Project for economic education

TOWARDS A NEW HEALTH POLICY

SOME TANGIBLE SOLUTIONS

Discussion Paper

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TOWARDS A NEW HEALTH POLICY
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A Discussion Paper based on the proceedings of a
Seminar held in Mumbai, October 18, 2008

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- All participants for an insightful and enlightening discussion.

DR. K. S. VARADHACHARY

We dedicate this Discussion Paper to the late K. S. Varadhachary, M.D. He was felled by a massive heart attack on October 31, 2008. Just 14 days earlier, on October 18 he was an enthusiastic participant at the Seminar and was looking forward to a follow up of the decisions taken to develop a New Health Policy.

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Introduction

The Project for Economic Education, in association with the Indian Liberal Group held a workshop inquiring into the need for a new National Health Policy. This was on November 11 and 12, 2006 in Hyderabad. It was followed by a discussion in Mumbai on October 18, 2008. The Hyderabad workshop worked on a broader canvas. The discussion in Mumbai, drawing upon the Hyderabad workshop, was more sharply focused – a critique of the National Rural Health Mission and an innovation called 'Argoyabanks'- both these, on the initiative of Dr. Shyam Ashtekar and Dr. Dhruv Mankad.

I had the opportunity to initiate the discussion at both Hyderabad and Mumbai. In the light of the fact that both are really an extension of the same subject – taking a fresh look at the need for a National Health Policy from a liberal perspective – the introduction that follows deals with the subject as a whole.

The criticality of health care is in terms of what it does for the human being and collectively for the national economy. What is our record since independence in trying to reduce mortality rates, or increasing life expectancy and enhancing the quality of life? Even under the present conditions of global economic slowdown the Gross Domestic Product (GDP) has been rising, per capita income has been increasing, but has it made a substantive impact on the human development index? In the 2008 Human Development Index (HDI) Report, of the 179 countries, India is ranked at a disturbingly low 132. What is of critical importance, therefore, is to ensure progressive improvement in the area of HDI, which would eventually translate into greater human happiness. These are the two areas that are central to our approach to an integrated National Health Policy.

What ought to be the scope of the area covering the Health Care sector? Very loosely, it includes hospitals, primary and secondary

care centres and nursing homes, specialty cares, tertiary cares, diagnostic centres, the drugs and pharmaceutical industry's contribution in terms of trying to improve the health services in the country, ancillary services, health insurance and state of the art medical equipments.

So, in this entire framework, we need to identify what ought be the respective roles of the various agencies and institutions that are associated with the health care sector. The most important, obviously, are the central government, the state governments and the local authorities.

Then there is the private sector comprising the corporate and non-corporate entities. The interests of the corporates in the health care sector, are in the drugs and pharmaceutical industry; and production of medical equipments. Civil society has also started taking interest in the entire activity of health care. There are also a number of Trusts running hospitals. What should be their role, what kind of a control or regulatory mechanism should they be subjected to. It is imperative to discuss their respective roles; and, in the process, consider the need for equilibrium between the suppliers and the users of this activity, viz. the consumers, the patients, the human beings, who are the central focus of the health care activity.

Let us look at what happened with some of the erstwhile economic activities which were within the domain of the public sector. During the initial years of liberalization and privatisation, for instance, in the power sector, we did not have adequate and appropriate regulatory framework in place. This should not be repeated when we are trying to open up the health sector to private sector participation. The regulator's role needs to be clearly identified at the levels of the central, state and local levels, and regulations enforced effectively.

Economic and social factors are key determinants in the progress of the health sector which encompasses nutritional

conditions, drinking water supply, sanitation, proper management of solid waste, handling of epidemics and concerns of public hygiene. There is also a strong relationship between the levels of literacy and education and the levels of health care. It would not be wrong to say that higher the levels of education better are the standards of health in the society.

We must, at the same time, recognize the crucial factor of fiscal constraints. Today, the health scenario reveals the fact that the role of the public sector has declined owing to fiscal constraints. Consequently, the role of the private sector is increasing. This, in turn, adds to the burden on the households in coping with mounting medical expenses. Fiscal constraints of the government are here to stay, despite various efforts to introduce fiscal discipline and fiscal consolidation. So, while constructing a new national health policy, we need to keep in mind the limitations arising from the government's own fiscal constraints.

In an international comparison, the USA stands out in terms of the total amount of spending on health care shared equally between the public and the private sectors. It spends roughly 14% (or USD two thousand billion) of its GDP on health. Cuba's communist regime is credited with great success in its health care policy which is largely driven by government expenditure. China is a communist country, though with an open market economy, but private spending on health is larger than public spending. China wants to have more privatization to happen, as is evident in the case of health insurance. What are we spending? We are spending roughly 5% of the GDP on health. These facts clearly suggest a relationship between life expectancy and per capita income, the relationship between life expectancy and mortality rates in terms of money that you spend per capita on health care.

