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February - July 2011

Towards a Regulatory Framework for Private Providers in UHC

-Anant Phadke and Abhay Shukla[1]

1. The Broader Canvas of Regulation of Medical Practice in UHC

The UHC (Universal Health Care) system would be a national system predominantly based on public funds. Therefore it will have to be an appropriately regulated system - both its private and public components included, although the concrete mechanisms of regulation of these two components might differ in certain aspects. Regulation of that portion of the private health care which would become part of UHC would thus be part of the overall regulation of the system of Universal Health Care India, so that the private health care component of UHC would also follow the basic logic of the UHC, while retaining its 'private' character. Even that private care which is out side the UHC will have to be subject to some regulation so that it works in tandem with the UHC system; at least it should not work at cross purposes. It should also be noted that there is a *definite need to move towards a more people-oriented and participatory system of governance of the entire health system,* which would be strongly reflected in the forms of regulation for UHC.

The objectives of this regulation would be consistent with the objectives of the UHC and would be three fold:

1. To ensure provision of UHC to all residents in India. This care will have to be rationally and ethically sound, humane and appropriate. These and other desirable dimensions of health care in UHC have been ingrained in the 'core principles of UHC' and need not be repeated here.
2. To provide job satisfaction and honourable conditions to all health care providers.
3. To promote democratic relations amongst various stake-holders in the UHC - the medical personnel, bureaucrats, managers, policy-makers, patients, and society at large.

Society should reach at the earliest, a stage in which all stake-holders are on equal footing and inherent vulnerability of patients with respect to health care providers is adequately addressed.

Taking a look at the overall canvas of regulation, we may note that a Health care system involves -

1.1 A set of relationships amongst various stake holders that need to be regulated-

a. Doctors working at various levels, in various capacities
b. Paramedics of various kinds and levels
c. Hospital and health system administrators, managers
d. Policy makers
e. Patients and citizens
f. Pharma-industry and other medical industry

1.2 A range of activities including -

g. Education, training of medical personnel
h. Continuing Medical Education
i. Clinical and non-clinical health care with its components like rationality, ethics, observance of patients' rights, planning, research, etc.

The relationships and activities mentioned above will have to be regulated with the help of following measures-

- Appropriate constitutional changes and ***legal*** enactments
- Enabling National ***Policy*** to concretize the political commitment to UHC

[1] *Based on the discussion among certain HLEG members, PHFI members and civil society representatives on Jan 15, 2011 at Mumbai. This note is an improved, expanded version of our note for this Jan 15 meeting. Attempt has been made to incorporate various valuable suggestions from the participants. Email ids: <anant.phadke@gmail.com>, <abhayshukla1@gmail.com>.*

- Appropriate ***regulatory agencies/structures*** adequately supported by financial and appropriate human power resources
- ***Multi-stakeholder mechanisms and processes*** in which patients' and other civil society organizations too would have an important space and role to play - processes like peer review, monitoring, redressal and periodic review

Though the pace of progress as regards these measures may vary, all these measures are essential and should work in tandem with each other, and the success of UHC would depend upon this holistic progress.

The above would be the ***overall broader canvas of regulation for all the components of the UHC, both Public and Private.*** Out this broad canvas, this short note would focus only on a sub-set of relations and activities - namely, those which constitute ***provisioning of medical care by private providers in UHC.*** However, it is to be noted that if the rest of the canvas is not addressed, it will adversely affect this regulation proportionately. Thus for example in a situation where high-fee based private colleges or irrationalities and exploitation by pharma industry, or inadequate supply of trained nurses and sub-standard private nursing colleges in the context of paucity of qualified nurses continue, the private medical sector would not provide good quality medical care in the UHC system.

Thus even if focus our attention on a sub-set of the broader canvas, this broader canvas has to be kept at the back of our mind during this small exercise also.

2. Towards a Regulatory Framework for Private Providers in UHC

2. 1. Background

On the one hand, private medical care is widely accessed by people and sections of private providers in India have shown their capacity to provide technically competent, quality care, on the other hand it suffers from serious problems and has the following features:

- Very large, predominant, highly stratified private medical sector (ranging from rural 'informal' providers to corporate hospitals)
- Complete lack of regulation of medical practices leading to -
- Large scale irrationality,
- Massive wastage due to excessive medications and interventions
- Frequent exploitation of patients
- Violation of patients' rights
- Complete failure of self-regulation by IMA, etc., and by MCI

In combination with this situation, there is weak and inadequate public health provisioning which is unable to significantly influence private care towards fulfilling social goals.

In UHC, this background will have to be changed by:

- Comprehensive and effective regulation of the entire health care sector, including the private sector. Certain regulations would be applicable across the board for all health care providers (related to physical and humanpower standards, patient rights, equity in distribution) while some further regulations would be enforced regarding providers involved in the UHC system (guidelines and protocols for rational care, norms on costs of care) although even the latter regulations would be expected to have a progressive, system-wide effect.
- Considerable strengthening and improving the Public Health System so that it would become the backbone of the UHC, and would lead the Private Health Care within the UHC system, in many respects.
- Due emphasis in UHC policy towards enhancing utilisation of public facilities.

2.2. 'Insourcing' of Private Providers or 'PPP'?

Involvement of the private providers in UHC would be more in the form of 'insourcing' and 'expansion of the public system' unlike the typical 'PPP' in which there is mostly 'contracting out to private providers'. This 'contracting out' means the concerned private medical care provider does not organically become part of the UHC.

This is especially relevant since the experience so far in India points out to the following risks associated with most current 'PPPs' in India:

- Continued and even intensified irrational medical practices
- Unjustifiably high costs being offloaded onto the public system
- Lack of quality care, standardization
- Dual charging (charging from both public system and also illegal charging from users)
- Shunting off 'difficult cases' and focusing on treating 'profitable cases'
- Collusion between certain public health staff and private providers, to channelise patients from public facilities to 'preferred' private hospitals

Given this background, the policy for interaction between the public UHC system and private providers should ensure that:

- There should be preference to in-sourcing of Private Health Care into the publicly organised

UHC system, rather than outsourcing and dilution of public control - the latter is typical of existing PPPs.

- Appropriate, comprehensive regulation of the Private Providers would be an essential pre-condition for such 'insourcing'.
- This insourcing into the UHC should strengthen and not weaken socialization of health care; utilization of existing Public Health Facilities should increase and not decrease due to this insourcing. This interaction should expand pro-poor investment and expand services in the health sector - not substitute public sector by private sector
- Private facilities involved in UHC would be subject to similar transparency and accountability conditions as the public system - such as RTI, community based monitoring, etc.
- Rights of staff in private facilities as regards wages and working conditions must be protected
- Effective participatory monitoring and redressal mechanisms must be in place to ensure that stipulated regulations are being followed

2.3. Domains of Regulation

Key areas requiring regulation would include the following:

a. Standardization of structures and human-power to ensure quality of care
b. Protecting patients rights
c. Equalizing accessibility/distribution of establishments
d. Standardization and rationalisation of process of care based on standard protocols
e. Rationalizing costs of care

Of these major domains of regulation, areas (a), (b) and (c) above would need to be regulated for the entire health care sector, including private providers who do not participate in UHC. However (d) and (e) would mainly apply to health care providers within the UHC system, yet even these regulations would progressively have a broader, 'induction' effect on providers outside the UHC system.

2. 4. Measures for Regulation

Appropriate regulation of Private Medical Care in UHC would require the following measures keeping in mind the changed background mentioned above:

2.4.1 Formation of adequate law/reformulation of existing law through multi-stakeholder (including citizens') participation

- Multi-stakeholder process for law formulation to take into account the concerns of various stakeholders so that no serious lacunae remain; for example the current Clinical Establishments Registration Act does not have provisions for patients rights or ensuring public health obligations of private providers.
- Rules under the act should be formed immediately after the enactment, so that implementation is not delayed.
- Observance of patients' rights must be included in minimum process standards.
- Rules should include specifying a decentralised framework of implementation by an autonomous regulatory authority
- Rules should include specify multi-stakeholder bodies (including civil society organizations working for Patient's Rights) in promoting and monitoring the regulatory work

2.4.2 Policy and Regulatory Structures to Implement the Law

Appropriate agencies/structures would be required, which must be adequately supported by resources, to operationalise regulation and standardisation. These bodies would be in two parallel streams:

1. **Health care authorities** at various levels, which would be offices with full time, professional staff entrusted with direct implementation of regulation
2. **Health boards or councils** at various levels, which would be multi-stakeholder bodies with variety of representatives, meeting periodically

	Healthcare Authority (full time, paid professionals for execution of regulation mechanism)	**Health Boards/Councils** (multi-stakeholder body with appropriate decision making, monitoring powers and functions)
National level	National Healthcare Authority	National Health Board
State level	State Healthcare Authority	State Health Board
District level	District Healthcare Authority	District Health Council
Block/City level	Block / City Healthcare Authority	Block/City Health Council

and carrying out broader planning, decision making, standard setting and monitoring of regulation.

2.4.3 Health Boards and Councils

- **National and State level boards** would have multi-stakeholder composition led by Public Health Authorities and including elected representatives, medical profession and health care providers, and civil society organisations. The State Boards would be the autonomous apex bodies in respective states who will shape the concrete policy directives and standards for the respective states, in the light of the Policy and standards framed by the National Board and by the Health Ministry.
- The State Boards would also formulate policy directives for implementation and overall oversight.
- The State and National Boards would be supported by adequate, appropriate staff and adequate funds
- At ***district, block and city level*** also there will be multi-stake holder ***'Health Councils'*** (consisting of health officials, representatives of providers, health care employees, elected / panchayat representatives and community/ citizens' representatives) who would give oversight to the regulatory process, would take local policy decisions for execution at local level, and would monitor implementation aspects
- Monitoring by Health councils would be dovetailed with existing participatory monitoring mechanisms like ***Community-Based Monitoring*** with clear space also for organizations of patients/health interest groups
- National and State health boards would also carry out ***periodic reviews*** to make progressive improvements in the UHC system. These reviews too would have to be multi-stake holder accompanied by with feedback and involvement of the general public and civil society organisations.

2.4.4. Healthcare Authorities

- To ensure proper implementation, the ***executive wing of the regulatory process*** would be an Autonomous Public Authority in each state / district / block city, supported by appropriate, adequate staff and funds
- ***Fees collected from Private Providers*** would be used to augment the budget of this authority and should not be spent on other budget items

2.5 Mechanisms/Processes for Regulation

These processes may be of three types:

i) There would be ***enabling mechanisms*** to foster delivery of rational, ethical, appropriate care:

- Appropriate orientation of students in ***medical colleges,*** specifically about rational, ethical practice and patients rights, political economy of health care etc.
- ***Continuing Medical Education*** of doctors and other health care providers
- ***Elimination of unethical promotion and marketing by pharma*** and other health care related industries

ii) There will be ***binding norms*** like setting of standards which will restrict the scope of irrational, insensitive care:

- Preparing Indian, local ***minimum standards*** for structures, processes about
- ***Quality, rationality and costs of care,***
- Observance of ***Patients' Rights***
- ***Standard protocols*** to be evolved by State and National level boards with involvement of professional organizations
- System of ***regular audit of prescriptions*** and inpatient records, death audit and other peer review processes,
- ***Clear norms for payment and quality/ rationality*** of care, (There may be a tendency not to economize while preparing standards, even when commercial interests are absent)
- ***Certificate of need*** would be needed for licensing of all new establishments according to norms and presence of existing facilities in a particular area (block / town). This would promote more equitable distribution of health care facilities.

iii) To ensure adherence to binding norms, there will be ***'external inspection and direct monitoring mechanisms'*** to ensure the observance of standards for structures, processes and outcomes of health care -

- ***Inspectors*** of the Local Supervisory Authority would monitor observance of standards through checking of records and by visiting the health care facilities
- Participatory monitoring (on the lines of ***Community Based Monitoring)*** by Health Councils

2.6 Redressal Mechanisms

" User friendly, independent, redressal mechanism

at local level would be needed. This mechanism will have to be made widely known.

- One option may be of 'Grievance redressal cells' with Ombudsperson type functions, supported by small teams/civil society organisations to carry out enquiries and inspections, supported by public funds.

Maximum possible transparency would have to be ingrained in all the above mechanisms. This can be done by extensive dissemination of all important information through web based information centres.

The overall objective of such a regulatory system would be to move towards progressive socialization of the entire health care system, including private providers who are involved in the UHC system. The direction would be to systematically develop participatory governance (including professional regulators but not confined to top-down, bureaucratic regulation) including elements of self and social regulation, towards an accountable and effective system for Universal Health Care.

Annexure

Standard Charter of Patients' Rights in Proposed Rules under BNHRA 2005 (amended)

Section 16, Rule 14

Standard Charter of Patients' Rights

1) No person suffering from HIV may be denied care only on the basis of the HIV status, provided the curative or diagnostic care is available at the Nursing Home. Not having a Voluntary Testing and Counseling Centre cannot become grounds to refuse care. *For management of patients who is HIV positive, the nursing home would follow guidelines circulated from time to time by NACO (National AIDS Control Organization)*

2) Every nursing home shall maintain an inspection book and a complaint register (for the patients' party), which shall be produced before the LSA as and when required.

3) All nursing homes must adopt a Standard Charter of Patient's Rights, observe it and orient their staff for the same. This *Standard Charter of Patient's Rights* would include that -

A) The patients and/or Person authorized by patient should receive:

- The relevant information about the nature, cause, likely outcome of the present illness.
- The relevant information about the proposed care, the expected results, possible and the expected costs complications.

