healthcare and laments that the allocation by states has in fact decreased in the past decade. There is a veiled attempt to castigate the states for their inability to increase expenditure. Such insinuations are meaningless without a detailed analysis of the manner in which the process of economic liberalization in India has shattered the financial stability of states.

TOP-DOWN PRESCRIPTION

The NHP 2002, for all the rhetoric on community participation, is replete with 'top-down' prescriptions. While admitting the wastage involved in running centrally sponsored and controlled vertical disease control programmes and envisaging their integration in the decentralized primary healthcare system, it goes on to recommend that we would need to retain many of them! All subsequent formulations in the policy, especially in the section on policy formulations, assume the continuance of vertical programmes. Moreover, the policy repeatedly asserts that the Centre will continue to plan all public health programmes. It continuously harps on the availability of expertise with the Centre to justify strong Central control. It is not clear where the basis of such assertions lie. The document is vague about the actual devolution of responsibility and financial powers to Panchayat Raj institutions (PRIs) and relocation of accountability to appropriate levels of local self-governments. In the absence of such clarity there is danger of the primary healthcare system becoming a collector-driven exercise, which is controlled by the Centre, thereby defeating the entire effort at decentralization.

The policy talks about using Indian health facilities to attract patients from other countries. It also suggests that such incomes can be termed 'deemed export' and should be exempt from taxes. This formulation draws from recommendations that the industry has been making and specifically from the 'Policy Framework for Reforms in Health Care' drafted by the Prime Minister's Advisory Council on Trade and Industry, headed by Mukesh Ambani and Kumaramangalam Birla. Such a proposal, termed by many as 'health tourism' will divert our best resources within the country. The policy also talks of encouraging 'the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages'. Further, the document refers to the 'valuable' contributions made by the private sector and the need to 'encourage' more such contributions. While it is often critical of the public health system (justifiably so), there is no criticism of the ills of the unregulated private medical care system, though reference is made to the need to develop regulatory norms.

In brief, the NHP 2002 identifies many of the gross deficiencies of the existing healthcare scenario, proposes a substantial rise in Central Government expenditure on healthcare and has some other positive features such as the proposed regulation of the private sector. However, in operative terms, it constitutes an abandonment of the Alma Ata Declaration, and legitimizes further privatization of the health sector.

(At the National Medical Journal of India 2002, formulated by the Jana Swasthya Abhiyan: A network of Health Movements across the country.)

Draft National Health Policy 2001: A leap forward in assessment but limping in strategies

V. MOHANAN NAIR

SITUATIONAL ANALYSIS AND STATED OBJECTIVES

The 'Draft National Health Policy—2001' is a leap forward in the history of evolution of healthcare in India. The background against which the draft was prepared is realistic because it was clear that the country could not make all the expected strides mentioned in the previous National Health Policy (NHP) of 1983. The claims on the initiatives in primary healthcare and control or eradication of communicable diseases, and the quoted achievements in demographic, epidemiological and infrastructural indicators are well founded. The concern shown regarding the alarmingly increasing trends of morbidity, even in the wake of declining mortality and the relative inability of the public healthcare system in the country to cope with the mortality and morbidity burdens, is also apt. Thus the justifications provided for the new health policy are convincing and the attempt to have a framework for accelerated achievement of the set public health goals optimistic.

The draft document realizes that the greatest impediment in achieving the set goals of NHP 1983 were factors outside the formal healthcare delivery system such as the fiscal crisis. The equity considerations which the policy emphasizes are also relevant in the current context. Wide variations in health indices across regions is a matter of concern and even in 'better performing states' the overall indicators mask the reality of differentials across regions. This amply justifies the concerns about 'access'. Inequitable distribution of services has worked to the disadvantage of the poor. Still worse is the case of women, children and marginalized sections such as coastal, tribal and migrant populations. Against such a background, the stated objectives of the policy appear realistic.
NATIONAL HEALTH PROGRAMMES AND PUBLIC HEALTH PRIORITIES

