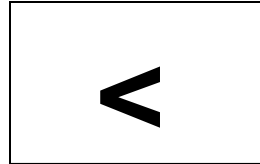


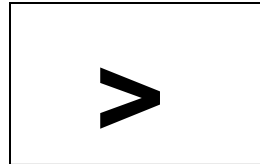
# Health Sector Reform: Initiatives under NRHM

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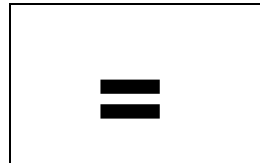
R e f o r m



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# Structure of the presentation

- Basic Concepts, philosophy & Definition of HSR
- HSR in Indian context: Plan period & NRHM
- Notable Reforms area During the journey of NRHM
- Progress during NRHM
- Key Issues & Challenges

- No consistent and universally accepted definition of what constitutes Health Sector Reforms thereby leading to varied meaning and connotations.
- Reforms are stimulated by economic recession, fiscal problems or ideologically driven taste for reform
- Complex process & no universal Package
- Public health challenges are marathon, not a sprint

# Definition

- "Sustained purpose ful change to improve the efficiency, equity and effectiveness of the health sector"-Peter Berman (1995).
- "Defining priorities, refining policies and reforming the institutions through which those policies are implemented"- Cassels (1995).
- HSR initiatives are more focused on process than health outcomes (WHO 1999, Foster et al. 2000b).

# Dynamics of HSR

- Shift in international thinking from Public provision to private one during SAP of 90s
- squeeze of the resources available for the provision of care, including not only unpaid care, but also care services provided through the public and private sectors (HDR, 1999)
- reduction of government expenditures on tertiary facilities, specialist training; implementation of user fees & contracting out of services. (WDR 1993)
- budget cuts, tax reforms, limited privatization, liberalization of prices and, most conspicuously, efforts to downsize the public sector need to be initiated to cut government expenditures and to revive the private sector as visualised in WDR 1997 (Björkman on HSR)

# Factors influencing HSR

- Changing health scenario,
- Macroeconomic situation,
- Political environment,
- Societal values,
- Dwindling resources and external influences
- four main core functions of the health system
  - governance, provision, financing and resource generation.
- health sector reform is deliberate, planned and intended to make long term, permanent changes, rather than ad hoc or emergency action.

# With these background.....

HSR deals with

Equity, Effectiveness, Efficiency, Quality,  
Sustainability issues in provisioning, Defining  
priorities, Refining the policies, Reforming  
institutions for policy implementations

# HSR consists of

- Implementation of new public management systems
- Reorganization of the health ministry linked to overall reform of the public sector's budgeting, accounting and planning systems;
- Decentralization of sector activities, including local ownership and accountability for the planning and/or management of service delivery; decentralization of financial management;
- Introducing alternative financing mechanisms,
- HSR is not a uniform concept. It covers a wide range of structural and institutional changes also

# Types of HSR

- “first generation” of reforms was supply-side driven and focused on the health sector (Standing, 2000).
- assigned priority to the following elements:
  - improving health sector management systems
  - public sector reform
  - reform of financing mechanisms, cost containment
  - decentralization
  - working with the private sector
- “second generation”- emphasizing demand side, anti-poverty interventions and intersectoral approaches to health. Added agendas are-
  - partnership with key stakeholders;
  - focus on community/user needs; and
  - health as part of the poverty agenda.

# Björkman on HSR

- First generation
  - downsizing, contracting out, improved control over budgeting and public expenditures
- Second generation
  - public sector reforms to improve the efficiency and effectiveness of government, decentralization to sub-national levels, reforms of human resources management (including recruitment, selection, training and performance)
- Third Generation
  - coherent program for delivery of services that involves both governmental and non-governmental organizations. i.e. SWAp

# Health Sector Reforms in India

- Started in early 1990's
- India's reform measures are piecemeal and incremental
- Gradual shift in the organization, structure and delivery of health care.

