# AIPSN National Convention on Medical Education and Strengthening of Public Health Care Services
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## Contents

# The Crisis in Medical/Health Care Education and Recent Policy Developments

Government policy on medical and health care education wavers between two conflicting objectives: Healthcare education as an investment opportunity for private funds and healthcare education to provide human resources with training and motivation relevant to the needs of the country.

The government continues to pay lip service to the latter goal but the policy changes brought in recently seem to be aimed at the former. The excuse given by the government for making medical education investor friendly is the shortage of doctors in the country. However, despite decades of whining about doctor shortage, the government, till today, does not even have data on the exact number of doctors practicing in the country, nor does it have quality data on the distribution of doctors across states or within states in urban and rural areas. Yet, there is enough evidence to show that the real problem is of skewed distribution of doctors rather than just a shortage of them.

In most urban areas, the availability of doctors is well over the minimum prescribed by WHO -- one doctor for 1,000 people. But nearly 70% of India's population lived in rural areas according to the last census and the number is unlikely to have fallen below 65% even today. In populous states like Bihar and Uttar Pradesh, the proportion of rural population is as high as 90% and 80% respectively. Blind over-production of doctors will hardly address the severe doctor shortage where it is most acute, rural India, and where the majority of Indians live. Yet, there has been little or no policy direction/process to address this reality.

**Why just producing more doctors is no solution**

Government policy is driven by the logic that if there is over production of doctors, they will be forced to move out of urban and semi-urban areas into rural areas. However, this logic has not been shown to work in the case of nurses or dentists. Neither has it worked in a state like Karnataka, which has more than one doctor for every thousand people and is still churning out huge numbers every year. Even after offering adequate salaries, the Karnataka government states that it has been unable to find any takers for rural postings showing that throwing money at the problem might not necessarily work. In states like Tamil Nadu and Kerala, which too have a glut of doctors, it has not been as difficult to find doctors for rural areas only because both these states are highly urbanized (close to 50%) with a few pockets being really cut off from all amenities. Moreover many more of their doctors are products of affordable public education spread across the state.

Most health personnel do not want to work in rural areas for reasons that are fairly well known — lack of civic amenities such as roads, water, electricity, quality schooling for their children, residential facilities, safety concerns, poor health infrastructure and concerns about isolations from their peers and the latest advances.

While the government might be working towards improving rural living conditions and amenities, what happens to the health needs of the majority of the population living in rural India in the meantime? Across the world, and in India, it has been shown that students from rural areas trained to be doctors are more willing -- or at least have lesser resistance -- to serving in rural areas. Aiming at greater representation of students from rural backgrounds and residences in under-serviced districts, is just one of the many policy changes required to address the shortage where it is most acute. But there has been no policy of giving preference to rural students or regions with large HR gaps. If anything, the recent policy changes have made it even more difficult for rural students to access healthcare education.

As yet, the government has not even made an effort to study the representation of students from rural and regional backgrounds in every batch of medical students. This is despite the data on every single student who has gained admission into medical colleges being available with the government/MCI for each year. The data has not been used to inform policy. This government has spoken non-stop about digitalization and data driven policy-making. Yet it appears unable to even have a credible, publicly available database of all students doing MBBS.

The question that arises is whether the non-availability of data is deliberate, as the government does not want any close scrutiny of such data, which could reveal uncomfortable truths such as showing that medical education is almost entirely dominated by students from urban background and mostly from higher socio-economic categories. If such data was available publicly, public health students and practitioners could have analysed it to provide valuable inputs for the government.

Currently, there are two excuses being used by the government to ramp up privatization of medical education and to deregulate it by diluting norms and loosening oversight. One excuse is that of shortage of doctors and hence the need to produce a large number of them within a short duration or as soon as possible. Another is lack of funds with the government itself to invest in medical education and hence the need to seek private sector investment.

As far as the first excuse is concerned, as mentioned earlier, while there is a hurry to achieve numbers and targets, there seems to be little or no interest in addressing the actual problem of skewed distribution beyond the naïve belief that over-production will automatically address it. The private sector in hospitals, especially large hospitals and hospital chains, and those owning private medical colleges actively encourage the overproduction-as-solution theory. The private hospital sector, almost fully restricted to cities, realizes that doctors will continue to stick to cities. That would mean a glut in cities. That in turn would mean greater availability of doctors for these hospitals thereby helping them drive down doctors' salaries. And many of the government's policy inputs appear to come from this sector.
Private medical colleges, quite obviously, benefit immensely from a sort of blanket obsession with numbers. It would be detrimental to their interests if the government took a more nuanced view of the doctor shortage or looked closely into what kind of doctors the country needs. For private medical colleges there is just one concern - finding students rich enough to pay whatever fees they demand to fill the seats so that they can make good their investment. It wouldn't be in their interest to examine too closely if these students have the aptitude to become the kind of doctors the country needs.

This problem is exacerbated by the same mal-distribution across states. States with a high excess production of doctors continue to accelerate in the production of doctors, where states with huge deficits expand at too slow a rate. This despite clear evidence that movement of health professionals/ medical graduates from more economically developed states to weaker states almost never happens.

This also brings great misery to the graduating doctor. The government is unwilling to expand public employment and in the urban cities where these doctors are obliged to settle, the practice is so over-crowded, that many are in effect un-employed or under-employed and often reduced to making the greater part of their income from commissions and kick-backs. It also means a very poor quality of life where one has to stick to the practice every day of the year.

To the public this over-crowding means a much higher level of unethical care that is driven by the domination of kick backs and commissions, even where most unmet needs remain completely unmet.

One important legitimization of the drive to over-produce doctors and at the same time not create the necessary jobs in under-serviced regions lies in the claim that no doctors, nurses or dentists are available for government services in these over-producing states. Yet every junior doctors association and medical students movement would testify to the fact that at least half the graduating doctors are interested in public services- and within this would even prefer it- even if posted in rural areas. The reasons lie in recruitment policies that are 'designed to fail" even in states where compulsory rural posting is a mandate- like in Maharashtra. Not one state practices campus recruitment and not one state offers regular full time employment as soon as the complete their course. Further hostile workforce conditions like contracts that have to be annually renewed, delayed payment, arbitrary transfers and postings, delayed promotions, harassment on the job etc can be so high, that many doctors are just forced to drop out.

When it comes to all other posts- nurses, pharmacists, laboratory technicians, ANMs etc- the failure to create the necessary posts cannot be legitimized by lack of availability- but a variety of excuses are always provided.

**Does the government really lack funds?**

Coming to the second excuse regarding lack of funds to invest in medical education, the last two decades have shown that the biggest challenges in medical education are guaranteeing running hospitals with adequate patient load and ensuring availability of the required number of faculty. Private parties in medical education have struggled on both counts. Large blocks of buildings with or without the physical infrastructure required for medical colleges lying abandoned or devoid of patients across the country are evidence of this struggle, especially in the private sector, though there are a few such examples in the government sector too. In the case of the government, it has plenty of hospitals overflowing with patients even though officials blithely insist that people prefer the private sector.

The reason is quite simply because three-quarters of the population cannot afford private healthcare. In the case of the government, it also has the additional responsibility of providing healthcare to the people and it hasn't invested enough in provisioning of healthcare care, either secondary or tertiary healthcare through more hospitals or even primary healthcare through more sub-centres (now called health and wellness centres) or even primary health centres.

Thus, the running of hospitals cannot possibly be counted as an expense towards medical education alone. It is part of the government's job of providing healthcare. When a government hospital, for instance a district hospital, is converted into a medical college, it could get more doctors as faculty and better facilities and hence could offer better health services to people in those areas. Thus, the government could combine its responsibility to provide healthcare with that of providing quality medical education. Plus, the government needs to invest only the extra cost of adding facilities required for a medical college to an existing hospital unlike private players, most of who build hospital and college from scratch and look to make profits from both. About 157 such government medical colleges with 100 seats each are to be established in this manner adding at least 15,700 seats, but that is still not enough. Further there has to be a clear plan to locate all these regions in the states and within states, the districts/regions where there is a short fall.

Meanwhile, the Niti Aayog and some states like Maharashtra and Gujarat have been using this opportunity to push for establishing medical colleges using district hospitals through the public-private partnership (PPP) model, where the government will give its district hospital to be used as the teaching hospital for a private medical college. This is a clear cut case of handing over public health infrastructure to serve private interests. Though it is being couched as an answer to the government's lack of funds, it is in reality a way to save private investors in medical education from having to bear

the cost of putting up teaching hospitals and to solve their problem of not being able to get patients into their teaching hospitals.

India already has over 75,000 MBBS seats with roughly 50% of them in government medical colleges. The government plans to add about 15,000 more seats taking the total to over 90,000. Niti Aayog member for health and nutrition Dr VK Paul says the target is to have about 1 lakh MBBS seats. The urgency to achieve this target appears to be the reason for the rush to increase MBBS seats exponentially. If India created 1 lakh MBBS seats, would that automatically address the shortage? Or would it simply show an achievement of the minimum required according to WHO, the one doctor to 1,000 population ratio, on paper? It looks like the latter would be true, since the distribution skew would remain unaddressed, or worse, could be exacerbated. Also, would the government pay greater attention to quality of medical education once the 1 lakh target is achieved? Can we afford to overlook quality of medical education in the rush to achieve quantity? The current dispensation in the government seems to think so. They appear to think that achieving quantity is a more urgent need than achieving quality.

**Why NEET has failed:**

There is no dearth of students who want to become doctors. The number of students aspiring for MBBS seats far outstrips the available number of seats. For instance, over 13 lakh students sat for the National Eligibility cum Entrance Test (NEET) in 2019 for a total of 61,000 Seats. Over 10,000 students are estimated to be going abroad to study medicine when they are unable to get admission in a medical college here or because the colleges here, especially private ones, are unaffordable. With the profession of doctors being seen as an aspirational one associated with higher status and money, there is great demand for MBBS and the government has ostensibly tried to regulate the admission process to make it fair and 'meritorious' along with ensuring equity and access. The introduction of NEET was meant to address the problem of corruption in admissions including the payment of capitation fees.

While the admission process in most state-owned medical colleges has been largely above board and transparent, barring stray incidents like the Vyapam scam, most state governments and the Medical Council of India failed to regulate private colleges. Private colleges held bogus entrance examinations and sold MBBS seats for lakhs of rupees. They cleared MCI inspections by arranging fake patients and ghost faculty. Innumerable reports on such practices for decades, which MCI and governments failed to put a stop to, had the central government stepping in with a highly centralized entrance examination for all MBBS seats in the country, NEET.

From the Oversight Committee appointed to oversee functioning of MCI to judges of various courts who ruled on medical admission and corruption matters, all have claimed that there can be no difference between government medical colleges and private ones. This is a false equivalence. The two are different. In comparison to private medical colleges, there has been far less corruption in the admission process of government medical colleges. Private medical colleges have collected fees from students and then shut shop and turned them out on the street. In most such cases, large numbers of students had to be accommodated in government medical colleges because according to an MCI affidavit in court, "in private medical colleges... the clinical material is not as abundant as that in the government medical colleges... The government medical colleges... have abundant clinical material/inflow of patients, which is the most crucial aspect of the teaching and training of medical students." Moreover, while private parties can shut shop and walk away, the government cannot do the same and has not done it in a single case. Thus, it seems rather unfair to apply the same yardstick to government and private medical colleges.

By bringing government colleges within the ambit of NEET, the central government has upset the system in states like Tamil Nadu, which ensured that students from rural areas and poorer background got admission in government medical colleges. (However, Tamil Nadu turned a blind eye to the rampant corruption in its private medical colleges, many owned or patronized by state politicians). If corruption was the issue, NEET ought to be applicable to all private medical colleges which have been caught repeatedly gaming the system and to state government colleges of only those states which ask to be included in NEET.

If we are to accept the use of NEET, let's examine if NEET is achieving what it set out to do. NEET was to make medical admission fair, 'merit-based', accessible and transparent and to put an end to the sale of medical seats. However, NEET admission data shows that it has not achieved even one of these goals. It has simplified medical admission by replacing a number of state level entrance examinations with one single national multiple-choice entrance exam. One immediate consequence of this is a further big boost to the multi-crore coaching industry inaccessible to poorer students. Thus, right from the start, NEET privileges or gives an unfair advantage to those with the means to attend such coaching classes. One could argue that all entrance exams, whether state-level or a centralized one, give a boost to coaching classes.

The health ministry along with the MCI changed the system of percentage cut-off to percentile. Then they fixed the qualifying percentile so low that for just over 61,000 seats almost 8 lakh students qualify, a ratio of about 13 students for every seat. A look at admission data will show that ranks of those who got admission went down all the way to 8.45 lakh in 2019. If students with abysmally low ranks could get in, NEET's claim of ensuring merit-based admissions is obviously hollow.

It was also found that the higher the college fees, the lower the average rank of students who got admission, showing clearly how colleges go down the list of 'qualified' NEET candidates till they find ones who can afford the fees they charge. Thus, instead of a merit-based selection, it has remained a money-based selection, at least for most private colleges. Moreover, many of those who supposedly qualified (got overall marks within the qualifying percentile) got single digit marks, zero, or even negative marks in physics and chemistry. If it is alright for a student who got zero or negative marks in a subject to be qualified for admission, does it make any sense to test in those subjects at all? This is happening because the health ministry and the MCI have refused to fix a subject-wise minimum cut-off.

These issues have been brought to the notice of the health ministry and the MCI. Yet they remain unaddressed. The reason for that could be understood from what a bureaucrat in health ministry said - if percentiles are raised and subject cut-offs are introduced, private colleges might not be able to find students to fill the seats. "We surely don't want the private colleges to shut down, do we? That would not be in the interest of students as they will have fewer seats. And there is already a shortage of doctors." That explanation from a health ministry official to a newspaper means that private colleges will not be able to find students with enough money among the qualified candidates if the percentiles are raised. If only 3 lakh students qualify, it would mean a ratio of about five students to every seat and a percentile cut off of 78. Just 3 lakh instead of 8 lakh qualifying could reduce the 'demand' in this market for seats and hence force the 'sellers' to lower their price (the fees), as with any commodity (since that's what medical education has now been reduced to). So raising cut-off percentiles could lead to more 'meritorious' students qualifying, but would shrink the market for seats from 8 lakh to just 3 lakh. Clearly, merit is not the primary concern in the health ministry. Ensuring that private medical colleges can continue to charge exorbitant fees and still find takers for their seats appears to be the primary concern.

In their desperation to protect the interests of private medical colleges, NEET has become more and more opaque rather than going the other way. In the initial years, states put up the entire list of

NEET candidates from the state with marks, rank total score and percentile. Many colleges too put up such detailed lists of those students who got admission. After media reports exposed how students with abysmally low ranks and score got admission while those with much higher scores could not get admission in private colleges where the fees were too high, such lists stopped being put out in the public domain. And when the National Testing Agency took over conducting of NEET they started giving students only percentiles in individual subjects instead of actual score. Officials in NTA said that they had decided to do away with revealing the marks scored in individual subjects as it created a bad impression when students with single digit, zero or negative marks got admission. They are so worried about the poor scores coming to the knowledge of the public that even the students themselves are not given the individual marks scored in each subject. But they give the total marks scored plus percentile and rank. A majority of such admissions of students with abysmally poor scores happens in private medical colleges. The government agencies seem to be bending over backwards to protect the interests of private colleges and trying hard to keep this fact from the public.

It is up to the health ministry to clarify if the raison d'etre of medical education is to make good the investment of owners/investors in private medical colleges or to produce quality doctors to address the health needs of the people.

**Is the NEXT step obvious?**

Along with the corruption in admission into medical colleges, there have been reports of colleges, especially private ones, and in particular those which are deemed universities, fixing the exams so that even poor performers pass the final MBBS exams. Most of these colleges also have poor infrastructure and patient load and inadequate faculty. Thus, teaching and training in these colleges is sub-standard as observed by the Supreme Court in the case of RKDF Medical college in Bhopal. Yet, batches of students are being allowed to study and graduate from this and many other such medical colleges. This has raised concerns regarding the quality of doctors being produced, since 50% of MBBS seats are in the private sector. However, instead of fixing the problems in training, infrastructure and the corruption in the way exams are conducted, the government has decided that a final licentiate exam is the answer to all the problems - National Exit Test or NEXT.

This is what Dr Harsh Vardhan the union health minister said at a press conference: "We believe that instead of such physical infrastructure, the performance of students passing out from that college is a better parameter. Now, the colleges will be assessed on the basis of how their students score in the National Exit Examination (NEXT). The better the students of a particular college do, the better ranking it will get."

NEXT is supposed to be a licensing exam as well as an entrance exam for post-graduate courses in medicine. The exam is supposed to test a student's readiness to start practice. However, there appears to be little clarity within the government regarding the structure of the examination, whether it should be a theory exam or a multiple-choice one and whether it should have a component for testing clinical skills and if yes, what the format of such a test ought to be. It would be testing close to 75,000 students. There is no clarity on how many times a year the test might be conducted and how many times students can reappear for the test if they fail it. The government has also not clarified what happens to students who fail to clear the exam or to those who clear the exam but do not get a post-graduate seat and hence might want to re-appear.

Reports about corruption in examinations has been mostly in medical colleges which are deemed universities or which are affiliated with a private university (usually owned by the college management) or a private deemed university. Reports of corruption or malpractice regarding

examinations, including final MBBS examinations, conducted by state-run universities have been few and far between. Earlier, clearing the final MBBS examinations conducted by a state or central university was good enough for students to start practicing. That's being junked in favour of a centralized NEXT to be allowed to practice. Will it lead to MBBS students abandoning colleges to attend coaching centres to clear NEXT? Will it lead to greater or lesser attention being paid to clinical skills? There is no way to know these till we have a clearer idea of what the government has in mind. But what is evident is that the increasing corruption in medical education from accelerated privatization has been forcing the government to come up with more and more complicated, resource intensive, centralized, one-size-fits-all kind of solutions.

What is evident is that regulations meant to check corruption are increasing the cost of medical education in publicly funded institutions as they are being subjected to the same regulations. The ever-increasing crores of rupees having to be spent on regulation and endless litigation arising out of privatization might have been better invested in publicly funded medical education.
(A good article on NEXT read -https://thewire.in/health/nmc-bill-mbbs-exit-exam)

**Is the NMC an improvement on MCI?**

After years of promising to reform the MCI though amendments to the Indian Medical Council Act, the government decided to bring in a whole new law to replace the current MCI. The law drafted by earlier governments met with vociferous protests from the Indian Medical Association and doctors. Finally, a more recently drafted National Medical Commission Bill was passed by this government despite such protests, but after one major concession-- the dropping of a clause that would have allowed AYUSH doctors to practice allopathy in a limited way after doing a bridge course.

The fundamental difference between NMC and MCI is that while government-nominated persons will dominate the former, the latter had been filled with doctors elected from various state councils. The 108-member council, of which 70 were elected, has shrunk to a 25-member commission. The commission is supposed to deal with regulation of the medical profession and medical education. As far as medical education is concerned, the commission's mandate seems to be to deregulate it as much as possible and to ensure ease of business for private entities investing in the sector.

Using the inspector raj bogey, the new NMC is all for doing away with inspections as much as possible despite ample evidence that private colleges are notorious for flouting all norms for medical education. Though inspections during the MCI's time were infamous for corruption, the fact remains that most of the colleges deemed unfit by MCI inspectors later turned out to be just that. Many of these later shut down leaving students stranded. Yet this is what is in store in the health minister's words- "When a new medical college opens, it will have to self-certify that it is conforming to the standards laid down by the NMC. If the NMC receives a complaint that the college is not conforming to the standards as promised in the self-certification, the regulator will do an inspection." Who does the minister expect will complain? Not the management for sure. The staff would be unwilling to complain and face the prospect of the college being shut down and being unemployed. Similarly students too rarely complain about the non-availability of staff, patients or facilities as they are scared of losing the precious MBBS seat if the college is shut down. Usually, they complain only when colleges are not allowed intake after an adverse MCI inspection report and their chance of getting an MBBS degree from the institution is jeopardized. Otherwise, they are usually happy to just get the degree whether they have received proper training or not. Then who does the government expect will complain? And if there is no complaint, there will clearly be no inspection and things will be allowed to continue based on self-certification by the college management.

