Researching health governance

The case of health care regulation in India

Kabir Sheikh MBBS MPH PhD
Head, Health Governance Hub

Nossal Institute, Melbourne, 5 March 2012
Creating a strong, evolving evidence base on critical health governance issues

Building capabilities for high quality HPS research

RESEARCH

Civil society organizations

Health Governance Hub at PHFI

Academic partners

Decision-makers

KNOWLEDGE TRANSLATION

Bridging between grassroots CBOs and policy-planners for effective knowledge translation

RESEARCH CAPACITY BUILDING
Research Capacity Building

- Fellowships for junior and senior CBO researchers
- Cross learning: research forums and exchange visits
- Training and workshops: research methodologies
Knowledge Translation

- **Policy forums**
  - Formal dissemination seminars with decision-makers, advocates and researchers

- **Papers, briefs, conferences**
  - Journal articles and conference presentations
  - Policy briefs through PHFI-government channels

- **Direct engagement** with decision-makers and CBOs
  - Inform formulation of research questions
  - Enhance uptake and utilization of findings
Research at the Hub

THEMES

1. Health Care Regulation
2. Health Workforce Policy
3. Community Action for Health
4. Decentralization (PRIs)
5. Public-Private Partnerships
6. Health Information Systems
7. Private Philanthropy in Health
8. Universal Health Coverage
What is Health Governance Research?

- The empirical study of decision-making and policy implementation at all levels of the health system and in communities.

- Investigates policy processes and systems performance as well as the interface of health systems with citizens and communities.

- Can be exploratory, diagnostic or evaluative.

- *Frameworks and approaches*: policy mapping, implementation analysis, health system ethnography, realistic evaluation, ethical analysis, archival research, decision space analysis.
Completed projects

- **Universal Health Coverage: Human Resources for Health; Community Participation / Social Determinants (2010-12)**
  - Planning Commission

- **The Regulatory Architecture for Health Care Provision** – tool development and piloting in two states (2010-11)
  - Univ. Melbourne

- **Systematic review of impact of social health insurance schemes on payments made by the poorest (2010-11)**
  - DfiD UK

- **Why some doctors serve in rural areas: an assessment from Chhattisgarh state (2009-11)**
  - WHO / NRHM

- **Regulating availability of TB medicines: India, Tanzania, Zambia, Brazil** – policy process appraisal (2009-2010)
  - WHO (STOP TB)


Publications - II

• SHEIKH K. *Engaging All Health Care Providers in TB Control: A Tool for National Situation Assessment;* Stop TB Department, World Health Organization; Geneva, 2006 (URL: ...)
• VELLAKKAL S, Juyal S, Mehdi A: Healthcare Delivery and Stakeholder’s Satisfaction under Social Health Insurance Schemes in India: An Evaluation of Central Government Health Scheme (CGHS) and Ex-servicemen Contributory Health Scheme (ECHS), ICRIER Working Paper No. 252, 2010
CURRENT RESEARCH
TOPIC 1: Mapping regulatory architecture for health care provision

• **Rationale**: institutional contexts for failures of regulatory policies are poorly explored

• **Aims and methodology**:  
  – Applying research tool designed, piloted in MP and Delhi  
  – Empirically map the regulatory architecture for health care provision in 6-8 (additional) states  
  – Identify gaps in design and implementation of regulatory policies
TOPIC 2: Health Workforce Policy

a) Mainstreaming TCAM providers in essential health services
   – Implementation analysis of integration in 3 states, qualitative methods
   – Large team grant from Wellcome Trust-PHFI consortium

b) Nursing policy in India: policy mapping and governance analysis
TOPIC 3: Scaling up community action for health – realistic evaluation

• **Rationale**: Some prominent initiatives (in Nagaland, Chhattisgarh, TN, Gujarat) have unusually demonstrated success in scaling up and sustaining community action processes at scale

• **Aim and Methodology**:
  – To understand the mechanisms and conditions that contribute to successful scale-up and integration of community action in health
  – Realistic evaluation using in-depth qualitative methods
TOPIC 4: Private philanthropy and country health policies

- Archival research: literature and document reviews
- Typology of private philanthropic organizations and influences on country policies
- Theories of power applied to assess types and mechanisms of influence
TOpIC 5: Governance Toolkits for Universal Health Coverage in India

• Framework for specific architectural improvements in the health system, with a view to translate the Expert Group recommendations into points of action for Central and State Governments

• Allows States flexibility in how to implement these reforms, depending on the specific needs, and status of reform processes in the State
TOPIC 6: Role of Panchayati Raj Institutions in health planning: appraising decentralization reforms
• In spite of large scale policy failures in decentralizing health planning, lack of knowledge on progress of decentralization reforms, and on prevailing obstacles
• Multi-state policy and implementation analysis using the decision space approach

TOPIC 7: Stewardship of purchased private health care: institutional analysis
• Obstacles to PPP success located in failures of government stewardship
• Policy analysis to investigate policy architecture, design, and implementation of stewardship
• Roadmap guided by UHC principles – equity, affordability, accountability, appropriateness, quality

TOPIC 8: Responsive health information systems
• Existing HIS not grounded in needs of users, citizens
• Policy analysis investigating channels of information production, processing and use, roadmap for reforms
CASE STUDY: HEALTH CARE REGULATION
Attempts to regulate health care in low and middle-income countries have had limited success, and regulatory failure is a pre-eminent challenge for future health policy in LMIC.

