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INSTITUTIONAL ARRANGEMENTS IN PROVIDING URBAN HEALTH SERVICES: CURRENT CONTEXT AND POSSIBLE WAY FORWARD

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This Note looks beyond the parameters of a three-tier public health care system, to the supportive institutional arrangements necessary for provision of effective and accountable services to improve health conditions of the urban poor. In doing so, it proposes a three-pillared approach for creating the institutional foundation of urban public health services. These entail considering executive agency-like institutional mechanisms; developing the potential of ward-level committees for improving participatory local urban governance; and institutional mechanisms of 'voice' for empowering the mobile urban poor to additionally hold the system accountable. In co-existing, each institutional pillar is further enhanced and buttressed, than when considered in isolation.

Government neglect of health services to the urban poor residing in slums has been publicized in the recent past. In contrast, broader enabling institutional arrangements necessary to support and implement urban-focused public health care services, has received limited attention. The central government too (GOI, 2006; GOI, 2008) has drawn attention to the disregard faced by urban health care services[1], which have worsened due to the rapid increase in urban population (see **Policy Note #8**). These reports and studies must be applauded for making central to public debate, the near absence of health services in urban slums and the larger issue of poor governance in the provision of urban health. Contrary to progress on this front, discussion on institutional aspects of urban health remains embryonic.

Unlike rural health care, standards and institutional support for primary urban healthcare, at present, is lacking. This weakness does provide an opportunity to espouse a delivery system different from the model of rural health care adopted by the National Rural Health Mission (NRHM). Instead, the official draft for the proposed National Urban Health Mission (NUHM) seeks to extend this existing institutional mechanism to the urban context as well. The NUHM intends to provide primary care in urban areas through strengthened facilities, wherever existing, and new Urban Health Centers (UHCs) modeled on the rural Primary Health Centres (PHCs), where facilities are not available (one UHC per 50,000 population or 25-30,000 slum population). A separate community health worker– USHA (Urban Social Health Activist), modeled on the ASHA of NRHM is to provide outreach service. The UHCs fit into a pyramid structure like NRHM's and are succeeded by two tiers of referral hospitals of secondary and tertiary care. This three-tier system, it is hoped, will address urban health challenges; requisite infrastructure and manpower being chief concerns.

The NUHM framework acknowledges the difference in urban and rural contexts in terms of service provision and allows greater private sector participation at each level. The urban context in India is vastly different from the rural and not merely in its greater density of private providers. The NUHM has to contend with challenges unique to the urban context, such as institutional governance structures; land availability for UHCs; and a highly mobile, employed target group of urban poor. It also has to consider opportunities, such as those presented by exposure to market forces (of which little exists in rural/remote areas).

This policy note is exploratory, chiseling a vision of health care delivery for larger towns and cities, different from the existing familiar system. The note proposes a three pronged strategy for the provision of urban health services. First, a case is made for an Executive Agency to deliver urban health services. Second, it calls for a more collaborative effort at the ward level (multi-sectoral 'horizontal' efforts in tandem with the Health Department 'vertical' tasks). Finally, it recommends empowering the community with incentives to build institutional 'voice' that holds authorities tasked with policy and implementation functions for urban health services, accountable. This strategy entails crafting institutional arrangements, which are either created or modified from existing systems.

AN EXECUTIVE AGENCY APPROACH TO URBAN HEALTH CARE

The idea that an executive agency actually delivers public services is not new.[2] Rather, the model is adopted widely in countries across the world. Examples from India are both

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recent and are partially compliant with the model (Das, 2010). Executive agencies are institutions in the public domain formally contracted by ministries to deliver specified outputs or outcomes. While they are empowered with substantial managerial flexibility, their contracts are performance-based, and they are held accountable for agreed deliverables. Authority is divided with the minister retaining formal control, while the Chief Executive of the agency holds operational control over implementing the services that the executing agency provides. Similarly, tasks are bifurcated: government develops policy while the executive agency implements the policy to meet planned targets. Agreements are reached regarding services to be provided by the agency in the financial year (and this clarity of purpose itself being an important development), with the system further incentivizing good performance with bonuses and poor performance with termination of contract.

