Governance and Partnerships in Community Health

The Karuna Trust Experience

* Dr. H. Sudarshan ** Dr. Prashanth N. S.

India, a nuclear power with an anaemic mother; an irony of sorts for a country which claims 9% economic growth and yet is grappling with problems of access to health care. Inequities in this vast country range from a curious mix of technology of tomorrow in the software capital of Bangalore to the problems of malnutrition and infant deaths a few hundred kilometres outside the city. Economic growth and increasing globalization have brought their own problems in urban areas, while the rural areas are still 'stuck' within an unresolved 'backlog' of partially successful disease-control programmes. The double load of chronic non-communicable diseases and infectious diseases continues to form a significant health burden for the people.

As one of the signatories of the Declaration of Alma-Ata, and an early convert to comprehensive primary health care, India has developed a huge public health infrastructure. However, the Indian health care system is a heterogeneous one with a mix of unorganized and largely unregulated private for-profit sector, corporate sector and a burgeoning non-profit network, working alongside a large public infrastructure. While there have been huge investments in building up public health infrastructure, there has been a disturbing under-utilization of this infrastructure. Health sector reform has been taken up over the last decade calling for large-scale private sector involvement in the form of contracting in/out of services, franchising and sometimes, even privatization.

An ANM hands over bangles and flowers to a pregnant woman during a function to spread awareness on reproductive and child health, held at a PHC run by Karuna Trust

Privatisation or partnership?

Core social sectors like health, education, social, child and women welfare should not be privatized. When the 8 – 10% GDP growth has not percolated to the poor and the gap between the rich and poor is increasing steadily, these sectors are primarily the government's obligation. However, partnering with non-profit NGOs to strengthen the public health system and address gaps and problems in these sectors in the form of public-private partnerships (PPPs) is called for.

The term 'private' has classically been used to lump together both the for-profit and the not-for-profit sector. However, the distinction between the two is very important. The Indian non-governmental organization movement, which includes over a million organizations,

with over half of them working in the rural areas, is visibly not-for-profit. Lumping them along with for-profit sectors in areas such as contracting may not be suitable. A more suitable way of looking at these heterogeneous entities is to divide them based on not only their ownership (Government or private), but also on their goals. This distinction is all the more important for partnerships in primary health care, which hardly sees any participation by the for-profit sector. Such partnerships with the not-for-profit sector cannot be treated as simple contracts with outputs and need to be seen in a more long-term, dynamic perspective.

The Vivekananda Girijana Kalyana Kendra(VGKK) founded in 1981 and Karuna Trust(KT), founded in 1986 are non-profit, voluntary organizations that have taken up this role of identifying gaps in the public health care delivery system and partnering with the Government to address them. A total of 26 PHCs spread across 24 districts of Karnataka have been handed over to Karuna Trust. The trust takes up the poorly performing PHCs in these districts to strengthen the primary health care services, improve quality of care as well as address gaps in these PHCs through innovations. In 2001, a community health insurance programme was piloted in partnership with United Nations Development Programme (UNDP) and National Insurance Company, with a low premium of 22 rupees/person/annum providing for wage loss compensation in case of hospitalization as well as reimbursement of out-of-pocket expenses. The scheme has now been expanded to cover 25 PHCs of KT in Karnataka. Other innovations include mainstreaming of traditional medicine in primary health care. Twenty PHCs of Karuna Trust have the facility for promoting validated traditional medicines for routine primary health care problems at the PHC. A demonstration garden at the PHC includes commonly used herbs, and a nursery at the PHC provides SHGs and other individuals with saplings for their home herbal gardens. Tele-ECG facility through dial-up internet connection at remote places allows early detection of ischaemic heart disease making timely referral possible. In collaboration with ISRO, 17 PHCs have been upgraded as Village Resource Centres with facilities for telemedicine, tele-education, weather advisories and training programmes for rural people on livelihood, agriculture etc.

The concept of PPP includes partnering with a diverse set of for-profit and non-profit entities. However, for primary health care, it is clear that partnering with non-profit and community-based organizations to strengthen and supplement the public health care system is necessary. In Tumkur, KT, in partnership with other institutions with public health expertise, has formed an entity called Swasthya Karnataka, to build capacities of district health staff in planning, managing and monitoring the district health system as a whole. This programme will provide critical, need-based support to district health staff to strengthen the public health system. In collaboration with Community Health Cell and other NGOs, Karuna Trust has taken up community monitoring exercise under the National Rural Health Mission (NRHM).

