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# Health Policies in India

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## 1. Introduction

When so-called developing countries embarked on processes of 'modernisation', this often went along with westernized hegemonic definitions, according to national elites, about modernity and development. During these processes, the health sector was increasingly defined in terms of Western scientific knowledge and standards of living, i.e. allopathic approaches to curative and preventive treatment and longevity. This was crucially triggered by educational elites from upper class sections of local society, whom had a vested interest in promoting their (pro-Western) 'scientific' knowledge that at the same time defined their social positions, vis-à-vis lowly or locally educated groups. Thus, Curtis (2004: 2) has argued that "health can […] be viewed as a socially constructed phenomenon, having different meanings for different people."

In the current decade, health policies have a tremendous importance with regards to the Millennium Development Goals (MDGs), addressing three of the eight goals. This is also reflected in the size of financial aid provided by the donor community. At the same time, health policies are undergoing substantial changes in many countries. Because of this, these changes in health policies should be understood as the outcome of (re-) negotiation processes between different stakeholders, based on ideas of health governance (see also Graner 2008 and 2009). While the article itself focuses on health policies, the last section also provides a research agenda for investigating into how these policies are being implemented.

The article is divided into five sections. Following this introduction, the second section will provide a brief introduction to conceptual ideas. The third section introduces a number of crucial stakeholders and briefly introduces the relevant issues about health policies in general and how these have been translated into national policies in India. The fourth section addresses a few critical issues in regard to conflicting interests among these stakeholders. The fifth section includes a brief outline of research questions that arise from these theoretical vantage points. Methodologically, the study is

based on a critical review of policy documents, project reports, and books and articles. Most of these focus on India, where there is a most lively scene of social scientists engaged in this field. In addition, a few formal and many more informal discussions have been held with a number of resource persons and scholars in India and Nepal (for more details see Graner 2008 and 2009).

## 2. Identifying stakeholders and the rules of the game

Development concepts and theories share a number of core features. First of all, the regional and social "contexts" are usually addressed in either naturalistic metaphors (as "environments") or in positivist terminologies, related to either structuralism or system theory. Secondly, agents are usually subsumed into the single category of stakeholders, irrespective of their categorically different power positions. As a result, the rules and regulations that define power positions remain unaddressed. On the other hand, any development policy, and thereby health policies, needs to be understood as an outcome of a negotiating process, between different stakeholders, with distinctly different power positions.

Therefore, when we investigate health policies from the vantage point of health governance, the focus of (academic) research needs to be shifted. The Institute of Governance Studies in Dhaka defines governance as "the sum total of the institutions and processes by which society orders and conducts its collective and public affairs" (IGS 2010: 1). However, a shift in focus to an analysis of how government policies are being (re-)negotiated among various stakeholders is essential in giving the health sector the attention it needs. In addition, this shift, benefits from ideas of structuration theory, where Giddens (1984) concentrates on the question of how these structures could emerge. When investigating the agency of stakeholders, aspects of power are of vital importance, defined as allocative power and authoritative power (IGS 1984: 55; see also Corbridge 1993 and 2000). All these conceptual approaches avoid the (semi-)naturalistic metaphors of the terms "context", "situation" or, above all, "environment".

Based on these ideas, agents or stakeholders are of core interest for this study (for details see Graner 2007 and 2009). For health policies, stakeholders may be based among a variety of different interest groups at different levels. They may have a crucial role in the set-up of the state, such as being employed in the civil service or as policy makers, politicians or legislators. Some of them may be based in the field of the private sector economy or national or even international NGOs. Others may be simple workers or peasants, cultivating their own fields. Or they might be tenants constrained

by various rent-arrangements. Among the first group, many may have multiple identities and/or are closely connected to various other groups based on social and/or family networks. Others, mainly among the latter group, may be less well linked or even marginalized.

When applying these ideas to an investigation about health policies, such a study needs to consider the following core aspects: identifying the key agents at several levels, their interests and power positions during the negotiation process. This will offer a basis for examining the (re-)negotiation processes within and between the different groups of agents and identifying conflicts and mechanisms along with their solutions including opportunities for women to strengthen their position.

## 3. Health policies in India – analysing stakeholders and policies

Seen through these analytical lenses, any policy and its implementation is the outcome of processes of (re)negotiations among the core stakeholders. From a governance perspective, the government needs to be seen as a core entity and it is crucial to point out its double function. On one side, the government directly provides services. On the other side, it conceptualizes and administers all health regulations which set the rules for all parties involved. In addition, it is responsible for the strict implementation and monitoring of health policies and reforms.