# Contd..

- Eight Five Year Plan (1992-97)
- Revocation of free Medical Care
- Levying of User charges
- Encouragements of Private sectors
- Ninth Five Year Plan (1997 - 2002)
- Enabling PRI in planning & monitoring health programs
- emphasis on public, private and voluntary health care providers Participation
- **Tenth Five Year Plan (2002 - 2007)**
- Emphasis was on equity and financing health care
- Social Health Insurance for BPL population
- Human resource development;
- Skill up gradation of health care providers
- Horizontal integration, Formation of a single health and family welfare society
- Quality Assurance, delegation of powers to PRIs, PPP,
- National Rural Health Mission.

# NRHM

Architectural corrections in delivery system is reform agenda

- ✓ Promote equity, efficiency, quality and accountability in public health systems
- ✓ Enhance community-based approaches to health
- ✓ Ensure public health focus
- ✓ Promote new innovations, methods and process development
- ✓ Decentralize and involve local governing bodies

# Key concepts



# Areas of HSR

- Decentralization
- Human Resources
- Financial reform
- Re-organization & re-structuring of existing system through management input
- Communitisation
- Quality assurance
- Convergence
- Public Private Partnership
- Governance
- Innovation/ initiatives

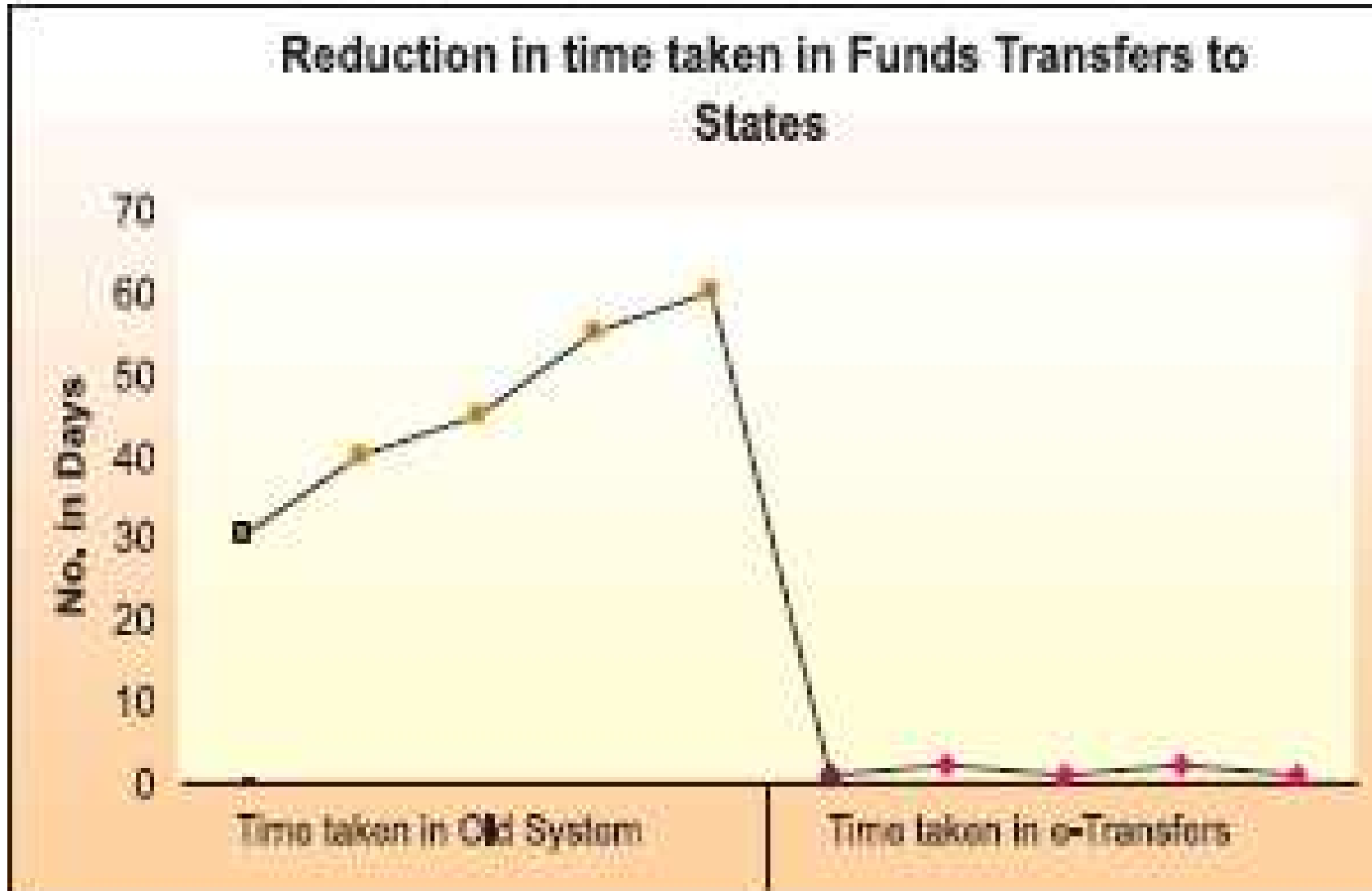
# Decentralization

- *Devolution of authority and responsibility*
- *Deconcentrate the functions* through delegation of responsibility for managing financial resources, deployment of human resources, and managing for hospitals and health centres.
- *Delegation of responsibility and functions*
- Shifting power from the central offices to peripheral offices of the same administrative structure (Bossert 1995).
- Merger & formation of Societies, VHSC, RKS
  - Transfer of authority, functions and financial resources to lower level units.
- Decentralization of Planning Process
- Decentralization of Financing mechanism
- NGO participation in NVBDCP, RNTCP, NAIDSCP, NBCP, MNGO scheme