Which way do we now need to move forward? Do we move in favour of private sector spending or do we rely on public sector spending? We surely need to think in terms of how to manage the

private sector's increased spending on health care. However we need to ensure that the delivery mechanism is streamlined in what is going to be spent in the public sector. If we compare the data of China with India, the aggregate spending is virtually the same. China spends 4.7%; India also spends roughly 5% of its GDP. But China has better life expectancy – 72 years against India's 65 years; and a better infant mortality rate of 23 per thousand as against India's 57 per thousand live births. What explains this divergence in the outcome? Is it due more to efficient and effective delivery mechanism? We certainly need to explore the cause and effect more meaningfully.

In India, the burden of health care is borne substantially by households that spend roughly 70% on health care. This means that in the rural areas, if they are going to spend more on health care, they are depriving themselves of their basic needs and will, in the process, slide below the poverty line. This is an aspect we need to bear in mind.

What is the size of the health care industry? Currently, and in broad terms, India is a 40 billion dollar market in the health care sector. And there are expectations that this market will double, probably in the next five years. If it has to double, some contributions have to come from the public sector though such contributions could be circumscribed by financial constraints. Obviously, in such an event, the private sector is likely to bear the entire momentum of the health care activity. If so, the mechanism that should regulate the private sector's role becomes an important issue.

Emerging Trends in the Health Care Sector

If Information Technology (IT) was the powerful growth-engine of the last fifteen years, it is now probably the turn of the health care sector to become one of the rapid drivers not only of economic performance but also of social development. There are global compulsions coinciding with our own compulsions and requirements. India is being viewed as an emerging global hub for the health care industry.

The growing role of the private sector looks likely to take care of the tertiary, specialty cares and, to some extent, the secondary hospitals and the top-grade diagnostic centers. What about the other areas – the primary and secondary health cares where, because of fiscal constraints, private sector participation has to take place within the framework of the emerging pattern of public-private partnership. Is there an alternative we could think of – an alternative that makes it attractive for both governmental institutions as well as the private sector? Otherwise, the private sector would not be interested in that kind of an activity.

Pressures of Commercialization on Public Health

- Already a number of free public (state owned) hospitals have now gradually started levying user charges. Municipal and government hospitals in Mumbai have started levying user charges and this is bound to impact the poor even more.
- In addition to the rising burden of health care expenditures on households, there is going to arise a conflict of interest among the various actors in this sector – the drug and pharmaceutical industry *versus* the government as a consumer (for the government is a major buyer and will be keen on imposing drug price control). There will also be a conflict of interest between civil society and the private sector.
- What also needs to be reflected upon are the implications of the WTO framework, especially the specific provisions relating to health care services and patents under the Intellectual Property Rights (IPR). Whether GATS' rules has something to do in terms of India's compulsion to open up the health sector extensively to foreign participation, say in a year or two, also needs to be carefully evaluated.

Challenges facing the Health Care Sector

To sum up, there are enormous challenges as well as opportunities for reforms in the health care sector of our country.

These are:

- Decline in public spending and issues of governance
- Changes in disease patterns
- Impact of urbanization and modernization in terms of emerging new diseases. In the integrated National Health Policy we are working on, we need to think in terms of issues that are going to be there, say, up to 2020.
- Life expectancy, i.e. demographic transition and the dependency of the senior citizens. India is currently seen to be advantageously placed for the next 20-25 years in terms of a younger population and our current proportion of the aged (of 65 plus) is about 6.5% of the population. But this ratio is going to increase, as a result of which the kind of problems that advanced nations are now facing to support their senior citizens, would be with us by 2030.
- Market failures: We cannot rely entirely on the private sector. Liberalization does not mean freedom and complete liberty to the private sector. Our Integrated National Health Policy should lay down checks and balances that should prevail when the markets are opened up in the health sector.
- We do not have adequate information and documentation in a number of areas. When we talk about networking and integration of various players, and medicinal disciplines, we do not seem to have the right kind of data. The National Health Policy could think in terms of providing some kind of a structure leading to an integration of the various disciplines in the health sector.

Finally there are two other crucial issues calling for intensive deliberations:

1) What could be the cost and budget implications of an Integrated National Health Policy? Does it mean that since the central government is spending about Rs.17,000 crores or less than 1% of India's GDP, it will have a much smaller role to play? Would

it also imply that because health is largely a state subject the central government is not likely to give the priority it deserves?

2) Will spending alone deliver the kind of goods or services that are expected? Our aggregate spending at the national level, which is roughly 5% of GDP, is comparable to what many other countries spend. For example, China spends about 4.7% of its GDP on the health sector, and seems to be getting much better results than India. The number of physicians in China is 1.5 per thousand, whereas in India it is 0.6; contraceptive prevalence rate is 87% in China, while it is 47% in India; infant mortality is 23 in China, while it is 57 in India. China's HDI rank is 81, India's is 128. While China is not the ideal model to emulate in its political system, it seems to offer very useful and relevant benchmarks in its very effective public expenditure on the health sector.

We begin this Paper with a list of 16 policy prescriptions for a national health policy that provides a comprehensive benchmark to assess the current state of India's health scene and its future direction.

S. S. Bhandare

Tenets of A Liberal Health Policy

AIM, GOALS AND PRIORITIES

1. **The Aim**: To alleviate human suffering caused by ill health and create conditions for individuals and communities to work and live longer happily. We uphold *Health for All* (HFA) without discrimination based on income, gender, caste, creed or place of origin. Good Health is integral to the national economy, contributes to inclusive growth, as well as to sports and pleasures of civilized life.