Unlike the UGC, the NMC has failed to include any provision to regulate working conditions of faculty and resident doctors and there's nothing on their salary or stipend. The IMC Act too had

nothing on these, which was cited by MCI to express helplessness over colleges not paying faculty or resident doctors decent and regular wages. Thus the oft reported and widespread problem of private medical colleges not paying their faculty and residents decent wages remains unaddressed and they can continue doing so with impunity with the new law offering no protection. It remains to be seen whether the NMC will bring in rules or codes to enforce what is not provided in the new law.

With the introduction of NEET, the government had claimed that selling of seats would come to an end. The ministry claimed that in order to help private colleges collect money to run them, on the seats controlled by the college management and those set aside for NRIs, managements would have to be allowed to charge much higher fees. The logic was that a majority of seats in private medical colleges in most states were in state quota or were seats for which fees were controlled by states. Through several court rulings, in most states, a fee regulatory committee stipulated fee ceilings for all seats in private colleges barring seats in colleges which were deemed universities.

In the NMC, the section on the powers and functions of the commission states that the commission only has the power "to frame guidelines for determination of fees and all other charges in respect of 50% of seats in private institutions and deemed universities". This is an improvement over the 2017 version, in which the commission was to regulate fees for "seats not exceeding 40%" in private medical educational institutions, but a dilution of the parliamentary committee's recommendations. The parliamentary committee had recommended that the existing fee regulatory mechanism by states for private colleges should not be diluted and had sought regulation of at least 50% of the seats even in deemed universities.

Several states argued for fee regulation. Odisha pointed out that under the Orissa Professional Educational Institutions Act, 2007, a fee structure committee headed by a retired judge regulates the fee charged for all seats in private colleges - 85% as state quota and 15% as NRI quota with the fee at four times what is charged for a state quota seat. Similarly, fees are fixed for 100% of seats in Himachal Pradesh, Haryana, Rajasthan and Punjab. Maharashtra too pointed out that its fee regulatory authority decided fees for all seats. Uttar Pradesh and West Bengal also objected to this clause. The AIIMS director told the committee that the fee structure suggested in the bill "would result in a decline in merit and creation of an economic reservation wherein the medical seats would be given to those who can pay a higher amount of fee instead of those who deserve them based on merit". This is what is happening in private medical education today, just as the AIIMS director had predicted.

Yet, the NMC can merely frame guidelines. Will guidelines stand in court when colleges challenge it? Why did NMC say guidelines instead of talking about mandatory regulation? The justification given by the government for restricting regulation to half the seats was that capping all fees would discourage entry of private colleges, thereby undermining the objective of rapid expansion of medical education. This is despite the fact that before NMC, colleges were already being subjected to regulation on all seats. Even with such regulations, fees across states have been steadily going up to the point where MBBS courses cost over Rs one crore in several private medical colleges. Yet again, the government appears more concerned about investors in private medical colleges than about medical education being affordable for students. To make things worse, the government is insisting on pushing up the fees in government medical colleges too in the name of making them self-sustaining and talking about helping students access education loans to fund their studies. Surely, we are headed towards a US model where students graduate with such huge debts that they would have to seek jobs with huge salaries to service the debt. Huge doctors' salaries will push up healthcare costs even more as it has done in the US. For healthcare establishments, especially private ones, those salaries will come at the cost of driving down the salaries of all other health personnel as is already happening.

Thus it appears that while there have been some changes with the coming of the NMC, most of them don't portend well for medical education or for healthcare in the country. NMC has failed to address most of the problems that plagued medical education during the regime of its predecessor, the MCI.

**Community Health Providers and the IMA's fears**

One major new inclusion in the Act is the clauses which allows for training and limited licensing to allow clinical practice to a newly created professional entity-called the mid level healthcare provider or the community health provider. The Indian Medical Association(IMA) is up in arms against this, and they label this as a form of permitting quackery. In deference to these protests allowing Ayush doctors as an entrance stream into this role was deleted- but otherwise the clauses remained.

It is a fact that many developing nations, and even a few developed nations do have such a mid-level healthcare provider in place. This form of healthcare provider is one successful approach to providing healthcare in areas where doctors are scarce or unwilling to serve, and in providing assistance to doctors even in other areas, so that the doctors are freed to attend to more complex duties. However most such nations which implement this, have a separate legislation and scheme for training and supporting such providers. There are such councils in place for nursing and pharmacists. What this act (NMC-2019) does is to hurriedly pack an entirely new strategy into the Act without even definition of what the term means, what qualifications these new cadre of providers would have, and how the government would ensure that they would be limited to the geographical area and to the set of services for which they are licensed and how they would ensure that these providers are working only within government. Without this clarity, it is quite likely that the IMAs dire warnings of this scheme degenerating into quackery, would come true, and we would have one more poorly qualified healthcare provider in urban areas, rather than a well trained public health extension worker, prioritized for areas which doctors cannot reach. It would be therefore essential that at least in the stage of framing the rules there is insistence on adequate definition, role clarity training and terms of service for this new cadre.

**Here is some more material to be attached with the paper**

This is a pretty comprehensive piece on how medical education has been privatized one policy change at a time. It gives a pretty good overview of the process over the last two decades.

https://timesofindia.indiatimes.com/india/how-medical-education-became-a-business-one-policy-change-at-a-time/articleshow/69709297.cms

Also see Frontline, August Issue for article on healthcare education policy:
https://frontline.thehindu.com/cover-story/article28259419.ece?homepage=true

Main Author: Ms Rema Nagarajan, Times of India,

With contributions from Sundararaman and others in resource team

## An explainer on the NMC

### What are the main differences between the Medical Council of the India (MCI) and the National Medical Commission (NMC) meant to replace it?

The roughly 108-member medical council was dominated by elected members while the 25-member commission will have a majority of nominated members, mostly nominated by the central government. In the council, barring eight central government nominees and one nominee from each state and union territory, the remaining almost 70 members were elected, by a university senate or by doctors registered with a state medical register/council. The Indian Medical Council (IMC) Act allowed for re-nomination and re-election of members. The NMC bill is silent on this aspect. According to the NMC Bill, half the members of the commission including the chairperson, i.e. 12 persons will constitute a quorum. In the MCI, 15 members were enough to form a quorum and all acts were decided by a majority of the members present and voting. The council had several private practitioners as its members, especially among those elected. The proposed commission too has no bar against representatives from the private colleges or universities being nominated to be members of the commission or the various boards. The council tenure was five years and that of the commission is four years except for part-time members for whom the tenure is two years. The council was supposed to meet at least once a year while the commission has to meet every quarter. The executive committee of the council which took most of the decision consisted of the president, vice-president and not less than seven and not more than ten members. The council had no jurisdiction whatsoever over statutory bodies like the various AIIMS and other central government institutions like JIMPER Pondicherry or PGI Chandigarh. For starting new courses, deciding on intake and on norms for setting up of an institution, these statutory bodies will continue to be outside the ambit of the NMC. But the Bill stipulates that all these institutions will take candidates through the same entrance exam (NEET) as other medical institutions in the country. Interestingly, the National Board of Examination (NBE) and the post graduate medical degrees it regulates have not been brought under the NMCthough such a provision was present in the first draft of the bill and was recommended by the Niti Aayog and the Parliamentary Standing Committee on Health that had examined the earlier draft bill of 2017. NBE will continue to function as a regulator outside the ambit of the main medical regulator in the country.

### Why is the NMC said to give short shrift to state representation?

The NMC itself has no representation from the states except for six part-time members appointed on a rotational basis from amongst nominees of the states. Since the tenure of such part-time members is just two years, each state will get a chance to be represented in the commission, roughly every 10 years. Similarly, the four autonomous boards-- the under-graduate medical education board, the post-graduate medical education board, the medical assessment and rating board and the ethics and medical registration boards-- consisting of a president, two whole-time and two part-time members under the commission, are constituted by the central government. Just one of the part-time members will be from amongst the elected members of the state medical councils. All central government nominees in the NMC and the boards are identified by a five-member search committee constituted by the central government, including just one person from amongst state nominees. The only representation that states get will be in the medical advisory council, the "primary platform through which states and union territories may put forth their views and concerns before the commission to help in shaping the overall policy and action relating to medical education and training". The advisory council will be chaired by the commission's chairperson and will include all 25 commission members and four nominees of the central government from amongst persons holding the post of Director in the Indian Institutes of Technology, Indian Institutes of Management and the Indian Institute of Science. It will include one member nominated from each state who is the vice-chancellor of the state's health university and one member from each state's medical council,

taking the total number of persons from states to 72, but only in an advisory capacity. Thus the commission members and chairperson will sit in the advisory council meant to give advice to the commission and then as the National Medical Commission they will decide on whether to accept the advice or not.

**Does NMC have any non-medico representation?**

The 25-member commission will have three part-time members "appointed from amongst persons of ability, integrity and standing, who have special knowledge and professional experience in such areas including management, law, medical ethics, health research, consumer or patient rights advocacy, science and technology and economics". There is also a non-medico is the search committee and one in the medical assessment and rating board from the field of management, law, economics or science and technology. The third member of the Ethics and Medical Registration Board is to be "a person of outstanding ability who has demonstrated public record of work on medical ethics or a person of outstanding ability possessing a postgraduate degree in any of the disciplines of quality assurance, public health, law or patient advocacy from any University" with experience in such field for at least 15 years. There are four central government nominees in the medical advisory council who are non-doctors to. Other non-doctors include bureaucrats such as the cabinet secretary and union health secretary in the search committee and a representative from the health ministry not below the rank of additional secretary in the commission. The secretary to the commission, also appointed by the central government, too could be a non-doctor as this has not been specified as a position for a person with a medical degree, merely a person with "proven administrative capacity and integrity, possessing such qualification and experience as may be prescribed".

**How is the NMC consolidating the Central government's control over medical education and the medical profession?**

To start with there is a preponderance of central government nominees and employees in the proposed medical regulator. Moreover, the central government is the appellate authority for almost all decisions taken by the Commission barring decisions of the Commission on appeal by a doctor against any decision of the Ethics and Medical Registrations Board. "The decisions of the Central government whether a question is one of policy or not shall be final," says the Bill adding that the commission and the autonomous boards shall be bound by directions given from the central government in writing to them from time to time. It also categorically states that the central government may give directions to the state government for carrying out provisions of the Act and that the state government will have to comply with such directions.

**What are some of the most glaring omissions in the MCI that the NMC Bill has addressed?**

The medical council's decisions were not binding on the state medical councils and even after the council upheld a decision to suspend a doctor from the medical register, the state council often refused to do so. However, the Bill clearly states that the Ethics and Medical Registration Board of the commission will "exercise appellate jurisdiction with respect to actions taken by state medical councils" on issues of compliance with the code of professional and ethical conduct.

The central government did not have direct powers to take action against the council if it did not comply with the provisions of the Indian Medical Council Act. The government had to constitute a three-member-commission of inquiry of which one member would be decided by the council. The commission could suggest remedies, which is not implemented the central government could amend regulations or take whatever steps necessary to ensure implementation of the commission's recommendations. That's why dissolution of MCI had to be done through an ordinance and any action against MCI president could be taken only if directed by court. In the NMC Bill the central government has the power to remove the chairperson or any member of the commission for several

reasons including if their continuation in office is prejudicial to public interest or the person has abused the position or has acquired financial or other interest that is likely to affect the functioning as a member.

Unlike council members, members of the commission will have to declare assets and liabilities at the time of entering office and when demitting office. They will also have to give a conflict of interest declaration of professional and commercial engagements or involvements and all of these are to be displayed on the commission's website. They will also have a two year cooling off period after their tenure by which they cannot take any employment in any capacity, including as consultant or expert in any private medical institution whose matter might have been dealt with by them directly or indirectly. This cooling off period can be waived off if permitted by the central government.

The council had no powers to regulate fees in medical colleges. The commission will be "framing guidelines" for determining fees on 50% of seats in private medical colleges. Since guidelines are not justiciable, critics have pointed out that this was as good as allowing 100% seats in private colleges to be unregulated. Currently, most states have fee regulatory committees to fix fees for medical education. However, while the council organized its own inspection of medical colleges using faculty from government medical colleges, the Bill says that the Medical Assessment and Rating Board can "hire and authorize any third party agency or persons for carrying out inspection" of medical colleges.

**Has the NMC dropped all references to bridge course and training of Ayush doctors to deliver primary care in an allopathic set up?**

Open reference to a bridge course for ayush doctors has been dropped. But it lurks in the reference to an annual sitting of the commission with the Central Council of Homoeopathy and the Central Council of Indian Medicine "to enhance the interface" between these systems of medicine. In such a sitting all the members present and voting can "decide on approving specific educational modules or programmes that may be introduced in the undergraduate course and the postgraduate course across medical systems and promote medical pluralism". The bill also provides for "Community Health Providers" (CHPs) who are defined as persons granted a licence to practice medicine at mid-level. Criteria or eligibility to become CHP will be defined through regulations framed under the Act. The Bill merely says that they will be persons "connected with modern scientific medical profession". Only limited licences will be granted for CHPs so that their number "shall not exceed one-third of the total number of licenced medical practitioners". Since there are an estimated 8 lakh plus registered doctors, the number of CHP licences could be as much as 2.7 lakh. CHPs are envisaged to prescribe specified medicine independently, only in primary and preventive healthcare, but at higher levels they could "prescribe medicine only under the supervision of medical practitioners ". The Ethics and Medical Registration Board is expected to maintain a separate register for CHPs along with all their recognized qualifications. Thus it seems that the bridge course details have been deferred to the framing of regulation stage rather than in the law, though the Bill clearly makes space for a non-MBBS practitioner at the primary health level or even at a higher level, if under supervision.

**What does the NMC Bill say about a consolidated Exit/licentiate exam for MBBS graduates?**

The bill states that "a common final year undergraduate medical examination, to be known as the National Exit Test shall be held for granting licence to practice medicine as medical practitioners and for enrolment in the State Register or the National Register". The designated authority to conduct the examination and the modalities of the exam are to be framed through regulations. The exit test is expected to become operational within three years of the NMC bill becoming law. The exit exam will be common for Indian and foreign medical graduates which is a long standing demand of foreign medical graduates who have been subjected to a screening test which no Indian medical graduate had

to clear. The bill envisages the exit exam serving as an entrance exam for post-graduate medical education in any institution coming under the ambit of this law. But the modalities of this exit-cum-entrance exam has been left to be decided at the stage of framing regulations. Counseling for post graduate medical seats will continue to be done by the designated authorities at the central and state level.

**What has the NMC missed addressing, which was missing in the earlier MCI too?**

The Bill says all state medical councils shall maintain and regularly update the state registers in specified electronic format. But for updating and maintaining a live register there has to be a stipulation for re-registration or re-accreditation of doctors every five years as is done in many countries. This was not stipulated in the IMC Act which made it impossible for many state medical councils to maintain an updated register as doctors refused to re-register saying that the IMC Act did not mandate this. The NMC Bill too has nothing on re-registration or re-accreditation of doctors. Some critics have pointed out that unlike the UGC which stipulates working conditions and pay for college teachers, the NMC has failed to include any provision to regulate working condition of faculty and resident doctors and nothing on their salary or stipend. The IMC Act too had nothing on these which was cited by MCI to express helplessness over colleges not paying faculty or resident doctors decent and regular wages.

**On how high MBBS fees leave many doctors in debt trap**

https://epaper.timesgroup.com/Olive/ODN/TimesOfIndia/shared/ShowArticle.aspx?doc=TOIPU%2F2018%2F07%2F22&entity=Ar01115&sk=BC5F499E&mode=text

# Saving and Strengthening Public Health Services

Soon after Independence, with the beginning of the planning era, the Indian state began with a clear commitment to invest in health services. The First Five Year Plan of India acknowledged health to be fundamental to national progress in the form of a resource for economic development. It recognised that "The development of the primary and secondary health units is of the greatest importance in providing broad-based health services to the community" and proposed to work in an inter-sectoral framework with a thrust on public provisioning through shared responsibilities among State and Central Government.

Bringing the global focus on persisting health inequalities between developed and developing countries and within countries, the Alma Ata Declaration (1978), of which India was one of the signatories, called on all governments to "formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors".

With health being one of the basic needs of the people, state has the prime responsibility towards provisioning of healthcare services. Concerns of access and equity are addressed only within a rights framework which is to be guaranteed by the state. While the earlier policy documents (Bhore and Mudaliar Committee reports) and the earlier Plan Documents and the first National Health Policy(1983) envisaged a strong role for the state and public sector, since the nineties the trajectory has been towards privatisation of basic services such as education, health, nutrition. Today the proportion of curative health services provided by public facilities is only about 30 % of all out patient care and about 45% of all in-patient care.

**Why Public Provisioning is Important - Evidence**

The rationale offered for privatisation is that the public health system is constrained due to inadequate funding, shortage of human resources, infrastructure shortfalls and weak management capacity and thus offers poor quality of services and is inefficient and unaccountable. And, as suggested by NITI Aayog, this can be dealt with by "leveraging the private health sector, to deploy resources and infuse greater efficiencies...". Thus, privatisation is considered an effective way to deal with these challenges and ensure "quality services".

However, contrary to such prevailing perceptions, studies have shown that private sector falters on many of these grounds. Through a systematic review of studies across low and middle income countries by Basu et al. (2012), results were organised into six World Health Organization health system themes, namely,

- accessibility and responsiveness;
- quality;
- outcomes;
- accountability, transparency, and regulation;
- fairness and equity; and
- efficiency

The review concludes that private sector delivery of health care in low- and middle-income countries does not come out to be more efficient, accountable, or effective than public sector delivery. In both

sectors, financial barriers to care, and poor accountability and transparency were a problem. The specific observations from these studies point out the following –

- providers in the private sector more frequently violated medical standards of practice and had poorer patient outcomes, but had greater reported timeliness and hospitality to patients
- Efficiency tended to be lower in the private than in the public sector, resulting in part from perverse incentives for unnecessary testing and treatment.
- Public sector services experienced more limited availability of equipment, medications, and trained healthcare workers.
- When unlicensed and uncertified providers such as drug shop owners were included in "private sector", most patients appeared to access care in the private sector; however, when unlicensed healthcare providers were excluded from the analysis, the majority of people accessed public sector care.

A recent UN Report of the Special Rapporteur on Extreme Poverty and Human Rights (2018) brings to light the evidence and experience with privatisation where it shows that privatisation has a negative impact on people living on lower incomes or in poverty. That is private provisioning is inherently discriminatory. It cites the study conducted by the National Audit Office (United Kingdom) which concludes that "the private finance initiative model had proved to be more expensive and less efficient in providing hospitals, schools and other public infrastructure than public financing".

The UN Report points out that "privatisation often involves the systematic elimination of human rights protections and further marginalisation of the interests of low-income earners and those living in poverty" and that "the existing human rights accountability mechanisms are clearly inadequate for dealing with the challenges presented by large-scale and widespread privatisation".

In 1992 World Bank 'proclaimed' that "There are virtually no limits on what can be privatised". After over two decades, in an evaluation of the World Bank's support to public-private partnerships across various countries over a period of ten years (from 2002 to 2012), it has been conceded that, due to large data gaps, it is difficult to assess how far PPPs have benefited the poor.

**India's Experience with Strengthening Primary Health Care**

The first few decades after Independence saw the development of a number of medical colleges and tertiary care centres - which was then essential to generate the human resources required. But these were largely urban in location. There was also a parallel investment in primary health care systems, but far less than required. The new nation was prioritising its core industrial and infrastrucure development, and the resources available for social development were constrained. But the bigger problem was that the work agenda of these networks were overwhelmed by a narrow focus on just two services - family planning and malaria control.