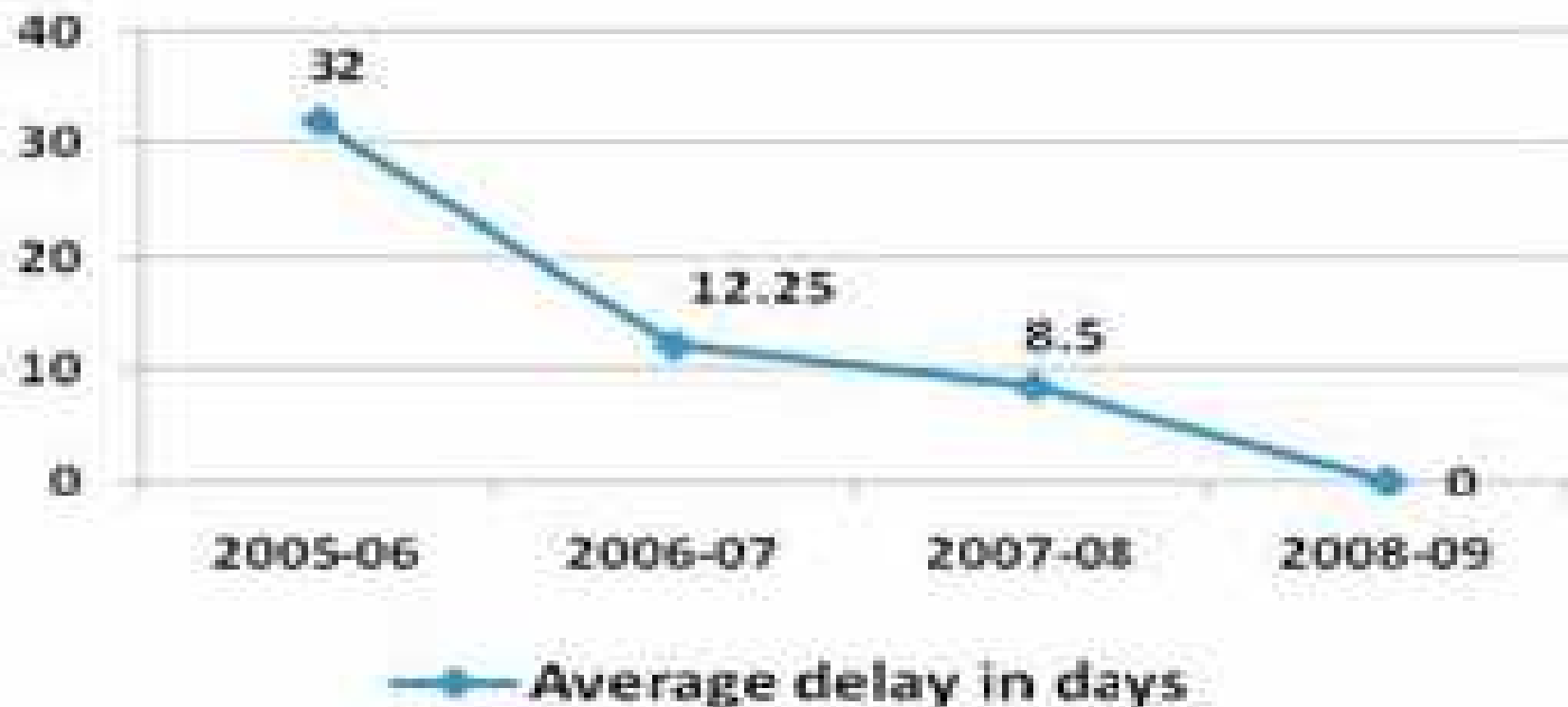
# Financial reform

- Commitment to raise the public expenditure on health from 1% of GDP to 2-3% of GDP over the Mission period
- Currently increased from .9% to 1.4%
- New financing mechanisms of untied funds, breaking the traditional Treasury route, Flexi pool
- Society mechanism for fund transfer
- Untied grants to village, PHC, block, district
- Demand side finance through Insurance (Raj, Kar) & RSBY, Conditional cash transfers (JSY)
- Flexible financial resources to ensure service guarantees
- State Government's increase their allocation by 10 % every year and also contribute 15% to NRHM.