Stakeholders operate on different levels – global, national, sub-national and local (see Figure 1). More importantly, they are characterised by distinctly different power positions. While these power positions are defined by an institutional framework, the agents define and continuously re-define the overall institutional framework. Thus, there is a structuration process that at times perpetuates and at other times changes the institutional framework and its respective power positions. With regards to the health sector at the global level, Woodward et al. (2001: 2) have argued that "the key challenge facing health policies is the increasing tension between new rules, actors and markets."

At the interface of the global and national level, the conceptual framework addresses the crucial role of multi- and bi-lateral donors and implementing agencies (see Figure 1). These support, financially as well as in terms of policy guidance, the national agents. Most prominently engaged in this field are United Nations organisations. In addition to the World Health Organization (WHO), there are the United Nations Children Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA) and, more recently, the United Nations Programme on HIV and AIDS (UNAIDS). Many European (Department for

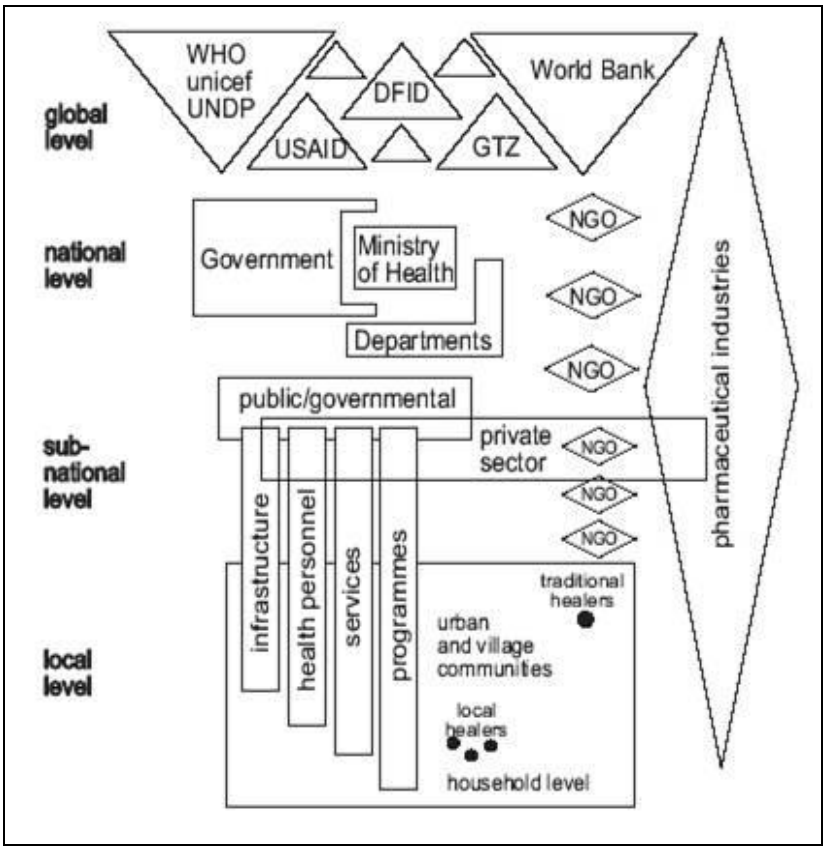
International Development/DFID, Deutsche Gesellschaft für Internationale Zusammenarbeit/GIZ, Kreditanstalt für Wiederaufbau/KfW, Swiss Agency for Development and Cooperation/SDC), American (United States Agency for International Development/USAID) and Japanese (Japan International Cooperation Agency/JICA) organisations have also been present and active in most South Asian countries. Some of these have been engaged in financially self-sufficient projects over the past decades, others (mainly DFID) have opted for basket funding. Recently, their cooperation has been more systematically coordinated.

At the national level in India, the core public stakeholder is the Ministry of Health and Family Welfare (see Figure 1). As the name indicates, this ministry has two distinctly different sections, in form of departments, and functions: general health and reproductive health. These departments also have two distinctly different sets of personnel at the local level, namely allopathic medical staff and personal with a strong training emphasis in social welfare and community services, such as midwifery. In the mid 1990s, a third department was added with a strong focus on traditional medicine.