It was only at the end of the seventies - with the pushback of the family planning programme, subsequent to the excesses under the emergency and the resurgence of malaria, that there was a re-think on strengthening primary healthcare services. Internationally this was the same period when the Alma Ata declaration was adopted (1978) and India signed the international covenant on social, economic and cultural rights ( 1979) and the first National Health Policy (1983) was adopted. Under the 5th Five Year Plan and its minimum needs programme there was a period of expanding and strengthening primary health services. This period also saw an expansion of immunisation, and more comprehensive maternal and child care services being introduced. But this period was short lived.

By the early nineties, the commitment to primary health care, now reaffirmed by the Alma Ata declaration was again being undermined. This time it was due to structural adjustment policies and the subsequent health sector reform that pushed the concept of selective primary health care. It must, however, be noted that in India, selective healthcare was not introduced as a result of the World Bank inspired reforms. It was already there during the first few decades due to the family planning programme. But what changed during the nineties was how this selective health care was legitimised and IMR and MMR became the only measures of progress in healthcare.

In the late nineties and the first few years after 2000, there was deep dissatisfaction with rising costs of care and decreasing access to healthcare. This period also saw the emergence of peoples' health movements and the right to food movement which were able to bring back the agenda of strengthening public healthcare services within a primary healthcare approach into the public discourse. Thus, when a more liberal government with left support came to power in 2004, it led to the introduction of National Rural Health Mission and its limited but important commitment to strenghten public health services.

The National Rural Health Mission, launched in 2005, stated its objectives as providing accessible, affordable and quality health care to rural populations, especially vulnerable and underserved population groups. It acknowledged that along with increased investment, there was a need to improve the institutional design to improve effectiveness and accountability of public services. It termed this as "architectural correction, "to distinguish itself from the "health sector reform" of the earlier period. It elaborated this notion of architectural correction as consisting of a 5-pronged approach which included –

1. Flexible Financing: which included sanction of funds against annual district and state plans as well as a considerable part flowing as untied funds
2. Community participation: in the form of village committees, public participation in hospital and district committees, community monitoring programmes, more space for civil society participation and a nation-wide community health worker programme (the ASHAs)
3. Monitoring progress against standards: in particular the creation of Indian Public Health Standards
4. Innovation in human resource management: a major increase in ANMs and nurses deployed
5. Improved management through capacity: creation of posts with management skills, creation of management skills in existing staff and creation of new institutions that were designed for management and governance functions..

Thus, NRHM provided a broad-based structure and planning to achieve the objective of Health for All, addressing the key concerns of equity, access, affordability, quality of services, accountability, community participation. It saw a sharp increase in funds for public services as well as investments in health infrastructure and health work force, though all of this was about one-third of what was required by its own estimate. Further, the launch of National Urban Health Mission was pushed back by over 8 years and only a weakened version got sanction as late as 2013. This delay was because there were forces which had sought a private sector based approach for urban areas. In rural areas, the obvious lack of a private sector had been a strong argument for investing in public services but in urban areas that argument could not be made.

The central problem of the NRHM was, however, that it never broke away from the selective healthcare approach and remained centred on programmes such as RCH, TB, HIV and vector-borne disease control. Although NRHM talked of integrating these vertical programmes and did move in that direction, it was limited by the fact that these vertical programmes were externally funded. Because of this NRHM was called "an additionality to RCH and other vertical programmes". This was limiting the health systems strengthening agenda to that which was required for the success of

these narrow vertical programs focused on very few health conditions, rather than an overall health systems strengthening that could address all the major causes of morbidity and mortality. After 2010, the whole process of district planning and decentralization got further undermined and with it the commitments to architectual corrections. Also, although it was clear that additional human resources had been the key to many improvements, the workforce remained at contractual terms of employment and was never regularised.

By 2012, there was enough evidence emerging that the NRHM was making a positive difference and more investment towards systems strengthening would pay off. But there was also a relentless pressure to shift the discourse to one of routing all further public health expenditure through private sector and stigmatize the public system as inherently doomed to fail. After 2012, the investment in public services plateaued, and the discourse started shifting to the choice between insurance and other forms of engaging with the private sector. This shift was not necessarily because the NRHM was failing. On the contrary, it could have been due to the fact that it was in danger of succeeding.

**Constraints towards Strengthening Public Health System**

Some of the major constraints that have hindered the strengthening of public health system, over all these 70 years, and even under the NRHM are as follows. Concerted action on these would help save the public health system and strengthen it.

1. Decline in public funds/budget allocation for health

There has been a consistent decline in the funds allocated to strengthening public service delivery through flagship programmes such as National Health Mission. The share of funds dedicated to strengthening public health system has remained stagnant as proportion of GDP and is one of the lowest in the world. This has led to large inadequacies in infrastructure and in the lack of human resources and lack of access to essential medicines and diagnostics. The allocations have not kept up with the increasing requirements of the sector.

As the economic situation worsens, and the national security needs rise, the funds available for healthcare decreases. In such a context, diversion of funds from public health services towards insurance based model of healthcare through PMJAY, where the emphasis is on purchasing care from private sector, would further exacerbate the problem.

Starving the public health systems of essential funds is not by oversight. In part it is due to economic and political policy. But in part it is due to ideology, where the aim is to encourage private services and provide public services only as "residual care".. which is minimal care to those who cannot be pushed to the private sector, and provide such care on terms that it can be used to stigmatize public services.

2. Skewed Access to healthcare

The distribution of health care centres – sub centres, primary health centres, community health centres and hospitals is skewed. Those which are in place are not functioning optimally and are even in dilapidated conditions. Due to non-existence and non-functioning of adequate health facilities, the footfall in some facilities increases and increases the work load, which, in turn leads to sub-optimal services.

Further, there are also concerns about the inequity in access to healthcare whereby the vulnerable and marginalised groups are denied access. Such denials are higher in the private set up and hence private sector in inherently iniquitous. In a review of the SDG Agenda 2030 by a group of civil

society organisations, it has been that "privatisation and PPPs involve disproportionate risks and costs for the public sector and can even exacerbate inequalities, decrease equitable access to essential services and jeopardise the fulfilment of human rights."

3. Selective Package of Healthcare services:

The range of services available within district health systems, especially towards the peripheri – in primary health centres and health sub-centres has been far too narrow. Thus, a typical PHC provides care in normal pregnancy, immunization, and access to medicines for TB, malaria and HIV. These account for less than 12% of illnesses. For the rest it manages something called "general OPD" where minor ailments are treated and symptomatic treatment is given. All the rest are referred away. Almost all chronic illnesses thus get referred away, or worse is given some 'placebo' medicine of no value.

This is the core reason why there is a public perception of poor quality. Although rudeness, waiting times etc. are problems, the problem of not getting effective care for the illness is the big limitation. This is not the local providers fault, it is the way the system is designed. Thus close to three fourth of patients either have to go to a private provider nearby or be part of the over-crowding in the district or medical college hospital. Because of the resultant over-crowding in the centers where care is available, waiting times become very long, leading to very poor quality of care.

For the same reason so many emergencies crowd the public hospital, that doctors there are forced to do triage - make a choice between those who can wait a day for admission. These forms of poor quality are often addressed as if they are due to lack of accountability of salaried regular work-force. Which seems justified since providers working in such conditions respond irritably and unsympathically. But one can begin to address such issues only when one goes beyond accountability and sees the design flaws.

4. Human Resources for Health

One of the major constraints has been the availability and deployment of trained and skilled human resources. The NRHM did help in two signficant ways. First it brought about a million strong cadre of community health workers called ASHAs. This is remarkable because it happened in a context where the ideological mood and policy directive was still to keep the workforce small. But as the system became increasingly dependent on her services and as communities started appreciating and acknowledging her services, political pressures developed and most reluctantly and incompletely the process of making her into a regular employee started. It is only in a context of universal healthcare that her regularization will happen.

Secondly, central funding helped close the gaps between IPHS defined requirements and what exists in human resources at the level of PHCs, CHCs and DHs, especially with respect to nurses, ANMs, medical officers and some categories of management staff. This was owing to one of the principles of NRHM, *viz.* that facilities would be strengthened as per newly created Indian Public Health standards. This objective was slow to take off in many States due to lack of a pool of available nurses and doctors, and by the time it became available, the commitment to close such gaps with central financing had waned.

Also lack of government investment in publically funded institutions and encouragement of private institutions has led to a skewed growth in medical and nursing institutions, both geographically and in terms of health requirements of the populace.

The other big issues are getting doctors and specialists to work in public services, especially in rural and remote areas. The answers to how this problem can be solved are now well known and widely

practiced, yet most states prefer to articulate this as a rhetorical question and fail to carry out the administrative reforms and institutional changes that can address the problem. This also applies to HR issues related to motivation and performance.

Poor working conditions and inadequate remuneration across various categories of public health workers are one major part of the problem. But an equal problem is creating public salaried staff who see themselves as serving the community, rather than part of a colonial administration whose purpose is to control and regulate the population.

5. Quality of Care

NRHM framework has built in measures for quality control, whereby monitoring progress against standards was an essential component. The 12th Five Year Plan had noted that – "All government and publicly financed private health care facilities would be expected to achieve and maintain Quality Standards. An in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements." A National Quality Accreditation Standards (NQAS) has been built up, specifically to serve public institutions. But as of today less than 10% of facilities are so accredited and even sustaining this is a challenge. The institutional mechanisms needed to reach universal quality accreditation are so under-financed and under-imagined that clearly there is a lack of political will to make a success of it.

Reduced funds for the public sector have a direct bearing on this policy reluctance in ensuring quality in public health facilities. A universal quality assurance of public facilities would bring out large gaps in infrastructure, and human resources, and problems such as over-crowding, limitations of outsourcing services and poor mangement practices, all of which would require both funds and considerable process re-engineering to address.

The perception created that public health services are a 'residual services' only in the absence of private care has furthered the idea that quality of services in public health facilities need not be a priority. Public demands for improved quality of care are initiated by such a discourse. Introduction of user fees, whereby hospitals were asked to recover costs, was instrumental in pushing away middle classes and reinforcing the perception that free care is care for the poorer sections and is therefore 'poorer quality' is justified. Further the dominant discourse links quality to market choice, and user fees was meant to foster such choice. But as discussed earlier, the nature of health services is such that pricing and other market mechanisms do not contribute to better quality.

Generating an alternative discourse where the right to healthcare means the right to quality healthcare and where the processes of production of the services, especially the relationships within the team, and not market forces and choice is seen as the determinant of quality would be important to ensure quality in public health services.

6. Involvement of Community

The NRHM for the first time made systematic efforts in this regard by creating institutions that could anchor and facilitate community participation at every level. However in implementation, given the relationships of power within the community and in the government hierarchy, the levels of community participation are far below what is required.

Active participation of communities through Village Health Sanitation and Nutrition Committees (VHSNCs,), Rogi Kalyan Samitis ( RKS) have great potential. To realize this potential one needs more democratic norms for representation, measures to build capacity, a delineation of powers,

functions and finances that is aligned to the systems context. One also needs to provide a greater role for elected local governance bodies.

Community based monitoring, as done by VHSNCs with facilitation from NGOs, has also shown positive results. But again, as with many such initiatives under NHM, these need to expand in scale and in scope.

At the level of district and state, and national level representations and roles for civil society organizations, active on health issues, is essential. This requires professionals and activists who have the capacity to speak on behalf of peoples' requirements and who are alert to pressures from corporate agencies and other vested interests. One needs a consultative process to select such persons. The political will to include such persons at the higher levels is quite a challenge.

7. Lack of Decentralised Processes

Although the importance of decentralised planning is recognised in theory, in practice it is most often top-down planning that prevails. In many cases, the needs of the community are not decided by the community but enforced from officials. There are a number of bottlenecks to successful district level planning.

One is the lack of capacity that is relatively easy to overcome. One dimension of this which is more of a challenge is need-based budgeting especially at the district and sub-district levels, based on good quality epidemiological and service delivery data and a proper analysis of unit costs. But the biggest challenge remains to make sure that process of public financing of service delivery and health systems strengthening are responsive to district plans that have expressed the varied needs, the differences in capacities and utilization of services, and equity considerations. Fund flows are neither timely nor responsive, and process of expenditure and accounting are so cumbersome and intimidating, that even when funds are provided as untied lump sum there is poor utilisation despite overwhelming needs and a complete dis-incentivization of all local innovation. The cobweb of rules and restrictions and the processes of auditing are often defended as necessary to prevent corruption. But the truth is that corrupt environments are so rule-dense that no file moves unless a consideration is paid, and every honest officer is almost at equal risk, since all dynamic action would require some transgression of rules. In such an administrative environment, the top-down always wins.

8. Accountability

There are many levels of social accountability and there is a need to examine each of these institutions and their effectiveness.

At the highest level is the legislative where the minister is accountable to parliament or state legislatures. The judiciary and the auditor generals' office are also important avenues of accountability. However these bodies are too distant and have time to attend only to the larger questions of policy and key failures of governance. Therefore, for effective service delivery in a context where market forces are not in play, one also needs robust mechanisms of accountability at the levels of service provision and mid level managements.

Recent efforts at increasing accountability have therefore focused on creation of participatory structures, with participation from community based and other civil society organisations to ensure accountability. For instance, this was one of the functions of Rogi Kalyan Samities (RKS) and Village Health and Sanitation Committees (VHSNCs). However, these structures have often got dominated by a few. Proper elected representation is one of the keys to ensure accountability.

A further push to accountability can be through ensuring community based monitoring and social audits. Making social audits part of a regular mechanism would help ensure accountability of the structures to the people.

Another key element of accountable systems is transparency. Many categories of information, which do not impinge on privacy and confidentiality, should be available for public review. Forums with dialogue and response to queries from the public are also important. Access of information to media and a non-sensationalist, serious journalism would also go a long way to ensuring accountability of public health services.

9. Transparency in procurement and appointments

Corruption is one of the major challenges that public services face. To understand the pervasive nature of corruption one must conceptualize it as a relationship of power and heirarchy, where persons in power seek rent from those below them. The dysfunctional systems that result and the complete lack of transparency are a consequence of this relationship of power and rent.

One of the areas where corruption is rampant is in procurement of medicines and equipment. Tamil Nadu initially and now Rajasthan and Kerala have shown how this could be completely avoided and further how it assures quality of drugs at much lower costs and almost completely eliminates stock outs. If most states have failed to follow this, and their facilities continue to face stock outs, the likely cause is vested interests that gain from a dysfunctional system.

Another important area of concern is lack of transparency in the appointments of various officers at different levels, be it chief medical officers or district level health officers. The postings and transfers of officers are also marred with corrupt practices. States like Karnataka, Tamil Nadu have put in place systems of transparent declaration of vacancies, seniority lists and then a transparent proces of counselling by which the posts are filled.

A third and now growing area of rent-seeking is in the contracting of services to private agencies. This leads to weak contracts and non fulfilment of contractual terms and inappropriate choices of service agencies. Where management of public services is compromised, privatization seldom solves the problem. It would be more likely to worsen it.

**Emergence of Ayushman Bharat**

There is a clear trajectory of increasing private sector involvement in the provision of health services; as envisaged under the National Health Policy 2017 and as being implemented under Ayushman Bharat. The recently announced Ayushman Bharat has two components – the Pradhan Mantri Jan Aarogya Yojana (PMJAY) and Health and Wellness Centres (HWCs)

Pradhan Mantri Jan Aarogya Yojana: The Government has been projecting the PMJAY as a path breaking scheme. However, the design of the scheme is largely based on its predecessor the RSBY which had been fraught with number of problems and had limited spread. The 92nd Parliamentary Standing Committee had recommended that the Government should form a Committee to analyse the failures of RSBY and ensure that inadequacies plaguing the operation and implementation of RSBY are not repeated. Further close to 15 states already had state funded insurance schemes for the poor, that PMJAY absorbs into itself, in return for paying part of the premium.

PMJAY intends to cover nearly 10 crore families. Each covered family will get free hospital care up to Rs. 5 lakh in a year. The families will be identified as per the Socio-Economic Caste Census (2011). Private and public sector hospitals will be empanelled to provide services under this scheme and

there would be Viability Gap Funding provided to private hospitals to set up facilities in Tier2, Tier3 cities. The funding of this scheme is in the form Centre-State sharing in the ratio of 60:40. NITI Aayog advertises this scheme as "business for private sector" While most States have joined the scheme, adapting their existing government funded insurance scheme for the purpose, four States have refrained from it.

The scheme by design does not cover out-patient or ambulatory care, which accounts for most of out of pocket expenditure.
Potentially if public funded insurance programmes effectively eliminates catastrophic health expenditure, reduces out of pocket expenditure on hospitalization and increases access to secondary and tertiary care that is not available in public hospitals, it would be a useful addition. But then it would in all likelihood remain a small but important supplement to public services, not a substitute for it. But that clearly would not be compatible with the the ideology of privatization. It is in this context that we must review the current experience with public funded insurance programs.

*Issues & Challenges with Insurance-based Model:*

The PMJAY is as of now only a little more than a year old. Hence it is difficult to comment on its effectiveness. However since it is largely based on the design of earlier government funded insurance schemes, we present below the main problems noted with such programmes.

- Most of the claims have been made in the private hospitals. The share of public hospitals is low and often declines.
- It is not clear whether access under the scheme, supplements or substitutes for existing public health services. A large number of cataract surgeries, normal deliveries, C-sections which were hitherto happening in public hospitals has shifted to the private sector at much higher costs to the system, often undermining public hospital capacity
- Most claims are from private hospitals operating in cities rather than in remote areas, which effectively means a greater allocation of funds and benefits to urban patients.
- There is enough evidence that much of the utilization of services is due to unnecessary care and supplier induced demand. Not only is it wasteful, the existing unmet needs for services may remain. Providers cherry pick services where margins are favourable and refer away the rest.
- Exclusion: Patients from marginalised vulnerable backgrounds are turned down or their use discouraged by empanelled hospitals. Most of the hospitalisation reimbursements are made by the upper income quintile
- The private sector has been demanding/negotiating higher package rates
- Not all private hospitals are empanelled. There are a mix of formal and informal methods that limit empanellment favouring the larger hospitals. Some of this is done as a way of controlling spiralling expenses on this scheme. The distance of the empanelled hospital from the patient's home becomes a factor that discourages beneficiaries. Patients are often not aware of which hospitals are empanelled. Those who are empanelled will get a competitive advantage over those who are not, which leads to monopoly, and as mechanisms are not transparent it would lead to cronyism. The PMJAY may be different in this aspect, but that remains to be seen.
- But perhaps the most damaging observation from a host of studies is that the rates of catastrophic health expenditure do not decrease. A recent comprehensive review on various studies related to RSBY (Prinja, 2017) revealed that in majority of studies (8 out of 14) there was increase in Out of Pocket Expenditure related to RSBY. A WHO (2010) analysis estimated that up to 40% of health spending globally is wasted, with insurance fraud being a high contributor

- Even where there is no fraud, multiple layers of intermediaries under insurance programmes lead to huge administrative costs and avenues of profit.

  One aspect of PMJAY and publicly funded insurance schemes is whether they have any positive impact on public hospitals, or on the few pro-poor not for profit hospitals. There is no clear evidence of it either way. Some public hospitals with limited budgets have been able to offer larger number of high cost procedures which otherwise they would have to charge since it did not fit into their budgets. Given the non-responsive nature of public financing, such insurance payments are much more responsive. Potentially therefore it can increase the range and quantity of services provided.

  In practice the problems are as follows:

  1. Payments to public hospitals are much more delayed and incomplete leading to a stress on planned budgets
  2. When reimbursements/earnings are shared within the public providers, some of the private sector type behaviours related to unnecessary care, cherry picking and exclusions start appearing.
  3. Many of the gaps related to both quantity and quality of services relates to infrastructure and human resources. But money from insurance transactions does not lend itself to use on such investment. However it can lead to cutbacks in budgetary funding since insurance is seen as a source of income.
  4. Patients may also game the system by not revealing their insurance coverage. Because anyway they are eligible for free or subsidized care, they would like to reserve their sum assured for when they may need insurance care.
  5. Insurance based funding of public hospitals can mean legitimization of user fees and cost recovery for those who are not beneficiaries. But this would run counter to the core purpose of moving towards universal health coverage.