Partnering with non-profit, public-oriented NGOs to address critical gaps in the public healthcare delivery system is an important step, and KT and VGKK have made strides to this end. Good NGOs should not be mere 'contractors' of services; they must be involved in planning, monitoring and implementation as well, keeping public goals in mind.

Corruption has roots in many areas—from recruitment to transfers to medical reimbursement or procurement—and is found at all hierarchical levels, from peons to investigation officers. A typical case of corruption in health services is that of doctors with their own private practice, pharmacies and blood banks, and these same doctors usually refer patients to their private nursing homes. All these have led to the doubling of market cost for various healthcare services, i.e. diagnostic or surgical emergency services.

Good governance

The Government of Karnataka constituted a Task Force on Health and Family Welfare under Dr H Sudarshan's chairmanship (vide Government Order No. HFW 545 CGM 99) on 14th December 1999. The mission of the Task Force was to make recommendations for improvements in public health and on major issues like population stabilization, departmental

management and administration, educational system reform covering both clinical and public health sectors, and developing a plan for monitoring implementation of these recommendations. The final report of the Task Force highlighted twelve major issues concerning health care and placed corruption right on the top. The Task Force concluded that corruption in health services is the major issue of concern, even in Karnataka. The others were neglect of public health; distortion of primary healthcare; lack of focus on equity; gaps in implementation; ethics or lack thereof; human resource development; gaps in culture and medical pluralism; movement from an exclusive toward an inclusive approach; ignorance of health's political economy; research; and the growth of apathy within the system.

New technological innovations are not enough to improve health outcomes - good governance is also necessary for progress in health services. Through good governance, quantum jump in healthcare outcomes can be achieved. Good governance, as a concept, becomes most important in the light of corruption, which serves only to eradicate health systems. Every year, Transparency International (TI) comes out with the Corruption Perception Index (CPI), ranking various countries around the world. More than two-thirds of the 158 nations surveyed under the 2005 TI-CPI scored less than 5 out of an optimal clean score of 10, indicating serious levels of corruption in their system. The CPI for India was 2.9, with a rank of 88th worldwide. Iceland had the lowest level of corruption, while Bangladesh and Chad were found to be the most corrupt countries.

Epidemic of corruption in health services

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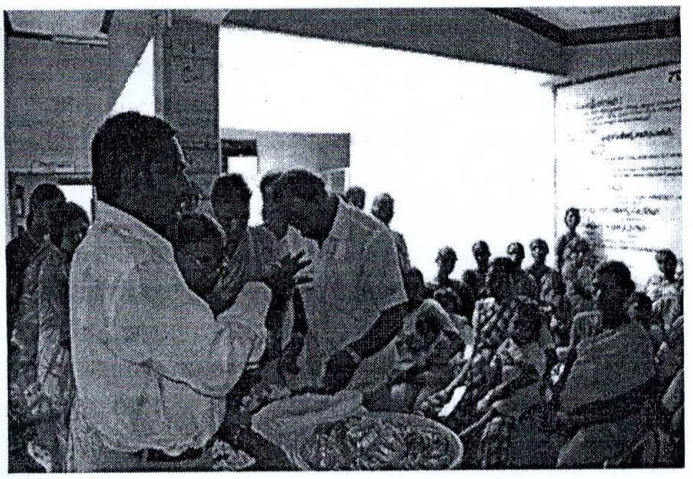
Health sector corruption can be divided in the following ways:

