribal populations has been strengthened by improving integration with the on-going Primary Health Care project"(World Bank, 2002 p.17).

The UP project had one component of integration in the health systems development that is the integration of alternative systems of medicine with the allopathic systems of medicine in general health services. Physicians of alternate systems of medicine including Homoeopathy and Ayurvedic were placed at the district level hospitals, CHCs & PHCs. The project reported a rise in patients seen by these practitioners during the project implementation (Bank, 2011 p.50).

The Tamil Nadu project laid a special emphasis on strengthening and integrating existing health interventions like the RNTCP, RCH, NLEP and other existing welfare schemes of the government and claimed that this project was fully integrated within Government structures at all levels. The project report claimed that the project activities were an integral part of the Department of Health

and Family Welfare's work. The project report notes that the full financing of project activities was absorbed into the State health budget or nationally-funded health programmes during the final years of the project.

> "Project activities like mobile outreach and emergency ambulance transport, counselling services, sickle cell anaemia, bed grant scheme, health waste and information systems management were absorbed in and funded by the general health services and only the technical support and monitoring and evaluation of these components continued to be funded by the project" (World Bank, 2016 p.42).

Karnataka project also aimed at an integrated implementation of the project activities with general health services and State health programmes to ensure sustainability. The Project Development Objectives were stated to be directly relevant to the Karnataka State Integrated Health Policy and committed to significantly increase resource allocation for the health sector. However, the project report noted dilemmas like "the implementation arrangements presented a trade-off between efficiency and sustainability and it is not clear whether an alternative approach relying on a parallel project implementation structure would have been better in the long term" (World Bank, 2018 p.27).

Another project component related to integration was noted with regards to the consolidation of a health insurance agency Suvarna Arogya Suraksha Trust (SAST) and merging multiple State sponsored health insurance schemes operated by SAST into one Universal Health Coverage Scheme. The project implementation report noted that before the announcement of the merger, SAST was operating at State and national level insurance schemes and this was overburdening its institutional and implementation capacity.

5.2.2.3 Focus on one level of care versus an integrated approach

The first phase of health systems development projects focused on the improving the secondary level care. The first health systems project in Andhra Pradesh focused on establishment of a well performing referral system through upgrading staff and facilities at secondary level hospitals while completely ignoring the primary level tier of the health system. The secondary level hospitals were planned to be equipped to treat the patients referred from the primary level, but no attempt was mentioned for improving the functioning of the primary level facilities. This focus on the

secondary level services has continued in all the projects. The second health systems project document stated that

> "The first referral level was the focus of much of the project's work because of the observed disproportionately high contribution to the tertiary level of health care at the expense of first referral facilities and preventive and promotive care services; and the fact that health facilities at the primary and first referral hospitals in the States continued to face operational deficiencies due to inefficiencies…" (World Bank, 2004 p.2).

The Orissa project document noted that

"The main reasons for focusing on the secondary level were: (i) to complement investments made at the primary level by other IDA programmes; (ii) treatment of the same conditions cost two-thirds of that at the tertiary level; (iii) inability to extend these services to the Primary Health Centre level due to inadequate investment resources, low absorptive capacity, staffing issues and difficulty in providing emergency obstetric care at the primary level; (iv) increased credibility and hence increased utilisation at the PHC level due to improved First Referral Units (FRUs) and referral systems; and (v) in-patient treatment at public hospitals was more equitable and that the poor were more likely to access government facilities for hospitalization"(World Bank, 2006 p.7).

The health systems development approach of these projects was selective and targeted opposed to an integrated and holistic approach. The initial projects targeted improving health services for the vulnerable population, but the focus on 'neediest section of the society' slowly disappeared in the later projects. The first project stated an overall goal to "improve the health status of the people of AP, especially the poor and under-served, by reducing mortality, morbidity and disability" (World Bank, 2002 p.2), but by the fourth project in Maharashtra, this focus did not find a mention. By the fifth project in Uttar Pradesh and Uttarakhand the main goal (not stated as goal in the document) got reduced to "establish a well-managed health system …which delivers more effective services through policy reform, institutional and human resource development, and investment in health services" (World Bank, 2009 p.2).

The Uttar Pradesh and Maharashtra project had performance indicators targeting the increased utilisation of services like OPD, In-patient Department (IPD) by women, poor and tribal populations, however neither any specific interventions were devised, nor any data was made

available in the reports to reflect on performance of the project in relation to the access to these population. In case of Maharashtra where the increase in OPD utilisation by tribal population is observed, the report state that the data should be "interpreted with caution due to difficulty in elicitation of caste, misclassification of tribes and upward social mobility resulting in change of status" (World Bank, 2006 p.7). In the same project regarding the increase in access by poor, calculations were made by using women of scheduled castes as a proxy indicator for poor populations. In the Andhra Pradesh project, through there was an explicit focus on poor and under-served population, no specific strategies other than setting up of 'Quality assurance groups' at all the District and Area Hospitals were mentioned (World Bank, 2002 p.5). No indicator was set to monitor the project performance in these areas. This missing overall goal or focus on equity in service provision shows the failure of these projects to capture the differential improvements in access to vulnerable populations stratified by caste, class and gender.

5.2.3 Multi-sectoral action

5.2.3.1 Promoting private sector engagement

Reduction in the role of State and promotion of the engagement of private sector was at the core of administrative reform ideas pushed by the Bank under the umbrella of reforming the size, role and efficiency of the State. Bank's basic premise for promoting private sector engagement as idea for HSS was based on the assumption that "engaging private sector is more cost-effective as the private sector has a comparative advantage in (emergency transportation, service delivery to tribal populations and in remote areas, disposal of health waste, counselling services, diagnostic & laboratory tests)" (World Bank, 1992a). The Bank suggested to "Lower public spending on hospitals and medical education…where the private returns are high and the social returns relatively low…"(World Bank, 1993 p.16).

With this assumption, major strategies that were used in these projects to encourage private engagement started with encouraging public-private partnerships and supporting private sector in areas of comparative advantage like non-clinical support services; and gradually expanded to providing incentives to train, finance, and integrate private health care providers in diagnostics and

case-finding, treatment for priority health problems; and later shifted to involvement of private sector in direct provision and direct financing of services.

Bank's disease-specific projects in early 1990s made a clear use of non-State agencies, NGOs and the private sector in areas in which they thought that private sector had a comparative advantage. For example, private advertising agencies and NGOs formed a significant part of the component on creating awareness and community support for AIDS prevention under the first HIV/AIDS project. This was followed by ideas for roping in the private sector in delivery of health services justified by stating the inefficiencies in public sector functioning. For example, under the first phase of HIV/AIDS project, private clinics in the metropolitan were supported for control of STDs, clinical services and case management. Sexually Transmitted Infection (STI) services were enhanced through participation of private practitioners including doctors, nurses and paramedics justifying it by stating that "there was a perceived lack of privacy, confidentiality and associated stigma in seeking treatment from public sector health facilities and most STI patients seek management of STIs from the private sector"(World Bank, 2000 p.32).

Participation of private sector was further enhanced during the second phase of AIDS control project as the private sector was roped into planning of the project interventions. Key private and voluntary sectors including NGOs and People Living with HIV/AIDS (PLWHAs) participated in co-designing of the project as they joined in the planning workshops at the State-level. Representatives of labor organisations and large industries were involved for creating workplace-based interventions, giving the responsibility of implementing services to the States and municipal corporations, expansion of State AIDS Societies to all States, and completion of a baseline survey of HIV prevalence. This was done through holding various NGO consultations for expanding GoI and NGO collaboration. A consortium of external partners (including other Bilateral, Multilateral actor) was established under this project to work under the leadership of NACO (World Bank, 2000 p.6).

In other disease-specific projects as well, a deliberate effort to promote private sector engagement in health was made. This was done by completely dropping those components of disease-specific projects where there was a perceived higher advantage for the private sector. Not taking up these areas created a vacuum in public health systems so that it can be filled by the private sector. For example, during the first Leprosy project in 1994, one of the project objectives regarding the impact of disability was left out by the GoI to be taken up by the private sector (NGOs) because it

was believed "that the private and voluntary sector had a comparative advantage in this field"(World Bank, 2001). Though the work was given to private sector, GoI encouraged and continued to support private actors like NGOs to deliver services related to disability care including the reconstructive surgeries. Other areas in which private sector was involved included provisioning of Multi-drug treatment (MDT) by local bodies and local volunteers and creating public awareness about Leprosy and availability of free MDT (World Bank, 2001).

Other disease-specific projects like the Blindness control project (1995-2002) had a specific objective to enable the participation of non-profit organisations and private sector in the running of the project. During the Malaria control project too, the private sector was roped in for improving the accuracy and speed of diagnosis of Malaria cases. The Tuberculosis project had one of its components aiming at strengthening the involvement of the NGOs and private sector in the project implementation. Incentives like educational materials, free drugs, diagnostic facilities, training, treatment evaluation were given to NGOs and private practitioners for adopting the RNTCP strategy and agreeing to notifying the cases to the Government. Other areas of involvement of NGOs and private practitioners were in operations research with regards to service delivery and entering into contracts with the governments for providing comprehensive RNTCP services at the level of district or sub-district [53].

Tuberculosis programme developed a supportive supervision system for the volunteers including unqualified private practitioners, postmen, teachers, women members of self-help groups, NGOs, nurses and other private practitioners[54]. The low contribution of private sector in case detection rates and its low participation in RNTCP was noted to be critical deterrent for achieving the

[53] It was noted that during the span of the project that is in around nine years (1997-2006) over 9,700 private practitioners were officially providing RNTCP services and more than 1,600 NGOs were involved in the program mainly through providing assistance in tracking and treatment follow-up of smear positive patients. More than 100 corporate sector units and private enterprises outside the health sector like sugar mills in Uttar Pradesh and tea estates in West Bengal and Assam. The Federation of Indian Chambers of Commerce and Industry were also involved in promoting TB control (World Bank, 2006f).

Table 3: Contributions of the Private Sector to the TB Program

	Contribution to referral of TB suspects	Contribution to New Case Detection Rate	Contribution to DOTS provision	Contribution to treatment success rate
NGOs	6%	5%	8%	8%
Private Providers	3%	5%	9%	10%
Corporate	1%	1%	1%	1%
Medical Colleges	25%	23%	7%	6%
Gov't, other than Health Dept.	8%	10%	4%	3%
Health Dept.	58%	55%	70%	73%

Source: GOI MOHFW, 2012a

[54]

programme's goal of providing universal access to services. By the third project, private sector was almost considered a part of public health system playing a dominant role in provisioning of services. Major new initiatives taken for private sector's enhanced role were early adoption and implementation of Standards for TB Care in India (STCI) and implementation of a new online information system (named as Nikshay) covering cases managed by private sector. Another initiative taken during this period was the development of Terms of Reference for planned engagement of the 'Public-Private Interface Agency' model. This model was later developed into the GOI's flagship initiative following initial support from the Bill and Melinda Gates Foundation. The health systems development projects also promoted private sector engagement in service delivery later expanding to financing of services. Since the first project in Andhra Pradesh, the Private-Public Partnerships (PPPs) were initiated in the areas where there was a perceived gap due to low public spending. Civil works , supplies and telemedicine services were few areas where PPPs were initially sought (Bank, 2002 p.23). By the second project, engagement of private sector in provisioning of better health services and a greater role of the voluntary and private sector in the management and delivery of health services constituted the main development objectives of the project (World Bank, 2004 p.2).

The second State health systems development project which supported Karnataka, Punjab and West Bengal aimed to increase a structured involvement of the voluntary and private sector .Apart from the huge involvement[55] of private contractors in providing support and non-clinical services like ambulance, sanitation and maintenance, dietary services and IEC in remote and under-served areas, this project marked a major step in private sector engagement as the State Government partnerned with private sector to run Mobile Health Care Services (MHCS) in Sunderbans in West Bengal. Another PPP initiated under the project was delegating the management of Organisation of the Petroleum Exporting Countries (OPEC) funded hospital to APPOLO management in Raichur and Mudigere Hospital in Karnataka assigned to Bapuji Memorial Trust.

This involvement was met through establishment of partnerships and contracting out relationship between the NGOs or private contractors and the public sector implementing agency. It has been noted in the implementation report that

[55] 178 out of 214 hospitals in West Bengal, all 154 hospitals in Punjab, and 170 out of 204 hospitals in Karnataka contracted-out supporting services (ambulance, sanitation, and maintenance) to private sector service providers.

> "contracting out support services to private sector and involving NGOs in providing health services in remote areas has proven to be cost-effective and markedly increased patient satisfaction…the State Governments have expressed more acceptance and appreciation of role of private sector in providing support services and NGOs in delivering clinical services to the poor and shown intention to continue and expand involvement of NGOs and the private sector"(World Bank, 2004 p.9-10).

However, the same report also noted that the

> "project mainly focused on contracting out some supporting services …which does not necessarily facilitate engagement and development of "private health sector" as anticipated in the health sector strategy…may have missed opportunities to facilitate the engagement of private health sector in providing essential health services where larger numbers of people (including the poor) are obtaining health services" (World Bank, 2004 p.4).

The project report observed that the "beneficial impacts on private health providers were not fostered through project activities…there was virtually no clear spill-over impact on the private sector in terms of the development of a regulatory framework to monitor private health sector development and ensure quality of health care provision" (World Bank, 2004 p.5). It was noted that the services made available at cheaper prices at upgraded hospitals may have "crowded-out the private sector in providing health services, where as in principle, the public sector should seek to crowd-in rather than crowd-out private health services" (World Bank, 2004 p.12).

By the start of the health systems development project in Orissa, the Central and the State government initiated increased participation of private sector in areas like infrastructure but the openness for PPPs was limited in the areas like health (World Bank, 2006b p.3).The Orissa project deemed increased engagement of private sector by going beyond the "hotel functions" and engaged in delivering healthcare. The project implementation report stated that the "focus of the PPPs should be on improving access to and quality of healthcare in remote and tribal areas where the public sector may have poor reach and contracting in of specialist services to provide comprehensive emergency obstetric and neonatal care" (World Bank, 2006 p.29).

To improve the partnership between public can private sector in tribal areas, the project undertook training of Informal Service Providers in seven tribal districts to create a bridge between the tribal people and health delivery system and increased the institutional deliveries in the tribal area. According to National Sample Survey Office (NSSO) data cited by the project implementation report, by the end of the project the utilisation of services grew significantly for private sector but not so much for the public sector facilities (Urban area- IPD- 674% for private and 134% for public) and (Rural areas IPD- 312% for private and 62% from Public) (World Bank, 2002 p.5). The share of OPD access in private sector increased by six percent in the rural areas, but in the government sector it remained around the same levels. Whereas in the urban areas, a significant rise of twelve percent in the governments' share was noted and a drop of thirteen percent was noted in the private sector (World Bank, 2006 p.45).

The next project in Maharashtra further pushed for private sector involvement by setting two key strategies for PPP in its project objectives. The first one was to include private sector in the public facilities referral chain with the aim to improve linkages with private sector in referral mechanism. And the second was to set up a super-specialty hospital (named Gokuldas Tejpal Hospital in Mumbai city) as an innovation for close collaboration between the private and the public sectors through the adoption of modern management practices (this objective was dropped after mid-term review and unused budget was cancelled). Contracting out of non-clinical services like cleaning, laundry, dietary services and out-patient registration till this project has become a norm but this project also outsourced trainings to private agencies. A huge increase in allocations to grants-in-aid (GIA), from 0.95% of the health budget in FY00 to 23.9% in FY06 was noted in this project. Since GIA is applied towards contracting private providers for the delivery of selected services, this project reflected the government's increasing commitment to partnering with the private sector, including NGOs (World Bank, 2006c).

A Strategic Management Board (Neeti Nirdharan Prakoshtha) and a Public-Private Forum were formed under the Uttar Pradesh project to contribute to policy development. Few of the major decisions taken by these bodies included hiring of agencies for cleaning and security services on contractual basis and modification of user charges. However, neither of these initiatives could be as effective as anticipated in initiating appropriate policy reforms as there was a lack of technical support for analysing the policy issues and making evidence-based decisions.

Private sector was the dominant provider for both IPD and ambulatory services in UP, even for the poor, but the project further attempted to increase connections between the private and public sectors by giving contracts to the private doctors from the local areas. The project claimed to increase the access to health care by increasing the capacity of doctors of Indian System of Medicine (ISM) for providing both the curative as well as preventive care. The project implementation report noted that "although the current project did go further in partnering with the private sector by contracting in doctors/specialists and NGOs, the objective of developing a comprehensive vision for the health sector involving all health sector partners is yet to be addressed" (Bank, 2011 p.11).

It was also mentioned in the report that private agencies were not up to the mark in terms of quality and timeliness of construction work and the consultancy for civil works should be awarded to government agencies (World Bank, 2009).

The Rajasthan project went a step further for fostering partnerships between public and private by connecting the public and private sector for common treatment facilities (CTF) for waste collection and disposal. This project undertook the development of documentation and models for public-private partnership with the aim of building MoHFW's capacity to contract with the private sector. Model PPP contracts were developed for contracting of the private sector for the provision of ambulance services, mobile health services, operating PHCs and contracting in specialist services. Private sector was expected to be included for delivering services at secondary level of care. However, it was noted that the intent of private sector and the project efforts could not be successfully merged. The policy aiming to promote engagement of private sector in Health could not attract many big players. Few of the small players which were attracted belonged to the Medical education sector providing Tertiary care services. The framework for regulating private sector in health was also found to be ineffective (World Bank, 2012).

The Tamil Nadu project completely erased the distinction between public and private sector in health by explicitly stating both these sectors as parts of the health system. In one of its main objectives, the project aimed to "significantly improve the effectiveness of the health system, both public and private…improved health outcomes, access and quality of service delivery through strengthened oversight of the public sector health systems and greater engagement of non-governmental sector..."(World Bank, 2016 p.7).

A public-private partnership policy framework and terms of reference (TORs) for a proposed PPP oversight unit were prepared. The government of Tamil Nadu made extra attempts to increase the participation and enhanced ownership of the Social Assessment by actively engaging staff at all levels of the DoHFW, beneficiaries (individuals and communities), community organisations, donor agencies, local authorities, NGOs, academic institutions and the private sector in the consultations. This project aimed to deepen PPPs by going beyond contracting out "hoteling" functions which do not impact clinical care and included measures to enhance public hospital management including twinning with well-performing private hospitals.

In the latest health systems development project in Karnataka, the partnership with the private sector was justified as a sensible approach

> "given the limited capacity of the government's own health service delivery network (like emergency transportation, service delivery to tribal populations and in remote areas, disposal of health waste, counselling services, diagnostic laboratory tests), and the very high use of private sector health services by the population at all income levels "(World Bank, 2016 p.26).

Example of models where the project made capital investments (e.g. procured the ambulances) and then "contracted out" operation and maintenance to NGO/private partners (many of which would not have been able to finance the needed investments) were cited as examples of good project design (World Bank, 2016 p.26). Ten percent of the funds in this project were allocated to PPPs. Capacity building activities were envisaged for enhancing the ability of the private sector and the Government to design and enforce health facility accreditation processes and for working under service agreements. This project placed a special focus on training and technical assistance for stakeholders in the private sector to strengthen project capacity for management of PPPs and development of an accreditation system for private sector health service providers**.**

5.2.3.2 Enhancing community engagement

Community engagement has been a component of Bank's ideas for HSS. However, not as strongly diffused as those of administrative reforms and private sector engagement. Wherever applied, community engagement has mostly been conceptualised in terms of its value in initiating

behavioural and cultural change. Most of the initiatives under community engagement included activities like educating or creating awareness among communities for changing their health behaviours. Most population and nutrition projects had components of IEC and community mobilisation targeting behaviour change among the population. For example, the Andhra restructuring project, which was a multisectoral investment conceived development of a community nutrition fund and establishing 17,000 creches (World Bank, 2007c). In the HIV/AIDS project, the Tribal Strategy called for involving community for implementing culturally appropriate community awareness programmes and training (World Bank, 2006d).

In addition to this, community engagement has largely been applied in implementing project objectives through participation of civil society organisation and community-based, or faith-based organisations. For example, the early population projects, which sought to improve the linkages between the provision of Family Welfare services and other basic health interventions (like clean drinking water and sanitation facilities), involvement of community constituted a main part of the strategy but was attempted in form of engaging various stakeholders from NGOs and CBOs for project implementation (World Bank, 2006g). Similarly, the disease-specific projects like Tuberculosis focused on outreach and community involvement component mainly for the promotion of better TB care by the community, private practitioners and NGOs (World Bank, 2006f). Community involvement included engaging women's groups, grass-roots organisations, Panchayats and NGOs in various outreach activities to support TB patients. Strategies like provisioning of free drugs, training, educational materials, diagnostic facilities, supplies for referrals were used to engage these organisations and practitioners (World Bank, 2006f).

Similarly, in HIV/AIDS projects, promoting public awareness and community support constituted one component of the project and under this component, behavioural change and condom promotion was emphasised through involvement of NGOs (along with other channels like television and radio stations and private advertising). Capacity building of NGOs to deal with HIV/AIDS was planned and it was noted that the number of trainings done for NGOs has exceeded the original scope of the project. The role of NGOs expanded from the first to the third project. For example, in the first project, NGOs were encouraged to design interventions which could benefit from public sector funding (World Bank, 2000). In the second project, they were involved in participatory mapping and conducting a baseline study of the high risk population in providing estimates on their number and location of (World Bank, 2006d). In the third project, along with

these roles, NGOs were also involved in implementing and monitoring quality of Targeted Interventions and running school AIDS education programme and community care centres (World Bank, 2013a). In the Malaria project, the NGOs and community groups were identified as the potential agents for creating an enabling private market for the commodities related to the control of Malaria. These agencies were included by using strategies like provisioning of vouchers in public facilities (World Bank, 2006e).

CONCLUSION

The World Bank has promoted the HSS ideas under two broad categories of increasing resources and improving processes. Under increasing resources, infrastructure development remained a key idea for health systems development since the early 1970s. Human resource development also constituted an integral component of Bank's health systems projects. Regarding finances, increasing state health budgets and public sector allocations was prioritised till early 2000s along with two more ideas for increasing finances that is enhancing the collection of User fees (in the initial projects five HSS projects) and an emphasis on supporting the state funded health insurance schemes (in more recent projects).

Bank's HSS ideas have seen a shift from increase in resources to improving process or policy and governance reforms. This shift in ideas was accompanied by the increasing role in policy advice post 1990. Post liberalisation reforms and structural adjustment program, the Bank started to make a departure from its earlier HSS ideas focusing heavily on mere increase in infrastructure development, human resource, drugs and equipment and health financing. This shift (continued) focused on these areas but stressed on the effective utilisation of these resources in comparison to merely increasing it in the past. Post 1990s, ideas of the Bank suggested governance reforms focusing on administrative and civil services reforms. Major strategies under this included cost-containment measures, strengthening personnel management, improving effectiveness and efficiency of public agencies, decentralisation reforms and creation of quasi government bodies. Reducing the role of state and promoting the engagement of private sector was at the core of administrative reform. Bank had claimed to push an integrated approach for health systems

development, however in practice it has diffused the selective and verticalized development of health systems. It has promoted a vertical health system at three levels. First and most dominant of these has been through supporting a number of standalone population, nutrition and disease specific projects. Second is by focusing on one (secondary) level of care versus an integrated primary, secondary and tertiary levels and third is by creating parallel standalone state health systems development projects. Community engagement has been a component of Bank's ideas for HSS. However, community engagement has mostly been conceptualised in terms of its value in initiating behavioral and cultural change. The next chapter will discuss the processes used by the Bank to diffuse and implement these HSS ideas in India.

