

Essential Services

Health Service Inequities as Challenge to Health Security

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Abstract

While the last two decades have been marked by sustained high economic growth, they have also witnessed growing concern about unequal gains in health outcomes. This is partly due to factors pertaining to financing, provisioning, and governance of health services in both, the public and private sectors. Several studies as well as government policy have recognized the lacunae in the present state of health services and the multiple axes of inequities that characterize it. The first section of the paper provides an overview of the inequities in health outcomes and their variation across regional, social, and economic groups. It seeks to explain these variations by focusing on health services as a determinant of the health status. It identifies and analyses the key drivers of inequities in health services, namely, weak public provisioning and rampant commercialization. These factors have implications for equity and cost across income quintiles, especially for those who are socio-economically marginalized.

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Introduction

Over the last two decades there has been growing recognition of the persistence, and in some cases, the widening of inequities in health outcomes as well as access to health services in India. The Health Policy Document of 2002 and the subsequent Plan documents have highlighted these concerns in some detail:

‘... Also, the statistics bring out the wide differences between the attainments of health goals in the better- performing States as compared to the low-performing States. It is clear that national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country. Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide inter-State disparity implies that, for vulnerable sections of society in several States, access to public health services is nominal and health standards are grossly inadequate.’ (Gol: 2002).

This observation is reinforced by some studies that show the growing inequities in mortality and nutrition at All India level, across states, as well as within states and social groups (Deaton & Dreze: 2009). These studies show the persistence of inequities and worsening of health outcomes for vulnerable groups such as scheduled caste, scheduled tribes, and women, especially those belonging to the lower caste-class combine. These groups have faced social and economic discrimination that disadvantages them in terms of access to resources and basic needs which is reflected in poor health outcomes.

TAKING STOCK OF INEQUITIES IN HEALTH

Table 1 compares inequities in health outcomes in terms of Infant Mortality Rate, Life Expectancy at Birth and Maternal Mortality Rate for India with some South Asian countries. It clearly shows that India is among the poor performers despite high economic growth rates in recent times. Compared to countries that enjoy sustained high growth like China, Japan, Malaysia, and Korea, India is extremely

backward in terms of health outcomes. In fact, India's health outcomes are comparable to those of countries like Nepal, Bangladesh, and Pakistan that have poor economic growth and health outcomes.

TABLE 3.1.1
Health Indicators among Selected Countries

Country	IMR (per 1000 live births)	Life Expectancy M/F (in years)	MMR (per 100000 live births)	TFR
India	58	63.9/66.9*	301	2.9
China	32	70.6/74.2	56	1.72
Japan	3	78.9/86.1	10	1.35
Republic of Korea	3	74.2/81.5	20	1.19
Indonesia	36	66.2/69.9	230	2.25
Malaysia	9	71.6/76.2	41	2.71
Vietnam	27	69.5/73.5	130	2.19
Bangladesh	52	63.3/65.1	380	3.04
Nepal	58	62.4/63.4	740	3.40
Pakistan	73	64.0/64.3	500	3.87
Sri Lanka	15	72.2/77.5	92	1.89

Note: * Projected (2001–06).

Source: India—RGI, Government of India (GoI) (Latest Figures); Others—State of World Population (2006).

Source: 11th Five Year Plan, Chapter 3, pg.58

Averages Mask Inequities: Disaggregated View of Health Outcomes

Given the size, diversity, and stratified nature of Indian society, the health outcomes can be described as mirroring the multiple axes of socio-economic inequalities, such as rural-urban; inter and intra state; caste; income; and gender. Several studies have tried to capture these inequalities by using the association between variables like level of education, type of housing, income, and social groups with health outcomes like Infant Mortality Rate and Under-5 Mortality Rate. The 1998-99 National Family Health Survey (NFHS)-2 reveals sharp regional and socio-economic divides in health outcomes with the lower caste, the poor, and less developed states bearing a disproportionate burden of mortality. The scheduled castes and scheduled tribes are clearly at a

disadvantage and studies show that improvement has been slow in case of these groups as compared to others. It is well known that IMR is a sensitive indicator for socio-economic and health services development. This can be discerned when the IMR is disaggregated across socio-economic groups and the association between the two is obvious. As Deogankar's (2009) analysis shows: 'The Infant Mortality Rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family. A child in the 'Low standard of living' economic group is almost four times more likely to die in childhood than a child in the 'High standard of living' group. A child born in the tribal belt is one and half times more likely to die before the fifth birthday than children of other groups. A female child is 1.5 times more likely to die before reaching her fifth birthday as compared to a male child'

Based on the analysis of two rounds of NFHS, Subramanian *et al.* (2006) show the existence of gender and caste differentials. The gender differentials are not marked for IMR but the divide becomes apparent for the Under-5 Mortality Rates, indicating that social discrimination against girl children begins early and contributes to their progressive neglect throughout their life. The risk of mortality before the age of 5 is higher for girls than for boys on one hand, and for schedule caste, schedule tribe, other backward classes, and the rural areas of one of the poorest states than for all India on the other. While the all-India average for U-5MR came down from 95 to 74 between 1998 and 2006, it shows an increase in inequality in U-5MR for the scheduled caste and scheduled tribe communities when compared to the all India average.

The socio-economic inequalities get further compounded by inter-state and intra-state inequalities in IMR and the Under-5 Mortality Rates. The sharp inter-state inequality in health outcomes can be illustrated by contrasting Kerala and Tamil Nadu, that represent the better developed states, with Uttar Pradesh and Bihar,

that are ranked as less developed. A comparison of IMR across these states clearly shows these differentials, as can be seen in Table 2.

