Governance and institutional capacities for Universal Health Coverage:

*Driving the Research Agenda*

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National Conference on Universal Health Coverage in India
April 12th, 2012. New Delhi
* Inform and support **implementation** of proposed governance and institutional reforms
  * Understand, and assess gaps and strengths of existing systems
  * Develop roadmaps to strategize reforms
* Develop clarity on the **meanings** of good health governance
* **Engage stakeholders** and sensitize them to the importance of reforms

A continuing research agenda ...
THE RESEARCH AGENDA

DOING GOVERNANCE RESEARCH

health governance hub: SOME RESEARCH FINDINGS

CAVEATS AND CHALLENGES
THE RESEARCH AGENDA

DOING GOVERNANCE RESEARCH

health governance hub: EARLY RESEARCH FINDINGS

CAVEATS AND CHALLENGES
* **Purchasing** care efficiently and fairly
* Enhancing **citizen oversight** and civil society role
* **Regulating** health care costs, quality and access
* Capacities to develop and deploy the **workforce**
* Aligning **drug policy** with public health goals
* Making interoperable, user-friendly and citizen-friendly **information** platforms
* Setting up and managing **implementing institutions**
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themes
health regulation
health workforce
community action for health
panchayati raj institutions
public-private partnerships
implementing universal coverage

✧ research
✧ research capacity-building
✧ knowledge translation
→ **HOW** can we strengthen existing state apparatus for purchasing health care?

→ **WHAT** are the institutional contexts for widespread failure of regulatory policies? **HOW** can these be corrected?

→ **WHY** do only some initiatives succeed in scaling up community action? **HOW** can we learn from these initiatives?

→ **HOW** can we create better decision-spaces for PRIs to be involved in health planning?

→ **HOW** can we best marshal poorly developed and deployed segments (TCAM, Nursing) of India’s massive health workforce?

→ **CAN WE** translate the Expert Group recommendations into specific points of action for Central and State Governments?
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CAVEATS AND CHALLENGES
**What is Health Governance?**

* 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)

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**Governance works well if these are assured** (Brinkerhoff & Bossert 2010)

- Accountability
- Fairness:
- Capacities: sufficient state capacity, power and legitimacy
- Engagement of non-state actors

**What makes governance good?** (DfID 2007)

- State Capability
- Accountability
- Responsiveness
* 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

* Investigates systems hardware (finance, HR, medicines) as well as software (ideas, interests, values, norms, relationships, power)

* Can be exploratory, diagnostic, evaluative and/or strategic

* Uses a range of “HPSR” methods: policy analysis, economic analysis, ethnography, realistic evaluation, ethical analysis
* Policy architecture maps
* Gap diagnoses (policy design and implementation)
* In-depth analyses of policy and implementation process
* Governance toolkits
* Reform roadmaps (developed consultatively)
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CAVEATS AND CHALLENGES
1. Mapping Regulatory Architecture

MP and Delhi States: empirical mapping of ‘expected’ and ‘actual’ policy architecture for regulation of health care

Diagnosing **gaps** in **policy design** and **implementation**

Methods: in-depth interviews; policy document review

<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 <strong>expected</strong> of organization</th>
<th>COL 6. Relevant activities <strong>actually</strong> performed by organization</th>
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<tbody>
<tr>
<td>Costs of Care for Users</td>
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<td>Quality of Care</td>
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<td>Conduct of Providers</td>
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<td>Accessibility of Care</td>
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**DESIGN GAPS**

**IMPLEMENTATION GAPS**
## Regulatory Architecture: Design Gaps

<table>
<thead>
<tr>
<th>Delhi</th>
<th>Madhya Pradesh</th>
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<tbody>
<tr>
<td>No financial protection for non-EWS.</td>
<td>No known laws or regulatory policies for the curtailment of costs for users of health care, other than recently introduced Janani Sahayogi Yojana (Scheme)</td>
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<td>No direct control of care costs, no regulation of competition.</td>
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<tr>
<td>No credible regulatory mechanism to limit practice by unqualified providers. Absence of community-based forum for grievance redress.</td>
<td>Absence of credible community-based forum for grievance redress</td>
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<tr>
<td>Accessibility of care not addressed through act or policy</td>
<td>Variable accessibility of care (workforce distribution): only mandatory rural service, no incentive based policies</td>
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## Regulatory Architecture: implementation gaps

### Delhi

- Information asymmetries impede uptake of social insurance scheme, also lack of stringent regulatory component.
- Partial implementation of NHRA due to personnel constraints and organizational inertia, active resistance of medical fraternity.
- Councils focused less on disciplinary function, more on protecting professionals’ rights, medical sanctity.

### Madhya Pradesh

- Clinical Establishments Act, PNDT, MTP: Implementation partial due to personnel constraints, problems of inter-departmental coordination.
- Self-regulatory council’s engagement with additional tasks such as reducing quackery greater than performance of disciplinary roles.
- Implementation of rural medical bonds hampered by problems in coordination between government departments involved in placements.
Aim: To characterize mechanisms, context and outcomes associated with scaling up community action for health

Methods: In-depth interviews with health system actors, community representatives; focus group discussions; participant observation; Document review
Pilot: SHRC in Chhattisgarh

**Context**
- New statehood
- ‘Pluralist’ governance

**Mechanism**
- Implementers from non-health domains
- Protection from overt political patronage
- ‘Recycling’ personnel at all echelons
- Balance of non-financial and financial incentives

**Outcome**
- Program sustained, expanded >10 yrs, positive evaluations
- Multiple claims of ownership
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CAVEATS AND CHALLENGES
* Challenge of capacity building for governance research

* Disparate views on what constitutes good governance

* Resistance to ‘post-positivist’ social science approaches in health policy (knowledge vs. proof)

* Organizational sensitivities

* Balancing specific nature of policy recommendations with general emphasis on institutional strengthening

We welcome active inputs, advice and positive engagement to help us move this agenda forward
THANK YOU

Acknowledgements:
Raman VR, Devaki Nambiar

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<tr>
<th>Arena</th>
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<td>CIVIL SOCIETY</td>
<td>Socializing, Enabling</td>
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<td>POLITICS</td>
<td>Aggregating, Representing, Legitimizing</td>
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<td>Constitutive, Adjudicatory</td>
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