National health programmes and their implementation are serious policy issues. These programmes, funded by the Central Government, should provide operational flexibility. A majority of these programmes are also supported by external agencies so they will have to be integrated into the general health services for sustainability, when the funding agencies bow out. Such integration has always been problematic. Shifting the role of the workforce from a single programme to several general priorities often leads to complacency and non-accountability. Integration often leads to work-site conflicts on the 'promotion prospects and career development' of employees. States may not be able to support the integrated workforce, with the result that they may neither be keen in filling up the vacancies of these workers nor interested in creating new posts, if necessary. The present plight of 'multipurpose male health workers' is an eye-opener in this regard. The creation of posts in vertical programmes and their subsequent integration should be in accordance with the felt needs rather than based on the availability of funding.

The financial autonomy given to district societies for implementing national health programmes needs monitoring. Resources routed through these societies are bypassing state treasuries and the usual monitoring mechanisms. Autonomy of these societies is sometimes taken to such an extent that even technocrats may be sidelined in their decision-making process. They make fund flows smoother and financial operations easier by bypassing bureaucratic tangles. However, this financial autonomy should not jeopardize professional decision-making. In that event, the system will fail in its ultimate goal.

Though the observations made about poor utilization of the public healthcare system are apt, the cited reasons are not convincing. The reason for the present plight of the public healthcare facilities is not the dearth of drugs alone. The assumption that availability of drugs is the reason for better utilization of such facilities in the southern states is also erroneous. Even in these states, the utilization levels of such facilities are not high. Several other factors such as better connectivity, health activism and involvement of Panchayati Raj institutions (PRIs) have led to these outcomes.

Prescribing a specific allocation or hike in the quantum of resources is not of much use as state governments may find it difficult to do this in the face of competing priorities. Unexpected calamities and catastrophes may jeopardize even the most balanced economies. There is an extent to which the government can fully support primary healthcare. Increased allocation may sustain the sector for a while, but the long term consolidation of gains and sustainability will depend on the resource generation potential of the sector. Alternate strategies such as involving the private and non-governmental sectors in primary healthcare should be thought of. It is usually argued that the private sector may not have any incentive to own the primary healthcare field. However, recent experiences in immunization and the revised National Tuberculosis Control Programme, in which private and non-governmental sectors are playing commendable roles, have shown that this is not necessarily true. The private sector, the major player in the curative sector, can also be encouraged to take up urban primary healthcare. In rural areas small dispensaries and single practitioners play important roles and they can be incorporated into the primary healthcare setup. For sustainability of primary healthcare, replicable components from models such as the National Health Services (NHS) of the UK can be incorporated into our health system.

The assumption that more investment in primary health centres (PHCs) will lead to provision of better quality services is unsound. Community involvement in health remains the pivot of primary healthcare. Allocations and expenditure have to be decentralized with PRIs assuming lead roles. This is happening in states such as Kerala, where healthcare delivery institutions have been transferred to the PRIs.

The vast idle capacity existing in many of these facilities needs to be utilized properly. The development funds of Members of Parliament and Members of Legislative Assemblies were utilized for the construction of buildings and inpatient blocks in several PHCs. They lack supportive manpower and allied facilities resulting in their remaining idle. In future, the concerned departments will have to be taken into confidence in drafting plans for such constructions and necessary manpower and ancillary facilities will have to be ensured. Already 'idling facilities' need to be made operational by suitable corrective measures. PRIs can take the initiative by providing manpower and facilities. Alternatively, they can be hired out to charitable, non-governmental or private agencies, with some governmental control to ensure proper service delivery.

Efforts in extending service provisions through paramedics and doctors of other systems are likely to have unpleasant consequences. In the developed world where such workers are being deployed, the socioeconomic milieu in which they work and the technical support rendered to them are different from those in India. The proposed attempts in India may lead to the creation of a cadre of 'half-baked paramedical doctors'. The case for using practitioners of other systems of medicine for implementation of central and state health programmes is similar. They may use this provision for unethical practices of modern medicine, leading to rampant 'quackery'.