Patient and all nursing homes must adopt a Standard Charter of Patient's Rights, observe it and orient their staff for the same. This Standard Charter of Patient's Rights would include that-

B) Patient and/or person authorized by patient has a right to have:

- An access to his/her clinical records at all times during admission to Nursing Home
- Photocopy should be available within 24 hrs when admitted to Nursing Home or within 72 hrs of making an application after discharge or death after paying fees for photocopy.
- A discharge summary at the time of discharge, which should contain:
- The reasons for admission, significant clinical findings and results of investigations, diagnosis, treatment and the patient's condition at the time of discharge.
- Follow-up advice, medication and other instructions and when and how to obtain urgent care when needed in an easily understandable manner.

In case of death, the summary of the case should also include the cause of death.

C) Treating patient information as confidential.

D) Patient has a right to personal dignity and privacy during examination, procedures 24 and treatment.

E) Patient and family rights include informed consent before anesthesia, blood and blood product transfusions and any invasive/high risk procedures/treatment. Informed consent includes information in a language and manner that the patient can understand, on risks, benefits, alternatives if any and as to who will perform the requisite procedure. Information and consent before any research protocol is initiated (see below).

F) Patient and family rights include information on how to voice a complaint. Appropriate procedure for grievance redressal must be put in place by the hospital.

G) Rights of women as patients:

- Privacy during examination. In case of examination by male doctor, a female attendant must be present.
- Right to confidentiality of reports and information not to be disclosed to any person other than one who is authorized by the patient
- Confidentiality of HIV positive patients

H) Patient has the right to seek second opinion. All medical and diagnostic reports must be made available to the patient or authorized person to facilitate second opinion.

I) Non-discrimination on the basis of HIV status:

- Patients and families should be informed about the above rights in a format and language, that they can understand
- Patients and family are informed about the financial implications when there is a change in the patient condition or treatment setting.

J) In case of Nursing Homes undertaking clinical research:

- Documented policies and procedures should guide all research activities in compliance with national (ICMR) and international guidelines

Moving Towards a System for UAHC in India

Modified broad understanding, some learnings and areas for further work based on MFC discussions during Jan-8-7, 2011

The Context: Model of development and Social Determinants of Health

- Due to inequitable and pathological model of development, traditional patterns of morbidity continue (infections, malnutrition, high child and maternal mortality etc.)
- In addition, new morbidities, addictions, mental health problems, accidents etc. are adding to burden of ill health
- Need to comprehensively address model of development and social determinants of health to minimise ill health and promote health; would be integrated with the UAHC health care system

UAHC: the Broad Direction

- In a framework of rights and equity, need to ensure required health services to all; care should be provided at lowest possible level and in closest possible manner
- Address the entire health system in integrated manner
- Considerable strengthening and expansion of Public health system with reorganisation and people-orientation; PHS as backbone and pivot of UAHC
- Regulation and some degree of social orientation of elements of the private sector while bringing them in to serve UAHC
- Expanding the ambit of 'public' to include socialised providers serving public health system and goals
- This would require large scale health system changes - a major socio-political process

Provisioning: Patterns of Care

- Promotion of self-care and home care - system is geared in this direction
- Promote choice of systems, AYUSH to occupy significant position; option of training of integrated doctors
- Taking into account people's own knowledge and skills, healthy local traditions while developing system
- Significant role to CHWs and paramedics, moving from doctor centred to health team model
- Need to discuss updated and modified PHC approach

Moving Towards a Different Model

- With a core of strengthened and expanded Public health system, involves regulation, incorporation and public orientation of non-public providers
- A system for UAHC is qualitatively different from generalising current 'PPPs'; instead public insourcing of private providers
- Three level option in order of preference - a. Public b. NGO/Charitable/Trust c. For profit private
- State specific models necessary to move towards UAHC

> Effective social and legal regulation is an absolute precondition for involvement of non-public providers in UAHC.

Provisioning - Primary Level Care

- For primary level care, with expansion and strengthening of public provisioning and insourcing of non-public resources it could become dominant provider in foreseeable future
- Health team based on CHWs, paramedics, AYUSH and allopathic doctors
- Recognise and address great diversity in presence and type of private sector in different areas
- Private doctors could be brought into system as 'Family practitioners' with regulation and overall public management

- Urban areas would require distinct context specific models

Provisioning - Secondary and Tertiary Level Care

- Strengthening of existing public facilities including insourcing specialists
- Pooling and coordinating all public facilities (ESI, CGHS, Railways, Army, PSU facilities etc.) to expand base
- Overall need for greater attention to solving dysfunctionalities of present PHS often related to over-centralisation of decision making, corruption, sluggish flow of finances, understaffing and lack of large scale new permanent appointments, poor management skills etc. etc.

Financing

- Tax based financing as the plank for supporting the UAHC system
- Various calculations show 3-5% of GDP may be required to support UAHC in India - but existing calculations need more discussion and working out
- Equitable allocation of resources combined with decentralised management
- No user fees, co-payment etc.

Governance and Regulation

- People-centered governance and orientation of entire health system
- Decentralised planning and decision making with involvement of various community representatives, organisations along with PRI and elected representatives
- Community based monitoring and system of Health councils at various levels
- Multi-stakeholder bodies including community representatives, providers, health care workers and public officials
- Need for large scale transparency and accountability
- Governance and regulation
- Need for comprehensive regulation of entire health system with participation of civil society organisations
- Need to decisively confront the medical profession on unethical and irrational practice.
- Create common standards for private sector and public sector.

Governance and Regulation

- Conflict of interest - the primary provider also being the regulator.
- Community monitoring vs. professional autonomy - need for balance.
- Organizational dynamics, institutional dynamics in the health system need to be addressed
- Changing roles, perception of roles within health team.
- Need for huge investment in regulatory bodies, more human resources, capability to effectively regulate.
- Need for a framework law to support regulation and ensure rights
- NO SUBSTITUTE FOR COMMUNITY MOBILIZATION AND SOCIO-POLITICAL MOVEMENT

Placing Politics at the Centre

- Whether, How and in What form India would move towards UAHC is essentially a socio-political process
- While debating and resolving gray areas and differences, we need to present broad contours for wider social debate and mobilisation
- **Reversing neo-liberal logic and replacing it by social logic in the health sector**

Some Non-Negotiables on the Road to a UHC System

- Need to comprehensively address model of development and social determinants of health to minimise ill health and promote health; would be integrated with the UAHC health care system
- Genuine universality: breaking through 'BPL fixation' - bringing in the privileged classes, encompassing the not-so-poor and 'APL', reaching out to the marginalised; public package would be same for all
- Spectrum of health care to start from self and home care, include CHWs, paramedics, AYUSH and other primary doctors and specialised providers; moving from doctor centered to health team model
- Significant expansion and strengthening of public health provisioning in both rural and urban areas; public health system as pivot and backbone of UAHC system
- Significantly increased tax based public health finances: tax based funding would be the basic plank of financing and should be adequate to meet needs of comprehensive UAHC
- UAHC system involves making all state facilities (Incl. ESI, Railways etc.) fully public, wherever required bringing private providers under public system, in framework of UAHC logic and socialisation of health system
- Legal and operational regulation of costs and standardisation, rationalisation of private health care with patients rights as precondition for engagement with private sector. Publicly defined principles and mechanisms to govern all facilities under UAHC
- Adopting a health system-wide approach with bodies managing the entire health system
- People centered and participatory planning and monitoring with decentralised framework of decision making

Process Related Suggestions

- Convening a larger conference with representation of all concerned stakeholders (incl. social movements and concerned trade unions, charitable and private sector providers)
- Exploring with some interested state governments about state level models
- Ongoing dialogue with civil society platforms including MFC
- Being aware of possibility of dilution, distortion or selective reading of report - should be addressed in report itself stating that this is an integrated package which stands or falls as a whole, not a cafeteria for 'pick and choose'

Some Concerns about the Politics of UAHC

- What is the underlying political logic and direction regarding UAHC?
- What is level of willingness to reshape the entire health system in direction of socialised system vs. continuation and generalisation of outsourcing type PPPs?
- Is there political will to significantly raise levels of public health financing?
- What is the role of private sector lobby, CII and FICCI, private insurance lobby?

UAHC with 'Community Participation' Or 'People Centre-stage'?

Implications for Governance, Provisioning and Financing

-Ritu Priya

In our people-oriented model for universal access to health care (UAHC), is the vision one of people's role as 'participation' in pre-designed services, or should the model itself keep 'people centre-stage'? This is the central issue for governance being addressed in this paper.

Some Considerations for an 'Indian Model of UAHC'

UAHC is the latest initiative in a series of endeavours that is meant to help India and other low and middle income countries break out of the prevailing situation of distress due to lack of access to quality health care when there is a felt need for it. Being in agreement with several of the issues taken up in the concept note for the MFC meet, I would like to take the discussion forward on two points: One relates to the intent stated in the note that it attempts to break the myth of the TINA syndrome; that There Is No Alternative to privatisation of health care and the health service system working on commercial principles, since the state cannot provide universal access to health care. The second is about the meaning of 'commodification' in health.

1. The TINA Syndrome and an Alternative Discourse for UAHC

As stated in the concept note for this meet, ***"The idea of this whole exercise is not just the development of a model but of creating an alternative people-oriented discourse in the present claustrophobic atmosphere of "TINA" and problematic 'PPPs' when it comes to 'development'."*** (Shukla et al, 2010)

My contention is that we have the opportunity at this point of time to do much more 'alternate' thinking and model building than in the model proposed for discussion. In fact the world is almost looking to India to generate a bolder alternative, since it is a 'felt need' of all countries and India has historically given pluralist alternative visions to the world in several areas, including in public health. We must address the challenge to the maximum possible.

The TINA syndrome to be broken in health care today is not so much about the desirability of UAHC as a responsibility of the state, as it is about 'how' the state is to ensure UAHC. There is a global discourse pushing for publically funded UAHC in all countries, as much with the intent of people's wellbeing as with the intent of ensuring financial returns of the highest order on investments in health care and allied industries. Recognising the positive potential of this trend, we need to bring all the synergies together and use all spaces possible for the former objective. The TINA syndrome being propagated is that it is only through public financing and private provisioning that UAHC is possible with efficiency and quality and therefore is the desirable principle for building health systems with UAHC. The predominant discussions and the model being proposed across the world demonstrate a remarkable similarity across very different contexts revealing some common characteristics that fall well within the neo-liberal paradigm: they are highly medicalised and doctor-centred, commodify health, and propose social insurance and purchase of services as the means to UAHC. What is the 'alternate discourse' that our 'model in the making' presents?

There is another perspective available to build a model for UAHC, as being articulated in the discussions on 'revitalising Primary Health Care', which though weaker in their salience and visibility, are also alive and kicking in the global discourse. We will have to consciously chose which one we adopt as our framework for UAHC -- one that is currently being most widely propagated internationally in the neo-liberal paradigm or the other which espouses the spirit of the Primary Health Care approach and is closest to the 'MFC perspective' available in the statement in the MFC website. Features of the two are tabulated here after analysis of recent documents on UAHC and Revitalising PHC. It should be recognised that such characterisation is always fraught with ideal type reductionism, and there will in reality be an overlap of the two.

**Background Paper for MFC Annual Meet, Jan 7-9, 2011, Nagpur. Author's email: <ritu_priya_jnu@yahoo.com >*

Features of Two Frameworks for Developing Systems of Universal Access to Health Care

No.	Current Dominant UAHC Discourse & Proposed Models in the Neo-liberal Paradigm	Proposed Alternative Discourse of UAHC with PHC Approach/MFC Perspective
1.	Medicalised perspective	Socio-biological perspective and multi-dimensional approach to dealing with health
2.	Doctor-centred	People as primary actors for health; providers as supports.
		Doctors and other providers equally important in appropriate roles
3.	Top down	Bottom up
4.	Commodification of health (purchasing of services)	People empowering; addresses the knowledge hierarchy in health
5.	Financing through social insurance/ private insurance/cess/tax revenues	Financing through tax revenue based budgetary allocations /health cess
6.	PPP under a private sector framework	PPP under a public service framework
7.	Efficient, feasible and effective services from institutional and clinical perspectives.	Cost effective and safe health care under the context specific people's life conditions.
8.	Universalist and singular technological content that reinforces bio-medical hegemony. The system that is exorbitantly expensive and with ever-escalating costs is sought to be made 'affordable'.	Context specific and pluralist technological content of services that is appropriate, cost-effective and deliverable at the closest point possible.
9.	Community participation is an externally generated involvement of people in services planned top down as ritualistic committee members or as users.	Community participation is more than 'community monitoring', it is inherent in the structures and content of provisioning, financing and governance.
10.	Governance mechanisms being proposed (such as the National Health Authority) are more corporate compatible than conducive to people's control or political control.	Structures of deliberative democracy have to be actively nurtured and mechanisms for assessment and articulation of people's felt needs have to be made central to the policies and implementation.
11.	Despite cost-cutting exercises, incrementally escalating costs due to structures that are promoting profit-based provisioning and defensive practice by doctors (as in the USA), and high levels of iatrogenesis despite systems for reporting of side-effects.	The only inherently non-commercial health interventions are home remedies and community services of local health care providers. Besides helping in cutting costs, they keep the possibility of a different vision alive. The danger of accessing medical help later than desirable has to be dealt with by a simultaneous strengthening of services to ensure access to primary and referral levels with quality. In addition, primary level workers who could facilitate self-care should also give information and skills about when to seek professional help.
12.	Addressing the social determinants of health is not a concern of the institution based medical care service systems and therefore are ignored, an issue of concern in contexts such as ours where water, sanitation and nutrition have yet to be addressed.	Possibility of inter-sectoral coordination and addressing the social determinants of health lies only in public systems with community level mechanisms.