Yet, the specific institutional contexts for failures of these regulatory policies remain poorly explored.

**STUDY AIMS**

Develop and field-test a research tool to:

1. empirically map the prevailing regulatory architecture for health care provision in a particular geopolitical unit (province or country)
2. Identify gaps in design and implementation of regulatory policies

*(Oxfam 2009, Nishtar 2010)*
What is ‘Regulation’?

• **Regulation** is said to occur when a government exercises control over the activities of individuals and firms (Roemer 1993)

• **Regulation** is government’s action to manipulate prices, quantities, and quality of products (Maynard 1982)

专业知识**Regulatory policy** refers to a diverse set of actions and arrangements undertaken by state and non-state actors, to control and modify individual and organizational activity (from John 1998, Scott 1995)
What are we seeking to regulate?

- Markets?
- Competition?
- Standards?
- Ethics?
- Distribution?
- Behaviour?
- Prices?
- Availability?
- Malpractice?
- Quality?
- Access?
Regulatory Targets for Mixed Health Systems

- Costs of care for users
- Quality of care
- Conduct of providers
- Accessibility of care

- Backward mapping: field level phenomena and behaviours which generate the need for policy (from literature review of LMIC ‘mixed’ health systems)

- Normative position: health care regulation as a means for achieving health equity and justice and promoting collective goals of public health and development (Mackintosh 2007)

Elmore 1982, Hjern & Hull 1981
Tool Outline

**METHODS**

- In-depth interviews with health systems officials
- Discussions with policy elites and key informants
- Policy document review
**Mapping Regulatory Architecture (Putative)**

<table>
<thead>
<tr>
<th>COL 1. Target of regulatory policy</th>
<th>COL 2. Group(s) tasked with relevant activities</th>
<th>COL 3. Type of authority invested with group</th>
<th>COL 4. Relevant policy(ies) and clauses</th>
<th>COL 5. Relevant activities expected of organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of Care for Users</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct of Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Design gaps**: particular target areas for regulatory policy may be inadequately assigned, or not assigned
### Mapping Regulatory Architecture (Actual)

<table>
<thead>
<tr>
<th><strong>COL 1. Target of regulatory policy</strong></th>
<th><strong>COL 2. Group(s) tasked with relevant activities</strong></th>
<th><strong>COL 3. Type of authority invested with group</strong></th>
<th><strong>COL 4. Relevant policy(ies) and clauses</strong></th>
<th><strong>COL 5. Relevant activities expected of organization</strong></th>
<th><strong>COL 6. Relevant activities actually performed by organization</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of Care for Users</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct of Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Implementation gaps**: differences in actual and expected roles of different organizations and groups
### Delhi State

#### Quality of Care: DHS

<table>
<thead>
<tr>
<th>Target of Regulatory Activity</th>
<th>Group(s) tasked with relevant activities</th>
<th>Type of authority involved with group</th>
<th>Relevant policies and clauses</th>
<th>Relevant activities expected of the organization</th>
<th>Relevant activities actually performed by the organization (and additional activities in italics)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Directorate of Health Services: Nursing Home Cell</td>
<td>Cancellation of the registration, imposition of penalties in case operating without registration</td>
<td>Inspections inadequately performed, typically only in response to complaints, attributed to lack of capacity, motivation, political factors within medical fraternity.</td>
<td>Cancellations of a small number of establishments. Action in case of non-registration rare, attributed to lack of capacity, motivation, political factors within medical fraternity.</td>
<td></td>
</tr>
</tbody>
</table>

#### Accessibility of Care: DHS

- Planning and establishment of hospitals, under supervision of DoHFW, following assessment of need and due inspections
- Reduced control over location of hospitals due to emerging PPP policies, and greater controlling influence of Urban development authority.
### MADHYA PRADESH STATE

<table>
<thead>
<tr>
<th>Target of Regulatory Activity</th>
<th>Group(s) tasked with relevant activities</th>
<th>Type of authority vested with group</th>
<th>Relevant policies and clauses</th>
<th>Relevant activities expected of the organization</th>
<th>Relevant activities actually performed by the organization (and additional activities, if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COSTS OF CARE</strong></td>
<td>Directorate of Health Services: Office of the Chief Medical and Health Officer (CMHO) of the District</td>
<td>Official (government scheme)</td>
<td>Janani Sahayog Yojana (JSY)</td>
<td>Assessment of applications of interested private sector providers, physical verification by a committee headed by the CMHO, and granting of accreditation.</td>
<td>The Madhya Pradesh Ayurvigyan Parishad Adhiniyam, 1987, § 15 ff, § 16 (1) &amp; (2), § 16 (3) ff. Receipt of complaint against practitioner or taking cognizance if the practitioner has been convicted in the court. In-camera hearing and adjudication by disciplinary committee. Suspension or cancellation of practitioner from the State medical register, if guilty. Restoration of the suspended name on expiry or of the term of suspension. Members ambivalent about value of disciplinary role, given other mechanisms such as CPA. No data on disciplinary procedures undertaken.</td>
</tr>
</tbody>
</table>

