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Good governance in health care: the Karnataka experience

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Governance has been defined as the process of decision making and the process by which decisions are implemented. Unsatisfactory governance, due to corruption in particular, is being increasingly connected with poor health outcomes in developing countries.[1–3] Corruption in health services is serious, being an obstacle to the achievement of good health outcomes for the state, and a cause of harm and avoidable injury to individuals.[4,5]

Studies of the perception of corruption by Transparency International show that more than three-quarters of the 180 nations surveyed in 2008 scored less than five out of an optimum clean score of ten,[6] which indicates serious corruption in their systems. The corruption perception index for India was 3·4, with a rank of 85th worldwide. The health sector, with high public interaction and large societal impact affecting almost the entire population, was the second most corrupt sector in India. Bribes related to health care comprised the highest portion of all bribes paid in the state of Karnataka in 2008, at 40%. More than 150 000 estimated households below the poverty line paid bribes for seeking basic health care in 2005 in the state.[7] In 2008, 64% of all bribes paid in the state for basic services was by people living below the poverty line and amounted to INR650 million.[8]

Under the chairmanship of one of us (HS), the Task Force on Health and Family Welfare of the Government of Karnataka put corruption at the top of 12 issues of concern for the health system in the state.[9] This was one of the first instances of a state-instituted committee identifying and accepting corruption in health services as a greater problem than the many other seemingly technical issues. The report strengthened the case for ombudsman-like organisations such as the Lokayukta. The Lokayukta is a statutory authority set up in 1984 "to improve the standards of Public Administration, by looking into complaints against administrative actions, including cases of corruption, favouritism, and official indiscipline in administrative machinery".[10] Corruption seriously hinders effective regulation and implementation of laws. A review of the pharmacies in Karnataka showed that nearly half lacked a qualified pharmacist.[9] However, there have been only 14 prosecutions since 2008.[9] Drug price-control orders are routinely used by governments to ensure transparency, efficiency, and quality when buying drugs. However, such reforms are rendered useless if the system lacks good governance.

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Karnataka's Lokayukta estimates that "nearly 25% of the health budget gets siphoned off due to corruption at various levels".[11] For example, 18% of the drug-procurement budget went on nimesulide, a non-essential drug.[12] Another example was the state-owned Hindustan Antibiotics Limited being bypassed in the procurement of intravenous fluids.[12] One of us (HS) also found suspected irregularities in the procurement of medical equipment above market rates, and that some equipment was not installed promptly.[13]

Again, one of us (HS) identified several instances of corruption in the health sector in Karnataka.[9] Dishonesty in health-service delivery is another major concern.[13] Corruption has roots in many areas—from recruitment, to transfers, to promotions—and is found at all hierarchical levels, from low-paid workers to investigation officers. From childbirth to post mortems, informal payments often occur for all services in government hospitals and, most often, it is the poorest people who are most at harm because of power imbalances.[14]

After a review of the situation, as the vigilance director of the Lokayukta, one of us (HS) proposed reforms to reduce corruption.[15] Establishment of, and reforms by, the state-level organisation that procures drugs, the Karnataka State Drugs and Logistics Society, improved

the procurement of essential drugs and their availability in public health facilities and hospitals.[13] Substantial improvements were noted in the turnover of health staff in headquarters by the posting of efficient district health officers with good leadership qualities.[16] Corruption was reduced in equipment purchases through enhanced vigilance. Vigilance cells within health departments have been developed, while e-governance initiatives (such as computerisation and web display of transfers, recruitment, policy-based promotion, and purchasing) played an important part in preventing corruption through transparency and accountability.[16,17]

The prevention of corruption is a bottom-up process, beginning with people's participation in planning, implementation, and monitoring in service delivery to overcome corruption. Several initiatives are underway at the community level in Karnataka, under the National Rural Health Mission (NRHM) launched in 2005. NRHM seeks to improve accountability of health services by providing mechanisms for community participation and management of these services and building capacity for decentralised planning, implementation, and monitoring of health services.[18] A simple management structure in the form of Arogya Raksha Samithi, a patients' welfare committee and hospital management society, has been developed by health centres.[19] The members of this committee are from various segments of society, including beneficiaries, service providers, local leaders, women's groups, and civil society. They act as trustees to manage the affairs of the hospital. The committee is empowered to generate and use funds for smooth functioning and to maintain the quality of services. These groups have been formed in all districts of Karnataka since the launch of NRHM. At the village level, village health and sanitation committees have been correspondingly formed and are being strengthened to monitor the functioning of first-line health services.[20] Additionally, Karnataka is one of the pilot states for community monitoring of health services under NRHM.[20]

Karnataka chose to integrate a planning component to its community monitoring, recognising that monitoring by people without their participation in planning is futile. The initiative in Karnataka is therefore referred to as Community Planning and Monitoring of Health Systems. Since March 31, 2009, the use of community planning and monitoring in health services has been piloted in 562 villages over four districts of Karnataka.[20] The community's involvement in planning has helped to raise awareness on various health issues, entitlements, and services, and mobilised communities for collective action—eg, village health and sanitation committees produced easily understandable village report cards to monitor health-service delivery and to show change over time.[21]

Technological and health-programme innovations are often advocated to improve health outcomes and quality of health care in developing countries. While such innovations are important for incremental change within health care, a huge leap in health outcomes and quality of health care can be achieved through good governance initiatives that focus on reducing corruption and promoting people's participation in health care.

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Civil society in ASEAN: a healthy development?

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Across southeast Asia, local citizens engage in collective action for health, the basis of networks of trust that are often overlooked by state agencies and external observers. Informal groups and Buddhist monks provided first aid and food assistance to survivors after Myanmar's cyclone Nargis in 2008, in the absence of governmental and external assistance.[1,2] In Vietnam, support provided by local Buddhist and Catholic congregations, and organisations such as the Women's Union, have expanded to fill the increase in demand for local health services as the previously subsidised state monopoly splintered into an uneven mixture of public and private health providers. Civil society in Thailand has contributed to major innovations in family-planning programmes, ensured universal access to antiretroviral drugs, and challenged international trade regimens to enable the licensing of domestically produced medicines.[3] The outcomes of action by civil society vary widely across the region and have not always been positive, as conflicts emerged within civil society and between society and the state.

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Citizen-based action on health takes place against the backdrop of varied political regimes in southeast Asia. Although authoritarian and illiberal democratic states attempt to restrict civil society, by a combination of legal and extra-legal means, citizens still organise ways of improving their health and environment.[4–6] These improvements are achieved in cooperation with the state and donors when possible, but separately and informally when not. The resulting mix of opportunities for civil society does not correspond easily with the usual ideas of civil society as autonomous and independent from separate state and market sectors. In reality, the situation in southeast Asia is characterised by degrees of state–society interpenetration, from positive synergies to co-optation of social forces by the state.[7]

Perhaps the most celebrated cases of civil-society involvement in southeast Asia have been in HIV care and prevention. Local networks and organisations, particularly groups of people living with HIV, have had a prominent role in responding to the burden of caring for patients and ensuring that those living with the disease in Cambodia and Thailand have a place in society. In Vietnam, funding has been channelled to grassroots networks that support patients by global health initiatives such as the US President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria.[8] Although the Vietnamese Government has encouraged religious groups to care for underserved and stigmatised populations,[9] groups operating programmes might nevertheless encounter difficulties with legal registration due to suspicion from some local government agencies.