Table 2. Variations in Infant Mortality Rates

State	Rural	Urban	Total
Kerala	14	18	15
Tamilnadu	37	23	31
Bihar	63	54	62
Uttar Pradesh	75	64	73
All India	62	42	57

Source: NFHS 3

Variations in Maternal Mortality

While the maternal mortality rate is 301 at the all-India level, there are huge inter-state variations. According to WHO sources the MMR ranges from a high of 700 to 500 in Uttar Pradesh, Bihar, Orissa, Rajasthan, and Madhya Pradesh. On the other hand, Tamil Nadu and Kerala have MMR less than 100.(<http://www.whoindia.org>). Due to paucity of data we are unable to present variations across income and social groups.

The inequalities in health outcomes can be partly explained in terms of availability, accessibility, and quality of health services.

Health Services as a Determinant of Health

While socio-economic factors are important determinants of health outcomes, health services play an important role in averting deaths by providing both preventive and curative services. Therefore, it can be argued that differences in availability, accessibility, and quality of health services are an important determinant of variations in health outcomes. Available evidence from India shows that there are variations in the financing and provisioning of public and private health services (Baru:1999; Krishnan:1999). The better developed states have a functional public sector as well as a large private sector, while less developed ones like Bihar, UP, MP, and Rajasthan have a weak public and private sector. NSS data on utilization shows that there is high reliance across states on the private sector for outpatient treatment, which is dominated by informal practitioners.

Inequities in Availability and Accessibility of Health Services in India

Given the federal nature of the State, the major responsibility for financing, provisioning, and administration of health rests with the respective states, that influence availability, accessibility, and acceptability of services. Rao (2007) in his analysis of financial variations shows that while per capita spending on health is Rs 35.05 for Kerala and Rs 42 for Tamil Nadu, it is abysmally low for UP at Rs 18.10p during 1998-99. This is just to illustrate the extent of variation in health spending while fully acknowledging that per capita figures are mere averages which, in themselves, mask inequities. The pattern of health spending influences the structure of provisioning of health services. Table 3 shows the variation in availability of infrastructure, human resources, and supplies across these states and the extent inequities within them.

Table 3. Inequities in Availability and Accessibility of Health Services for Selected States and All India

	Tamil Nadu	Kerala	UP	Bihar	All India
Population covered by a sub-centre	4022 (87)	4628 (100)	6416 (139)	8342 (180)	5111 (110)
Population Covered by a Primary Health Centre	24,462 (83)	29,570 (100)	45,095 (153)	45,094 (152)	33,191 (112)
% of Villages having access to a PHC within 5 km	58 (62)	94 (100)	48 (51)	49 (52)	44 (47)
PHCs with at least 60% of Inputs: Infrastructure	42.9 (66)	64.7 (100)	17.2 (27)	8.9 (14)	31.8 (49)
Staff	91.4 (94)	96.8 (100)	52.8 (55)	19.6 (20)	48.2 (50)
Supply	55.7 (72)	77.8 (100)	19.5 (25)	11.4 (15)	39.9 (51)
Equipment	34.3 (37)	92.2 (100)	28.6 (31)	6.2 (7)	41.3 (45)
Training	18.6 (67)	27.7 (100)	12.4 (45)	15.5 (56)	19.9 (72)
Population served per government Hospital	153917 (87)	177614 (100)	601241 (339)	869406 (489)	156556 (88)
Population per government hospital bed	1498 (115)	1299 (100)	20041 (1543)	28980 (2231)	2336 (180)
Proportion of public:private beds*	78:23	31:69	73:27	71:29	57:43

Source: 1. www.nrhm.nic.in accessed on March 6th 2009,
2. Govt of India, Ministry of Health and Family Welfare, Central Bureau of Health Intelligence, 2004 (* Relates to 2002).
3. IIPS, India Facility Survey 2003.

Note: The index of inequality across states has been calculated with Kerala=100 and given in brackets. These figures give us an idea of the variation in health service availability and accessibility across the selected states.

FACTORS RESPONSIBLE FOR INEQUITIES IN ACCESS

There are two broad set of factors that are responsible for the inequities in access to health services. The first set of issues concerns the weakening of public health services in terms of availability, accessibility, and quality. The second revolves around increasing commercialization.

- ***Weakening of Public Provisioning of Health Services:***

Several studies have shown the persistence of systemic weaknesses in the public health services. These weaknesses arise largely due to underfunding at the Centre and across states (NMCH: 2005). While there is an overall consensus that there needs to be an increase in investments, the critical questions are: how much, and what are the priorities in spending? Increasing investments is necessary, but may not be sufficient to address some of the systemic problems that health services face today. Studies have shown that the public sector faces severe constraints in infrastructural, human resource, and drug supplies, especially at the primary and secondary levels of care (NMCH: 2005).

Studies have also shown that Tamil Nadu and Kerala have less problems in terms of availability of human resources and drug supplies as compared to UP or Bihar – a fact that has far reaching implications for the effectiveness of public institutions. In addition, the behaviour of public services in terms of interactive quality is of serious concern and is an important factor that influences health seeking behaviour. While the public sector is notionally supposed to provide health services free of cost, the direct and indirect expenditures have been increasing.

