The Role of Planning in Health Care – What it should be in India

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Abstract – *This paper attempts to analyse the process of health planning in developing countries with special reference to India. Planning is essential if the meagre resources of less developed countries are to beget the maximum returns in health. Equity and efficiency are both important considerations in health planning, and the objective should be to arrive at an optimum mix of these two. Health planning experience in India has been characterised by radical pronouncement of the need for a total change in strategy to realise our objectives. But this rhetoric has not been matched with action, due to lack of political will to change the health system.*

INTRODUCTION

Better health status for all citizens is a developmental goal that all the nations aspire to achieve. But when resources to be employed in the health sector are severely limited, as is the case in most developing countries, it becomes imperative that they be not wasted in extravagant models in a trial and error fashion. Thus planning becomes an important component of the strategy of achieving better health for people. It is the blueprint of how, when and where to deploy the resources of men, money and materials to get maximum returns in health.

Most developing countries have adopted the 'social welfare' model of health care. Health is regarded as a right and the governments are committed to providing free access to health care for all citizens. But even in countries such as the United States, where the 'market' model of health care is in vogue, planning is in no way an insignificant component of health care management. In this paper I shall attempt to explore the roles that planning should play in the health care sector in underdeveloped countries, with India as an example.

HEALTH SECTOR IN THE LESS DEVELOPED COUNTRIES (LDCs)

The less developed countries (LDCs) are characterised by certain features in their economic systems. Some of these are:

- Low levels of per capita income
- Limited tax base, weak tax administration, and low levels of taxable surplus, and consequently
- Acute shortage of funds for public investment[1].

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What this means for the health sector, in combination with the public commitment to free and universal access to health care, is that resources in the governmental health sector are stretched thin. Conversely, the low per capita income also means that sufficient demand cannot be generated, especially in the rural areas, to sustain the development of the private sector in health. This is reflected in cold statistics: typically, the United States, spends 11% of its gross domestic product (GDP) on health, which in dollar terms turns out to be 100 times the per capita expenditure on health in an average LDC[2].

Perhaps more to the point, resource allocation within the health sector is characterized by large investments in favour of urban, hospitalized care. This means that

- Access is difficult for the rural people, who form the majority of the population in LDCs and
- This type of investment also incurs a huge recurrent expenditure.

Interestingly, this urban bias is sometimes more in evidence in the public sector. In Kerala, hospital beds tend to be more concentrated in the urban areas in the government sector whereas they are more evenly spread out in the private sector[3].

Early developmental theory saw development as a question of increasing material production. This was reflected in the health sector also. Thus health was seen as a consumption item, which drains resources away from savings and investment[4]. But later the importance of welfare was stressed with the human capital approach, and health came to be seen as an investment[5]. Thus investment in health resulted in returns in terms of a better work force and savings on loss of man days. The experience of certain societies like China, Cuba, Costa Rica, Sri Lanka and Kerala State in our own country, where considerable health gains were achieved without significantly increasing material production, expanded the horizon of what is possible in health with limited resources[6].

Planning in the health sector

Planning in the health sector, as indeed in any other sector, can be said to comprise of the following steps:

- Defining goals and a time frame for achieving them,
- Outlining the strategies through which it is expected to meet the goals,
- Mobilizing the resources and putting them to use, and
- Providing periodic assessment and midcourse correction.

Operationally, planning takes place both at the macro level and the micro level. At the macro level, health planning can be thought of as the process of defining health policy. Here, decisions ought to be made at the following levels:

1. **Prioritising health goals:** With the available resources, which of our health goals should take priority?
2. **Choice of strategy:** Which is the optimum or 'least cost' strategy to reach these goals? In this, the social cost of different strategies needs to be considered. The choice of one strategy, like investment in highly sophisticated hospitals, often means that other approaches are foreclosed. Thus the 'opportunity' lost of deciding to invest in a huge multi-speciality hospital may be that primary health care in many villages will have to wait.
3. **Choice of technology:** What level of technology do we promote in health care, diagnostics, drugs, etc? This depends on our choice of strategy. Primary health care implies a certain level of technology use, whereas vertical programmes mean a different level.
4. **Manpower planning and management:** This in turn depends upon the former choice. We need comprehensively trained basic doctors to run a primary health care programme, and highly specialized physicians with technical skills in a limited area to man multispeciality hospitals. Thus these four levels of decision making can be seen to form a hierarchy (Table 1). Mismatch between one level and the next produces inefficiency.