CHAPTER 6

WORLD BANK AND HEALTH SYSTEMS STRENGTHENING POLICIES IN INDIA: ANALYSING THE GOVERNANCE PROCESSES

INTRODUCTION

This Chapter addresses objective four of this study through the embedded case study on the World Bank. Using the operational framework described in chapter two, this chapter discusses the processes and tools though which the Bank participates in HSS policies in India. This analysis places governance at the cornerstone of the continuum of HSS including increase in resources and improvement in processes (see operational framework, chapter two). It examines these processes from a governance viewpoint at two levels and two aspects. In terms of levels, it examines governance functioning at the normative level in shaping macro-level policies for national and international health system reforms and second at the operational level of governance working for the national, sub-national government reforms and at institutional (health facilities) and community level (community-based health initiatives and interventions). In terms of aspects, it examines governance using both the conceptualisations of governance that is governance by the health systems (where governance is a function of the health systems) and also governance of the health systems (using a network-governance conceptualisation where different policy actors co-produce governance).

This analysis acknowledges governance as a 'global' process in which different actors at different levels of the health system are interacting with each other (sometimes) outside the authority of the State and are constantly exchanging and negotiating policy ideas. Applying the concept of policy networks and network-governance, this chapter examines the participation of the World Bank in

the health governance policy networks in India. Data for this chapter is mainly obtained from the stakeholder interviews, published and grey literature on the participation of the World Bank in health governance and health systems strengthening policies, World Bank's India health sector project implementation and evaluation reports and World Bank's website for understanding its various initiatives and partnerships. For building the understanding about the role of the Bank at global macro policy level, the data is largely drawn from published and grey literature (mainly journal articles and books) and for building the understanding on the role of the Bank at the national and operational level, data is drawn from the Bank's India project implementation reports and elite interviews. The data is then examined under two broad heads of processes operating at the levels {global, national, sub-national (States) and community} of health systems as well as the domains (normative and operational) of governance policies. Further the findings are analysed under the two broad themes of the World Bank's participation in shaping governance ideas at the normative or ideational level and shaping governance mechanisms at the operational level. The permeability of governance ideas and mechanisms across different levels of health systems is recognised and reference is made to the specific level of health system at which these processes are taking place. Links between are normative and operational level of governance are drawn where appropriate.

The chapter is divided into four parts. The first part gives a brief introduction to health governance in India and the prominence of the World Bank in health governance policy networks. Second and third part examines governance using the first conceptualisation that is governance as function of health system. The second part analyses the role of the World Bank in shaping normative ideas of health governance and focuses on the function of production of governance ideas by the Bank. Third part examines the role of the World Bank in shaping operational mechanism of health governance and focuses on the function of implementation and diffusions of governance ideas by the Bank. The fourth section examines governance using the second conceptualisation of governance that is network-governance and examines the role of the Bank in various governance policy networks operating at different domains and levels of the health systems.

6.1 HEALTH GOVERNANCE IN INDIA AND THE PROMINENCE OF THE WORLD BANK IN HEALTH GOVERNANCE POLICY NETWORKS

Governance in health sector has been defined by WHO as

> "a wide range of steering and rule-making related functions carried out by governments/decisions-makers, as they seek to achieve National Health Policy objectives that are conducive to Universal Health Coverage. Governance is a political process that involves balancing competing influences and demands. It includes: maintaining the strategic direction of policy development and implementation; detecting and correcting undesirable trends and distortions; articulating the case for health in national development; regulating the behaviour of a wide range of actors - from health care financiers to health care providers; and establishing transparent and effective accountability mechanisms"("WHO | Governance," n.d.).

Like many other British colonies, post-colonial society of India planned for its welfare services by largely drawing upon from the experiences of social-democratic and socialist countries. Though the ideologies adopted by India for planning welfare activities including health have been influenced by the socialist and welfarist countries, it has been argued that India by its virtues cannot be classified as a welfare State in the same way as welfare States are classified in the Western Europe (Jayal, 2003). The Role of Indian state in social sectors has been described by few scholars as an 'interventionist' or a 'developmentalist' State with only a limited welfarist orientation. It has been argued that the Indian state has adhered to a needs-based conception of justice in theory, while in practice followed a philosophy of welfare based on ideas of charity and benevolence (Jayal, 2003).

The development of health services in post-colonial period in India carried its colonial legacy and borrowed largely from the United Kingdom National Health Services model. The basic principles including the government provisioning of care funded mainly through taxes, aiming to provide free comprehensive healthcare to all its citizens regardless of their capacity to pay. The first health planning committee which was set up to provide a blueprint for health service development in

India recommended three tier health service units for providing primary, secondary and tertiary levels of care at village, blocks and district levels. The Committee recommended that "all services provided by the health organisation should be free to the population without distinction and it should be financed through tax revenues" (Ibid, II.14 cited by Duggal, 2001 p.14). It also suggested that "the health service should be a salaried service with whole-time doctors who should be prohibited from private practice" (Ibid, II.15 cited by Duggal, 2001 p.14).

Under the constitution of India 'Health' was listed as a State subject but health matters were divided among the State, Center and Concurrent list. The decision-making process at the Central level has largely been based on five-year national plans (replaced by a three-year action plan after the twelfth plan). A national level body (earlier the 'Planning Commission' and now replaced by 'National Institution for Transforming India' established in 2015) has been responsible for drafting these plans. In case of national health programmes, the Central Government has designed most of health programmes and the State Governments have adopted these programmes with or without modifications as per local realities.

Central government has largely been holding control over promotive and preventive programmes like the disease-specific programmes, Maternal and Child Health programmes and Family Planning programmes. The State governments have been responsible for implementation of programmes and providing health services through a network of health centres. Most of health sector related decisions are made at the level of the States and most of the finances are contributed from the State budget. In addition to this, there is a certain contribution to the State health budgets from the Central government. Few of the schemes of the Central government in addition to the National Health Programmes have also been implemented in different States from time to time like the national health insurance schemes. Most of the public health systems work through the tax-based financing and staff at the public health facilities in most cases are paid monthly salaries.

In addition to the national and sub-national governments a range of policy actors (discussed in chapter three) co-produce HSS and health governance policies in India. Chapter three shows the dominance and the level of participation of different policy actors in the policy networks at different periods of time. This in turn has implications for their influence on shaping governance mechanism. The section below will discuss the World Bank as an important policy actor in health governance networks in India.

As discussed in chapter four, the World Bank has been an important actor in health governance policy network in India from 1980s till 2000. It continues to be one of the largest donors in health sector in India and retain an important place in health systems governance because of its financial powers and continued long-time association with various other actors in the policy networks. Three characteristics of the Bank emerge as the most significant features which contribute to its significance as a health policy actor. These features include it being i) the largest donor among other global health policy actors, ii) longer duration of its (project) support to national and sub-national governments and iii) components of technical assistance attached to the financial support provided to national and sub-national government. The Bank expanded its support to India in the social sector including health only in 1970s but by 1990s it became the largest donor in health sector. As noted in one of the financing strategies papers of Bank in 1992, its contribution grew from less than thirty percent in 1985 to more than sixty-five percent in the total development aid in health in 1990. During this period other traditional donors like UNICEF and UNFDA contributed about ten and seven percent respectively (see table 6.1). The global patterns in aid confirm Bank's dominance in financing health sector till 2000.

Table 6.1- Percentage contribution out of total contributions by external actors

Organisation	1985-86	1986-87	1987-88	1988-89	1989-90
Bank	28	18	32	20	66
UNICEF	11	19	19	33	10
UNFPA	26	11	10	23	7
USAID	17	11	16	14	10
DANIDA	8	8	8		2
U.K.	6	1	3		

Source, adapted from (World Bank, 1992)

Though there have been periods in time where other donors have given more financial resources but Bank's technical assistance in addition to the financial support makes Bank an important actor in the policy networks in India. While explaining this as one the main reasons for the Bank's value as a policy actor, one of the Bank officers working in one of the State health systems development projects in India said that providing both financial and technical support is

> "like you have a bigger tool box, you are fixing a car and you have everything, a hammer, a screw driver and a wrench and it's not that you only have a screw driver and then you fix something with the screw driver which needs to be fixed with the hammer" (B1 New Delhi 2019)

He further stressed that Bank is more valued as health systems reform partner in the policy network because of its involvement in funding as well the implementation of the projects unlike another donor organisations which are mainly involved in project implementation.

> "specially like USAID, BMGF and DFID- which rely much on Implementation Partners. Bank's grants come to Implementation Partners which is a third party for actual implementation … so they don't have as direct a relationship with government as us" (B2 telephonic interview, 2019).

Bank officers claim that in the policy networks, they enjoy the government's trust more than others (development partners) as the Bank's officers "…lend funds to the government to help the government implement projects and programmes" (B1 New Delhi, 2019). As this money is loan money and the government are supposed to repay it to the Bank, the government takes ownership in the money provided which further strengthen their bond with the Bank.

> "none of these actors do that, at some point USAID had SIFPSA[56] in Uttar Pradesh, which gave a large corpus of money but not loans, Global Fund give grants, World Bank has a unique relation as we are financier with the government and the government has to give this money back to us, this is what makes our relationship very different" (B1 New Delhi, 2019).

The long duration of the World Bank projects also legitimises their association with the government and all other actors in the policy network

> "we do usually five years projects which generally take a couple of years to take off and usually get extended…largely our projects last five to eight years, as in Tamil Nadu we had engaged for ten years, in Karnataka for ten years, in Uttar Pradesh our current engagement has lasted for almost seven years, our projects are not-for any short terms gains" (B5 telephonic interview, 2019).

[56] **State Innovations in Family Planning Services Project Agency (SIFPSA)** has been a joint venture of Government of India, USAID and Government of Uttar Pradesh under Indo-US bilateral agreement for implementing the Innovations in Family Planning Services (IFPS) project in the State. During the two decades of successful implementation of IFPS project, SIFPSA has made its mark in the global arena in Family Planning and Reproductive Child Health.

These features explain the working of the Bank in health governance policy networks in India and also explain the reasons which make the Bank a comparatively 'stronger' actor among global health policy networks comprising other global health actors like the Bilateral, Multilateral, philanthropic organisations and global PPPs in India. The following section explains its participation in the shaping the governance ideas at the normative and operational levels.

6.2 ROLE OF THE WORLD BANK IN SHAPING NORMATIVE IDEAS OF HEALTH GOVERNANCE: PRODUCTION OF IDEAS

The main medium used by the Bank for influencing health governance policies is through participating in the three broad processes of i) shaping normative HSS governance ideas (through production of ideas) ii) diffusing and implementing these ideas through shaping or reforming existing governance mechanisms (through a combination of financial and technical assistance) and iii) legitimising these ideas and practices (through policy networks working under the networked governance).

This section describes the World Bank's role in shaping normative ideas of governance through examining its role in knowledge production, diffusion and legitimisation. This role is discussed in realm of 'influence through information' by the World Bank. Goldman (2004) argues that Bank's 'global expertise' makes it an unquestionable expert in the area of information generation related to policy formation. Another political scientist and a veteran of the World Bank research, Robert Wade, believes that "the Bank's legitimacy in the global marketplace of ideas and commerce depends upon the authority of its research and policies"(Wade, 1996 cited by Goldman, 2004 p.2).

The function of knowledge production operates across the levels of health systems. Though the final knowledge products in form of policy papers or governance tools might emerge at the supra-national or global levels, the information which shapes these knowledge products is collected from national as well as sub-national, institutional and community levels. Such permeability in knowledge exchange and production (though not examined in detail at different levels of health systems) is well acknowledged in this research. The discussion below on production of ideas is

situated mainly at the global level but it has relevance for its development as well as implementation at the national, sub-national and local levels.

6.2.1 Bank' engagement in production of ideas

Since 1990s, when the financial influence of the Bank started to wane, Bank repositioned itself as the 'knowledge Bank' announcing its strengths in knowledge production and knowledge as the new key for development than economics. Through World Development Report 1998 titled, 'Knowledge for Development', then-Bank President James Wolfensohn emphasised on the role of Bank as the one which will support development through knowledge production. This report stated

> "that knowledge, not capital, is the key to sustained economic growth and improvements in human well-being. It distinguishes between two sorts of knowledge: knowledge about technology, called technical knowledge or simply know how, and knowledge about attributes, that is, knowledge about products, processes, or institutions"(World Bank, 1998a).

It clearly outlined "three critical steps that developing countries must take to narrow knowledge gaps: acquiring knowledge, absorbing knowledge, and communicating knowledge" (World Bank, 1998a p.3).

However, much before the launch of this report and the knowledge production claim of the Bank, Bank has been engaged in producing a range of governance ideas, concepts and theories for health systems development. These were then diffused through the technical assistance work and project loans provided by the Bank. These ideas are produced by the staff in their individual capacities in the form of papers, blogs and articles and through the research units and expert groups inside the Bank.

In case of India, the HSS ideas as discussed in chapter five include mainly the governance ideas focusing on increasing health resources and improving processes for effective utilisation of the resources. These ideas are shaped by Bank's own understanding of the health systems and its (evolving) commitment to different issues impacting the performance of health systems. Based on its own notions, these ideas are then produced by the Bank at the global as well as country level through a range of mediums including research outputs and policy advice. A range of Bank's

documents produce these ideas which in turn give a direction to and sets a discourse on health systems development policies internationally and at the national level.

For example, Bank's involvement in shaping population control as a key HSS ideas was a product of its commitment to population control, which had its roots in the Family Planning movement of the mid-1960s. During this period Bank's development theory was limited purely to economic growth. Investing in physical capital and infrastructure was seen important by the Bank for its contribution in increasing national income (Ruger, 2005b). At this time, development economists were influencing the policy-makers in the United States and Europe and subsequently the experts at the World Bank, regarding the negative effects of rapid population growth on economic development (Sinding, 2007 p.2). Investing in population control was justified by stressing its contribution to economic productivity as all investments and advice from the Bank was mandated to make maximum contribution to economic growth. Robert McNamara, the then president of the World Bank believed that the rapid population growth was one of the greatest national-security threats to America and that the most fundamental point underlying all of Bank's foreign policy needs is overpopulation (Burdman, 1982). In this context, Bank had pushed most of the newly independent developing countries to devise population control programmes.

Few of these ideas also emerge from the need of the Bank to sustain itself and come up with innovative ideas and strategies for supporting the developing countries. Till 1970s, Bank was looking out for the ways and was seeking advice from outsiders for leads which can help the Bank to come up with loans which are poor friendly and also "bankable" by the World Bank standard. In 1971, McNamara, focused on small farmer's projects but kept looking for better poverty reducing strategies (Kapur et al., 1997). Gradually McNamara's interest in the area of Nutrition grew after being inspired by International Conference on Nutrition, National Development, and Planning at Massachusetts Institute of Technology in 1971. This interest was further deepened by the establishments of the International Nutrition Planning Program in 1972 funded by the Rockefeller Foundation and US Agency for International Development. By this time the calculation on economic costs of inadequate diets and related illnesses had pointed towards a considerable human and economic waste caused by inadequate nutrition and malnutrition was beginning to be seen both as a cause and as an effect of underdevelopment. These developments prompted the Bank to start considering its appropriate role in the area of malnutrition (Berg, 1987).

The Bank started a dedicated nutrition unit in 1972, after the release of the Bank's report 'Possible Bank Actions on Malnutrition Problems' (Ruger, 2005b). Bank's first nutrition policy paper, launched in 1973, suggested that improved nutrition would mean an improvements in equitable distribution of income, it would encourage population level planning to be more effective and it would improve the overall level of the well-being of the people (World Bank 1973). Though 'increasing the per capita income of the poor' was acknowledged as the most convincing and long run solution to malnutrition but such change was slowly perceived to be taking more than a generation's time to show improvements (Berg, 1987). As a result, other means like feeding programmes, vitamin and mineral supplements, strengthening health systems and improved nutrition education were deliberated as a solution to improve nutritional status of the poor. There was also a deliberation that despite increase in food production (like in the case of Punjab after the green revolution in 1960s) the surplus food has not made a dent on the malnutrition rates among the poor.

Similarly, as noted in in its first report on governance and health, World Bank noted that its "interest in governance derives from its concern for the sustainability of the programmes and projects it helps finance. If sustainable development is to occur… a predictable and transparent framework of rules and institutions for the conduct of private and public business must exist" (World Bank, 1994 p.7).

Engagement with(good)governance as an HSS idea started in late 1980s when the Bank started to reason most of the economic failures in poor countries as a failure of 'governance'. According to Diarra and Plane (2014), from 1950s to 1970s Bank supported State welfare principles and encouraged "public interventionism in developing countries to by-pass inefficient market mechanisms" (p.5).It encouraged the governments to take the lead in the development process, including by some pioneers of development economics who never ignored the problems arising from State failures. It is after 1980s with the appointments of Claussen as the president and Krueger as the chief economist that the liberal concept of economics spread worldwide (Ayres, 1983, Williams and Young, 1994 cited by Diarra and Plane, 2014). The Reagan administration exhorted the Bank to use its financial leverage more efficiently to support market rules which lead to the spread of free market perspective like never before.

Diarra and Plane (2014) argues that by this time, the Bank focused its work on reforming the public sector management in developing countries but gradually the concept of "good governance" became associated to the working of the "free market" economy. As noted earlier, concerns related to governance were not new to the Bank but its first explicit articulation about the concerns of governance started with its work in Africa with a 'frank discussion' of the 'crisis of governance' through a book in 1989 concerned with economic development in "Sub-Saharan Africa: From Crisis to Sustainable Growth: A Long-Term Perspective Study" and also through involvement in the economic reforms in Latin America, Eastern Europe, and parts of Africa and Asia arising out of political change. Bank assisted these regions to address a wider range of issues related to economic management, including the systems of procurement, the legal framework and financial accountability (Bank, 1992 p.5).

6.2.2 Policy documents- a primary source for producing practical and applied ideas for governance and HSS

Policy documents constitute a primary source of introducing key governance ideas. Often titled as policy study or policy research, these documents are mainly ideas of the authors and presents their views on host of issues of health sector based on a certain set of assumptions (often not clearly stated in the documents).

Most of Bank's HSS ideas for financing and governance of health systems have been introduced through various policy papers. For example, ideas for promoting user fees, health insurance and subsidies as alternative approaches for financing health services in developing countries were introduced through two key policy documents in late 1980s. First document was by a World Bank staff, David de Ferranti's working paper published in 1985, titled, 'paying for health services in developing countries- an overview'. At that time, Ferranti was a senior economist in the in World Bank in the Population, Health, and Nutrition Department and this paper was a review of principal issues, problems of in financing of the health services in the developing countries and presented policy options for the same (De Ferranti, 1985). It argued that a substantial re-orientation of policies is needed in many countries and suggested searching opportunities for recovering costs from users through charging fees for services as user charges, and fees for healthcare in form of

coverage charges. It also suggested charging fees through risk pooling mechanisms like insurance plans ranging from informal community level cooperatives to small formal health insurance plans. The ideas outlined in this document also aimed at promoting the public-private mix for provisioning as well as financing of health care. This paper asked for an extensive re-orientation of (the then) present health financing policies. It challenged the notion that government should take total responsibility of financing and provisioning of health care and called for encouraging pro private sector reforms which are tailored to service specific demands (De Ferranti, 1985)..

This document was followed by another key policy study in 1987, titled as 'financing health services in developing countries- and agenda for reform'. It was prepared by experts working in the Policy and Research Division of the World Bank's HNP department namely John Akin, Nancy Birdsall, and David de Ferranti. Like the previous working paper, this policy study advised that user fee should be instituted at the government facilities especially for drugs and curative services (Akin et al., 1987). These charges were said to improve the overall resources for the government and allow better spending on programmes which are under-funded. The major beneficiaries of these resources were said to be the poor. This paper stated that the approach of treating healthcare as a right to citizenry in developing countries usually do not work because it prevents governments from collecting revenue that many patients are willing and able to pay. This result in the entire cost of healthcare system being financed through overburdened tax systems. In addition to this, the paper highlighted that treating healthcare as a right to citizenry in developing countries i) motivates the clients to use the high cost hospitals when their needs could be addressed at the lower level of the systems. ii) deprives the health workers in government facilities of feedback on their success in satisfying consumer's needs. And iii) makes it impossible to reduce subsidies to the rich by charging for certain services or to improve subsidies to the poor by expanding other services (Akin et al., 1987 p.4).

As a result, the Bank suggested charging user fees and recommended that in the short run countries should institute modest charges for drugs and curatives services and this modest charge could generate fifteen to twenty percent of operating budgets for most countries. In the long run user charges were said to not just increase revenue but also to improve the utilisation of the resources of the government. It was suggested that over the years mechanisms should be developed to increase the user charges for curative services as this would free up almost sixty percent of the

government's current expenditure on health for reallocating it for the poor for providing the basic preventive programmes and primary curative level of services (Akin et al., 1987).

Similarly, the governance ideas for HSS were introduced through two seminal documents in the early 1990. The first was the 1992 document titled 'Governance and development', which sketched that Bank's 'mandate for governance concerned with economic and social development. Governance was defined in this document as "… the manner in which power is exercised in the management of a country's economic and social resources for development" (Bank, 1992 p.5). In this document, the Bank noted the need to encourage reforms in civil services for bringing more accountability in public sector funds and effective utilisation of budgets.

The other document which came out in 1994 titled 'Governance – the World Bank's experience' noted that 'Good governance' was

> "epitomised by predictable; open, and enlightened policy-making (that is, transparent processes); a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions, and a strong civil society participating in public affairs; and all behaving under the rule of law" (Bank, 1992 p.7).

The four major dimensions of Bank's work concerned with governance were categorised as: "(i) public sector management (PSM); (ii) accountability; (iii) legal framework for development; and (iv) transparency and information and out of these four public sector managements was the most significant one shaping the other three dimensions" (Bank, 1994a p.9).

Public sector management was defined as predominantly technical, concerned with changing the overall organisational structure of public sector encouraging a new model "which requires a smaller State equipped with a professional, accountable bureaucracy that can provide an 'enabling environment' for private sector-led growth, to discharge effectively core functions such as economic management, and to pursue sustained poverty reduction" (World Bank, 1994a p.25).

It stated that over the years Bank's approach in the dimension of public sector management has stretched beyond project-linked institutional strengthening and the Bank used broad based structural adjustment loans and improved financial management to expand its approach. This document made specific reference to Bank's position on the role of the State and private sector

and noted that along with civil service reforms which focused initially on containing the costs, the Bank has begun to encourage privatisation of public enterprises. Bank recommended that "in the so-called transition countries-that is, those making the transformation from socialised to free market economies privatisation has been a central thrust of the Bank's overall assistance" (World Bank, 1994a p.26). It further stated that these reforms are being suggested in response to the worsening of the condition of parastatal sector (World Bank, 1994 p.3).