- ***Commercialization and Inequities***

Inequities in access to health services cannot be attributed entirely to weaknesses in the public sector. The process of commercialization encompasses both the public and private sector, their growth, inter relatedness, and transformation over the last six decades. We use the term

'commercialization' rather than 'privatization' because it captures the role of markets and market relationships, both within and outside the boundaries of public services¹. Commercial interests were accommodated in provisioning from the time of independence. The Bhore Committee explicitly supported the independent private sector that was dominated by practitioners. It was assumed that a strong public sector would absorb and make the private sector redundant in the long term. Therefore, there was no effort to regulate, or even clearly demarcate the role of the private sector (Bhore Committee: 1946). Over the two decades following independence, the public sector did not grow to the extent envisioned, a fact that was acknowledged by the mid-1960s (Mudaliar Committee). The solution was sought partly in involving private practitioners in delivery of public health services, especially at the secondary and tertiary levels. In a sense it even allowed for the use of public facilities for treatment by private practitioners. In our view this is an early transformation in the role of both these sectors in terms of growth and engagement. Through the sixties and seventies, the unfettered growth of private sector resulted from a demand-induced supply as a result of stunting of public facilities. The demand-induced supply of the private sector resulted in the diversification and segmentation of the institutions. This meant that the private sector, while continuing to be dominated by individual practitioners, saw a growth of secondary and tertiary institutions. The secondary included small and medium nursing homes promoted largely by doctor entrepreneurs. These were mostly located in urban areas and better developed states, resulting in both inter- and intra-state inequities. By the early 1980s the role of the private sector was evident and reflected in utilization patterns demonstrated through analysis of macro data sets like the NSSO and several micro studies. The emergence of corporate medicine in the 1980s is yet another watershed in the transformation of health services. The establishment of Apollo hospitals as a corporate enterprise, and subsequently, the government subsidies for import of high-end medical equipment, demonstrated the priorities of the

¹ For distinction between privatization and commercialization see Maureen Mackintosh and Meri Koivusalo, 2005. **Chapter 1. Pg.4**

government with respect to health services. The Health policy document of 1983 is the first recognition of not only the importance of the private sector but a frank admission of the inability of the public sector to deliver services. This document not only legitimizes commercialization but has little to offer in terms of improving public services. The trends in commercialization get further accelerated and the boundaries between the public and private get blurred. This is seen in the nature and extent of private practice by government doctors across most states. These practices have also undergone transformation in light of the trends in private sector growth. As the private sector diversified, it sought the services of government doctors to act as consultants in order to ensure the supply of patients. It was a relationship of mutual dependence and resulted in gains for both.

This also set the stage for the reforms that were introduced during the 1990s, focusing primarily on the public sector as a corrective for its inadequacies. These reforms were informed by the logic of the markets and resulted in the introduction of market relationships and mechanisms in the public sector. Some of these measures/mechanisms included 'the demarcation of public and private goods; preventive services as the responsibility of the State and curative services of the market; the separation of the primary level from secondary and tertiary; introduction of user fees; decentralization; public-private mix, etc. These elements resulted in redefinition of the role of the State, from a central one in financing and provisioning to a fragmented one as part provider and regulator. These reforms were initiated by the World Bank with a broad internal consensus among the political class, bureaucrats, and technocrats within India. The Bank offered soft loans for health as part of the overall strategy of Structural Adjustment Programme in India during the 1990s. These loans had a number of conditionalities that included redefinition of the role of the public sector, support for private sector, introduction of market mechanisms in the public sector and choice of technology in the disease control programmes. This became the basis for yet another transformation of health services at the institutional level in both

the public and private sectors. These changes were meant to improve efficiency, effectiveness, and quality in both these sectors. However, the available evidence, although scanty, seems to suggest that these three goals have largely not been fulfilled. For example, the latest round of the NSS does not show an improvement in utilization of public services for out-patients and in-patients as a result of these reforms. In fact, there seems to be a decline in the utilization of public services (NSSO: 2004). Second, the cost of health care has risen over the last two decades and has affected the poorest most adversely, for both out-patient and in-patient care (Garg & Karan: 2005). Paying for care has either resulted in a rise of untreated morbidities or in indebtedness since people have to borrow in order to meet health-related expenditure. Studies have also shown that health expenditure is an important driver of poverty, which has increased slightly between the 60th and 61st Rounds of the NSS (Bonu *et al.*: 2007). Apart from rising costs, the variable quality of care in the public sector is cited as an important reason for its poor utilization. Both the NFHS and NSS show that perception about poor quality is the most important reason here.

