Conclusion - Towards a System for Universal Access to Healthcare

Given the large scale of healthcare resources in the country, a reorganised system of Universal access, ensuring good quality, appropriate healthcare for all could be a concrete possibility in the near future. However, this would require large scale changes in the way that healthcare in the country is organised. Keeping the interests of the general public paramount, powerful vested interests would have to be curbed, regulated and made accountable. Along with raising public finances for health, significant redistribution of healthcare resources based on equity considerations would be necessary. A paradigm shift would be required, with emphasis on rational, appropriate care for all based on integration of systems instead of expensive, often irrational care based on high-tech 'medical consumerism' for the few. Planning and control must shift from unaccountable international agencies and minimally unaccountable Ministries to the common people, their organisations, and their locally elected representatives in villages and urban areas. Besides the problems related to overall approach and policy, the unacceptable gap between positive elements of policy and their often dismal implementation would need to be addressed through a system of regular community based monitoring, rights and accountability mechanisms at all levels. The comprehensive transformation required in the healthcare system is a very large issue, which would be covered in a separate, detailed 'People's Health Plan' to be developed by JSA. However, in brief it is suggested that our programme for change could include some of the following measures:

> Planning and control must shift from international agencies and Ministries to the common people...

Improving and Reorganising Financing of Public Health, Equitable Public Health Financing

- There is a need for a qualitative increase in resources for public health to the level of 3% of GDP in the short term, moving to 5% of the GDP in medium term. These raised public finances for the public health system could be raised through general taxation along with various forms of special taxation and cesses for health security. In addition, ending subsidisation of the private medical sector and effectively taxing this sector, especially its upper end; a special health security cess on all financial transactions including international transactions above a certain level; and preferential taxation of industries with negative health impacts are some other measures that could be adopted.
- Corporations and employers in both organised and unorganised sectors could be required to contribute to the general health system. We need to consider moving towards a system of publicly organised, large-scale social security, covering the entire organised and unorganised working class, which could rope in all employers to substantially contribute to the public health system (see below).
- All donors funding (including that from UN agencies, bilateral donors, the World Bank and other international donors, global health initiatives) must be reviewed and managed within a sector-wide approach. This would mean that all contributions would be evaluated in the framework of the Indian public health decision making process and priorities, would be required to contribute to strengthening the overall public healthcare system, would be completely de-linked from programme specific prescriptions or the pressure to show results in specific programmes. Any donors not willing to operate in such a coherent framework would need to be politely shown the door. The participation and commitment of all external actors to a sector-wide approach, including 'overall health system goals' would need to be regularly monitored by the public health system and the people's health movement.

- Public health financing needs to be subjected to the equity principles of 'equal resources for equal need' and 'greater resources for greater need'. With this approach, we could work out a system of block budgeting wherein a general citizen in either urban or rural areas, whether in developed or less developed states, anywhere in the country would receive the same baseline level of public health resources, eliminating existing inequities in public health resource allocation. Added to this, there would need to be recognition of special needs (as for women, children, adivasis and other groups), which would merit additional resources being allocated for various services catering to these groups. Further, an assessment may be made of financial capacities and historical levels of development of various states in order to decide on additional resources required by states such as EAG states. However, the overall principle of equitable block budgeting would allow every citizen and every Panchayat representative to know, for example, what is the public support being given per person, per PHC, for each block in their district and in their state, along with the rationale, enabling everyone to monitor equitable distribution of public health resources.
- National health accounts would need to be regularly produced, to describe the way in which healthcare is being financed, as well as the pattern of healthcare expenditure, including measurements of the per capita expenditure inequities between geographic areas, between urban and rural areas, between socio-economic groups, and between secondary / tertiary hospitals and primary health services.

Public Health System Strengthening and Reorganisation

The overall objective would be moving in a time-bound manner towards a system for universal access to good quality, appropriate healthcare under the ambit of the Public Health System. This would include the following aspects:

- A radical break from existing top-down verticals and fragmented health programmes; instead horizontal integration and community orientation at all levels. Qualitative strengthening of the general health system at all levels would need to be accompanied by systems for financial and operational devolution with control and decentralised health planning by Panchayats and communities, in conjunction with the District Health System model which could provide an organisational framework for a comprehensive health systems development agenda. At least 40% of the entire resources for the health sector could be allocated to Panchayats or equivalent local representative bodies; such concrete decentralisation of resources needs to be implemented in a phased manner to make decentralised planning a reality. Combined with capacity building, this can create a framework for health plans and programmes to be developed based on the needs and characteristics of local communities; it can decentralise management authority and capacity, facilitate community involvement in health and provide a platform for the integration of policies and programmes emanating from the Union and State Health Ministries. Such a framework could form the basis for community oriented resource-allocation decisions and could promote integration between hospitals, clinics and community-based healthcare.
- Some specific issues which could be addressed in such a framework would include district level identification of local morbidity patterns, tracing of local disease transmission patterns (in a socio-ecological framework) and locally charting antimicrobial sensitivity of pathogens responsible for common illnesses. Such steps would enable locally appropriate priority setting and disease control strategies. Another measure which needs to be considered is decentralised surveillance, enabling health personnel from the community health worker and ANM /MPW upwards to detect outbreaks at the earliest stages using simple cut-off points and appropriate epidemiological tools.
- Guarantee of essential drugs based on programmes for

