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Précis

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Health Care in India: Learning from Experience

THE WORLD BANK HAS EMERGED AS THE WORLD'S largest lender in the health, nutrition, and population (HNP) sector of developing countries. The Bank also plays a major role advising on national health policies. But in India, where the Bank has invested more in HNP than in any other country—US$2.6 billion—over the past three decades, progress, particularly for the poor, has been slow and uneven. While India's health status has improved substantially, it still is not on a par with other countries at a comparable level of development. The root causes of this halting progress are poverty and low levels of education, particularly among women, but public health programs bear a share of the responsibility.

The Operations Evaluation Department (OED) found that, in the 1970s and 1980s, the Bank supported government programs that were seriously flawed. But in 1988 the Bank began to work more collaboratively with Indian experts to identify determinants of program constraints, as well as possible solutions. This enabled the Bank to push for better programming and policies and to propose new ways to address fundamental problems in the Indian health system. The results of this more recent approach have been encouraging. This experience with innovative projects, sector work, and policy dialogue in India's HNP sector offers important lessons for improving health in countries around the world.

Getting It Right

In analyzing why health progress in India has not been as rapid as it has in other settings, and why age-specific mortality and disability rates remain higher than in other countries and regions (table 1), OED identified a number of factors, including: (1) a population growth rate that puts a strain on government resources; (2) per capita public health expenditures that are half those of comparable countries and one-third the estimated cost of an essential package of health services; (3) inadequate funding of programs used mainly by the poor, and limited access for the poor to the programs that are available; (4) insuffi-

Table 1: Burden of Disease: Disability-Adjusted Life Years (DALYs) per Thousand Population Lost to Mortality and Disability in India, China, and Two Regions, 1990

Country or Region	Mortality	Disability	Total	Percent of DALYs lost, ages 0–4
India	235	103	339	45
China	104	80	184	24
Other Asia and Islands	168	92	260	38
Middle Eastern Crecent	209	91	300	50

cient provision of safe drinking water and sanitation; (5) poor quality of service, as a result of supply shortages, absenteeism, improper staff behavior, unrealistically large workloads, and low staff morale, and consequent underutilization of facilities; (6) inadequate mobilization of private and NGO resources; (7) excessive focus (until recently) on sterilization and use of financial incentives to achieve targets; and (8) inadequate focus on maternal and child health. The tenuous quality of public health assistance is reflected in the observation that 80 percent of health spending is for private health services, and that the poor frequently bypass public facilities to seek private care.

In addition, inadequate management and personnel policies limit the effectiveness of many initiatives. At the national level, management is highly centralized, leading to a uniform, inflexible approach throughout the country, despite major interdistrict disparities in fertility, health, and cultural and institutional characteristics. This overcentralization contributes to weaknesses in local service delivery, with local managers often unable to provide adequate support, supervision, and training to front-line workers. These problems are compounded by personnel policies that fail to provide incentives for better performance or for learning new skills.

Another reason for poor performance is that the limited resources devoted to health have not been used strategically. Many programs have failed to effectively target the most vulnerable groups. Nutritional supplements in some programs, for example, have been available to everyone, reducing the quantities available for poor women and children.

And finally, there has been a tendency to allocate expenditures to India's 25 states on a per capita basis, ignoring the enormous differences in their need and capacity to utilize such resources. Indeed, these states are as diverse in language, religion, level of development, administrative efficiency, and quality of governance as the nations of Latin America or Africa. The size and diversity of the country thus present unique challenges for the design and management of health programs. Clearly, one-size-fits-all programs do not belong here.

Evolution of Programs and Projects

Since the early 1970s, the Bank has funded 23 HNP projects in India, while also sponsoring important sector work and engaging the government in an ongoing policy dialogue. From rather simple beginnings, support has evolved slowly, in phases, as the Bank and the government have learned to tackle the weaknesses and limitations of India's health system in increasingly sophisticated ways.