While we adopt one of these frameworks, components of the other will continue to be elements within it. It seems safe to assume that MFC's predilection will be for the second approach. While adopting it, we cannot afford to be romantic about public systems or community initiative, and must recognise the importance of examining the experiences of implementing the first approach and learnings of analyses from its perspective, drawing upon the lessons wherever relevant, to be placed within the second framework. In fact there is no country among the low and middle income countries that has demonstrated the feasibility exclusively of the first or second design. Brazil and Thailand offer some degree of success and examining the relevance of these models for India shows that an eclectic mix of the two has worked to an extent. Experience of these two countries also shows that Social Insurance is inadequate in 'developing' country settings and tax based financing is essential. But they go further, demonstrating that comprehensive services with strengthening of community level and outreach initiatives is crucial for UAHC among the most marginalised. Between them, Brazil is the more medicalised (urbanised as well) but it has evolved some form of deliberative democracy (would it be difficult to replicate or sustain as some analyses suggest?). Thailand's is a more rooted rural-based model though with less procedural democracy.

2. Defining 'commodification' in health and thereby the content of 'health care'

Moving away from the definition given in the concept note, it is proposed that commodification is not only about public and private provisioning, or payment and non-payment at point of service, it is about how we conceptualise health care. Is health care only about something to be 'delivered' so that technology and services by experts have to be purchased, whether by governments or by individual households? In which case does it not remain a commodity?

Definitions of health care given in recent publications view it as only professional services, or even as 'goods and services'.

"The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions" (The American Heritage Medical Dictionary).

Health care embraces all the goods and services designed to promote health, including preventive, curative and palliative interventions, whether directed to individuals or to populations" (WHO, 2000).

In some instances there is a further shift, from 'universal health care' to 'universal health coverage' and then seemlessly on to 'universal health insurance' (as observed, for instance, from documents related to the Montreux symposium and in the Lancet)!

An alternative people-centred discourse has to go beyond this kind of definition and the following may be more useful from the Primary Health Care/MFC Perspective:

'Health care is a continuum from everyday activities and self-care by people to primary, secondary and tertiary levels of care provided by those with specialised knowledge about health who support the individual/community appropriately as and when necessary.'

This definition significantly changes the contours, content and functional design of a system for UAHC from that being widely propagated through the current discourse that views health care as only 'services to be delivered'. The two perspectives may accommodate the same services, but the functional quality and culture of health care they generate could be dramatically different. Can we develop this alternative discourse that goes beyond the professionals and medical institutions to a wider imagination that builds on and furthers the strengths of 'ordinary' people ?

If people are doing it themselves, why do we then have to think about self-care in a system for universal 'access'? It is important because even self-care requires certain pre-requisites for it to be accessible to people, it requires the knowledge, the confidence to use the knowledge on one's own and the material inputs required for it. Depending on their orientation to the issue, health professionals can dissuade people from self-care or facilitate effective and rational self-care. "Supporting self-care is about increasing people's confidence and self-esteem, enabling them to take decisions about the sensible care of their health, and avoiding triggering health problems. Although many people are already practising self-care to some extent, there is a great deal more that they can do, and do it more effectively. The key is having health and social care professionals enthusiastically supporting self-care." (Chambers et al, 2006)

Widening the boundaries of 'health care' to include self-care would change the meaning of 'participation' and the 'culture of citizen's participation' that the concept note refers to. If people's felt needs are given centrality, it takes us beyond mechanical 'community participation' to a more organic basis for the

community's active involvement in health care. It also requires an active change in the approach of clinicians and other health care providers, to what the patients and communities can and should be supported to do.

A separate note attempts to illustrate this approach by outlining the principles and possible model of evidence-based health service development with UAHC -- 'Conceptualising UAHC Bottom-up: Implications for Provisioning and Financing'. Some implications for governance are being discussed in the next part of this note.

II

Implications for Governance

A distinction has to be made between 'governance' and 'management'. In the present mainstream discourse there is much discussion about governance, but the content is almost entirely about management issues.

Governance is about setting down of the vision and objectives, the policy, principles and priorities of any institution or organised system. **Management** is about operationalisation of the principles to address the priorities set out in the governance exercise. This would require another set of policy/principle/priority issues/indicators to be decided for the more operational dimensions. For instance, financing such that there should be no out of pocket payment at the point of service is a governance issue, while working out of the mode of payment and the accounting systems to ensure this is more of a management exercise. Both are important and overlapping.

One of the primary governance issues is the process to be adopted for planning of the health services. Is it to be a top down process of building health service structures, giving primacy to the institutions and technologies, or is it to be a bottom-up process starting from the people's knowledge and possibilities of 'empowerment'? What are the decision-making structures and who gets primacy? Is it to be only about giving them membership in structures that function such that it becomes ritualistic 'community participation'? For instance, as one of several members of the RKS which is otherwise composed of and headed by officials who not only do not value their opinions but actually find it a 'problem'? Or is it also possible to give them power by giving weight to their perceptions and priorities, for example by designing some indicators used for assessing quality based on community understanding. The process would then have to be based on both, official policy and planning giving consideration to people's 'felt needs' and demand (as expressed through the findings of studies on people's perceptions and health seeking behaviours and through community monitoring) as well as on direct participatory decision making.

Empowerment comes by valuing their valid health knowledge and allowing their critical thinking to be given weight in official decisions, rather than only by giving them the capacity to buy commodified health care.

A second issue of vision and policy is about assigning roles to the public and private sector in UAHC. The non-fragmented, unified approach to the entire health service system requires that public, private, NGO, community action for health -- all be considered together. In a market economy, regulation of the private sector can only be through the market principle of competition and the public sector must be strengthened to provide it in the people's interest. The issue is of primacy to the public services framework under which all providers should become part of a unified system, or should the private sector framework be the unifying frame? The Primary Health Care approach suggests a public services-cum-community action framework. To move towards giving concrete shape to such an approach in health services development and management, an outline is given below.

The Planning Paradigm & Health Care Development

If the bottom-up paradigm of planning is to be adopted, then community needs in terms of AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa Rigpa, Homeopathy -- the acronym for textual systems of medicine other than modern medicine already existing in the country) and LHT (Local Health Traditions, the non-textually systematised folk practices) have to be the starting point for consideration of people's health care. 'Architectural correction' of the health care system as a whole should be designed with this perspective. Governance and management strengthening of the public services, along with people's empowerment, will be essential components of action for UAHC from this perspective.

National/State Level

The national and state policy framework may be based on the following considerations:

i. All providers of health care be viewed as interacting parts of the whole health service system: public, private, not-for-profit, and self-care; modern and traditional medicine; home to tertiary care.

ii. The service structure be designed in broad terms with flexibility for state, district and block levels.

iii. The service structure be designed with consideration to the linkages & dynamics of :
- an epidemiological need assessment for elements of comprehensive care
- people's felt needs, and perceptions of quality health care
- a mapping of existing sources of health care and utilisation patterns
- practices and perceptions of providers of all segments of the health care system

iv. Administrative structures should allow for contextual flexibility, be sensitive to people's perceptions and take community monitoring feedbacks seriously, as well as be generous towards doctors and all cadre of health workers in terms of their work conditions and dignity as well as their views on strengthening of the services.

v. Management mechanisms to be developed for the various sub-systems, such as:
- infrastructure planning based on population coverage and time taken by people to access services in specific contexts
- procurement and supply of appropriate medicines, equipment and other medical requirements that are need based and transparent
- human resources in line with the vision, with required levels and number of cadre, orientation and training, conditions of work etc. and systems for supportive supervision
- an effective HMIS that provides rapid information for monitoring and quick responses as well as periodic evaluation and course correction
- sentinel surveillance for diseases, with the information feeding into the ongoing evaluation and planning process, as well as a rapid response in epidemic situations

vi. Develop technical support structures that assist in assessment of technological options and system design at all levels, from the national to the block, with wide involvement of interdisciplinary expertise.

vii. Setting of Standard Guidelines for Treatment that include from home remedies to validated therapies of all 'pathies' at each level of care, with indications for referral to higher levels and/or cross-referral. The Essential Drugs List could include the validated medicines of traditional medicine as well (as in Thailand).

viii. In light of the framework adopted, appropriate changes should be brought about in the curriculum and pedagogy of modern medical as well as AYUSH graduates, nurses and paramedical cadres. Highlighting the evidence on advantages of self-care to patients and to the health care providers and equipping them with the orientation and skills to support self-care along with minimising its risks would be key components.

The MOHFW must strengthen its institutional technical capacity for its policy making and oversight role; to assess technologies and programme/scheme designs as well as innovative systems development on an ongoing basis. This will require more in-house technical personnel who can work on their own and are enabled to coordinate external expertise as and when required. The budget must allocate sufficient funds so that the ministry does not have to depend on international agencies for hiring consultants for it, as is currently the practice. This is important as a governance issue if we want to move towards independent, objective, professional expertise to guide the decision making processes.

In addition, more officers are required for adequate attention to the various sub-systems within the overall health service system. Presently each officer is handling so many of them that they cannot do justice to any, having to coordinate all across 35 states and UTs for a billion plus population.

In the present context, the NRHM is the largest currently on-going initiative for strengthening of the public services. While variable in implementation and outputs across the states, it can provide a number of negative and positive lessons that need to be built upon while attempting UAHC.

District Level Planning

In this framework, the District Health Services and district planning would be central to the service system. A framework for an approach to District Health Planning is outlined below, based on the experience of analysing and participating in state and district planning under the NRHM, the principles of public health planning discussed in the previous section, and the findings of an 18 state study on the 'status and role of AYUSH services in the public system as well as use of local health traditions' (Priya & Shweta, 2010):

1. Map the epidemiological profile of the district-- using institutional data on morbidity profile of patients attending, causes of mortality data

and priorities identified in consultation with community level health workers and community mobilisers (AWW, ASHA, ANM, MPW, VHSC members, traditional local health practitioners!

2. Map the prevailing health-seeking behaviours of all sections -- including use of LHT, AYUSH and Modern medicine, related to the most common and epidemiologically identified priority health problems. Studies of perceptions must be conducted to understand the reasons for the observed behaviour. Documentation of the health perceptions and behaviour should be an ongoing task at the district and state levels.

3. The documentation should be followed by validation of people's practices and local health traditions based on the locally prevalent systematised traditional medicine by the AYUSH doctors at district level. Validated effective practices should then be promoted for use by the community as well as put to use at the health centres. This would not only revitalise the LHT but also contribute to strengthening the knowledge base of AYUSH and promote its non-commercial practice using local herbs.

4. The IPHS requirement of a herbal garden in each sub-centre and PHC provides the opportunity to facilitate the linkage between the cultivation of medicinal herbs and plants and their local use, involving the local traditional practitioners for this activity and linking it with the AYUSH doctor of the co-located facility. This should be one of the community linked processes and the panchayat and VHSC should be associated with this activity.

5. Use of the LHT and AYUSH for MCH, NCDs and any other conditions found suitable must be identified and promoted for self-care, home-based care and institutional care as appropriate. They must be made part of the Standard Guidelines for Treatment for all health care providers (including the doctors of Modern medicine and AYUSH, ANMs and ASHAs), stating the role of AYUSH and LHT in primary care and the points of cross-referral.

6. Assessment should be made of the additional support required through home-based care by the paramedical workers, the support required from OPD services provided by a doctor, whether of the Modern medical system or the AYUSH. Further planning of services should then optimise the work load and role of the HR of both Allopathy and AYUSH in the institutions.

7. A consultative process of block planning be undertaken with the doctors and health workers as well as community members, with mapping of existing services to identify their optimal utilisation, the gaps and barriers in service delivery and thereby identify priority needs for health service development in the immediate and long term.

8. The principle should be that the point closest to the patient/community where the required appropriate care can be provided, should be equipped to handle the condition. No activity that can be performed at a lower level should be planned for the higher level. This would be the most cost effective and accessible health care that can be made available.

9. The extent of complications arising, or the incidence/prevalence of serious illnesses requiring higher levels of care, should be assessed and infrastructure, human resources etc. planned accordingly.

10. The orientation and knowledge of providers of all cadres should be assessed and in-service trainings planned according to the vision for UAHC.

Technical and administrative support structures will be required at district and block levels, working in tandem with those at the national and state levels. All this is to ensure provisioning of appropriate, quality health care to all. Finally, multiple check and balance mechanisms in place will lead to an incrementally strengthening, pluralist, flexible and transparent service system that generates trust and effective outcomes.

As Goldberg (2005) has argued after analysing health service developments in the USA and Canada in the early years of this century, it may be advisable to first define health care and then discuss its funding rather than the other way round. "We need to agree on the core principles, values, and practices of the health-care system. There must be frank discussions about what type of healthcare we will deliver in the future. The qualitative as well as quantitative parameters of the system must be defined. The expectations of the patients must also be clarified ..... Only after there is agreement by all parties on the core-values and quality of healthcare can there be a meaningful discussion about how the society will fund such a system."

[See companion paper 'Conceptualising UAHC 'Bottom Up': Implications for Provisioning and Financing]

References

Anonymous (2010): Montreux Statement from the Steering Committee of the first Global Symposium on Health Systems Research at http://www.hsr-symposium.org/index.php/montreux-statement, accessed Dec 24, 2010.

Chambers R, G.Wakley and A. Blenkinsopp (2006): *Supporting Self-care in Primary Health Care* (Radcliffe Pub: Oxford).

Chokevivat, Vichai (2005): "The Role of Thai Traditional Medicine in Health Promotion," 6GCHP, 7-11 August 2005, Bangkok.