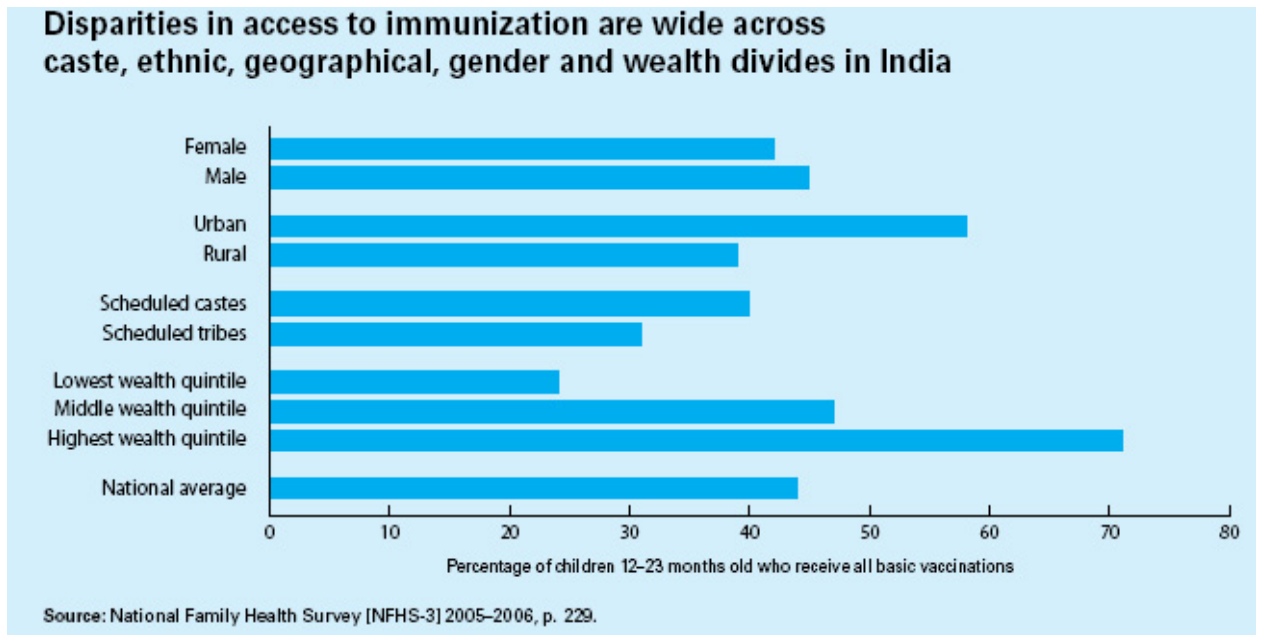
Implications for Equity

Inequities in Utilization of Preventive and Curative Services

The institutional weaknesses in public provisioning and the growing commercialization of health services gets reflected in the utilization of immunization and antenatal care across the identified axes of inequalities. Figure 1 below captures vividly the multiple axes of inequities in all basic immunization coverage. The inequities are sharp with respect to urban-rural and between the most deprived social groups and wealth quintiles. These inequities can be explained by the availability, and more importantly, by the accessibility and quality of services provided. Manju Rani *et al.* (2007) have shown that the quality of preventive services is a complex outcome between the availability of personnel, supplies, clinical competence, and behaviour of health providers. This study also shows the inter-state variation in the effectiveness of preventive

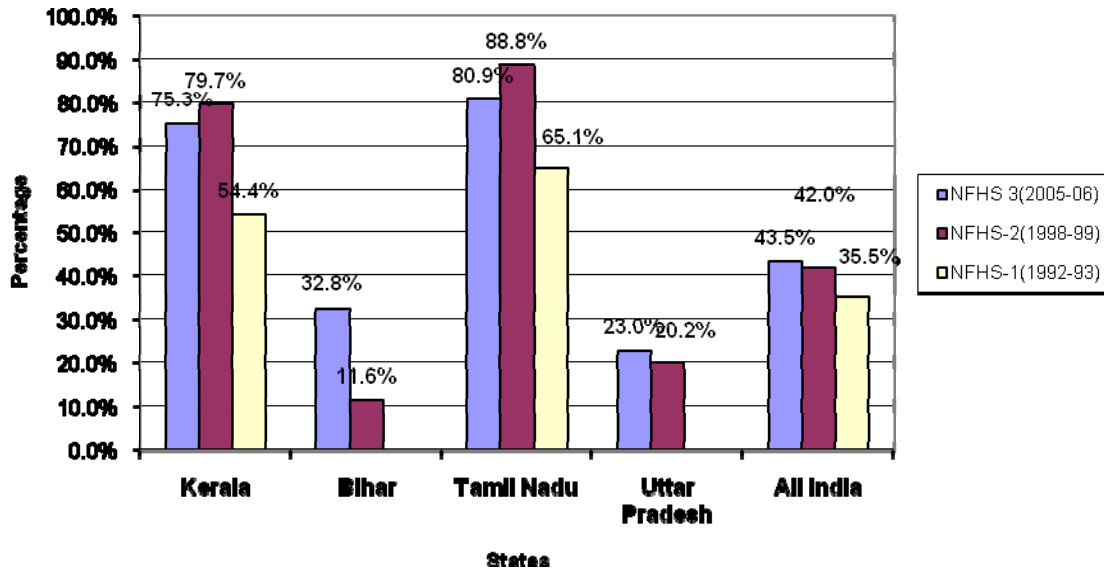
service delivery. It shows a clear north-south divide in the quality of services delivered.

Figure 1



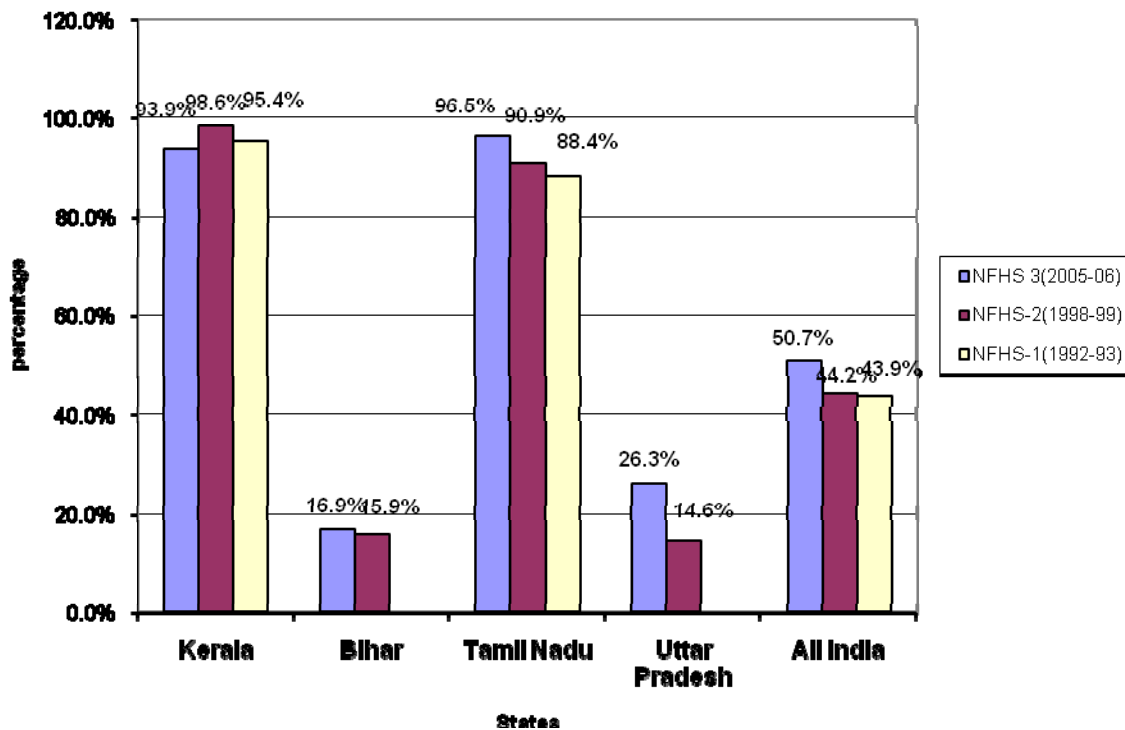
The pattern of utilization of preventive services like antenatal and immunization across selected states (Figure 2) shows the significant gap in coverage of immunization between Kerala, Tamil Nadu, and Uttar Pradesh, Bihar. This pattern is replicated in the case of antenatal care (Figure 34).