Population

In the area of population policy, Bank support has been separated into three distinct phases. Early projects, carried out from 1972 through 1988, had the narrow aim of helping the government carry out its Family Welfare Program. While designed to integrate family planning and maternal and child health services, in actuality the program emphasized sterilization and the expansion of facilities. The program gave little emphasis to increasing demand or improving the quality of family planning services, which reduced its impact on both contraceptive prevalence and total fertility rates. The Bank had little influence on the direction of this program. The government's approach was firmly established long before Bank involvement, the Bank's lending represented only 3.6 percent of total program funding, and the Bank was generally poorly positioned to suggest improvements or alternatives.

In 1987, a new and somewhat larger Bank team—one with a wider view of human resource development—undertook a series of sector studies that offered excellent diagnoses of the problems in India's population program. Yet the impact of the initial studies was limited. Over time, however, the Bank's sector work increased in influence, in large part because the Bank involved the government in selecting and designing the studies, and local experts were hired to carry them out.

The sector studies helped to generate important policy changes, including a new emphasis on outreach, maternal and child health, temporary contraceptive measures, and education campaigns, which became the basis of the Bank's newer population projects. The Bank also began to focus on high-fertility states and urban slums—areas with the greatest need.

Despite these improvements, it was more difficult to reorient practices and programming than either the Bank or the government had anticipated. Staff who designed these initiatives were perhaps too optimistic about what could be accomplished in states with weak administrations. Project development also suffered from the failure to involve local stakeholders in project design. Had there been more effective stakeholder participation, project feasibility and risk might have been more accurately gauged.

Another shift came in 1996, when the government dropped sterilization and numerical targets as the focus of its population program, adopting a "target-free" approach that gave greater emphasis to meeting women's reproductive health needs. The immediate result of the new policy was a reduction in contraceptive acceptance rates, in part because previously exaggerated rates were now more realistically reported. Recent data suggest that acceptance rates are recovering. To help this new policy succeed, the Bank is designing support programs that are based on need, that closely monitor results, and that provide timely feedback.

The design of the recent Reproductive and Child Health Project, for example, is based on related sector work and consultations with stakeholders and NGOs. This project offers practical ways to promote family planning without emphasizing sterilization targets and allows for different implementation models in different situations. It also introduces some elements of performance-based budgeting to increase accountability and puts monitoring and client feedback at the center of the project. These features should bring about improvements in program effectiveness.

Nutrition

The Bank has supported two quite different nutrition programs. The first, the Tamil Nadu Integrated Nutrition project (TINP), was an innovative program that operated from 1980 to 1997. Designed by Bank staff and Indian consultants, it focused on changing the way mothers feed themselves and their infants and preschool children. Mothers kept records of their children's weight, and received nutrition education, primary health care, supplemental feeding, and other medical interventions when necessary. Considerable care was taken in designing work routines, training and supervising staff, and ensuring that supplemental feeding was targeted only at underweight children. The program was quite successful in reducing severe malnutrition, but less so in reducing moderate malnutrition. This difference may suggest that improvements in feeding practices can only go so far, and that further gains require poverty reduction as well.

Despite the relative success of the Bank's Tamil Nadu project, the Indian government showed little interest in continuing or expanding it. Rather than pressing for its expansion, in 1990 the Bank also began to support the government's predominant initiative for preschool children, the Integrated Child Development Services (ICDS) program. The Bank advocated incorporation of elements of the Tamil Nadu project into ICDS, which was meant to be a holistic child development program, offering nonformal preschool education for children 3 to 6 years of age; supplemental nutrition, immunization, and regular health checkups for children ages 0 to 6; and nutrition and health education for pregnant and nursing women. Outcomes thus far have been disappointing. The TINP experience seems to have been lost on India, although the design has been used in other parts of the world.

While ICDS was eventually able to reach 80 percent of the development blocks in the country, it had no mechanisms to ensure that its services and supplemental food actually reached those most in need. In addition, workers were inadequately trained and were overextended, and the program's outreach, health, and educational components were often neglected. As a result, the Bank rates its ICDS projects as unsatisfactory. While the Bank originally attributed program flaws to rapid expansion and implementation problems, it now appears that significant changes in direction are required. Yet the program has developed widespread political support, in part because of its widely distributed benefits. Bank staff involved in designing the next iteration of the project are trying to find practical ways to implement such changes.