TABLE 1. Levels of Choice in Health Planning

Level 1:	***Prioritising Objectives***
	Leads to
Level 2:	**Choice of strategy**
	Leads to
Level 3:	**Choice of technology**
	decides
Level 4:	**Manpower training and utilization**

One common approach at all levels is that there are two broad considerations in each: equity and efficiency. The notion of quality in health care is not easy to define, though some view of the fairness of distribution is implied. Fairness of distribution may be desired across groups defined by geographic region, age, sex, income, race or a combination of these. Equity also implies fairness in relation to need. It is conventional to define equity and efficiency at the micro-level in terms of the site, size and output of a particular facility. Efficiency at this level can be thought of as minimising the costs for a particular level of output, or maximising output for a given

cost. For a hospital, the obvious strategy is cost minimisation for a particular level of services. For a particular facility such as a CT scanner, optimising the level of output is important. But one can immediately see that such strategies at the micro level can be effectively used only if information of various types is available[7].

- Prevalence and incidence of the conditions where the given technology is efficacious,
- The range of efficiency of the technology under consideration,
- Information on costs, economies of scale etc. Combining the considerations of equity and efficiency for a particular facility, the following possibilities might emerge:
  - Equity and efficiency criteria yield the same estimate of the number/size of the units – unlikely;
  - Estimates using efficiency exceeds estimate using equity: this might mean that to run on an efficient basis, hospitals at some places have to be of a size larger than what would be equitable. There is some underutilisation likely;
  - Estimate using equity exceeds estimate using efficiency.

Here, if services are provided upto the point of equity, costs will be higher than optimum. Such situations arise, for instance, when we want to provide immunisation in remote areas. The cost per child immunised may be much in excess of the average elsewhere, but the service cannot be denied.