6.2.3 Creation of tools of health governance

Creating concepts and theories as tools for governance has been one of the most significant tools used by the Bank for participating in HSS policies. These governance concepts are diffused as handy tools to be applied for effective policies. A broad shift in the belief, utility and thus diffusion of these ideas can be observed in the Bank's policy advice documents over the last few decades. However, these shifts are justified by stating that these merged in repose to the changing political economy and the emerging evidence on effectiveness of approaches. Nonetheless, these concepts and theories come in handy especially for countries to develop a broader vision, overall direction and tools for developing health plans. It has especially been accepted in countries which lack the advanced technical knowledge and resources for computing complicated estimates required for policy-making.

First of the few of these concepts diffused by the Bank to countries for health planning is the concept of 'human capital'. Human capital applies the economic theory on the individual which constructs health as stock, or a future investment in an individual. Sridhar (2007) notes that, though the Bank' economic justification for investing in health started much earlier but in 1980s with the launch of World Development Report on poverty, human capital framework started to be used predominantly by the Bank to lobby the governments for taking loans for projects related to nutrition. Human capital made direct linkages between the future economic productivity and labour with well-being and child nutritional for justify investing in child health (Sridhar, 2007). This was the time when investments in child health nutrition was being justified by using the calculation on economic costs of inadequate diets and related illnesses. These illnesses were measured in terms of the 'human and economic waste' caused by inadequate nutrition and malnutrition was suggested to be seen both as a cause and as an effect of underdevelopment. Given

these developments, Bank started considering its appropriate role in the area of malnutrition under the premise that: “was malnutrition a development problem and therefore one the Bank should address? If so, were there feasible things that could be done about it, particularly things that the Bank was suited to do?” (Berg, 1987 p.886). It approved a handful of nutrition projects in 1970s, the first being a Brazil Nutrition Research and Development Project, which started in January 1977, second was the Indonesia Nutrition Development Project in April 1977 and the third was the Colombia Integrated Nutrition Improvement Project which began in March 1978. Each of the four nutrition projects were designed with an aim to test different approaches to manage nutrition problems. There were a few common features of the projects including the components of institutional strengthening, delivery of nutrition services from primary health services, and nutrition related education programmes and components of subsidy programmes or supplementary feeding (Berg, 1987).

In India too, Bank’s interventions started in 1980 with the start of a nutrition project in Tamil Nadu, similar justification of economic productivity were given as a rationale to the project. The overall goal of the project was improving the nutritional and health status of the preschool children, primarily those of six to thirty-six months old and nursing and pregnant women. The approach of the project was mainly ‘supplementation’ and direct feeding unlike the previous projects which mainly involved consumer food subsidies through distribution of food coupons as in Brazil and Colombia. The supplementation strategy included a package of services focusing on Primary Health Care, nutrition education, periodic deworming, supplementary on-site feeding of malnourished children, administration of vitamin A, education for diarrhoea management and supplementary feeding of women (World Bank, 1998b).

Bank continues to apply this approach to calculate the returns on investments in health projects and devise cost-effective solutions to health problems. A 1994 Bank publication, “Enriching Lives,” showed that micronutrient interventions are among the most cost-effective for improving human capital and included an aim that the Bank would include micronutrient interventions relating micronutritent in all releveant project of the Bank concerning the crisisin arising out of micronutrient malnutrition (World Bank, 1994b). Post these development, in 2005, “Bank estimated a ten percent reduction in lifetime earnings among the malnourished children. This finding in terms of their future contribution to the workforce and economy was then taken as a

justification for making investments in children nutrition adult member of the workforce"(Sridhar, 2007 p.505).

The idea of Human capital was recently brought into the launch of the Human Capital Index (HCI) in 2018 which "measures the human capital that a child born today can expect to attain by her 18th birthday, given the risks of poor health and poor education prevailing in her country"(The World Bank, 2020 n.d). HCI is a metric index which guides health planning as it combines measures related to various aspects of human capital: health (child survival, stunting and adult survival rates) and the quantity and quality of schooling (expected years of schooling and international test scores). It consists of the knowledge, skills, and health that people accumulate over their lives and enables them to realise their potential as productive members of society. It is associated with higher earnings for people, higher income for countries, and stronger cohesion in societies (The World Bank, 2020 n.d).

The latest report has HCI ranking for 174 countries, with additional seventeen new countries in comparison to the edition in 2018. This index reaffirms the idea that for the country governments it is vital to recognise the significance of making investments in their citizens' human capital and to design policies and institutions that foster human capital accumulation using economic productivity approach. The recent HCI update States that

> "by bringing salience to the productivity implications of shortfalls in health and education, the HCI has not only clarified the importance of investing in human capital, but also highlighted the role that measurement can play in catalyzing consensus for reform. Better measurement enables policy-makers to design effective interventions and target support to those who are most in need, which is often where interventions yield the highest payoffs. Investing in better measurement and data use now is a necessity, not a luxury" (The World Bank, 2020 p.11).

Developing health governance metrics to measure the health impacts of certain diseases and interventions constitute Bank's key tools for influencing HSS policies. Another such tool introduced and used by the Banks is the metric developed for the Global Burden of Disease. The World Development Report 1993 engaged with a comprehensive and comparative study of the health loss across the world for developing objective assessments of the likely benefits of application of health interventions packages. For this purpose, the Global Burden of Diseases,

Injuries, and Risk Factors Study (GBD) was started by the Bank to do a comprehensive assessment of human health. (Murray and Lopez, 2017). DALY was introduced as a metric of calculating premature mortality and loss in functional health in population because of disability and death in the GBD study in 1990. As noted by Tichenor and Sridhar (2020) DALY was used to provide a "punchy, useable language for justifying public and private, national and international investment in health" (Tichenor and Sridhar, 2020 p.4).

In a recent article by Murray and Lopez (2017) [57] describe the study

> "as a systematic scientific effort to quantify the comparative magnitude of health loss from diseases, injuries, and risks by age, sex, and population over time. The goal of the study is to provide decision makers at the local, regional, national, and global level with the best and most up-to-date evidence on trends in, and drivers of, population health so that decisions are ultimately more evidence-based" (Murray and Lopez, 2017 p.1460).

Since its inception, both GBD and DALYS have continued to be used by various governments and development community. The World Health Report 2000 which presented an index of national health systems' performance compared disease burden estimates by applying DALY to quantify the health gap (World Health Organisation, 2000). Till 2017, the GBD study covered 195 countries, additionally it has done with sub-national assessments at sub-national level for twelve countries.

In India, a State-Level Disease Burden Initiative was launched in October 2015. Three premier institutions including the Institute for Health Metrics and Evaluation (IHME), and the Public Health Foundation of India (PHFI) and Indian Council of Medical Research (ICMR) conducted this study along with stakeholder and experts from all over the country. This study provided a comprehensive assessment of the causes of ill-health and premature deaths at sub-national (State) level. It included studying the risk factors for diseases burden, their trends over twenty-six years starting from 1990 to 2016. The findings of this study contributed to the 2016 GBD Study providing estimates from eighty-four risk factors and 333 disease conditions and injuries for each State (ICMR et al., 2017).

[57] Alan D Lopez and Christopher J L Murray, who were among the key individuals involved in producing and disseminating GBD (Tichenor and Sridhar, 2020)

Reference and use of DALYS for justifying investments in specific health systems interventions have existed in many of World Bank's assisted projects in India. For example, the DOTS strategy in the Tuberculosis programme in India was introduced based on its cost-effectiveness per DALYS saved. The Bank's Disease Control Priorities Project, found the DOTS strategy to be the most cost-effective among all other available interventions for improving health in LMICs and thus suggested RNTCP to be least costlier per DALYs gained in comparison to other health intervention (World Bank, 2006f). Usage of DALYS gained more legitimacy after the 2016 GBD study. Successive national health policies and plans used DALYS for monitoring disease burden and setting health priorities. For example, the National Health Policy, 2017 had a specific objective to, "establish regular tracking of DALY Index as a measure of burden of disease and its trends by major categories by 2022" (Government of India, 2017). Use of DALYS for informing health policies by creation of robust systems for disaggregated data has also been emphasised by the NITI Aayog) which is leading thinktank of the GoI (NITI Ayog, 2019).

6.3 ROLE OF THE WORLD BANK IN OPERATIONAL ASPECTS OF HEALTH GOVERNANCE: IMPLEMENTING OF IDEAS

6.3.1 From production of ideas to setting health governance discourse

As discussed in the previous section, Bank has diffused HSS and governance ideas through the project lending and technical assistance work in the countries. This section will examine the process for diffusing the ideas under the project and technical assistance work. It will draw attention to the structural and ideational power mechanisms used by the Bank to participate and influence health governance in India. It argues that through financial assistance in the form of project lending, Bank exercised not just the structural power but also the ideational power through the components of technical assistance inbuilt in these projects.

The ideational power is exercised through the policy advice and technical assistance (both inbuilt in projects and outside projects) pushed by the Bank while positioning itself as a technical actor. As the policy advice and technical assistance is backed with 'extensive research' (produced by the

Bank) and financial resources coming through project loans, the ideas diffused by the Bank gain more legitimacy.

For example, the idea of reforming public sector has been diffused through policy advice or technical assistance provided by the Bank. Bank has consistently pushed public sector reforms by setting a discourse on 'the poor-quality and ineffectiveness of governments' in providing health services. This discourse was built through pushing these ideas in different documents produced by the Bank followed by provisioning of financial resources and technical advice for reforming public sector in countries.

Setting the discourse on governance has been a major tool for the Bank to operationalise governance policies. Bank's engagement with governance dates back to early 1970s, however, its positioning on the effectiveness of governments in health provisioning has been consistent from 1980s. According to Diarra and Plane (2014) from 1950s to 1970s Bank supported State welfare principles and encouraged governments to lead the development process. It is after 1980s after the appointments of Claussen and Krueger that the Bank started to use its financial power for supporting the market rules to spread a free market perspective.

Poor-quality of government was first emphasised by the Bank as a central issue developmental in 1983 in the World Development Report (World Bank 1983). In this report, the section on, 'Management in Development, outlined the appropriate role, size, and managerial efficiency of the government (World Bank 1983). The Bank defined Public sector management as largely technical concerned[58] with changing the overall organisational structure of public sector encouraging a renewed model "which requires a smaller State equipped with a professional, accountable bureaucracy that can provide an "enabling environment" for private sector-led growth, to discharge effectively core functions such as economic management, and to pursue sustained poverty reduction" (World Bank, 1994a p.24).

[58] changing the organizational structure of a sector, agency to reflect new objectives. and to retrain staff; making budgets work better through better integration of capital and recurrent components; sharpening civil service incentives through new pay and grading structures. or placing public enterprise managers under performance contracts. Behind the emphasis on PSM as a key dimension of governance is the"-growing conviction that an efficient government is a sine qua non for sustainable economic growth

Reasserting these governance reform in different forms of documents ranging from country specific policy documents to global World Development Reports legitimised these ideas which facilitated its uptake in the country specific plans. For example, Bank's recommendation for increased participation of private sector in provisioning of healthcare services appeared in 1987 in a health sector policy paper and then in 1992 in the India specific health policy document followed by its re-enforcement in 1993 in World Development Report. These recommendations were then diffused and implemented through Bank's health sector projects in India. The financial support for implementing these recommendations played a big role in facilitating the normalisation of these HSS ideas. Over the years Bank's approach in the dimension of public sector management has strengthened with project-linked institutional strengthening (World Bank, 1994 p.3).

These shifts can easily be traced in the governance discourse in health sector in India. In India, Bank exerted this ideational power through diffusing the ideas of required administrative shifts in policy documents. These ideas were then implemented through policy-based funding in project loans from the Bank pushing for initiation of the structural adjustment reforms and adoption of the market-oriented macro-economic policies. Bank's policy-based funding tied to structural reforms helped it emerge as the strongest global actor involved in administrative reforms in 1990s.

Bank's 1992 document titled "India : Health care financing: coping with adjustment- opportunities for reform" (World Bank, 1992a) clearly outlined the dictates of Structural Adjustment Programmes (SAPs) and provided India specific recommendations aimed at reforming India's health sector. Similarly the World Development Report in1993, titled 'Investing in health' outlined strategies for health sector in 'low-income economies' reinforced these prescriptions (World Bank, 1993). The major recommendations of these reports included a reduced role of the State in provisioning of health services, provisioning of only a set package of selected services and levying user charges at the point of service delivery. These recommendations were contrary to India's effort of universal provision of healthcare services to all its citizens regardless of their ability of pay. Central government was advised to "place the highest priority on assisting States, especially the poorer States, to increase spending on non-salary inputs, such as drugs. Otherwise efficiency of Primary Health Care will sink so low that, in many of the more poorly served areas, the service will collapse altogether" (World Bank, 1992a).

According to Qadeer and colleagues (1994) Bank's analysis on the main reasons for the ill functioning of the health sector in India include " too much reliance on direct provision of services

and central control of health facilities and not making the use of the financial, informational and regulatory mechanisms present at the disposal of government" (Qadeer et al., 1994 p.16).

These believes were echoed in the above-mentioned seminal development report of the Bank published in 1993. According to Abbasi (1999) this report acknowledged four main issues with the international health systems which included "misallocation of funds to less cost-effective interventions; inefficient use of funds, such as purchasing brand name drugs, inappropriate deployment of medical staff and under-utilisation of beds; inequity in access to basic health care; and the explosion of healthcare costs outpacing the growth in income" (Abbasi, 1999a p.869).

Given these issue, the Bank recommended a shift in the government's investments toward the public health care and away from the tertiary level care. It promoted the engagement of private sector and social or private insurance schemes (Abbasi, 1999a). This report and its recommendations had its origins in the recognition of the systemic constraints encountered by the Bank in provisioning of equitable and efficient health services in 1980s when it had begun directly financing health services in the developing countries.

6.3.2 Implementation of ideas

In order to address the systemic governance constraints and ineffective governments, the Bank strove to initiate health governance reforms at national and sub-national (State) level. The engagement of the World Bank with the national government started from the 1970s but 1990s marked beginning of the Bank's enhanced participation in health systems governance in India (see chapter 5). 1993 marked the beginning of the Bank's direct engagement with sub-national health systems in India which gave an added opportunity to the Bank to implement its ideas and influence health systems development trajectories in the States while easily bypassing the Central government.

The first State health systems development project for Andhra Pradesh was also conceptualised in the same year (1993) as that of the rolling out of WDR. The governance ideas and recommendation suggested in the WDR were transferred to the health systems development project concept document. For example, as mentioned in WDR, the project document recognised similar issues in India. It included in its design several services that had not yet been provided in any other International Development Association (IDA) financed project in the HNP sector. The project was made effective in 1995 and named as 'The APFRHSP. Following this project in the next year in

1996, the largest health systems strengthening project was implemented. This project covered three States that are Karnataka, Punjab and West Bengal. By this time, one year into the implementation of this project, Bank has issued its Health, Nutrition and population strategy in 1997. This strategy was issued within the broad Human Development Network and made a cumulative commitment of $11.6 billion for HNP activities. The strategy identified "the Bank's strengths in the sector vis-à-vis the international community as its global expertise from the developing world, its multi-sectoral, macro-level country focus, and its ability to mobilise large financial resources, either directly or through partnerships"(World Bank, 2007 p.3). All the health systems development projects reflect the diffusion of these ideas through different reform strategies implemented during the execution of these projects.

Creation of (new) HSS knowledge by the Bank facilitated its role in diffusion of HSS ideas. For example, Bank claims that for the first five - Population projects, it did not have much say in influencing population policy in India. It then undertook a series of sector studies to understand the problems in India's population programme[59]. These studies helped in creating evidence for need as well as strategies for governance reforms in India. Bank then used these studies to negotiate policy advice with the Indian government. In January 1987, the Bank and Government of India agreed on a 'sector strategy' through which Bank could guide future operations in the population field under an evolved Bank- Borrower relationship between the Bank and India.

It is after the production of this evidence through the studies that by the sixth population project launched in 1989, a long-term strategy for the Bank was initiated with regards to its role in India. With the later, health systems projects too, the Bank has used a similar approach of creating ideas and diffusing these ideas through project lending. For example, Bank influenced existing strategies of disease control in most of the disease-specific projects in India. It justified the changes in the

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World Bank health sector studies 1988-98

- Family Welfare strategy in India: Changing the Signals, 1989
- Strengthening the role of Non- Government Organisations in Health and Family Welfare Programme in India, 1990
- Population and the World Bank: A review of activities and impacts from eight case studies, 1991
- India: health sector financing coping with adjustment – opportunities and reform, 1992
- India: policy and finance strategies for strengthening primary health care services, 1995
- Improving women's health in India, 1996
- India's Family welfare programme: Towards a reproductive and child health approach, 1996
- India: New directions in health sector development at state level: an operational perspective, 1997
- India: wasting away, the crisis of Malnutrition in India, 1998

disease control priorities as well as strategies by citing the evidence it has created or borrowed. According to Ridker and Musgrove (1999) notes that most of the disease-specific projects of the Bank were based on the experience of previous projects of the Bank in other countries.

Bank's Malaria project in Brazil established that treating Malaria can be more cost-effective than trying to prevent it, and that nearly all the gains come from preventing deaths, not simply cases (Akhavan, Abrantes, Gusmao, and Musgrove, 1998 cited by Ridker and Musgrove, 1999). The AIDS control projects in Brazil, Thailand, and several African countries demonstrated the importance of concentrating on high risk groups and of adapting IEC to particular sub-populations (Ainsworth and Over ,1997 cited by Ridker and Musgrove, 1999). Using its 'knowledge' of 'global experience' the Bank diffused these ideas and prompted changes in strategy and technical approach by bringing the world experts to work in each disease project (Ridker and Musgrove, 1999). Resultantly, intervention strategies for these projects were exported and not tested locally or based on local knowledge. Selectively based in most cases these interventions were based on their cost-effective value. For example, the very first disease-specific project on HIV/AIDS estimated the cost for six major project interventions which included sex worker intervention, STI management, interventions for high risk men, VCTC, youth interventions and MCTC, and selected the sex worker, STI management, VCTC and interventions for men at high risk as they were found to be more cost-effective.

Similarly, by the second disease-specific Leprosy project in 1994, Bank's publication in 1993 "The Disease Control Priorities in Developing Countries: An overview" was ready to suggest alternate cost- effective interventions for handling major infectious diseases in developing countries including Leprosy (Jamison et.al and World Bank, 1993).This 'knowledge' was picked up to be diffused through the upcoming Leprosy project aiming at eliminating Leprosy as a public health problem by the year 2000. The project aimed to reduce the prevalence of Leprosy from twenty-four per 10,000 population to one per 10,000 population. However, mid-term review of the project highlighted that the original target of reducing prevalence to one per 10,000 populations was over-ambitious and the objective was changed from three to four per 10,000 populations. The other objective of reducing the impact of Leprosy related disability was completely dropped as the focus on the inputs in the area of disease elimination were found to be more pressing and also because of the notions of comparative advantage of the private sector in this area (World Bank,

2001).Targeted interventions in some cases replaced the cost-effective interventions and formed the cornerstone of the second AIDS control project[60]. Although Mother to child transmission (MCTC) was found to be less cost-effective than the upstream interventions in the infection chain, it was picked up by NACO for large-scale implementation.

Not just the priorities in selecting areas or issues for lending but also the intervention of the existing health programmes were influenced (changed) by the Bank's through its disease-specific projects in India. All these changes were made in the pretext of 'global experiences', 'global knowledge' and 'global best practices' generated by the Bank in other countries. This knowledge diffusion through the disease-specific projects meant replacement and, in few cases, a complete shift in the core strategies of the existing National Health Programmes. This shift can be read as a major influence at the technical level exerted by Bank and the larger policy network comprising other donors and private sector enterprises like pharmaceutical agencies.

Replacement of existing drug treatment in Tuberculosis control project in the form of Long-Course Chemotherapy (LCC) with a (new) intervention, 'DOTS' was justified as internationally-recognised strategy for diagnosis and treatment of Tuberculosis. A series of pilot projects were started in India since 1993 to test this approach. These pilots were financed by SIDA and DFID and received technical assistance from DANIDA and WHO. The results of the pilots were cited to be encouraging[61] to recommend DOTS (World Bank, 2006f). Bank's Blindness control Project also replaced the so-called 'outdated methods' of Intracapsular Cataract Extraction (ICCE) with the (latest) technology of Extracapsular Cataract Extraction (ECCE) with intraocular lens (IOL) implantation. This change was recommended on the basis of pilot projects implemented by DANIDA in India between 1988 and 1992. The finding from these pilots suggested that this approach is effective in increasing reliability, expanding coverage and improving the quality of service provisioning in the periphery (World Bank, 2002d). Similarly, the Malaria control project, new strategies were introduced to the existing national health programme which involved shifting the focus from the mosquito control to prevention and treatment of human cases. These strategies

[60] The targeted interventions were directed at high-risk groups, including SWs, MSM, IDUs and truckers, migrant labor and street children. It included a package of prevention services like (i) Behavior Change Communication (BCC); (ii) condom promotion through free distribution and social marketing; and, (iii) treatment of Sexually Transmitted/Reproductive Tract Infections (STI/RTI).

[61] In the span of three years, the pilot projects reported to have treated close to 16,000 patients in a population of roughly 12 million, with cure rates as high as 92% in some of the pilot sites and an average of 80% for all the sites. These cure rates were found to be much higher than those achieved using the standard chemotherapy treatment, which WHO had estimated at about 35% in the public sector (World Bank, 2006f).

were also stated to be based on lessons learnt from previous Malaria control projects and on extensive interaction with international organisations (World Bank, 2002b). New strategies involved reducing reliance on existing strategy of indoor residual spraying with more targeted spraying of insecticides determined by epidemiological stratification and increase in use of non-insecticide vector control methods such as larvivorous fish and biolarvicides (World Bank, 2002b.). IDA financed selected insecticides, vehicles, equipment, training, consultant services, and operational research. However, this selective vector control strategy was noted by the project implementation report to be lacking sufficient quality of spray operations given the decentralised design of the project (World Bank, 2002b).

6.4 GOVERING THROUGH NETWORKS: LEGITIMISATION OF IDEAS

This section engages with second aspect of the health 'governance' that is the governance of the health systems. It examines the participation of the Bank in the area of health systems governance. It studies the participation of the Bank in different policy networks across the levels and domains of health governance and analyses the functioning of the Bank under the frame of network-governance. Harman (2010) suggests the theory of 'multi-sectoralism' to understand the functioning of the Bank in health systems. While discussing the role of Bank in setting global HIV/AIDS agenda ,she describes multi-sectoralism as the involvement of all aspects of the State, public and private sector, civil society and the individual within the global response to HIV/AIDS as a means of addressing the complexity and exceptionalism of the disease (Harman, 2010). Adapting from the theory of 'multi-sectoralism', policy networks and network-governance, this section shows that the Bank works through policy networks comprising of national and sub-national Bilateral and Multilateral agencies, governments, philanthropic organisations, academic institutions and private sector including profit and non-profit sector. Functioning through policy-networks facilitates the diffusion and legitimisation of Bank's knowledge and resultant exertion of its ideational influence. The following section discusses the Bank's participation in few of the health policy networks working at different levels of health systems including the global, to national and sub-national levels and in different domains of work including the evidence

generation (research organisations and policy thinktanks); and policy implementation (government, donors, civil society organisations).