Health Projects

The Bank began to support freestanding health projects in the early 1990s. Until that time, the government funded primary care on its own and did not seek policy advice from the Bank in the health sector. Financial difficulties in the early 1990s and new leadership in the Ministry of Health and Family Welfare, however, provided an opening for the Bank to fund two types of projects: disease-specific interventions and broader, state-level health system reforms.

Disease Control Projects

The Bank's 1993 study, *Disease Control Priorities in Developing Countries*, stimulated interest among Indian health officials to request Bank support to develop a series of disease control programs. The projects have introduced important innovations, such as greater integration of the private sector and nonprofit registered societies into the government's health efforts and new ways of fighting cataract blindness, tuberculosis, leprosy, and malaria. Implementation experience varies widely, but there have been notable successes.

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The Bank was instrumental in bringing the Indian government to move against AIDS seven years ago, and the Bank-financed National AIDS Control project has established state and national HIV control programs, instituted better diagnosis and treatment, and moved to change risky behaviors. Over 90 percent of the blood supply is now tested for AIDS, a threefold increase. While it is not easy to determine the exact number of HIV cases averted, an estimated one-third of a million cases may have been prevented.

To fight the resurgence of tuberculosis, the Bank has supported the introduction of Directly Observed Treatment, which now covers 115 million TB sufferers. The Cataract Blindness Control project has surgically restored sight to 8 million people, and 30 percent of these surgeries were performed with the advanced IOL method. And leprosy victims have benefited from the National Leprosy Elimination project—almost 12 million have been cured. It is estimated that 18 of 32 Indian states/UT will eliminate leprosy by the end of 2000, an additional 8 states by end-2002, and the final 5 states by end-2005.

These programs have focused on diseases that, while serious, together represent only about 6 percent of the mortality and morbidity burden. Cardiovascular disease, cancer, trauma, mental illness, and tobacco-related diseases have yet to be addressed. These illnesses will almost surely be more difficult to handle; they are less concentrated among the poor, and the government has yet to come up with proposals for their management.

State Health Reform Projects

State personnel policies and management systems play a fundamental role in determining system performance and health outcomes. To gain leverage over these critical determinants of success and to tailor programs to each state's needs and capabilities, the Bank has initiated four state-level health reform projects since 1995. These projects also offer the Bank a long-sought opportunity to influence the more fundamental determinants of how the public health system works at the state level, where the Bank can provide assistance that is tailored to the locality.

The first state-level effort was the Andhra Pradesh First Health Referral System project, a $159 million project approved in 1995. Its aim is to establish meaningful referral systems, provide training and equipment to strengthen management of the state public health system, introduce a cost-recovery mechanism, and improve resource allocation. The Second State Systems project extends the principles of the first project to three other states. It is the largest health project the Bank has ever funded ($350 million), and is showing signs of being too large and complex to be managed satisfactorily. Subsequent projects in Orissa and Maharashtra each focus on

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one state. Activities range from increasing access to primary care in remote areas, to establishing a new institution to manage the hospital system, to improving service quality at community health centers, focusing on maternity cases. The Maharasthra project also includes an innovative component to establish a new, specialized hospital that operates according to modern hospital management practices.

Supervision reports indicate that these projects are progressing satisfactorily. The Andhra Pradesh project, in particular, is progressing well, with some elements—notably management and monitoring and evaluation—rated highly satisfactory. There has been a modest increase in the share of the state budget spent on health and a slight increase in the proportion spent on primary and secondary care, but no evidence yet of significant progress on cost recovery or referral. The Second State Systems project is progressing better in some states than in others.

The use of different approaches tailored to the needs of individual states provides a unique opportunity to learn what does and does not work in different settings. But OED's study concludes that plans for monitoring and evaluation must be further strengthened if this is to take place.