# Milestones in Financial Management

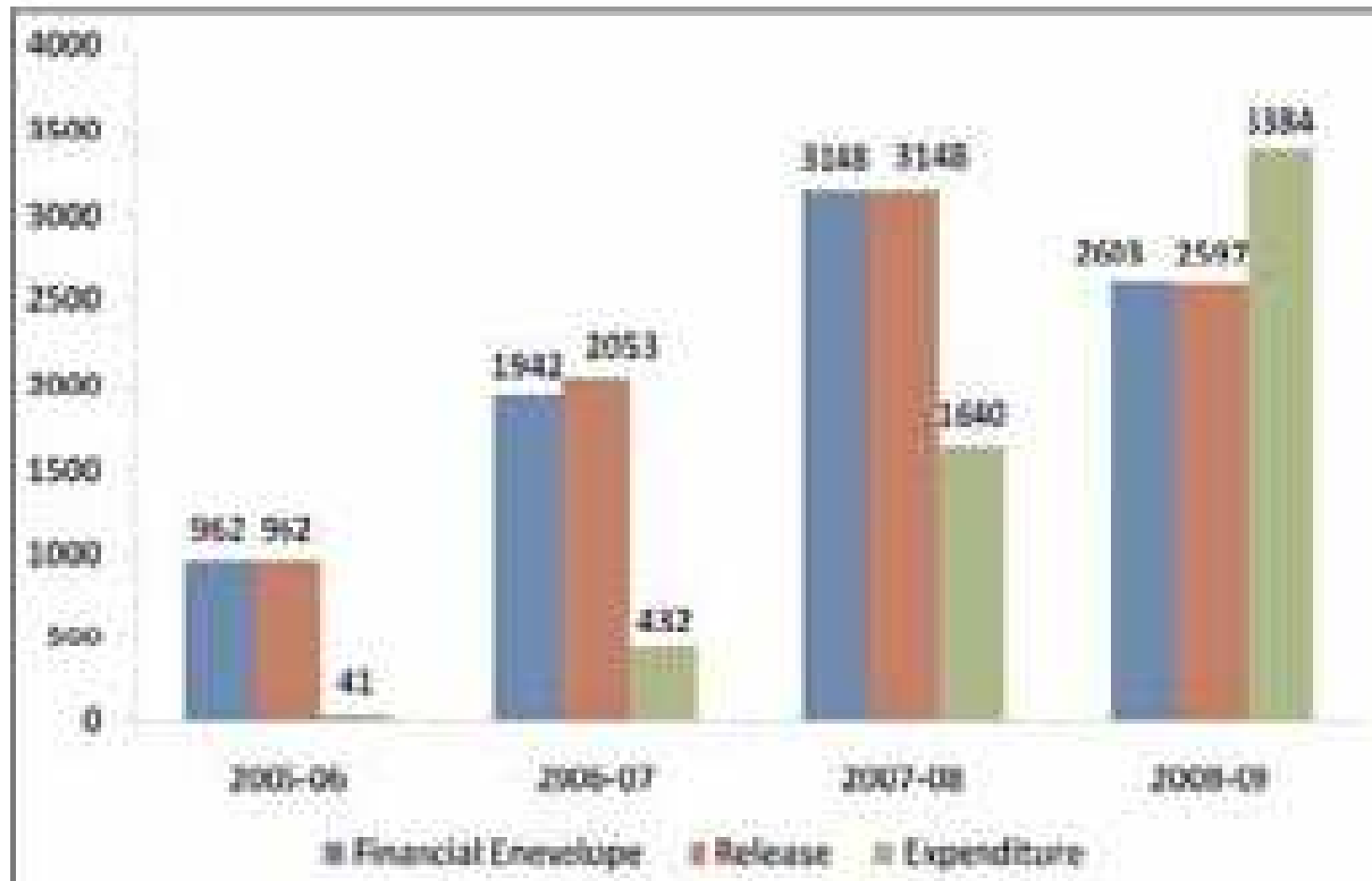


## Average delay in days in receipt of FMRs from States

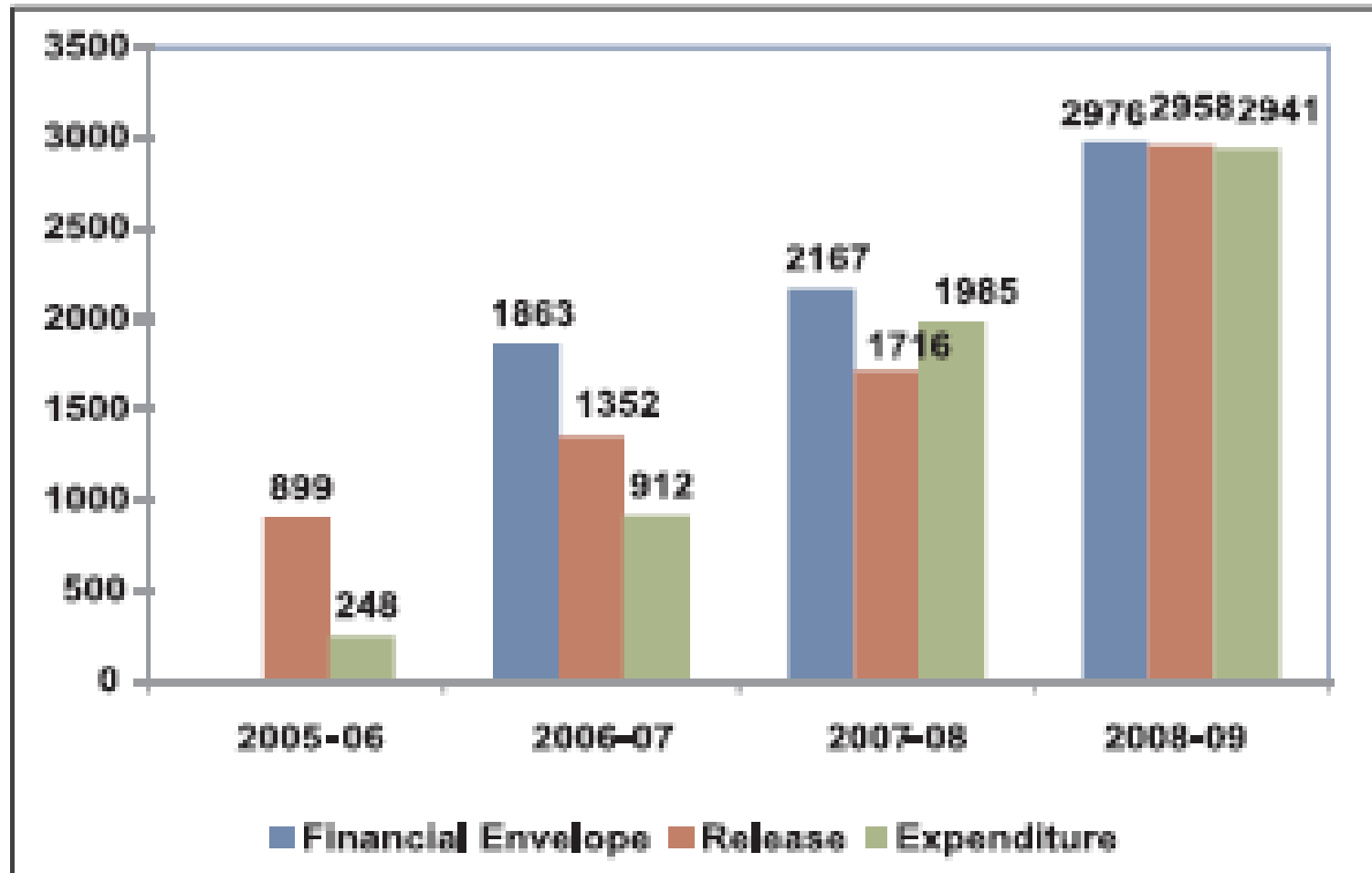


# Trend of Fund Utilization since 2005-06

Allocations and Utilization Mission Flexible Pool (Rs. In Crores)



### Allocations and Utilization RCH Flexible Pool (Rs. in Crore)



# Reforms in HR

## Creating the norms Through IPHS

- two ANMs per sub-center and one male MPW.
- Three nurses/ANMs per PHC plus two medical officers.
- Adding AYUSH staff into available pool.
- Nine nurses per CHC plus 5 specialists and 3 to 4 medical officers

## Expanding available skilled human resource

- More teaching institution through public private partnerships.
- More government seats in private medical colleges
- Reviving ANM and MPW training centers

# Contd..

## HR innovation in priority areas

- Compulsory rural postings- Orissa, Chhattisgarh, Tamil nadu, Assam