**Conduct of Providers: MPMC**

**Cost of Care: DHS**
Design Gaps

**Delhi**

- RSBY and government subsidies to private hospitals both aimed at reducing costs of private care for EWS do not address the high incident costs in public facilities, or financial protection of non-EWS. No direct control of care costs, no regulation of competition.

- No credible regulatory mechanism to limit practice by unqualified providers. For both quality of care and conduct of providers, absence of credible community-based forum for grievance redress.

- Accessibility of care not addressed through act or policy

**Madhya Pradesh**

- No known laws or regulatory policies for the curtailment of costs for users of health care, other than recently introduced Janani Sahayogi Yojana (Scheme)

- For quality of care and conduct of providers: absence of credible community-based forum for grievance redress

- Variable accessibility of care (workforce distribution): only mandatory rural service, no incentive based policies
Delhi

- **Cost of Care**: Information asymmetries impede uptake of social insurance scheme, also lack of stringent regulatory component. Reduced investment in regulatory capacity of relevant departments impedes enforcement of EWS free-bed condition for hospital subsidy.

- **Quality of care**: Multiple contestations of NHRA have diluted content. Partial implementation due to personnel constraints and organizational inertia, active resistance of medical fraternity.

- **Provider conduct**: Councils role transformation to less of disciplinary function, more on protecting professionals’ rights, medical sanctity.

- **Accessibility of care**: Health authority subordinated to urban development authority in determining location of new hospitals.

Madhya Pradesh

- **Quality of care**: Clinical Establishments Act, PNDT, MTP: Implementation is partial due to personnel constraints problems of inter-departmental coordination, affects relationships with hospital owners.

- **Provider conduct**: Self-regulatory council’s commitment to disciplinary functions, made problematic by closeness to associations who oppose regulation. Engagement with additional tasks such as reducing quackery greater than performance of disciplinary roles.

- **Accessibility of care**: Implementation of rural medical bonds hampered by extensive contestation by doctors’ groups, problems in coordination between government departments involved in placements.
Underlying factors

1. Pervasive influence of medical political interests (regulatory agencies are largely constituted of medical professionals, or reliant on their cooperation)

2. Discordance in inter-departmental relationships and coordination within the State regulatory machinery

3. Severe constraints in numbers and capacities of personnel for regulation
THANK YOU
Definitions

- A macro-level function involving the guidance of the health system through the six sub-functions of policy **guidance**, system **design**, stakeholder **management** and **regulation** and system-level **accountability** (WHO health systems)

- Intelligence, policy formulation, organizational ‘fit’, implementation, partnership, accountability (WHO – stewardship)

- The exercise of authority at all levels, comprising mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences (WHO)

- Leader selection, formulation and implementation of policies, citizen-state interaction (World Bank)

- Strategy, responsiveness, accountability, participation (UNDP)
## Institutional arenas and functions (Brinkerhoff & Bossert)

<table>
<thead>
<tr>
<th>Arena</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIVIL SOCIETY</td>
<td>Socializing, Enabling</td>
</tr>
<tr>
<td>POLITICS</td>
<td>Aggregating, Representing, Legitimizing</td>
</tr>
<tr>
<td>POLICY</td>
<td>Distributive, Redistributive, Regulatory, Constitutive, Adjudicatory</td>
</tr>
<tr>
<td>PUBLIC ADMINISTRATION</td>
<td>Implementing, Managing</td>
</tr>
</tbody>
</table>
Governance works well if these are assured (Brinkerhoff and Bossert 2010)

- **Accountability** some level of accountability of key system actors to the beneficiaries and broader public
- **Fairness**: a policy process that engages key and competing interest groups on equal terms (given fair rules of competition), and allows negotiation and compromise among them
- **Capacities**: sufficient state capacity, power and legitimacy to manage policy making and implementation processes effectively
- **Engagement by non-state actors** in policy processes, service delivery partnerships and in oversight and accountability.

What makes Governance good (DfID 2007)?

- State Capability
- Accountability
- Responsiveness
Researching health governance

• Policy (implementation) analysis
  – Empirical constitutionalism: de jure vs de facto
  – Backward mapping / forward mapping

• Evaluation paradigm
  – Outcome mapping
  – Realistic evaluation

• Measuring political commitment (IDS)
  – Policies and programmes
  – Legal frameworks
  – Public expenditures