6.4.1 Policy network across global organisation

Bank has developed strategic partnerships with varied organisations at the global and country levels to facilitate the diffusion and implementation of its HSS ideas. For example, in 1994, after a review meeting of the World Bank and World Health Organisation, a strategic partnership was developed between the two organisations for implementing health development. The recommendation for implementing this partnership was outlined in Bank's 1995 document titled 'WHO/World Bank Partnership, recommendations for action for health and development' (World Health Organisation et al., 1995). This partnership highlighted the collaborative working of the two organisations at two levels. First was at the country level in which WHO technical expertise was to be mobilised to improve the design, supervision and evaluation of Bank supported projects. And second was at the global level where the WHO and the Bank were to come together to advance international understanding of health, nutrition and population issues. The strategy paper outlined its focus on building the capacity of member States to be an effective coordinator to manage external support effectively. The document outlined actions for both the global originations and the country government. It recognised the strengths of both organisations in strengthening the policy networks and noted that this cooperative mechanism

> "would not only enhance WHO/World Bank collaboration but also provide an opportunity for other agencies to participate in support of national health strategies and ensures a timely exchange of information between all level of WHO. Such coordinated effort will make the task of collaboration with World Bank much easier. WHO with its network at global, national and country levels, is in a unique position to facilitate join WHO/World Bank /Government collaborations" (WHO and World Bank, 1996 p.7).

The Bank claims that over the years it has collaborated with the United Nations in almost all sectors and regions. These partnerships (as claimed by the Bank) deepened after the international development community has adopted the MDGs. In addition to the WHO, in the areas of health, UNDP, UNICEF and UNFPA continue to remain the most significant partners of the Bank. In

terms of the Multilateral development Banks, the World Bank works in partnership with all four of the Regional Development Banks that is the Asian Development Bank, the African Development Bank, the Inter-American Development Bank Group and the European Bank for Reconstruction and Development and. In addition to this, it has partnered with many other Multilateral development institutions and Banks that provide lending to developing countries. Few of these include the European Commission and the European Investment Bank, the Nordic Investment Bank and the Nordic Development Fund and the OPEC Fund for International Development. Its partnership also exists with various Sub-Regional Banks (also known as Multilateral Banks) established for development purposes, like, Central American Bank for Economic Integration, Caribbean Development Bank, West African Development Bank and East African Development Bank (World Bank, n.d.).

In terms of collaborations with Bilateral aid agencies Bank launched a Comprehensive Development Framework (CDF) in 1999 stressing that for successful development, there is a need for partnerships among development agencies, government, the private sector, local communities and the civil society (Wolfensohn and Fischer, 2000). This framework was launched after the 1999 Annual Review of Development Effectiveness (ARDE). The ARDE aimed to use the principles of CDF (including effectiveness of development assistance by national processes and institutions) to examine the development experience in the context of the changing global environment under globalisation (Hanna and Agarwala, 2000). In the section on questions regarding the working with and changing relationships with the development community, James Wolfensohn, the past president of World Bank answered that

> "Prior experience, and early experience from some of the CDF countries, shows that Bilateral donors are keen to move toward greater cooperation to avoid the duplication of analytical work, and to harmonise their processes for appraisal, monitoring, and evaluation - thus increasing their efficiency and reducing the workload for countries" (Wolfensohn, 1999 p.11).

Under this framework, it was proposed that "each agency will remain individually accountable, according to its own standards, for carrying out its agreed contributions. However, effective

partnerships, essential for the success of the CDF approach, require active nurturing of mutual trust and confidence among the players"(Wolfensohn, 1999 p.11).

Partnerships with Bilateral organisations existed much before the launch of this framework but CDF reflected "a growing consensus on the key ingredients for improving the effectiveness of development assistance through a more comprehensive and participatory approach than during the planning era of the 1960s and 1970s or the adjustment era of the 1980s" (Hanna and Agarwala, 2000 p.5). The actual roles and working of these partnerships at the country level were said to be developed as per the country context. However, a matrix of action for each actor was given in the document and four major actors (called as players) involved in policy process at the country level were identified. These actors (as mentioned in the framework proposal) included: "i) the governments at national, State, city municipal, within each country, regional groupings of governments, ii) Multilateral and Bilateral agencies, iii) Civil society in all its forms and iv) Private sector, domestic and foreign" (Wolfensohn, 1999 p.12). Parliamentary bodies were added as an additional element of government and a representative of civil society (Wolfensohn, 1999). As stated on Bank's website, Bank's partnership with Bilateral aid groups over the years have included:

> "Australian Agency for International Development, Austrian Development Agency, Canadian International Development Agency, Danish Development Agency, Department for International Development Cooperation (Finland), Agence francaise de developement, Deutsche Gesellschaft fur Technische Zusammenarbeit (GIZ) GmbH, Ireland Development Cooperation, Japan Bank for International Cooperation, Japan International Cooperation Agency, Kreditanstalt fur Wiederaufbau, Netherlands Development Cooperation, New Zealand Official Development Assistance, Norwegian Agency for Development Cooperation, Swedish International Development Cooperation Agency, Swiss Agency for Development and Cooperation, Swiss State Secretariat for Economic Affairs, UK Department for International Development, US Agency for International Development agency partners" (World Bank, n.d.).

Similarly, for philanthropic organisations, as per 2018 estimates, Bank has partnerships in almost hundred foundations all over different regions of the world. Among these partnerships,

> "The Bill & Melinda Gates Foundation is the Bank's largest philanthropic funder, funding programmes in the areas of agriculture, health and nutrition, water and sanitation, financial inclusion, and gender equality. Other major philanthropic partners include the United Nations Foundation, the Mastercard Foundation, the Children's Investment Fund Foundation, the Rockefeller Foundation, the William and Flora Hewlett Foundation, the Aga Khan Development Network, Bloomberg Philanthropies, and the Open Society Foundations" (World Bank, n.d.).

Partnerships with parliamentarians

Parliamentarians are treasured partners for the Bank as "they enact laws, debate and approve foreign aid budgets and loans, shape and review development policies, and hold governments accountable for World Bank-financed programmes…through its engagement with elected representatives, the Bank effectively integrates citizen voice in its programmes to achieve lasting and inclusive development results" (World Bank, n.d.). Several mechanism are applied by the Bank to engage with parliamentarians. Few of these mechanisms include holding conferences and workshops, arranging for field visits for having a first-hand experience of the working of Bank's programmes and holding consultations to consult MPs on CDF and the World Bank's policies like gender and safeguards. Spaces and platforms like the Parliamentary Network on the World Bank and IMF, an inter-parliamentary. independent organisation working towards improving accountability and transparency in International Financial Institutions (IFIs), provide a channel for parliamentarians to share experiences and ideas, and advocate for addressing development challenges like reducing poverty and improving inclusive growth. As per Bank's own records, parliamentarians from more than 140 countries have participated in this network engaging with the development and macro-economic challenges national and globally (World Bank, n.d.). Another such tool to engage parliamentarians is through the World Bank Group's Global Young MP Initiative which is a programme for young members of parliaments from around the globe to promote issues such as human capital investments and youth jobs creation (World Bank, n.d.).

6.4.2 Policy network at national level

At the national level, Bank has operated through the policy networks comprising of civil society organisations, national and sub-national governments, and private sector. Ridker and Misgrove (1999) have noted that, in India working directly with the States gave Bank an added "opportunity to influence more fundamental determinants of functioning of public health system as Bank had more leverage to provide assistance tailored to the vastly different circumstances in different States" (Ridker and Musgrove, 1999 p.6).

The Bank enables an enhanced participation of different actors in the working of policy networks in India through project funding. It operates as a facilitator and knowledge broker to build consensus among the national and sub-national government and private sector on objectives of the projects, design and technical framework for disease control projects. For facilitating its knowledge brokerage role, it has created intermediary organisations under various health systems projects. The role of the Bank in enhancing the participation of private sector is discussed in more detail in the chapter five under administrative reforms. However, the main component of enabling the functioning of policy networks included setting up of new autonomous agencies and roping in of the existing associations in the functioning of existing projects to meet the projects goals. For example, Bank mandated nearly all disease control projects with the task of managing and monitoring government's partnerships with NGOs. Example of such organisation include, International Federation of Anti-Leprosy Associations (ILEP) under Leprosy control programme. Leprosy project included component of redefining the role of NGOs in the context of integration with the health systems functions. Autonomous associations like Indian Medical Association were roped in to provide training and facilitate coordination with private practitioners in this project.

In the Blindness control project, under the component on institutional capacity building, the project focused on developing mechanisms for cooperation between the government and private sectors. In the area of service delivery, special emphasis was made to develop mechanisms to strengthen the engagement of the private and NGO sector to improve outreach coverage and to increase access to patients in peripheral areas. National Program for the Control of Blindness "sought to expand their coverage by providing field-based NGOs and private sector partners recurrent and nonrecurring grants to assist the government in reducing the backlog of cataract blindness" (World Bank, 2002 p.5)

Similarly, in the Malaria project, private sector was initially involved in mainly distribution of Insecticide Treated Bed nets. Arrangements of public-private partnerships like provision of vouchers in public facilities and purchasing of nets in private sectors at subsidised rates were considered as options for increasing private engagement. NGOs, private sector, social marketing agencies and community groups were identified as the potential agents for creating a sustainable private market for the commodities for Malaria control. By institutionalising these agents, it was hoped that the need for bulky centralised procurements would decrease. However, it was later noted that the "progress in distribution of nets through private sector channels remained limited and the project was unsuccessful in improving the quality and accessibility of Malaria treatment in the private sector (World Bank, 2006 p.12).

Tuberculosis project also followed the same strategy as that of Leprosy to deliberately create a space for private sector takeover of specific components of the project. During the restructuring of this project, the component on extending the programme's reach to TB patients in the private sector was completely dropped so that it is left for the private sector. With this change the indicators on measuring the performance of private sector engagement like "TB patients receiving care in the private sector notified to the government" and "Public-private interface agencies (PPIA) contracted" were also dropped. The reason cited for dropping these indicators was that the RNTCP programme was now implementing the same interventions in partnership with States, municipalities, and development partners such as the BMGF and USAID and thus IDA resources were not needed. According to the implementation completion report the modalities and approach for engaging the private sector were not yet figured out at the time the project was restructured and there was no consensus in the government for the project to continue supporting this sub-component (World Bank, 2006f).

This involvement was met through establishment of partnerships and contracting out relationship between NGOs or private contractors and the government implementing agency. It has been noted in the implementation report that "contracting out support services to private sector and involving NGOs in providing health services in remote areas has proven to be cost-effective and markedly increased patient satisfaction" (World Bank, 2004 p.9-10). Claims were made that through this practice, the State Governments have expressed more acceptance and appreciation of role of private sector in providing support services and NGOs in delivering clinical services to the poor

and shown intention to continue and expand involvement of NGOs and the private sector (World Bank, 2004).

Though Bank alone cannot specifically be held responsible in the complex policy network for the larger shifts in governance reforms and decentralisation policy but when it placed certain conditions before India for granting loans, it explicitly coerced India to make the changes as it desired and thought successful. For example, for obtaining the first disease-specific IDA loan for HIV/AIDS project, the creation of an autonomous NACO was put as pre-condition by the Bank for granting loan. This condition left no choice with the government then to go ahead to make the desired changes in the governance structures and mechanisms by creating a parallel administrative organisation like NACO.

NACO was held responsible for implementation of HIV/AIDS control efforts and it was believed that its autonomy with the status of quasi-government organisation would lead to a more effective and efficient implementation of the programme. However, as noted by Priya (1994) this might have been true in the short-term because the programme was initiated in a haste, but this move had several negative implications for the larger governance structures. The biggest of these implications was the branching off of the government structures into semi-government structures. This change meant that the funds were directly routed to this organisation by foreign donors sometimes bypassing the Ministry of Health. This change also meant creating a separate division in ministry and health thereby diverting attention from strengthening the general health services (Priya, 1994).

Formation of such quasi-government autonomous bodies were not only limited to the HIV/AIDS project but it was an inbuilt component of nearly all of Bank's projects. Other disease-specific and health systems projects supported by Bank like Leprosy elimination project in 1994 and Tuberculosis control project in 1997 also established state and district Leprosy and Tuberculosis societies and funds were routed from the State societies to the district societies. As a result, the role of State in these different projects got diluted. This growing confusion in the role of States was noted by the project implementation completion report of the Tuberculosis project.

Though on one side, Bank has promoted the engagement of private sector in public health systems in India through various mechanisms of contracting in and contracting out, on the other side its

sister organisation called the International Finance Corporation (IFC)[62] has invested in the private sector directly. Through IFC, Bank has exclusively focused on strengthening private sector in health by creating markets for addressing development challenges through its own resources and resources of other institutions (International Finance Corporation, 2016a).

IFC started to work in India in 1956, till 2018 its investments have grown to more than 400 companies including own financing as well as mobilisation of funds from other sources. Few of the loans as complied by Chakarvarthi et.al (2015) are presented in table 6.2. As of June 2018, in India IFC's total (committed) portfolio is more than $6 billion US dollars (International Finance Corporation, 2016b). Apart from investing in companies directly , IFC has also invested in private investment funds targeted at hospitals and healthcare industry in Asia including India[63]. According to Chakarvarti et.al (2015)

> "IFC's investments are closely aligned to the World Bank Group's strategy for private sector healthcare in India. It actively engages with and promotes the private sector in the name of increasing and improving access to affordable, quality health services, particularly in low-income States and Tier II–III cities" (Chakravarthi et al., 2015 p.54).

[62] IFC—a sister organization of the World Bank and member of the World Bank Group—is the largest global development institution which claims to advance economic development and improve the lives of people by encouraging the growth of the private sector in developing countries.

[63] IFC has also made investments in healthcare companies in Africa, in which Indian healthcare companies are partners such as ISO Health hospital in Kenya, whose shareholders included three Kenyan doctors, financial investors—IFC and the Abraaj Africa Health Fund—and NH, the strategic operating partner, which through its wholly owned subsidiary held 26% stake. ISO Health was to set up a greenfield 130- bed multi-specialty hospital in Nairobi. CIEL Healthcare Ltd, a Mauritius registered company, invests in tertiary hospitals across sub-Saharan Africa, in association with Fortis Healthcare (Chakravarthi et al., 2015)

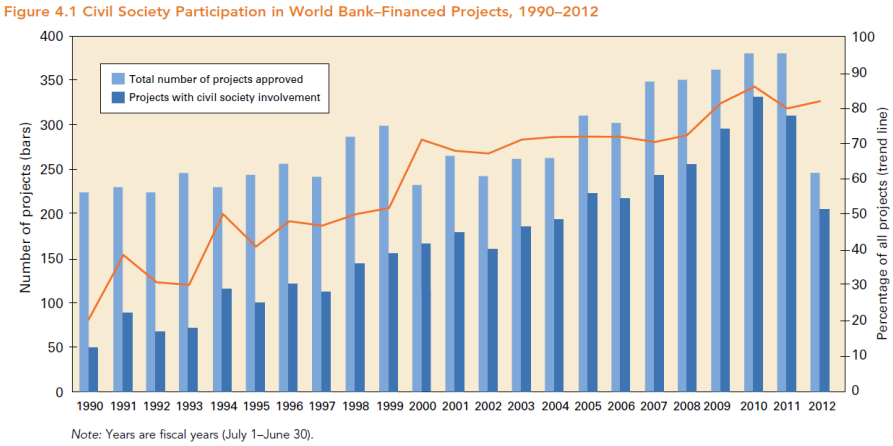
Table 6.2- IFC Investments/Loans to Healthcare Companies in India	
Company	Year of IFC Investment
Duncan Gleneagles, Kolkata	1999
Apollo Health Enterprises Ltd (AHEL)	2005, 2010, 2012, 2016
Max Healthcare, Delhi	2003, 2007, 2009
Rockland Hospitals, Delhi	2008
Super Religare Laboratories Ltd (SRLL)	2012
Zulekha Hospitals UAE*/Alexis Hospital, Nagpur	2012
Fortis Healthcare	2013
Global Hospitals, Hyderabad	2013
Nephropolus Health Services, Bengaluru	2014
EYE-Q Vision Private, Haryana	2015
Ivy Hospitals, Punjab	2015
Portea Medical, Bengaluru	2015
STS Chittagong Hospitals, Bangladesh (joint. venture with AHEL)	2015
Healthcare Global Enterprises (HCG), Bengaluru	2016
Regency Hospital, Kanpur	2016
Source: (Chakravarthi et al., 2015) Compiled from www.ifcext.ifc.org, www.ifcextapps.ifc.org. Disclosed Projects, retrieved on 5 August 2016.	

In addition to strengthening the private for-profit corporate sector through IFC, Bank has also engaged with private not-for profit sector including the Non-government, Civil society and Faith based organisations to legitimise its position in the policy networks. It has engaged CSOs in policy dialogue on its health policies for several decades and through this has gained their trust as a significant actor in health.

Globally, involvement of CSO in projects funded by the Bank has risen steadily, from around twenty percent in 1990 to nearly seventy percent in 2003 and nearly eighty percent in 2013 (see figure 4.1) (World Bank, 2013b). This engagement was formalised through a series of 'Health Roundtables'[64]. In 2010 a 'CSO consultative group' was created on the Bank's HNP work. It has partnered with NGOs and CSOs in three main forms. First is through directly supporting their training or providing technical assistance. Second is through encouraging NGO to participate in projects as subproject sponsors or intermediaries. And third is by sub-contracting them for specific activities under projects like service delivery for outreach activities (OED, Social Funds: Assessing Effectiveness (2002c) cited by (Operations Evaluation Department, 2002).

[64] The first roundtable, held in March 2010 in Washington, brought together Bank staff and senior-level representatives of U.S.–based CSOs for an informal discussion of Bank health policies. The second, in Brussels in April 2010, involved European CSOs. The third, held in Nairobi in October 2010, provided the opportunity for the Bank to hear the perspectives of CSOs from Africa, Asia, Latin America, the Middle East, and Central and Eastern Europe. After this meeting, the Bank and CSO representatives finalized the terms of reference for and launched the World Bank–Civil Society Consultative Group on Health, Nutrition, and Population.

Figure 4.1- Civil Society Participation in World Bank-Financed Projects, 1990–2012



Source : (World Bank, 2013b)

In India, CSOs have been extensively consulted in forming Bank's Country Programme Strategy (CPS) for India[65] and also in implementing projects. CSOs have been engaged in the roles of implementers, verification monitors, technical support providers and impact evaluators. This involves working together of CSOs and government actors and creating effective public-private partnerships for health programmes in India (see chapter 5 for more details).

6.4.3 Policy network in research and evidence generation

Another significant part of Bank's working is through its participation in policy networks across the policy continuum. This includes organisations involved in evidence generation (research & thinktanks) for policy formulation, to organisations involved in negotiating policy ideas to develop policies, to organisations and institutions involved in policy implementation (government, donors, civil society organisations). In other words, Bank collaborates as much with epistemic communities involved in creating knowledge or tools of governance or giving policy advice to governments, as much it collaborates with organisations responsible for implementing policy ideas.

[65] During 2011, more than 200 CSOs representing a range of sectors participated in consultation meetings, held in Assam, Chhattisgarh, Karnataka, Mumbai, and New Delhi.

The World Bank partners with a range of global as well as national organisations which are involved in evidence generation through research. Most part of the Bank's policy tools and ideas have been developed in partnerships with such organisations. For example, the health governance metrics tool of the Global burden of disease (see section 6.1) was initially commissioned by the World Bank in 1990 and involved inputs from the Harvard School of Public Health, WHO and the World Bank (Byass, 2017). It has gradually been developed in partnership with WHO and the IHME and other academic partners. Ten years later,

> "this study was updated by WHO for the years 2000-2002 and included a more extensive analysis of the mortality and burden of disease attributable to twenty-six global risk factors using a consistent analytic framework known as Comparative Risk Factor Assessment. The WHO estimates were subsequently updated for the year 2004 in the year 2010" (WHO, n.d.).

Tichenor and Sridhar (2020) have highlighted that the present form of the GBD is supported by four different institutional positions. Highlighting the participation of different kinds of actors in this partnership, they have called these institutional positions "traditional academic population health department", "think tank", "health policy-oriented Multilateral", and "economic-policy oriented Multilateral", the last three referring to the WHO, IHME and the World Bank. They have also pointed to the role of BMGF and private industry in this partnership as the IHME is "governed by the demand for deliverables by BMGF and have privileged access to private industry's data streams because of their ambiguous institutional nature" (Tichenor and Sridhar, 2020 p.6).

Other than the participation of policy networks in developing and implementing governance tools, the Bank has in house research unit which engages with evidence generation to support policy advice to various governments and other stakeholders. The Development Research Group, which is the principal research department of the Bank has expertise cutting across a broad range of countries and development issues. As per Bank's own claims, it is one of the most influential centres of development research in the world. This group specialises in six domains under which human development specialisation deals with the research on health education, social protection, and labour (World Bank, n.d.). While responding to the concerns regarding a controversial working paper (titled 'Do elites capture foreign aid') documenting "that aid disbursements to

highly aid-dependent countries coincide with sharp increases in the Bank's deposits in offshore financial centres known for the Bank secrecy and private wealth management" (Andersen et al., 2020 p.1), the Bank responded that "... The Bank is ranked first among research institutions in development, and our knowledge services undergo extensive review to ensure quality. The Bank publishes almost 400 working papers annually, often as works-in-progress disseminated informally to stimulate discussion and serve as a catalyst for more research" (World Bank, 2020).

CONCLUSION

The World Bank remains a key health policy actor in health governance policy networks in India. It has been a more influential actor than other global health actors because of a multitude of reasons including its financial powers, long presence in India, presence in nearly all other sectors than health including the private sector and presence in sub-national governments. It participates in health governance from both the aspects of governance, that is governing the health systems in India through a network of policy actors as well as the ways in which health systems performs the function of governance along the continuum of HSS. Its participation in realm of both governing the health systems as well as governance by the health systems exist at both the normative and operational level. In terms of governance by the health systems, it participates through knowledge production and diffusion and in terms of governing health systems, it participates through functioning via policy networks.

At the normative level, it participates through production of governance ideas and tools including metrics like DALYS and Human Capital Index, by generating policy evidence through in house and outsourced research as well as through various policy documents and country papers. For this purpose, it works closely with global policy networks in research and epistemic communities comprising of global health actors. At the operational level, it participates in policy networks at national levels involving the national, sub-national government, other global health actors working in the country as well as the non-State actors including private for-profit sector, across the levels of health systems till the institutional (health facilities) and community level (community-based health initiatives and interventions).