HEALTH SECTOR AND PRIs

In Kerala, primary healthcare has been transferred to PRIs. They are taking the lead role in the implementation of national health programmes. A sizeable part (about 35%-40%) of the 'Plan fund' is also diverted to PRIs to be used for 'bottom up' planning, project formulation and implementation. Such initiatives could be replicated.

MEDICAL EDUCATION AND FAMILY PHYSICIANS

The draft does not attempt any serious analysis of the medical education sector. The observation that students, on completion of their medical education, are unwilling to move away from their native places is without basis. On the other hand, students from rural areas seldom go back to their native places after graduation. Medical education has to be revamped in such a way that our graduates are suitable and willing to work in our circumstances. Our graduates need to be well versed with the realities of our healthcare delivery system. This requires the concerted efforts of administrators, academicians and policymakers. In the wake of the epidemiological and demographic transitions, medical students need to be sensitized about emerging and re-emerging infectious diseases, morbidity due to mental illnesses, problems of the 'elderly' and degenerative diseases. Postgraduate training and specialization should be 'need oriented' and ensure the services of specialists to the community.

Having more 'specialists in public health and family medicine' is a long forgotten agenda. In India, public health as a specialty has a very low priority. There is no incentive even for motivated professionals to take up this specialty. Facilities for public health
education are also meagre. The study of public health is often limited to the curriculum of community medicine. It needs to concentrate more on areas of current importance such as epidemiology, health management, health policy analysis, gender studies and environmental sciences. The cadre of family practitioners should be developed as the backbone of our health system and the existing imbalance between 'generalists' and 'specialists' should be corrected.

States should create cadres of health administrators and public health and primary healthcare experts. Though over the past few decades public health has emerged as a specialty in the developed world, it has been neglected in India. Family medicine should be developed to make available a sufficient number of family physicians. Better incentives and more seats for postgraduation in this specialty will have to be instituted. The National Board of Examinations needs to consider extending its facilities to medical officers ‘in service’ to undergo postgraduate training in the specialty.

MEDICAL GRANTS COMMISSION: A WHITE ELEPHANT?
The assumption that setting up a Medical Grants Commission will improve the quality of medical education seems too optimistic. The functioning of such bodies in other sectors such as higher education has not been very assertive. An alternative is to provide autonomy to individual institutions. The government’s role can be limited to quality assurance in education and provision of services. Resource generation and management should be left to the institutions. Creation of newer administrative structures may lead to wasteful expenditure, and overburdening and collapse of the system.

URBAN HEALTH: STARTING FROM SCRATCH
India at present lacks a streamlined urban primary healthcare model. In addition to the menace of pollution, vehicular accidents and poor environmental sanitation, repeated outbreaks of communicable diseases and other public health problems in these areas raise serious concerns. It is time to develop a suitable urban primary healthcare model. The government sectors including PRIs can develop partnerships with private and non-governmental sectors. The latter can be encouraged to adopt urban areas for primary healthcare provision.

NEED FOR A MENTAL HEALTH POLICY
In the wake of the epidemiological transition, mental health has emerged as an area of concern. The morbidity burden posed by mental problems is often overlooked. We do not have a sufficient number of qualified experts in this field. Community-based interventions would be the long term answer to these problems. We have initiatives such as the District Mental Health Programme and there are several institutions involved in the research and development of models. Kerala has developed a separate mental health policy in view of the high magnitude of such problems in the state. Such decentralized initiatives in the policy formulation process need to be encouraged. These issues can be looked at from a national perspective and acted upon locally. Since these maladies are going to assume greater importance in the future we need to have a comprehensive policy for mental health.

INFORMATION, EDUCATION AND COMMUNICATION
Reaching the unreached in a culturally compatible way
Information, education and communication (IEC) strategies are essential for effective implementation of health programmes. We need to develop culture-compatible, region-specific, individual-oriented IEC strategies. At the micro level, where technology-intensive methods may fail, strategies targeting individuals may succeed. Schoolchildren and adolescents should be targeted, as they form a large chunk of the vulnerable population.