efficient procurement, distribution and rational use: the aim should be to guarantee assured availability of all essential drugs in every public health facility of the country within one year. The Tamil Nadu experience of efficient procurement and distribution could be rapidly adapted and generalised in all states, and along with adequate drug budgets this could lead to universal assured availability of drugs at all levels of the public health system. This would tremendously boost people's confidence in the Public Health System. Along with this, ensuring rational drug use at all levels would greatly reduce unnecessary expenditure and would significantly improve the quality of care. (see below)

- First contact care must be de-medicalised and made universally available through a system of universalisation of Community Health Workers. Moving beyond the serious design limitations of the current ASHA programme, a community health worker in every hamlet, every village and every urban settlement could be made available through a decentralised and locally adapted capacity building process.

A framework of Rights, Community Control & Accountability

- Based on services and facilities which must be delivered as entitlements at various levels, healthcare would need to be made a right of every citizen. This could be done by means of Public Health Acts at National and State levels. This would need to be accompanied by reorientation of the Public Health System with strong systems of accountability and health rights at multiple levels.
- As mentioned above, the healthcare system would need to place communities at the centre of their planning and monitoring activities. Aside from developing community based structures and forums such as community health monitoring and planning bodies at all levels, there needs to be display and dissemination of information about the rights of service users through all public health facilities.

Abolish User Fees at All Levels

- User fees whether already in existence in several states, or being introduced under NRHM are an unjustifiable barrier to accessing healthcare. There is ample evidence that the exemption mechanisms for 'Below Poverty Line' patients do not work satisfactorily, and hence user fees contribute to denial of healthcare for a large proportion of patients. Hence, user fees must be abolished immediately at all levels in the public health system. As it is user fees contribute only a small proportion of public health budgets, and with increased overall revenues for public health, as mentioned above, they would become entirely irrelevant even as a source of revenue.

Comprehensive Human Power Plan for the Health Sector

- The first element of such a plan would be a clear demarcation of the number and skills mix of the health workforce required to provide essential healthcare (including important non-clinical personnel) with a focus on primary healthcare and under-served areas.
- This should be accompanied by a medium term investment plan particularly in schools of nursing, paramedic training, public health and other disciplines to attain the medium and long term production targets for the desired number and skills mix of the health workforce. This would address the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend emphasising production of personnel trained in medical super-specialties. Major portions of medical and health personnel training should be imparted in peripheral healthcare institutions.

- No more new medical colleges should be opened in the private sector. All private medical colleges charging fees higher than state colleges or taking any form of donations must be closed down. At least one year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education may be made mandatory, without which license to practice may not be issued. Similarly, three years of rural posting after post graduation could be made compulsory.
- The wage structure for public sector health workers, especially for those working at the peripheral levels should be reviewed. Extra support and incentives for health workers in isolated and difficult circumstances may also be required.
- Along with this, adequate non-financial, professional incentives should be developed at all levels, with opportunities for ongoing training and exposure. Good performance should be rewarded based on public feedback, coupled with implementation of transparent and non-discriminatory service rules and codes of conduct, and public accountability mechanisms at different levels of the Public Health System.

Transform and Integrate Disease Control Programmes

- Specific major health problems, both communicable diseases such as Malaria, TB and HIV-AIDS, and non-communicable health issues such as mental health would need to be addressed through modified programmes closely integrated with a robust comprehensive health system. These programmes integrated with the comprehensive system could subsume and replace the current selective, vertical programmes.
- Concerning communicable disease control, the emphasis would need to be on social-ecological methods appropriate to various diseases and situations, with involvement of communities in planning and implementation, which are presently major gaps. Intersectoral strategies related to drinking water, improvement of habitation and local environment linked with vector control, appropriate sanitation and nutrition would need to be given top priority.
- Programme-specific issues relating to each disease programme would need to be reviewed and addressed as exemplified above relating to Malaria, TB, HIV-AIDS and Leprosy.
- Certain features of immunisation programmes such as the Polio Eradication initiative, Universal Hepatitis-B immunisation and the current system of restricting use of Intradermal Rabies Vaccination in public health facilities need to be thoroughly critically reviewed and decisions need to be taken in keeping with epidemiological and public health considerations. (these have been covered in detail in a separate JSA booklet)
- All international sources of financing of selective health initiatives, including HIV-AIDS related funding, would be restructured in a sector-wide approach, would be required to allocate a substantial proportion (say one-third to half) of their funds to finance the core infrastructure for a functional public healthcare system. Rather than multiple strands of health funding attached to multiple disease-based or selective interventions, there could be a single fund for comprehensive health systems financing which would then form the platform for disease-specific interventions.
- Health system design should ensure that key dimensions such as the supply and distribution system of medicines and laboratory services should never be duplicated, nor should parallel systems exist for different diseases or programmes.