To study the process of participation of a single player in the complex network of global health governance is challenging. It is not only difficult to study the functioning of governance networks in the area of as broad as the policy of health systems strengthening or governance, but it is also problematic to delineate the influence of one actor operating in a web of many actors. Such analysis gets further complicated because of the complexities in the functioning of policy actors at different levels, domain of policies and in different sectors of the health system. For an actor like the World Bank, which operates behind the scenes, in a complex network of actors, has presence in many other social sectors, has multiple sister organisations with different mandate, studying its role in governance through examining its participation in different policy networks at different levels and domains of policies provides a good framework for analysis.

DICUSSION AND CONCLUSION

This research is as explanatory research on policy which engages with the 'how' and 'why' questions of the policy analysis. The analytical focus of this study is to understand the global health actors' landscape and their role in HSS policies in India. The study meets its objectives through an embedded case study on the World Bank analysing its participation in HSS policies in India. It is also focused on understanding the associated processes of liberalisation and globalisation which explain the global and national contexts and processes used by the Bank for participating in HSS policies. This research is not an evaluative research aiming to study the impact of Bank's HSS ideas or projects on the health improvements in the people (which would have been a different study, conceivably a policy implementation study at sub-national level or in a population group). However, the impact of HSS ideas of the Bank is studied in terms of its broad public health and health systems strengthening policies discourse.

This discussion is organised in four broad sections. The first part summarises the major findings of the thesis. The second part focuses on the theoretical and the policy implications of the study findings. The third section discusses the major contributions of the study. The fourth and the last section concludes the study and identifies the areas for future research in this domain.

MAJOR FINDINGS OF THE THESIS

This section summarises the main findings of the study. The findings are organised in three parts. First part focuses on the conceptual clarity of HSS and operational framework for studying HSS policies. Second part summaries the landscape of global actors' participation in HSS policies in India. Third part focuses on World Bank and its participation in HSS policies in India.

Understanding HSS

Though the idea of HSS has been used in policy papers since 1980s, the debates on what is HSS, its constituents and boundaries are being debated even forty years later. The attempts for deriving at a consensus on the broad principles and common understanding of HSS started emerging in

early 2010, however the application of this understanding is still not observed in policy-making. Different health policy actors including the global health actors continue to diffuse different ideas of HSS in the health policy networks at different levels of the health systems (see table 1.2). Though there are a few overlaps in the ideas of HSS promoted by the global actors, there exists differences in their approach and resultant support to HSS policies in the countries (they support).

The lack of application of common understanding of HSS is resulting from two factors. One is that the idea of HSS has been conceptualised in a variety of ways by different policy stakeholders. Three broad conceptualisations of HSS have been used by policy stakeholders referring to HSS as a strategy, a goal and a concept (see section 1.2.1). Second factor resulting in the lack of consensus on the idea of HSS results from the varied understanding of health systems by different policy actors (see section 1.3.3). The existence of more than forty health systems frameworks partly explains the existence of varied ideas of HSS among different health policy actors (see section 1.1.1). These three conceptualisation of HSS as suggested in this study present an important framework to bring more clarity in the usage of the term in health systems policies literature as well as in implementation of HSS policies.

As much as a clarity on the framing of HSS (as a strategy or a goal) is important for policy-making, clarity on the components of HSS also needs an urgent resolve. This thesis makes a departure from the debates on the confusion around defining HSS (as put forth in section 1.2.4) around: whether disease-specific initiatives (single-disease, multiple disease or cluster of diseases) should be treated as HSS or not (Marchal et al., 2009); differentiating between supporting and strengthening health systems (Chee et al., 2013); differentiating HSS from 'partial strengthening' (Balabanova et al., 2010); and between activities which contribute only towards improving health outcomes (Shakarishvili et al., 2011a p.3). This study agrees with the conceptualisation of HSS as a continuum given by Berman et.al (2009) and adapts their framework to suggest an operational framework for examining the HSS policies. This operational framework outlined in section 2.3, (figure 2.1) conceptualises HSS as a continuum involving two sets of broad interventions that is: increasing health systems resources and improving process for effective utilisation of health systems resources. The suggested conceptusliation of HSS as a continuum is useful from a policy perspective as it not only puts the diseases-specific versus sector-wide confusions about HSS to

rest but also provides a framework to differentiate between the range of interventions encompassed under the broad concept of HSS.

The suggested operational framework shows the centrality of the idea of 'governance' in the HSS continuum. This study finds the utility of the governance framework as a tool to analyse HSS policies as well as a central function under the continuum of HSS. This study however shows that within the discourse on governance as a tool to analyse HSS polices, the idea of governance has been narrowly conceptualised by the policy actors as only a function of health systems ignoring the broad political economy in which the health systems perform its governance functions. It agrees with the observations made of Greer et.al (2016) suggesting that most of the existing governance frameworks are focused on the desirable attributes of governance. This study adopts understanding of governance by Kickbusch and Gleicher (2013) alluding to the co-production of governance by a wide range of policy actors. This idea of governance is also in agreement with the ideas of Kjær (2004) referring to 'governance beyond government' or ' authority of State'. This thesis uses Rhodes (1997) conceptualisation of governance stating governance as "governing with and through networks" known as 'policy networks' (p. 10).

Though applying the concept of policy network provides useful insights into studying the type of global health actors and the modes of participation of these actors in HSS policies. Policy network framework is not enough to study the ideas of HSS diffused by the policy actors as well as the context which enables the participation of global health actors in HSS policies. For this purpose, the study also adapts from the policy-triangle framework for policy analysis by Gill and Walt (1994) which draws from the political economy frameworks of analysis and incorporates four main concepts of policy that is context, process, actors and content (see section 2.3) to study the participation of global actors in HSS policies in India.

Understanding the landscape of global health actors in India

This study adopts an embedded case study approach focusing on the global health actors as the main unit of analysis and the World Bank as a sub (embedded) unit of analysis (see section 2.5). Focusing on the main unit of analysis, it provides an overview of participation of major global actors in HSS policies in India over the years since independence. Though this study aimed to

examine their role only after 1990s, studying their participation in HSS policies in the early years is deemed important to contextualise their participation.

This study confirms the observations made by Jeffery (1986); Gupta and Gumber (2002); and Duggal (2001) on the role of American philanthropies in influencing India's health policy. It shows that the dominance of American philanthropies HSS policies in India (through differing in their approach to HSS) has completed a circle from pre-independence time to the twenty first century. In between this period of fifty years, different Multilateral and Bilateral agencies have enjoyed their dominance in HSS policies in India. Multilaterals including WHO, UNICEF and UNFPA and Bilateral like DFID, EU, DANIDA, SIDA were significant partners to the governments as well as to private health sector from the 1970s to 1990s supporting a range of disease-specific as well as sectoral health programmes. However, the role of private actors was largely limited to service provisioning during this period. It is after the liberalisation and globalisation reforms that the private sector gained a prominent place in the health policy networks. Their role was enhanced by the existing economic crisis in 1980s and facilitated by other global actors especially the World Bank through deliberately creating a space for their involvement in HSS policies.

Along with the shifts in the landscape of global health actors in policy networks, the ideas of HSS have also seen a shift. The ideas of HSS have shifted from mere increase in resources like goods, equipment, drugs and commodities, human resources to initiating policy reforms in existing administrative structures, introduction and application of management principles in health sector (like cost-effectiveness, performance-based funding, cost-benefit), multisectoral action (like enhanced participation of private sector & CSOs) and a verticalised delivery of health services. This shift in ideas in turn matches with the ideas of dominant policy actors in policy networks. The more the participation of non-State (private) actors increased in policy networks, the more the market principles were diffused and applied in HSS policies in India. This shift demonstrates the ability of policy actors to tilt HSS policies as per their understanding of health systems and their ideological affiliations with regards to the role of State versus market in health system especially in the area of health service provisioning.

Resultantly, the shifts in the ways of participation of global health actors in HSS policies occurred. Their participation in the 1950s was mostly in the area of the direct supply of goods and commodities, placements of consultants or training Indian experts abroad, infrastructure development. These roles shifted to those of global actors' participation in giving policy advice to national and sub-national government. For example, the most of the global health actors especially the large Multilateral, Bilateral and financial institutions got involved in providing technical assistance to the governments through various disease-specific and sector-wide health systems projects post 1990s. Their direct involvement in giving policy advice to sub-national governments has enhanced their role in policy networks and has given legitimacy to their participation in HSS policies.

This thesis affirms the observations made by other global health scholars stressing the changes and growing complexity in global health actors' landscape with the entry, exist and prominence of various global health actors in the past two decades (McColl, 2008) , (Szlezák et al., 2010) and (Hoffman and Cole, 2018). These shifts in actor landscape as well as their modes of operation in India aligns with the shifts in global health actors' landscape at the supra-national or global level. For example, Birn (2014) suggests the dominance of American philanthropies in global health at the international level and this study shows this cycle of their dominance in India level (see chapter 3). The dominance of same global actors at the global and country levels explains the functioning of global health policy networks at the country level and confirms the permeability of governance mechanisms between the supra-national, national and sub-national levels of health systems.

This thesis agrees with the governance challenges in the area of State sovereignty and accountability mechanisms as noted by (Frenk and Moon, 2013) and highlights the policy distortions arising from the dominance of large Multilateral, financial institutions, global PPPs and philanthropies which represent the voices and ideas coming only from the rich and developed nations. The complexity and plurality of actors in policy networks poses a threat to much needed diversity in policy networks in India. Though a range of policy actors operate in these policy networks at the country level, the stronger ones (with better financial resources like the financial institutions and global PPPs) assume a dominant position in comparison to the weaker ones (with low financial resources like grass-roots civil society organisations).

World Bank and its participation in HSS policies in India

The thesis further examines the role of a single global health actor in HSS policies in India though an embedded case study on the World Bank. It studies the specific characteristics of the Bank, its HSS ideas, the tools and strategies it uses and the overall context in which it participates in HSS policies in India. This analysis shows the link between the economics-dominated, market-driven and pro-privatisation HSS ideas of the Bank with its original mandate of providing financial assistance to countries; dominance of economic discipline among staff; mandate of its sister organisations; fund-raising mechanism through private markets and donations; and the dominance of United States in the World Bank's leadership.

It examines the broad 'context' and the overall environment which enables the Bank to participate in HSS policies in India. Using the framework of policy networks, it examines the relationship and negotiations between two policy actors in the health systems policy network in India that is the State (Indian government at both Central and state-level) and World Bank. Following five themes explain the relationships between the Bank and Indian government. Firstly, the chronic scarcity of funds and low allocation to health care budgets in India pushes the government to seek funds and technical assistance from the external global health actors. Secondly, the perceived lack of technical knowledge in public health officials in India creates an opportunity for the Bank to diffuse its technical knowledge and legitimise its supremacy as a technical adviser in HSS policies in India. Thirdly, the rigid administrative structures in public health systems in India encourages governments to seek (flexible and untied) funding from the Bank. Fourthly, the personal and professional interests of policy stakeholders (like demonstrating leadership skills through external projects) in government as well as in the Bank (like experimenting innovative ideas) act as a motivational factor for seeking and providing external aid and assistance. Lastly, the foreign policy and diplomatic relations under which India obliges to maintain international trade relations and commitments to international health goals enables the participation of external actors in domestic health policies.

The next part of the study discusses the HSS ideas diffused by the Bank through its health sectors projects and technical assistance in India (see chapter 5). The Bank has diffused HSS ideas along

the HSS continuum of increase in resources and improvement in processes. Under increasing resources, infrastructure development remained the most important idea of the Bank for HSS especially before the 1990s till its role in the policy advice sphere got more prominent. Human resource development also constituted an integral component of Bank's health systems projects. However, in the area of human resource development, the focus has not been on hiring but training the existing human resources as per the needs of the different projects. The focus on building the capacities of existing human resources got stronger with the dissatisfactory performance of initial population projects (see section 5.1.2). In addition to this, increase in finances has been at the core of HSS ideas promoted by the Bank. The initial State health systems projects aimed to increase the public sector allocations in health budgets but did not achieve this objective successfully in all States. Two more ideas have also been diffused by the Bank for increasing finances including enhancing the collection of user fees (in the initial five health systems development projects) and supporting the State funded health insurance schemes in the more recent projects (see section 5.1.3).

Under improving processes, the Bank has diffused three broad ideas of HSS including administrative and civil services reforms; verticalisation of health system; and multi-sectoral action. The administrative and civil services reforms remained the most significant policy ideas diffused by the Bank in India. Under these reforms, the ideas of cost-containment measures, strengthening of personnel management and the effectiveness and efficiency of public agencies dominated the policy discourse recommended by the Bank. An increased support to the policies for decentralisation, creation of quasi-government bodies and public sector management reforms were the main policy strategies diffused and implemented by the Bank through its health sector projects (see section 5.1). The second HSS idea diffused by the Bank is that of a verticalised health system development in India. Verticalisation of health systems has been supported by the Bank at three levels. Firstly, through Bank's support to several stand-alone population, nutrition and disease-specific projects. Secondly, by focusing on one (secondary) level of care versus an integrated system of care. Thirdly, through creating parallel stand-alone State health systems development projects which are not entirely integrated with the State health system development plans (see section 5.2). Third idea of HSS under the improvement in processes diffused by the Bank is the idea of multi-sectoral action. Under this, the Bank has promoted participation of private

and voluntary sector and an enhanced community engagement in health systems strengthening policies. Along with this, it has promoted a reduced participation of the State suggesting reforming its size, role and efficiency (see section 5.3.1). Creation of various PPPs, delegation of specific public sector activities to private sector and direct investment in private sector by the sister organisation of the Bank constitute the major strategies used by the Bank to implement these ideas. For community engagement, Bank has conceptualised and applied this idea mostly in terms of its value in initiating behavioural and cultural change. Participation of civil society organisations, community based, and faith based organisations in implementation of Bank projects and planning of Bank's strategies has been the main tools used by the Bank to implement multi-sectoral action (see section 5.3.2).

The next and the final part of the study examines the strategies and tools used by the Bank for participating in HSS policies. This analysis shows governance at the cornerstone of the continuum of HSS. It shows that the Bank has participated in health systems governance policies at two levels and two aspects. In terms of levels, it shows that the Bank is shaping the normative ideas of governance at macro (international and national health system) level policies at the national, sub-national government and at institutional and community level. This study shows the evolving role of the Bank from a financial Bank to a 'knowledge Bank' by examining the its role in production of various policy tools including policy and strategy documents and health governance metrics like DALYS and HCI (see section 6.1). At the operational level, the study examines the role of the Bank in setting a discourse on HSS ideas and implementing these ideas through health sector projects in India (see section 6.2). In terms of aspects, it shows the Bank's participation in shaping governance as a function or activity performed by the health systems (governance by the health systems) as well as the co-production of governance of health systems through policy networks (governance of the health systems and network-governance) across the global, national and sub-national levels and across the evidence generation and implementation partners policy networks (see section 6.3).

The section below brings all the findings of this thesis together and engages with the theoretical and policy implications of the study. The theoretical implications discuss the importance of clarity and consistency around the normative and applied ideas of HSS, the centrality of governance in

the idea of HSS and governance as a tool to examine HSS policies. The second part discusses the public health and health systems strengthening policy implications of the HSS ideas diffused by the Bank in India. The policy implications are discussed under the broad rubric of economic orientation to HSS, top-down approaches for HSS, anti-egalitarian approach to HSS and undermining of State sovereignty and accountability in HSS discourse.

THEORETICAL IMPLICATIONS OF THE STUDY

To study the HSS policies, there is a need to develop a conceptual as well an operational clarity of HSS. This study contributes to clarify both these aspects of HSS. At a conceptual level, this thesis adds to the existing literature on clarifying the concept of HSS by differentiating between the conceptualisation of HSS as a strategy, a goal and a concept. This conceptual clarity on HSS is important as the varied farming of HSS has policy implications for priority setting, resource allocation; and for integrated (or fragmented) strengthening of health systems. The framing of HSS as a goal attaches a heightened priority to HSS and results in better allocation of resources to HSS. Whereas when framed as a strategy, HSS remains one of the several other components of health systems development policies and fail to receive a large share of resources. In Bank's State health systems development projects, HSS is conceptualised as the ultimate goal of the projects, hence HSS received a host of resources for the improvement in the health services in comparison to the disease-specific, population or nutrition projects where HSS is conceptualised as a strategy. Similarly, the projects which framed HSS as a goal conceptualised an integrated, holistic and horizontal view of the health systems development in comparison to the disease-specific, population and nutrition projects which conceptualised HSS as a strategy. If policy actors are keen to prioritise HSS and focus on an integrated approach to health systems development, then they must conceptualised HSS as the goal.

At the operational level, this study presents an operational framework to study as well as implement HSS policies. This framework conceptualises HSS as a continuum involving two sets of broad interventions in increasing health systems resources and improving process for effective utilisation of health systems resources outlined (see section 2.3, figure 2.1). This conceptusliation of HSS is useful from a policy perspective as it not only puts the diseases-specific versus sector-

wide confusions about HSS to rest but also provides a framework to differentiate between the range of interventions encompassed under the broad concept of HSS. The operational framework shows the centrality of the idea of 'governance' in the HSS continuum alluding to the co-production of governance by a wide range of policy actors. The framework though is useful to understand the process of policy, but it is not enough to study the ideas of HSS diffused by the policy actors as well as the context which enables the participation of global health actors in HSS policies. Policy-triangle framework for policy analysis developed by Gill and Walt (1994) is useful to understand the content and the context of the policy along with the two other components of the process and actor (see section 2.3).

Policy analysis framework emphasises the importance of studying all four aspects of policy (that is actor, ideas, process and context) and their interrelations in order to build a complete understanding of the role of specific policy actors (the World Bank) in policy network. It is helpful in studying each of these four parts of policy (that is actor, content, process and context) independently in detail and in building linkages between the four components. It shows that policies are shaped by a combination of four components of policy-triangle and these components are in turn shaped by the ideological underpinnings of the policy actors (which often is shaped by their mandate and composition). The study shows that in order to understand the role of different policy actors in HSS policies, it is important to examine the underlying philosophical and political ideations of these actors towards the health systems.

The study proposes 'Governance' as an important tool to understand the process through which Bank diffuses these HSS ideas. On one hand, the Bank is shaping the normative ideas of governance at macro (international and national health system) level policies for reforms by producing these ideas. On the other hand, it is influencing the operational aspects of governance at the global, national, sub-national and institutional and community level by implementing these ideas through health sector projects and setting a discourse on HSS ideas. The influence of the Bank in both the ideational and practical sphere of HSS ideas shows its role in both aspects of governance that is governance by the health systems (where governance is as a function of health systems) and governance of the health systems (where policy networks are governing health systems through network-governance).

IMPLICATIONS OF BANK'S HSS IDEAS FOR GOVERNANCE AND HSS POLICIES IN INDIA

HSS ideas promoted by the Bank has policy implication for health systems governance in India for i) setting an economic orientation to health systems strengthening discourse, ii) Top-down approach to health systems strengthening, iii) Anti-egalitarian approach to health systems strengthening and iv) Undermining State sovereignty and accountability in health systems strengthening. These implications are discussed below.

Economic orientation to health systems strengthening discourse

The World Bank's participation in HSS and governance policies has been shaped by its role in providing financial assistance to the countries experiencing short-term deficits in their balance of payments (see section 4.1). Bank's association with private sector is inherent in its fund-raising mechanisms through private financial markets and donations from the world's wealthiest countries. The prime motivation of the Bank for supporting (investing) in health system, its early interventions in HSS focusing on large investments in infrastructure and physical capital are aligned with the economic orientation of the HSS ideas promoted by the Bank. Though Bank witnessed a shift towards the inclusion of the 'basic needs' of individuals in development policies leading its investments in human capital (with the changes in the development theory starting from the 1960s through the 80s) but the 'capital' interest remained at the core of its ideas and operations.

The economic benefits orientation of the Bank is found in almost all HSS ideas diffused by the Bank. The ideas of cost-effective solutions, which the Bank calls the "best buys" for achieving health improvements within a fixed budget has been used as a justification for various HSS reforms diffused by the Bank. The administrative reforms promoted by the Bank as a part of its structural adjustment policies recommending the reduced role of State in provisioning and financing of health services and advising alternate financing mechanisms also targeted improving the efficiency of government. Bank claimed to improve the allocative efficiency in the health system by strengthening services at the primary and secondary levels but in reality, only focused on few

aspects of improving technical efficiency by making few quality improvements and increased utilisation of the health system (World Bank, 2016).

Increasing finances has been at the core of HSS ideas promoted by the Bank. The initial State health systems projects aimed to increase the public sector allocations in health budgets but did not achieve this objective in all States. Two more ideas for increasing finances have been diffused by the Bank including enhancing the collection of user fees (later retrieved) and supporting the State funded health insurance schemes.

Top-down approach to health improvement and health systems strengthening

The underlying philosophy of advantage of markets and economic values attached to life and selection of health interventions based on their cost-effectiveness has serious implications for health systems development in India. The first implication is that the economic focus of HSS ideas always locates reforms in financing and governance areas of health systems and completely ignores the needs, demands and social and political realities of the people or the communities (demand side issues). In other words, the economic ideas of HSS follow a top-down approach to health systems improvements stressing the notion that improving the functioning of the government or creating more channels for raising additional funds for health service provisioning will improve the health of the people. Bank has conceptualised and applied the idea of community engagement in limited terms that is for initiating behavioural and cultural change. Its community engagement interventions have largely been applied through participation of civil society organisations and community-based or faith-based organisations.

Bank's governance reforms, announced through its World Development Report and Health Sector Policy published in 1980, made a clear departure from primary healthcare approach calling it as "more of a slogan than nationwide reality" (World Bank, 1980b). Its 1992 policy document titled "India: Health care financing: coping with adjustment- opportunities for reform"(World Bank, 1992a) plainly outlined India specific health governance and financing reforms asking for a reduction in the role of State in provisioning of health services (World Bank, 1992a). These governance recommendations asked the Central government to place the highest priority on assisting States (especially the poorer States), to increase spending on non-salary inputs (World

Bank, 1992a). Reduction in the role of State and an increased involvement of private sector in provisioning of health services was clear departure from the ideologies adopted by India for planning welfare activities through the socialist and welfarist approaches (Jayal, 2003). The gradual reduction in role of State and promotion of private sector engagement in health sector in India has resulted in the blurring of boundaries of and role of the public and private sector in health which in turn has serious implications for effective governance, accountability and comprehensiveness of health services (Nundy and Baru, 2008). Other scholars have noted that such expansion of private sector without development of adequate regulatory mechanism in India has resulted in an unchecked growth of private sector which is "aggressively seeking expansion and profits from the provision of healthcare, and attracting investments by global finance capital" (Chakravarthi et al., 2015 p.1).