At present, there are numerous administrative and managerial problems in the implementation of IEC activities. They need to be stratified to reach the lowest levels of organizations (at present, they stop at the district level). The current practice of fragmented, watertight compartments for IEC activities for individual national health programmes leads to duplication of activities and wastage of resources. This must be coordinated and streamlined.

MEDICAL RESEARCH
Along with medical research, operational research in health systems should also be given priority. Such studies should be the basis for sustainable development of our health systems. Currently, there is no incentive for research. Serious research needs to be encouraged and incentive and reward mechanisms need to be instituted to attract the best brains. To improve the quality of teaching and research in medical education, academic excellence and research activities of teachers should be sufficiently rewarded. Ethical concerns in medical research have been neglected and require immediate policy interventions.

PRIVATE SECTOR
The private sector has emerged as the major provider in the field of curative services even in rural areas. There are private institutions ranging from single doctor dispensaries to multi-specialty corporate establishments. The phenomenal growth of the sector has made the government think in terms of its regulation. However, regulatory mechanisms often fail due to weak implementation. An alternative will be to put accreditation mechanisms into place, at least to begin with. Associations of professionals, such as the Indian Medical Association, could be accreditation agencies as they can influence their members to stick to standards. The PRIs can take up the responsibility of licensing because they have statutory powers in this regard. To ensure uniformity in management protocols followed by various providers, standardization of institutions and referral protocols will have to be developed. Option of non-governmental practitioners into national disease control programmes is a welcome move. This should be extended to all national health programmes and to the delivery of primary healthcare. This may ensure uniformity in medical practice across sectors.

WOMEN’S HEALTH: THE NEED FOR A ‘POLICY FOR WOMEN’
Women’s health has not received enough attention in the document. Gender equity has to assume a central role. Healthcare delivery systems have to be made more gender sensitive. Gender discrimination and growing instances of violence, including domestic violence against women, are of great concern. Healthcare ensuring confidentiality and a supportive attitude should be ensured as a policy. The policy should have addressed not only women’s health issues, but also the broader perspectives of health and development. The government should come out with a comprehensive policy for women encompassing all these aspects.

MEDICAL ETHICS
We need to develop culture-compatible and community-specific ethical guidelines in keeping with our societal peculiarities rather
than depending on western models. There is no strong official machinery to ensure ethical medical practice and research. Professional organizations can shoulder these responsibilities and ensure compliance with ethical standards, at least till a regulatory machinery is formed and fully empowered. Human rights violations in places of healthcare delivery are more common in the developing world. Poverty, illiteracy and other social factors contribute to their occurrence. Under these circumstances ethical concerns, both in medical practice and research, must get priority.

OCCUPATIONAL HEALTH
The policy is very vague about this important area of healthcare. Occupational health is much more than periodic screening. Ensuring the health of employees by stringent health standards, safety measures and recreational facilities in workplaces should have been addressed in the policy document. Rehabilitation should be given adequate importance in occupational health. Safety standards and healthcare facilities should be made statutory requirements for the licensing of industrial establishments.

INFORMATION TECHNOLOGY
The potential of information technology will have to be tapped fully by the health sector. Streamlining the flow of information, developing referral linkages, providing feedback and making available the most recent developments in the medical field even to the remotest practitioner are all now possible.

MEDICAL FACILITIES TO OVERSEAS USERS
The proposal for providing medical facilities to users from overseas so as to earn foreign exchange requires serious rethinking. The public healthcare delivery system is not even self-sufficient. Health tourism, as a means of earning foreign exchange, should be left to the private sector. Quality of services will have to be ensured and the possibility of cultural invasion attendant to this tourism will have to be borne in mind. Overall, it will be better for the government to not venture into this field.