The NUHM acknowledges both private entrepreneurial interests and private care providers more than NRHM, as is evident from its greater openness to Public-Private Partnerships (PPP). It is precisely in this setup that an executive agency model can provide an appropriate institutional mechanism to harness private interests in delivering efficient and effective public services.

Executive agencies are also influenced by market competition. The fear of losing a government contract due to poor performance can be a powerful driver for meeting output and outcome targets defined by government policies. Experience from Brazil has demonstrated that autonomous public hospitals facing competitive pressure or held accountable for results, behave differently from those that are not. Hence, the degree of autonomy, accountability to both government and provider, and market exposure are key organizational arrangements that influence behavior and, ultimately, performance of executive agencies or hospitals (as in this case). Studies here have shown that public hospitals operating under autonomous organizational models display higher production, efficiency, and quality than facilities in which managers have little or no decision-making authority (La Forgia and Couttolenc, 2008).

In the Indian urban context, an autonomous statutory board, functioning as an executive agency for instance, can provide institutional support and managerial oversight of UHCs (public or private) contracted in the government service delivery program. Towards this, the Board may be reporting to the municipal authority of respective towns and cities or to the state health department.[3] (See **Policy Note #2** for possible alternative metropolitan arrangements for better urban governance).

Lastly, it is imperative that an enabling environment is created with credible controls to stymie corruption that may try to gain foothold due to greater autonomy afforded to executive agencies. This is an important institutional challenge in the Indian context.

Brazil has also amply brought out the importance of key legal and regulatory provisions in determining the success or failure of such autonomous bodies. India's plans for urban health care need to be cognizant of the important, supportive role of a legal framework for optimal functioning of executive agencies.

INSTITUTIONALIZING INNOVATIONS OF COLLABORATIVE GOVERNANCE AT WARD-LEVEL

Consequent to the 74th Constitutional Amendment Act that aimed to empower people through participatory governance, every Indian town and city was to be divided into Wards and governed by ward committees. The ward committee is an institutionalized, local collaboration of citizens, councilors and ward personnel. It comprises Councilors representing the electoral wards within the territorial area of the ward committees, the concerned Assistant Commissioner, and not more than three members from local NGOs/CBOs (Community-Based Organizations) nominated by the ward committee. The key functions of ward committees range from technical: passing of budget proposals, to redressal of citizens' grievances concerning water supply, drainage and sanitation, to promotion of good governance. Despite this strong role envisaged for ward committees, their ineffective and moribund state in Mumbai, Kolkata and other cities is a sad, documented reality (See chapters 2, 3 & 4 in Baud and De Wit, 2009).

Using ward committees for local-level oversight of urban health services is a possibility worth exploring. The experience of the Urban Health Resource Center (UHRC), Indore, Madhya Pradesh is shared here as a successful example of the role of ward committees. UHRC's Urban Health Program (UHP) was designed to facilitate cooperation between different stakeholders working in the slums of a single ward (Agarwal et al., 2008). Ward 5 of Indore was selected in March-April 2003 and its Ward Coordination Committee (WCC) was charged with implementation of the ward coordination approach. Stakeholders participating in the WCC included representatives from the public sector [Indore Municipal Corporation (IMC), Directorate of Public Health, District Urban Development Authority and Department of Women and Child Development], private health service providers, and civil society organizations (NGOs and CBOs). The WCC was mandated to develop strategies for better and complementary utilization of local resources and met on a monthly basis to review progress of its coordinated efforts. The health impact of this single innovation has been reported as significant (see Box 1).