Similarly, Bank's financing reforms recommending the provisioning of only a set package of selected services and levying user charges at the point of service delivery was contrary to India's effort of universal provision of healthcare services to all its citizens regardless of their ability to pay as planned in the original blueprint of health systems development in India (Bhore Committee, 1946). The Bank was cognizant that these reforms are a deviation from the original health systems development plans of India. The policy advice document of the Bank specifically noted that "such moves may not conform to the original intentions of the health planners to provide universal free health care, but they certainly ensure that at least the poor have access to free services" (World Bank, 1992 p.88). Regarding the user fees, the Bank suggested that it is a "step towards restoration of equity: the poor should benefit proportionately more than the non-poor" (World Bank, 1992 p.88). However, the State's health systems development projects do not substantiate these claims. Various issues arising out of lack of clear guidelines on the exceptions and utilisation of user fee were reported (World Bank, 2006b) and (World Bank, 2006c). During the Uttar Pradesh health systems development project, it was noted that lack of careful monitoring of user fees can result in user fees to become a barrier to access services for the poor, "stipulating annual recurrent increases in user fees to the point of making them prohibitively high is counter to project objectives, Especially when mechanisms to exempt the poor are not in place"(World Bank, 2009 p.21).

These financing reforms gradually saw a change with the promotion of State sponsored health insurance. However, the insurance schemes focused on covering the in-patient tertiary care services. Given the maximum out of pocket expenditure for the poor in India is in out-patient care, the financing reform focusing on insurance schemes remain to be of limited effectiveness in providing financial protection to all households. There is a lack of clear evidence on the reduction in out of pocket expenditure and higher financial risk protection under the Publicly Financed Health Insurance Schemes in India (Prinja et al., 2017) and (Selvaraj and Karan, 2012). Analysis of the 71st round of National Sample survey by Ranjan et al., (2018) shows that only fifteen percent of the population of India is covered under health insurance schemes. Difference between the percentage of hospitalisations receiving cashless services under State funded health insurance schemes and those receiving services without insurance is only one percent. In terms of reduction in 'catastrophic health expenditure , the contribution of the insurance schemes is found to be only one percent for the bottom three quintiles of the population (Ranjan et al., 2018 p.1).

Anti-egalitarian approach to health systems strengthening

The diffusion of these selective ideas and approaches to HSS have public health policy implications in not just skewing public health priorities in India but also distorting India's plans towards an integrated and welfare-oriented health systems. The Bank has used and diffused an anti-egalitarian process for health system development in India. It has adopted and promoted a selective approach for HSS policies in India at three levels. First and foremost, Bank's practice of selectivity of States for health systems development projects set an anti-egalitarian precedence for health systems development in India. At the start of State health systems development projects, Bank chose only those States for investments which showed readiness for economic and structural reforms or were in the process of implementing these reforms in 1990s. Kirk (2010) notes that the Bank started its projects in the relatively "leading reformers States" like Andhra Pradesh, Karnataka, Tamil Nadu and Kerala. This approach of working with only few selected States started with a so-called "focus States strategy" of selective assistance for purportedly reform-committed States in the late 1990s set a discourse on health systems strengthening for States which are comparatively 'better-performing', advanced in health status and are pro-privatisation. This selection was also dependent on the States which had the potential to help the Bank remain engaged

and relevant to India because of their political affiliations. Andhra Pradesh remained the Bank's flagship "focus State" from 1998 to 2004. Till date the maximum number of projects had been rolled out in Andhra Pradesh and this has been linked with the leadership in Andhra Pradesh headed by, Chief Minister N. Chandrababu Naidu who was a big supporter of central coalition government in the early 2000s and claimed a highly disproportionate share of India's external assistance for his State (Kirk, 2010 p.26).

Kirk (2010) notes that after this skewed assistance to Andhra Pradesh was observed by the Central government, the Central government exerted its steering function and stepped in to reassert their authority over the Andhra Pradesh's relations with the Bank (and its DFID partner in the assistance programme) and also rationalised the entire strategy of selective sub-national assistance. It insisted on changing this policy of assistance from "leading reformers" in 1990s to "lagging performers" in 2004 which included States like Bihar, Orissa and Uttar Pradesh with widespread poverty and weak human development indicators. This push for the selective sub-national engagement initially came from the Bank, as a bid to enhance its relevance to India's economic reform process (Kirk, 2010 p.23). However, even with this shift in focus, the strategy still remained to be focused on few selected States and not on the whole country.

Second level of selectivity practiced by the Bank was in setting disease control priorities through disease-specific project lending aimed at improving the performance of the existing public health programmes. The Bank supported a number of stand-alone disease-specific projects in India post 1990s starting with HIV/AIDS project (1992), Leprosy (1993), Cataract blindness (1994), Tuberculosis (1997) and Malaria (1997). This selectivity in prioritising disease like HIV/AIDS did not have an epidemiological basis. These projects were purely based on the experience of previous projects of the Bank in other countries, keeping the feasibility and adequacy of the project design, seriousness of the government commitment and existence of new protocols as the main criteria for selecting the projects (Ridker and Musgrove, 1999). Resultantly, intervention strategies for these projects were exported and not tested locally or based on local knowledge and selectively based on their cost-effective value. The HIV/AIDS project amounted to a loan from IDA credit of SDR 59.8 million (US$84.0 million equivalent) with a contribution of 2.2 million from the World Health Organisation and 27.5 million from the Government of India and thus has been extensively criticised for reducing the allocation by Central government to other important health related issues

by shifting the scare funds to the project. The skewed budgets of the Central government for health with one-fourth of its outlay going for AIDS further weakened the general health services which were responsible for bearing the major burden of HIV testing and case management (Priya, 1994, p. 11). Sridhar and Gomez (2011) also point to a bias in disproportionate government investments favouring HIV/AIDS over other diseases in India shaped by the interest of external aid (Sridhar and Gomez, 2011). In addition to skewing health care priorities, the influence of the Bank on changing existing disease control strategies in the National Health Programmes has distorted the goals and impact of the original national disease control programmes.

Third level of selectivity lies at the focus on one level of the health services that is the secondary level. For the first four health systems development projects, the Bank focused heavily on the improving the secondary level of care. The focus was on establishment of a well performing referral system through upgrading staff and facilities at secondary level hospitals while completely ignoring the primary level tier of the health system. In addition to this, Bank's focus on addressing the health needs of the 'neediest section of the society' slowly disappeared from the State health systems development projects.

Undermining State sovereignty and accountability in health systems strengthening

The power relations between India and Bank as that of a lender and a borrower undermines the sovereignty of India to solely develop policies for its citizens. The conditionalities of the loans has prompted India to initiate neo-liberal and new public management reforms in health sector in India. The changing of almost twenty major legislations in India to qualify for World Bank loans is a testimony to the threat to India's sovereignty in decision-making (Public Interest Research Group,1994 cited by Abbasi, 1999).

Qadeer and colleagues (1994) argue that the Bank's analysis of India suggest that the failure to improve the health of people do not arise from placing wrong objectives but from choosing wrong instruments to meet these objectives. Bank believed that the inequality and misallocation by the government "have been caused by the mistakes in deciding what facilities to be build, where to locate them, how to staff them and what services to provide" (Qadeer et al., 1994 p.15-16). As noted by Baru and Jesani (2000) the Bank has clearly distorted India's priorities in the area of

communicable disease programmes. They support this claim by citing the excessive focus of the Bank on HIV/AIDS, Malaria and Tuberculosis than communicable disease and within these programmes the influence of the Bank in shifting the programme design from that of an integrated National Tuberculosis Program to a fragmented programmes relying on expensive second-line drugs for the treatment (Banerji, 1995 cited by the Baru and Jesani, 2000) . The skewed budgets of the Central government for health with one-fourth of its outlay going for AIDS (Priya, 1994, p. 11) are a few of the criticism widely written about the Bank's threat to India's sovereignty. The health systems development discourse should place people at the centre of all health policies and respond to the diverse and evolving health needs of the populations.

Another important and interrelated aspect of governance is the accountability mechanisms. The challenges for accountability lie at two levels. One is the blurring of accountability mechanisms for health actors operating in policy networks and second is the total lack of accountability mechanism for policy outcomes for advisers like the Bank. The mode of functioning in networks and partnerships limits the creation of clear accountability mechanism to hold the policy actors accountable for policy outputs and impacts. This challenge for accountability for external actors is twofold. One is for delineating the role of a particular actor (in a host of actors operating in policy networks) in specific policy outcomes and other is the lack of existence of direct accountability relations between the global health actors and people or communities at the receiving end of global health policies. Though few of the UN agencies and other global health actors are directly accountable to the governments of the respective member countries, the channel of accountability to the communities is not explicit.

Others have noted that the Bank has been giving loans with policy advice without taking any responsibility for its outcomes. The Bank then uses the experiences gained through these loans in different contexts and countries to modify or abandon certain policy directions in different sectors. Alluding to the policies on user fees and privatisation, Baru and Jesani (2000), note that the "Experimental approach" adopted by the Bank where new strategies are tried and tested in the developing countries is extremely exploitative as these "experiments" are costless to the Bank but the cost of failures are borne by the respective countries (Baru and Jesani, 2000 p.184). There is a need to establish clear accountability mechanisms attached to the policy ideas and reforms initiated and pushed by the global health actors like the Bank.

CONTRIBUTION OF THE THESIS

Theoretically, this thesis contributed to the existing theory on global actors' involvement in HSS in two ways. i) it adds to the conceptual clarity on health systems strengthening by proposing an operation framework for HSS as a continuum and proposing 'governance' as the cornerstone of the HSS continuum. ii) it contributes to the conceptual clarity on governance arguing for expanding the current discourse on governance focusing on governance as a function of health systems to a network and relationship-based understanding of governance and policy-making.

Methodologically, this study contributes to the method of studying the role of global actors in HSS policies by i) adding to the method of policy analysis and expanding the existing focus of policy analysis studies from 'actor -oriented' studies to a 'process-oriented' study which engages with the mechanisms, strategies and tools of participation used by policy actors in policy networks. ii) Showing that the processes of knowledge production through generating evidence for policy and creating health governance tools is the central strategy of the Bank to shape the HSS discourse and push for HSS reform at the country level. iii) Showing that the strategy of partnerships and networks (across the level of health systems, health sectors and thematic area of work) is used by the Bank to legitimise its knowledge and HSS ideas across health system levels and functions.

This analysis emphasises the importance of distinguishing between the ideas and processes of different global health actors and sets the context for using a holistic approach for examining the role of global actors by studying the features as well as the connections between the actors, their ideas and their ways and the context of their participation in HSS policies. The evidence presented in this thesis also suggests that a blanket approach to study global health actors' role is incomplete as different actors come with different philosophical orientations, diffuse different ideas and use different approaches to participate in health governance networks.

This study also contributes to the methods of health policy and systems research by showing the strengths of transdisciplinary methodology for health policy analysis. The study draws from various disciplines to address different objectives of the study. and combines the methods of analysis from economic: economic analysis focusing on budget and grant portfolio analysis;

political science: global governance focusing on the study of power of international organisations in norm-setting and policy transfer; public health focusing on epidemiological logic of disease control priorities and understanding health systems policy and programmes.

CONCLUSION

This study is a 'country level' analysis of global actors' participation in HSS policies, examining the HSS ideas and process of policy participation by global actors through an embedded case study on the World Bank. It shows that a large number of global actors influence HSS policies in India based on their own mandate and understanding of the health systems. Secondly, it shows that operating through 'networks' and 'partnerships' is evolving as the most dominant tool to influence HSS policies. Thirdly, it shows the permeability of power and hence diffusion of specific HSS ideas among global, national, sub-national and community health systems.

The evidence presented in this thesis, contributes to the evidence on the influence of global actors on health policies and links their influence and ideas with their philosophical affiliation and mandates. The study shows that the World Bank has distorted India's original plans for health systems development and skewed India's health systems priorities in accordance to its own mandate, disease priorities and beliefs about health systems development. However, the Bank cannot be held entirely accountable for the shifts in India's health policies towards economic orientation, privatisation and verticalisation. A host of other policy actors including the governments at national and sub-national level have worked in a partnership to bring about these shifts in India's health systems strengthening policies. There remains a gap in the understanding of the relative power of specific policy actors and the trust relations between different actors in the policy networks. Further policy research is needed to understand the functioning of specific health policy networks including global, national, sub-national, private, civil society, academic and all other relevant policy actors to unpack the processes of negotiation of policy ideas and the process leading up to the evolution of the final policy (including its implementation). Future policy research targeting a specific HSS idea or reform could fill this gap in understanding by studying the development of policies through a study on involvement of and power relations among different policy actors in respective policy networks. There is also a need to understand the real-time population level impact of specific HSS ideas, projects and technical assistance work of the

Bank. More policy research targeting at the impact of specific HSS idea or reform could fill the gap in understanding the health impact of Bank's HSS policies on the ground.

The COVID pandemic has once again refocused the attention on strengthening health systems and making health systems more resilient to respond to public health emergencies. There is currently a renewed commitment for strengthening health systems in India by the global actors including the World Bank which has announced a 1.5 billion grant to India for health systems preparedness and COVID response. The two-part loan by the Bank had recommended a fragmented, selective, short-term approach to manage COVID through cash transfers and food distribution and provisioning of social assistance to the severely impacted households. However, the conditionalities of these loans have asked for the participation of the private sector in COVID-related diagnostics, services provisioning as well as in research. This study provides a framework to critically analyse the different HSS strategies proposed under such loans and assistance programmes of global actors in light of the public health implications of integrated health systems development, maintaining the State sovereignty and establishing clear channels of governance and accountability by the global health actors.

In conclusion, this study advocates for a critical examination of the India's policy for development aid in health under the view of the merits and demerits of participation of global actors' participation in domestic HSS policies. It recommends an examination of the influence of each of the global health actors' participation in HSS policies in the view of the public health and health systems strengthening implications noted above. This examination is more urgent in the light of provisioning of miniscule funding by the global actors and their relative power in shaping HSS policies in comparison to other policy actors, especially the local government, small Bilateral organisations, academia and the grassroot civil society organisations. Efforts must be made to maintain a diversity as well as equality in health policy networks for developing inclusive and contextual health systems strengthening policies.

REFERENCES

Abbasi, K., 1999a. The World Bank and world health: Changing sides. BMJ 318, 865–869. https://doi.org/10.1136/bmj.318.7187.865

Abbasi, K., 1999b. The World Bank and world health: Interview with Richard Feachem. BMJ 318, 1206–1208. https://doi.org/10.1136/bmj.318.7192.1206

Abbasi, K., 1999c. The World Bank and world health: Under fire. BMJ 318, 1003–1006. https://doi.org/10.1136/bmj.318.7189.1003

Address to the 61st World Health Assembly, 2008.

A.F. FERGUSON & CO, n.d. Documenting the experiences of Danish Assistance to the Health Sector in Tamil Nadu – Final Report iv. A.F. FERGUSON & CO.

Akin, J.S., Birdsall, N., De Ferranti, D.M., 1987. Financing health services in developing countries: an agenda for reform, A World Bank policy study. World Bank, Washington, D.C., U.S.A.

Aluttis, C., Clemens, T., Krafft, T., 2017. Global health and domestic policy – What motivated the development of the German Global Health Strategy? Glob. Public Health 12, 1156–1168. https://doi.org/10.1080/17441692.2015.1094706

Andersen, J.J., Johannesen, N., Rijkers, B., 2020. Elite Capture of Foreign Aid: Evidence from Offshore Bank Accounts (Policy Research Working Paper No. 9150). World Bank Group.Washington, D.C. :

Balabanova, D., McKee, M., Mills, A., Walt, G., Haines, A., 2010. What can global health institutions do to help strengthen health systems in low income countries? Health Res. Policy Syst. 8, 22. https://doi.org/10.1186/1478-4505-8-22

Banerji, D., 1999. A fundamental shift in the approach to international health by WHO, UNICEF, and the World Bank: instances of the practice of "intellectual fascism" and totalitarianism in some Asian countries. Int. J. Health Serv. Plan. Adm. Eval. 29, 227–259.

Banerji, D., 1973. Population Planning in India: National and Foreign Priorities. Int. J. Health Serv. 3, 773–777. https://doi.org/10.2190/BX14-R8NY-FN54-5WT4

Bank, T.W., 2011. India - Uttar Pradesh Health Systems Strengthening Project (No. 64425). The World Bank.

Bank, T.W., 1995. India - India's family welfare program: toward a reproductive and child health approach (No. 14644). The World Bank.

Bank, T.W., 1972. India - Population Project (No. PP9). The World Bank.

Baru, R.V., Jesani, A., 2000. The role of the World Bank in international health: renewed commitment and partnership. Soc. Sci. Med. 50, 183–84.

Bass, J.M., Beecham, S., Noll, J., 2018. Experience of industry case studies: a comparison of multi-case and embedded case study methods, in: Proceedings of the 6th International Workshop on Conducting Empirical Studies in Industry - CESI '18. Presented at the the 6th International Workshop, ACM Press, Gothenburg, Sweden, pp. 13–20. https://doi.org/10.1145/3193965.3193967

Bendavid E, et al., D.T., 2017. Development Assistance for Health, in: Gelband, H., Horton, S., Jha, P., Laxminarayan, R., Mock, C.N., Nugent, R. (Eds.), Disease Control Priorities, Third Edition (Volume 9): Improving Health and Reducing Poverty. The World Bank. https://doi.org/10.1596/978-1-4648-0527-1

Bennett, C.J., 1991. How States Utilize Foreign Evidence. J. Public Policy 11, 31–54. https://doi.org/10.1017/S0143814X0000492X

Berg, A., 1987. Malnutrition: what can be done?: lessons from World Bank experience. Published for the World Bank [by] Johns Hopkins University Press, Baltimore.

Berman, P., 2009. Unpacking health systems strengthening. Presented at the Paper presented at the Inter-Agency Technical Workshop on HSS., Washington, DC July 2009. Unpublished document.

Birn, A.-E., 2009. The stages of international (global) health: Histories of success or successes of history? Glob. Public Health 4, 50–68. https://doi.org/10.1080/17441690802017797
Birn, A.-E., Pillay, Y., Holtz, T.H., 2017. Textbook of global health, Fourth edition. ed. Oxford University Press, New York, NY.
Brown, T.M., Cueto, M., Fee, E., 2006. The World Health Organization and the Transition From "International" to "Global" Public Health. Am. J. Public Health 96, 62–72. https://doi.org/10.2105/AJPH.2004.050831
Burdman, K., 1982. Robert McNamara makes population cuts the criterion for economic policy. Exec. Intell. Rev. Volume 9, Number 13,.
Buse, K., Tanaka, S., 2011. Global Public-Private Health Partnerships: lessons learned from ten years of experience and evaluation: Global Public-Private Health Partnerships: lessons learned. Int. Dent. J. 61, 2–10. https://doi.org/10.1111/j.1875-595X.2011.00034.x
Byass, P., 2017. Global health estimated over two decades. Nature 545.
Cassels, A., 1995. Health sector reform: key issues in less developed countries. J. Int. Dev. 7, 329–347.
Chakravarthi, I., Roy, B., Mukhopadhyay, I., 2015. Investing in health: Healthcare industry in India. Econ. Polit. Wkly. 52, 7–8.
Chan, M., 2012. Best days for public health are ahead of us, Dr Director-General of the World Health Organization Address to the Sixty-fifth World Health Assembly.
Chee, G., Pielemeier, N., Lion, A., Connor, C., 2013. Why differentiating between health system support and health system strengthening is needed: BETTER DEFINING HEALTH SYSTEM STRENGTHENING. Int. J. Health Plann. Manage. 28, 85–94. https://doi.org/10.1002/hpm.2122
CIFF, 2016. CIFF In India (TWO-PAGER).
Clift, C., Royal Institute of International Affairs, Centre on Global Health Security, 2013. The role of the World Health Organization in the international system.
Clinton, C., Sridhar, D., 2017. Who pays for cooperation in global health? A comparative analysis of WHO, the World Bank, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance. The Lancet 390, 324–332. https://doi.org/10.1016/S0140-6736(16)32402-3
Community Systems Strengthening Framework [WWW Document], 2010. URL http://www.who.int/tb/dots/comm_hss.pdf (accessed 5.13.17).
Dash, M.K., Mishra, A., n.d. External assistance for health sector: trends and impact during economic reforms, with a special reference to Orissa. Cent. Multi-Discip. Dev. Res., CMDR Monograph Series No. - 47.
De Ferranti, D., 1985. Paying for health services in developing countries: an overview-Staff working paper.
Department Of State. The Office of Electronic Information, B. of P.A., 2008. The Bretton Woods Conference, 1944 [WWW Document]. URL https://2001-2009.state.gov/r/pa/ho/time/wwii/98681.htm (accessed 5.17.19).
DFID, 2012. Evaluation of DFID's Support for Health and Education in India (Evaluation report No. 11). Independent comission for aid impact.
Diarra, G., Plane, P., 2014. Assessing the World Bank's Influence on the Good Governance Paradigm. Oxf. Dev. Stud. 42, 473–487. https://doi.org/10.1080/13600818.2014.949651
Dolowitz, D.P., Marsh, D., 2000. Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making. Governance 13, 5–23. https://doi.org/10.1111/0952-1895.00121
Duggal, R., 2002. Health Planning in India.
Duggal, R., 2001. Evolution of Health Policy in India.
e-Pact consortium, 2015. Assessing Value for Money in DFID's Health Portfolio for Bihar, Madhya Pradesh and Odisha, India. e-Pact Consortium.
European Commission, 2007. Evaluation of European Commission's support to Republic of India (Evaluation report). European Commission/ EuropeAid/ Evaluation Unit.