Goldberg R E A (2007): "First Define Healthcare - Discuss Funding Later," *The Internet Journal of Healthcare Administration,* 5:1.

Priya R. & A.S. Shweta (2010): "Status and Role of AYUSH and Local Health Traditions under the National Rural Health Mission: Report of a Survey." (New Delhi: National Health Systems Resource Centre, NRHM, MOHFW).

Shukla, Abhay, Anant Phadke and Rakhal Daitonde (2010-11): "Towards Universal Access to Health Care in India, Concept Note for Medico Friend Circle, Annual Meet 2011," *mfc bulletin,* No. 342-344, Aug-Jan.

WHO (2008): *The World Health Report 2008: Primary Health Care: Now More than Ever* (Geneva: WHO).

WHO (2010): *Health Systems Financing: The Path to Universal Coverage* (Geneva: WHO).

WHO-SEARO (2008). Regional Conference on Revitalising Primary Health Care, Jakarta, 6th-8th August.

WHO-SEARO (2009): "Self-care in the Context of Primary Health Care", Background Note, Regional Consultation on Self-Care in the context of Primary Health Care, Bangkok, Jan 7-9.

World Health Organization Report (2000): *Why do Health Systems Matter?* (Geneva: WHO)

Conceptualising UAHC 'Bottom Up': Implications for Provisioning and Financing

-Ritu Priya

Health care is a commodity if it is only viewed as something that can be obtained by accessing services that have to be purchased, whether the provider is in the private sector or a public institution. While this external source of health care is a major part of health care, there are others that cannot be thus commodified, and access to those must be ensured as well.

Health care consists of preventive, promotive and illness-management activities, as a continuum from self-care at home to primary, secondary and the highest levels of tertiary care. Self-care is the commonest at the beginning of any illness and in chronic illnesses, consisting of use of home remedies, common medical prescriptions such as pain killers and anti-pyretics, use of formulations of traditional medical systems and, in long-term conditions consists of modulation of regimes that are prescribed for repeated or long-term use. Often, a combination of these is resorted to. Commonly, the second line of action depends on the nature of illness and its severity; based on their collective experience people develop a general pattern of health-seeking behaviour with an understanding of what works best for which health problem in their context. It could be going in for doctor's medicine, or in cases where it is known not to be effective there would be resort to the traditional systems, including in some cases faith-healing as well. This pattern varies across different settings and in groups with diverse ecological, socio-economic and cultural backgrounds.

This experience-based behaviour pattern of people has been found to be a good guide to cost-effective solutions in several instances, such as in the case of diarrhoeal diseases and pulmonary tuberculosis, where the 'default' was found to be more on the part of the service providers than on the people's behaviour. There is also the spectrum of iatrogenic problems that make people use various options other than those causing side-effects.

TM (Traditional Medicine) & CAM (Complementary and Alternative Medicine) are being increasingly adopted world-wide, even where universal access to quality services of modern medicine exists. Ideological reasons such as dissent with the modern development paradigm based on eco-social considerations and against the personal disempowerment due to medical hegemony (women's movement spearheading this since the 1970s and 80s) have led many to 'return' to TM and CAM. However, larger proportions of the population use such means to health by choice based on experiential knowledge, viewing them as cost-effective means of dealing with ill-health and promoting health. Estimates of up to 70% of the world's population using them have been made (Bodeker & Burford, 2005).

This is not to deny that there is much suffering that can be mitigated by a better access to appropriate modern health care and that people desperately require better access to medical services. The implication is that developing systems to ensure 'Universal access to health care' has to factor in the agency of lay people themselves in action for their own health as well as the pluralism in forms of health care. It is necessary

to prevent the developing of hegemony or monopolies of any one form, it prevents over-medicalisation, and it allows people to get the benefit of the strengths of each form of health knowledge while allowing others to fill in the gap due to each ones limitations.

Developing systems for universal access with only one form defining the content of health care will result in de-legitimising the other forms and undermining the support structures for them. For instance, in Europe and the US people with medical insurance are spending more out of pocket to get complementary and alternative forms of medicine (CAM) than they are having to on allopathy because CAM is not covered by most insurance packages. Once there is insurance, people also tend to go sooner for medical services than they may otherwise, decreasing the use of home remedies and other modes of self-care. Now, in societies where there has been a relative saturation with medical services, there is also an increasing demand for CAM. So we should not let go of our advantage of having live practice of various forms of traditional medicine and discuss a framework that is based almost exclusively on the modern medical/allopathic doctor. Doing so has brought us to a situation where Illich's analysis of medical nemesis seems to be proven true even while large sections are denied access; medical and 'cultural iatrogenesis' are evident -- a truth recognised by 'scientific' medical research as shown by advances in dealing with cases of, for example, diarrhoea, CVDs., diabetes, personalised treatment, over-medicalised deliveries -- but still unnecessary interventions are widely accepted and adopted in formal medical practice.

Several committees and Five Year Plans have recommended using the availability of traditional practitioners to advantage as they are providing services in otherwise underserved populations. Some states have recruited them to provide allopathic services in PHCs, such as in Maharashtra, J&K and UP. What public health has ignored until now is the inherent worth that is recognised in the 'other systems' by lay people, elements of which are now increasingly being validated even by the frontiers of inter-disciplinary bio-medical research (such as psycho-neuro-immunology, Integrative Medicine, etc.). We have also not incorporated the presence of AYUSH facilities in the public system in our analyses of public services, despite the fact that there is a whole parallel structure of AYUSH dispensaries and hospitals in most states (see Table 1). The number of service delivery institutions is high, with almost as many stand-alone AYUSH dispensaries as there are PHCs in the country, and AYUSH hospitals about one-third the number of allopathic hospitals. The total number of AYUSH colleges is more than that of modern medicine and their intake capacity is somewhat less. However, all this infrastructure is supported by less than 3% of the health budget!

Table 1

Features of AYUSH Services in the Public System

No.		AYUSH	Modern Medicine
1.	Service Delivery Infrastructure	Nil for outreach services	SC = 1,46,036 Dispensaries = 22,312 PHC = 23,458
		Hospitals = 3378	RH (including CHC)= 6281 UH = 3115 Total = 11,613
		Beds= 68,155	Beds (R)= 1,43,069 Beds (U)= 3,69,351 Beds (T)= 5,40,328
2.	Colleges	Total AYUSH Colleges= 492 Annual intake capacity= 30,086	Medical Colleges= 300 Annual intake capacity= 34,595
3.	Budget Allocation	Department of AYUSH= 2.7%	Dept. of H&FW= 90% NACO = 4% Dept. of Health Research=3%

Sources: National Health Profile, 2009, CHEB, GOI; *AYUSH in India*, 2007, Dept. of AYUSH, GOI.

With the low funding, quality of infrastructure and functioning of AYUSH institutions is often weak, and utilisation is reflective of this. This was the finding of a study across 18 states in 2008-09 (Priya & Shweta, 2010), a comparative analysis showing that the utilisation is high where quality is good. In states such as Tamil Nadu and Kerala, where quality of modern and AYUSH services is very good, utilisation was found to be high of the AYUSH as well (see Table 2). This reflects a demand by choice rather than under the constraint of access to modern medicine. Household responses revealed an even higher use of AYUSH and LHT, many going to the private sector.

Responses of doctors of modern medicine in the public system too reflect a high perception of usefulness of the AYUSH and of home remedies by them, reflecting their perceived/observed strengths, especially in case of shortcomings of modern medicine. The practice of combined therapy and cross-referral being practiced informally is indicative of the perception of the complementary role of the various systems.

Some Key Contemporary Global Issues in Organising Health Care

There are various streams of thought developing within health services development in the world at this point of time, all charged with some commonly recognised problems with the existing systems. One strand attempts to reform the financing and provisioning without questioning the knowledge content while the other challenges the prevailing dominant knowledge base and provides openings for a different direction for development of health care in the future. In fact there is much frontier research that is changing the state-of-the-art practice of medicine from a high technology to a lower and more appropriate technology use, often drawing from other systems of knowledge. The findings of a rich body of analytical studies can be summarised as follows:

Consequences of Bio-medical Dominance

- Over-medicalisation, specialist services further increase unnecessary interventions and costs
- Iatrogenesis
- Commodification of health
- Unaffordable and Escalating Costs
- Pharmaceutical and insurance industry attempting to generate higher markets for fewer technological advances; pressure for higher public funding of medical services and for absorbing the costs of R&D in curative and preventive medical technologies.

Challenges to the Bio-medical Dominance

- High and increasing NCD load even while Communicable Diseases remain high; an aging population
- Widening recognition of significance of the social determinants of health
- Increasing use of Traditional Medicine (TM) and Complementary & Alternative Medicine (CAM)
- Questioning of development models that ignore natural environments and processes
- Demands around 'right to quality health care', 'rights of patients' especially in terms of information and role in decision making, 'rights of providers'; involvement of communities in decision making.

In this context, optional paradigms for solutions to the lack of access to health care:

A. To make the bio-medical dominance 'affordable' through social insurance/tax based financing.

B. To break the dominance by supporting and legitimising the cost-effective pluralistic forms, ensuring universal access to all the forms through making knowledge and material requirements of all forms accessible to all.

Health Services: The Indian Context

In addition to the issues faced by health systems globally, some specific issues are relevant for consideration for UAHC in India (as well as other low and middle income countries):

- Large infrastructure of public services of modern medicine and AYUSH, but still inadequate coverage
- Larger private sector, formal and informal, single dr. to polyclinics and nursing home to corporate hospitals and their franchisee outlets
- Large paramedical cadre along with community level 'volunteer workers'
- Large pharmaceutical industry of modern medicine and traditional medical systems
- Yet, access poor due to concentration of services in some parts and sparse in others and due to costs
- High unethical and irrational practice, lack of trustworthy and quality services; completely unregulated
- Pervasive nexus of vested interests, normalisation of unethical practices
- High availability of health human resources, yet shortages due to lack of/distorted policies of production and deployment
- High 'untreated' illness episodes on one hand, and high unnecessary use of medical technologies and specialist care on the other

Table 2

Utilisation of AYUSH Services of the Public System and Use of Home Remedies: Data from an 18-State Survey

	AYUSH & LHT	Modern Medicine
1. Utilisation: Average OPD attendance/ facility/day)	Highly variable across states from 8 to 78. In Tamil Nadu: Stand-alone Dispensaries and Co-located PHCs = 50-80	Data not available for all states. In Tamil Nadu: PHCs = 100-150
2. Utilisation: Households reporting use of AYUSH services in last 3 months.	Households reported use of AYUSH services in the past 3months: 1/3rd states = 0-30% 1/3rd states = 30-60% 1/3rd states = 60-98%	
3. Pattern of Use: Morbidity profile and duration of illness of OPD attendees (exit interviews) [Acute illnesses = less than 1 month Chronic illness = more than 1 month]	Utilised for all kinds of problems -- for curative services in case of acute and chronic, communicable and non-communicable illnesses, except for emergencies & serious conditions. The proportion of chronic illnesses was higher than among the patients taking treatment of modern medicine. For preventive-promotive purposes as well. For instance, as per exit interviews: In Tamil Nadu: Acute illnesses = 40% Chronic illnesses= 60% In Uttarakhand: Acute illnesses = 42% Chronic illnesses = 58%	In Tamil Nadu: Acute illnesses = 100% Chronic illnesses = 0% In Uttarakhand: Acute illnesses = 92% Chronic illnesses = 8%
4. Utilisation of Home Remedies	Variable use of home remedies reported by households across states : For common illnesses =12-82% For MCH care= 40-98%	Utilisation of home remedies together with doctor's medicine was high as reported at exit interview by OPD patients at government institutions = 2-73%
5. Validity of community knowledge against AYUSH principles and texts.	Home remedies for a given list of 21 conditions = more than 75% found valid in all states	
6. Opinion of Medical Officers of modern medicine regarding AYUSH and LHT		70% respondents said AYUSH were of value; 30% thought they were redundant. 55% perceived value in home remedies and also prescribed them to patients, but some were thought to be harmful as well. However, did not write it in the prescription.
7. Combination and Cross-referral of AYUSH and Allopathic treatment	Listed conditions that matched well with people's utilisation behaviour: " in which combined therapy is useful, " for which cross-referral is done to and from providers of modern medicine.	Listed conditions that matched well with the AYUSH doctor's lists: " in which combined therapy is useful, " for which cross-referral is done to and from AYUSH providers. However, did not write it in the prescription.

- Triple burden of disease with continuing CDs., increasing NCDs and Injuries
- High resort to the private sector (formal and informal), and to Traditional Medicine (TM) and the use of Local Health Traditions (LHT) -- pluralist health seeking behaviours widely pervasive in all communities
- Large no. of civil society experiments and formally trained doctors of modern medicine are combining TM interventions and modern medicine for maximum benefit to patient
- NRHM is the ongoing country-wide initiative by the state for strengthening the health service system and any future efforts at health systems development must examine and build upon its achievements/potential/negative possibilities -- (i) setting into motion mechanisms for revival and internal strengthening of the public system and its sub-systems on one hand and involvement of the private sector on the other; which have been multiple and diverse across the states, and can provide positive lessons, (ii) strengthening of structures for community level action and involvement on one hand and institutional strengthening on the other, again multiple and varied implementation with lessons, but generally weak on people's role in governance processes; (iii) commercialisation, contractualisation, and/or monetary incentivisation of activities, which may be counter-productive to strengthening of the public system and community processes.