- Rural Health Service cadre in Raj
- Contractual appointments - Additional ANMs, nurses in bihar, west bengal, tamil nadu, Specialists in madhya pradesh.
- fair transfer policy- rotational postings... tamil nadu..
- Incentives for difficult areas- eg Himachal and Orissa.
- 'Pooling' of medical officers - West Bengal, Bihar, Jharkhand.
- Multi skilling option for existing staffs

# PPP options as HR solutions

## Contracting-in options -

- MP for specialists

## Contracting-out options -

- PHCs to Karuna trust in Arunachal Pradesh, Bihar: Of PHCs; of diagnostics, of district planning, Gujarat: PHCs, CHCs and a district hospital for CHIRANJEEVI scheme, Punjab: village level dispensaries

# Improving workforce performance

- Putting an accountability framework in place:
  - Hospital development committees.
  - Community monitoring programme.
  - Involvement of PRIs.
- Linking funds for new contractual appointment to filling up of regular vacancies.....
- Untied funds to enable local health care providers...
- Bringing in a cadre of health managers and data managers and financial managers.
- Introducing health management courses and promoting health management certification for key posts.
- PG preference to the doctors

# Structural Re-organization

- Creation of Societies- bypass regular government procedure
- National/ State level technical support organisation like - NHSRC, NE -RRC, SHSRC
- SHSRC established/ in process at Chhatisgarh, Gujrat, Uttarakhand, Punjab, Karnataka, AP
- Emergency response systems- 108, EMRI
- Procurement initiatives - TNMSC, KMSC, Assam, UP
- National HMIS
- meaningful partnerships with the non-governmental providers for reaching quality health care
- Co location of AYUSH in 7244 PHCs/CHCs/District Hospitals