2. Health is both a **right and a responsibility** of every individual. A right cannot exist without responsibility, particularly in a democracy.

3. **Hippocratic Oath**: We need to restore the Hippocratic Oath in Health Care, asking for evidence-based and ethical health care. What is more, ethics and evidence are also necessary for public health.

4. **Antecedents and Determinants** of health such as nutrition, lifestyle, water and sanitation are integral to any public health policy. It is equally important to combat health deterrents such as smoking, pollution and occupational hazards, etc. Health is like a Banyan Tree (*see illustration on page 12*)

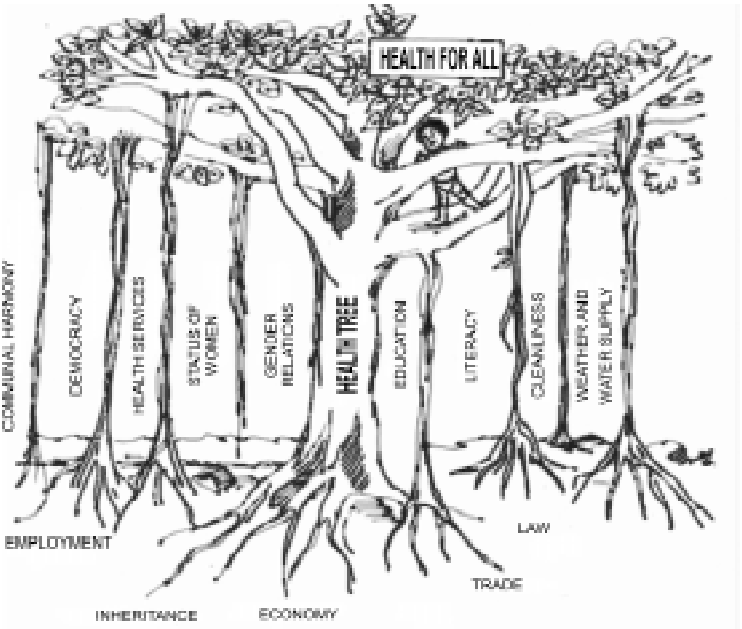
5. **Prioritizing of Goals and Programs**: In a Liberal Health Policy, goal setting and strategy making in health should be based on sound information and reasonable evidence, with due space for health concerns of individual, family, community, province, nation and international community. A Liberal Health Policy accords primacy to goal setting by India's citizens and its democratic institutes rather than by transnational donors and institutes. We especially note the mismatch created by our

campaigns on polio and AIDS in this regard. In all but globally infectious threats, the domestic perspective must be pre-eminent.

HEALTH CARE

6. **Universal Cover**: We discourage the prevailing fragmented nature of insurance for health care as a commodity. Although Health is constitutionally a state responsibility, the accumulated Indian experience of the state-run health care is dismal and marginal. We should promote Universal Health Insurance Cover (UHIC) to be the larger vision of health care wherein all efforts and subsets should ultimately converge. Equity, relevance, access,

Health is like a banyan tree – antecedents & determinants



cost-feasibility and participation are essential elements of Medicare in the UHIC approach.

7. **A Pyramid of Graded Facilities** – primary, secondary, tertiary – is necessary in a country like India with half a million villages and half of our cities filled with displaced villagers to ensure proper distribution, easy access, participation and low-cost national health care system. Medicine cannot be equated with only doctors, drugs and hospitals. We note with concern that the Joseph Bhore Health Care model adopted by free India was severely handicapped as it could not go beyond the straightjacket of hospitals and doctors and had no significant instrument to deal with the village as a unit of India.

8. **Primary or First Level Care** at family, community and clinics should take its optimal, major and pre-eminent position in medical care, rather than hospitals and institutions. This will also promote humane care and minimize information asymmetry. In the same vein, we are for utilizing health workers and so-called quacks with good training and regulation in the domain of primary care in disadvantaged areas.

HEALTH ECONOMICS AND LAWS

9. **'No' to Monopolies and 'yes' to PPPs**: We reject monopolies either by the State[1] or private or corporate sectors. We cannot wish away the large private health sector in India, nor can we ignore the failure of the public health sector. UHIC can be built

[1] Although public health is constitutionally a State responsibility – in the Indian federal system, it is state governments' responsibility – the accumulated Indian experience of the State running the health care system is dismal and marginal. The State's contribution to Public health is just 20% whereas 80% is in the hands of private institutions. It is floundering in the UK too and that is why medical tourism in India is booming because of the European and American failures. Somebody's loss is somebody else's gain. We need to build a better system – neither an entirely US model, nor the UK public health (or tax) model.

even from today's diverse and competing providers, given effective Public Private Partnerships (PPPs). We need to evolve a secondary-tertiary health sector through a PPP approach, making available good care in 'public' as well as 'private' hospitals for all citizens – those who can pay and those who cannot pay by using cross subsidies and public finance and thus start to unify the secondary-tertiary sector under the single umbrella of UHIC.

