EXPLORING A ROADMAP FOR HEALTH CARE FOR ALL/UAHC

(*Framework Paper for the 39th Annual meeting of the medico friend circle*)

Organizing Committee of the 39th mfc Annual Meet

Background

The medico friend circle has been discussing the theme of Universal Access to Health Care (UAHC) for nearly the last two and a half years. At the Mid annual meet (MAM) held in Pune in July 2009 it was decided that it was very important for a group like mfc to move beyond only providing critiques of various aspects of the present system to actually evolving a framework for Universal Access to Health Care. Given the increasing inequities as well as the continuing lack of access to health and the resources for health, as well as the further privatization on a sector wide scale, it was decided to develop and propose a broad plan for ***Universal Access to Health Care Health Care for All***. ((UAHC/HCA Towards this it was decided that instead of preparing for a year for a theme for the Annual MFC Meet, as is the usual practice, we should work on the same theme (UAHC/HCA) for two annual meets. It was also decided that the second meeting would be held on a much larger scale than usual, when at least the broad contours of an mfc position / plan of UAHC can be explored and discussed. Thus we had an annual meeting in January 2010 focusing on the health and health-care situation in India as it is now and highlighting the gaps, that need to be filled in, and barriers to be overcome in order to reach the goal of UAHC/HCA. Through 2010 we met in groups, twice, including the mid-annual meeting in Sewagram in July 2010, to plan out the second annual meeting on UAHC/HCA that aimed to evolve, in broad strokes, an "mfc framework" of UAHC. We had very intense, rich discussions during the annual meeting in Nagpur in January 2011 on ***'Towards UAHC/HCA : a realizable dream'.*** In this meet, in addition to a larger number of mfc members we also had the participation of some of the members of the High Level Expert Group (HLEG) on UHC appointed by the Planning Commission. The background papers of this meet and the report including the summary of the consensus have been published in the MFC Bulletin and are also available on the MFC web-site (mfcindia.org). At the end of this meeting it was felt that we should continue on the theme for another year (given the amount of work that has already gone in) but focus specifically on the current context in India, namely the National Rural Health Mission (which is in its last year in 2012) and on road-map for UAHC starting from the reality of the post-NRHM scenario. The Annual Meeting of January 2012, ***"Exploring Road-map to UAHC",*** would thus focus even further on the specificities required and the road map envisaged. Further there were also many un answered questions / grey areas that came up during the annual meeting in Jan 2011 that were identified in the mid-annual meeting in July 2011 as those which could form the basis of discussions at the Annual Meeting of January 2012.

Both health activists as well as corporate heads are talking equally passionately about Universal Health Care. This fact should alert us of the ways in which private capital seeks higher profits from the health industry, which includes supporting such concepts. Hence a very clear people-centric approach to UAHC has to be formulated by MFC. This concern was echoed in the discussions we have had so far and is crystallized in the papers by Ritu Priya published in the Feb-Jul 2011 edition of the bulletin.

The conceptual and contextual terrain of Universal Health Care

Ever since the Annual Meeting at Nagpur, there have been a number of significant interventions / publications on the concept of Universal Health Care. These include the Lancet series on India, The report of the High Level Expert Group (HLEG) of the planning commission, the approach paper of the 12th plan document on health. In November 2011, the Jan Swasthya Abhiyan, is to discuss UAHC during it's extended National Co-ordination Committee Meeting and is expected to come up with it's approach to UAHC and the developments related to it. Similarly the fact that the NRHM will be completing its 7 year period and is poised to evolve into the National Health Mission which is to include urban health care and the Prime minister announcing that like the last five year plan could be considered an "Education" plan, this plan would be a "Health plan"; it is clear that health is clearly on every body's agenda.

While it is beyond the scope of this concept note to delve into the details of these individual approaches, a reading of all three 'approaches' show that each of them addresses major issues in areas of financing, provisioning and governance and there does seem to be some level of overlap / consensus between specific aspects of the approaches. Given that moving from the present state of affairs to a Universal Health Care system will require system wide as well as social and political changes, what emerges from these various papers is a range of approaches to the problem. This exercise is done specifically with reference to the "mfc model" (still evolving) with a hope to identify some of the broad areas that need to be discussed in the forthcoming annual meeting. (A more detailed exercise comparing the different approaches will be circulated as a background paper for the annual meet). In the next section we will present some of the major areas discussed by the different papers and highlight some of the areas of overlap and divergence. In the section after that, we delineate how the mfc model differs from these and map out some of the major emerging themes of the mfc model and specific questions that will guide the discussion at the annual meet.