At the local level several stakeholders are present. The most visible are certainly government personnel (see Figure 1) and its infrastructure in the form of hospitals, health centres, or primary health posts. On the other hand, the lowest level is usually only seen as a 'target group' of policies rather than a core stakeholder. Thus, from the perspective of external development partners, the term 'partners' usually only refers to the national level of politicians and top level administrators, who may, or may not, legitimately represent those in need of health services. For India, Sainath (1996: 55ff.) has critically discussed this issue. It is doubtful if India is a particularly bad case because the same situation prevails in other countries all across South Asia.

Health policies worldwide have undergone significant changes over the past decades. The Alma-Ata conference in 1978 is often referred to as a milestone in policy reform which suggested the provision of health care for all (Qadeer 2001; Banerji 2001; Sen 2001). On the other hand, a virtual U-turn was initiated from the side of the World Bank and the International Monetary Fund (IMF). They demanded policy reforms for developing countries that were to dramatically reduce the influence and funding from the public sector in favour of the private sector. Indian scholars have criticized this policy. They argue that such a withdrawal will have a "devastating impact" (Sen 2001: 143–148), particularly on the poorer sections of society.

FIGURE 1: An inventory of core agents in the Indian health sector




Source: Graner 2008: 66.

The *National Health Policy 2002* addresses a number of crucial issues. As an overall assessment, it states that "despite the impressive public health gains [...] the morbidity and mortality levels in this country are still unacceptably high" (GOI 2002: 3). Above all, the government clearly evaluates these (low) indicators as "an indication of the limited success of the public health system." At the same time, they characterise the earlier *National Health Policy 1983*, guided by the Alma-Ata principle of "Health for All by the year 2000," as "optimistic empathy" (GOI 2002: 3). The previous policy had mainly focused on improving infrastructure, the setting up of

"well-dispersed networks of comprehensive primary health care services" (GOI 2002: 3–4).

A core feature of the current policy also includes a renewed acknowledgement of traditional Indian medical systems and homeopathy, subsumed as AYUSH (*ayurveda*, *yoga*, *unani*, *siddha* and homeopathy). This was reflected in an administrative reform in the mid 1990s. During this time, a new department (AYUSH) was set up, in addition to the existing Department of Health and the Department of Family Welfare. Yet, it remains unclear if AYUSH can rely on an independent and a sufficient budget. Health expenditures have been increased, from an all-time-low of 1.8 percent during the early 1990s (Sainath 1996: 25) to about 5 percent of the total of all state budgets.

The Indian government is assisted financially by several donor agencies. Yet, the policy document of the Indian Ministry contains only a brief section on external funding (GOI 2007: 285–93). Instead, it emphasizes the role of India as a donor: "[the] Government of India plays a significant role in providing annual assistance to the renowned international (health) Organizations" (GOI 2007: 292). In terms of receiving funds, the WHO is an important source, and the *Annual Report* points out that "India is the largest beneficiary", with an overall budget of nearly 9 million US$ for two years (2004–06; GOI 2007: 285). Much higher amounts are provided by UNFPA, mainly to six states (Rajasthan, Madhya Pradesh, Orissa, Gujarat, Maharashtra and Kerala). In addition, Uttar Pradesh was the focus of funding from USAID since 1992. It received 325 million US$ over a ten-year period, 62.5 million US$ from 2004 to 2008. More recently, there has been a rapid expansion of a sector wide approach (SWAp) in order to better coordinate donor activities (GOI 2007: 285).

As a sequel to the *National Health Policy 2002*, the National Rural Health Mission (NRHM, 2005–2012) was started as a "flagship programme" (GTZ/India 2005: 8). Its counterpart for urban areas, the National Urban Health Mission (NUHM), was scheduled to commence in 2009, but the start was postponed until today (i.e. 2012). The NRHM advocates decentralisation and district management of health programmes. In its policy guidelines it demands community participation and "ownership of assets" (GOI 2005: 3). Multi-tier health committees must be established at the district and village level as well as multi-tier health plans. The NRHM favours the Indian Medical System (AYUSH) which provides at the community and household level for female "accredited social health activists." The overall objective is thus "to improve the availability of and access to quality health care to people (rural, poor, women and children)" (GOI 2005: 5ff.). This policy is implemented in 18 states where the health indicators are