10. **On Health Economics**: India is spending enough (5% of GDP) on health care, with a larger share in the private sector. We need to get our allocations right and look for efficient use of resources. Cost-optimization, cost-efficiency and cost sharing are guiding factors for health economics. In the long run, separation of point-of-payment from the point-of-service should be the goal, which alone will cleanse the health sector of its current profit-mongering or even sickness-bias. While we are sure that free health care is a mirage to chase, we should ensure that effective and adequate health cover is available to all the disadvantaged, poor, and to risk groups like women in prostitution or inhuman occupations.

11. **Health Laws**: As health and medicine are about saving life and limb and costs of care, the state should do its regulatory role (along with its partial provider's role) in adequate measure and manner. The role of health laws should be limited to prevent harm, deceit and exploitation of the unsuspecting ordinary citizen, but should refrain from regulating individual choice and freedoms that do not harm other individuals. However the rapidly declining female sex ratio is an unwise and inhuman trend and, for this we presume, that the unborn girl child in the womb has an equal right to survival just as the male baby, and society must protect it.

12. **Medical Practitioners' Laws**: Medical Education has not served large sections of our population well, since it has dealt largely with graduate and post-graduate programs. The Medical

Practitioners Act has not been fair to the *other* country, Bharat[2], within our nation. Instead, Bharat has not only been deprived of health care but the Act has led to its exploitation. We need to make available accredited and graded or stepladder academic programs to ensure that we have well trained paramedics in good numbers to ensure health for all in villages and cities and use flexi-learning systems to reach out.

13. **On Pharmaceuticals**: Indian drug policy should be oriented to ensure availability of essential medicines at reasonable cost to the people of India and to promote rational drug use at all levels, rather than merely for trade. Ayurveda and homeopathy also need quality control along with modern pharmaceuticals.

14. **Pathy choice**: A Liberal Health Policy believes that there is no need for hegemony or dominance of any pathy of healing. Modern medicine will take its own due place while we remove the disadvantages faced by other known pathys and alternative-healing systems (AYUSH - Ayurveda, Yoga, Unani, Sidha and Homeopathy) within a broad framework of evidence based health care (EBH).

15. In India's federal system, health is a state responsibility (on the subject list of states). However the states have shown very little initiative to improve the health of its people due to various factors including dominance of policies and programs from the centre. The Liberal Health Policy presumes a greater role, initiative and freedom for individual states to improve the health and health care of their people within a broad national policy framework. Similarly the panchayats and local governments have to play a greater and pro-active role in health and health care especially after the 73rd Constitutional amendment.

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[2] Bharat and India refer broadly to rural and urban India. In Dr. Satish Chandra Das Gupta's book entitled *Home and Village Doctor in* the 1940s for which Mahatma Gandhi wrote a preface, Gandhiji says that he knew that doctors will not go to the villages, so he wanted to have a program for health workers.

16. The use of IT (Information Technology) will help us achieve the HFA goals provided we use IT to further the distribution and depth of primary care to empower people and health workers rather than enrich and empower tertiary institutions through selective telemedicine. We should instead enrich Telehealth to spread the gains of IT equally to the base of the pyramid of health care.

We believe that a *good* health policy is mandatory for a modern nation and that our country's current policy risks poor health and financial exploitation by an uncaring health system.

Dr. Shyam Ashtekar / Dr. Dhruv Mankad

Note: In this Paper, the terms National Health Policy and Liberal Health Policy have been used interchangeably.

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National Rural Health Mission – A Critique

Dr. Shyam Ashtekar

National Rural Health Mission (NRHM) is a programme launched in 2005 by the UPA Government and slated to run up to 2012. It is therefore already half way. I have been critical of its design and implementation, more of its design than implementation.

The Pre-NRHM Scenario in India (context issues)

- India has a very large private health sector – 70%; and a shrinking public health sector, declining in both coverage, utilization and quality
- We have shrinking public investment in health and small central help
- India has no village based health care but mainly vertical (central) health schemes

Objectives of NRHM : The Millennium Development Goals (MDG)

- Reduce infant mortality rate
- Reduce maternal mortality rate
- Improve health care services

NRHM Prescriptions/Content

- Increase fund allocations from 0.9% to 3% of GDP by the year 2012
- Improve facilities – IPHS (Indian Public Health Standards) which includes physical, and human resources
- Decentralisation to zilla parishads and panchayats – devolve powers and funds

- Converge all health programmes and schemes under a single umbrella
- Appoint an ASHA (Accredited Social Health Activist) in every village
- Ensure community involvement, especially Village Health Committees (VHS) through Rugna Kalyan Samitis (RKS) for each public hospital
- To provide incentive to institutional access for childbirth – through Janani Suraksha Yojna (JSY)
- To have inter-sector cooperation with water supply, rural development, women and child development schemes

Schemes and Components of NRHM

- RCH – Reproductive and Child Health (alias Family Planning)
- NVBDCP – National Vector Borne Disease Control Programme (mosquito and flea borne illnesses like malaria, filaria, kala azar, dengue, chikengunya, etc.)
- NLCP – National Leprosy Control Programme
- NPCB – National Programme for Control of Blindness
- NACP – National Aids Control Programme
- IDSP – Integrated Disease Control Programme
- AYUSH – Ayurveda, Yoga, Unani, Sidha and Homeopathy