Looking Toward the Future

The difficulties experienced in gaining the desired results from HNP projects in India before 1988 can be attributed to a number of factors: there were no free-standing health projects; population projects were usually supply-oriented; the Bank was not forceful enough in addressing weak performance or in pressing for policy changes; and the Bank did little sector work to identify the most pressing issues and needs.

Specific factors that inhibited the success of projects included:

- Lack of adequate information
- The Bank's image of itself as a provider of hardware and infrastructure rather than a developer of human resources
- Resistance from Indian counterparts to addressing systemic issues
- Shortages of resources and effective managers
- Focus on the public sector and on expanding the public health system
- Application of a single model to areas with very different characteristics
- Inadequate attention to changing health-related behavior
- Neglect of important determinants of health and demographic status, such as the education of women.

After 1988, however, sector work helped to initiate a policy dialogue. This led to important changes in approach, including a focus on health system reform, a shift from family planning to maternal and child health, and a more collegial and collaborative relationship between the Bank and the government.

A number of factors contributed to this change in approach, including evidence that old approaches were not working; pressures to pay more attention to the needs of women; and, perhaps most important, a deterioration in economic conditions in 1990–91, which increased the government's interest in acquiring foreign assistance. Also significant was a renewed acceptance of decentralization, which allowed the development of promising state system reform projects. While there is some controversy over how instrumental the Bank has been in effecting policy changes, it was prepared with new kinds of projects when the opportunity arose.

Most criticisms of the Bank's program pertain to its first 20 years; the program as it is now constituted is essentially on the right track. There are, however, several cross-cutting areas where there is room for additional analysis and improvement.

Referral is arguably the crucial feature of a well-functioning health system. Programs promoting a referral system must improve the functioning and skills of health workers at the secondary and primary levels and develop linkages among them. They must also address the transport and communications problems that constrain development of an effective referral system. Flexibility in programming as well as additional study of relations among institutions at different levels, both public and private, will be needed to build good referral systems in India.

Information, education, and communication (IEC) are also necessary, since many health problems can only be remedied by changing behavior. While the Bank has encouraged the government to allocate more technical and financial resources to IEC, this area of health programming continues to be relatively neglected, and government IEC programs are often not well implemented. The Bank must continue trying to build IEC into new projects, using a client-oriented approach to formulate messages, train outreach workers in interpersonal communication and counseling, carefully research campaigns, and monitor impact.

In addition, *personnel problems, performance incentives,* and *accountability* continue to be difficult challenges in improving service delivery quality. The Bank has done little in this area except to provide managerial and technical training, which fails to get at the heart of the problem. Complementary changes in management practices, work routines, and career development policies—including incentives for staff to get more training—are needed to permanently modify the behavior of health workers. This cluster of problems needs careful, detailed study.

Accountability for performance in the Indian health sector is also weak. Performance-based budgeting, by linking disbursements to performance, would better engage implementing agencies in designing and managing programs and increasing accountability. The Bank is promoting performance-based budgeting in some new projects, and must carefully study and test initiatives that use it.

Another cross-cutting issue is the need to *better integrate NGOs and the private sector*, which provide the vast majority of health services, into health sector programming. Efforts to incorporate NGOs and private organizations have had mixed results. These efforts have been most successful when such organizations work alongside government agencies in complementary rather than competitive roles, and where government staff are sympathetic and effective managers. A strategy needs to be developed to involve the private sector that considers the division of labor, pricing and subsidy policies, licensing and regulation of private providers and health insurers, and appropriate training programs. The Bank has little experience with these challenges in India, but can help by examining experience in other countries and in other sectors in India; encouraging the private provision of services, where appropriate; and encouraging and evaluating experimental programs.

Finally, it is clear that India's diverse health problems, needs, and health sector capabilities require multiple approaches. The Bank should therefore continue to support decentralization and experimentation in order to better meet the needs of individual states.

►This *Précis* is based on *Case Study of World Bank Activities in the Health Sector in India*, by Ronald Ridker and Philip Musgrove, Report No. 19537. Available to Bank Executive Directors and staff from the Internal Documents Unit and from regional information service centers, and to the public from the World Bank InfoShop.