The experience of Ward 5, Indore brings out the potential of an institutional mechanism for not merely better local oversight and collaboration for tighter implementation, but also for creatively using the constitutional provision for such committees (through the 74th Amendment) to ensure better health outcomes in town and cities. In addition to preventive health measures such as sanitation, clean water

Box 1: Collaborative Health Benefits in Ward 5, Indore

A total of 204 outreach camps were organized in a span of 3 years (May 2003-April 2006) in Ward 5. The WCC, with support of the Health Department, forged linkages and collaborated with the National Neonatology Forum (NNF) and Indian Academy of Pediatrics (IAP), for its doctors providing counseling support to mothers on newborn care, diarrhea management, and safe delivery practices. The WCC additionally collaborated with local NGOs (November 2003 onwards), and intensified frequency of camps from one to about 7 per month across 28 slums. An independent evaluation of this collaborative intervention in Ward 5 reported extremely positive results: children (up to 12-23 months age) completely immunized increased from 27.1 to 64 percent; children (up to 12-23 months age) received measles vaccination increased from 60.7 to 76.4 percent; and drop-out rate from DPT-1 to DPT-3 more than halved from 55.1 to 21.1 percent. (Cited in Agarwal et al, 2008: Fig. 8, p.322)

and drainage, ward committees can assume additional health care responsibilities such as brokering collaborative horizontal linkages with the Health and the Women and Child Development Departments along with important vertical links with higher municipal authorities. If an Executive Agency model for urban health care is adopted, such functional ward committees can be the local-level oversight bodies and enablers for the implementation of specific activities that the executive agency is expected to undertake in the wards. As a further result of such an alternate institutional arrangement, there would be a potentially stronger link between the ward committees and the municipal authority or state health department, since both have at different levels a role in overseeing and enabling the executive agency undertake its specific tasks.

BUILDING INSTITUTIONS OF ACCOUNTABILITY THROUGH COMMUNITY ENGAGEMENT FOR URBAN HEALTH SERVICES

Community-level organizations, importantly "owned" by the inhabitants of slums, are known to be more empathetic towards and better informed about the various dimensions of deprivation among the urban poor (Woolcock and Narayan, 2000). However, it is the government, more than any other agency (including NGOs/CBOs) that can catalyze development of the enabling institutional environment required for effective community-based monitoring of services provided by an urban health care system. The absolutely critical role of the government here is that of a facilitator, through a combination of appropriate legal framework provisions, information, and basic financing for sustaining such "community/people owned" institutions. Direct government role in furthering each would be still to facilitate community 'voice' on issues of health care in urban areas. NRHM, faced with the far greater challenge of covering dispersed poor in vast spans of rural areas than the more concentrated urban poor in slums, has made a laudable attempt at developing a community-based monitoring mechanism for public health services. Yet, it is precisely this greater challenge of dispersed rural populations that makes it much harder for institutions to build social capital.

The different urban context can also be addressed differently from the NRHM approach. NRHM, for instance, depends on nodal NGOs at block level and committees formed at village, PHC, block and district levels to harness social capital because of the geographical challenges of the vast rural landscape. The process of 'monitoring committees' developing report cards on health service delivery at village, PHC and thereafter collated at block level, is an exercise 'external' to the community, when compared to the *Jan Sunwais*–public hearings, pioneered by the *Mazdoor Kisan Shakti Sangathan* (MKSS). The latter process is more directly 'owned' by any member of the community who chooses to participate in the public hearing and brings the community face-to-face with the authorities on an effective social audit platform.

In an urban context, the government may take lead to develop institutional platforms such as *Jan Sunwais* described above, which have also informed the Right to Information Act. Urban health (including environmental health factors like sanitation, drainage and clean water), call for a grievance redressal mechanism 'owned' by the slum-dwellers in every slum. A dedicated staff representative of the community logs grievances on a daily basis which could be collated and presented every month in an institutionalized dialogue with relevant authorities. These authorities, at the local level could, for instance, be represented by the strengthened ward committees, discussed in the previous section of this Note. The potential for this social capital holding providers accountable and influencing change are tremendous, especially when buttressed by the other two pillars of executive agencies (held accountable for performance in implementation) and empowered WCC for health (overseeing use of finances to meet peoples' demands). The government's investment in providing the physical space and for limited staffing from within the community for such an institutional mechanism will incentivize the urban poor to participate in improving urban health services by holding administrative and elected authorities accountable, and compelling them to respond to this empowered 'voice'.