GLOBALIZATION AND THE HEALTH SECTOR
The policy document trivializes the consequences of TRIPS and globalization as cost escalation of drugs alone. The impact of globalization may affect the basic philosophy of equity. Heavily subsidized primary healthcare, as it exists in India, would suffer the most. At present, we do not have a viable alternative to the government-owned and -operated primary healthcare. Anything that affects it would affect the health of our population. The rural, marginalized and poor would be the worst sufferers. The currently operational social security measures should not be allowed to suffer due to restrictions imposed by globalization. Even while trying to reap the benefits of globalization, we have to consolidate and preserve the achievements hitherto made.

LICENTIATE MEDICAL PRACTITIONERS
A retrograde step and a bone of contention
Attempts to fill the gaps of manpower shortage by creating a cadre of 'Licensed Medical Practitioners' (LMPs) was tried in Kerala and discarded decades back due to its adverse outcomes. The apparent shortage of doctors in rural areas is not due to an absolute shortage of healthcare professionals. The reasons for such shortage need to be addressed by suitable mechanisms. In Kerala, when such a facility was extended to the practitioners of other systems, it led to immense chaos and turbulent situations in the healthcare delivery system due to the unethical practices resorted to by these medical practitioners. Past experience suggests that such a step will lead to rampant quackery. Entrusting the practice of modern medicine, even to a very small extent, to practitioners of other health systems will have far-reaching consequences and can never be accepted as a policy prescription.

RECRUITMENT PROCEDURES
Recruitment procedures need revamping to make available more medical manpower in rural and underserved areas. Incentives such as better remuneration and reservation of seats for postgraduate studies could be instituted. One can even consider compulsory rural service as a prerequisite for postgraduate admission and bonded obligation to serve in rural areas for medical admissions. Such compulsory measures are justified because medical education in the government sector is heavily subsidized. The cost of medical education has to be fully recovered from candidates unwilling to serve the public. District-wise selection for medical and paramedical courses and recruitment of doctors and paramedics can also be tried. In the case of the underserved tribal and coastal areas, the ultimate aim should be to train local manpower.

TRAUMA AND ACCIDENT VICTIMS
Road traffic accidents and other emergencies are on the increase. The problems of rapid urbanization, rapidly increasing vehicular population and poor road conditions lead to a heavy burden of road traffic accidents. Since the time lag between the occurrence of an accident and receiving proper medical attention is the crucial factor in saving lives, it is mandatory that proper medical attention reaches accident victims in time. Fully equipped and streamlined emergency management facilities with referral linkages and transportation facilities should be made available. The policy should focus on this aspect and formulate prescriptions accordingly.

SCHOOL HEALTH PROGRAMMES
School health programmes have not achieved the desired results in the majority of states. The programme has become almost defunct because of administrative, managerial and logistic problems. This should be incorporated into the primary healthcare delivery system along with better coordination between the education and health departments.

ENFORCEMENT OF QUALITY OF FOOD AND DRUGS
The quality of drugs, both of modern medicine and other systems, has to be ensured. There should be a specific delineation between drugs and food items. Here also the current implementation machinery is very weak. An agency ensuring the quality of drugs needs to be empowered and equipped with infrastructure to compete with the research and development wings of drug companies. The proposal for regulation of standards in paramedical disciplines is a welcome move. The agency constituted for this should also focus on giving a thrust to quality assurance of paramedical courses with a high job potential.

SOME FORGOTTEN ISSUES
The policy draft is silent on several other issues of current concern. Some of these are discussed below.

Resource generation mechanisms, allocation priorities and workforce management
Rather than relying on user fee and medical insurance alone, as the policy prescribes, payment mechanisms such as social security...
schemes, community financing and a whole gamut of models should be developed to sustain the healthcare delivery system. Regional payment–provider mechanisms also need to be developed and instituted considering the socioeconomic diversities.