Challenges for Building an Alternative Paradigm with UAHC in the 21st Century

In the context of both the global and India specific sets of issues related to a health system that is sustainable and cost-effective in improving people's health and wellbeing, some challenges are highlighted below for evolving any meaningful system of UAHC:

- Hegemony of the provider and medical technology needs to be broken--demystifying the information gap and role of technology--while simultaneously empowering the doctors/ providers to practice ethically and with dignity
- Nexus of provider-prescriber and pharmaceuticals is to be broken.
- Nexus of provider-prescriber and commercial diagnostics is to be broken.
- Levels of appropriate care that can be provided to all must be publically funded. This has largely to be by the state, but also by facilitating workers' cooperatives, civil society organisations organisations, philanthropic bodies, etc., to the task of providing rational health care universally, as distinct from the commercial for-profit private sector.
- Limiting the escalation in demand for newer technologies as access to services improves. Escalation in available technologies and their marketing strategies change people's perceptions, especially of those who are already advantaged in terms of achieving access. Thereby there is a distorting of the rationality of 'need' such that the system cannot gear up to reach those who do not have access to even the basic services.
- A wide diversity of context requires that priorities be decided based on context specific problems and ways of handling them.
- Centralised, capital intensive structures can only be at centres of concentration in order to allow access to the maximum number and to ensure all required inputs -- for example, hospitals have largely to be located in urban areas (and wherever a successful rural hospital is set up, the area tends to get urbanised), therefore outreach services and referral systems are more necessary for the rural areas. Even in a setting such as of Canada, it has been found that universal access resulted in overcoming the disparity in mortality rates as well as in inequity of access for primary level and generalist services but not for specialist services which continued to be disproportionately utilised by the better-off (Veugelers and Yip, 2003). This also implies that, by norms of equity, developing services other than hospital based and specialist dependent care should be prioritised for all settings--rural and urban.
- The GP, paramedic, providers of AYUSH services and self-care must form a larger part of the formal health service delivery system everywhere, both for cost-effective rational care for a majority of health problems, and for the widest possible coverage and access. This is as necessary for the middle-class and urban as it is for the poor and rural.
- PG education must be oriented towards producing specialists who should not only be able to use more and higher level technology but even more so, be more knowledgeable and skilled in assessing which patient management approach will be most suited to a patient with least intervention, and refer the patient appropriately to the GP / paramedic / providers of TM services, as well as inculcate capability

for self-care.

Thus, in addition to the norms for coverage of institutions and health human resources, a model for the structure of health services will have to take into consideration: (i) the content of services to be provided since optional methods and technologies have their own imperatives for levels and forms of service delivery; their inherent rationality varies in diverse contexts; comparative cost-effectiveness analyses may imply huge financial differentials; (ii) people's health seeking behaviours since they may provide indicators of the most cost-effective ways of dealing with problems within their context, as well as an understanding of rationality of people's expectations from a health service; and (iii) the work culture of health care providers since that would determine the rationality, quality and outcomes of care. In fact, the norms may have to be re-considered in light of these factors. Diversity of context in terms of the level of health services development would have to be factored in. An incremental process of strengthening universal access may be envisaged for realistic planning and implementation.

The Framework for UAHC

There are two clear trends in health care -- a medical technology, doctor and institution-centred approach and a social determinants and people-centred, pluralistic approach. The model for UAHC would have to adopt one of the frameworks, incorporating within it elements of the other as required. The former can only be developed as a top down process since it inherently relies on the medical expert. The latter can be developed as either a top down process or a bottom up process.

If cost-effectiveness is a major criterion for evaluating a health intervention, then the choice of framework is clearly the second, given the prevailing and emerging morbidity profile and the need for preventive, promotive, curative, palliative and rehabilitative services. However, since it is counter to the prevailing policy environment and the larger political economy framework, the challenge is how to get it accepted and operationalise it. Unfortunately, the imperative of technology development and marketing, as of the commodified mindset, is to make the social determinants and humanist health care approaches seem 'unacceptable' or 'not feasible'. Evidence from experience of countries across the world, at all levels of health service development, tells us otherwise; that the prevailing bio-medical paradigm including its public health dimensions, is not sustainable either in economic terms or in terms of continuing to improve health and wellbeing of all. At one end of the socio-economic divide, the US has faced a recession, partly fuelled by health care costs for their employees that the corporates have had to pay, resulting in a fierce controversy about how to finance health care for all citizens. At the other end is the revelation by an analysis of implications for the poor and marginalised of the most rational and low cost medical care being provided by Jan Swasthya Sahyog-Bilaspur. Presented at the MFC meet at Vellore three years ago, it showed how even the most low cost and rational services of modern medicine remained unaffordable for over one-third (35%) of the community members (in an area where they themselves provide rational services) who died without accessing any care for their terminal illness (JSS, 2006). Countries that have had an ideology-backed adoption of the principle of universal health care and of the principle of people's empowerment together with a perceived resource constraint, have relied on community structures and TM/people's knowledge for primary health care (China, Sri Lanka, East European countries). Even Cuba, with its surplus of doctors, has incorporated TM and is currently teaching children about home herbal remedies through schools. Thailand has, as part of its UHC initiatives promoted the use of home remedies as well as strengthening of institutional structures for Traditional Thai Medicine.

PPPs for UAHC

Given the reality of our existing health service system, PPPs are a necessity. With what purpose and within what kind of framework are the issues to be worked out in congruence with the larger perspective adopted for UAHC. Drawing the private providers into an integrated system of universal provisioning is essential from the PHC/MFC perspective since they can fill gaps of general and specialist doctors in some settings. Engaging them in the UAHC framework is also important if a unified, low cost and appropriate technology service system is to be generated over time. Without regulation of the private sector is this possible? Strengthening of the public services, with contracting in of private providers as a last resort seems to be the way forward. As the public services incrementally increase coverage and quality, more of the practitioners could come into the public system if regular positions are given or be contracted in when required. Both, the public system and the private providers will have to work towards developing an effective working relationship and a work culture of cooperation that puts the users centre-stage and takes STGs seriously.

I am proposing that we add on three dimensions relevant to provisioning and financing that are missing in the present discussion and need to be incorporated

as central to UAHC for the alternative discourse to be meaningful in our real life settings-- self-care, traditional medicine and strengthening of public provisioning.

A Model for Universal Provisioning of Health Care

We began by answering some key questions and making some assumptions based on a large body of available literature:

1. How do people define 'quality' of health care?
   - Produces effective results
   - Convenience in access
   - Reasonable quality of infrastructure
   - Knowledgeable personnel
   - Personnel pay adequate attention to all
   - Tests and medicines available as needed
   - Short waiting time
2. What is access most commonly defined by:
   - Distance
   - Cost
   - Trust in providers
3. How to assess comparative advantages of different pathies, self care and professional care?

   Cost and effectiveness for all types of optional regimens needs to be analysed rather than base assessments only on RCTs that compare a candidate drug merely with another existing drug. Also, the assessment should be conducted for different forms of service delivery--as self care, and by primary/secondary/tertiary level providers. Providers and users are well known to have other valid considerations in use of each regimen within their context. Thus, for example, evaluations of pharmaceutical products, should include under diverse conditions:
   - Objective evaluation of proposed/ practiced regimens vs placebo or symptomatic treatment
   - Objective evaluation of proposed/ practiced drug regimens vs drugless management
   - Provider's assessment of the advantages and disadvantages of the various options
   - Users' assessment of the advantages and disadvantages of the various options

   Multi-dimensional and innovative mechanisms could be evolved for dealing with each requirement through optimal solutions in light of all the experience of different countries and within India. For instance:

To decrease waiting time:

- decrease unnecessary prescribing/demand for interventions
- increase coverage of population with providers and facilities
- strengthen management to improve functional efficiency

To decrease prescribing/demand for unnecessary interventions:

- by a rational use of interventions,
- using a pluralistic approach to management

To evolve a model for UAHC, make evidence based estimates for common problems, bringing together (i) Epidemiological data on disease profile, (ii) People's health seeking behaviour and perceptions, (iii) Providers' practices, (iv) Learnings from realist evaluations of systems of UAHC in diverse settings. Estimation of need may be based on computations of the following and the service structure and human resource planning may be done accordingly:

- % of illness episodes amenable to home care and not needing allopathic medicines or doctor's attention
- % of illness episodes needing primary care or long term support from paramedics + allopathic medicines + AYUSH
- % for GP care (allopathic)
- % for GP care (AYUSH)
- % needing specialist attention
- % using home remedies effectively (with or without other treatment)

Strengthening Public Services

The Planning approach outlined in the accompanying paper "UAHC with 'Community Participation' OR 'People Centre-stage'? : Implications for Governance, Provisioning and Financing" provides a framework within which strengthening of services in the government system can be envisaged. It also provides a rational basis for appropriate 'contracting-in' PPPs.

In addition, if universal access is the goal and the public system is to be strengthened, coverage of services will have to be increased to bring them physically closer to users. A structure for the public system is given below to illustrate the possible integration of AYUSH and paramedics for preventive and curative services at all levels. Introducing a social worker into the system would facilitate the effective operationalisation of participatory structures such as the VHSCs, RKS and village to district health planning.

Proposed Structure for Public Services for UAHC

[Village level facilitation of government and community action by AWW+ASHA+VHSC members]

Institutional structure:

1. Sub centres for 2000-4,000 persons with 2 ANMs + 2 MPWs + 1or 2 AYUSH doctors + 1 Social worker
2. PHCs for 15-25,000 persons, with 2 AYUSH Drs. of different systems and 2 GPs of modern medicine.
3. CHCs/Sub-district hospitals for 50,000 persons with GPs and specialists of AYUSH and modern medicine.
4. General District Hospitals and AYUSH sub-district and district hospitals
5. Medical and AYUSH colleges

Existing functional AYUSH dispensaries can be used to co-locate a sub-centre or a PHC, with the AYUSH doctor retaining charge. Infrastructure could be suitably upgraded. The AYUSH hospitals should be strengthened to function entirely for their respective systems and provide specialised OPD and indoor services.

The AYUSH doctors at the sub-centers and PHCs must provide only services of their own system and promote cultivation of herbal gardens and use of herbal medicines, as well as provide supervisory support to the paramedics for promotion of home remedies and use of AYUSH as well as specified national health programmes. At the CHC and DH, they should exclusively practice their own systems and work with the allopaths to give patients the benefit of all health knowledge as well as provide referral support and technical advice to the primary level providers.

The ANM and MPW should be trained in multi-pathy health care along with public health activities so that they provide comprehensive promotive, preventive and curative services as well as promote and supervise self-care. Regular outreach activities and institutional services would constitute their duties. Supervisory staff and other paramedics would be appropriately included at each level.

The doctors of all systems would need to be trained in promotion of self-care as well as sensitised to the strengths of the other systems and oriented to use of STGs.

The social worker will have the responsibility of overseeing community activities, such as the VHSCs activation, inter-sectoral coordination and other local specific needs, eg for palliative terminal care at home, adequate referral linkages and transport etc., as well as ensuring that the most marginalised sections in the villages in her area are not neglected during implementation of various schemes and service delivery.

Thus, by combining all existing infrastructure, the need for capital investments would be reduced while comprehensive and integrated services would become possible and provide greater choice of pathy to the patients. Wherever doctors are not available in the public system they may be contracted in from the private sector. Where the private doctors are also not available, paramedics and referral services need to be strengthened, along with nurses who can be trained for basic care.

To support such a structure, education and training capacities will have to be strengthened at district levels. With a large part of the everyday illnesses being taken care of by self-care, paramedics and AYUSH, the need for setting up more medical colleges will be limited leading to saving on capital investments and the high recurring costs at that level.

Paramedical education and training will have to be strengthened all round. Existing ANM-Training Centres and Health Schools should be upgraded and additional institutions after assessment of need.

Technical Support will need to be made part of the organisational structure for setting of technical guidelines for clinical practice as well as programme design and their implementation. This should include the following:

Institutionalising mechanisms for technology assessment and choices would require a national level body to work out the modalities and principles on which health technology use should be undertaken in the country. The NICE that has been doing this task for the NHS of the UK provides a structure to start our thinking on this. However, we would require expertise to assess old and new allopathic medicines and other interventions as well as AYUSH regimens, especially for continuing and emerging epidemiological priorities, including communicable diseases, NCDs, MCH and mental illness.

Creation and updating of RDU guidelines, EDLs and STGs with the spectrum from home remedies to optional or combined AYUSH and allopathic regimens at primary, secondary, and tertiary levels, conducting studies to monitor prescribing practices and identify

context specific adaptation needs, would all be supportive tasks for improving the quality of clinical practice.

The State Health System Resource Centres should have an AYUSH unit to contribute to innovation and change in the health system. At the district level, a ***District Interdisciplinary Resource Centre for People's Health Knowledge*** could perform multiple functions, including documenting and validating LHTs, health education for promoting the useful and weeding out the harmful traditional practices, sensitising medical and AYUSH practitioners and other health workers to the local health traditions and the significance of people's health knowledge as well as self-care.

The accreditation system for all service delivery institutions should include criteria for 'promotion of health and self-care' as an important element. Thailand, for instance, accredits those hospitals as 'health ***promotion hospitals'*** that promote self-care, produce traditional herbal medicines and use them for their patients. Referral audits could help in restricting referrals to higher levels to only the essential, and provide pointers to the kind of support required by doctors within the system to perform at their optimal.