Universal Healthcare Coverage for Unorganised Sector Workers

Unorganised sector workers, estimated to constitute nearly 37 crore workers in India, do not have any assured healthcare coverage. On the other hand, the Employees State Insurance (ESI) system for organised sector workers is becoming increasingly dysfunctional due to a variety of reasons, leading to large-scale stagnation and under-utilisation of healthcare assets such as ESI hospitals. This is a scenario where we need to consider coverage of all unorganised sector workers

by a National Social Security Scheme incorporating a reorganised, rejuvenated and expanded ESI combined with involvement of the general Public Health System and some regulated private services where necessary. This could lead to coverage of all unorganised (and organised) sector workers by an effective form of healthcare coverage, could bring in unorganised sector employers to contribute to their workers health, and could lead to reorganisation and effective utilisation of ESI along with some increased utilisation and resources for the public health system. This proposal of course needs to be worked out in much more detail, but the idea should be not to leave healthcare coverage of unorganised sector workers to commercial insurance companies and private providers, but rather to use this opportunity to reorganise and strengthen ESI and the public health system.

Meeting the Specific Healthcare Requirements of Various Groups with Special Needs

The outstanding special health needs of various sections of the population including women, children, industrial and unorganised sector workers, Dalits, adivasis, persons with mental health problems, persons with HIV-AIDS, elderly persons, differently abled persons would need to be met through sets of measures worked out and implemented with participation of groups of these beneficiaries, sensitively delivered by the general health system. Such specific measures are being dealt with in separate JSA booklets, dealing with particular groups having special health needs.

Effective Private Sector Regulation, Including Minimum Standards, Standard Management Protocols, Patients Rights, Ceiling on Fees and Licensing Based on Need

Despite some rhetoric, nothing substantial has been done so far on this important front. Urgent steps need to be taken to enact legislation and institutionalise minimum standards, standard management protocols and patients rights in the private medical sector. Similarly, given the wide variation and often unaffordable fees charged, it may be considered whether a ceiling on the basic fee for all essential health services (such as normal delivery, cesarean section) could be considered. (As a precedent of developing standard costs, already CGHS reimbursement rates for services from private medical facilities have been worked out nationally and we have a parallel precedent in form of the Drug Price Control Order, which mandates a definite ceiling on the price of essential drugs.) Further, given the over-concentration of private facilities in large cities, the procedures for licensing of new hospitals and diagnostic centres should incorporate an assessment of need. A positive side impact of such licensing regulation would be to regulate the unchecked proliferation of ultrasound centres used for sex determination. The overall intention should be to curb irrational proliferation of the private medical sector and bring it in line with public health goals.

Standard Protocols for the Entire Medical Profession

There is an urgent need to eliminate widespread irrational medical practices including unnecessary medications and procedures, which would considerably cut down costs in the health system. This should be done for the entire medical profession, both in private and public sector, through standard treatment protocols and management guidelines whose adherence could be monitored by prescription audit and other means. These guidelines would specify indications for various investigations, surgeries and procedures. Various low-cost yet effective, innovative healthcare methods and techniques developed in the voluntary sector also need to be encouraged and generalised by the Public Health System.

Promotion of Alternative Systems and Integration of Various Systems of Medicine

The important resource of traditional and alternative healing systems needs to be encouraged, reasonable standards need to be introduced and it should be integrated with the modern medical system. This would entail enhanced public system support to AYUSH systems with appointment of practitioners, both at primary level and in form of specialised clinics, at various levels in the Public Health System. This would maintain plurality of systems and would offer choice of providers to patients. At the same time, regulation of traditional practitioners should be developed within the framework of each system, based on reasonable standards. Research related to optimal effectiveness of various therapeutic measures with involvement of practitioners of the respective systems, and research related to integration of systems needs to be encouraged.

Regulation and Rationalisation of the Drug Industry

To help ensure universal availability of essential drugs, there is a need for a much more regulated and rationalised drug industry. This would require inclusion of all essential drugs under effective price control, elimination of irrational and unnecessary formulations and combinations, ending unethical promotion by the drug industry and their unhealthy influence on prescribing by doctors and various other measures. (Covered in detail in a separate JSA booklet)

A System for Universal Access to Healthcare

Based on a spectrum of such measures, as a further step, along with a greatly strengthened and reoriented public health system, regulated and rationalised elements in the private medical sector could be progressively brought under control of the Public health umbrella to harness their medical expertise to operationalise a system which would ensure universal availability of rational, quality healthcare. This system should ensure free services for all (without any targeting or user fees), and would need to be financed from the general taxation system along with perhaps social insurance with contributions from employers and better off sections of the population. We could look at the British (NHS) and Canadian (Universal Social Health Insurance) models among the systems from which elements could be adapted for the Indian situation.