Major aspects discussed in the HLEG report, the Lancet – Call to Action and the 12th Plan Approach Paper on Health:

Financing

- The **HLEG** suggests that there should be a predominantly tax based financing of the proposed UHC. There seems to be a clear recognition that private sector insurance based financing will not be able to achieve the goal. The HLEG is very explicit about this, stating, ***"Use general taxation as the principal source of health care financing"*** (Recommendation 5.1.3), and ***"Do not use insurance companies or any other independent agents to purchase health care services on behalf of the government"*** (Recommendation 5.1.9).
- The **Lancet** piece makes the boldest demands with a demand for 6% GDP as public financing with 15% of the taxes being earmarked for health (Box on key messages on the first page of "Call to action").
- ***The 12th Plan approach paper however merely talks about the 12th plan to "explore the possibilities of introducing a government funded health insurance plan for every citizen along the lines of the RSBY, which is currently limited to the poor and for certain select groups. Insurance under the plan will focus on both preventive and curative services. The***

premiums should be contributed by the beneficiaries and their employers".

- There is a general idea in both the HLEG and Lancet article that the various schemes / social insurance etc. need to be consolidated into a common pool. The HLEG states, ***"All government funded insurance schemes should be integrated with the UHC system"*** (Recommendation 5.1.11). Similarly, the Lancet series states, ***"Merge all the existing health insurance funds"*** (Panel 4 in the "Call for Action"). Whereas the 12th plan document does not specifically mention anything on this issue.

Provisioning

- Both the Lancet and the HLEG share a broad consensus that the public health system needs extensive strengthening Thus, the Lancet series says, ***"Health care should be provided through the diverse providers who are already active in health care, with substantial strengthening of the public health-care delivery system...".*** (Pg 4 Call to action). The HLEG calls for, ***"reorient health care provision to focus significantly on primary health care."*** (Recommendation 5.2.3), **"Strengthening of district hospitals."** (recommendation 5.2.4). ***"Ensure adequate numbers of trained health care providers and technical health care workers at different levels – giving primacy to the provision of primary health care."*** (Recommendation 5.3.1). The 12th PAP, however, is not as explicit. In fact in the section on Urban health it states, ***"(public health) infrastructure cannot be based on mechanical application of population based norms since many people in urban areas have access to private medical care"*** (p. 120, 12 PAP).
- The Lancet paper calls for ***an Integrated National Health System where all providers will need to register with a National Accreditation Authority.*** (Pg. 1 Call to Action), and the HLEG calls for a ***strengthened public health system with 'contracting- in' of the private sector where needed / to complement provisioning.*** The 12th PAP merely envisions the ***PPP as a finance generating arrangement.***
- There is a consensus among the HLEG and the Lancet on the need for ***defining standard treatment guidelines as well as the costing of the various interventions and that prices be strictly regulated.*** They also talk of ***strengthening the regulation of the private sector.*** However the 12th PAP is silent on this aspect of regulation.
- There seems to be an increasing voice for the strengthening of the production capacity of the public sector undertakings for drugs and vaccines sector. The HLEG states, ***"Strengthen the public sector to protect the capacity of domestic drug and vaccines industry to meet national ends."*** (Recommendation 5.5.3). Similarly the approach paper for the 12th plan states***, "PSUs which have manufacturing capabilities, can play an important role in ensuring reasonably priced supply of essential drugs and they should be strengthened for this process."*** (Point 9.23 pg. 119)

Governance[1]