Health and Wellness Centres: This component of Ayushman Bharat intends to upgrade all health Sub-Centres and all primary health centres into 1.5 lakh Health and Wellness Centers. This component tries to make a transition from selective healthcare of the past into a comprehensive set of health care services. Further it aims to provide continuity of care which means the necessary referral support and population based care.

As of now, some 20,000 centres are reported as upgraded into HWCs. These are early days, but from current observations a number of problems are noted:

- The current list of services under the HWC is not comprehensive enough. In implementation often it is just the addition of two or three screnning for NCDs.
- The budget allocated for upgrading the SCs to HWCs is grossly inadequate
- The need for greater emphasis on preventive and promotive services is under-played.
- The most common distortion is to equate the HWC with appointing a mid level health care provider. The rest of the team is not in place and not even planned for. There is neither a clear work distribution, nor the requisite training for the others.
- Continuity of care in terms of referral support is weak.

Although these problems of HWCs could be overcome, there is concern on whether much of this is mere tokenism, or whether there is serious implementation and adequate financing for this second component of the Ayushman Bharat.

## Ayushman Bharat: Health and Wellness Centers:

The design, the many variants and the key barriers- and what people's movements should do about it.

1. **What are Health and Wellness Centers?**

This component of Ayushman Bharat promises to upgrade health sub-centers and primary health centers into what is called health and wellness centers. The target is 1.5 lakh HWCs, which is roughly equivalent to the total number of sub-centers in existence (1.46 lakhs). Each sub-center caters to about 5000 population. In tribal and hilly and desert areas it could cater to 3000 population or even less. This target of 1.5 lakh HWCs would, according to the government, be achieved by 2022.

Health and Wellness Centers differs from both the existing sub-centers and urban dispensary services and even the primary health centers in four important ways:

a. The primary healthcare services available to households in that area are comprehensive- NOT selective.
b. All the services are organized in a manner that ensures continuity of care. There are two types of continuity- if a patient with chronic illness comes in periodically, the center is equipped to provide follow up and medication so that the treatment can be continued without a break 365 days of the year. And secondly –vertical continuity between the primary healthcare provider and the consultant/specialist/doctor at the higher levels. For most illnesses, the doctor or specialist will see the patient and confirm the diagnosis and make a treatment plan- and then the treatment is continued by the service providers in the HWC
c. The services at a HWC are delivered by a team- ideally of at least one Mid Level Healthcare provider or doctor plus two female multi-purpose workers and one male multipurpose worker plus about 5 ASHAs( community health workers).
d. The services are population based- not limited to individuals. The doctor in a urban dispensary, like a Mohalla clinic, or the usual general practitioner in private practice feels responsible for those who sought their care. But a HWC is responsible for the health of the entire list of households/individuals assigned to them, those who are usually resident in their area. Thus children or adults who are at risk, and the population who need preventive services like screening for common cancers even if they appear well.,

2. **Why is this such a big thing. Was this not what primary health centres were always mandated to do?**

A. If we are referring to the Alma Ata declaration, the answer is yes. This was exactly what primary healthcare was meant to be. However if we are referring to currently existing primary healthcare facilities and even the healthcare policy since 1993- the answer is a big NO. Sub-centers and PHCs fulfil the criteria of continuity of care and being population based for only a very selective package of services- typically immunization, and care in pregnancy, contraceptive services and care in tuberculosis, HIV, malaria and leprosy. To some extent for cataract blindness also. This accounts for only about 10 to 15 % of all primary healthcare needs. For the remaining 85% of health care needs there are NO services at the primary level- or at best very sporadic, one time consultations with no arrangements to ensure continuity or compliance or control. Under the re-branding of this concept as HWCs, there is a potential to bring back the full notion of

primary healthcare. Even within the understanding of achieving universal health coverage, the HWCs would be the main strategy.

B. Even the current list of services under the HWC is not comprehensive enough. But it makes for a big start. The 12 services listed for delivery by HWCs are as follows:
    i. Care in pregnancy and child-birth
    ii. Neonatal and infant health care services
    iii. Childhood and adolescent health care services.
    iv. Family planning, Contraceptive services and other Reproductive Health Care services
    v. Management of Communicable diseases including National Health Programmes
    vi. Management of Common Communicable Diseases and Outpatient care for acute simple illnesses and minor ailments.
    vii. Screening, Prevention, Control and Management of Non-Communicable diseases
    viii. Care for Common Ophthalmic and ENT problems
    ix. Screening and Basic management of Mental health ailments
    x. Basic Oral health care
    xi. Elderly and Palliative health care services
    xii. Emergency Medical Services

The first five of these are already on the existing health sub-centers and Primary Health Centre mandate. The Health and Wellness Center adds the other 7 services also.
Since most Primary Health Centers (PHCs) are also not providing these services, by including these in the list the government is making the point that these too should be capable of providing this list of services. The PHC would not need additional human resources if it has the level mandated by Indian Public Health Standards (IPHS), but it would need to organize its service delivery better.

**3. Primary Health Care is about preventive and promotive services. But this above list of HWC services seems dominated by curative care.**

a. The emphasis must remain on prevention and promotion. Inter-sectoral action on environmental and social determinants will be limited to what can be done at the level of the village through village health, sanitation and nutrition committees (VHSNCs) and with respective departments taking a lead role in their areas of accountability. Public health tasks such as vector control continue without losing emphasis. This has never been questioned nor have they been in doubt.
b. But what is added on now is "secondary prevention". The early detection of diseases like hypertension and diabetes through screening programmes and appropriate treatment is what saves lives in a large number of non-communicable diseases. Even in chronic communicable diseases like TB, HIV, leprosy,etc, early detection and appropriate treatment has a major preventive role. So it is quite misleading to think of preventive and curative as being in two separate silos in a public health care system.
c. Establishing such secondary prevention as part of primary health care would also give urgency to primary prevention in terms of reduction in exposure to risk factors. This would include change in diet, increased exercise, better life styles, reduced use of tobacco and alcohol and such factors. Currently very little happens in many elements of such promotive care.
d. This is not to diminish the importance of how economic policies and development policies act as determinants of ill health. But building awareness for policy changes in development policies at the state and national levels must be accompanied by and

would be reinforced by local action to ensure the above elements of care as individual entitlements.

4. **The government claims that they now have about 7500 to 10,000 HWCs that are functional. Are the HWCs on the ground similar to what is promised? Or like the way the Alma Ata declaration of primary healthcare was reduced to selective healthcare, are there major deviations from the conceptual framework when it comes to implmentation? The World Bank and other international aid agencies and global health institutions played a key role in reducing the Alma Ata declaration to selective primary health care. What are they upto now.**

**Response:**It is important to note that the conceptual framework on which HWCs is based is part of a progressive framework on comprehensive primary health care that has evolved over many decades and which peoples movements have contributed greatly to shaping. Therefore there is great urgency for peoples movements to be alert to deviations that trivialize or divert from the main objectives and call out/expose such deviations. Otherwise a government that is reluctant to implement the HWC concept in full will make use of the discontent with HWCs as implemented to scuttle the whole concept itself.

Some of the main deviations and distortions in the implementation of HWCs are listed below:

**A) Distortions related to what services are provided in the HWC:**

i. Instead of comprehensive primary healthcare, just one or two NCDs- usually hypertension and diabetes is added into the selective package. There is no effort to move to other services at all. In some states, even for hypertension and diabetes only screening and an unstructured referral up is done. There is no feedback from the referred doctor/specialist and no effort to ensure access to medication and follow up tests throughout the year at the HWC. In some states, it is even more cynical and HWCs have become only a branding exercise. A new coat of paint is given, the name of the center is changed- but no expansion of services occurs.

ii. In some states the focus is yoga. The scheme does see yoga as an important element of promotive health- and as one element among many there is case for it. But it certainly should not be the central or main agenda, displacing the other core services that HWCs are meant for. Any efforts to expand infrastructure in terms of yoga halls etc would be a distortion of priorities. There are many local administrators or officers who may take this path- since there is much less work involved, and it can distract from the main purpose,and since there is money that can be made in infrastructure.

iii. Improving infrastructure is one important element- but it is not and should not become the central component.There are examples where the entire emphasis is on beautifcation- painting the walls, putting ceramic tile flooring, re-building rooms and toilets etc. Part of this happens because this is what local administrators have understood the program to be. A more negative view would be that this happens because there is more opportunity to spend and to make money in infrastructure activity.The real danger is that equating upgradation to HWCs with improved infrastructure, would lead to a betrayal of expectations. Worse, when after all this expenditure, utilization does not go up, it would become another argument to favor privatization. The reasons for poor utilization lie in the lack of appropriate services – not in the lack of ceramic flooring.

iv. In some states the attention is given to starting up a general out-patient clinic and providing medicines and even some diagnostics in it. This helps, and like in the Mohalla clinic, can even be welcomed. But without the continuity of care

for chronic illness, without the population based coverage, without the referral platforms, it will not make much of a difference. The initial welcome will soon go away because people will have to go in search of better care for their healthcare needs than what such a clinic can prepare.

v. In most states, the feeling is that we should proceed gradually to add services to the package. But gradually based on what? Now the entire healthcare system waits for central directives before any service is added on. However, there is no reason to deny any service from these 12 service areas if there is a suitable specialists who is available to confirm diagnosis, make a treatment plan and communicate it to the the staff at the HWC, and then also be available if there is any complication

**B) Distortions related to Human Resources:**

a. The most common distortion is to equate the HWC with appointing a mid level health care provider. The rest of the team is not even thought about or planned for. There is neither a clear work distribution, nor the requisite training. The mid level healthcare provider alone cannot make a difference.

b. The other common distortion is to understand the mid level healthcare provider as a substitute doctor- because doctors do not go to rural areas. In most or all chronic illnesses the doctor or specialist is not substituted by the MLHP. Once the diagnosis is confirmed and treatment plan made by the doctor, the MLHP would , with the help of the team, ensure follow up Related to this distortion, is the failure to design training programes that enable MLHPs and the rest of the team to play this role.

c. Another problem is the debate about whether the MLHP should be a B.Sc nurse or a GNM nurse, or an ANM or an AYUSH provider, or a three year new graduate. Can dentists and physitherapists be allowed to become MLHPs? This debate diverts us from the main features of a MLHP- which should be a) he/she should be of that locality/block/district and happy to be working there b) he/she should be trained close to their place of work and preferably in state language using standard treatment protocols – and this training should be a periodic life long process c) that he/she should be conditionally licensed only to work in primary health care within government institutions- and not to become private providers- which means that even at the time of recruitment into the training, their employment position should be assured and d) one would need them as part of a permanennt workforce- and not on an ad hoc contractual basis. E) they should always be working under the supervision of doctor/doctors in the public health system. It does not really matter which allied health professional or nursing qualification they have to begin with. If these five conditions are fulfilled, they would play their role- and if these are not, whatever their qualification they would not be able to work.

**C) Distortions related to continuity of care:**

a. The most common distortion is a complete failure to plan for the link with the doctor/specialist who shall recive the referral confirm diagnosis, make the treatment plan and rule out or manage complications, and communicate to the providers in the HWC- all according to a standard treatment protocol.

b. The other common distortion is to assume that the providers empanelled with PMJAY will take care of this referral function. Not only does the PM-JAY not provide for such consultation, the incentive environment for the PM_JAY hospital is not to promote preventive care and avoid or delay the need for procedures . Rather, their interest is in increasing the number of secondary and tertiary care opportunities they have.

c. A third distortion is to grossly underestimate the quantity of medicines required to provide continuity of medication and diagnostic support to patients with chronic illness. Thus, even if all persons with hypertension in a community were taking only one tablet per day, a population of 5000 with about 10% of those about 30 years having hypertension would need close to a lakh anti-hypertensive tablets. There is little effort in understanding and organizing the logistics for such increase in access to medication. The same goes for diagnostics. If the government is serious about HWCs as the route to UHC and of the promise to free drugs and diagnostics, it can certainly manage this.

**D) Distortions related to Population Based Care**

a. Most HWCs still limit population based care to immunization, pregnancy, tuberculosis. There is no commitment to seek out those who have not been screened, or those defaulting on taking medicines, or those not taking care for complications etc. But ASHAs should make household visits that ensure this. And there has to be a system of documenting the health needs of different families and individuals and being able to follow it up. For example, a HWC team would know what proportion of population at risk have been screened for hypertension or diabetes, what proportion were confirmed to have that disease and how many of these are registered with the HWC for regular care, and finally in what proportion of them was hypertension controlled.

b. There is no allocation of households to each HWC. This problem is most ….in urban areas. In rural areas there is at least an implict understanding. That would further mean that every household and individual would have a health card that indicates which is the HWC that is closest to their residence and to which they are attached. That card would also help support access for their health needs if they have any health risk or chronic illness.

c. All of this would be greatly helped if the right ICT tools are available- but ICT tools and smart cards are not a substitute for the team building and coordination that is required. One distortion of HWCs is to equate it with introduction of ICT and smart cards. Often ICT tools add an additional layer of work for the overburdened providers without enabling local planning or decision making. Good ICT design should decrease the burden of data collections and reporting of the HWC providers. It will take quite a while to use UHC app (ICT tool) appropriately- and HWCs need not wait till then to expand the services they provide.

d. The defnition of population should include all households and individuals usually resident in that area. Even three months residence in a year should be counted. No exclusions based on ID documentation should be permissible- since healthcare is an inalienable human right. Special care must be taken to ensure that migrants and seasonal workers are included.- And if they are from another place in Indiathe continuity of care should be assured. If a person not usually resident in that area seeks care, that care should be provided. The only difference is that there is no assurance of follow up at household level to ensure compliance.

**5. What should be the popular demands that peoples health movements should make at the level of the village/urban poor?**

There is a need for popular campaigns to demand the following as an entitlement:

a. Any person with a chronic illness who needs to take medicines every day, or very often for the rest of their lives would be able to get their medicines in the sub-

center(HWC), free of costs. This is a long list. It includes medicines for hypertension, diabetes, angina, mental illnesses, epilepsy, asthma, chronic obstructive pumonary disease, arthritis- just to name some of the most important ones.

b. If any person is detected with any of these illnesses when he or she comes for a visit for any other illness or a health check- up, they would be entitled to a reference for confirmation at the higher level (facilitated by the HWC) and they would have a treatment plan made by the specialist- with some elements of routine follow up being provided at the HWC.

c. Every person over 30 years would be actively screened at the HWC once a year for diabetes, hypertension and once in three to five years for chronic illnesses like cancer cervix, breast and oral cancers. If they are suspected of having the disease, they would be referred to a higher center and have the diagnosis confirmed and a treatment plan made. Similarly all newborns have to be screened at the place of their birth. All pregnant woman are already being screened.

d. There should be an out patient service on all 5 days of the week in the HWC- so that a much wider range of acute simple illness can be treated. This would include fever, acute respiratory infections, common infectious diseases etc.

6. **What should be the demand of peoples movements at the level of policy, advocacy and agitation? What should peoples movements be alert about with respect to pressures from international donors and corporate India?**

    a. There is a great danger that the HWC can turn out to be another jhumla. The real push is on PM-JAY, while the HWC is only for show- to give the appearance of a evidence based progress towards UHC for public consumption and for international agencies like the UN. There are two key indicators of whether it is jhumla or a real action on the ground. The first indicator is the financial resources allocated to it. The second is the human resources policy.

        i. Financing : By the governments own estimates it requires about 9 lakhs recurrent and 8 lakhs non recurrent expenditure- additional to what is currently spent on sub-centers and PHCs. This is a serious under-estimate – but even if we use this figure the allocation would be 13,500 crores per year or 65,700 crores recurrent plus 12,000 crores non-recurrent or about 77,000 crores over 5 years. The actual amount needed, if full HR and medicines and referral costs are included is likely to be at least twice that. But that would be about 1 % of GDP- a reasonable estimate. In the current year the allocation was only 1600 crores. In the previous year, the allocation was notional.

        ii. Matching Human Resources Policies: The HR policy needs to provide resources for hiring the entire team, plus the ASHAs on a regular basis. And also we need to create HR policies which enable us to overcome the very skewed availablity of human resources. Very often the governemnt starts by stating that other than increasing HR, one can consider all options. Which means negating the whole program.

    b. There is a need to identify distortions of the concept and build public and even provider understanding of what comprehensive primary health care means. Equating these distortions with HWCs would lead to loss of credibility regarding the whole idea of primary health care - and HWCs would be quietly shelved or reduced to some token level- while all the media attention etc. is focussed on the insurance scheme. An alert peoples movements and a democratic polity has a choice in how it goes about its protest ; It can demand that HWCs ought to be developed without these distortions, as the route to comprehensive primary health care and expose efforts that deviate, distort or trivialize the scheme. OR it could be dismissive of

HWCs and thus add to the energies that for a variety of often varied reasons, call for ignoring if not scrapping the scheme. The PM_JAY is in no danger of being ignored- and there would be an active lobby of healthcare industry very ready to support and shape it. Every single media channel, newspaper and periodical, especially those specializing in health care, would be watching it roll out. ( PMJAY covers journalists also). Comprehensive primary health care, on the other hand, does not attract such attention or support. It has no support except sections of the health policy community and peoples health movements. What peoples health movements do would therefore be critical.

c. The other big danger is the push to outsource clusters of HWCs to the private sector- and within that to the corporate sector. The BMGF ( Bill and Melinda Gates Foundation) has a number of pilots and intiatives to do just this. BMGF currently leads this effort. USAID too actively supports these intiatives. Swasthya Piramal, Tata Trusts, Apollo Hospotals/enterprises are major corporate players who are interested in developing such models. The World Bank is more focussed on PMJAY. Niti Aayog has been pushing for private sector participation in HWCs - and has included a commitment to outsource at least a proportion of HWCs as part of the mandate of Aysuhman Bharat. There are also efforts to push part or all of HWCs into the National Health Authority and/or fuse it with the PMJAY platform in the name of integration. In all of these models the aim is to create a network of private providers linked to a corporate entity, which the government would contract in. The corporate agency will then engage the private providers either as a sub-contract or as employees. Till date, this approach has not succeeded. This lack of success is partly due to good sense prevailing in the ministry about their own ability to ensure that private sector abides by the contract, and partly because private players are not very keen. Part of the lack of progress in outsourcing despite political pressures to do so is because of the technical complexities of contracting a corporate consortium to provide primary healthcare. But a number of international agencies and Indian pro-industry academicians and consultancy organizations are trying to address the technicalities of contracting and promoting innovations in organizing services. This has given time and space for the public sector/healh ministry to come up with viable and visible government run HWCs.Would corporate India run better primary healthcare than what government would?. Given the prevailing culture and perceptions fostered by neo-liberalism and the rise of right wing populism, many would support such a perception. But if experience and evidence is any guide, then what is far more likely is that it would, like in PMJAY, only lead to profits for private health sector, a weakening of public services and no major contirbution to health.

**7. Is this idea of HWCs a new idea? Has it been tried anywhere?**

The name is new. But this is the basic concept of primary health care, before selective health care came along. Many nations in the world have organized care along these lines and are doing it for very long and very successfully. In the developed world, UK's National Health Services is a model of such care- and it has been there for over 70 years. Most other developed nations also have similar arrangements for primary health care. In the developing world Cuba, Thailand and Brazil have very similar programmes. Thailand in particular is very similar to what is proposed in India. Over 95% of primary health care providers in all these nations are within the public sector- just like in India.

In fact this is what was always meant by primary health care. Such organization of services is what peoples health movements have been demanding since its inception.

## Demystifying UHC - The counter narrative

Universal Health Coverage (UHC) is the most popular word in the health circle currently with an extensive literature available to explain its theoretical underpinnings. Even though the idea of UHC was well conceived by many nation states including India, the means and ways to reach the last mile beneficiary remains largely inconspicuous.

Among the flagship schemes that were introduced in the last few years by the Government of India, Ayushman Bharat was one among the notable one, and was given a big push by all policy makers at national and state level. Ayushman Bharat consists of two major health initiatives namely, Health and Wellness centres (HWCs) and National Health Protection Scheme (NHPS). Among this the former, is lauded by almost all in the public health circle and is seen as the window of opportunity to strengthen primary healthcare and the path to achieve UHC in India. Health and Wellness Centres envisage to provide the 12 comprehensive primary healthcare services at Health Sub-Centers through Mid-Level Health Providers and Primary Health Centers through existing staff.