The Ground Realities Despite NRHM : Mid-course Assessment

- ASHA programme is poor and incomplete
- IPHS coverage has many question marks
- Fund utilization is either tardy or hasty – causing both under-utilization and misuse
- Transparency in procedures and purchases is not adequate

- Hospital births have increased all over the country

States Show No Ownership

- Health is a state subject, but most states have become passive receivers of central schemes. The NRHM uses the phrase 'absorptive capacity' of the states.
- Very little effort to expand health care for people, whereas it has no qualms about purchasing health care from the private sector for its employees.
- Regulation of private health sector also poor or absent in many states.
- Availability of doctors and nurses, especially for the rural services, are serious problems.
- Funds from states have declined post economic reforms.

Is the NRHM Prescription right?

- Village based health care not addressed. ASHA is a mere fetcher of cases. ASHA is poorly equipped, poorly supported and poorly paid.
- IPHS should improve facilities, but HR unlikely to improve substantially, since NRHM does not directly address HR supply.
- Institutional deliveries are increasing, but quality of care will take longer to improve.
- Many other components of health will maintain the status quo as they are not addressed specifically, for instance, the growing menace of high blood pressure and diabetes.
- Special fund flow arrangements *sans* effective accountability may be counterproductive.

ASHA & Village-based Agenda

- The most important issue of village based health care system

is still a gap waiting to be filled. ASHA is too weak a concept to fulfill peoples' needs in health care.

- Large enrolment of ASHA, but poor training, poor payment, scarcity of drugs, and no infrastructure.

Making Doctors Available

- India faces paucity of doctors in rural India due to urban attraction and private sector allurement.
- Pay and working conditions in the state sector are poor as compared to central cadres[3], hence attrition and work 'on paper' and absenteeism.

The PPPs (Public Private Partnerships) under NRHM

- Large private health sector demands a good and long term PPP towards Universal Care.
- The 'campaign against privatization of public facility', on the one hand and, 'corporatization', on the other hand, is pulling the health sector apart as public sector for the poor and corporate for the rich is resulting in an increasing divide.
- A careful and long term arrangement for PPP is necessary, as also separation of point of payment and services. Hence, health insurance.
- In NRHM, PPP is only for childbirth or child survival agenda.
- The terms are not defined well. Fosters crony PPPs.

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[3] Recently I found that doctors in some Assam PHCs are paid Rs.9,000 to Rs.13,000 at the entry level, while a doctor in the Central Government can be paid as much as Rs.50,000 plus at the entry level. Thanks to the Sixth Pay Commission, this central government doctor may get close to Rs.80,000 per month, while the doctor in Assam may get just Rs.20,000 per month. Therefore, the salary component for doctors in states is poor, both in absolute and relative terms. Similarly, for nurses.

The Institutional Obsession of NRHM

- NRHM has an overwhelming institutional agenda mainly for child births.
- This should be supply driven and quality oriented, rather than incentive-based as in JSY.
- We should not neglect the foundation of the health system – primary level care – in this obsession.

Funds and Funds Flow in NRHM

- NRHM increases funds from 0.9% to 1.2% of GDP and upto 3% till 2012. States are expected to hike their allocations in health.
- The District Health Society (DHS) system is a parallel fund receiving system from the centre. This bypasses the usual checks and balances in the government accounting system.
- This divides the health departments into 'haves' and 'have-nots' of NRHM.
- Is it a good system? If so, then why the need for the treasury system?

Decentralization

- NRHM's decentralization is quasi. No real freedoms for states and districts, leave alone villages.
- The prescriptions may not suit local conditions in states.

NRHM-NHM with its Urban Component

- NRHM is slated to expand and cover urban slums (UHM)
- But it lacks substance and can be an empty promise unless the health care sector expands and/or involves PPPs.
- In many states the urban development department is aloof from

state health department.

Health Insurance

- Schemes for poor families have been started, NRHM provides some funds. This is highly tentative and marginal at this stage.
- There are no service providers at this cost in many areas.
- Fragmented insurance may push us into the US type abyss. What we need is a UHIC (Universal Health Insurance Cover).

NRHM in the Context of Our Liberal Health Policy framework

- Neglecting village level primary care, since ASHA is not a serious effort – poor in concept.
- No real freedom to panchayats to redesign health systems.
- Neglect of medical and nursing HR policies.
- No major effort on PPP, in fact, wants to win back clientele from the private sector.
- No effort to involve rural quacks – NRHM turns a blind eye!
- Goal setting by foreign donors through MDGs without attending basic context issues of the 'goals'.
- No big front on antecedents or determinants of health.
- *Rights based approach (!)* but no universal cover available to realize the *rights*.

Positives Aspects of NRHM

- A renewed attention to rural health issues
- Greater allocations
- Some involvement of district bodies and panchayats
- ASHA

Will NRHM Survive the Election? It may!

Because:

- NRHM generates a political will to raise allocations and efforts.
- ASHA is a vindication of the need to create primary care like CHWs (Community Health Workers).
- It talks of devolution of funds and powers to districts.