- One area where there is a broad consensus among all the three papers is that ***communities need to be more involved in monitoring and planning in the health system. Community monitoring/ accountability*** is clearly mentioned in all the three documents. While the Lancet paper talks about, ***"Creating systems for accountability of local health – care services to fully empower civil society groups and creating a decentralized governance structure that responds to local needs and is accountable."*** (Panel 4 Call to Action). The HLEG is more explicit in this aspect calling for a range of ***community structures and processes like Participatory Health Councils and Health Assemblies*** etc. (Recommendation 5.4.1, 5.4.2). Similarly, the 12th PAP talks about, ***"the introduction of an accountability matrix - with community based data collection and monitoring as being critical".*** (Point 9.7 pg 115)
- Both HLEG and the Lancet paper suggest the ***formation of a number of newer bodies to oversee the development and implementation of the various components of the system and improve the governance of the health system.*** The HLEG recommends the following agencies: ***National Health Regulatory and Development Authority, National Drug regulatory and Development Authority, National Health and Medical Facilities Accreditation Authority, Health System Evaluation Unit and National Health Promotion and Protection Trust.*** (Recommendation 5.6.5). The Lancet series talks about the setting up of: ***"Integrated National Health System, national health regulatory agency, a fully autonomous council that compiles and synthesizes relevant information to develop guidelines for evidence based health care and its assessment.*** (From Call for Action).

In terms of specific significant ideas in each of the documents, the following are notable:

- The HLEG also envisages a ***district level information center*** "Jan Sahayata Kendra" for dissemination of all types of information for the people.(Recommendation 5.4.5)
- Significantly, the HLEG talks about the setting up of ***a grievance redressal mechanism at the district level.*** (Recommendation 5.4.5)
- While the HLEG talks about a predominant tax based financing - it clearly notes ***that no private sector body should be involved in the handling of these funds and that the primary purchaser of all services should be the government.*** (Recommendation 5.1.9)
- The HLEG also envisages ***the district hospitals developing into nodal centers where a whole range of educational activities for professionals, para-medics as well as community based workers is hosted.*** (Recommendation 5.2.4).
- There is detailed discussion on the ***role of information and research as well as the development of standard treatment guidelines*** in the Lancet paper***.*** (Both in Box on page 1 as well as in Panel 4).

[1] Suggested definitions for Good Governance are:

Governance means exercising of power or authority – political, economic and administrative - to design and implement the broad vision of using our common resources and services provisioning to all the members of the society. This would mean mechanisms, processes and institutions which the citizens or groups can use to articulate their interests, exercise their rights, carry out their responsibilities and settle their differences.

Good Governance means doing so competently in a way which is open, transparent, accountable, equitable and responsive to people's needs.

- Very significantly the 12th plan document ***faults the government for filling a large number of posts through the mechanism of contracts.*** They talk instead of ***building up the overall capacity of the health system through the increased intake of permanent cadre.*** (Point 9.29 pg 121).

The mfc approach: critical areas of divergence

While agreeing with the broad ideas of a unified system of financing and the fact that it should predominantly be tax based, the idea of an integrated health system that includes the private sector providers and that communities need to be integrally involved in all steps of the governance of the health system; the mfc sees certain critical divergences from the overall framework of the other three models. This will be discussed below.

Critique of the present model

The mfc has embedded in its framework a critique of current pathogenic developmental model which has meant a double burden of diseases – older health problems like malnourishment, TB, malaria have continued and in addition there is the high incidence of 'newer' diseases arising out of stress, pollution, addictions, violence etc. Any Public Health approach must try to curtail this high disease burden and hence must question the pathogenic model of development. Secondly, there has been no regulation of the quality, quantity of private medical sector, majority of the private producers are in the business of money making through irrational, excessive medical interventions at the expense of the patients. The private sector will need to be effectively regulated and to some extent 'socialised' in some form, to become compatible with a genuine system for UHC. The mfc approach believes that ***just providing large scale, increasing public funds to an irrational, over-medicalised, ever-expanding, profit-seeking industry may not be the best way forward.***

A people centered system

The mfc approach goes beyond the concept of community or people's 'participation' to the concept of 'people centeredness'. Thus the central question is not how people can get involved in the health system but rather ***how the health system can respond to the emerging needs of the people in ways that are relevant, accessible and respectful.*** The mfc approach thus starts from the concept of self-care and the critical question is ***how does the health system ensure support to self-care?*** Similarly, AYUSH and other local folk remedies are not seen merely as 'gap fillers' in the present system, but are seen as contributing to the overall health and therefore, need ***a respectful and comprehensive approach.***

Involving the private sector

There is a broad consensus on the involvement of the private sector in the provisioning of services in the system. The exact method / mechanism, however, needs clarification. This is also one of the major bones of contention of the model proposed by / being discussed by mfc. While the other groups merely stop at ***"contracting - in" of the private sector*** – the mfc talks about progressively socializing the private medical sector. How will it differ from the envisaged integrated national health system of

the Lancet series? We need to take into account the fact that in today's world and especially in the health system, private capital actually adapts to various institutions to maximise accumulation[2] and many times in counter-intuitive ways.