While this spectrum of changes that are required may appear daunting and even somewhat 'utopian', there are many things that health activists can start doing here and now to move towards such an improved and accountable health system -

- Persistently demanding quality health services from the public health system, including the health services that are now being guaranteed under NRHM. Documenting availability of health services at the village level through tools such as Village Calendars and Village Health Registers. Arranging dialogues between public health officials and health activists, carrying out social audit of these services and organizing periodic 'Jan Sunwais' may be some of the methods that could be used.
- Documenting instances of denial of healthcare at various levels of the Public Health System and demanding that justice be done in these cases, along with taking steps to prevent further such denial.
- Developing systems for regular community monitoring and planning of Public Health Services, both through committees now mandated in the NRHM framework and as independent people's initiatives.
- 'Watching' the implementation of NRHM by collecting information and publicizing it - both to demand implementation of health service guarantees and accountability mechanisms, and to critique and resist negative tendencies such as certain forms of public-private partnership.
- Auditing the availability of essential drugs in public health facilities such as PHCs and CHCs and demanding that all essential drugs must be available to all patients requiring them.
- Demanding abolition of user fees in public health facilities,

documenting the exclusions that take place due to 'BPL-APL' targeting, analysing the functioning of 'Rogi Kalyan Samitis' or similar bodies to check steps towards semi-privatisation of public health facilities, and opposing privatisation of public health facilities.

- Proposing 'People's Health Plans' at all levels - from village to national - to push genuine community priorities, alternative suggestions for service delivery, low-cost and integrated methods of healthcare, and organisational changes in a pro-people direction, especially keeping in mind various sections of the people with special health needs.
- Documenting exploitative practices by the private medical sector and raising the issue of patient's rights - including the right to information, to rational medical care, to emergency care irrespective of ability to pay, to informed consent, to all patient records, to display of all rates, to second opinion etc. Organising public functions and dialogues on the issue of regulation of the private medical sector and patients rights. Documenting the level of fulfillment by Trust hospitals and private hospitals availing of public subsidies, of their obligations to treat poor patients, and demanding independent systems to monitor and ensure that these obligations are effectively fulfilled.
- Generating public awareness about widespread irrational practices, especially in the private medical sector. Publicizing the need for people to avoid these and for doctors practices to be subject to professional and social regulation with the help of guidelines, so that unnecessary and irrational investigations, treatments and operations are prevented.
- Involving a range of social organisations such as women's groups, trade unions, citizens and consumer organisations, youth groups, students' organisations, self-help groups, people's organisations and NGOs in the above mentioned activities, sensitizing them about the agenda of the Health movement and making them active participants in the process.

- Developing people-based initiatives for improved healthcare such as community health worker programmes (attempting to utilise resources from the public health system), appropriate use of traditional healing systems and low-cost, appropriate models of healthcare delivery.
- Analysing and critiquing Health policy issues at the state level, including state health budgets, availability of infrastructure and human power in public health facilities, drug procurement and distribution mechanisms, state-specific health programmes, repressive aspects of population control measures, and legislation regarding the private medical sector. In the form of a Health movement coalition, all these issues could be discussed in public functions involving social organisations and decision makers.
- Analysing and critiquing policies in the state regarding medical education and private medical colleges, demanding that no new private medical colleges based on 'capitation' or 'donation' be opened. Proposing a comprehensive health human power policy for the state taking into account the need for increased number of nurses, paramedical personnel and public health professionals.
- Sensitising political decision makers from Panchayat members, Zila Parishad members and corporators to MLAs and MPs about key health issues requiring policy change, programmatic modification or improved implementation. Convincing them that Public Health is an important political issue.
- Developing and strengthening linkages with movements in other social sectors such as education, food security, water, housing and workers' social security. Giving health related inputs to these allied movements, such as strengthening the justification for food security by demonstrating the negative health impacts of malnutrition.

To achieve the required spectrum of changes of course demands a much wider social process. A powerful people's movement on health issues is needed, to enable people to more actively claim their

health rights and to push for changes in the health sector. We need to work for reorganisation of the health system as part of a larger movement for reorganisation of society, which ensures that needs of people are given priority over profits. A reorganised, strengthened and accountable healthcare system in conjunction with improved access to the entire spectrum of health determinants - food, water, sanitation, education, housing, environmental and working conditions - could lead to an India where everyone enjoys their Right to Health, and we are able to achieve the dream of Health For All.