- Corruption in Civil Works: found in construction and repair of PHCs, CHCs, Taluka and District Hospitals.
- Corruption in Administration: found in offices at the level of District Health, Directorate and Secretariat for reasons related to recruitment and posting in cities/ hometowns; promotion and transfer; leave sanctions; medical reimbursement; monitoring of external private practice; absenteeism; suspension; and reinstatement.
- Corruption in Medical Education: in sanctioning of new Medical, Nursing, and Indian Systems of Medicine & Homeopathy(ISM&H) Colleges; in seat increases for Nursing Colleges; in admissions; in examinations, via bribes for Undergraduate and Post-Graduates examiners; and in recruitment of teaching staff and registration.
- Corruption in Hospitals: varied forms of corruption are perpetrated by administrative hospital staff—in the conduct of private practice; referral to nursing homes that are owned by spouses or relatives of medical staff and business partners; referral to private hospitals; ownership of private pharmacies by staff; blood banks; and excess of staff assets over income and chronic absenteeism, sometimes over years. Corruption is also found in admission processes; issuance of medical certificates; in technical services such as laboratories, X-rays, or scanning; transporting of patients; elective or emergency surgical services; and blood transfusions. Interestingly, corruption insinuates itself into the natural cycle of life and ironically the lifecycle approach to corruption is what is seen in our country today: it is present at birth, when a relative must pay Rs.200/- extra to see the newborn, and it is also present at death, when a bribe must be paid for the postmortem.



The Medical Officer of a Karuna Trust PHC addresses pregnant women during a function to spread awareness on antenatal and post-natal issues

Corruption in private sector

In this regard, private hospitals are not very different from the public sector. Many multi-national companies have started giving bribes as a means of acquisition of

contracts. Commissions and incentives are given to doctors for prescription of specific tests/drugs. It is also a standard practice to give 'cuts' for prescription of expensive diagnostic investigations like CT scans and MRIs. In some cases, laboratories run only a few tests and fill in normal values for the rest based on a code with the prescribing doctor, and collect charges for all the tests. Extensive organ-trading has occurred earlier in Bangalore and throughout Karnataka: around 400 transplants among unrelated people were reported in 1999-2002 after organs were bought from poor people.

Reforms in health services

After a review of the situation, a few health sector reforms were developed to reduce corruption. Reforms by the Drug Logistic Society led to improvements in obtaining essential drugs that made such drugs available in all PHCs and hospitals. Significant improvements were observed in the number of health staff staying in headquarters through the presence of efficient District Health Officers with leadership qualities. Corruption was reduced in equipment purchases due to enhanced vigilance, and at the same time there was quality compliance with inspection notes.

More reform for good governance of health services has been initiated in a variety of ways, with a pro-active Lokayukta visiting all the 176 Talukas and institutionalizing the reforms. Vigilance cells in health department and the DME were developed to build capacity, while e-governance initiatives (such as computerization and web display of transfers, recruitment, policy-based promotion, and purchasing) play a significant role in preventing corruption through transparency and accountability. In all, the author had visited over 1500 Primary Health Centres (PHC) in Karnataka and not a single Medical Officer could tell the budget of their PHC. Capacity-building in health and hospital management, leadership, decision making, and problem solving are very important in improving the systems within our healthcare institutions. In addition, initiatives for staff welfare, improved community participation and monitoring through hospital and health committees, citizen's charter, report card system, and public grievance redressal are other measures to counter corruption at the grassroots level.

Prevention of corruption

The prevention of corruption is however a bottom-up process, beginning with a People's Movement against corruption. It is common knowledge that corrupt people have better networks than people with integrity. There is thus a dire need for networking of people with integrity. In addition, stress on value-based education, awareness of the Right to Information Bill and Transparency Act and consumer forums needs to be strengthened. Simultaneously, there is a need for electoral reforms so that the gains in the grassroots are not lost at the policy-makers level.

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As in many other countries, corruption in India is just a passing phase, as evidenced by the changes of the past few years. Today, with the same budget of 80 crore, it is now possible to provide primary care in most hospitals in Karnataka. In a few districts, with good leadership, doctors are staying at the headquarters. This is a good sign for our country. Also, various technological packages may produce marginal gains in health care. However, through good governance, 20-30% improvement in the health outcomes may be attained.

As the Chairman of the Task Force, and later, as the Vigilance Director of the Karnataka Lokayukta, the first author's involvement with these institutions helped in disseminating the learnings of Karuna Trust and VGKK, and in fact, they are vibrant examples of partnership in action in primary health care and good governance. There is a need for organizations like Community Health Cell and Karuna Trust to engage on a long-term basis with the State to strengthen the public services and governance. ■

*(*Padmasri Awardee, Honourable Secretary, Karuna Trust, and Treasurer and Executive Committee member of SOCHARA.*

***Coordinator, Health and Biodiversity, Karuna Trust, Karnataka)*