Promoting Innovative High Quality Low Cost Solutions in Clinical and Surgical care: Several innovations are made every day by doctors, surgeons and health workers in order to provide optimal care to their patients and these largely remain restricted to individual use or within their hospital. A number of such innovations and experiments related to screening and diagnostic tests (Phadke A.), surgery (Thomas G), trauma services (John J), deliveries (Bhattacharji S.), leukemia (Chandy, M) were shared and discussed at the MFC Annual Meet at Vellore in January 2006, and are available in the MFC bulletin. Several AYUSH medical regimens have been evaluated by RCTs and found to be effective. Integrative medicine combining the principles of allopathy and TM has produced good results in serious dermatological conditions such as the 'elephant foot' of filariasis (Ryan T, 2010). Wound healing in intractable chronic ulcers, and chemical fistulectomy by Ksharsutra (Shukla et al, 1994) are well acknowledged as more effective than modern surgical methods. A Golden Triangle initiative is underway as a collaborative effort of the AYUSH Dept., ICMR and CSIR for evaluating Ayurvedic regimens for 28 conditions and standardising the effective ones (GOI, 2010). Facilitating systematic work on such innovations, with sharing of the experience and dissemination of findings would be motivational, generating critical interest and excitement of the providers in working with marginalised communities, as it provides a professional challenge. It would also be useful for all practitioners including those in the private sector which can use these in a win-win situation for their patients as well as profit margins. Institutionalising this through organisations such as the Association of Rural Surgeons of India is important but the resources of time and finances remain stretched so that systematic dissemination is difficult and does not impact the mainstream of the profession. The ICMR/Department of Health Research could develop a special unit for the purpose, bring together such clinicians, publish and publicise their innovations and also feed them into in-service orientations and CMEs.

Conclusion

Many more organisational and clinical ideas for ensuring and facilitating universal access must be in the minds of a large number like us, some based on evidence from literature and some also working it out on the ground. The basic issue is the framework for attempting such a challenging task. The building blocks are all there. How do we put them together to move towards an optimal, long-term, sustainable system of universal access? A major barrier is the lack of readiness to think 'with the people'. Whatever model we adopt, if it does not deal with the divide between the health provider system and the people, it cannot create the sense of solidarity required to ensure universal access. Then UAHC may only become another source of greater profits for the health industry with little addition to the health and wellbeing of India's marginalised, and in fact, even as it provides some relief, it may act as a source of additional suffering for a vast majority.

Annexures

1. Costing of the proposed service delivery structure

2. Some rough costing exercises for the alternative approaches, as applied to a few disease conditions

References

Bodeker G and G. Burford (2007): "Traditional, Complementary and Alternative Medicine,*" Policy and Public Health Perspectives.*

Borkan J. M., Morad M., Shvarts (2000): "Universal health care? The views of Negev Bedouin Arabs on health services," *Health Policy and Planning,* 15:2, 207-216.

Chambers R, G. Wakley and A. Blenkinsopp (2006): *Supporting Self Care in Primary Health Care* (Oxford: Radcliffe Pub)

Chokevivat, Vichai (2005): "The Role of Thai Traditional Medicine in Health Promotion," 6GCHP, Bangkok, August

7-11.

Duggal, Ravi (2010-11): "Organising the Provisioning for a Universal Healthcare System," *mfc bulletin*, Issue 342-344.

Govt. of India (2010): "Golden Triangle Partnership." http://www.ccras.nic.in/Golden_Tiangle/20081011_Golden_Tiangle.htm, accessed 021211

Illich, Ivan. (1975): *Medical Nemesis.*

JSS (2006): "Is Curative Care Possible without a Welfare State?: Lessons form a Non-profit Community Health Programme in Rural Chhattisgarh."

Priya, Ritu (2011): "UAHC with 'Community Participation' OR 'People Centre-stage'? Implications for Governance, Provisioning and Financing", Background paper for MFC Annual Meet, Jan. 2010, Nagpur. Reprinted in this issue of the bulletin.

Priya, Ritu and A.S. Shweta (2010): "Status and Role of AYUSH and LHT under NRHM," NHSRC, New Delhi.

Ryan, Terrance (2010): "Trials in Integrative Medicine: A short perspective based on the experience at Institute of Applied Dermatology," Presentation at the 4th World Ayurveda Conference, December 10-13, Bengaluru.

Sadgopal, Mira and Alpana Sagar (2006): "Can Public Health open up to the AYUSH Systems and Give Space for People's Views of Health and Disease?", Background paper for MFC Annual Meet, January 2006, Bangalore.

Shukla, N.K., R. Narang, N.G.K.Nair, S. Radhakrishna and G.V. Satyavati (1994): "Multicentric randomized controlled clinical studies of kshara-sootra in management of fistula-in-ano," Indi J. Med. Res. (B), 177-185.

Veugelers P. J., and A.M. Yip A. M. (2003): "Socioeconomic Disparities in Health Care Use: Does Universal Coverage Reduce Inequalities in Health?" *Journal of Epidemiology and Community Health,* 57: 6, 424-428.

Annexure 1

Costing of Services Provisioning for One District As Per the Proposed Health Services Structure (approximate cost)

Population	**20,00,000**		
Healthcare Cost	**(Approx.) in** *Rs. crores*		**per facility** *Rs.crores*
Sub centre+outreach	70.00	17.50%	0.10
PHC	22.25	5.56%	0.30
CHC	280.50	70.12%	7.00
DH	15.00	3.75%	15.00
Sub-total	**387.75**	**97%**	
Systems Cost			
Logistics & Warehousing	0.10	0.02%	
ANMTC	0.20	0.05%	
Supervision & Admin	4.00	1.00%	
Referral Transport	2.00	0.50%	
M&E	2.00	0.50%	
IEC	2.00	0.50%	
Outreach	2.00	0.50%	
Sub-total in Rs cr.	**12.30**	**3%**	
Total in Rs cr.	**400.05**		
Rs. Per capita	**2,000**		

The costing framework of District Health System includes two major components - (a) Health Care Costs: the cost of provisioning services at various levels of facilities (b) Systems Costs: institutional/ systems overheads (training, logistics, supervision and monitoring).

For arriving at health care costs, facility-wise costing is done as to what is needed for provision of services keeping three major components:(1) HR Costs (2) Consumables (3) Overhead Costs. The costing was done for an "average" district with a population of 20 Lakhs (rural and urban), number of blocks and number of institutions based on the following norms; Sub center for 3000 population, PHC for 25000 population and CHC for 50000 population District Hospital for 20 Lakh Population. Accordingly there will be 667 sub centers, 80 PHCs, 40 CHCs and one District Hospital.

The HR costs are calculated as per the IPHS norms and adding the additional HR requirements as per the norms prescribed in the proposed health service structure. The additional requirements to the existing are: at the sub center level two MPW, one AYUSH Doctor, and one social worker; PHC level includes two AYUSH doctors; CHC level includes seven medical officers and seven specialists.

Type of Facility & no. per district	HR	Consumables	Overhead	Total per Facility
Sub Center (667)	840,000	75,000	125,000	**1,040,000**
PHC (80)	2,004,000	224,450	547,250	**2,775,700**
CHC (40)	8,196,000	40,737,500	21,191,250	**70,124,750**
DH (1)	100,000,000	20,000,000	30,000,000	**150,000,000**

All Figures in Rs. Lakhs

System Costs includes logistics and warehousing costs, ANM training centers, supervision and administration, referral transport, Monitoring & Evaluation, IEC and Outreach services. The costing is largely based on NCMH estimates for cost of care for core, basic and secondary healthcare package, while drawing reference to NSSO (60th round) estimates of out-of-pocket expenditure and utilization of public facilities for hospitalization and OPD services. The costing of supervision and administration, referral transport, Monitoring & Evaluation, IEC and Outreach services is broadly built around the IPHS norms of NRHM. The cost of logistics, ware housing and ANM training centers is based on actual data from the state of Bihar.

When the state and national level costs are included, the systems costs are expected to increase to over 10%. Decentralised planning based on local epidemiological needs and the stated principles of service provision at the lowest and closest level possible is likely to lead to variation in number of institutions and HR such as decrease in specialists and increase in PHCs, and accordingly a variation in costs.

[We thank Gautum Chakraborty and Arun B. Nair for doing the costing, and for including the systems heads. This is to get a rough idea of the financial implications for the proposed structure of services.]

Annexure 2

Optional Treatment Regimens and the Continuum of Care from Self-Care Practices, Prescriptions of AYUSH & Allopathic Doctors in Tamil Nadu Public Services and Rational Treatment Guidelines for Four Common Conditions

S. No.	Disease conditions	Home remedies/Self care at home	AYUSH prescriptions (Siddha)			Allopathic prescriptions		
			Sample Prescriptions at Exit Interviews	Rational		Sample Prescriptions at Exit Interviews	Rational	
				Non Pharmacological	Pharmacological * (Standard dosage with duration)		Non Pharmacological	Pharmacological
1.	**Cough & Cold**	Pepper 1/2 teaspoon + palm jaggery, honey, tulsi juice , Melagu Rasam, turmeric powder with milk	a) Adathodai decoction b) Sivanaar amirtham c) Thalisathi choornam	Dietary regimens, Yoga	a) 50ml twice a day b) 100mg twice a day c) 1tab three times a day **For 1 week**	T-Erythro, T-Dexa, T-Cetrizine, T-Ranitidine Inj Gent, Inj Para	Rest ,Self limiting	**Non specific**:Tab Paracetomol 500-1000mg6-8hrly or Tab Ibuprofen 400-600mg 8hrly or Tab Nimesulide100 mg 12hrly **Specific**: Antibiotics /Antimalarials depending on tests and diagnosis.
2.	**Fever**	Nilavembu leaves+ pepper decoction ,Hot water sips, Cold water sponge	a)Linga chenthooram b)Thirikadugu choornam c)Pavala parpam	Dietary regimens and rest	a)100mg three times a day b)1g three times a day c)100mg three times a day **For 4 days**		Hydrotherapy and rest	
3.	**Diarrhoea**	Arrowroot kanji pomegranate outer skin dried powder, drinking tea	a)Thayirchundi choornam b)Nathai parpam c)Sundaivatral choornam	Dietary regimens	a)1g twice a day b)250mg twice a day c)1g twice a day **For 5 days**	T-Norflox, T-Metero, T-Rantac Inj Gent	Adequate fluid replacement at home, juices soups or ORS. Milk Products to be avoided.	**Very ill patients with bloody diarrhoea**: Tab Ciprofloxacin 500mg 2 times/day **Amoebic dysentery**:Tab Metronidazole 800mg 3 times a day Tab Tinidazole 2g single
4.	**Diabetes**	naval fruit, naval seed powder + water taken every day	Mathumega choornam	Dietary and lifestyle regimens ,Yoga	1 cap three times a day **Long term (cost for 7 or 15 days)**	Not found in the sample prescriptions	Dietary management and excercises	Tab Glimipride 1-8 mg /day or Tab metformin 500mg once or twice a day or Insulin and Metformin as per blood sugar levels

Sources :
Columns 3, 4 and 7: Priya Ritu & A.S. Shweta, 2010: Status and Role of AYUSH and LHT under NRHM, NHSRC, New Delhi.
Columns 5 and 6: Essential drug lists of Siddha as per IPHS ,Consultation with Senior Siddha Researcher (CCRAS) as well as Siddha Doctor practicising in Tamil Nadu PHC for standard treatment.
Columns 8 and 9: Standard Treatment Guidelines, DSPRUD
*This implies the medicines of AYUSH prepared by the fundamental pharmacological principles of AYUSH.

Cost of the Rational Modern Medicines for Treating the Four Common Conditions

Tab	Qty	Dose	Pack Rate	Single Tablet	Daily Exp(Rs)
Tab Paracetomol	500 mg	6-8hrly	15.0	1.5	**4.5**
Tab Ibuprofen	400 mg	8hrly	29.3	2.9	**8.8**
Tab Nimesulide	100 mg	12hrly		1.5*	**3.0**
Tab Ciprofloxacin	500 mg	2 times/day	84.5	8.5	**16.9**
Tab Metronidazole	800 mg	3 times a day	67.7	6.8	**20.3**
Tab Tinidazole	2g	single		8.74*	**8.7**
Tab Glimipride	1 mg	single	7.8	0.8	**0.8**
Tab Metformin	500mg	single	12.6	1.3	**1.3**

Sources:

http://www.tnmsc.com/tnmsc/new/html/pdf/drug.pdf

* http://www.medlineindia.com/antibiotic/tinidazole.htm

Cost of the Rational Siddha Medicines for Treating the Four Common Conditions

Diseases	Standard Drugs Used at PHC	Standard Dosage With Duration	Unit Cost *	Total Cost	Daily Expenditure
Cough & Cold	Adathodai decoction Sivanaar amirtham Thalisathi choornam	50ml twice a day 100mg twice a day 1tab three times a day **For 1 week**	50ml=5/- 100mg =50paise 1tab =70Paise	Rs.70.00 Rs.7.00 Rs.15.00 **Rs.92.00**	**13/- per day**
Fever	Linga chenthooram Thirikadugu choornam Pavala parpam	100mg three times a day 1mg three times a day 100mg three times a day **For 4 days**	100mg =50paise 1g=1/- 100mg=1/-	Rs. 7.00 Rs. 12.00 Rs. 12.00 **Rs. 31.00**	**7.75/-per day**
Diarrhoea	Thayirchundi choornam Nathai parpam Sundaivatral choornam	1g twice a day 250mg twice a day 1g twice a day **For 5 days**	1g=75paise 250mg =60paise 1g=50paise	Rs.7.50 Rs. 6.00 Rs. 5.00 **Rs. 18.50**	**4.625/-per day**
Diabetes	Mathumega choornam	1 cap three times a day **Long term (cost for 7 or 15 days)**	1cap=1/-	**Rs.21.00**	**3/- Per day**

Source: *From govt. pharmacy rates and TAMCOL

The Regulation of Surrogacy in India: Questions and Complexities

- Preeti and Vrinda [1]

While instances of commercial surrogacy have risen by leaps and bounds (a recent article in a leading national daily estimates that the cost of the surrogacy market is over Rs 2000 crore), its regulation or rather non-regulation has been a matter of concern. Within this flourishing market, even as clinics and other players continue to make huge profits, there are several ethical concerns that arise out of the increasing commercialization of women's bodies and bodily labour; this includes concerns about the health and rights of the surrogate and the child/children born out of surrogacy. Given such a context, the need for a comprehensive legal framework cannot be overemphasized. This is particularly evident in cases involving legal tussles about the citizenship status of children born through transnational surrogacy arrangements.