Need for Larger UHIC vision

- NRHM is not enough – *it is like the goat's tail – neither good enough to ward off flies nor for providing cover*. (A Marathi proverb.)
- We need a larger vision and commitment of Universal Health Insurance Cover covering all people, all providers, all problems and creating a grid of institutions in three layers.

Caution

The US health care model is a trap. Many insurance companies float their policies and instruments, some health problems are covered, some doctors are covered, and some patients are covered, whereas others are not covered. Many people fall through the 'gaps'. The small print becomes more important than the large print. Even in the US, they could not solve this problem as many Senators are on the Boards of these insurance companies. This kind of US insurance model is unique in the world, and it is now also coming to India, but it is *not* the solution for India; on the contrary, it may lead to other problems. Going from fragmented to general universal cover, we need to ensure that the fragments lead to a larger system.

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AROGYABANK

Dr. Dhruv Mankad

A 'Nano' Solution to Health Care

Our country still lives in its villages. We need to have a good health care system for the villages. However, one cannot ignore the urban health scenario. The problems are not only in the slum areas of the cities. The main problem is that there is a lot of flocking around big hospitals and the concept of the family doctor is either receding or being replaced. A direct linkage between individuals, families, communities and hospitals is a big job. There are many other intermediary facilities that are required. The base of the health care pyramid – the primary level care – is nearly non-existent in India. Most states have little or no primary health care. The general practitioner is available only in rural bazaar clusters, and not in every village. A major national challenge, therefore, is how to create the foundation of our health system. It is in this context you will find that the concept of Arogyabank focuses more at the village level.

Arogyabank is a model based on several small experiments done in several places and trying to put together the good things to see if we could construct a better model out of it. These experiments are still on. Some NGOs and study centres are trying out this model. So, we will call it "Our Arogyabank" as it is a collective effort.

What is an Arogyabank (AB)

- It is an outlet for health information, primary care services, health promotion activities and contact/coordination services.
- It is a store of health information and some set of schemes, services as in a bank. Services differ from bank to bank. A bank also means some type of financial transaction.
- Any bank has to be managed by a trained person. The YCMOU

(Yashwantrao Chavan Maharashtra Open University) at Nashik has an Arogyamitra program designed specifically for training such a person.

- It can be situated in every village and, in the urban context, at any place where a community lives – slums, residential complex, etc.

Types of services AB can provide

Public Health Services:

- Disaster management
- Health information for nutrition
- Preventing and reporting outbreaks
- Water quality testing
- School health
- National Health Programme
- AYUSH system
- Supply and follow-up of material, program, etc.

Personal Health Care

- Primary care for simple illnesses like cold and cough, malaria, diarrhea, etc.
- Screening for medium illnesses like diabetes and BP, other chronic illnesses

Profile of an AB

- AB could be situated in a shelter – a scrap vehicle or locally constructed shelters using bamboo or any other local material, a health club, etc.
- It would have simple medical instruments like BP apparatus,

simple test materials, etc.

- It would have AYUSH medicines for simple illnesses.
- It would have first aid material.
- It would have printed material or CDs for health information.
- It can also have a computer with internet connection and cell phone.

What Would be the Minimum Cost?

1. Setting up cost: Rs.1 lakh
2. Running cost: Rs.50,000 per annum
3. Training cost: Rs.5000 per Arogyabank

What is the legal framework for AB?

Although there are provisions on various applicable laws, these are still on a trial. There may not be any legal implications if it is not run commercially.

What are the benefits?

- Reduction of load on hospitals
- Regulates untrained practitioners
- Helps early detection and prevention of illnesses
- Easy access
- Contributes to healthy lifestyle

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Health Policy – A Clinician's Perspective

Dr. Nikhil Datar

I am a prototype of a typical urban medical specialist who never worked in any rural area, never felt the need to concentrate on the subject of preventive and social medicine, rushed in for the post-graduation and started practicing in Mumbai. Now, when I grow older and probably wiser, I feel I should have studied that subject in much more depth and with much more seriousness. I am very glad to have Dr. Ashtekar here, who is an M.D. in preventive and social medicine.

I work as a gynaecologist in a five-star hospital in Mumbai, as well as in the municipal hospital where I am a post-graduate teacher and an honorary doctor. I also run a nursing home where I double up as gynaecologist and hospital owner. I am a member and active worker of important doctors' organizations and understand the problems of doctors as well. The degree of law to my credit helps me understand the legal angle of the situation.

In the municipal hospital where I work, we deliver about 7000 patients a year. I have patients lying on the cot, below the cot, between the cots and may be three or four patients sharing two cots. And, on the other side, at the five-star hospital, in the richest class, I find someone not happy because his insurer has declined to pay up the bill! To summarize, I say that the medical problems of patients across the society are more or less same, but non-medical problems are totally different.

Our Aim : "Health for All"

The WHO slogan of "Health for All" is dear to our heart. But to achieve this objective, have we set out goals right?