Similarly the mfc has suggested a ***hierarchy in prioritizing the involvement of various types of health-care providers - starting with public sector, then charitable,not-for profit hospitals and only then the corporate hospitals.***

This whole conceptualization needs more detailing - as it will emerge as a crucial aspect in the regulation / control of private sector as well as in the socialization of the health sector.

Civil society vs the people

The mfc approach also makes a ***clear differentiation between civil society and the people,*** clearly recognizing that civil society when taken as ***NGOs alone cannot be considered as 'representatives' of the people.*** A much wider range including most centrally the panchayats need to be taken into account. Equally importantly, we recognize that ***people imbibe the values of 'commodification' that form the practice of the system.*** Thus, there may well be a difference between what people 'demand of a system' (based on their assessment of what that system can offer) and what the people's values and needs really are. Similarly the way in which people may finally choose to 'demand' UHC and 'own' our various concepts and approaches depends on how well the model fits in with the lived reality of the people

The way forward

One of the key aspects of the mfc approach is to see the ***evolution of a Universal system as an intensively political process.*** There needs to be ***massive mobilization, mapping and networking with the whole range of pro-peoples forces including mass organisations, social movements, trade unions, health sector employee associations, sections of rational doctors, consumer groups*** etc. A mere introduction with various technical interventions without the parallel social and political change will merely lead to co-option of the various 'solutions' by the elite.

Emerging questions for discussion at the annual meeting

Based on the above analysis and the ongoing discussions, we pose a few questions in this section which will indicate the broad focus of the Annual meet of 2012. Due to time constraint, only some of the key questions would be taken up for discussion during the MFC meet.

[2] Because Health constitutes a politically unique terrain, it has been noted that, "Privatization and corporatization can meet bitter resistance and that the health industry maneuvers very carefully when trying to extend its avenues of accumulation. This side of the sector is best captured by the idea of 'accumulation by institutional adaptation" . In this conceptualization an institution is "the crystallization of power relations and class struggle...", and adaptation means "enabling an environment in which agents of the health industry can gain the most from existing institutional parameters, as they change over time". (Loeppky, Certain Wealth; Accumulation in the Health Industry, Socialist Register 2010)

Provisioning

- What would be the mechanism for identifying, accrediting, inducting and monitoring the services of the public sector and private sector at various levels of health care provisioning?
- What would be the mechanism to evolve Standard Treatment Guidelines, especially including focus on self-care and AYUSH which the mfc sees as crucial components in any UAHC system?
- What would be the mechanism to decide on the level of technology / diagnostics and other aspects of care at each level? How would these be up-dated? Again how does this take into account our focus on self-care and AYUSH?
- What are the mechanisms for ensuring the provisioning of universal quality care to marginalized populations like homeless, rag-pickers, street children, construction and brick and lime kiln workers, sex workers, and other temporary migrants etc.?
- What are the mechanisms for ensuring the provisioning of universal quality care to people with special needs like those with disability, mental health issues, non-normative sexualities etc.