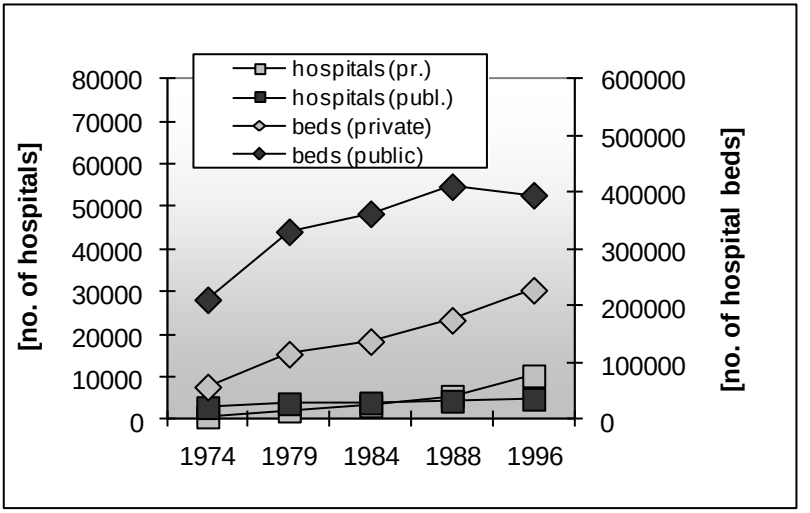
below average. Yet, a regional analysis also shows a strong focus on the northern and north eastern border states, where the health indicators are often above average. This clearly shows the political interests which intrude on health policy.

## 4. Health policy reforms in India – some critical voices

In India, the "Health for All" strategy was promulgated in the *National Health Policy 1983*. Among the donor agencies, one particularly strong stakeholder was the World Bank, both in terms of budgetary support and with regards to influencing policies. This influence was extremely obvious when it aimed at implementing its Structural Adjustment Programs (SAP), which brought about a massive shift towards the private sector. Indian social scientists have always criticised this policy. Thus, the seminal *World Development Report. Investing in Health* (World Bank 1993) found an immediate and harsh response from Qadeer (1994) who argued against "The Brave New World of Primary Health Care." She wrote that "the IMF and the World Bank were freely using the debt trap of Third World countries to compel them to accept a set of new economic deals […]; [these plans] were conceived for them but not necessarily by them" (120ff.). She characterises these policies as "techno-centric intervention strategies" (Qadeer 1994: 120). She points out that "[these] take public health back to the bio-medical model where technology dominates and there is no feel for the social, political, cultural and economic realities of a people" (Qadeer 1994: 120). Banerji (1993) denounced it as a "totalitarian approach."

A similarly strong critique came from Kasturi Sen (2001) who characterised the "predominant role of the market" as an "ideological thrust" (144ff.). When analyzing the private sector, she complained about escalating costs, due to inappropriate technologies, over-prescription and a "captive market." She pointed to the emergence of "segmented care", with high technology for the rich and underfunding for the poor. A dominant feature of the current health policy is the crucial role of the private sector – celebrated as a 'public-private partnership' (PPP) in accordance with global policies.

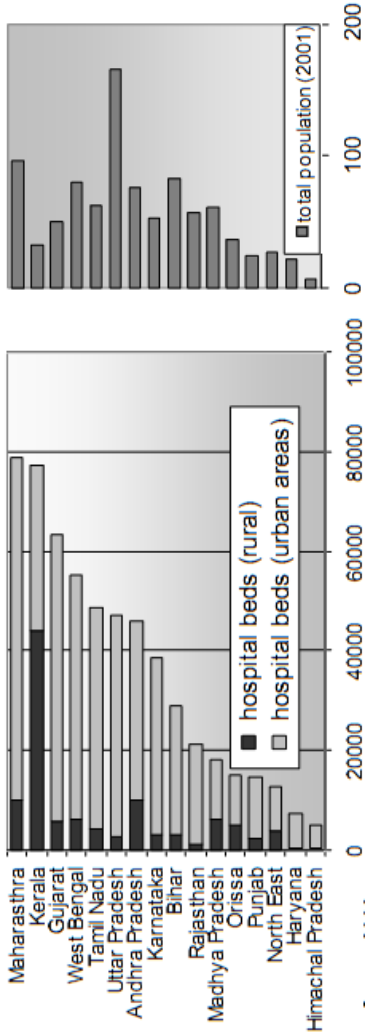
FIGURE 2: Numbers of hospital beds in public and private hospitals




Source: Misra et al. 2003.