The doctors in this country have been divided into four or five streams as if we are born as an allopathic doctor or homeopathic

doctor. This is typically like someone born in a particular caste and having hatred or misunderstanding about another caste. Similarly, the doctors of one "pathy" have apathy to another "pathy". In fact, there should have been a major thrust on integration of various systems of medicine. Now we want to achieve this goal "Health for All" with manpower that is fractured or disintegrated!

Do we want health or do we want treatment? The focus of health especially in the private sector is on treatment and not on prevention. The economics of health shows that prevention is cheaper than treatment. However less thrust is given to this aspect. The major budget is spent in buildings and upgradation of high tech equipment as compared to preventive medicine.

We also need to decide about the word "All" in the slogan "Health for All". Does the word "All" mean every citizen or only consumers? If it is "for All", should the standard of care be the same, irrespective of whether a citizen pays for it or otherwise.

Are We Facing A Crunch of Doctors?

A recent Planning Commission report stated that India is facing a crunch of doctors to the tune of 6,00,000. One does not know whether the Commission has taken into account only allopathic doctors or doctors of all streams. There is reason to believe that if doctors of all streams are taken together there should not be a crunch and definitely not a severe crunch. It must be noted that the deficiency of nurses is even more serious as compared to doctors. The efforts taken to raise this paramedical staff look to be very deficient as compared to efforts taken to churn out more doctors. Is the mushrooming of private medical colleges actually necessary and justified?

Compulsory Rural Health Service

Owing to a lack of MBBS doctors in the villages, the Government announced compulsory rural health service for one year.

There was a provision of a bond of Rs.1 lac which students signed before taking medical admission.[4] Still the system failed. Students paid up the bond rather than put in a year's work at the villages! The bond amount was raised to Rs.5 lacs and still the system failed!

Why did this policy fail? It failed owing to lack of medical infrastructure and supplies in the villages, no proper housing facilities for the posted doctor, no water and electricity. The newly graduated doctors realized it as a waste of time to stay in a village where due to lack of armamentarium they could do nothing to cure patients.

Considering this crunch of doctors (probably of allopathic doctors) in the rural areas, government brought out the idea of "barefoot" doctor who could go in to the rural areas and practice. We don't have the willpower to bring the existing doctors into the main stream and we now want to create a new cadre of doctors. What is the guarantee that the " barefoot" doctor does not become a " booted" doctor and then a "suited booted specialist" and prefers staying back in the city!

Revamp the Medical Curriculum

The medical curriculum taught today is hospital-centric. The aim of the medical graduation course should be to bring out a good family physician – a doctor who can diagnose common illnesses with basic cost effective diagnostics armed with great preventive and counseling skills. Today, a medical student may be able to write umpteen pages on a rare disease but not able to treat a simple snakebite. The textbooks that are read still continue to come from western countries. The developed world has different spectrum of medical problems. The medical curriculum has to be "Indianized" to address Indian problems.

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[4] This bond was to ensure that after graduation the newly graduated MBBS doctor would work for a year in a village.

Do We Need Specialists or Generalists?

Most of the MBBS doctors aspire to become specialists. The real crunch of MBBS doctors is even more than that of specialist doctors. We need to re-strengthen the category of family physicians. These level one physicians should be utilized for preventive health, vaccination, etc. The NHS (National Health Service) of UK has a good system of very special incentives if the person does anything in community medicine. If they have reached a particular target, say in the area of contraceptives, the NHS gives a very good incentive to the practitioners. So the practitioners are very keen on participating and achieving their targets.

Skill Upgradation – An Urgent Need of the Hour

All over the world physicians have to upgrade their skills by attending CME (Continuing Medical Education) programmes. Their medical licenses are revoked unless the doctor puts in certain hours in learning newer skills. This system does not exist in India. Similarly, those doctors who want to acquire special skills or advanced training after the basic graduation are demoralized as there is no authentic way to learn the skill and practice it.

Medical Colleges – Public and Private Sectors

The specialist courses are being offered from various state and national boards and universities. Today a specialist as soon as he passes his postgraduate degree is eligible to practice. The students who postgraduate from private medical colleges may not get adequate hands on experience and are still legally authorized to practice. So, there has to be some system in which it must be confirmed that the post graduate is able to perform in practice.

Health Personnel We Need

Nurses, nursing/physician assistants, paramedics and technicians play an important role in the total health care scenario. However, what we find is a severe paucity of nurses, even in a metro

city like Mumbai. A suggestion had been made to downgrade the course from a Nurse to a Nursing Assistant because a good number of things can be done by a nursing or physician assistant, but it still awaits legal sanction.

Emergency Medical Care

Many attempts have been made to set up an emergency medical care system. None of them have delivered the desired success. Mere judicial pronouncement on the subject may not deliver the results. For that, a well thought out strategy needs to be worked out.

Today's Indian health system does not recognize the word "paramedic". He/she is either a doctor, or a nurse, or a quack, and there is nothing in-between. Emergency medical services, all over the world, are managed by paramedics. In India, we do not have a term called "paramedic", we do not have a term called "nursing assistant". The social recognition and empowerment of the paramedical professionals is poor. This becomes a disincentive for people to take up paramedical courses because they do not have attractive careers and, most importantly, they do not have adequate social recognition in the system, as of now.