Human resources

- What is the possible national UHC model for urban rural localities for HHR estimation? What should be the ratio of nurses to doctors;
- What would be the HHR requirement of medical, nursing and paramedic personnel including public health nurses, specialist nurses, dentists, physiotherapists, optometrists, audiometrists etc.
- Unlike the current situation, will the body entrusted with regulation of the private practioners be an autonomous body with staff appropriately trained for this work? If yes, how will it be constituted and run?
- What is the envisaged role of the 'three year doctor', the 'nurse – practitioner' etc. and the community health worker in this system?
- What are the current HHR problems in the Public Health Services- about placement, transfer, remunerations, anomalies between contractuals and permanent, motivational, clinical, professional trainings, eligibilities for posts?
- What would be the performance appraisal system for competency testing, quality assurance, managerial tasks which can lead to promotion (right now it is entirely seniority based ?)
- How to “recycle & redistribute” the existing HHR? How about absorbing practicing doctors?
- What about the educational infrastructure for HHR, also the CME: planning, teaching infrastructure, educational training to the teaching staff, curriculum building mechanisms
- What are the legal arrangements required for various levels – licensing, practicing, dispensing, contractual appointments, wages, all laws related to pharmaceuticals, registration, establishment, protection, medico-legal issues, ethical issues, professional conducts, reporting systems, medical insurances etc.
- What should be the financial layout for HHR: regulatory, monitoring, educational, training, evaluating, quality assurance etc.
- What are options for integration of different systems of medicine – in terms of infrastructures, in managing HRs, in medical education and training, in competencies etc.?

- How do we tackle the "un – registered practitioner" problem in HHR framework? What about the unregistered but informally or formally trained nursing staff?

Financing

- What would be the total health care expenditure for UAHC in India? How do we assess Ravi Duggal's estimate of 4.5% of GDP, and the HLEG's estimate of 3% of GDP? Would it not be better to talk in terms of per capita health care expenses at constant prices because it would be based on estimates of actual expenditure needed for UAHC? NCMH had estimated in 2004 that to provide comprehensive care, it would require Rs. 1200 per capita annually. Do we have the details of this exercise? How rational, realistic is this estimate. Has there been any discussion on this estimate? Is it possible to take this estimate as a benchmark and prepare an improved estimate for 2011-12 at constant prices and current prices? Can we have some reasoned estimate of the situation of health care financing in 5, 10 years from now if we are to march towards UAHC in 10 years? Translated into Public Health Care expenditure as proportion of GDP, what would be the target for 5 and 10 years? Translated into Government's Health Care expenditure as proportion of it's total budget, what would be the target for 5 and 10 years?
- What about the fund flow system in public health infrastructure? Financial sanctions for non-salary expenses of the health dept. come quite late; from October onwards and an important part is released during last couple of months of the financial year. This is an important barrier to full utilization of budgeted amounts and to ensuring adequate, regular supplies to the Public Health Facilities. What steps would be needed to ensure timely release of the budgeted funds?
- Learning from the experience of the developed countries, who find it difficult to cope with progressively increasing, limitless demand for health care expenses, what measures would be required in India to prevent this situation? How can unnecessary or wasteful expenditure be curbed?
- What is the basis of the HLEG's contention that 70% will be spent on Primary, Health Care? Any details of the exercise of the estimated health care expenditure's break-up into expenditure for primary, secondary, tertiary health care?
- Health-care is a state subject in India's constitution; 80% of the govt. health care expenditure is by the State governments and yet state governments have very little powers for taxation. How will this contradiction be resolved?
- Starting from a Public Health Care expenditure of Rs. 500 per capita today, how much would be required to move towards the goal of UAHC in 5 years and 10 years? Compared to the increase in the Central govt. health care budget due to NRHM, how much increase would be needed in 5 and 10 years to reach a budgetary healthcare allocation to reach the goal of say Rs. 1500 per capita, and Rs. 2500 per capita during coming 5 and 10 years?
- What are the mechanisms through which the existing low tax/GDP ratio of 14% can be increased to more than 25%, taking note of the fact that India has a large unorganized sector including agriculture? What has been the experience of the 'turn over tax' on trading of securities, shares?
- How much fund would be required to ensure 'medicines for all'? How much for Primary Health Care, how much secondary and tertiary care? What is the basis of the estimate by NCMH that for Primary Health Care a provision of Rs. 50 per capita is adequate? (Currently the govt.

expenditure for medicines is about Rs. 4 per capita for PHCs and around Rs. 30 per capita in total)

- What would be the overarching health authority to manage funds? At national, state levels district and municipality levels? Would the funding be on the basis of block per capita budgeting, plus some additional allocation for special needs?
- What mechanism would be needed for reimbursing private doctors who opt for the regulated private health care under the UAHC system without bureaucratic hurdles and corruption?