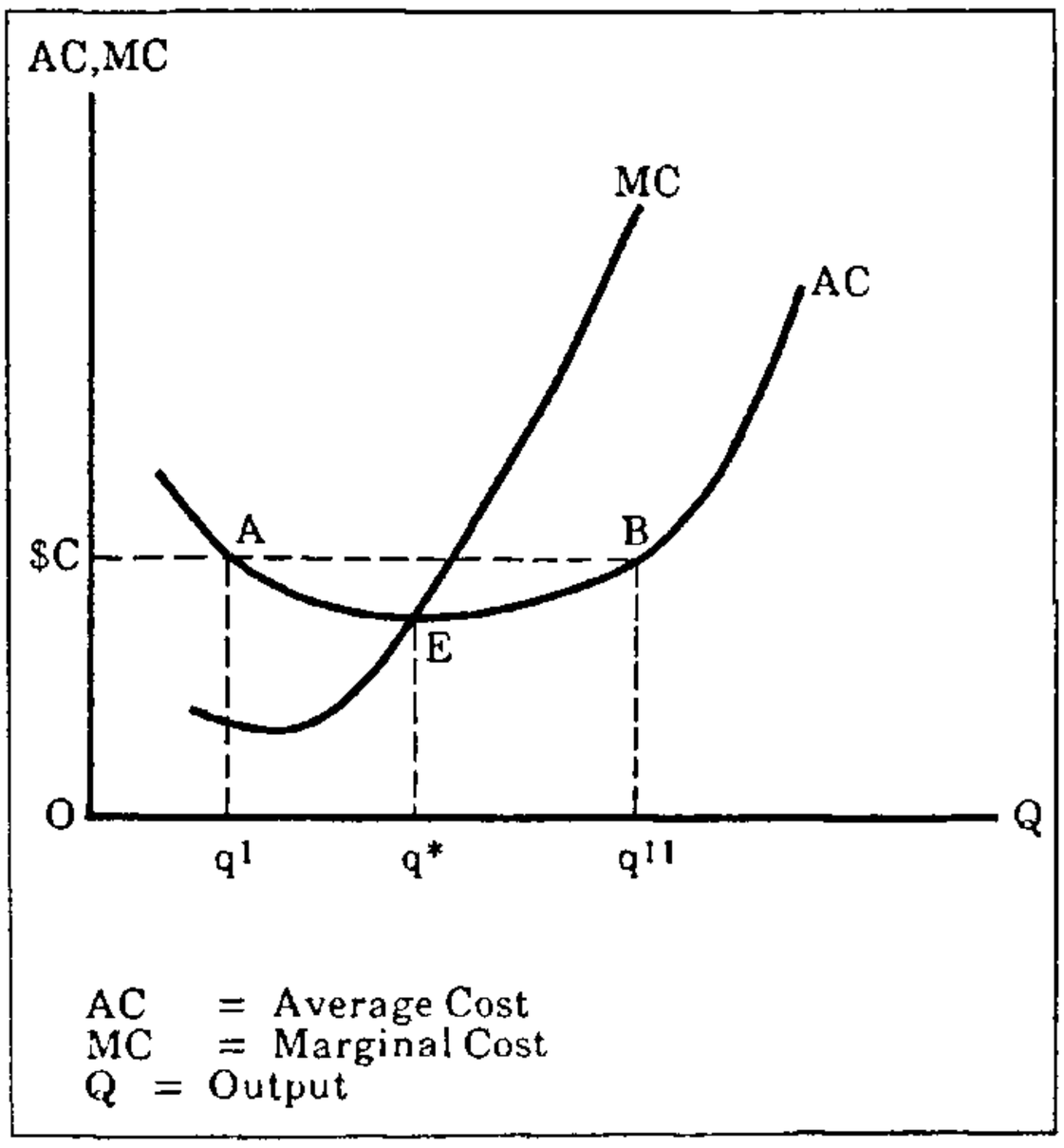

FIGURE 1. From Labelle R. Planning for the Provision and Utilization of New Health Care Technologies in Feeny D *et al.* (ed) *Health Care Technology: Effectiveness, Efficiency and Public Policy*. Montreal, The Institute for Research in Public Policy 1986, p. 139.

These different alternatives are diagrammatically represented in Figure 1. As every student of economics knows, costs are at their minimum when AC (average cost = total cost/number of units) = MC (marginal cost = cost of providing one additional unit). This point, represented by q^* in the diagram, is the optimum number (size) of the facility if we consider efficiency as the criterion. If equity suggests that we need provide only q1, then by providing q^* we are creating some underutilised capacity = q^*–q1. But if equity suggests that we have to provide q11, then the costs are much higher than optimum. This is a dilemma which many planners have to face. But what is more important to note is that if we have only a single estimate of cost = \$C, then we do not know where we are on the cost curve, A or B. Thus detailed cost information is an important pre-requisite of microlevel planning.

ROLE OF THE STATE, INSTITUTIONS AND SOCIETY

In a vast country with great regional variation in agroclimatic and socioeconomic characteristics such as India we need to acknowledge the differences in disease prevalence and health service utilisation. For this, individual states, districts, and units need some measure of freedom to work out their own costs, identify their priorities, and find their own resources. At the same time the overall health sector development needs to be in line with the national goals. Decentralization should define the role of the state, institutions and society in making sure that resources are optimally utilised. The process should not be one where the administrators set down the goals and strategy, institutions are the instruments of implementation, and society the passive recipients. At each level, the *panchayat* or district upwards, there should be the voicing of felt health needs of the society. These may even be related needs like garbage disposal or good drinking water. The institutions should remain accountable to the population they serve, and should in turn feed back to the government (the state) in the running of the health care sector.

For the above model of health care planning we find that the essential requirements are a good quality knowledge base and the freedom to make choices. The interaction of other sectors with health and the contribution of non-governmental initiatives in health care have to be acknowledged.

HEALTH PLANNING IN INDIA

India was one of the first among Third World countries to acknowledge the importance of planning in development. In defining the goals and identifying the strategies, we were not far off the mark. The primary health care concept was accepted as the basis of the building up of Indian health services long before this was incorporated into the WHO's agenda.

The health services in India at the time of independence were a carry-over from the colonial administration. These were developed within the context of a western approach to India's health problems. According to Banerjee, 'the government's commitment to provision of basic health services to all within not too long a period necessitated a fundamental shift in the approach to these problems and concurrent radical changes in the approach to medical education, training and research[8]. The landmarks in the development of health planning in India are listed in Table 2.

TABLE 2. Important Health Committees in India.

Year	Committee	Chair
1943	Health Survey and Development Committee	Sir Joseph Bhore
1948 (report)	National Health Committee	Col. S. S. Sokhey
1948	Committee on Indigenous Systems of Medicine	Col. R. N. Chopra
1949	The Environmental Hygiene Committee	B. C. Das Gupta
1961	Health Survey and Planning Committee	Sir A. L. Mudaliar
1963	Special Committee on National Malaria Eradication Programme	M. S. Chadha
1966	Study Group on Medical Care Services	A. P. Jain
1966	Committee on Multi Purpose Worker	Kartar Singh
1975	Committee on Drugs and Pharmaceutical Industry	Jaisukhlal Hathi
1981	Working group as Health for All by 2000 AD.	Dripa Narain

Source: Manesh Mankad: FRCH News Letter IV, 1-2, p. 19, 1990.

- **Subcommittee on National Health of the National Planning Committee chaired by Jawaharlal Nehru,** constituted by the Indian National Congress in 1938. This committee submitted an interim report in 1940. But before its final report was published in 1946, the Bhore committee had already come out with their recommendations. This committee represented the first effort by nationals to think about the country's health problems in their totality and suggest solutions.
- **Health Survey and Development Committee (Sir Joseph Bhore):** This was constituted in 1943 by the colonial government, and submitted its report in 1946. The Bhore committee made many recommendations which laid down the pattern of future health service development in India. (Table 3).