Evans, R., 1981. Incomplete vertical integration: the distinctive structure of the health-care industry, in: Health, Economics, and Health Economics. North Holland Publishing Company, North Holland.
Fair, M., 2012. From Population Lending to HNP Results The Evolution of the World Bank's Strategies in Health, Nutrition and Population. World Bank, Washington, DC.
Feldstein, M., Friedman, B., 1976. The Effect of National Health Insurance on the Price and Quantity of Medical Care, in: Rosett, R.N., Universities--National Bureau Committee for Economic Research (Eds.), The Role of Health Insurance in the Health Services Sector: A Conference of the Universities--National Bureau Committee for Economic Research, Universities--National Bureau Conference Series. National Bureau of Economic Research : distributed by Neale Watson Academic Publications, New York.
Feldstein, M., Friedman, B., Luft, H.O., 1972. Distributional aspects of National Insurance benefits and finance. Natl. Tax J. 25, 497–510.
Fidler, D.P., 2005. From International Sanitary Conventions to Global Health Security: The New International Health Regulations. Chin. J. Int. Law 4, 325–392. https://doi.org/10.1093/chinesejil/jmi029
Field, M.G., 1973. The concept of the "health system" at the macrosociological level. Soc. Sci. Med. 1967 7, 763–785. https://doi.org/10.1016/0037-7856(73)90118-2
Finnemore, M., 1996. Constructing Norms of Humanitarian Intervention, in: The Culture of National Security: Norms and Identity in World Politics. Columbia University Press, New York.
Fischer, F., 2003. Reframing public policy: discursive politics and deliberative practices. Oxford University Press, Oxford ; New York.
Frenk, J., 2010. The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress. PLoS Med. 7. https://doi.org/10.1371/journal.pmed.1000089
Frenk, J., 2006. Bridging the Divide: Comprehensive Reform to Improve Health in Mexico., in: Lecture for WHO Commission on Social Determinants of Health,. Nairobi.
Frenk, J., 1994. Dimensions of health system reform. Health Policy Amst. Neth. 27, 19–34.
Frenk, J., Moon, S., 2013. Governance Challenges in Global Health. N. Engl. J. Med. 368, 936–942. https://doi.org/10.1056/NEJMra1109339
Fryatt, R., Bennett, S., Soucat, A., 2017. Health sector governance: should we be investing more? BMJ Glob. Health 2, e000343. https://doi.org/10.1136/bmjgh-2017-000343
GAVI Alliance, 2012. Health Systems Strengthening (HSS) Support - Proposal form submiited by India.
Global Fund, 2019. Country Impact report India (Country Imapct report).
Global Fund, 2007. The Global Fund Strategic Approach to Health Systems Strengthening Report from WHO to The Global Fund Secretariat (No. WHO/HSS/2007.1). World Health Organization, 20, Avenue Appia CH-1211 Geneva 27 Switzerland.
Global Fund, n.d. Grant Portfolio , India [WWW Document]. Glob. Fund Fight AIDS Tuberc. Malar. URL http://portfolio.theglobalfund.org/en/Country/Index/IND (accessed 2.28.14).
Gordon, L.A., 1997. Wealth Equals Wisdom? The Rockefeller and Ford Foundations in India. Ann. Am. Acad. Pol. Soc. Sci. 554, 104–116. https://doi.org/10.1177/0002716297554001007
Government of India, 2017. National Health Policy 2017.
Government of India, 1983. National Health Policy.
Greer, S.L., Wismar, M., Figueras, J., European Observatory on Health Systems and Policies (Eds.), 2016. Strengthening health system governance: better policies, stronger performance, European observatory on health systems and policies series. Open University Press, Maidenhead, Berkshire.
Groot, A. de, Ramachandran, C., Slob, A., Willemsen, A., Jerve, A.M., 2008. Managing Aid Exit and Transformation India Country Case Study (Evaluation report). Swedish International Development Cooperation Agency(SIDA), Stockholm.
Gupta, D.B., Gumber, A., 2002. External assistance to the health sector and its contributions: problems and prognosis- working paper 88.
Hafner, T., Shiffman, J., 2012. The emergence of global attention to health systems strengthening. Health Policy Plan. 28, 41–50. https://doi.org/10.1093/heapol/czs023

Hanna, N., Agarwala, R., 2000. Toward a Comprehensive Development Strategy (OED Working Paper Series No. No. 16). World Bank Operations Evaluation Department, Washington, D.C. , U.S.A.
Harman, S., 2010. The World Bank and HIV/AIDS: setting a global agenda, Routledge advances in international relations and global politics. Routledge, London ; New York, NY.
Healthy Development -The World Bank startegy for HNP results, 2007a. , What is a Health System. World Bank.
Hoberg, G., 1991. Sleeping with an Elephant: The American Influence on Canadian Environmental Regulation. J. Public Policy 11, 107–131. https://doi.org/10.1017/S0143814X00004955
Hoffman, Cole, C.B., Pearcey, M., 2015. Mapping Global Health Architecture to Inform the Future [WWW Document].
Hoffman, S.J., Cole, C.B., 2018. Defining the global health system and systematically mapping its network of actors. Glob. Health 14. https://doi.org/10.1186/s12992-018-0340-2
Howard, L.M., 1983. International sources of financial cooperation for health in developing countries. Bull. Pan Am. Health Organ. 17, 142–157.
Hsiao, W.C., 2003. What is a health system? Why should we care. Harvard School of Public Health, working paper.
Hsieh, H.-F., Shannon, S.E., 2005. Three Approaches to Qualitative Content Analysis. Qual. Health Res. 15, 1277–1288. https://doi.org/10.1177/1049732305276687
Hugh Heclo, H., 1972. Review Article: Policy Analysis. Br. J. Polit. Sci. 2, 83–108. https://doi.org/10.1017/S0007123400008449
Hurst, J.W., 1991. Reforming health care in seven European nations. Health Aff. (Millwood) 10, 7–21. https://doi.org/10.1377/hlthaff.10.3.7
ICMR, Public Health Foundation of India, University of Washington, Institute for Health Metrics and Evaluation, 2017. India: health of the nation's states : the India state-level disease burden initiative : disease burden trends in the states of India, 1990 to 2016.
India economic overview, n.d. The World Bank and India : Chapter 1 [WWW Document]. India Econ. Overv. URL http://www.ieo.org/world-c1-p1.html (accessed 5.20.19).
International Finance Corporation, 2016a. IFC The First Six Decades : Leading the Way in Private Sector Development--A History.
International Finance Corporation, 2016b. India- International Finance Corporation [WWW Document]. Int. Finance Corp.- World Bank Group. URL https://www.ifc.org/wps/wcm/connect/REGION__EXT_Content/IFC_External_Corporate_Site/South+Asia/Countries/India/India+Country+Page (accessed 9.6.19).
Jamison, D.T., World Bank (Eds.), 1993. Disease control priorities in developing countries, Oxford medical publications. Published for the World Bank [by] Oxford University Press, New York, N.Y.
Jayal, N.G., 2003. The Gentle Leviathan: The Welfare and the Indian State, in: Restructuring Health Services: Changing Contexts and Comparative Perspectives. Zed Books ; distributed exclusively in the United States by Palgrave, London ; New York : New York, N.Y.
Jeffery, R., 1988. The politics of health in India, Comparative studies of health systems and medical care. University of California Press, Berkeley.
Jeffery, R., 1986. New Patterns in Health Sector Aid to India. Int. J. Health Serv. 16, 121–139. https://doi.org/10.2190/77X4-KHYV-14CN-PJQL
John, P., 1998. Analysing public policy, Critical political studies. Pinter, London ; New York.
Kaasch, A.M., 2011. Global Social Policy in the Field of Health Systems International Organisations and their Policy Models (Doctoral thesis). Department of Sociological Studies University of Sheffield, Sheffield.
Kapur, D., Lewis, J.P., Webb, R.C., 1997. The World Bank: its first half century. Brookings Institution, Washington, D.C.

Kaur, M., Prinja, S., Singh, P., Kumar, R., 2012. Decentralization of health services in India: barriers and facilitating factors. WHO South-East Asia J. Public Health 1, 94. https://doi.org/10.4103/2224-3151.206920
Keeley, B., 2012. From aid to development: the global fight against poverty, OECD insights. OECD, Paris.
Kenney, C., Glassman, A., 2019. Gavi's Approach to Health Systems Strengthening: Reforms for Enhanced Effectiveness and Relevance in the 2021–2025 Strategy.
Khan, M.S., Meghani, A., Liverani, M., Roychowdhury, I., Parkhurst, J., 2018. How do external donors influence national health policy processes? Experiences of domestic policy actors in Cambodia and Pakistan. Health Policy Plan. 33, 215–223. https://doi.org/10.1093/heapol/czx145
Kickbusch, I., Gleicher, D., 2013. Governance for health in the 21st century. World Health Organization, Regional Office for Europe, Copenhagen.
Kickbusch, I., Szabo, M.M.C., 2014. A new governance space for health. Glob. Health Action 7, 23507. https://doi.org/10.3402/gha.v7.23507
Kieny, M.P., Bekedam, H., Dovlo, D., Fitzgerald, J., 2017. Strengthening health systems for universal health coverage and sustainable development. Bull. World Health Organ. 95.
Kirk, J.A., 2010. India and the World Bank: the politics of aid and influence, Anthem South Asian studies. Anthem Press, London ; New York.
Kjaer, A.M., 2011. RHODES' CONTRIBUTION TO GOVERNANCE THEORY: PRAISE, CRITICISM AND THE FUTURE GOVERNANCE DEBATE. Public Adm. 89, 101–113. https://doi.org/10.1111/j.1467-9299.2011.01903.x
Kjær, A.M., 2004. Governance, Key concepts. Polity Press, Malden, MA.
Koch, M., 2015. World Organizations – (Re-)Conceptualizing International Organizations. World Polit. Sci. 11. https://doi.org/10.1515/wps-2015-0003
Koplan, J.P., Bond, T.C., Merson, M.H., Reddy, K.S., Rodriguez, M.H., Sewankambo, N.K., Wasserheit, J.N., 2009. Towards a common definition of global health. The Lancet 373, 1993–1995. https://doi.org/10.1016/S0140-6736(09)60332-9
K.Srinath Reddy, Balasubramaniam, P., Bhokare, S., Chitkara, P., Maulik Choksi, Thammarao Damisetti, Subhojit Dey, Yogeshwar Gupta, Hasan, H., Kanav Kahol, Shivangini Kar, Manjot Kaur, Kumar, P., Mathur, S., Subhadra Menon, Mishra, R., Misra, M., Devaki Nambiar, Narayan, K., Panda, R., Pathak, G., Prakash, D., Ramani, S., Ramesh, G., Krisha D. Rao, Prasanna Saligram, Salunke, S., Satija, A., Seem, T., Shativel Selvaraj, Manasi Sharma, Preety Sharma, Sheikh, K., Namrata Verma, 2011. High Level Expert Group Report on Universal Health Coverage for India. https://doi.org/10.13140/RG.2.2.12162.27843
Kutzin, J., 2013. Health financing for universal coverage and health system performance: concepts and implications for policy. Bull. World Health Organ. 91, 602–611. https://doi.org/10.2471/BLT.12.113985
Lee, K., Kamradt-Scott, A., 2014. The multiple meanings of global health governance: a call for conceptual clarity. Glob. Health 10, 28. https://doi.org/10.1186/1744-8603-10-28
Lidén, J., 2014. The World Health Organization and Global Health Governance: post-1990. Public Health 128, 141–147. https://doi.org/10.1016/j.puhe.2013.08.008
Litsios, S., 2004. The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach. Am. J. Public Health 94, 1884–1893. https://doi.org/10.2105/AJPH.94.11.1884
Litsios, S., 2002. The long and difficult road to Alma-Ata: a personal reflection. Int. J. Health Serv. Plan. Adm. Eval. 32, 709–732.
Lyne, M.M., Nielson, D.L., Tierney, M.J., 2006. Who delegates? Alternative models of principals in development aid, in: Hawkins, D.G., Lake, D.A., Nielson, D.L., Tierney, M.J. (Eds.), Delegation and Agency in International Organizations. Cambridge University Press, Cambridge, pp. 41–76. https://doi.org/10.1017/CBO9780511491368.003

Madsen, M.R., Christensen, M.J., 2016. Global Actors: Networks, Elites, Institutions. SSRN Electron. J. https://doi.org/10.2139/ssrn.2731098
Mamdani, B., 2007. Governance in healthcare. Indian J. Med. Ethics. https://doi.org/10.20529/IJME.2007.074
Marchal, B., Cavalli, A., Kegels, G., 2009. Global Health Actors Claim To Support Health System Strengthening—Is This Reality or Rhetoric? PLoS Med. 6, e1000059. https://doi.org/10.1371/journal.pmed.1000059
Marten, R., 2019. How states exerted power to create the Millennium Development Goals and how this shaped the global health agenda: Lessons for the sustainable development goals and the future of global health. Glob. Public Health 14, 584–599. https://doi.org/10.1080/17441692.2018.1468474
Martens, J., Seitz, K., 2015. Philanthropic power and development: who shapes the agenda? Bischöfliches Hilfswerk MISEREOR, Aachen.
McColl, K., 2008. Europe told to deliver more aid for health. The Lancet 371, 2072–2073. https://doi.org/10.1016/S0140-6736(08)60901-0
McPake, B., Normand, C., Smith, S., Nolan, A., 2013. Health Economics: An International Perspective, 3rd ed. Routledge. https://doi.org/10.4324/9780203394076
Michaud, C., Murray, C.J., 1994. External assistance to the health sector in developing countries: a detailed analysis, 1972-90. Bull. World Health Organ. 72, 639–651.
Mills, A., 2004. Mass campaigns versus general health services : what have we learnt in 40 years about vertical versus horizontal approaches ? : Public Health Classics. Bull. World Health Organ. Int. J. Public Health 2004 824 315-316.
Murray, C.J., Anderson, B., Burstein, R., Leach-Kemon, K., Schneider, M., Tardif, A., Zhang, R., 2011. Development assistance for health: trends and prospects. The Lancet 378, 8–10. https://doi.org/10.1016/S0140-6736(10)62356-2
Murray, C.J.L., Lopez, A.D., 2017. Measuring global health: motivation and evolution of the Global Burden of Disease Study. The Lancet 390, 1460–1464. https://doi.org/10.1016/S0140-6736(17)32367-X
National Health Systems Resource Centre, 2018. National Health Accounts Estimates for India (2015-16),. Ministry of Health and Family Welfare, Government of India, New Delhi,India.
National Rural Health Mission , Meeting people's health needs in rural areas Framework for Implementation 2005-2012, 2005.
Newmark, A.J., 2005. AN INTEGRATED APPROACH TO POLICY TRANSER AND DIFFUSION. Rev. Policy Res. 19, 151–178. https://doi.org/10.1111/j.1541-1338.2002.tb00269.x
Ng, N.Y., Ruger, J.P., 2011. Global Health Governance at a Crossroads. Glob. Health Gov. Sch. J. New Health Secur. Paradigm 3, 1–37.
Nielson, D.L., Tierney, M.J., 2003. Delegation to International Organizations: Agency Theory and World Bank Environmental Reform. Int. Organ. 57, 241–276. https://doi.org/10.1017/S0020818303572010
NITI Ayog, 2019. Health System for a New India: Building Blocks. Potential pathways to reform. Delhi.
Nundy, M., Baru, R.V., 2008. Blurring of Boundaries: Public-Private Partnerships in Health Services in India. Econ. Polit. Wkly.
Ogden, J., Morrison, K., Hardee, K., 2014. Social capital to strengthen health policy and health systems. Health Policy Plan. 29, 1075–1085. https://doi.org/10.1093/heapol/czt087
Okuonzi, S.A., Macrae, J., 1995. Whose policy is it anyway? International and national influences on health policy development in Uganda. Health Policy Plan. 10, 122–132. https://doi.org/10.1093/heapol/10.2.122
Ollila, E., 2005. Global health priorities - priorities of the wealthy? Glob. Health 1, 6. https://doi.org/10.1186/1744-8603-1-6
Ooms, G., Hammonds, R., 2015. Anchoring universal health coverage in the right to health: What difference would it make?

Ooms, G., Van Damme, W., Baker, B.K., Zeitz, P., Schrecker, T., 2008. The "diagonal" approach to Global Fund financing: a cure for the broader malaise of health systems? Glob. Health 4, 6. https://doi.org/10.1186/1744-8603-4-6
Operations Evaluation Department, 2002. Non-Governmental Organizations and Civil Society Engagement in World Bank Supported Projects (Lessons from OED Evaluations No. Lessons and Practices No. 18).
Paris Declaration On Aid Effectiveness., 2005.
Partridge, E.E., Mayer-Davis, E.J., Sacco, R.L., Balch, A.J., 2011. Creating a 21st Century Global Health Agenda: The General Assembly of the United Nations High Level Meeting on Non-Communicable Diseases. Diabetes Care 34, 1440–1441. https://doi.org/10.2337/dc11-9999
Paul, S., Steedman, D., Sutton, F., 1989. Building capability for policy analysis- Policy, Planning and Research Working Papers.
Peabody, J.W., 1996. Economic reform and health sector policy: lessons from structural adjustment programs. Soc. Sci. Med. 1982 43, 823–835.
Peters, D.H., Paina, L., Schleimann, F., 2013. Sector-wide approaches (SWAps) in health: what have we learned? Health Policy Plan. 28, 884–890. https://doi.org/10.1093/heapol/czs128
Planning Commission , Government of India, 1951. Introduction- First Five Year Plan, Five Years Plans 1951-56.
Prinja, S., Chauhan, A.S., Karan, A., Kaur, G., Kumar, R., 2017. Impact of Publicly Financed Health Insurance Schemes on Healthcare Utilization and Financial Risk Protection in India: A Systematic Review. PLOS ONE 12, e0170996. https://doi.org/10.1371/journal.pone.0170996
Priya, R., 1994. AIDS, public health and the panic reaction (Part II). Natl. Med. J. India 7, 288–291.
Qadeer, I., Gupta, N., Chussudovsky, M., 1994. Unhealthy trends, The World Bank, structural adjustment and the health sector in Inida, in: Unhealthy Trends, The World Bank, Structural Adjustment and the Health Sector in Inida. Public interest research group, Delhi, India, pp. 11–19.
Radelet, S., 2006. A Primer on Foreign Aid (- Working Paper 92). | Center For Global Development.
Ranjan, A., Dixit, P., Mukhopadhyay, I., Thiagarajan, S., 2018. Effectiveness of government strategies for financial protection against costs of hospitalization Care in India. BMC Public Health 18. https://doi.org/10.1186/s12889-018-5431-8
Ravindran, T.K.S., 2007. World Bank and India's Health Sector. Medico Friend Circ. Bull.
Ravishankar, N., Gubbins, P., Cooley, R.J., Leach-Kemon, K., Michaud, C.M., Jamison, D.T., Murray, C.J., 2009. Financing of global health: tracking development assistance for health from 1990 to 2007. The Lancet 373, 2113–2124. https://doi.org/10.1016/S0140-6736(09)60881-3
Reich, M. (Ed.), 2002. Public-private partnerships for public health, Harvard series on population and international health. Harvard Center for Population and Development Studies, Cambridge, Mass.
Reich, M.R., Takemi, K., 2009. G8 and strengthening of health systems: follow-up to the Toyako summit. The Lancet 373, 508–515. https://doi.org/10.1016/S0140-6736(08)61899-1
Report on the Health Survey and Development Committee Vol.II, 1946. . Ministry of Health, New Delhi.
Resilient & Sustainable Systems for Health [WWW Document], n.d. URL https://www.theglobalfund.org/en/resilient-sustainable-systems-for-health/ (accessed 4.19.20).
Rhodes, R.A.W., 2007. Understanding Governance: Ten Years On. Organ. Stud. 28, 1243–1264. https://doi.org/10.1177/0170840607076586
Ridker, R., Musgrove, P., 1999. Case Study of World Bank Activities in the Health Sectorin India. Sector and Thematic Evaluations Group Operations Evaluation Department, World Bank.
Roemer, M.I., 1993. National Health Systems Throughout the World. Annu. Rev. Public Health 14, 335–353. https://doi.org/10.1146/annurev.pu.14.050193.002003
Rome Declaration on Harmonisation. 2003., 2003.
Ruger, J.P., 2005a. The Changing Role of the WORLD BANK in Global Health. Am. J. Public Health 95, 60–70. https://doi.org/10.2105/AJPH.2004.042002
Ruger, J.P., 2005b. The Changing Role of the WORLD BANK in Global Health. Am. J. Public Health 95, 60–70. https://doi.org/10.2105/AJPH.2004.042002

Ruggie, J.G., 1992. Multilateralism: the anatomy of an institution. Int. Organ. 46, 561–598. https://doi.org/10.1017/S0020818300027831
Rutkowski, D.J., 2007. Converging us softly: how intergovernmental organizations promote neoliberal educational policy. Crit. Stud. Educ. 48, 229–247. https://doi.org/10.1080/17508480701494259
Sabatier, P.A., 1991. Toward Better Theories of the Policy Process. PS Polit. Sci. Polit. 24, 147. https://doi.org/10.2307/419923
Scholz, R., Tietje, O., 2002. Embedded Case Study Methods. SAGE Publications, Inc., 2455 Teller Road, Thousand Oaks California 91320 United States of America. https://doi.org/10.4135/9781412984027
Schouten, P., 2015. Theory Talk #72: Robert Wade. URL http://www.theory-talks.org/2015/12/theory-talk-72.html (accessed 2.20.19).
Selvaraj, S., Karan, A., 2012. Why Publicly-Financed Health Insurance Schemes Are Ineffective in Providing Financial Risk Protection. Econ. Polit. Wkly. 47.
Senkubuge, F., Modisenyane, M., Bishaw, T., 2014. Strengthening health systems by health sector reforms. Glob. Health Action 7, 23568. https://doi.org/10.3402/gha.v7.23568
Shakarishvili, G., Atun, R., Berman, P., Hsiao, W.C., 2009. Building on Health Systems Frameworks for Developing a Common Approach to Health Systems Strengthening- DRAFT FOR DISCUSSION, Prepared for the World Bank, the Global Fund and the GAVI Alliance Technical Workshop on Health Systems Strengthening Washington, DC, June 25-27, 2009.
Shakarishvili, G., Lansang, M.A., Mitta, V., Bornemisza, O., Blakley, M., Kley, N., Burgess, C., Atun, R., 2011. Health systems strengthening: a common classification and framework for investment analysis. Health Policy Plan. 26, 316–326. https://doi.org/10.1093/heapol/czq053
Shekar, M., 1991. The Tamil Nadu Integrated Nutrition Project: a review of the project with special emphasis on the monitoring and information system, Working paper. Cornell Food and Nutrition Policy Program, Ithaca, N.Y.
Sinding, S.W., 2007. Overview and Perspective 1, in: The Global Family Planning Revolution. The World Bank, pp. 1–13.
Singh, A., 2006. Strengthening health systems to meet MDGs. Health Policy Plan. 21, 326–328. https://doi.org/10.1093/heapol/czl008
Smith, O., 2018. Insuring India: States learn about health insurance from each other [WWW Document]. End Poverty South Asia. URL http://blogs.worldbank.org/endpovertyinsouthasia/insuring-india-states-learn-about-health-insurance-each-other (accessed 1.30.19).
Sridhar, D., 2007. Economic Ideology and Politics in the World Bank: Defining Hunger. New Polit. Econ. 12, 499–516. https://doi.org/10.1080/13563460701661520
Sridhar, D., Gomez, E.J., 2011. Health Financing in Brazil, Russia and India: What Role Does the International Community Play? Health Policy Plan. 26, 12–24. https://doi.org/10.1093/heapol/czq016
Stephens, N., 2007. Collecting data from elites and ultra-elites: telephone and face-to-face interviews with macroeconomists. Qual. Res. 7, 203–216. https://doi.org/10.1177/1468794107076020
Steurs, L., Van de Pas, R., Delputte, S., Orbie, J., 2017. The Global Health Policies of the EU and its Member States: A Common Vision? Int. J. Health Policy Manag. 7, 433–442. https://doi.org/10.15171/ijhpm.2017.112
Stoeva, P., 2016. International Relations and the Global Politics of Health: A State of the Art? Glob. Health Gov. - Sch. J. New Health Secur. Paradigm 10, 97–109.
Storeng, K.T., 2014. The GAVI Alliance and the 'Gates approach' to health system strengthening. Glob. Public Health 9, 865–879. https://doi.org/10.1080/17441692.2014.940362
Straw, W., Glennie, A., 2013. In aid of India? Defining a positive role for the UK. Institute for Public Policy Research, 14 Buckingham Street London WC2N 6DF.
Swarup, A., 2019. Not just a civil servant. New Delhi, India.