This piece of article is purely the lessons from experiential learnings of UHC implementation in the State of Tamil Nadu through the Health and Wellness Centres (UHC-Health Sub Centers and UHC-Primary Health Centers). This paper deals about how the State has conceptualized the UHC and currently being implemented in Tamil Nadu, with the Health sub center as the cornerstone of all primary healthcare activities. At all levels of care, the key focus is on re-organization of service delivery for improved population outcomes.

**UHC: a perception for convergence and not another vertical**

UHC should never be seen as another national vertical program with a separate set of guidelines for health programmes. UHC may have the indicators for operationalization, but not to have separate guidelines for existing programmes like TB, Leprosy, Maternal & Child health care.

Globally, UHC aims to reduce the out of pocket expenditure, expanded services and coverage. This shall be conceptualized at the local context to converge all health and related activities by establishing a harmonious programme networks to ensure intact forward, backward and lateral linkages. For example, a diabetic patient for getting drug doesn't need to depend on single facility, single doctor or fixed timings. Instead the patient can get same drug based on his/her convenience at Health Sub centre, Primary Health Centre, Patient Support Group, Mobile Medical Unit or even at doorsteps through authorized health workers/volunteers. UHC should bring the perception to health systems that the responsibility of ensuring continuum of care (screening, minor ailment treatment, major ailment first aid, referral service, follow up and rehabilitation), lies with themselves.

The idea of UHC can only be achieved if we are able to develop 'local health systems' at a decentralized level- at least at the block level with local ownership. The ultimate goal is about democratizing and communitizing healthcare where an individual's eighty to ninety percent of healthcare needs are provided, managed and followed up at a block level. While selecting the HWCs, the best mode is to follow the block saturation policy i.e. select all the primary care facilities at the block level except the co-located.

While conceptualizing UHC through HWCs, the States should not follow any national or global guidelines instinctively; but has to self-conceptualize and contextualize to place it within the State public health architecture without altering much of the existing State policies. While conceptualising the ideas should actually emerge from the community/field learnings and needs rather than a top to bottom approach. The strategies and concepts are dynamic and ever evolving. Ideally, each block should have a strategic plan considering the epidemiologic and demographic burden, health seeking behaviour of the community, human resource for health and other socio-cultural aspects. The major components of the HWCs-whether it is Human resource, Infrastructure including branding, Training, IT Systems, Medicines and Diagnostics should be tailor made for the State's public health systems. Health Sub Centre (HSC) strengthening should be considered as the

cornerstone of Universal Health Coverage (UHC) implementation, since it is the nearest and first point of contact in the primary care systems.

**Major Components of UHC: The key lessons**

**Human Resources**

Even though, human resource is the key to implementation of any health related activities, under UHC the notion should be to build a strong and dedicated primary care team at all levels. The perception that HWC can be operationalized only if we deploy a Mid-level Health provider (MLHP) is not true. The MLHP is meant to work with the team of primary care providers (Multi-purpose Health workers- male/female) and community volunteers (ASHA/Anganwadi workers/SHG network) to provide the expanded range of primary care services.

The idea is to bring all the available block level human resources from multiple programs (RBSK, MMU etc.) under one umbrella with clear job roles and responsibilities for providing comprehensive primary healthcare services. Each state can have its own strategies in pooling of these human resources and strategically using them in health service delivery. For example pooling and placing lab technicians at Hub (Block level) on 24x7 basis using existing human resource and maximizing the service delivery. It is not a HR reduction strategy, but strategize the assured service delivery to manage acute shortage of lab technicians. Hence, the States with human resource gaps can re-organize their service delivery mechanisms to roll out the UHC implementation by optimally utilizing the existing human resource capacity and then progressively fill the gaps as and when resources are available.

Another important aspect is the entry qualification for a MLHP. The key aspect of human resource deployment at the sub center shall be based on the State context. Available and appropriate work force with primary care skills and motivation to work in remote and rural centers shall be the primary criteria of placing the human resource. Retention of human resource at the center shall be given due importance in placement of the MLHP.

The job roles and responsibilities also shall be clearly laid down- the MLHP does not replace the doctor, but extends their outreach. The objective of HWC is not to produce qualified quacks should be kept in mind. The MLHP should be guided and bound by the Standard Treatment Guidelines. The career pathways of the MLHP shall also be clearly laid down at the initial stage itself.

All the health staff in State, Health Unit District, Block and institutional level will contribute to UHC implementation as per their existing roles and responsibilities. Health staff job chart shall be periodically updated based on the services delivered from HWCs aiming the harmonious implementation of UHC programme. For effective community engagement, a cadre of community work force is pre-requisite (ASHA, SHG members) in UHC implementation. Here, volunteers from organized sector (SHG) is preferred over the institutionalized health workers.

At State level, establishing a dedicated program management unit for converging the existing healthcare programme resources is also needed for effective co-ordination with the district and block units as well as with other vertical program units at the State level itself.

One of the major challenge any State should anticipate is getting sustained financial commitment from the State government for the additional human resources for the HWCs since it involves huge recurring investment and activities that are difficult, even impossible, to cancel, close or scale down once rolled out. The first concern of the finance department will be 'what is the value for money in spending for an additional human resource in primary care'. To counter this State has to create strong evidences of 'functional UHC models at local level', which can substantiate the fact that primary care strengthening can yield higher health outcomes at lower per capita total health expenditure.

**Capacity Building**

The key aspect of training should be that it has to be a continuous process and focus on improving hands-on-skills of the MLHP for triaging the walk-ins into screening, minor ailment treatment, major ailment first aid, referral, follow-up and rehabilitation services. The training has to be based on the standard treatment guidelines (STGs) developed for the MLHP. This should impart them skills related to management of common symptoms / common illnesses. The do's and don'ts should also be a part of the STG. The protocols for various conditions (NCD, IMNCI etc.) and programmatic guidelines like NCD services should be incorporated as a part of the STGs. The capacity building should also include imparting administrative skills, team building skills, skills to manage care pathways and referrals, use of information technology systems etc.

The capacity building should be given to the whole primary care team including community volunteers working in providing comprehensive primary healthcare services. The team should also be given regular trainings together to make each other understand their roles and responsibilities and empowering all the members to work as a team. The case study method is an effective approach to sensitize the importance of job oriented skills rather than teaching them big volumes of theory materials.

**Infrastructure**

Infrastructure strengthening is a key priority area in UHC, but unnecessary focus on branding can yield negative outcomes and wastage of resources. Since, the major proportion of money from HWC is earmarked for infrastructure strengthening, the funds for the same should be spend towards strengthening of appropriate infrastructure for service delivery. For example, laboratory strengthening, training infrastructure at block should be given priority over the new HSC construction.

The States should initially select sub-centers with reasonably good infrastructure and convert it as HWCs and concomitantly build new constructions through public works department than outsourcing to private enterprises to build branded monuments in place of good quality health centers, where even a poor patient from lower social strata finds hesitant to come. As an interim arrangement for transforming HSCs without Government Buildings into HWC, Village Panchayat Service Centres (VPSC) building or other Government rent free buildings can be utilized. Ownership of the HSC level activities to health staff comes along with health infrastructure for delivering the services.

Patient waiting area covered to accommodate at least 10-15 chairs, citizen charter, designated space for lab/diagnostics, provision of wellness room for Yoga, Bio Medical Waste Management, well-ventilated clinic room with examination space and office space for MLHP, rack for storing medicines, equipment, documents, health cards and registers, display boards for Information, Education and Communication (IEC) in local language which also includes assured services and HWC details, assured water supply – Running / Potable, Power supply, Appropriate Backup with Solar source, Inverter, Emergency lamps and Solar Torch lights, Separate male and female toilets, Proper drainage facility, adequate residential facilities for the service providers are essential for a functional HWC.

Additionally, at Primary Health Centres electronic display boards for IEC and HWC services, space for laboratory and pharmacy are to be strengthened. At Block Primary Health Centre CPHC training hall for Tele mentoring and dedicated laboratory buildings should be present. The HWCs should also be linked with the quality assurance program and kayakalp.

**Drugs & drug delivery systems**

A robust drug and diagnostics systems is a pre-requisite for any UHC model from the financial point of view since the maximum out of pocket of expenditure for any individual accessing a health facility is towards drugs and diagnostics. The first and foremost aspect in drugs component is finalizing the drugs to be dispensed through the Health and wellness centers, well aligned with STG and displaying it at the HWC. The drugs other than Kit A, Kit B and family welfare kits should be selected with expert committee consultations which must include field level implementers and based on local profile of diseases. The NCD drugs dispensation will be a key factor in success of any UHC implementation due to the prevailing epidemiologic and demographic transition across almost all states in the country. Additional consumables and surgicals are also to be made available to provide the CPHC services under UHC. In view of bringing clarity to health staff involved in CPHC service delivery, drafting the process of each activities related to service delivery, drugs and diagnostics requirement, meeting demand and supply at HWC level have to be decided at State level before implementing the UHC.

In view of preventing antimicrobial resistance, rational use of antibiotics is strategically restricted by advisory stating that antibiotics should only be used as per IMNCI, SBA, Sepsis and other State/Nation approved protocols. Health staff should be oriented to ensure the completion of antibiotic course initiated at all levels.

Every UHC HSCs should be issued a separate drug passbook which has to be maintained by the MLHP. This should be included as a job role of the MLHP. The drug inventory should be made as a part of the Health Information Technology Systems (HITS). This will be the sustainable solution to track procurement and adequate supply, drug usage, avoid wastage, proper redistribution of drugs etc. There should also be a proper mechanism for safe storage, transport and redistribution of drugs. Drug utilization should be generated from the line list of walk-ins availed services at HWC.

**Diagnostics systems**

The diagnostic systems are as important as drug delivery systems. The number of diagnostics tests available at each level of primary care should be arrived at first instance, which depends upon lab technician availability, diagnostics and reagent availability, infrastructure status etc. Since lab technician availability is a perennial problem in many parts of the State, the ideal model is to roll out Hub and Spoke model of laboratory services with Lab Information Management Systems (LIMS). This is also the most efficient system from patient's point of view since it cut downs indirect costs as well. Tamil Nadu has fixed 5 lab tests to be done at HSCs, 20 lab tests at PHCs, 5 additional tests at CHCs, 11 tests at District Public Health Lab (DPHL) and 4 tests under insurance (CMCHIS) through the "HUB and Spoke" model.

The major aim is to provide the basic investigations at HWC and refer samples instead of patients for higher investigations. Transportation support has been arranged through bike and available means in the local area. The major challenge here will be the operationalisation aspect i.e. to institutionalise the sample transport mechanisms. A "*One size* fits all" may not work here- the need of local systems at each block/district level based on the terrain, availability of human resource etc. should be arrived for effective implementation.

Finally, the hub and spoke model should be extended and integrated to Government Hospitals and Medical College Hospitals for provided essential diagnostic services with expanded list of test menu. The success of an efficient drug and diagnostics systems will be a key determining factor for the success of any UHC models.

Mere provision of drug allocation, supply chain management system, diagnostic equipment, consumables, hub and spoke transportation support and lab technicians will never work unless the networking and process is insured on daily basis. The health system should aim to provide the drugs

and diagnostic service on 24x7 basis to gain the confidence of public who unknowingly spend money towards seeking health care at least in identified strategically located HWCs.

**Service delivery**

**Table I: Overview of Service Delivery under UHC**

| | |
|---|---|
| Whom? | Residents of Tamil Nadu, immigrants and nomads/homeless peoples |
| Who? | The Government Organizations |
| What? | Free Drugs, Diagnostics and Consultation. Differential Primary Healthcare services at different levels. |
| How? | IT enabled service delivery from Community to Tertiary care centre including follow up with intact linkages. |

UHC is not provision of universal set of services at health Sub Centre, but it's about provision of differential services at differential level of health systems. This should not be read as provision of selective packages of services. Under UHC, the patient should have choice to avail services at any convenient point of service delivery without any cost of care.

The service delivery has to be conceptualised in such a way that the primary care team with MLHP, supported by the supporting staff does the early detection, the medical team establishes diagnosis and treatment plan, and the primary care team supported by community volunteers (ASHA/Women Health Volunteer/SHG network), patient groups ensures follow up and medication compliance.

The State which is currently going through the epidemiologic transition has conceptualised expanded service delivery with focus on NCD services without compromising MCH services & communicable disease management. Patient centric convergence of all existing health and related activities at block level is what the State is aspiring for under the UHC program.

In many States the MLHP's role is conceptualized as a healthcare provider, providing diagnosis and treatment for a wide variety of illnesses- going beyond the RCH range. The focus now is just on increasing footfalls in what is described as a general OPD. This is also setting a wrong precedence and diluting the service delivery aspect to mere numbers. The thought of enumerating complete population and creating a starting point for service delivery is quite inappropriate in highly dynamic population. The ultimate focus should be on population based outcomes rather than counting footfalls. Health promotion activities, addressing social determinants should also be considered as an important component and are to be built into the programme, usually as community-based response to high incidence of related diseases/risk factors in the community.

One of the challenges of operationalizing HWCs is the integration of hitherto vertical disease control programmes viz-control of TB, HIV, vector-borne diseases, leprosy and blindness into primary health care programmes. Under UHC, the focus should be on provision of integrated services at four levels: the family or the community level, at the service delivery level (health and wellness centre), convergence level (block) and the first referral unit.

The following aspects are key in improving service delivery under UHC:

1. Standard Treatment Guideline (STG) for VHN and Staff Nurse for providing the Primary Healthcare Services
2. Hands-on training at Block level for service provision and IT systems,

3. Linkages of CPHC services from community to First Referral Unit
4. Clear job responsibility of Public Healthcare Team
5. Effective IEC strategies through local innovations
6. Ensuring adequate Drug availability and indenting from the level of Sub centre
7. Hub and Spoke Model to maximize the lab support to HWCs
8. Building Mentoring Teams and motivated local leadership among healthcare providers at Block Level for Clinical Audit and regular monitoring
9. Changing the reporting pattern from raw numbers to line lists and sharing it at all levels up to the community volunteer (can start with NCDs, TB, High risk mother etc.)
10. Reinstating community's faith in public health systems through community engagement in service delivery

**Community Engagement**

Health system has lost its community linkages like coordination with ICDS, direct cash benefit over MCH outreach, immunization target over programme target. Outreach service under UHC is the re-entry to community to reinstate the faith in public health care systems of community. Community based Palliative and Geriatric care, NCD follow up may be the initial focus of outreach. Establishing the linkage between Institutional services and outreach activities like MCH services, Immunization, family welfare services, Hospital on Wheels (HoWP), School Health (RBSK) Team will throw light on the path to UHC. The concept of UHC has to be kept open for accepting the feedback and evolve over the time within healthcare systems.

Population based screening of NCDs and specific Communicable Diseases including enumeration of beneficiaries by house to house visit, screening for 18-29 for NCD risk factors using Community Based Assessment Checklist (CBAC), Screen for 30 & above for Diabetes, Hypertension, Cervical, Breast and Oral Cancers (Blood sugar & Blood pressure), Symptomatic screening of TB, leprosy, Mental health, COPD & CKD through Woman Health Volunteers (WHV)/ASHA/AWW) are the new value addition under UHC program in Tamil Nadu. Understanding the field reality and tailor made guidelines for each programme will help in improved service delivery and bring health staff together ensuring the readiness for programme convergence.

Organizing meetings at HSCs with the Community to showcasing the HSC services, Self Help Group (SHG) meeting and Village Health Sanitation & Nutrition Committee (VHSNC) meetings, Organising School Children for HSC visits (Schools located within the village only), conducting Village Health Nutrition Day regularly at the HSC in coordination with ICDS, Community Partners meeting, Regular meetings with mothers and NCD patients (patients support groups), district/block health assemblies, inviting all Govt/local body staff working/residing in the village to the HSC for sensitization on expanded service delivery at HWCs are few strategies which will strengthen community engagement. The vision is to create HSCs as epicentre for major activities in the community.

All the community action from health department should collaborate with the guidance of the Gram Panchayat and the local community to take action on environmental and social determinants. This can be made more vibrant under the Community Action for Health (CAH) program which should also be integrated with the UHC program.

The HWC has the potential to communitize and democratize health care, provided the community engagement is robust. When a volunteer reaches the community, she able to get follow up details of each affected/diseased individual from both Government beneficiaries and Private. The sustainability quotient of UHC solely depends on demand creation among the local community. In the absence of good community models, the outcomes of most NCD control programmes can be very poor. Patient Support Group formation is a way forward, since the health institution models by itself can't achieve the desired follow up rates for care going by the long standing experience of Government of Tamil Nadu in facility based NCD management.

**Information Technology**

All current health applications are currently focussed on getting the footfalls i.e. numerator. The state has conceptualized that the Comprehensive Universal Health Coverage IT platform with population as denominator is essential to establish a continuum of care from community to referral units. As a first step, Health IT standards was drafted. Family Folders module, outpatient module and drug inventory module were developed using the standards.

**Conceptualization of UHC IT Platform**

The following are the key conceptualization points while developing Universal Health Coverage Information Technology (UHC IT) Platform in Tamil Nadu

1) Master Registry (denominator): A Common list of health facilities, service area mapping, family folders with unique identifier
2) Offline capability, Quick search, Local Language, Near real-time data exchange, cross-platform usage
3) Longitudinal Personal/Public Health Record for continuum of care
4) Intact forward and backward referral mechanism, within and between the health applications and, from community to tertiary care facility
5) Aligned with State, National and Global health data requirements
6) Portal for public communication
7) Digital Cohort of the State with Data Cooperative Model (DCM)
8) Interactive dashboard for evidence based decision making with GIS, AI/ML
9) Compliance Health IT standards, IT Systems and security standards
10) State Owned Platform for IT enabled health service delivery

6.6 crore individuals as 2.05 crores families are mapped with 13,640 hospitals across 2.03 geographical units with GIS based organizational hierarchy levels. This common database with unique identifier is pivotal in linking the programme data and converting data points into digital cohort. Robust IT Systems with master registry is required to support intact forward, backward and lateral linkages from community to tertiary care centres. State should think of linking the births and deaths into the master registry to keep it alive. All health facility and community extensions should take the responsibility to update the datasets periodically or as and when they come to know at the earliest.

**IT Systems Approach**

UHC IT Platform approaches the users as systems approach which is the environment where users will interact with the IT Platform. The following major components are given priority

1) Hardware: Laptop, Tablet-PC, Desktops
2) Software: Applications and credentials
3) Internet Connectivity & networking: sustained internet in all health facilities
4) Hands-on training: Block level training given to VHN/SN/ANM
5) Mentoring and supervision: Daily performance audit and clinical audit

The block, district and state level teams has been oriented through Training of Trainers (ToT) on IT systems gap analysis. Offline usage of application and quick search of patient details were the two major feedback received during the ToTs. The provision of IT systems has to be ensures at local levels, maintenance over time, logistics, roles and responsibilities bring the dream to reality. Users at all levels are in need of platform with cross platform capability, so investing in devices may be restricted to which are used by field staff. Instead of forcing them to use tablets which is less powerful in the same price range. Assured Internet connectivity provision to all health staff is identified as bottleneck in implementing the UHC IT Platform.

The State has started activities for establishing elastic search facility and offline packaging of the existing online application with 8 modules in phased manner. IT systems evolution at global level

like quantum computing, Artificial Intelligence should never be a mandate for the health system change. Instead the Health IT architecture should be flexible and robust enough for horizontal (programmes), vertical (organization levels) and lateral (inter department) expansion. The learnings from the State is that appropriate use of Health Information Technology systems would support service delivery under UHC but would never be a substitute for them and the program convergence should precede before IT convergence.

**Role of development partners**

The role of civil society organization and other development partners are crucial in success of UHC program. The Government should take this step cautiously when it comes to selection of development partners-both for funding as well as technical inputs from private sector. Think tanks may be established by empaneling subject matter experts. Government has to periodically review the progress of programme and contributions from these think tanks.