TABLE 3. Major Recommendations of the Bhore Committee

1. National Health Services should be an integral part of an overall programme of reconstruction.
2. The National Health Services should be
   - free,
   - provided by salaried (as against practising) doctors,
   - patients should have choice of provider.
3. Services should provide curative, promotive and preventive care.
4. Special programmes for certain diseases like malaria and certain sections like mothers and children.
5. A 3-tier district health scheme, comprising of primary health centre, the secondary health centre, and the district hospital in an ascending order of efficiency.
6. Enhancing the funding of the health services sector in the government budget to around 15%.

- **The Health Planning and Development Committee (Mudaliar) (1961):** The primary mandate of this committee was to see if the Bhore committee recommendations had been carried out effectively and whether they had borne fruit. But the committee also made further recommendations.
- **The Health Policy Document of 1983:** The Government of India for the first time came out with a policy document on health.

All these efforts took a common direction and could be said to have had some common approaches:

- A strong critique of the existing model of health care and the statement of the need for alternate models,
- The idea of the integrated, bottoms up approach characterised by the establishment of the primary health centres in the country in the fifties,
- The concept of the basic doctor, combining the curative, preventive and leadership roles in the community. Thus in many ways Indian health planning anticipated the primary health care approach later adapted by the World Health Organization in 1978.

But anyone who studies the health sector in India since independence will notice that it is characterised by emphasis on curative care, large investments in hospital based medicine, strong urban bias and specialist orientation – all of which go against the spirit of the various guiding documents such as the Bhore committee report. This dichotomy between precept and practice

becomes obvious when one actually studies the process of health planning in the states.

- **Setting goals:** Health goals are mostly dictated by current thinking at the national level. This in turn is decided mostly by the international agencies, who are perhaps not aware of the subtler aspects of many problems at the community level. States such as Kerala, for example, have totally different health needs when compared to the rest of India. This is not taken into account at the national level in planning.
- **Identification of strategies:** In theory, there has been a shift of emphasis to primary health care. But in practice, most administrative time is taken up by unproductive decision making such as transfer postings and sanctioning of new posts.
- **Mobilisation of resources:** New sources of revenue for the health sector, as also newer methods of financing health programmes, are not tapped. Aid programmes in the health sector are accepted without a consideration of the recurrent expenditure that they would incur. As a result, there is a widening gap between available resources and the demand for them. Sectoral allocations are made dependent on political clout. There is no appraisal of how the money has been spent in the past, no cost estimations and no budgeting.
- **Evaluation and monitoring:** These are conspicuous by their absence. Whatever little is done, is through the agencies of implementation, and therefore likely to be biased.
- **Indifference to the interaction of other sectors with health,** and
- **A bureaucracy not attuned to the special needs of health management.**

WHAT HEALTH PLANNING SHOULD BE

From our consideration of the ills pervading the health sector planning, we should be able to evolve an outline for an ideal model of health planning in India. The following aspects should become essential components of any such model:

- Health goals should be defined in terms of process and outcome indicators at the national and regional levels separately. Each district health authority, primary health centre, and hospital should have definite prospective plans which fit into the overall national health perspective. New facilities and investments should be justified in terms of national as well as regional priorities.
- Other sectors which have tremendous impact on health should be explicitly acknowledged and taken into consideration in the health sector planning options. Two such sectors are agriculture and water supply.
- A large chunk of health care in India is provided by private and voluntary agencies. At present planning in the health sector completely ignores the existence of these agencies. The government sector should interact with them in various ways. On the other hand, there should also be mechanisms to check undue exploitation of the people in the field of health. Independent and statutory bodies should guide the working of agencies in the government as well as private sectors in health.
- Evaluation of performance of various institutions, agencies and programmes should be a periodic exercise, and should be undertaken by independent agencies. The results of these evaluations should be taken into consideration when the plans are revised.
- We should be able to build up, from the lowest level upwards, an information base in the health sector. This should cover not only traditional types of indicators such as incidence and prevalence rates, but also information on health service utilisation and related behaviour. Since India has been able to create a good quality data base in other areas such as agriculture and the census, this is not beyond our capabilities.

CONCLUSION

Health planning in India, as in most developing countries, suffers not from lack of good intentions, but from the lack of will to carry them out. This is because the existing administrative and power structure is loaded heavily against those sections of the population whom health planning should benefit most. Unless this is explicitly acknowledged and acted upon, we shall not be able to go forward from our present woeful state.

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