Figure 2. Percentage of Children 12-23 months fully immunized (BCG, measles, and 3 doses each of polio/DPT) for Selected States and All India



Source : NFHS Reports 1,2 &3.

Figure 3. Percentage of Mothers who had at least 3 antenatal care visits for their last birth (in %) (for births in the last 3 years) Across Selected States and All India



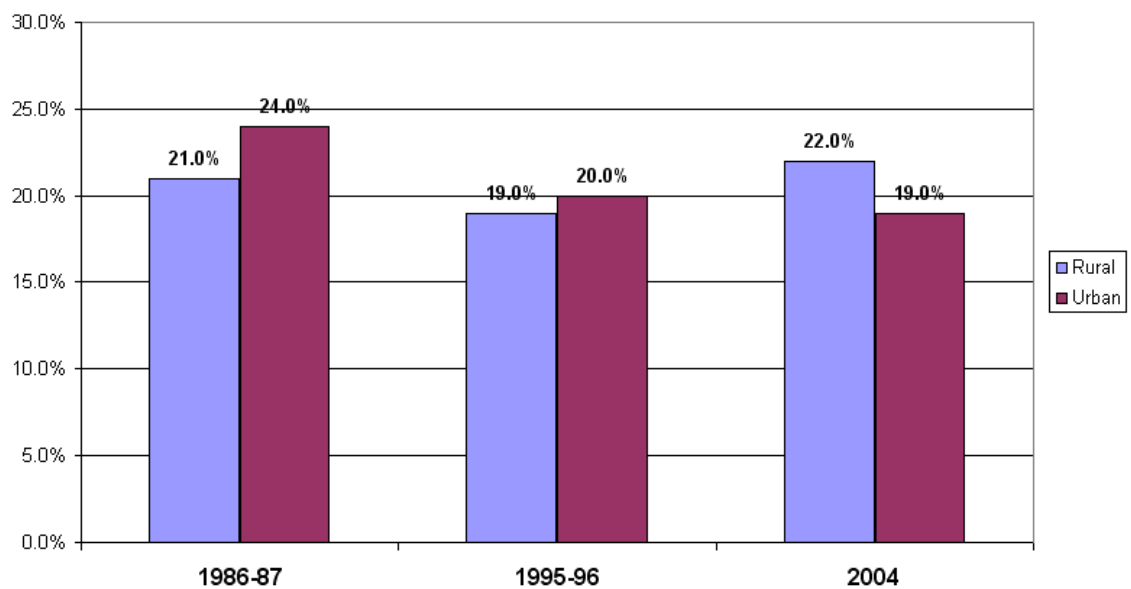
Source: National Family Health Survey Reports for respective years

Inequities in Utilization of out-patient and in-patient care

There has been little improvement in the utilization of public services during the last two decades for both out-patient and in-patient care. In fact, the NSS data clearly shows that there is growing dependence on the private sector for out-patient care during this period. Thus, the proportion of those using public services was as low as 20 per cent for rural and 19 per cent for urban areas in 2004 (See Figure 4). In the case of in-patient care the proportion using public

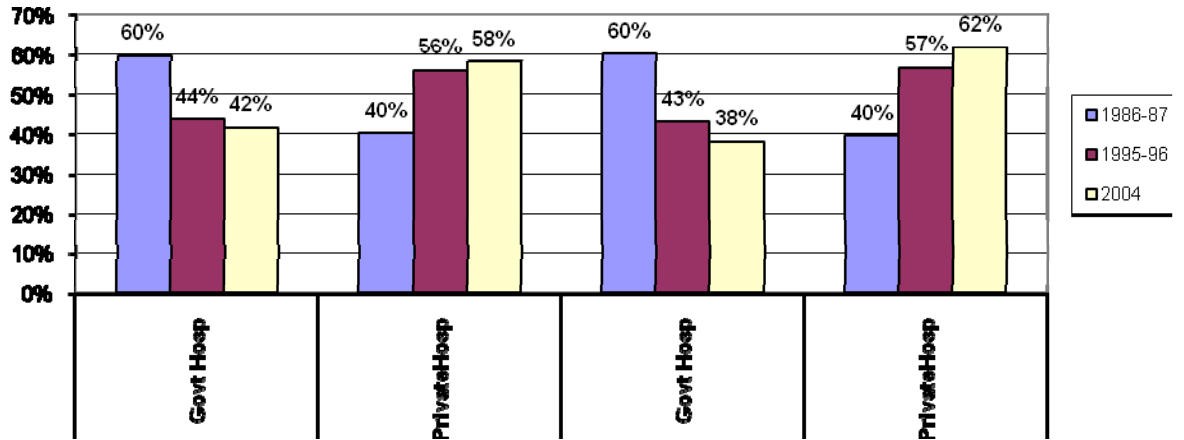
hospitals is slightly higher than for out-patient care. Even in this case there has been a gradual increase in the utilization of private services in rural and urban areas over the last two decades (See Figure 5). When these national averages are disaggregated for select states and socio-economic groups the sharp inequities become visible.