For instance, many doctors based at public health facilities work in adjacent private hospitals even during their official working hours. Even worse, some of them seem to "pilfer" public supplies of medicine for the benefit of the latter facilities (Sainath 1996: 30ff., see also Jeffery 1986). More recent studies, however, indicate that these incidences are declining. Some of these private facilities clearly cater to top income groups, as Sainath (1996: 26) argues, "The burgeoning private sector gets ever more expensive, ever less accountable." In addition to social inequality, there is regional inequality: Thus, Kerala has the highest number of beds, even in absolute terms, while states like Uttar Pradesh have a much lower infrastructure (see Figure 3). Overall, the private sector dominates in the urban areas in all sub-sectors, although the public sector is still of importance for secondary and tertiary health care. In addition, access to these facilities is likely to show even higher disparities.

FIGURE 3: Numbers of hospital beds in urban/rural areas of major states of India (and population distribution 2001/in million; based on Misra et al. 2003 and Population Census 2001)



Besides the rapid expansion of private hospitals, the pharmaceutical industry now plays a crucial role (see Figure 1, above). Interestingly enough, this 'agent' is hardly ever mentioned in reports. Chauhan et al. (1997: 45) show that in 1994–95 this sector had a total turnover of 85.3 billion Rupees (4 billion US$), and that the 15 largest companies accounted for about 55 percent (46.8 billion Rupees). Their profits accumulated to an impressive value of 11.97 billion Rupees (0.57 billion US$), with the largest 15 companies accounting for 62 percent. Above all, the largest among these (Ranbaxy) even increased its sales within the last decade by nearly 100 percent. By 2007, it aimed for "global leadership", as it announced in its *Annual Report 2007* (for details see Graner 2009). Indeed, due to their prominent role in exports these 15 companies are likely to be in a position to wield power over national and international policy makers.

## 5. Health policies – a research agenda for their implementation

When investigating national policies, it is crucial to understand the different interest groups who design, adapt and later on, implement these policies at the national, sub-national and local levels. While some of these agents are easy to identify ("the usual suspects"), others may be less obvious. In addition, some groups who seem to be integrated entities (such as ministries or *the* civil service) may in fact be characterised by more or less articulate factions and frictions. These groups and subgroups are engaged in more or less transparent negotiation processes. These groups form strategic alliances that may function, develop and change over time. In order to understand these processes, the analysis of their various power positions is fundamental – in terms of their allocative and authoritative power. Power positions can be conceptualised as structuration processes that constantly (re-)define the overall institutional framework of health governance – a field that needs a significant amount of further research.

Research into negotiation processes among national and international agents can partly be carried out by analysing their planning and evaluation documents. More important insights will be gained by attending regular meetings, both official and unofficial (for a more detailed account see Justice 1986: 34ff.). During these meetings, some negotiation processes might be obvious – e.g. conflicting interests over budgets and controversies about the definition of indicators for monitoring. Other negotiations may take place within smaller groups. A second crucial type of negotiation takes place between the central policy apparatus and the local level administrative bodies, such as district health offices where questions of transfers and budgets are likely to be crucial issues. In this context, negotiations between the pub-

lic and the private sector stand out. Two types can be identified: first, construction companies, eager to 'support' infrastructural projects, or industries producing technical equipment; second, the pharmaceutical industry and their commissioners interested in the funding of particular programmes, such as malaria or, more recently, HIV/AIDS (see Rao 2007).

In addition, research should focus on the local level – as it comprises the 'target' population. Such research must comprise a representational approach. Women's and children's health, their participation, access and resources should also be a focus, because both are the most critical groups. One promising methodological approach could be inclusive and representational focus group discussions based on Participatory Rural Appraisal (PRA) and Appreciative Inquiry (Cooperrider & Whitney 2005; Lamichhane 2006). Questions should center on the utilisation of health services and obstacles that hinder their function. Many studies point out the high financial burden shouldered by families in the form of 'out-of-pocket' expenses (Rao 2007; Misra et al. 2003).

Policy research needs to investigate and discuss the relevance of particular global and national policies at the local level. Ideally, these discussions should bring about a localized version of requirements for health policies, and, above all, budgeting. At later stages, these focus groups should be jointly held with local level representatives from the public sector and NGOs.

If this were to happen, health policies would come a long way in attaining and securing the MDGs and health-related human rights.

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