Even though we completely agree with the fact that anyone not functioning in public can't be labelled as private, most of the NGOs and research organizations working as development partner for various State Governments are funded by philanthropic capitalists who lacks the critical understanding of the public health systems objectives and moreover the local contexts. Most of these organizations ulterior motive is not to catalyze social transformation or improvement of public health systems but as mere instruments of a funder trying to meet a goal. But, the collaboration with other government departments and agencies (Panchayati Raj, Rural/Urban Development, Women Development, Education etc) is quintessential for the success of any UHC models.

The various State Governments who are striving towards achieving Universal health care to all its citizens should clearly understand the fact that only a public funded and owned UHC model will work sustainably in the long run, even though with all its deficiencies and defects. Hence, the development partners impersonating the hard work of public health systems should be dealt vigilantly. All the developments and guidelines should be owned by the public systems (Source codes, datasets, copyrights, intellectual property rights). States should get the stack from the outcomes of implementing the IT Platform and not seen as agency for data collection.

**Major challenges foreseen during implementation of UHC**

The following challenges may be considered during implementation of UHC

1) Upscaling UHC program to entire state in a short span by the unrealistic timelines set up.
2) Sensitizing the health staff on operationalizing the HWCs to provide CPHC services i.e. from selective care to comprehensiveness
3) Shortage of trained manpower to deliver the 12 CPHC services
4) Training of health staff on job-oriented syllabus and career progression advantages of trained staff.
5) Strengthening the community linkages
6) Moving from paper-based registers to IT based systems
7) Generating population enumeration line list: Fixing the denominator
8) Functional Lab Information Systems (LIS) and Hub & Spoke model
9) Convergence of established programmes like NCD, MCH services, Family Planning services, RBSK, Urban polyclinics under UHC
10) Political and Financial requirements and commitments.

**Conclusion**

Experiential learnings of health systems, readiness for implementing the UHC programme and financial support from Government of India made the conceptualization acceptable to health staff and administrators in context of Tamil Nadu. The States should capitalize UHC as an opportunity to strengthen the primary healthcare machinery through public systems strengthening but not at the cost of secondary and tertiary care facilities, which is also required to complement the primary care systems.

Tamil Nadu's experience has proved that strategic purchasing of health care from private sector either through Insurance or Public Private Partnership (PPP) mode without the presence of a

strong and robust Government sector is a recipe for disaster, and will be unviable in the long run. The States should strive for creating their own local models and try to build each components under UHC through in-house models rather than outsourcing/PPP modes, which has its own moral hazards and sustainability and equity issues.

The paper stems from the field learnings during the UHC implementation in Tamil Nadu through HWCs. The major learning was that each field visit during the implementation phase gave new insights and conceptual clarity regarding the concept of UHC. The major challenge in implementation is also the same- i.e. the concept is dynamic and various local health systems perceives it in different ways. The only concluding point is that each state Government should conceptualizes and place the UHC concept within its local health systems rather than fixing borders for the UHC cube.

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## Medicines and Access Barriers

Medicines are an essential component of modern health systems and have helped in reducing the burden of deaths and diseases significantly. Despite India having the distinction of the Pharmacy of the Global South, around 68% of the Indians have limited or no access to essential medicines. Moreover, research suggests that in the past two decades the availability of free medicines in public health facilities has declined from 31.2% to 8.9% for inpatient care and from 17.8% to 5.9% for outpatient care. Thus, medicines constitute a major part of expenditure – over 70% of overall out of pocket expenditure (OOP).

National Sample Survey Office (NSSO) data shows that every year, 5.5 crore Indians are pushed into poverty because of having to spend on their healthcare. Out of this, 3.8 crore fall below the poverty line due to the spending on medicines alone. Further, as per 71st round of NSSO on health, the purchase of medicine accounted for 72% in rural areas, and 68% in urban areas, of the total spending on non-hospitalised treatment of ailments. Thus at the household level, expenditure on medicines is a significant cause of impoverishment or this expenditure forces the family to forgo other essential aspects of well-being.

**Access Barriers:**

1. **Low public spending**: According to the latest National Health Profile (NHP) 2018, India has one of the poorly resourced and managed public health systems in the world and is among the countries with least public health spending. i.e. mere Rs. 3 per person per day that translates to 1.02 % of the Gross Domestic Product (GDP).

The low levels of public spending on health leads to poor access to affordable health care, and affects majority of Indian's negatively. The National Crime Records Bureau says that 38 crore people in India committed suicide between 2001 to 2015 owing to lack of access to treatment, which is 21% of the total suicides in this period. Price of medicines is the leading contributor to the high cost of treatment and this in turn was the major reason for decreased access.

2. Lack of adequately functional and accessible health services: The Government of India has a scheme for free medicines and diagnostics which has been passed by all the states. However, its implementation is far from satisfactory and government facilities at primary, secondary and tertiary levels do not have stocks of these medicines. This is called stock-out of medicines. Thus, patients are forced to buy them from private pharmacies. This calls for a more robust procurement and distribution system.

3. Irrational Prescriptions: WHO defines irrational prescribing as use of a therapeutic agent when the expected benefit is negligible or nil or when its usage is not worth the potential harm or the cost.

Irrational Prescription includes incorrect, inappropriate, excessive, unnecessary or inadequate prescribing. The role of medical representatives becomes crucial here. They have the task of promoting medicines of pharma companies they work for through all means, including unethical ways. This leads to irrational prescribing by health practitioners.

Irrational medicines can act a barrier to essential medicines, because the patient may be persuaded to spend all their money on the inessential medicines( because they give more commission to the shop-keeper or are indivisible like tonics) and therefore there is no money left to buy the necessary

quantity of the essential medicines (like the antibiotic). There are nations like Bangladesh which have banned almost all inessential medicines- but these are freely available in India.

4. **High Drug Prices:**

Since 1970, the Government of India has attempted to regulate the prices of some drugs through successive Drug Price Control Orders (DPCOs). The DPCO is an order issued by the government under section 3 of the essential Commodities Act 1955 empowering government to fix and regulate the prices of the essential bulk drugs and the formulations.
The number of drugs covered by the DPCI came down from 342 in 1979 to 74 in 1995. After a Public Interest Litigation filed by the All India Drug Action Network (AIDAN) and others in 2003, highlighting that high drug prices were a major cause for catastrophic medical expenses in the country, the Supreme Court issued a directive to expeditiously put in place a mechanism to control essential drug prices to affordable levels. In response to the Supreme Court directive, the government has now introduced price control on 348 drugs listed as essential. Ceiling prices have been notified by National Pharmaceutical Pricing Authority (NPPA).
However this did not bring around the expected decrease in the prices of essential medicines because, keeping the interest of pharmaceutical industry in view, the DPCO 2013 changed the formula of calculating the ceiling price to a "Market-based price determination". Earlier the fair price of a drug was estimated by calculating the cost of production and over that allowing a 50 or 100 % profit. This was known as the "cost-plus price determination" approach. DPCO 2013 calculates the ceiling price by averaging the current market price of all brands owning 1% of market share. Since the market share of the drugs depended on the promotion and not the prices, drug companies could use this approach to keep the prices high.
Additionally, the price control is applied only to specific drugs, in specific dosage mentioned in the essential drug list and it applies only to the formulations. The present methodology of calculation is in contrast to the previous methodology, where all combinations of the drug, with any other drug or in any dosage or delivery form (tablet/syrups/injections) were under control. Since, DPCO 2013 is confined to the specific drugs and the dosage as indicated in the essential drug list, the extent of price control is very limited.

5. **Patents**:
Intellectual property and patents in particular, have become one of the most debated issues on access to medicines, since the creation of the World Trade Organization (WTO) and the coming into force of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Patents play a significant, or even determinant, role in creating barriers to access to life-saving medicines. Patents give exclusive rights to a company to sell its medicines in a market. Thus, during the term of patent protection, the patent holder has the ability to determine prices in the absence of competition. It can result in the medicine being unaffordable to the majority of people living in developing countries.

An example of competition bringing prices down is antriretrovirals for HIV/AIDS treatment. The HIV/AIDS pandemic and the urgent need to make treatment available for the 14.6 million people in need of treatment continue to bring the question of the affordability of antiretroviral (ARV) medicines to the forefront of international attention. When ARVs were first introduced, the cost of treatment per person was over US$ 10.000 a year (about US$ 30 a day). This cost put ARVs out of reach for the vast majority of HIV patients in developing countries, where more than 3 billion people live on less than US$ 2 a day. Introduction of competition has resulted in significant reductions in the prices of ARVs. Since then, there has been an increasing reliance on low-cost generic ARV therapy as a strategy for treating more patients; today the annual first line treatment per person is available at less than 100 US$.

# Neo-liberal Health Sector Reforms and Universal Health Coverage: A critical reflection

**The idea of this background paper is to discuss the key elements of health sector reforms and their implications on human health. We also attempt to throw light on the discourse of Universal Health Care and assess its efficacy and limitations as a response to the challenges faced by health systems across the developing world.**

## Elements of Structural Adjustment Programs and Health Sector Reforms:

In the last three decades economies around the developing world have gone through waves of structural reforms with disastrous consequences on lives and health of people. In India, though Economic Reforms got formally introduced in the wake of Balance-of-Payment Crisis in the 1990s some key reform measures, including liberalisation of trade were introduced during mid-1980s. In order to tide over the BoP crisis, Government of India embraced loans from IMF and World Bank conditional upon introduction of Reforms program in the country which were expected to generate economic growth and stabilize the economy (Sen 2001)1.

The reforms program had two key wings- macro-economic stabilization policies and structural adjustment programs. **Macro-economic stabilization** essentially meant that government has to reduce its deficit to allow market to work freely so that prices are determined freely by market forces. The understanding was that if government borrows and invest, it created barriers in private investment (crowding out). Series of policies prescribed by IMF included reduction in government deficit by cutting back public investment, liberalise trade by reducing tariffs and taxes on import and export; withdraw subsidized provision of goods and services in wide range of sectors including health care.

**Structural Adjustment Programs,** on the other hand are sector specific reforms intended to infuse market principles in areas where there is considerable presence of state, through various measures like user charges, contracting out of services, shifting from direct provisioning to insurance like mechanisms and bringing in principles of market into functioning of public sector (Sen 2001 op cit). The implicit understanding was market is a superior institution compared to state and hence role of state should be to facilitate free flow of market resources and play a steering role rather than direct provisioning of services.

Thus **Health Sector Reforms** brought about major shifts in the basic philosophy about role of government in health care. At the national level, restriction on and restructuring of subsidies became a major issue of policy debate. Government subsidies were categorized into three groups, namely **public groups** which deserve complete government intervention; **merit goods,** where based on societal judgments, subsidies would be provided and pure private goods. Among the sectors relevant for the second group were public health, sewerage and sanitation. The third category, where consumption is rival and exclusion is possible, was considered as **'non-merit services'**. It was emphasized that strict reduction of subsidies in these services would be required and user fees would be introduced. Among the health services, all curative cares were considered 'non-merit' services (Srivastava and Sen 1997)2.

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[1] Sen, K. (2001), "Health Reforms and Developing Countries: A Critique", in Qadeer, et al. (edited) *Public Health and Poverty of Reforms: A South Asian Perspective*, New Delhi: Sage

[2] Srivastava, D. K. and T. Sen (1997), 'Government Subsidies in India". National Institute of Public Finance and Policy, New Delhi.

Followed from the understanding of public good was the idea that an essential package of health service to be publicly funded on the basis of cost effectiveness and positive externalities of these interventions- an approach called **'selective primary level care',** a mark departure from Primary Health Care Approach emerging through the Alma Ata declaration. To quote the World Development Report 1993, one of the most influential and widely quoted document, recommended that "Poorer countries must, of necessity, define their essential packages more narrowly." (WDR, 1993, pp57). The aim was to gradually withdraw states from funding services other than a small group of services including preventive health care, family planning and immunisation (Ravindran, 2010).3 The other integral part of the package were promotion of private sector participation in health sector, especially in areas which are comparatively more profitable like super specialty hospitals; contracting out clinical and non-clinical services and introducing user charges for various out-patient and in-patient services for the non-poor4.

**User charges** were introduced into health sector with the objectives of additional revenue generation for recurrent costs and ensure financial sustainability (Leighton 1995) with minimum external inputs (LaFond 1995). It was argued that high use of secondary and tertiary care by rich people will cross subsidise the use of services by poor in rural areas. The rich should not be subsidized and resources should be targeted towards the poor and user fees can facilitate cross subsidization. It will also free government resources for provision of additional care to the poor. It can also promote equity if targeted differentially (bitran 2003), based on age, disease, level or care and rural/urban divide (WDR 2004). Fees generated were supposed to be used for strengthening the services and hence improving quality of care.

**New Public Management** became the mantra for functioning of public systems. The strategy has been to introduce private sector management, organization and labour market ethos and practices into the public sector with the expectation that public services can be made to deliver with the 'efficiency' that the private sector (and its competitive environment) has supposedly realized. More specifically, there has been an aspiration to introduce **'internal markets'** within the domain of public provision. **Public Private Partnerships** of various kinds were introduced- Outsourcing of ancillary and auxiliary services; outsourcing of key supportive functions; outsourcing of key geographic areas; outsourcing for reaching key vulnerable groups; facility Management Contracts; Build –Operate - Run/Transfer models etc. A key element of the NPM was **abolition of permanent recruitments and contractualisation of human resources.** Demand side schemes like vouchers and strategic purchasing were introduced to meet the demand gaps and make up for the purchasing power of the people.

## Implications of HSR on peoples' health:

**Cuts in public spending:** Stabilization policies have led to considerable decline in government spending on social sector in general and health in particular (Tulasidhar 1993[5], Dev 2002[6]; Duggal 1995[7]; NIPFP 1993[8]). Public expenditure as a percent of GDP fell sharply during 1990s (Dev 2002

[3] Ravindran, S. (2010), "Health Sector Development Projects of the World Bank", in Kelley M. and Deepika D'Souza (edited), World Bank in India: Undermining Sovereignty, Distorting Development, Orient BlackSwan, New Delhi

[4] *ibid.*

[5] Tulasidhar V. B. (1993). Expenditure compression and health sector outlays. Economic and Political Weekly, Vol. 28, No. 45. Nov. 6, pp. 2473-2477

[6] Dev, S.M. and J. Mooij (2002), "Social Sector Expenditures in the 1990s: Analysis of Central and State Budgets", Economic and Political Weekly, 37(9), pp. 853-866.

[7] Ravi Duggal, Sunil Nandraj and Asha Vadair (1995). Special Statistics-10: Health Expenditure across States: Part I; Economic and Political Weekly, Vol. 30, No. 15 (Apr. 15, 1995), pp. 834-844;

[8] National Institute of Public Finance and Policy (1993). Structural Adjustment Programme - Its impact on the health sector (Draft Report); New Delhi, India.

op cit., Tulasidhar 1993 op cit.). This resulted in decline in combined social sector expenditure of Centre and state (as % GDP) during the early 1990s and consequently health expenditure also declined. Cuts in Union budget during early 1990s also meant that transfer to states declined and consequently expenditure of state governments declined (Tulasidhar 1993 op cit.; NCMH 2005[9]). Since developed states had better fiscal capacity and hence lesser dependence on central transfers, they were affected by the cuts in Union budget to lesser extent compared to their poorer counterparts. This, in effect exacerbated the interstate variations in developmental deficits. In the poorest 37 countries, public per capita spending on health had shrunk by half in the 1980s (Sanders 2000). There was a significant decline in public health expenditure in most African countries, in other developing countries.

One immediate impact of the squeeze in spending was observed in the decline in capital expenditure implying that there was **virtual stagnation of expansion of health facilities** and upgradation of existing infrastructure. Share of Medical and Public Health within health budget shrunk and thus maintenance and development of medical care services have suffered. Whereas **public health programs which are of preventive in nature received more severe contraction due to cuts in central transfer** (Tulasidhar 1993 op cit.). It was observed that salaries were taking up an increasing proportion of total expenditure though there was overall **freeze in recruitments resulting in huge vacancies.** Expenditure on medicines and consumables declined in absolute amounts as well as in share. Medical care facilities which are largely financed and run by state governments suffered considerable deterioration, affecting urban poor specifically (Duggal 1997[10]). At the same time secondary health care facilities, which are mostly located in rural and semi urban areas, have received lower share, lacked basic amenities (Varatharajan 2004[11]).

A reduced quality of secondary care in government hospitals led to **increased dependence on private sector**. Cutback in drug spending and consequent unavailability of medicines in public facilities forced people to purchase increased part of the prescription drugs from private sector (Duggal 1997 op cit.) Further, freeze in recruitments in public sector during 1990s led to huge vacancies, especially affecting facilities serving rural areas (Varatharajan 2004 op cit.).

Increased role of private sector and decline in public provisioning has enormous implications for **cost of health care**. Over the two decades under consideration there is substantial increase in the cost of hospitalisation in both public and private facilities. The increase is more pronounced in private sector. Doubling of costs within the span of two decades, even when inflation is taken care of, had significant bearing on the medical catastrophy and impoverishment. Cost of medicines remained the most prominent driver of costs.

**User fees** were advocated as one of the important source of revenue generation (World Bank 1993). However, user fees failed to generate enough resources to cover a small part of the recurring expenditure, but it succeeded in pushing a huge section of marginalized people and entire rich and upper middle-class out of public services. Driven by the disastrous consequence of user fees many of the African countries have started rolling back user fee policies and going back to universal and free care with positive effects on utilization of services (Ridde and Morestin 2011).12

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[9] Ministry of Health and Family Welfare, Government of India (2005). Report of National Commission of Macroeconomics and Health,

[10] Duggal R (1995). Health Care Budgets in a Changing Political Economy. Source: Economic and Political Weekly, Vol. 32, No. 20/21, May 17-30, pp. 1197-1200

[11] Varatharajan D, S. K. Godwin and B. Arun (2004). Unimaginative tinkering; Economic and Political Weekly; Vol. 39, No. 33, Aug. 14-20, pp. 3672-3675

[12] Ridde, V. and F. Morestin (2011), "A Scoping Review of the Literature on the Abolition of User Fees in Health Care Service in Africa", *Health Policy and Planning*, 26(1), pp. 1-11.

Privatization of health care and the consequent rise in costs of care have severe bearing on **access to care, both physical and financial, indebtedness and loss of earning**. The divide between the rich and the poor, the rural and urban people, between different social groups in accessing health care is constantly increasing. Financial constraints and unavailability of medical facilities are being sighted more frequently as reasons of seeking no treatment.

## Universal Health Coverage: the panacea?

In order to tide over the situation of crumbling health systems in developing countries and rising burden of household health care costs, by mid-2000s international institutions espoused for Universal Health Coverage (UHC). There was renewed call for increasing public spending on health to finance different types of demand side financing mechanisms to ensure financial protection. The underlying belief appeared to be that if the finances were secured, provisioning of health services could be taken care of by existing mix of private and the public sector. The use of the term **'coverage' rather than 'care'** symbolizes the move away from concerns of health systems design toward financing.

UHC is conceived as a system that would progressively move towards: i) the **coverage of the entire population by a package of services;** ii) an increasing range of services; and iii) a **rising share of pooled funds** as the main source of funding for health care, and thereby a **decrease in co-payments** by those accessing healthcare services. It is argued that such a system requires a clear split between **'provider and purchaser'** of health services split, the issues of financing and management being entirely divorced from provisioning (Sengupta A 2013).

The importance of public healthcare services is not part of this narrative and the **state is confined to the role of manager of this system**. Advocates of UHC emphasize on the role played by governments in strategically 'purchasing' care to improve 'efficiency'. The WHO Bulletin argues: "Countries cannot simply spend their way to universal health coverage. To sustain progress, efficiency and accountability must be ensured. The main health financing instrument for promoting efficiency in the use of funds is purchasing, and more specifically, **strategic purchasing**" (Kutzin 2012).