In the proposed Draft Assisted Reproductive Technology (Regulation) Bill and Rules-2010, prepared by the Indian Council of Medical Research (ICMR), a substantial section is devoted towards regulating surrogacy arrangements. Though a welcome step, significant gaps in the protection of surrogate women and children still remain. The most striking of these perhaps is the provision for payment to the surrogate woman, which appears to undermine her rights by favouring instead the intended parents. According to the present Draft, payment to the surrogate is to be made in five installments instead of three (as in Draft 2008, the only previous version). The majority, that is 75 per cent of the payment, is to be paid as the fifth installment, following the delivery of the child. This is in complete contrast to the Draft 2008, in which there was provision for the majority 75 percent of the payment to be made as the first installment. This not only shows a clear priority accorded to the intended parents, but also betrays that the worth of the surrogate's labour, pregnancy, related emotional and physical risks etc are considered reducible to and meaningless without a tangible reproductive output, the baby. The potential health risks that a surrogate might face (as a result of undergoing IVF) do not appear to be a cause of concern at all. For instance, according to the Bill, only gestational surrogacy, that is through IVF, will be permitted, and genetic surrogacy, that is through IUI, which is the less invasive option, is ruled out. While this may be to avoid any contesting claims over the custody of the baby later, it again reveals that the 'commercial angle' outweighs the 'human', and no nuanced understanding of the surrogate's rights, who may have voluntarily entered into a contract but may also relate to the baby in emotional ways, .

The present Draft has also increased the number of permitted successful live births for a surrogate from three (in the previous Draft) to five; this is inclusive of the surrogate's own children. This provision inadequately addresses an aspect critical to the surrogate's health: the number of permitted cycles she can undergo. Since the number of live births is not equivalent to the number of ART cycles, to effectively ensure that the surrogate's health is not exploited, the maximum number of permitted cycles must also be specified.

In lieu of the recent and controversial cases of international surrogacy that have resulted in legal battles for citizenship status for the child/ren, the Bill has made provisions to address this issue. The draft Bill now makes it mandatory for foreign couples to produce a certificate from their countries declaring that the respective countries permit surrogacy, and that the child will be considered a legal citizen. As an increasing number of couples from other countries access surrogacy services in India, such a provision will be a useful legal framework. The Draft Bill should take concrete measures to address the legal needs of the surrogate women.

Therefore, it can be concluded that while a legislation to regulate the untrammeled commercialism of ARTs and surrogacy in India is a much-needed step towards checking unethical medical practice, the human rights of the surrogate and the children - legal, financial, and health-related - need to be better protected.

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The Travesty of Informed Consent: Case of HPV Vaccination "Demonstration Projects"

- Sarojini N and Anjali Shenoi [1]

The Human Papilloma Virus (HPV) vaccination 'Demonstration Projects' were conducted in Andhra Pradesh and Gujarat by PATH International (an American NGO), in collaboration with Indian Council of Medical Research (ICMR) and the State Governments of Andhra Pradesh and Gujarat, since 2007. Following reports of deaths, adverse events and violation of ethics, including fact-finding investigations carried out in Khammam district in Andhra Pradesh by concerned groups and Smt. Brinda Karat (MP), the 'Post-licensure observation study of HPV vaccination: demonstration project' was suspended in April 2010. At the same time, the Ministry also appointed a Committee to enquire into these "Alleged irregularities in the conduct of studies using HPV vaccine" with a time frame of three months to submit its report.

Almost 10 months later in February 2011, an interim report submitted by the Committee and was made public after a demand from the members of Standing Committee on Health in Parliament. The Committee has identified several deficiencies in the planning and implementation of the project, however, failing to fix responsibility for any of these violations on any individual or agency. In this article we would address one of the key concerns raised by the members of the Committee is related to the way the consent was obtained for the implementation of the Demonstration project. The report establishes that, "The legality and morality of the circular of the Government of Andhra Pradesh authorizing the Hostel Wardens and Head Masters to sign the consent on behalf of the minor girls included in the study is questionable."

A fact-finding report by civil society groups last year pointed out the similar observation. The report mentioned that the wardens of the residential schools and hostels, which were selected for the 'demonstration project', were asked to provide consent or permission for vaccination. The report questioned the basis where the wardens be considered legal guardians to provide consent? The report further states that: "How can a warden, whether a legal guardian or not, be allowed to sign or provide consent for hundreds of children without consulting with the parents, who are the natural guardians."

The consent form for this project does not include any information on compensation, procedures to be followed, alternative treatments if available or risk management as mandated by the ICMR guidelines, necessary for informed consent. The consent form also states that "If you are not willing to participate you will not lose any benefits that you are entitled to; you will not be fined".

The very nature of this project appears to be in violation of all ethical norms as a warden, whether a legal guardian or not, be allowed to provide consent for hundreds of children without consulting their parents, who are their natural guardians.

The travesty of the entire process of informed consent in Andhra Pradesh (also pointed out by the Committee in the report and by the civil society) is in complete and absolute violation of both the Drugs and Cosmetics Act and the Ethical Guidelines for biomedical research. Such a process requires the 'researcher' to directly provide information mandatory for consent to the person (s), in this case the parents, which was not done. Schedule Y of the Drugs and Cosmetics Act states that, *"Paediatric Subjects are legally unable to provide written informed consent, and are dependent on their parent(s)/ legal guardian to assume responsibility for their participation in clinical studies. Written informed consent should be obtained from the parent/ legal guardian. However, all paediatric participants should be informed to the fullest extent possible about the study in a language and in terms that they are able to understand. Where appropriate, paediatric participants should additionally assent to enroll in the study. Mature minors and adolescents should personally sign and date a separately designed written assent form."* Also, according to the ICMR guidelines, *"Before undertaking any trial, the investigator must ensure that… a parent or legal guardian of each child has given proxy consent; the assent of the child should be obtained to the extent of the child's capabilities such as in the case of mature minors from the age of seven years up to the age of 18 years."*

Although the committee states that there was "no specific targeting of any particular group' later once again contradicts themselves when a specific case by remarking on the inappropriate nature of conduction of such a project on young girls from the tribal belt, particularly where it is 'impractical to take consent of parents."

While identifying several deficiencies in the planning and implementation of the project, the report, submitted to the Ministry of Health and Family Welfare, has failed to fix responsibility on any individual or agency. Rather than suggesting any punitive or disciplinary measures, the report identifies 'minor' deficiencies as lessons for strengthening clinical research in future.

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[1] *Email: <sama.womenshealth@gmail.com>*. Sarojini and Anjali work with Sama Resource Group for Women and Health, dated March 22, 2011

[2] *See Sarojini N, Anjali S and Ashalata S (Ed.) (2010):"Findings from a Visit to Bhadrachalam: HPV Vaccine 'demonstration project' site in Andhra Pradesh," March 27-30.*

Conflict of Interest in Policy Making

Another Face of Corruption

-Radha Holla[1]

Most people view corruption as limited to an individual or group of individuals illegally receiving some form of gratification, pecuniary or not, in return for granting or attempting to grant a favour. However, conflict of interest in decision-making processes generates corruption in that the former "bribe giver" now becomes the decision maker.

The Many Faces of Conflict of Interest

Conflict of interest can exist in several forms, both obvious and not so obvious.

Examples of obvious forms of conflict of interest include the following situations:

- When persons known for being corrupt frame legislations, rules and regulations for controlling/preventing corruption (the presence of corruption tainted ministers in the Group of Ministers mandated to draft the Lokpal Bill);
- When public officials take policy decisions based on their personal interest (eg., Ashok Chavan in the Adarsh Housing Society scam);
- When food manufacturing companies sit on scientific panels to evaluate research and to set food standards (eg., Nestle, Hindustan Lever, Coca Cola, PepsiCo, ITC on scientific panels of Food Safety and Standards Authority of India (FSSAI); food manufacturers, pesticide manufacturers included as members of the national delegation at international bodies such as Codex Alimentarius that set standards for foods);
- When companies producing genetically modified seeds evaluate their own products as "safe" and this evaluation is accepted by public regulatory bodies without independent validation (eg., Validation of Research of Monsanto/Mahyco for Bt Brinjal by Genetic Engineering Approval Committee in 2009) .

Taking note of the conflict of interest in setting up FSSAI's "independent" scientific panels, on February 8, 2011, the Supreme Court of India ordered the government to remove persons linked to food and soft drink companies from the statutory panels tasked to enforce safety and standards on edible items, including products of these firms. The Judges felt that company representatives on scientific panels was a clear breach of the mandate under Section 13(1) of the Food Safety and Standards Act, 2006, and asked FSSAI to rectify the mistake and re-constitute the panels with independent scientific experts as members within two weeks and report back to the court.[2]

We discuss below the less 'obvious' situations where conflicts of interests can take several forms.

Front Organisations of Corporations and Conflict of Interest

The Infant Milk substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 as amended in 2003, commonly called the IMS Act, prevents baby food manufacturers from directly advertising any of their products for children under two to parents and the public, as well as prevents them from giving gifts and goodies to health workers or sponsoring conferences, seminars, workshops, lunches, for them. Similarly, in January 2010, the Medical Council of India amended the Indian Medical Council (professional conduct, etiquette and ethics) Regulations, 2002. The modified code of ethics prohibits medical practitioners from accepting gifts, travel facilities, hospitality and monetary grants from the healthcare industry either in their name or in the names of their family members. The code bars the doctors and their family members from accepting rail or air travel facilities, cruise tickets and paid vacations from the industry. They cannot accept any hospitality either.

Industry has tried to bypass this by creating front organisations, often registered as NGOs, or trying to reach nutrition professionals, which are not covered by the existing laws in their continued attempts to influence policies and decisions. For example, Nestle has created the Nestle Nutrition Institute; Mead Johnson, the baby food manufacturers, have set up Mead Johnson Nutrition; GlaxoSmithKline, makers of Horlicks, as well as pharmaceuticals, has set up the Horlicks Nutrition Academy, which are not covered by the IMS Act.

Examples of conflict of interest involving front organisations include:

- Nestle Nutrition Institute co-hosting the annual

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conference on nutrition with PGI (Chandigarh) and the Indian Society for Parenteral and Enteral Nutrition in January 2011. The conference was cancelled because NGOs brought this to the notice of the government and the media.

- Nestle Nutrition Institute entering into Public Private Partnerships with agricultural universities to take up programmes for "creating health and nutrition awareness of village women and girls in government schools in rural areas", thus expanding their influence on consumers and strengthening their brands.
- PepsiCo was a sponsor of the conference - "Leveraging agriculture for improving nutrition and health" - organised by International Food Policy and Research Institute (IFPRI) in February 2011. PepsiCo is using fortification and ready-to-use packaged food as an entry point into the malnutrition market. Ironically, the Prime Minister, who addressed the conference, chose to remain silent about the presence of the multinational company's commercial interests in the sector.

BINGOs and Conflict of Interest

Another mechanism leading to conflict of interest is when the private sector creates a lobbying body, usually a Business Interest NGO (BINGO), and then uses this persona to influence policy making or create markets for its products. The Global Alliance for Improved Nutrition (GAIN), Global Alliance for Vaccines and Immunisations (GAVI) and International Life Sciences Institute (ILSI) are examples of BINGOs. GAVI and ILSI have pharmaceutical, food manufacturing and agribusiness corporations as their members.

GAIN, for instance, is committed to developing business partnerships in order to increase private sector investments in nutrition. In 2005, GAIN established the GAIN Business Alliance to mobilize business to play a greater role in combating malnutrition and facilitate business partnerships between governments, NGOs, civil society, academia and media in order to create opportunities for the private sector to enter into the business of malnutrition.[3]

GAVI is a global health partnership that brings together developing world and donor governments, private sector philanthropists, vaccine manufacturers, research and technical institutions to make new vaccines and create markets for them. Pfizer and GSK were the first beneficiaries of GAVI's lobbying, followed by Indian Companies such as Panacea Biotech.[4] WHO, which influences national policy related to immunisation, is a member of GAVI. WHO has reworked the classification categories for vaccines to reduce evidence of negative impacts.

ILSI India is a regional branch of International Life Sciences Institute (ILSI), providing scientific inputs and assistance to the South Asian Region. Its activities primarily focus on local and regional critical public health issues like complementary foods and food fortification. ILSI India members include Bikanerwala Foods Pvt. Ltd., Coca-Cola India, DSM Nutritional Product India Pvt. Ltd., Frito Lays Div., PepsiCo India Holdings (P) Ltd., Haldirams Marketing Pvt. Ltd., ITC Foods Business, Kellogg India Pvt. Ltd., Mars Incorporated, Monsanto Enterprises Ltd., Nestlé India Limited, Nicholas Piramal India Limited, RSA Vitamins Private Limited, and The NutraSweet Company, among others. However, there are several members of government and public institutions on ILSI's board: the Directors of the National Institute of Nutrition and the Central Food Technological Institute and scientists from Indian Agricultural Research Institute are trustees of ILSI. Senior officials of ICMR, Dept. of Biotechnology, Ministry of Health and Family Welfare and other government departments, senior officials of universities including agricultural universities are members of the various expert committees along with representatives of companies such as Coca Cola, PepsiCo, Monsanto, Nestle, Hindustan Lever, etc.[5]

While it is not possible to prove that the BINGOs use illegal means or corruption to influence policy decisions, the presence of policy makers on their boards are clear examples of conflict of interest.