The policy does not lay much stress on ‘workforce management’, especially of professionals. States are facing problems with finding adequate manpower for their health systems. In addition to the unattractive remuneration, the workers are often dissatisfied with poor job prospects and career development. Specialist doctors posted to a primary health centre have no facilities to utilize their professional skills and the community loses the opportunity of the professional services of a trained and skilled professional. Healthcare delivery systems in states should have specialty cadres to allow for better utilization of specialists. Similarly, the cadre of public health and primary healthcare professionals should get adequate importance. States such as Tamil Nadu have already functional directorates of public health and primary healthcare and other states should follow suit.

The proposed rigid reallocation of resources in a ratio of 55:35:15 across the primary:secondary:tertiary sector is uncon- vincing and based on unrealistic assumptions. It would be better to keep these options open and allocate resources based on a community’s felt needs. Though the emphasis has to be on primary healthcare, a balance among these competing sections must be ensured.

Growing menace of substance abuse
The growing menace of substance abuse, especially drugs and alcohol, is not given due importance in the document. In an era of high consumerism and stressful living, these problems are likely to increase and initiatives are needed to address them.

Health information system and PRIs
The lowest level of PRIs should be developed as nodal points for the health information system. This will ensure a countrywide foolproof database on health. Such a community-based system can be sustained only by the PRIs.

Atrocities against hospitals and medical personnel and a patients’ charter
Atrocities against healthcare providers are on the increase. Either the community expects more than what the provider can offer or providers fail to fulfil the community’s expectations. The services that should be available at different levels of institutions are not clear and this leads to conflict. To safeguard the interest of citizens, a patients’ charter should be developed. Standardization of institutions should follow and services expected to be provided at each level need to be made known to the public. Similarly, community organizations can monitor the functioning of these institutions for better outcomes.

Problems of the elderly, the ‘challenged’ and the epidemic of cancers
In the wake of the demographic transition, the health system has to be tuned to meet the needs of a fast expanding population of old people. Similarly, problems of the disadvantaged groups such as the physically challenged do not receive any importance in the document. The growing incidence of various types of cancers, especially those related to tobacco, have not received much attention. Lifestyle adjustments aimed at ‘primordial to primary prevention’ of these maladies need to be stressed.

Adolescents
The Reproductive and Child Health (RCH) programme tries to address some problems of adolescents. The policy document is vague on this very important area. Even the interventions proposed under the RCH programme have not gained momentum. Interventions such as family life education, adolescent counseling, adolescent clinics and other general interventions need to be instituted with zeal.

Updating of interventions according to scientific development
National programmes and healthcare interventions have to keep pace with modern scientific developments. For example, in the context of newer emerging problems and the availability of newer vaccines, periodic updating of vaccination regimens needs to be taken up as a policy initiative. Innovative mechanisms of resource pooling can be tried for achieving complete coverage of beneficiaries. This can be tried in diseases such as hepatitis B and meningitis.

Private practice and government doctors
The NHP 1983 set out to abolish private practice of government doctors in a phased manner. It is still a burning issue in several places. The government has to come out with definite policy initiatives on this important issue.

Medical advertising
The advertising of drugs and therapeutic measures in the lay press and media need stringent regulatory measures. This will have to be applied to all systems of healthcare. Making claims of cure in the absence of a proper scientific basis, guaranteeing cure, advertising drugs, encouraging over-the-counter sales of potentially harmful drugs and encouraging self-medication have to be firmly dealt with by regulatory measures.

CONCLUSION
After about two decades of the previous National Health Policy, the Government of India has released its new Draft National Health Policy for widespread dissemination and deliberations. It ‘attempts to set out a new policy framework for the accelerated achievement of public health goals in the socioeconomic circumstances currently prevailing in the country’.

Administrators, policymakers, academicians, elected representatives, representatives of various groups and organizations and members of the public deliberated the draft policy in depth.

The situational analysis of the healthcare scenario and the set goals were found to be realistic. The strategy prescriptions made in the document were assessed to be grossly inadequate to achieve the set goals. Several areas of concern have also been left out in the policy document.

The consensus was that the policy initiative will provide a new impetus to the ‘development of the health sector’ leading to overall development. Incorporating the feedback from various sources could rectify the limping strategies.