Roots of such design could be traced back to 'Medicaid' scheme in the US introduced during the 1960s, where government provided subsidies to enroll poor into private health insurance schemes. Some early initiatives in the late 1990s and early 2000s – especially in Latin America where reforms were based on **public funded health insurance (PFHI) schemes**- shaped the UHC agenda across the globe. Mechanisms adopted in Chile, Colombia and Mexico, for example, shared certain key features: increases in national healthcare expenditures, both public and private; and a market logic centred on '**individual care' conceived as a 'private' good**. Notably, the World Bank played a key role in consensus-building around reforms that were to become precursors to UHC, much before the World Health Organization (WHO) formally adopted it as part of its policy plank (e.g. see Kutzin 2000)- though there remained limited evidence that these schemes have been successful in improving financial protection and bringing in health system efficiency.

India has witnessed a plethora of PFHI being introduced both at the national and state level. Yeshasvini started as an insurance scheme for worker cooperative in 2003 in Karnataka, including all rural co-operative society members, members of Self-Help Groups /Sthree Shakti Groups and their family members (including joint family). The Rajiv Aarogyasri Scheme (RAS), the first of this class targeting below-the-poverty-line population of Andhra Pradesh was introduced in 2007. The Rashtriya Swasthya Bima Yojna (RSBY) that was launched in 2008 is on the other end of the spectrum. It is also voluntary in enrolment, was initiated by the Central Government (Ministry of Labour and Employment) as a national health insurance scheme targeting the BPL population. Other notable state sponsored schemes include Chief Minister's Health Insurance Scheme in Tamil Nadu

(2009) and Vajpayee Arogyasri (2009) in Karnataka. **Prime Minister's Jan Arogya Yojana** is an aggressive extension of these schemes which aims to merge all the existing schemes and provide coverage upto 5 lakh rupees for hospitalization.

UHC is a step forward to the extent that it represents an explicit recognition of two important aspects of public health. The financial catastrophe due to healthcare costs, the need to go beyond the selective package of services and the need for state intervention in a an area of marketfailure., UHC recognizes that '**market failures'** are a feature of private health care that is detrimental to the interests of patients. Second, UHC also recognizes that even clinical healthcare services are an area of market failure due to uncertainty in outcomes of the services purchased, due to high levels of information asymmetry, due to lack of alignment of incentives of provider and the patient and also due to the nature of professional power. (Kenneth Arrow, 1963)[13] The state has responsibility to ensure access to health services.

But the UHC uses the framework of public choice theories where the failure of individuals to exercise choice is countered by building intermediate agencies/institutions that can make the purchase on behalf of people.

Thus, though UHC provides the possibility to exercise this choice, for making pro-people choices, it is quite likely and more often seen that this power is used to make choices is that foster monopoly, aggregating services for that purpose and that peoples choices get even more restricted than in free markets. Financial pooling through UHC could make it easier to develop comprehensive public systems, but instead this is used to route public expenditure through private providers, especially monopoly in a time of global recession. (Sengupta 2013).

## Universal Health Coverage: New face of neo-liberalism

The dominant approach of UHC is in sharp contrast with the vision of Primary Health Care (PHC) envisaged in the Alma Ata declaration of 1978. PHC called for the building of health systems that would provide comprehensive care, would be integrated, organized to promote equity, and driven by community needs (PHM et al 2005, 56). Instead UHC envisages health care as bits and pieces of a jigsaw puzzle, connected only by a common financing pool and by regulation of an array of private and public providers.

The UHC concept provides choices in a particular political and economic environment that is not neutral. The dominant neoliberal environment can exploit the ambiguities inherent in the conceptualization of UHC and **promote a model that is market-driven.** Such a model, through a combination of pooling of funds and private provision, becomes a convenient way for private capital to extract profits using public resources. With the state intervening to pool healthcare funds in one basket (the locus of collection may range from primarily tax-based to a combination of employee, employer and government contributions), new avenues for profit-making are opened up through the medium of insurance companies and health management organizations (Sengupta 2013 op cit)[14].

Pooling of funds provides an effective demand (i.e. purchasing power) for the healthcare industry in settings where most people live in extreme poverty. It also **opens up a new and lucrative private market: the administration of health insurance funds**. Further, in an insurance-based UHC model, although more public funds are earmarked for health, this is done through demand subsidization (putting money in the hands of the users) rather than subsidizing supply by increasing the budget of public institutions. As a result, a new layer of competition is added to the system. Not only do public and private service providers compete, we also see competition between public and

[13] Arrow, Kenneth J. "Uncertainty and the Welfare Economics of Medical Care." The American Economic Review, vol. 53, no. 5, 1963, pp. 941–973.

[14] Sengupta A (2013). Universal Health Coverage: Beyond rhetoric. Occasional paper, No 20, Municipal Services Project; November 2013.

private insurance plans. Furthermore, private companies are offered a series of advantages in order to break the "monopoly" of public institutions (Laurell 2010)[15].

The consequences of private sector led model of provisioning are well known **distortions, induced demand for unnecessary provisioning of services, drive towards more technology intensive care and above all high cost of care**. One of the reasons why private sector need to indulge such unethical practices is the failure to achieve economies of scale for the investments made on capital intensive equipment and diagnostics. In order to create product discrimination and provide 'state of the art' technologies, there is always a tendency to over supply some of the high end services like Compute Tomography (CT) scans, magnetic resonance imaging (MRI) etc. It is often the case that if one follows standard treatment protocols, given the patient load, usage would be less and hence returns would be less compared to investments made to procure such services. One of the ways to achieve economies of scale is to plan on **epidemiological basis and develop systemic ways of cooperation between providers for sharing the load and ensure continuum of care**. Public owned and managed district health systems with clear referral links are the main feasible approach by which many nations have achieved this goal. But if the reliance is only on demand side financing of private providers, then this possibility is lost.

Consequences of private sector led growth on people are well-documented. A large number of studies on state publicly funded insurance in India, and on the centrally funded RSBY and a lsuggest that cashless insurance mechanisms fail to reduce out of pocket expenses (Sakthivel 2012[16], Alok Ranjan, 2017[17], Sulakshana etc). The same mechanisms would prevail under managed care model and there is no reason to believe that exploitation of poor would stop. Experience of OECD countries shows that the cost of care is increasing faster than growth of GDP and every day a larger share of resources are being invested to finance health care while entitlements are getting gradually curbed. Global experience suggests that most of the **developing countries do not have the capacity to regulate private health sector and especially corporate hospitals**.

Another key contention is regarding the inclusion of **informal non-poor**, who do neither come under formal social security protection nor do they come under tax funded insurance scheme because they are supposed to have greater ability to pay. It is argued that if they are left to open market for health services, they would either under-consume or to make the in-efficient choice given information asymmetry. In such situation it is being advocated by International agencies and their allied consultants that **private voluntary health insurance (PVHI)** be promoted and regulated by government and thus bring in efficiency in risk selection and greater choice.

This kind of approach to depend on PVHI is problematic on many counts. First and foremost most of the conditions insurance mechanisms usually cover are select set of hospitalization conditions. In out-patient care insurance either do not work because of moral hard problem or come with heavy co-payments. Insurance works on pre-payments and hence reduces cost of care for additional services. Since the cost reduces both providers and patients tend to consume more care than required- this is typically called **moral hazards.** We can see that C-section rates are very high in India among those who are covered by insurance- a major reason for this is moral hazard- unnecessary care introduced by providers on insured mothers. It remains extremely difficult to limit moral hazards and particularly supply induced demand under insurance for hospitalization. But for out-patient care this is virtually impossible, hence remain out of ambit for insurance.

Global evidence suggest that PVHIs make profit trough means like **adverse selection, crème skimming and rejection of claims**. Adverse selection and crème skimming creates **problems of**

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[15] Laurell, A. C. 2010. Can insurance guarantee universal access to health services? Social Medicine, 5(3): 137-138.

[16] Selvaraj S, Karan AK. Why publicly-financed health insurance schemes are ineffective in providing financial risk protection. Economic Politcal Weekly. 2012;47:61–68.

[17] Alok Ranjan, Priyanka Dixit, Indranil Mukhopadhyay, T Sundararaman (2018). "Effectiveness of government strategies for financial protection against costs of hospitalization Care in India". BMC Public Health (2018) 18:501; Online ISSN: 1471-2458

**exclusion**. Insurance companies charge very high levels of premiums for people who are already seek or are more likely to fall ill, like the elderly, thus making it **unaffordable for them who genuinely need care**. As a result people with pre-existing conditions tend to hide their conditions and join plans which are more affordable to them and when they seek more care insurance costs eventually spiral-up. On the other hand PVHIs tend to cover the healthy and younger population through insurance so that they continue to pay premiums for years without seeking care. Eventually people age and need care they are denied claims through various complex means and procedures. Most advanced insurance markets like the US have failed to address these issues, even though they have put in very extensive systems of administration and regulation, which tend to take up a quarter to almost a third of health care costs.

## Towards an alternative vision:

What is needed is an alternative framework of healthcare delivery where the right to healthcare is seen as a justiciable right. This needs enactment of appropriate legislations both at the centre and state levels to ensure universal access to good quality and comprehensive healthcare including the entire range of primary, secondary and tertiary services for the whole population. This would entail an expansion of public expenditure on health, financed primarily through general taxation, to 3–5 per cent of the GDP.

The fiscally prudent way to reduce the high burden of out-of-pocket expenditure and improve equity in access to quality care would be to expand and strengthen the public healthcare system to ensure quality and availability of healthcare entirely free of user fees. Universal access to the entire range of essential drugs and diagnostics at public facilities with a matching human resource policy and much better governance and management would be crucial.

The direction would be of selectively using private healthcare resources, especially those in the non-profit sector with clear motivations of public services, to strengthen public systems, and this would contrary to the approach of indiscriminate use of public resources to strengthen private healthcare providers. The pre-requisite of strong public sector in ensuring greater access has been demonstrated in all kind of contexts, from the most developed countries like UK, Sweden or developing countries like Cuba, Sri Lanka, Thailand, and Brazil etc.

One challenge is to bring qualified and ethical general practitioners from various systems of medicine into the public fold before they get completely integrated into the medico industrial complex. Experience of initial decades of NHS of Britain shows that the General Practitioners ( GPs) who were contracted on terms that excluded them from any private practice, can provide cheaper services, can be regulated, rational treatments can be ensured through them and most importantly indirectly curb the growth of tertiary hospital sector. The political context under which such radical transformations had happened in UK was vastly different from the neo-liberal regime that we are living in and even now as we speak it is being further undermined. The strength of progressive political and civil society movements would be tested at such a juncture.

Rebuilding public provisioning based on Primary Health Care approach is going to require not only increased investment but also creative re-organization of servies and democratisation leading to better accountability. For the public sector, it cannot be business as usual- it has to reform – but on theoretical foundations completely different from what was pushed under New Public Management and Health Sector Reform of the nineties. The change of emphasis from reform to health systems strengthening represents this in part- but it is a concept that has to be built on.

Medicine costs are almost two third of the OOP on health in India and causes 3.3 crore people to fall below poverty line. Small ray of hope is seen in the provisioning of free drugs in public sector. An entitlement which was unobtrusively dropped during the era of liberalization may now bring patients back to public facilities and create demand for better services. There are also many interesting examples of very vibrant and successful public service delivery- that we need to highlight to prevent stigmatization of public services as inherently doomed to failure- a dangerous discourse that currently draws its inspiration from the Niti Aayog.

Global evidences suggest that PPPs have been either unsuccessful or brought in disastrous consequences to people and health systems. Several country governments, local bodies have rolled

back PPPs and have de-privatised public systems, withdrawn user charges and reclaimed public spaces. Often these initiatives have come through mass movements where citizens and workers affected by corporatization and privatisation of hospitals have come together to halt PPPs or de-privatise services. It is important to build strong peoples' movements and defend and reclaim public systems and make these systems pro-people.

However, the battle to rebuild public sector in a Primary Health Care approach cannot be fought in isolation and in current context of neo-liberalism possibilities of rejuvenating government health services are really bleak. Under the present regime, where exploitation of labour is taking place in most advanced and pervasive form, state still plays its role in generating demand. But only in a manner which doesn't interfere in the process of production or price setting. That is why artificial means of demand generation like cash transfer, voucher schemes, insurance and other market guarantee schemes are promoted; which allow market to operate freely and make plunder over peoples' money. That is why health care, food and nutrition, water services are packaged and epitaph of universal and comprehensive public provisioning is written in unprecedented hurry.

## Strategic Purchasing – the Dominant Global Health Reforms Agenda in UHC Era

Nations of the world have committed to the target of Universal Health Coverage (UHC) under the Sustainable Development Goals (SDGs). UHC, as defined by UN and emphasized in SDGs, broadly means that all individuals and communities receive the health services they need without suffering financial hardship. UHC gives prominence to ensuring 'financial protection' for utilization of required healthcare as its key goals, with efficiency being the intermediary objective. Universal Coverage and healthcare financing as a means to achieve it, find a prominent mention in WHO resolutions in 2005 and in 2011. In 2008 UHC is one of the chapters in the World Health Report of WHO. UHC occupies a dominant position in the current global health policy discourse and that has been the case for more than a decade now.

The consensus under UHC is that adequate public funding for healthcare is necessary. But, the public funding is to be used by the governments to "purchase" the services i.e. to arrange the services by hiring the best providers – public or private, who can get the job done. 'Strategic Purchasing' (SP) has been advocated as a healthcare financing measure by global health institutions as central to improving health system performance and making progress towards UHC. 'SP' has been defined by WHO as "a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom" It is primarily meant to achieve efficiency and relies on "new universalism" promoted by WHO and written into its documents by experts deputed by the World Bank in 1999 and 2000. According to this approach, public or private ownership of facilities does not matter and the more efficient providers could be contracted to get the services delivered. Under 'new universalism' government role has been transformed from provisioning to 'stewardship' - mainly deciding priorities for funding and providing the funds. A level playing field between public and private providers is thought to be necessary for fair competition between the two and therefore Purchaser-Provider split is advocated i.e. government should set up a separate arm for purchasing services, distinct from its facilities involved in providing services directly.

There is a tendency to term the Input-based funding to public sector as undesirable and "passive purchasing", whereas hiring the most efficient providers is seen as "active" or strategic purchasing. Purchasing from private sector was even visualized as contributing to social solidarity, provided the governments paid the bill.

'SP' has also been advocated as an alternative mechanism for regulation of private sector and as means to harnessing energies of the large private sector for public health goals in Low and Medium Income Countries (LMICs) and allowing the poor access to its services. According to WHO, SP can help in bringing a large number of private providers into a structured public–funded system, thus allowing their regulation through contracts. Contracting private providers through public coverage arrangements is also seen as an important avenue for setting rules.

Another justification given for 'SP' is that it can encourage 'risk pooling' and avoid "Fragmentation" of health systems. Some have emphasized 'equity' as goal of SP with the hope that it would bring in more contributions from the rich through mechanisms like 'mandatory insurance', and it would bring the poor and the rich into a single pool and further governments in Low-income countries could leverage these pooled funds to build their public-health systems.

**Theoretical Underpinnings of Purchasing**: SP draws its theoretical basis from the Principal-Agent framework. In this context the principal is the citizen and the agent is the government or its bureaucracy. The argument is that government follows its selfish interests and is not sufficiently accountable to the citizens but converting government services into markets where services are commodified will give the power back to the citizen. E.g. a citizen armed with health-insurance will have the power to buy the healthcare he/she wants, to "exit" from the inefficient public system and to be free to access private hospitals of his/her choice.

SP draws heavily also from the "New Public Management" (NPM) discourse where government operations have to be stylized on private-sector lines. Under NPM around 1990s, a move from market to a quasi-market was seen as desirable and adequate. 'Quasi-markets' were the form of public service delivery that retains state funding for the service, but with users having the choice of independent providers operating in a competitive market. SP is a result of the re-assessed form of quasi-market. It was an evolved form of NPM. It retains Purchaser-Provider split, the central principle under NPM. SP focuses on use of contracts, focus on outputs and measurement of performance – all essential features of NPM. Under NPM, the prescription was more explicit – make less, buy more. SP on the other hand seems to be more 'nuanced' and a preference for hiring for-profit providers is less explicit. It is willing to accept the possibility of some situations where government is more efficient than private sector and recommends use of public-provisioning in such cases. SP positions itself as willing to buy from either, based on its strategic considerations. While early NPM had its roots in neoclassical theories, SP as its evolved formulation relied more on Economics of Organisation (EO) theories.

According to (EO) theories, competition is needed to avoid market failure. But it is not easy to find competition in healthcare due to several reasons including spatial monopolies. Purchaser-Provider split is the mechanism to have competition under quasi-markets. Applying EO theories, SP was seen as a move from hierarchy structure of conventional public sector bureaucracy to the market-structure. It seeks to shape the market by promoting competition, through demand stimulus. Competition is also a rationale for the recommendation to move towards output based payments. Demand side financing is important for promoting free choice for consumers or "money follows the patient".

The important point is that 'SP' still seeks to distance itself from neo-liberalism. 'SP' recognizes 'information asymmetry' and the market failure in healthcare but seeks to make the markets work or mitigate the 'market failure' by aligning the incentives through contracts. Contracting is the physical form through which 'SP' seeks to align the

interests of the providers and the patients. It therefore proposes performance-based financing i.e. providers giving better services to people will be rewarded and that will also aid greater competition, which in-turn delivers efficiency by reducing costs and improving quality.

The SP discourse is built on the following main theoretical premises:

- Competition and Choice increases efficiency
- Output based payments 'Money follows the patient' make the 'supply' more responsive to 'demand'
- Alignment of Incentives gives desired performance, irrespective of ownership of facilities and the public/private character of providers
- Contractual conditions are effective in regulating provider behavior

**Purchasing in practice** - Purchasing is mainly concerned with the Government or its agencies or Insurers buying healthcare services from health facilities. Thus it is different from input-side procurements e.g. of drugs or outsourcing of auxiliary inputs like transport, laundry or catering. SP is about buying services side of healthcare i.e. clinical/medical care services like ambulatory visits to consult a doctor or nurse, hospitalization, surgery, other intervention procedures or diagnostics.

In LMIC situations, Publicly Funded Health Insurance (PFHI) and Public-Private Partnerships (PPPs) are the main examples of purchasing for healthcare by government, involving contracts with private or public providers.

PPP experience in India shows that a large proportion of PPP contracts in clinical care did not work and hardly any could survive beyond a decade. Some of them transferred public resources to private hands. The assumptions of private being 'better' did not work. The few PPPs that performed better and survived were characterized by purchasing being limited to filling a critical gap in public provisioning, with a limited scale of activity. Diagnostics services remains one of the key areas of PPPs but even in that part there is a growing realization of its inadequacies, lack of quality and dangers of promoting over-prescription. They fail to take into account the relationship between physician and laboratory.

Publicly funded health insurance (PFHIs) schemes involving insurance companies and contracting of private providers are now the most pervasive form of SP in many LMICs including India. PFHI based purchasing in India so far has mainly been for in-patient/hospital care. Such schemes have now completed a decade of implementation in several states of India. 'Ayushman Bharat', the current flagship of Indian Central Government in healthcare, prominently includes PFHI scheme called Pradhan Mantri Jan Arogaya Yojana (PMJAY), which aims to expand the coverage under strategically purchased services to 500 million people. It represents a big boost to SP in Indian policy. PFHI has emerged as the biggest form of purchasing in India, in coverage, volume and funds involved. However, there is clear evidence of its failure in its fundamental purpose – of ensuring financial protection. A majority of the hospitalizations in private sector involved catastrophic expenditure for patients despite being enrolled under PFHI. The Out of Pocket Expenditure (OOPE) in private sector has remained almost same for

hospitalizations of the PFHI-enrolled as compared to the non-enrolled. It represents price discrimination by private providers, to capture the insurance benefit. It operates through 'double-billing', where private providers take claim-amounts from PFHI and also take extra money from patients. There is evidence that the decision-making in purchasing of healthcare by government involved 'provider-capture' with private sector dominating the decisions of service-mix, pricing and monitoring. The overlap in services purchased, between public sector and private sector shifted some services and revenues away from public sector. PFHI took away a substantial part of state health budgets. Most of the PFHI insurance claims went to private providers. Private sector services were concentrated in urban areas. It increased inequity for rural population, who get enrolled but have poor availability of providers. Studies find that Tribal sub-plan was used to fund substantial share of PFHI, representing transfer of resources from tribal to urban areas. Literature evaluating PFHI in India has asked the question whether the poor achievements of PFHI schemes could have improved with a bigger cover. The answer from recent studies is that it does not. PFHI did not perform well even in states known for better governance capacity in India. Public sector due to several times lower OOPE, offered better efficiency and financial protection. Increasing share of public-sector provisioning can bring down total cost of healthcare for society.