Philanthropy and Conflicts of Interest[6]

Philanthropic organisations, exemplified by the Bill and Melinda Gates Foundation (BMGF), which are riddled with conflict of interest are increasingly getting involved in the formation and implementation of national health policies, creating yet new situations of conflict of interest.

BMGF, together with Berkshire Hathaway Holdings (owned by Warren Buffet and being transferred to BMGF) hold large amounts of stocks/shares in Coca Cola, Kraft foods, GSK, Sanofi Aventis, Johnson and Johnson, Proctor & Gamble, McDonald, and Monsanto. Several of the Foundation's members of the management committee, leadership teams, affiliates, and major funders are currently or were previously members of the boards or executive

branches of several major food and pharmaceutical companies including Coca-Cola, Merck, Novartis, General Mills, Kraft, and Unilever.

BMGF is an important funder of WHO, GAIN, GAVI, and other bodies that are lobbying for new vaccines and foods to prevent malnutrition, and promoting communities to become business affiliates of Coca Cola, develop agricultural technologies together with Monsanto in Africa through the African Agricultural Technology Foundation.

BMGF's recent and earlier visits to India have been primarily to get pentavalent vaccine and rotavirus vaccine introduced in the national universal immunisation programme.

Why should philanthropic organisations be brought under national conflict of interest legislation?

Philanthropic organisations such as BMGF have budgets often larger than national budgets, and use their finances to influence national policies that affect every citizen in the country. However, these organisations are not accountable either to governments or to the people whose lives they impact. Their influence often results in policy decisions that transfer public money into the private corporations in which they hold shares or stocks. Their influence in policy making thus constitutes conflict of interest.

Movement of Bureaucrats between Government and Private Sectors and Conflict of Interest

Movement of persons between bureaucracy and public policy-making bodies is a very important source of conflict of interest. Such movements are of three kinds:

1. When public servants including bureaucrats and elected representatives of the people, after leaving public service, work for the companies they used to regulate, there is conflict of interest, as these bureaucrats can use their experience and contacts to get decisions made in the favour of the company. Retired bureaucrats have recently been joining the private sector even before the stipulated two years after retirement are over, and provided huge bonanzas for their private employers. For example, Pradeep Baijal, ex-Chairman of TRAI, joined Nira Radia's companies soon after retirement. Naresh Dayal, ex-secretary, Ministry of Health, joined GlaxoSmithKline Consumer Health-care as a non-official director.[7]

   When serving bureaucrats and policy makers are deputed to work for the commercial sector. Such deputation to profit making bodies is covered under IAS Cadre Rules. Rule 6(2)(ii) in the case of IAS officers, which has recently been changed to allow serving bureaucrats to be deputed to private sector companies for up to five years.[8]

   Movement of policy makers, including technical persons, to and from the private sector also finds place in the new National Health Research Policy finalized in April 2011.[9] Besides other provisions reflecting conflict of interest, point 4 of the "10-point Action Programme" of the NHR policy seeks to develop *"Mechanisms favouring seamless movement of personnel between teaching, research and industry."* [10]

2. Popularly called the "revolving door" policy, this allows the movement of industry-friendly experts into positions of decision-making. An outstanding example of such policy is the presence of Arun Maira in the Planning Commission. Chairman of the Boston Consulting Group, Maira has worked for the TATA Group, and has advised clients across a wide variety of industries ranging from automobiles, steel, and oil, to pharmaceuticals, and financial services. He has been Chairman of several of CII's National Councils, including the National Council for Corporate Governance, and Chairman of CII's Leadership Summit.

Conflicts of Interest Distort National Priorities

The increasing clout of industry and its lobbies like GAIN, Micronutrient Initiative (MI) and GAVI, in policy/decision making allows them to dictate national priorities. Thus GAIN and MI promote fortification of food products with micronutrients to reduce micronutrient deficiencies, rather than talking of or promoting policies that are based on equity - changing agricultural policies to ensure adequate production of diverse foods, making these diverse foods available to all people by controlling prices, improving the public distribution system and widening the food basket there, demanding reduction in use of agricultural chemicals because they deplete the soil of micronutrients; these demands will not ensure profits for their members. GAVI's pressure has resulted in the National Vaccine Policy including new, costly and unproven vaccines in the public system.

Conflicts of interest in policy making often result in Public Private Partnerships (PPP) that operationalise the transfer of money from the public to the commercial, profit-making sector.

Public Private Partnerships and the Abrogation of State Responsibility

PPPs allow the state shrug off its responsibility and pass it on to the private sector. When the State does not carry out its duty, it can be called to account through tools such as PILs and RTIs. The Supreme Court Orders in the Right to Food Campaign's PIL are examples of how these tools can be used. However, in the case of PPPs, this is not easy. The answer to an RTI application to the Punjab Agriculture University on its MoU with Nestle to provide nutrition education to school children said that the MoU could not disclosed as it contained information of a commercial nature. This is also the view of the Planning Commission. Reacting to chief information commissioner Satyananda Mishra's letter asking for PPP documents to be made public, the Deputy Chairman of the Planning Commission, Shri Montek Singh Ahluwalia said:[11] "Right to information is not right to information of private companies. It is right to information on public authorities."

The above view blatantly ignores the fact that public money is being transferred to a private corporation for creating markets and earning profits through PPPs, which, in the case of the Nestle- PAU PPP, allows Nestle to use the public education system to strengthen its brand image, and also be paid public money to do this.

Managing Conflict of Interest: Putting Public Interest Centre Stage

The government 's All India Service Rules and Central Secretariat Service Rules do not include the words "loyalty", "integrity", or "responsibility"; "public interest" is mentioned only once in the context of extending pensions. "Duty" is mentioned only in the context of "duty posts". There is no reference at all to the fact that the bureaucrat is a "public servant", whose primary duty and accountability is to the "public".

Mere declaration of conflict of interest is not enough if the conflict of interest affects decision-making in governance, especially policies, rules and regulations that impact people's fundamental rights to a life with dignity. The integrity and independence of our public institutions is of paramount importance. Some actions that need to be taken up immediately by the government include:

- Recognise existence of conflict of interest in policy making as a form of corruption
- Develop mechanisms for managing conflict of interest
- Legislate to prevent conflict of interest in policy making by creating new legislation or including it in existing/proposed legislation like Prevention of corruption Act 1988, Lokpal Bill, etc.
- Create a statutory body to examine cases of conflict of interest.

Endnotes

2. "Remove food, soft drink co agents from scientific panels: SC", *Times of India,* Feb 9, 2011
3. http://www.gainhealth.org/partnerships, accessed on 16th April 2011
4. http://www.gavialliance.org/, accessed 7th July 2010
5. http://www.ilsi-india.org/about-ilsi-india/board-of-trustees.htm, http://www.ilsi-india.org/PDF/ILSI-India%20Expert%20Committees.pdf, accessed 16th April 2011
6. This section is primarily based on information provided in Stuckler D, Basu S, McKee M (2011): "Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed?", *PLoS Med* 8(4), accessed on 17th April 2011
7. http://hotnhitnews.com/India_A_Democracy_on_the_Road_to_Kleptocracy_by_Piyush_Pant_020311006.htm, accessed on 8th April 2011
8. Copyright: *India Today*. Cited in "Plum jobs in private sector for our babus." www.thefreelibrary.com/Plum+jobs+in+private+sector+for+our+babus.-a0249594481, accessed on 14th April 2011
9. Aarti Dhar. "National health research policy finalized", *The Hindu*, April 4, 2011. http://www.thehindu.com/news/national/article1597255.ece, accessed 4th April 2011
10. "National Health Research Policy", http://icmr.nic.in/guide/draft_nhr_policy.pdf, accessed 4th April 2011
11. "Pvt cos outside RTI purview: Planning Commission", *Times of India*, March 5, 2011

OPEN LETTER TO PRIME MINISTER REGARDING SELECTION OF PERSONS WITH CONFLICT OF INTEREST, AS BOARD MEMBERS OF MCI

Date 26th May 2011

Dr. Manmohan Singh,
The Prime Minister of India,
New Delhi

Dear Prime Minister,

We, a concerned group of citizens and civil society members, express grave concerns over recent media reports1 regarding the selection of persons with multiple conflicts of interest as board-members of the Medical Council of India (MCI).

MCI is an apex body that regulates not just medical education in the country, but also acts as a watchdog to ensure that the Indian medical fraternity adheres to the highest level of ethics. However, it has not been playing its expected role. Considering the recent turn of events, we believe that MCI would be in a similar situation as it was when Dr. Ketan Desai was the president of MCI. Corrupt practices had sullied the image of the MCI2 and affected the credibility of the entire Indian medical fraternity. We fear that unless tough measures are taken, the same situation will recur. People with unblemished backgrounds need to be involved in running the MCI otherwise the important role of oversight of medical ethics in India will remain unfulfilled.

As you are aware, at the time that Dr. Ketan Desai was arrested, the Central government promulgated the Indian Medical Council (Amendment) Ordinance 2010 suspending the MCI and giving itself the power to re-constitute the Council for one year. The Central Government then appointed a group of esteemed and well respected medical professionals to oversee the reform of medical education and the oversight of the medical community. During their year's tenure, one of the foremost tasks of this re-constituted Council related to the revamping of medical education in the country. This work resulted in the key recommendation of the centralization of Medical Entrance Tests. In May this year the time period under the 2010 Ordinance was to expire. However, the Central Government has promulgated another Ordinance extending the time of the re-constituted Council by another year. It has come as a surprise to the health community that along with the one year extention the government has seen fit not to re-appoint a single member of the original re-constituted Council and has made new appointments.

The manner in which the previous Council has been disbanded and the appointment of the new members has caused considerable disquiet among the health community. There is a danger that the government's actions will be seen as arbitrary and questions in the media about the potential conflicts of interest of the new Council members are already circulating.

India has a very large private health sector (perhaps the largest in the world) which has contributed positively in some ways, but has also exacerbated the problems of unethical practices like recommending unnecessary medical investigations and over-prescribing medicines. Today it accounts for 82% of outpatient visits, 58% of inpatient expenditure, and 40% of births in institutions3. Private sector interest in medical education has also grown

considerably and there is now significant overlap between doctors in the private se\ctor, private hospitals and the medical education business. This gives us an idea of the extent of the problem which needs to be addressed. These practices need to be reigned in urgently so that exploitation of the common people can be stopped. To achieve this we need people of integrity to be at the helm of MCI and definitely not the type of persons that have been reportedly selected.

As the Prime Minister is also aware, the Supreme Court of India had recently given the go-ahead for the Centralised Medical Entrance Test as recommended by the previous Council. In a recent case involving another regulator, the Food Safety and Standards Authority of India, the Supreme Court has also made it evident that appointments to regulatory bodies cannot have conflicts of interest.

The MCI as the regulatory body for medical education and medical ethics cannot afford to be tainted yet again. Towards achieving the goal of transparency and accountability in the functioning of MCI, we suggest the following:-

1) An immediate review of the manner and reasons behind the disbanding of the original re-constituted Council and the new appointments made by the Health Ministry;

2) Selection of individuals who have also worked in the field of medical education rather than selecting pure clinicians,

3) Avoid appointments and short-listing of persons with conflicts of interest including practitioners who are primarily from the private sector, that have ethics complaints pending against them or the hospitals they supervise, have private interest in decisions of the MCI including those related to medical education such as changes in the eligibility criteria or relaxation of norms for setting up of medical colleges, etc.

4) Create mechanisms for background checks of potential candidates and eliminate people who do not have a clean track record,

5) Ensure that the decision making process, including the selection of board members is done through a free, non-arbitrary and transparent process.

We urge you to look into this matter on a priority basis as it concerns the future of an important national Council. We trust you will take immediate action in this regard.

Yours truly,
Members of AIDAN, mfc, et al.

References

1) 'MCI board smacks of conflict of interest', *Mail Today* (E-paper), 17th May 2011, http://epaper.mailtoday.in/Details.aspx?boxid=15354515&id=53362&issuedate=1752011

2) 'MCI boss Ketan Desai arrested', *The Times of India*, 23rd April 2010, http://articles.timesofindia.indiatimes.com/2010-04-23/india/28143618_1_gyan-sagar-medical-college-cbi-on-corruption-charges-mci-boss-ketan-desai,

3) 'The private sector in India', *BMJ*, http://www.bmj.com/content/331/7526/1157.full

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The Medico Friend Circle bulletin is the official publication of the MFC. Both the organisation and the Bulletin *are funded solely through membership/ subscription fees and individual donations.* ***Cheques/money orders/DDs payable at Pune, to be sent in favour of Medico Friend Circle,*** *addressed to Manisha Gupte, 11 Archana Apartments, 163 Solapur Road, Hadapsar, Pune - 411028. (Please add Rs. 15/- for outstation cheques). email: masum@vsnl.com*

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MEDICO FRIEND CIRCLE BULLETIN
PRINTED MATTER - PERIODICAL

Registration Number: R.N. 27565/76
If Undelivered, Return to Editor, c/o, LOCOST,
1st Floor, Premananda Sahitya Bhavan
Dandia Bazar, Vadodara 390 001