CONCLUSION: A DIFFERENT WAY FORWARD

The Indian government is focused on and occupied with formulating policies as well as providing health services through its three-tier delivery system–the challenges of which have consumed almost in entirety its intellectual and financial resources. Rather than focusing on the familiar three-tier public health system of rural India for the urban context, there is an urgent need to be imaginative so as to: (i) optimize the potential of market exposure in urban areas and utilize interests and skill-capacities of the private sector to

work with the public sector executive agency model; (ii) develop participatory governance at local (ward) levels in urban settings; and (iii) empower the mobile, employed urban poor to coalesce with institutional mechanisms for 'voice' to hold the system accountable for health services.

Review of existing literature and work on each of these pillars brings out the tendency to focus on or advocate one of these three institutional mechanisms, which implicitly (or even explicitly) puts disproportionate weight on the chosen pillar over the others. This is true for the majority of literature on executive agency-like institutional arrangements (the body of New Public Management works), the subject of local urban governance, and in the work empowering community 'voice' driven by rights-based advocacy groups. The case for a synergetic relationship between the three is rarely, if ever, made. This Note strongly emphasizes that each of these pillars must not be worked in isolation, but as an institutional arrangement where, if existing together, each further enhances and buttresses the other.

The lubricant for truly empowering and making the proposed institutional arrangements synergetically functional is finances. This could be done by investing authority in executive agencies (or Statutory Boards) and ward-level committees, to plan and manage finances. Or through the minimal financial investment required for building institutions for community 'voice' to hold different authorities mandated with the provision of urban health services, accountable. While Government could be the key source of these finances, an entirely privatized financing of the institutional arrangements of urban health care with built-in checks and balances could also be a feasible option. The success of municipal financial powers decentralized to zonal levels, is evident from the Surat case story (see **Policy Note #5**). However, at present, we curiously have both very inadequate finances devolved to urban local bodies and simultaneously, high averages of under-spending (Mohanty et al., 2007).

It is indeed a travesty of the system that the Councilors of ward committees (where institutional potential is immense), using their limited powers can collectively sanction only Rs. 5 lakh , but individually control over Rs. 2 million. The stalled NUHM (to have begun in 2008) may have ironically presented just the right opportunity to critically re-think the institutional arrangements necessary to the provision of urban health care.

[1] The key health income indicators of IMR, under-5 mortality, immunization fare worse for urban slums on average than in rural areas (GOI, 2008).

[2] The so-called New Public Management reforms in industrial countries have sought to move delivery out of the core public sector. Executive agencies need not necessarily be private corporatized bodies, and may continue to be public sector entities.

[3] In fact, cities in India have different authorities invested with the urban health function: at one end is Hyderabad where municipal authorities have very limited engagement with health care provision and is instead with the state government, while at the other extreme is the powerful Mumbai Municipal Corporation that directly runs a vast network of hospitals. (Ruet and Lama-Rewal, 2009, Ch. 7).

REFERENCES

- Agarwal, S., A. Satyavada, P. Patra, and R. Kumar (2008) '**Strengthening functional community-provider linkages: Lessons from the Indore urban health programme**' Global Public Health, 3(3): 308-325.
- Das, S.K. (2010) '**Effective Delivery of Public Services: The Executive Agency Model**' in V.K. Chand (ed.) Public Service Delivery in India, Oxford, New Delhi.
- GOI (2008) **National Urban Health Mission** (2008-12): Draft for Circulation Urban Health Division, Ministry of Health & Family Welfare, New Delhi.
- GOI (2006) **Draft Final Report of the Task Force to Advise the National Rural Health Mission on "Strategies for Urban Health Care"** MOHFW, New Delhi.
- La Forgia, G.M., and B.F. Couttolenc (2008) **Hospital Performance in Brazil**, The World Bank, Washington, D.C.
- Mohanty, P.K., and others (2007) **Municipal Finance in India: An Assessment, Department of Economic Analysis and Policy**, Reserve Bank of India, Mumbai.
- Woolcock, M., and D. Narayan (2000) '**Social Capital: Implications for Development Theory, Research, and Policy**' World Bank Research Observer, 15, 225-249.

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