ACKNOWLEDGEMENTS
The workshop was held with financial assistance from the Department of Health and Family Welfare, Government of Kerala and supported by the Sree Chitra Tirunal Institute for Medical Sciences and Technology. Shri P. Sankaran, Hon. Minister for Health and Family Welfare, Government of Kerala was kind enough to inaugurate the workshop. The support rendered by Shri Chandrasekharan Nair, Principal Secretary; Shri K. Ramamoorthy, Secretary and Dr Rajan Khobragade, Joint Secretary of the Department of Health and Family Welfare, are gratefully acknowledged.
The support and encouragement rendered by Dr K. Mohandas, Director; Dr K. R. Thankappan and Dr P. S. Sarma, Associate Professors of the Achutha Menon Centre for Health Science Studies of Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram are acknowledged. Dr V. K. Rajan, Director of Health Services, Kerala rendered invaluable help.

Other faculty members, Dr Mala Ramanadhan, Dr Sukanya and Dr Varatharajan also rendered immense support. The help and support provided by Mr Sundar Jaisingh, Assistant Registrar and Ms Bindu, data entry operator and all the students of the institute are gratefully acknowledged.

Most of all, immense gratitude is due to all the participants of the workshop, without whose unconditional support this endeavour could never have materialized.

PARTICIPANTS

Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram
K. Mohandas, C. C. Kartha, George, Jayasingh, K. Radhakrishnan, Sivaskandan

Achutha Menon Centre for Health Science Studies
K. R. Thankappan, P. Sankara Sarma, Mala Ramanadhan, Varatharajan, V. Mohanan Nair, Sukanya, Paul Kumaran, K. P. Pradeep Kumar, Manju Nair, Sandeep, Rani, Ajay, Jeemon

Government of Kerala
Health and Family Welfare Department

Government of Kerala
Health and Family Welfare Department

Regional Cancer Centre, Thiruvananthapuram
Kalavathy

FIRM, Thiruvananthapuram
Mythreyi

SCERT, Thiruvananthapuram
Radhakrishnan Nair

Consensus and conflicts in health sector reforms in India: A Delphi study

K. ANAND, C. S. PANDAV, S. K. KAPOOR

ABSTRACT

Background. Health sector reforms have generated much debate in India, especially in the context of economic liberalization. The World Bank intensified this debate in 1993 when it tried to redefine the role of the public and private sectors in healthcare. The Government of India has recently announced the National Health Policy. We are not aware of any formal exercise by which a consensus has been reached or conflicts in the issues related to health policy have been assessed. We present the results of such an exercise conducted in the format of a Delphi study.

Methods. Based on a review of the current literature, a 9-domain, 56-item questionnaire was prepared. This was sent to a panel of 132 respondents with diverse backgrounds, from the grassroots workers to policymakers by surface or electronic mail. They were asked to identify the three top priorities and to give their degree of agreement to the statements. The results of the first round were analysed and sent back to the respondents for reconsideration. Consensus was defined as the presence of ≥75% of the respondents in agreement whereas conflict was said to be present if >35% of the respondents were on either side of the divide. During the subsequent round, the respondents were also asked to give three suggestions on how to approach the previously identified top three priorities.

Results. Half (66) of the original list of panelists replied to the questionnaire. The three priorities identified and later ratified were: improving the quality of care of the primary healthcare system, improvements in medical education and setting up a disease surveillance system. Other areas of consensus identified were: setting up a formal channel of interaction with the private health sector, instituting cost recovery systems in the government sector, setting up a technology assessment commission and bringing accountability into the system. Conflicts were in continuation of subsidy in medical education, the role of and need for health insurance and the role of health professionals vis-a-vis Panchayat Raj institutions.

Conclusion. We have demonstrated, on a small scale, the feasibility of assessing consensus on a wide range of issues. The approach is replicable, cost-effective and ensures that the scope of involvement is widened. Also, there is likely to be a greater feeling of self-involvement in the decisions made which would