Figure 4. Utilisation of Government Services for Non-hospitalization Treatment (in %) Across Three Rounds of the NSS



Source: NSSO Reports - 42nd, 52nd and 60th Rounds

Figure 5 . Hospitalization in Different NSS Rounds

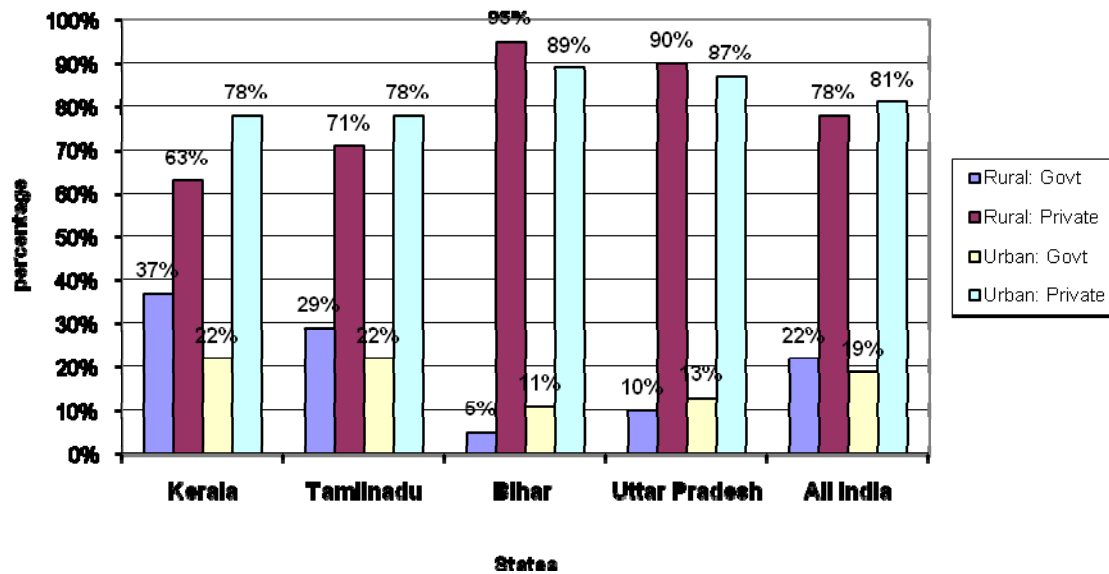


Source: NSSO Reports -42nd, 52nd and 60th Rounds

There are sharp inter-state and rural-urban variations in accessing treatment for general morbidities. The trend over the last three decades shows a marginal increase in utilization of public services compared to private services for non-hospitalized care in rural to urban areas. While overall the level of utilization of public facilities for general morbidities is very low in case of both urban and rural areas, the decline in the case of urban areas is evident between the mid-1980s and 2004.

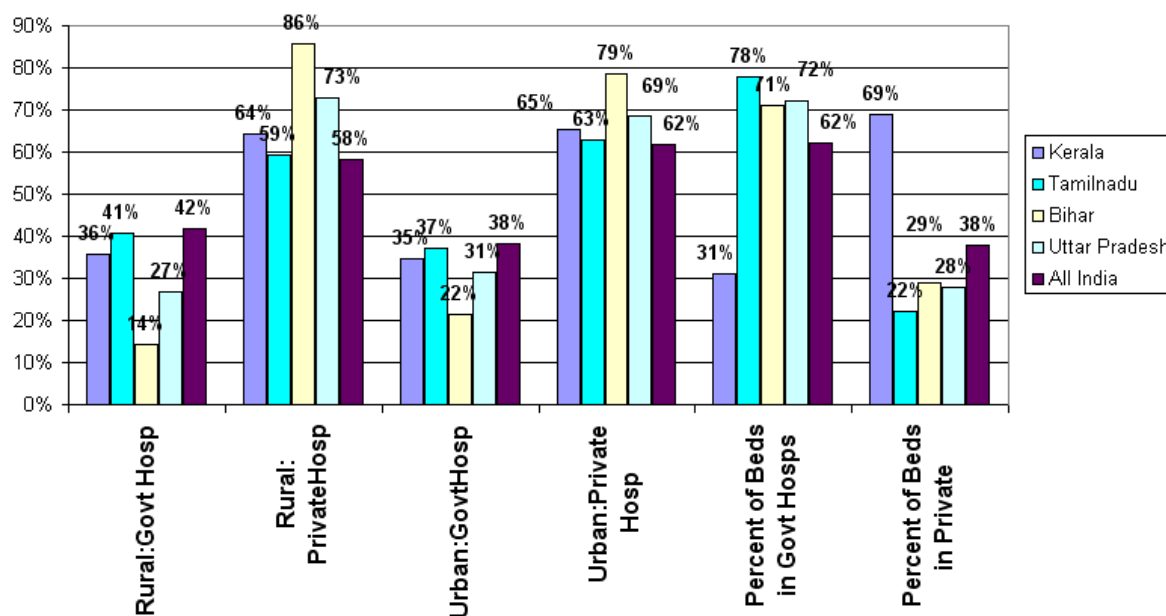
Interestingly, the gap in utilization of public and private services becomes smaller in better-off states as compared to the poorer performing states. When we examine the utilization pattern across the selected states these inequities are self-evident (figures 6 and 7)

Figure 6 . Percentage Distribution of Non-hospitalized Cases Treated in Public and Private Sources for Selected States and All India-2004



Source: NSSO, Report Nos. 507, 2004

Figure 7. Percentage Distribution of Hospitalized Cases Treated in Public and Private Hospital for Selected States -2004



Source: National Sample Survey Report No.507, 2004

In cases of hospitalization there has been an increase in private sector utilization in both urban and rural areas between the mid 1980s to mid 1990s. Here again, the differentials across states are significant, with poorer states showing lower levels of public sector utilization than better-off states.