In many High Income Countries (HICs), public sector continues to play the dominant role in provisioning. Nearly 95% of the total hospital-beds in Europe were in public or non-profit sector in 2013. WHO acknowledged the role of 'classical universalism' in building successful health systems while advocating 'new universalism' in 1999. 'New universalism' was an attempt to redefine solidarity, where public funding was essential but public provisioning was not. This recommendation was aimed more at LMICs. Some of best known successful health systems in LMICs involve a dominant role of public sector in provisioning, e.g. Thailand, Srilanka, Malaysia, Cuba, Brazil and Costa Rica.

NPM kind of reforms have been justified by pointing out the poor responsiveness of public sector and widespread corruption in it. But NPM reforms are unsuitable for LMICs because of high likelihood of opportunistic behaviour by private sector there. The ability of government to regulate private sector is poor. Purchasing from private sector was more problematic than direct public provisioning in the Indian context. The public sector showed some advantage also in terms of being more accessible to the vulnerable populations in remote rural areas. There was OOPE involved in utilizing public sector too but it was several times less than in private sector. According to EO theories, Hierarchy governance structure offered advantages when reducing opportunistic behavior is priority. Hierarchy (though weak on incentives) can have advantages in a context where powerful providers dominated and the system was deficient in control mechanisms and regulation. Hierarchy also offers advantage when societal objective is equity in access and providing according to 'need'.

Aligning the incentives through purchasing contracts has been found to be most difficult. Even in the first-world situations, it was highly difficult to align the incentives of investor owned for-profit private hospitals with public-health goals. Contracting with not-for profit sector has been suggested as a solution. India's National Health Policy

advises a similar prioritization of partnering with the not-for profit sector, but the advice seems to be ignored in implementation.

**Current Big Push for Purchasing in LMICs including India -** SP is being aggressively promoted as the policy option every country has to take if it is to make progress towards UHC. It seems that a global consensus is being imagined around SP without the concept and its practice receiving adequate scrutiny. The reforms involving contracting of private providers by governments were initiated in rich countries Recent years have seen the policy-community stepping up its advocacy for LMICs to adopt SP. Global institutions like WHO are organizing multiple global/regional events to engage with policy-makers from LMICs and coming out with guides for countries to take up SP. There is a clear visible focus of WHO on promoting SP especially after the World Health Report 2010. Academic institutions involved in policy research and advocacy are also actively advocating for SP for LMICs. Influential global donors and non-state actors are also promoting SP in LMICs including India. Global institutions like World Bank and WHO are promoting 'SP' as desired policy for LMICs, even though the evidence of success of such reforms has been very limited. The role of international financial and health institutions in promoting SP on LMIC agenda requires scrutiny.

SP figures as a prominent strategy in the recently unveiled National Health Policy (NHP) of India. Different sections of NHP articulate different roles of SP. One section of this policy document sees SP as a route for improving 'access', by filling critical gaps in services which public provisioning is unable to provide currently (GoI 2017). The focus of this policy seems to be on secondary and tertiary care. For 'purchasing', it prioritizes government owned facilities followed by non-profits and the for-profit private sector is included as the last option. However, there are other sections in the policy that call for SP for across the board services in urban areas, including for primary care. Another section of the policy sees promotion of private sector as a desired goal and envisages SP as a means to provide stimulus to it.

The biggest proponent of SP in Indian policy space is the NITI Aayog. This powerful body has in collaboration with experts from World Bank come up with a formulation of new pathway for reform in form of its publication "Health System for a New India – Building Blocks". We are familiar with the health-systems Building Blocks proposed by WHO and they are structured around a public provisioning system are about its input-based financing and other components. The NITI Aayog version is a brazen attempt to replace the WHO's building-blocks with a "market" based formulation. 'SP' finds a prominent place in this vision of health-system based on market logic. Another threat to public provision has emerged from the emphasis on the problem of "fragmentation" of healthcare which gets exploited by the neo-liberal policy-advisers to push for integration through the market route.

**Conclusion –** The recommendation in SP is to be pragmatic. Public financing is seen as enough for achieving solidarity and choosing providers is to be guided by efficiency and quality. However, solidarity is essential for ensuring healthcare and it is incompatible with most forms of market in healthcare, and strategic purchasing cannot address these shortcomings.

Market ideology in healthcare is a shape shifting ghost and Strategic Purchasing is the shape it has taken under the UHC discourse. While privatization relied on the small government of neo-liberalism, Purchasing is built on Principal-Agent frameworks. The purchasing paradigm and the market template have no solutions to the continuing challenge of information and power asymmetry. It has failed to understand the fundamental nature of healthcare production. The progress towards the goals of UHC are likely to remain elusive under a 'strategic purchasing' approach that perceives healthcare as a market commodity.

Achieving the Right to Health and HealthCare: A strategy for peoples movements
A DRAFT for DISCUSSION

This background paper makes ten key statements for us to think about and act upon: (The first six statements are elaborated upon in the annexure)

1. **The Government Commitment**: The Indian government is already committed to achieving the right to health and right to healthcare and should be held accountable to this commitment. We should neither forget, nor let government ignore or distract us from this commitment.
2. **Learning from Past experience:** Many nations including almost all developed nations except the USA have some right to health act or equivalent in place. There have been past moves to pass such an Act in India and one state has actually passed such an act. We must learn from them.
3. **Necessary Political Conditions** Present political conditions are not favorable to an Act. Peace at the borders, diminished internal conflict, a commitment to federalism, a commitment to a welfare state, a commitment to equity are also essential political conditions of the realization of the right to health and healthcare. Emphasizing equity and sustainability in all development policies is essential for achieving the right to health with equity in health outcomes.
4. **Need for a Road Map**: A road map to achievement of universal healthcare is also a requirement for achieving the right to healthcare – which is an essential sub-set of the right to health.
5. **Need for a Campaign:** A campaign for right to healthcare is almost a necessary condition for saving and strengthening public health systems.
6. **The Campaign as a Platform**: A campaign for right to health and right to healthcare act would be a campaign to address the political conditions required for the act as well as to reorient health systems in the direction of equity. This is an achievable goal that can attract many sections of health professionals, healthcare providers, students aspiring for employment in health and healthcare related occupations, employees in the private and public sector, and working peoples from all walks of life, and students, youth and women to become a part of.
7. **The Central objective of the Campaign**: Their main objective of this campaign would be to shape the public understanding of what is required for the right to health and right to healthcare and propose a road map to achieve this. An equally important collateral objective is to contest the dominant discourse imposed by international health agencies and large sections of international academic community, which legitimizes and facilitates shaping health services as vehicles for corporate profits- usually on the lines of the US healthcare system.
8. **The roles of AIPSN and the JSA:** This campaign would by AIPSN and its member organizations in partnership with the Jan Swasthya Abhiyan of which the AIPSN is a founder and an active constituent. The participation of the AIPSN with large membership among school and college teachers, students, and working people, gives its an opportunity to take this campaign to many new sections. The JSA is a major source of both resource persons and fraternal organizations. Many NGOs who work with us may have different priorities due to the nature of funding support that is available to them. Because PSMs are membership based and raise resources in a decentralized way, they should be able to set their own agenda much better. But what would limit us is the lack of capacity to do so.
9. **State Specific Content Development:** One of the immediate tasks is to develop PSM understanding, at the state level, on the main causes of ill health and disease that affects the state population. This is important because selective healthcare (selective benefit packages) has colored our thinking. Selective healthcare packages in the public sector, is one of the

central tenets through which privatization of services has been promoted and discrediting of public services and misdirection of reform efforts has taken place. Once the main causes of morbidity and mortality and their social determinants are understood and articulated, this can be linked to an understanding on the key themes of the political economy of health and healthcare, issues related to organization of health services and human resources, and the measures/demands needed to save and strength hen public services. The JSA already has developed a robust understanding on gender equity and issues of equity in health and health care, access to medicines and its relationship to issues of patents and trade, and issues related to nutrition and environment and these understanding would also be incorporated. This means the development of a number of booklets or papers with good quality academic support and with participation of those who are close to community and work on such issues.

10. **Outlines of a state activity plan**: Such a campaign would require creating resource persons in the district level who would be PSM members, earning from their respective jobs, but working "voluntarily" to take forward the discourse (a) into their work places, (b) in their professional/worker associations as well as in (c) local media channels and (d) social media groups. The bulk of the messaging would be educational and focus on what local communities and families can do to safeguard their health. (This also would needs its own content and media development). But in addition the messaging must also include such inputs are as necessary to the political determinants of universal health care and the right to health.

**Annexure- Elaboration of Statement 1 to 6.**

**Statement 1: The Indian government is already committed to achieving the right to health and right to healthcare and should be held accountable to this commitment. We should neither forget, nor let government ignore or distract us from this commitment.**

1. Achieving the right to health and healthcare is a most important social goal. At the international level this was highlighted first in the Universal Declaration of Human Rights in 1949 and the reiterated in the International Covenant of Economic, Social and Cultural Rights (ICESR) adopted in 1976, and acceded to by India in 1979. This was further reinforced by the adoption of the Declaration of Health for All by 2000 AD at Alma Ata in 1978. General Comment 14 adopted in 2004 has further elaborated upon the health rights under Article 12 of the International Covenant. As a signatory India has an obligation to progress towards achieving this right
2. The right to health and right to healthcare also flows from the Directive Principles of the Constitution, where over a time frame this was to be a realized as a constitutionally guaranteed right. A number of Supreme Court rulings linking the right to health with the right to life have also sought to treat the right to health as implicit in the constitution.

**Statement 2: Learn from past efforts at making health and healthcare into a justiciable right:**

1. The experience from across many countries is that adopting the right to health is critical to achieving universal health care Most efforts at adoption a Right to Health or similar legislation happen in politically favorable periods Sometimes like in Thailand and Brazil, there are transient- but once passed into law, these can be sustained and act as drivers for achieving universal healthcare.
2. Most European nations, all social democratic states and the former socialist nations have such a law in place. Many of these were adopted in the period just after the second world war, due to both the international political situation, the post war commitment to democracy and equity, and economic theories and ideologies supporting either a welfare state or the socialist state. Even the US had a similar plan in FDR's new Deal, but that alone among the industrialized world got scuttled. In happened in
3. Brazil and South Africa in the context of an internal de-colonization, where repressive discriminatory regimes were over-thrown by struggle. In Brazil there was a long gap between the Act and its implementation, but when a progressive government came to power, it could be scaled up rapidly. Thailand it also came as part of a transient political mobilization and change-but the party that brought it about was soon to lose power. But it had such great success in the roll out that it was difficult to reverse. A active public health community that created a public discourse in favour of the act and its implementation was also one reason it sustained across regime changes. In South Africa, a continuing dialogue over the road-map ( choice of strategy) to universalization limits the progress made.
4. In India the most recent effort was in 2007 to 2009, when the National Health Mission was peaking, under a centre-left coalition that was in power. A right to information, an employment guarantee scheme which included a right to food component, and a right to education got enacted in this period. But many political, economic and health systems factors blocked the same push for the right to health. There are also contestations regarding key parameters of the draft law, which contributed to failure to adopt an Act. The key political divide was whether it should be based largely on strengthening public health services, or whether there should be a shift to purchasing. In the absence of a shift to purchasing, the largely neo-liberal leadership of financial policy and planning commission failed to support the move. When the UPA-2 moved the discourse further to the right, talk of an Act was abandoned altogether. Since then in 2014 Assam passed such an Act, but with

neither the road map or the finances in place and the judiciary declining to intervene, it remained powerless. The experience with right to education is also important.

5. The National Rural Health Mission and its design, and these aborted attempts at enacting right to health was not only due to left-liberal government in power. It was also a direct outcome of a public discourse critical of structural adjustment and health sector reforms promoted largely by peoples health movements/ Jan Swasthya Abhiyan. The final shape of the mission is not the responsibility of the JSA. That was still influenced by many strands of liberalism and the influence of international aid agencies- and therefore the NRHM was an incomplete agenda with even greater hesitation during implementation. But clearly the progressive context of strengthening public service delivery that was at its core would not have taken place without the influence of peoples movement. By 2010 and under UPA -2, as the influence of neo-liberal thought asserted itself (through the planning commission) the political discourse was often characterizing widespread welfare interventions of UPA as freebies. Public services were systematically stigmatized in the public discourse and forms of engagement of private sector and routing all additional public health expenditure through private sector had become dominant.
6. Other than the readiness to invest in health, three constitutional and political issues that thwarted the Right to healthcare Act (a) should healthcare remain a state subject or should it be on the concurrent list- OR should the right to health and healthcare be a state law rather than a central one ( b) should the law be limited to access to healthcare services, which falls under the purview of the health ministries or should it extend to health- where public health measures related to nutrition, safe water, sanitation, environment pollution get equal or more traction. If the latter it stepped on the accountability of other ministries and the legal frameworks that already existed there. (c)whether the responsibility of provision would be completely or dominantly with public providers with legal action/compensation mandated on failure to provide. Could denial of care by private providers, even when under contract be justiciable as right rather than as a contractual violation. The National Human Rights Commission had ruled against this, and earlier court ruling were unable to push such a right in the private sector beyond a preliminary care in emergency situations.
7. Clearly therefore, a consensus on the answers to these questions as well as on a road map to universal health care, (which potentially could be financed and enforced) was required for making the right to health feasible – whenever the political window of opportunity opened up.

**Statement 3 : Necessary Political Conditions**

1. Present political conditions are not favorable to an Act. Peace at the borders, diminished internal conflict, a commitment to federalism, a commitment to a welfare state, a commitment to equity are also essential political conditions of the realization of the right to health and healthcare. Emphasizing equity and sustainability in all development policies is essential for achieving the right to health with equity in health outcomes.
2. We note that France and Germany had been at war for over 300 years or even more- leading to the disastrous first and second world overs, where millions died. Yet after 1945 there has been complete peace between these nations- and even a visa is not required Though both nations had built systems of social insurance, it was only after the peace that they could achieve universal health care and the right to health. India's borders with its neighbours has been tense and there has been considerable enmity, but only peace and a sense of national security that comes from friendships would enable us to find the money that is required for universal health care. Similarly there are huge costs of maintaining control in Kashmir through exercise of state power. Exercises like NRC also have huge costs, and convert huge swathes of a productive population into stateless persons with huge costs in detention.

3. Similarly in a nation as large and diverse as USA or Europe or Africa, federalism is essential. Therefore we should be calling for states acts of Right to Health and Healthcare, with the center committing to addressing uneven development and cross-state issues. But most important, there is a big need for fiscal federalism and federal approach to health policy and implementation is we must move forward. In this context the recent centralizing moves like NEET, NEXT, NMC, PMJAY etc are not the way forward.
4. Finally and understanding of equity and fairness, where the more vulnerable and marginalized the sections the more they have the first claim on the government is essential for universal health care as reflected in the slogan- leave no one behind. This does not sit well with a supremacist culture. Internationally mobile and migrant populations, refugee populations and stateless persons are the special responsibilities of government with respect to health care.
5. Over 70% health outcomes are attributable to social determinants and social determinants in turn are determined by the political economy and how all economic development policies are designed keeping both equity and environmental concerns as central. In a context of growing inequity, with a rapid accumulation of wealth in a few, and mass unemployment and under-employment for the many, better health outcomes become difficult. The nation is going through a period when consumption has fallen, perhaps for the first time ever since independence, unemployment has risen, there is an ongoing agrarian crisis and there are huge problems of water availability and air pollution.
6. It becomes therefore mandatory for the right to health and healthcare campaign to address these issues. Further we believe that a public debate on right to health and healthcare can be shaped to bring pressure to bear on the above determinants of health policy. At a societal level, this may not be the best entry point to addressing these issues, but to those in the peoples health movement and peoples health movement, this is where we stand, and therefore this is where we can start in addressing all of the above.

**Statement 4: Need for a Road Map**:

1. A road map to achievement of universal healthcare is also a requirement for achieving the right to healthcare. The right to healthcare can be seen as an essential but distinct sub-set of the right to health.
2. There are two important reasons why we need an understanding of the road map in public discourse. First we need to ensure that universal health care assures equity in access to all health services that are required and not just selective packages of care-whatever name by which this is done. (essential benefits package, nationally determined sets etc.) In our understanding only important exclusions need to be stated.
3. Second reason for building a public understanding and consensus on the road map is to ensure that universal healthcare is build around robust, good quality, universalized public health services playing the dominant role in healthcare delivery. This caution is important, because there is a planned systematic effort to stigmatize public services, and equate universal health coverage (as different from care) with insurance mechanisms where the emphasis is on government purchasing on healthcare.
4. We believe that the right to healthcare cannot be enforced the same way with private providers, even if contracted, as it can be with public providers- at least under our law. Also the very nature of healthcare demands a relationship which is ring-fenced from monetary incentives and supply and demand logic. Healthcare must be produced at terms where it is not seen as a commodity with the emphasis on its exchange value. It must be produced in terms where it is a human right, a public service- where its use value alone matters.
5. There are also reasons to believe that if the reasons for public provisioning is not built up a right to healthcare can be used (in combination with corporate pressures and judiciary rulings) to include costlier packages of care into insurance packages where more profits for

insurance companies and corporate providers and this is equated with providing access. There are some nations where this has happened. In our own nation, the experience with right to education(RTE) needs to be examined and learnt from. The regulatory controls, that comes with such an Act can squeeze out affordable private providers and build monopoly. The RTE also failed to deal with adverse effects of market forces on costs, quality of education, and inequities in access and outcomes. And as the experience of the RTH in Assam shows with building a public discourse/ understanding/consensus on the road map a RTH act could be a non-starter, even after it becomes the law.

**Statement 5: RTH Campaign is essential for saving and strengthening public health services**

1. The right to healthcare can be enforced only with public providers. In Indian jurisprudence, with private sector one can ask for enforcing contracts- but can one enforce rights to a service. The National Human Rights Commission has repeatedly stated that it cannot bring private services, even those which are contracted under insurance schemes or PPPs to their scrutiny.
2. Since in most rural and remote areas and in under-serviced and marginalized populations, private providers do not operate a right to health care law would force governments to provide services to these sections. This has been the experience in many nations like Brazil and Thailand. But we would need a political window of opportunity to enact such a law.

**Statement 6: The Campaign as a Platform**:

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1. There is a need to bring forth a slogan that can be introduced into the political agenda, an issue that can unite all sections of the people – at least 99%. This is an achievable goal that can attract many sections of health professionals, healthcare providers, students aspiring for employment in health and healthcare related occupations, employees in the private and public sector, and working peoples from all walks of life, and students, youth and women to become a part of.
2. There is a need to develop an agenda in the peoples science movement, and peoples health movement such that it can attract and bring in young medical professionals, and young healthcare providers, researchers and public health scholars as well as many young scholars and graduates working in all social sciences.
3. The right to health and right to healthcare has a clear focus, and an objective that is achievable, and which the government is technically already committed to.
4. Since the right to health and right to healthcare needs to build public understanding on ill-health and its determinants- and these determinants including household and community level causes- there is an opportunity to engage with very wide sections, far outside our usual circles which over time have become very small- such that quite often we are speaking only to those who are already convinced.
5. Since the right to health and healthcare can be addressed only along with addressing the social and political determinants of ill health, it provides us with an entry point into the larger political discourse around democracy, federalism, secularism and nationalism that the country is seized with.
6. A campaign for right to health and right to healthcare act would therefore be a campaign to address the political conditions required for the act as well as to reorient health systems in the direction of equity.