Governance[3]

- How do we conceptualize and concretize a people-centered health system and what are the specific principles, institutions and processes that we need to introduce into the present system to move towards such a system?
- How does one institutionalize the incorporation of inputs from the Village health and Sanitation committees into the evolution of the district health action plans and then further into the State Health Plans? How does one ensure the voice of the marginalized like homeless, rag-pickers, street children, construction and brick and lime kiln workers, sex workers, and other temporary migrants, those with disability, mental health issues and non normative sexualities etc. is heard?
- How does one institutionalize the concept of community based monitoring and the collection and discussion of community based data? How does one ensure that it sustains?
- How would a system be evolved that will ensure the answerability and transparency of the health system to the people at all levels of policy making, priority setting, implementation and evaluation of any health related program / process to the Panchayat system and to communities as a whole? What institutions are required to initiate a process of consistent feedback for building up a consensus between the representatives responsible to design and implement policies and programmes, to oversee and monitor its effectiveness and responsiveness and those who receive the services?
- How would the issues of inter-sector cooperation/co-ordination both at the departmental as well as the field level be addressed? What should be the mechanism that is inclusive of the bureaucracy, the representatives and civil society and its various facets – gender, societal and

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3 Some principles of Good Governance:

Political Principles:

1. Good governance is based on representative and accountable form of government.
2. Good Governance requires a pluralistic society with freedom of expression and association.
3. Good Governance requires good institutions – set of rules governing the actions of individuals, groups and organizations and the negotiations about differences in them.
4. Good Governance requires primacy of law maintained through competent and independent enforcing mechanism and overseen through an impartial and effective legal system.
5. Good Governance requires a high degree of transparency and accountability in public and organizational processes. A participatory approach of service deliveries particularly of public services is important to be effective.

Economic Principles:

1. Good Governance requires policies which promotes broad based, inclusive economic growth. It requires economic policies which allow economically free but socially regulated dynamic entrepreneurship to grow.
2. Good Governance requires social policies for both private and public sectors which ensures poverty reduction and ecological balance.
3. Good Governance requires incremental development in intellectual and physical abilities of human resources through policies and institutions for quality education, health care and other services.

regional? What should be its powers and responsibilities?

- What is the legal framework for defining the health rights of the service receivers in the private and public sectors as well as the grievance redressal system and regulation of quality?
- What should be the legal framework and mechanism for specific rights as citizens from public health infrastructure about preventive, promotive and rehabilitative as well as the regulatory actions?
- What should be the principles and guidelines of private health care mechanism being a people-centric (patient centric to be precise for private hospitals)
- What should be the specific responsibilities of citizens to ensure and respect the other citizens's health rights?
- What should be the enforcing mechanism for people's health rights so that they have legal obligations?
- How would the discourse on the people's orientation of the health system take shape? How would it be converted into political mobilization and then into political commitment in the long run? What should the mechanism/political institutions to mobilize and sustain its vibrance be?
- How would the cynicism of the people with the present elite dominated systems and about the faltering, corrupt public health services be overcome?
- How would the present state where the commodification of the health sector services and products has created a false sense of what is "good quality health care" among the people be overcome?
- How would it be ensured that there is a freedom to choose the health care provider? What mechanism should be created so that the choice is rational but flexible?
- How would there be institutionalization of the dialogue / multi-logue between various systems of medicine in the evolution of a Universal Health system and more importantly between the people and the various systems of medicine and the health system? How does this feed into the issue of choice of 'pathy' during the evolution of a truly people-centric health system providing Universal Health? (All the questions are included.)

Conclusions

There are some issues like medical education, medical research, the type and nature of the HMIS etc. that have been alluded to, to some extent in the HLEG or the Lancet paper but have not been discussed in mfc. Similarly the issues like medical tourism, clinical trails and research, conflict and public health, surrogacy etc. need to be discussed at some point.

We hope that the discussions in the upcoming annual meeting will move us further on the path of a concrete set of suggestions, aspects of an alternative and truly people centered health model. And more importantly chart out a road map on reaching this ideal from the morass of the here and now.

We of course have no illusion that UAHC is going to come as we would like it. The kind of UAHC that we want would require huge socio-political mobilization around a truly pro-people road-map. But putting forth a MFC view of UAHC and road-map for it can be part of the counter-hegemonic people's politics. Hence the relevance of having discussions on ' road-map for a realizable dream'.