Szlezák, N.A., Bloom, B.R., Jamison, D.T., Keusch, G.T., Michaud, C.M., Moon, S., Clark, W.C., 2010. The Global Health System: Actors, Norms, and Expectations in Transition. PLoS Med. 7, e1000183. https://doi.org/10.1371/journal.pmed.1000183

Tago, A., 2017. Multilateralism, Bilateralism, and Unilateralism in Foreign Policy, in: Oxford Research Encyclopedia of Politics. Oxford University Press. https://doi.org/10.1093/acrefore/9780190228637.013.449

Tarimo, E., Webster, E.G., Services, W.H.O.D. of S. of H., 1994. Primary health care concepts and challenges in a changing world: Alma-Ata revisited.

The World Bank, 2020. The Human Capital Index 2020 update ,Human Capital in the Time of COVID-19. Washington DC.

Tichenor, M., Sridhar, D., 2020. Metric partnerships: global burden of disease estimates within the World Bank, the World Health Organisation and the Institute for Health Metrics and Evaluation. Wellcome Open Res. 4, 35. https://doi.org/10.12688/wellcomeopenres.15011.2

Travis, P., Bennett, S., Haines, A., Pang, T., Bhutta, Z., Hyder, A.A., Pielemeier, N.R., Mills, A., Evans, T., 2004. Overcoming health-systems constraints to achieve the Millennium Development Goals. Lancet 364, 900–906. https://doi.org/10.1016/S0140-6736(04)16987-0

UNDP, 2018. Government of India - United Nations Sustainable Development Framework (SDF) for the period 2018-2022 (Strategy document). United Nations Resident Coordinator's Office. All rights reserved. Cover Photo Credit: UNDP.

UNDP, n.d. Sustainable Development Goals | UNDP in India [WWW Document]. UNDP. URL https://www.in.undp.org/content/india/en/home/sustainable-development-goals.html (accessed 9.23.20).

Unger, J.-P., De Paepe, P., Green, A., 2003. A code of best practice for disease control programmes to avoid damaging health care services in developing countries. Int. J. Health Plann. Manage. 18, S27–S39. https://doi.org/10.1002/hpm.723

UNICEF, 2012. India Country programme document 2013-2017 (Strategy document). Unicef, Unite for Child, India.

United Nations, 2011. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, Sixty-sixth session Agenda item 117.

United Nations (Ed.), 1993. Improving public policy analysis: study material for top executives. United Nations Dept. for Development Support and Management Services, New York.

Universal Health Coverage | National Health Portal Of India [WWW Document], n.d. URL https://www.nhp.gov.in/universal-health-coverage_pg (accessed 9.20.20).

University of Washington, Institute for Health Metrics and Evaluation, 2010. Financing global health 2010 development assistance and country spending in economic uncertainty. Institute for Health Metrics and Evaluation, University of Washington, Seattle, Wash.

Van Olmen, J., Marchal, B., Van Damme, W., Kegels, G., Hill, P.S., 2012. Health systems frameworks in their political context: framing divergent agendas. BMC Public Health 12, 774. https://doi.org/10.1186/1471-2458-12-774

Venice Draft Concluding Statement on Maximizing Positive Synergies between health systems and Global Health Initiatives, 2009.

Walley, J., Lawn, J.E., Tinker, A., de Francisco, A., Chopra, M., Rudan, I., Bhutta, Z.A., Black, R.E., 2008. Primary health care: making Alma-Ata a reality. The Lancet 372, 1001–1007. https://doi.org/10.1016/S0140-6736(08)61409-9

Walsh, J.A., Warren, K.S., 1979. Selective primary health care: an interim strategy for disease control in developing countries. N. Engl. J. Med. 301, 967–974. https://doi.org/10.1056/NEJM197911013011804

Walt, G., Gilson, L., 1994. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy Plan. 9, 353–370. https://doi.org/10.1093/heapol/9.4.353

Walt, G., Shiffman, J., Schneider, H., Murray, S.F., Brugha, R., Gilson, L., 2008. "Doing" health policy analysis: methodological and conceptual reflections and challenges. Health Policy Plan. 23, 308–317. https://doi.org/10.1093/heapol/czn024

Warren, A.E., Wyss, K., Shakarishvili, G., Atun, R., de Savigny, D., 2013. Global health initiative investments and health systems strengthening: a content analysis of global fund investments. Glob. Health 9, 30. https://doi.org/10.1186/1744-8603-9-30

WHO, 2005. WHO | World Health Assembly concludes: adopts key resolutions affecting global public health.

WHO, n.d. WHO | About the Global Burden of Disease (GBD) project [WWW Document]. WHO. URL https://www.who.int/healthinfo/global_burden_disease/about/en/ (accessed 12.6.20).

WHO | Governance [WWW Document], n.d. . WHO. URL https://www.who.int/healthsystems/topics/stewardship/en/ (accessed 2.4.19).

WHO | Health Systems Strengthening Glossary [WWW Document], n.d. . WHO. URL http://www.who.int/healthsystems/hss_glossary/en/index5.html (accessed 4.28.14).

WHO and UNICEF, 2018. Declaration of Asthana- Global Conference on Primary Health Care From Alma-Ata towards universal health coverage and the Sustainable Development Goals. Astana, Kazakhstan,.

WHO and World Bank, 1996. World Health Organization/World Bank partnership : procedural strategies for implementation of recommendations for health development. World Health Organization. (No. WHO/INA/96.1). World Health Organization. Division of Interagency Affairs & World Bank.

Wolfensohn, J.D., 1999. A Proposal for the Comprehensive Development Framework.

Wolfensohn, J.D., Fischer, S., 2000. The Comprehensive Development Framework (CDF).

World Bank, 2018. Implementation completion and results report : Karnataka health systems development and reforms project (Implementation completion report No. ICR00004290). Health, Nutrition and Population Global Practice (GHNDR) South Asia Region.

World Bank, 2016. Implementation completion and results report : Tamil Nadu health systems project (Implementation completion report No. ICR00003518). Health, Nutrition and Population Global Practice (GHNDR) South Asia Region.

World Bank, 2013a. Implementation completion and results report : for the third national HIV/AIDS control project (Implementation completion report No. ICR2437). Health, Nutrition and Population Global Practice (GHNDR) South Asia Region.

World Bank, 2013b. World Bank– Civil Society Engagement- Review of Fiscal Years 2010–2012. World Bank, : Washington, DC.

World Bank, 2012. Implementation completion and results report : Rajasthan health systems development project (Implementation completion report No. ICR2078). Human Development Sector Unit South Asia Region.

World Bank, 2009. Implementation completion and results report : Uttar Pradesh health systems development project (Implementation completion report No. ICR00001139). Health, Nutrition and Population Sector Department India Department South Asia Region.

World Bank, 2008a. India - Country strategy for the period FY2009-2012 (Country Assistance Strategy Document No. 46509- IN). World Bank Group.Washington, D.C. :

World Bank (Ed.), 2008b. Public sector reform: what works and why?: an IEG evaluation of World Bank support. World Bank, Washington, D.C.

World Bank (Ed.), 2007b. Healthy development: the World Bank strategy for health, nutrition, & population results. World Bank, Washington, DC.

World Bank, 2007c. Implementation completion report : Andhra Pradesh Economic Restructuring Project. (Implementation completion report No. ICR0000000100). Poverty Reduction and Econiomic Management Unit, India Country management Unit South Asia Region, World Bank, Washington, D.C. , U.S.A.

World Bank, 2007d. Approach paper: Evaluation of the World Bank's Assistance for Health, Nutrition, and Population.
World Bank, 2006a. Project Appraisal Document , Reproductive and Child Health Project II (Project appraisal report). World Bank.
World Bank, 2006b. Implementation completion and results report : Orissa health systems development project (Implementation completion report No. ICR000012). Human Development Unit South Asia Region, World Bank.
World Bank, 2006c. Implementation completion report : Maharashtra health systems development project (Implementation completion report No. 35390). Human Development Sector Unit South Asia Region.
World Bank, 2006d. Implementation completion and results report : for the second national HIV/AIDS control project (Implementation completion report No. ICR-000022). Health, Nutrition and Population Global Practice (GHNDR) South Asia Region.
World Bank, 2006e. Implementation completion report for a Malaria control project (Implementation completion report No. 36629- IN). Health, Population and Nutrition Unit South Asia Region, World Bank, 1818 H Street, N.W. Washington, D.C. 20433, U.S.A.
World Bank, 2006f. Implementation completion report : for a Tuberculosis control project (Implementation completion report No. 34692). Health, Nutrition and Population Global Practice (GHNDR) South Asia Region.
World Bank, 2006g. Implementation completion report- India- Eight population project. Health, Nutrition & Population Unit South Asia Region,The World Bank, Washington, D.C., U.S.A.
World Bank, 2004. Implementation completion report : State health systems development project II (Implementation completion report No. 30066). World Bank.
World Bank, 2002a. India - Andhra Pradesh First Referral Health System Project (No. 25204). The World Bank.
World Bank, 2002b. Implementation completion report for Family Welfare (Urban Slums) Project (Implementation completion report No. 24994). HUMAN DEVELOPMENT SECTOR UNIT SOUTH ASIA REGIONUnit South Asia Region, World Bank, 1818 H Street, N.W. Washington, D.C. 20433, U.S.A.
World Bank, 2002c. Implementation completion report : The Andhra Pradesh First Referral Health System Project' (APFRHSP) (Implementation completion report No. 25204). World Bank, Washington, D.C. , U.S.A.
World Bank, 2002d. Implementation completion report for a cataract blindness control project (Implementation completion report No. 25232). Health, Population and Nutrition Unit South Asia Region, World Bank, 1818 H Street, N.W. Washington, D.C. 20433, U.S.A.
World Bank, 2001. Implementation completion report : for the national leprosy elimination project (Implementation completion report No. 21931). Health, Nutrition and Population Global Practice (GHNDR) South Asia Region.
World Bank, 2000. Implementation completion and results report : national HIV/AIDS control project (Implementation completion report No. 20138). Health, Nutrition and Population Global Practice (GHNDR) South Asia Region.
World Bank, 1999. Implementation completion report- India- Seventh population project (project report No. 18976). Health, Nutrition & Population Unit South Asia Region,The World Bank.
World Bank, 1998a. World Development Report 1998/1999 : Knowledge for development: including selected world development indicators, 1. printing. ed, World development report. Oxford Univ. Press, Oxford.
World Bank, 1998b. Implementation completion report India: Second Tamil Nadu Integrated Nutrition project (Implementation completion report No. 17755). Health, Population and Nutrition Unit South Asia Region, World Bank, 1818 H Street, N.W. Washington, D.C. 20433, U.S.A.
World Bank, 1997. Implementation completion report Child survival and safe motherhood project (Implementation completion report No. 16353). Population and Human Resources Operations

Division Country Department II South Asia Region, 1818 H Street, N.W. Washington, D.C. 20433, U.S.A.
World Bank, 1994a. Governance - the World Bank's experience (English) |. World Bank, Washington, D.C. , U.S.A.
World Bank (Ed.), 1994b. Enriching lives: overcoming vitamin and mineral malnutrition in developing countries, Development in practice. World Bank, Washington, D.C.
World Bank, 1993. World Development Report 1993 Investing in Health, Volume1. The World Bank, Washington, D.C.
World Bank, 1992a. "India : Health care financing: coping with adjustment- opportunities for reform" (No. 10859- IN). The World Bank.
World Bank, 1992b. Governance and development (No. 10650). The World Bank, Washington (DC).
World Bank, 1989. India - Sixth (National Family Welfare Training and Systems Development) Population Project (No. 7731). The World Bank.
World Bank, 1980a. Health sector policy paper (No. 40968). The World Bank.
World Bank, 1980b. World development report 1980. International Bank for Reconstruction and Development / The World Bank, 1818 H Street, N.W., Washington, D.C. 20433 U.S.A.
World Bank, n.d. Partners [WWW Document]. World Bank. URL https://www.worldbank.org/en/about/partners (accessed 12.6.20a).
World Bank, n.d. About I The Parliamentary Network on the World Bank & International Monetary Fund. Parliam. Netw. URL https://www.parlnet.org/about/ (accessed 12.6.20b).
World Bank, n.d. Global Young MP Initiative Program [WWW Document]. World Bank. URL https://www.worldbank.org/en/about/parliamentarians/brief/global-young-mp-initiative-program (accessed 12.6.20c).
World Health Organisation, 2012. Official Development Assistance (ODA) for Health to India 2000-2010.
World Health Organisation, 2011. World Health Organization, Country Cooperation Strategy 2012-2017 [WWW Document]. SEARO. URL http://www.searo.who.int/india/areas/country_cooperation_strategy/CCS_complete_document/en/ (accessed 8.26.19).
World Health Organisation, Affairs, W.H.O.D. of I., Bank, W., 1995. World Health Organization / World Bank partnership : recommendations for action for health development.
World Health Organization, 2012. WHO country cooperation strategy: India 2012-2017. World Health Organization. Regional Office for South-East Asia, India.
World Health Organization, 2007. Everybody's business: strengthening health systems to improve health outcomes : WHO's frmaework for action. World Health Organization, Geneva.
World Health Organization, 2000. The world health report 2000 00: Health systems: Improving performance. World Health Organization, Geneva.
World Health Organization, 1988. Strengthening district health systems based on primary health care.
World Population Prospects - Population Division - United Nations [WWW Document], n.d. URL https://population.un.org/wpp/Download/Standard/Population/ (accessed 9.14.19).
Yett, D.E., Drabek, L., Intriligator, M.D., Kimbell, L.J., 1972. Health Manpower Planning. Health Serv. Res. 7, 134–147.
Yin, R.K., 2009. Case study research design and methods, 4th ed. ed. Thousand Oaks, Calif Sage Publications.

ANNEXURE AND APPENDIX

ANNEXURE 1- INTERVIEW GUIDE

Introduction

I am studying the role of World Bank in health systems development in India post 1990- focusing on its influence in shaping governance structures (role in priority setting , promoting multi- level and multi-agency governance) and promoting alternate financing mechanisms (user fee and RSBY & State insurance schemes).My interest is to understand how network-governance has worked in India's health sector context , if few actors (Bank is this case) are more influential than others and how these influences are exerted ?

I would like to take your permission to audio record this conversation

I would also like to know who you would like to be identified while writing the research findings.

Following is a broad outline for our discussion.

1. Your association with the Bank? how did it begin? Your first direct involvement?

2. Who do you think are the main/powerful/influential global actors involved in health systems in India (taking up systems development agenda)?
   How do you think the role of Bank is different from these actors?

3. Why do you think India asked for assistance from Bank in health (the financial part is too low to support), how do you think the nature of this support has changed over time, 60s, 90s and after NRHM?

4. What has been Bank's role in NRHM – which activities did they support and why do you think they invested in those activities against others?

5. Bank often claims that it works on demand- how true is that and what is the role of Bank in conceptualising projects and technical assistance work?

6. In your experience did you ever feel that the Bank had influenced shaping our priorities (putting certain diseases like HIV on agenda, replacing certain technologies in National Health Programmes RNTCP- DOTS) and move towards user fee , now RSBY (Ayushman Bharat) & State specific insurance schemes?

7. How would you compare Bank's say/ influence/place on the policy decision tables in comparison to your organisation?

8. Do you think Bank had a role in promoting decentralisation of governance? setting up of autonomous institutions? NACO, SACS, and other quasi-government societies/bodies under National Health Programmes- has it helped the overall health systems development?

ANEEXURE 2- ETHICAL CLEARANCE CERTIFICATE

INSTITUTIONAL ETHICS REVIEW BOARD
Jawaharlal Nehru University
New Delhi-110067

Name of the Ethics Committee: IERB-JNU IERB Ref. No.2015/Student/80

Title of the Project Proposal: **"The role of Global partners [illegible] in strengthening health systems in India post 1990"**

Principal Investigator: Ms. Sumegha Asthana (Ph. D Student) C/o Dr. Ramila Bisht (Supervisor)
CSM&CH/SSS/JNU

Sponser: NA

Telephone: 9999191363 Email: drsumeghasharma@gmail.com

Collaborators' Name:

FOR OFFICIAL USE

The proposal was reviewed in a meeting held on 20th October, 2015 at 4:00 PM.
The following members were present:

1. Professor Shiv K. Sarin, Chairperson
2. Professor Madhuri Behari, Member
3. Dr. Tripti Khanna, Member
4. Advocate Rukhsana Chaoudhary , Member
5. Prof. Sangeeta Bansal, Member
6. Dr. Sushil Kumar Jha, Member
7. Dr. Paul Raj , Member
8. Prof. Amita Singh, Member Secretary

The committee resolved to

[ ] Approve - indicating that the proposal is approved as submitted;
[✓] Approve – after clarifications – indicating that the proposal is approved if the clarifications Requested are provided to the satisfaction of designated committee members;
[ ] Approve after amendment/s – indicating that the proposal is approved subject to the incorporation of the specified amendments verified by designated committee members;
[ ] Defer – indicating that the proposal is not approved as submitted but it can be reassessed after revision to address the specified reason/s for deferment;
[ ] Disapprove – indicating that the proposal is not approved for the reason specified.

Comments:

Amita Singh
Member Secretary,
IERB, Ethics Committee

Date of Approval: 14.12.2015
*(1st part to be filled in by PI and presented at the time of Review (Periodic, Continuing

Prof. Amita Singh
Member-Secretary
Institutional Ethics Review Board
Jawaharlal Nehru University
New Delhi - 110067

APPENDIX 1- World Bank Health sector projects in India				
Project Title			**Commitment Amount**	
National Nutrition Mission (also known as ICDS Systems Strengthening and Nutrition Improvement Project: Additional Financing)		Nutrition -6	200.00	
Uttarakhand Health Systems Development Project		HSS-11	100.00	
Nagaland Health Project		HSS-10	48.00	
Bihar Transformative Development Project		Transformative development	290.00	
Jhelum and Tawi Flood Recovery Project		Flood recovery	250.00	
Karnataka Multisectoral Nutrition Pilot	KR	Nutrition -5	4.55	2014
Accelerating Universal Access to Early and Effective Tuberculosis Care		TB-3	100.00	2014
National AIDS Control Support Project		HIV-4	255.00	
India - Bihar Panchayat Strengthening Project		Panchayat strengthening	84.00	
India: Karnataka Health Systems Additional Financing	KR	additional_karnataka HSS	70.00	2012
India: Uttar Pradesh Health Systems Strengthening Project (UPHSSP)		HSS- UP-9	152.00	
Tamil Nadu Health Additional Financing	TN	Additional health _ TN	117.70	2010
APRPRP 2nd Additional Finance	AP	Additional - AP	100.00	2009
India: National Vector Borne Disease Control & Polio Eradication Support Project		DS_ NVBDCP- 1	521.00	2008
Andhra Pradesh Rural Poverty Reduction: Drought Adaptative Initiative Project	AP	Rural poverty	65.00	2007
India: Third National HIV/AIDS Control Project		HIV-3	250.00	2007
India: Second National Tuberculosis Control Project		TB-2	170.00	2006
Karnataka Health System Development and Reform Project	KR	HSS- Karnataka-8	141.83	2006
India: Reproductive and Child Health Second Phase		RCH-5	360.00	2006
Orissa Socio-Economic Development Loan/Credit II	OR	Socio-economic development	225.00	206
India: Tamil Nadu Health Systems Project	TN	HSS- Tamil Nadu-7	110.83	2004
Orissa Socio-Economic Development Loan/Credit	OR	Socio-economic developemnt	125.00	2004
IN: Integrated Disease Surveillance Project		IDSP-1	68.00	2004
India: Rajasthan Health Systems Development Project	RJ	HSS- Rajasthan-6	89.00	2004
Andhra Pradesh Economic Reform Program II	AP	Economic reform	220.00	2004
India Immunisation Strengthening Project - Supplement		Immunisation-2	83.41	2003
Food and Drugs Capacity Building Project		Food and Drugs	54.03	2003

Andhra Pradesh Rural Poverty Reduction Project	AP	Poverty reduction	150.03	2003
Reproductive Health I (Supplement)		RCH-4	12.00	2002
SECOND NATIONAL LEPROSY ELIMINATION PROJECT		Leprosy-2	30.00	2001
Uttar Pradesh Health Systems Development Project	UP	HSS- UP-5	110.00	2000
Immunisation Strengthening Project		Immunisation-1	142.60	2000
Second National HIV/AIDS Control Project		HIV-2	191.00	1999
India: Maharash Health System	MH	HSS- Maharashtra-4	134.00	1998
Orissa Health Systems Development Project	OR	HSS- Orissa-3	76.40	1998
Woman and Child Development Project	KR,TN,MH,RJ ,UP	ICDS/Nutritiion 5	300.00	1998
Andhra Pradesh Economic Restructuring Project	AP	Economic restructuring/Nutrition	543.20	1998
Malaria Control Project		Malaria-1	164.80	1997
Reproductive and Child Health Project		RCH-2	248.30	1997
Rural Women's Development and Empowerment Project		Women Empowerment	19.50	1997
Tuberculosis Control Project		TB-1	142.40	1997
State Health Systems Development Project (02)		HSS- Punjab , Karnataka, West Bangal-2	350.00	1996
Andhra Pradesh First Referral Health System Project	AP	HSS- AP-1	133.00	1994
Family Welfare (Assam, Rajasthan and Karnataka) Project	Assam, Rajasthan and Karnataka	Population/FW-(Assam, Rajasthan and Karnataka)-9	88.60	1994
Cataract Blindness Control Project	AP,MP,MH, OR,RJ,TN,UP	Blindness-1	117.80	1994
Maharashtra Emergency Earthquake Rehabilitation Project	MH	Earthquale Rehab	246.00	1994
National Leprosy Elimination Project		Leprosy-1	85.00	1993
Karnataka Rural Water Supply and Environmental Sanitation Project	KR	WASH-2	92.00	1993
Integrated Child Development Services Project (02)	MP,Bihar	ICDS/Nutrition-4	194.00	1993
Social Safety Net Sector Adjustment Programme Project		Social Safety Net Sector Adjustment Programme Project	500.00	1992
Family Welfare (Urban Slums) Project		Population-8	79.00	1992
National AIDS Control Project		HIV-1	84.00	1992
Child Survival and Safe Motherhood Project		RCH- 1	214.50	1991
Maharashtra Rural Water Supply and Environmental Sanitation Project	MH	WASH-1	109.90	1991
Integrated Child Development Services Project-1	OR, AP	ICDS/Nutrition-3	106.00	1990
Tamil Nadu Nutrition Project (02)	TN	Nutrition - TN-1-2	95.80	1990
Population Project (07)		Population-7	96.70	1990

National Family Welfare Training and Systems Development Project		Population-6	124.60	1989
Population Project (05)		Population 1-5	57.00	1988
Urban Development Project - Tamil Nadu	TN	urban development	300.20	1988
India Technical Assistance for Project Development			50.00	
West Bengal Health Sector Development Project			12.00	
Kerela Health Sector Support			142.98	
ICDS Reform			60.00	
India: TB II Additional Financing			100.00	
Third Karnataka Structural Adjustment Loan			200.00	