# Communitisation

- Community accountability through RKS and community monitoring process
- Community Health volunteer - ASHA
- PRI involvement in health care
- Village health & nutrition days (VHND)

# Quality Assurance

- New standards for government facilities - IPHS
- ISO process, NABH & NABL standards
- Focus on service guarantees

# Management Mechanism

- Management teams at various level
- New Financial Manangement
- Procurement, logistic mangement

# Convergence

- Bridging the gaps between link dept
- Envisaged horizontal and vertical linkages within Health sector
- Intra sectoral and Intersectoral integration
- Mainstreaming of AYUSH

# Key Reforms in States

Cadre Reforms to attract more doctors / Para medics/Nurses in public system	Bihar, Madhya Pradesh, Rajasthan, West Bengal, Orissa, Andhra Pradesh, Haryana, Maharashtra, Himachal Pradesh.
Incentives, performance based systems, for difficult areas	Assam, Madhya Pradesh, Uttarakhand, Rajasthan, Chhattisgarh, Orissa, Andaman & Nicobar Islands.
Transparent procurement and logistic systems to ensure availability of quality drugs and equipment.	Kerala, West Bengal, Bihar, Madhya Pradesh, Gujarat, Karnataka, Maharashtra.
Rationalization of posting of doctors and paramedics	Uttar Pradesh, Assam, Tamil Nadu, Jharkhand, Bihar.
New multi skilling courses to increase the pool of Specialist services in emergency situation	In nearly all the States.
Increase in intake of nurses, ANMs, Lab Technicians, etc.	Orissa, Maharashtra, Madhya Pradesh, West Bengal, Assam.

## Gains during NRHM

Indicator	The Gain under NRHM
IMR	IMR down to 55. Down by 2 points in 2007 as compared to a point a year in earlier years (2003-2006). Possible to achieve the required reduction, if neonatal mortality is effectively addressed through 48 hour stay after institutional delivery.
Instt. Delivery	Increased by 66.4% in MP, 50.2% in Raj, 47.3% in Bihar, 43.8% in Orissa, 20.9% in AP & 12.4% in UP between DLHS - II (2004) and DLHS - III (2007).
Immunization	Full immunization increased from 20.7% to 41.4% in Bihar, 25.7% to 54.1% in Jharkhand, 30.1% to 36.1% in MP, 53.5% to 62.4% in Orissa, 23.9% to 48.8% in Rajasthan and 25.8% to 30.3% in UP between DLHS - II & III.
MMR	Down from 301 in 2001-03 to 254 2004-06.

# Key Issues

- 'project approach ' to health sector reform under Govt Agenda
- Issue of co-ordination among donors & overlapping of priorities and agendas
- Problems of inculcation of Institutional memory regarding HSR in system level - adhocism
- substantial variation across States in terms of their commitment to undertake reform and their capacity to implement
- Each state at a different juncture in the reform process
- incremental changes Vs Reforms.
- No nodal agency at centre or state level to locate reforms

# Challenges

- Owning of the program through involvement of Directorate
- Acclimatization of Management process in health sector
- Operationalisation of Communitisation/ Decentralisation as envisaged
- HMIS standardization maintaining context specificity and uniformity
- Sustainability HR issues & devise state specific HR policy which is implementable
- Regulation of PPP
- Re-strengthening of training instt.
- Quality issues of SC, PHC, CHC
- Increment in Utilisation of Financial Resources
- operationalise True delegation and ownership

## Contd..

- Real time Mainstreaming of AYUSH and role definition of AYUSH practitioners under NRHM, cross referrals
- Block plan, Social auditing,
- Sustainability of Demand side financing
- DHAP based budget allocation and its implementation
- Convergence between PRI and Health (DPC & DHS)
- Promotion of Multi skilled work force management
- Inbuilt supervision and monitoring mechanism
- Rational Drug Use, STG, Generic medicine availability

Thank You