When utilization is disaggregated across social and income groups, there are inequities between the scheduled tribes, scheduled castes which form a large part of the poor -- who rely more on public services as compared to the 'forward' castes (Subramaniam *et al.*).

Given the growing inequities in access to health services, there is growing concern among a wide cross section of academics, public health workers, non-government organisations and political parties. Various alliances and coalitions of these concerned sections have come together demanding a policy response. The United Progressive Alliance of 2004 which consisted of coalition of Left and Centrist parties in their common minimum programme had committed to

addressing the inequities in the socio-economic spheres including health. As the Common Minimum Programme states:

'The UPA government will raise public spending on health to at least 2 to 3 per cent of GDP over the next five years with focus on primary health care. A national scheme for health insurance for poor families will be introduced. The UPA will step up public investment in programmes to control all communicable diseases and also provide leadership to the national AIDS control effort. The UPA government will take all steps to ensure availability of life-saving drugs at reasonable prices. Special attention will be paid to the poorer sections in the matter of health care. The feasibility of reviving public sector units set up for the manufacture of critical bulk drugs will be re-examined so as to bring down and keep a check on prices of drugs' (CMP:2004).

Recent Policy Initiatives for Addressing Health Service Inequities:

With the launching of the Common Minimum Programme in 2004, there was a political commitment to revitalize rural health services. This was implemented in select districts across states that were seen to be socio-economically deprived, as a centrally driven programme. This programme, launched in 2005, was called the National Rural Health Mission (NRHM) and was to be implemented in 'mission mode' by the central government. The NRHM has been supported and complimented by several other initiatives like the *Rashtriya Bima Swasthya Yojana*, a health insurance scheme for families below poverty line in rural and urban areas and *Janani Suraksha Yojana*, a cash transfer scheme for women below the poverty line for promoting institutional deliveries in rural areas.

Apart from the Centre, some state governments have also initiated equity enhancing programmes. We find that it is the better developed states that have initiated programmes to address inequities in meaningful ways. Tamil Nadu and Kerala have introduced several programmes in this regard. The key programmes in Tamil Nadu focus primarily on promoting better access to reproductive services. These include maternity picnics, Bangle and Birth companion

programme, and short stay home for a period of ten days for expectant tribal mothers. In Kerala there is an effort to address equity issues by strengthening general health services. A comprehensive health insurance scheme is being implemented in collaboration with the Department of Labour for vulnerable sections among the working population. Efforts made by the poorer states like Uttar Pradesh and Bihar pale into insignificance when compared to those by the better-off ones (Common Review Mission: 2008).

During the last four years the NRHM has been monitored and evaluated by the government as well as by Non-Government Organizations. The findings of the second Common Review Mission (2008) provide valuable insights into the workings of the NRHM across states. This report observes that while there has been an increase in utilization of public services, it has been uneven across states. There is variation in the degree of strengthening of institutions across levels of care across states. While in Kerala and Uttar Pradesh all levels of care have been strengthened, in Bihar additional Primary Health Centres remain weak, and in Tamil Nadu the sub centres have been weakened. This uneven pattern in strengthening across levels of care undermines the idea of a comprehensive approach to health service planning. The major gap in health service effectiveness is availability of the full compliment of human resources. Here again, there are inter-state variations. The north Indian states, particularly, are facing shortages in supply of doctors, nurses, and paramedics. This is bound to influence the effectiveness of the NRHM in these states. This is just an example to demonstrate the differentials across states in uptake of different components of the NRHM. It is generally seen that states with stronger public provisioning have been able to improve their infrastructure, human resource deployment, and financial uptake of funds across levels of care. As the report observes: 'states that have better baselines and similar programmes in place had been quick to take off on NRHM strategies and have added several innovations to strengthen their services' (p.10)

While the NRHM is essentially 'supply led' growth of public services, there are schemes that are 'demand generating' through cash transfer or insurance arrangements. The review report of the mission categorically states that the *Janani Suraksha Yojana* is the key driver of the increase in utilization of health services across states. This programme has also led to an excessive focus on reproductive services, thereby privileging it over other health problems that include routine morbidities and other national health programmes. This undermines the spirit of a comprehensive health service and reinforces the anomalies of the past that privileged family planning over general health services.

It is important to note that there is little hard evidence to assess whether access has improved for those who need it the most. The monitoring mechanism provides descriptions of schemes for enhancing equity but this is inadequate for systematic evidence to study the impact. Introduction of user fees in the public services has a negative impact on equity. Some observations by the review mission of the NRHM on user fees in public hospitals in Bihar show that these are as high as the charges in the private sector. While those Below Poverty Line are exempted from paying user fees, there is a substantial section of the populace that is situated just above the poverty line, but may be unable to pay these charges. This raises an important question about exclusion of those who may require care the most. Similarly, it has been observed that in Bihar the JSY scheme is not reaching all social groups equally: the proportion of institutional deliveries among the SC/ST is much lower than amongst other castes. The report argues that this is largely due to selective strengthening of the secondary level over the primary level in Bihar.

FUTURE CHALLENGES FOR ADDRESSING INEQUITIES: WHAT ARE THE IRRECONCIABLES?

While the NRHM and other equity enhancing initiatives are welcome, these are far from adequate in addressing some of the historical systemic anomalies. The design of the NRHM was largely informed by the RCH 2, and therefore, is limited in its ability to overcome all the weaknesses of the health services. Given the large private sector at different levels of service delivery, this initiative does not address its role adequately. Studies have shown that public service strengthening will be ineffective if the private sector's role is not challenged and addressed. The private sector's growth has been anarchic and unregulated. It has drawn on public subsidies and the boundaries between the public and private sectors in provisioning, pharmaceuticals, education, and research have been blurred. The NRHM's promotion of public-private partnerships is shying away from the systemic concerns of a mixed economy in health service delivery. The Review of NRHM clearly points to the mixed outcomes in PPPs across states. This is due to the constraints in forming, institutionalizing and operationalizing these partnerships and the larger question of whether these are even desirable in the long run. Therefore, in our view, unless there is a systemic planning where the role and function of the private sector is clearly delineated, no amount of tinkering with public services is going to help. This is a major weakness of the NRHM and its allied programmes.

The second concern is the mission mode approach to improving public services. There is already concern at the state level about the sustainability of human resources and supplies once the programme's mandate is over. For example, many states have sought to recruit doctors on a contract basis, but the worry is how will the states sustain the financing of these when the programme winds up?

The third concern is the tension between a universal and targeted approach to welfare services in general and health in particular. This has been extensively

debated and there is a viewpoint that targeted schemes for the marginalized often results in poor quality care since these sections do not have the 'voice' to demand for better. It is here that the issue of accountability and quality of health services becomes important. Quality enhancement has remained peripheral across different states and there is adequate recognition that this must be addressed. However, without the tangibles (infrastructure, human resources, drugs, and other supplies) the intangible dimension of improvement in interactive quality between the provider and the patient will not be possible. Here, the perception of users is significant when they say that while infrastructure has certainly improved, the quality and range of services provided is still inadequate.

The fourth concern is the urgent need to monitor the equity impact of the various programmes -- the targeted programmes and the NRHM. Here, the idea of creating a Health Equity Gauge along the lines of the South African experience could be a way forward.

The fifth concern is regarding the challenges to decentralization and district level planning within the NRHM framework. The evidence suggests that the interface between the providers and the panchayats at the local level presents a mixed picture. While there have been efforts to revive the health and sanitation committees in the panchayats it is seen as a time-consuming process to initiate further programming. It is important to note that progress has been made on evolving district plans but the next stage requires that it be operationalized effectively. There have been questions about how far the idea of decentralization and district planning can be taken forward within the constraints imposed by the design of the NRHM. Qadeer and Dasgupta (2005) argue that the NRHM framework is far too rigid and does not allow flexibility or innovations in order to achieve decentralization in its true spirit. There are even concerns regarding the scope and forms of integration of other health programmes with the ongoing NRHM.

The sixth concern is the conceptualization of the NRHM that emphasizes the relationship between health services and health outcomes. In our view this is misplaced and erroneous because the social determinants of health go beyond a responsive health service. Judging the effectiveness of NRHM in terms of health outcomes may actually defeat the objective of strengthening health services if there are insufficient improvements in the health status. It is here that the other flagship programmes like NREGS; JNURM; etc. that have health-enhancing elements need to converge and move towards integration in the long run. The fragmented, vertical programming creates multiple centres of command and can prove to be a burden on an already overloaded and weak bureaucracy at the state, district and block levels. The critical debate would centre around why convergence is necessary and how it can be implemented. We are of the opinion that the Health Ministry can play a proactive role to provide a health rationale for such a convergence. Many of these ideas are not new. Most of these have been detailed by the Alma Ata Declaration on Primary Health Care in 1978 and some by the recent Commission for Social Determinants and Health in 2007.

THE WAY FORWARD: STRATEGIES FOR EQUITY, UNIVERSALITY AND COMPREHENSIVENESS IN HEALTH SERVICE DELIVERY

Despite all the constraints and contradictions the Indian political class cannot afford to ignore growing inequities, especially as it aspires to emerge as a global player. In order to address the inequalities in health there needs to be a multi-pronged, comprehensive strategy. This would require greater political attention, a radical rearrangement of health services delivery and simultaneously addressing the socio-economic determinants of health. What are the concrete actions that can be undertaken for this?

There are initiatives that need to focus on the public sector. These include an enhancement of investments in infrastructure, human resources, and availability of drugs/ technology. Some of this is being addressed through NRHM but the

scope needsto be widened. Merely focusing on the public sector is inadequate because the private sector has a large presence across levels of care and support systems like drugs, technology, and education that significantly shape the public sector. The public and private sectors are not independent of one another, and therefore, the need to recognize the forms and extent of this interrelatedness is essential. In recent times public subsidies to the private sector need to be reviewed, especially in light of lack of adherence to equity conditionalities, i.e., tertiary hospitals not complying with the injunction to treat a fixed percentage of patients below the poverty line. There is a need to review human resource deployment, conditions of work, wages, recruitment, and promotion procedures in both the public and private sectors. In addition, the norms for accountability need to be spelt out. With globalization many of the health policy options are being shaped by international debates and organizations. Human resources, drug production and pricing; and high-end technology deployment are being determined by the debates taking place and decisions taken in the World Trade Organization (WTO). The challenge for addressing equity by national governments in the context of globalized policy making is, in our view, highly circumscribed. Here, the role of civil society organizations is important but we must not have a naïve view of what they alone can do, given the unequal power relationship that exists between global organizations, national governments, local politics, and civil society organizations.

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