Public-Private Partnerships (PPPs)

We have a long way to go before the PPPs become a happy reality in the health sector. Today, the atmosphere in the medical fraternity is very insecure between the public and the private sectors. To cite an example, a woman who had delivered a baby in a private nursing home, developed fever on the fourth day of her delivery and her gynaecologist investigated her and found her to be dengue positive with low platelet count. He explained the sickness to the woman and her husband and added that she may require intensive care later and shifting her at that time would be difficult. So he offered to take her in his own car (she was hale and hearty at that time to travel by a private car) to an institute that is affordable to them where

her dengue problem can be treated. They agreed and the doctor dropped them at a public hospital. The hospital registered the case as a medico-legal case just because of the fact that the case was being transferred from a private hospital to a public hospital. This is the kind of distrust currently prevalent.

Role of Private Nursing Homes in Health Care

70% of the health care is being delivered by the private sector. Almost more than 50% of hospitalization health care is provided by the unique concept of private nursing homes. The nursing homes are smaller hospitals with limited infrastructure where a solo practitioner (sometimes, a few practitioners) work and administer health care. Private nursing homes have a pivotal role to play in the health care segment. They are cost-effective, affordable and approachable. They offer personalized care with a personal touch (the doctor knows the patient, his family, the family's medical history) which one would miss finding in a tertiary hospital. However, they lack in standardization and accreditation.

The insurance and legal sectors are unfriendly towards the nursing homes. The standards of medical care and administrative governance set by the government through these laws are not feasible for the nursing homes due to paucity of infrastructure and manpower. Hence, these nursing homes often come into trouble with legal and insurance representatives. If such a situation continues, the nursing home sector will be extinct one day and we will lose an institution which provides a cost-effective and accessible health care. It must be reiterated here that this sector, if standardized and accredited, made accountable and well governed can perform a salutary role in the health delivery system.

Referral System and Standardization

Standardization of health care from the primary level to tertiary level hospitals in terms of manpower and infrastructure requirements has been adequately dealt with above. A systematic methodology

to shift the patients from one level to another level needs to be worked out. This is equally important.

Laws that Trouble Us

The laws that deal with medical practice have to be reviewed in terms of their success in achieving their objectives. Some laws like MTP Act and the Nursing Home Registration Act need to be upgraded. Most of the new Acts such as PCPNDT Act, Clinical Establishment Act appear to be more of an administrative nature, full of documentation, forms, licensing. These laws are like "misfired missiles" which are fired with intent of curbing a specific anomaly with a path set in some another direction and will obviously not produce expected results.

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Stocktaking of NRHM and Arogyabank

Dr. Srijit Mishra

The presentations by Dr. Shyam Ashtekar and Dr. Dhruv Mankad have brought before us some relevant issues. The discussion raised by Dr. Nikhil Datar from a practitioner's point is equally interesting. I hope that I can add value to these.

NRHM's Goal

To reiterate the NRHM's goal : "To improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children."

Fairness - Some Issues

Keeping this in the background, I will dwell upon some notions of fairness. For this I draw upon three thinkers. To begin with, I invoke John Rawls and his ideas of original position and the two principles of justice. In the original position, the parties who decide on rules, norms and policy are under a veil of ignorance; they do not know which group they represent. This does away with vested interest. In his principles, he emphasizes first, on equal liberties and second, provides equal opportunities and allows for inequalities if it is to benefit the least disadvantaged group.

Amartya Sen has pointed out that, though in an abstract sense, the veil of ignorance is a very powerful tool, but may have difficulties in implementation when it comes to real life situations. He therefore invokes Adam Smith and suggests that the original position may be replaced with an impartial observer.

Another powerful social thought with a greater practical relevance is the Gandhi talisman: *"I will give you a talisman. Whenever you are in doubt, or when the self becomes too much*

with you, apply the following test. Recall the face of the poorest and the weakest man [woman] whom you may have seen, and ask yourself, if the step you contemplate is going to be of any use to him [her]. Will he [she] gain anything by it? Will it restore him [her] to a control over his [her] own life and destiny? In other words, will it lead to swaraj [freedom] for the hungry and spiritually starving millions? Then you will find your doubts and your self melt away." The original position, or the impartial observer, or Gandhi talisman can be used from a public policy perspective.

Equity – Some Concepts

Now I go on to discuss some equity related aspects, particularly from the health care perspective. Equity is not the same as equality. It is based on ethical and moral values based on principles of distributive justice. According to the World Health Organization (WHO), "equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided." Margaret Whitehead's famous quote suggests that health inequities are the "differences in health that are unnecessary, avoidable, unfair and unjust." It is also important to distinguish between horizontal equity, treating people with similar health needs in the same fashion, and vertical equity, treating people with different health needs in a different fashion.

Equity versus Efficiency – Income

Sudhir Anand, Economics Professor at Oxford distinguishes between efficiency and equity. He indicates that more aggregate income is positively valued as a good thing (efficiency), whereas more inequality of income around the average is negatively valued as a bad thing (equity). There could be a trade-off between these two based on aversions to inequality or concern for equality. One may have no concern for inequality – only average matters; or have extreme concern for inequality – the distribution is assessed by the minimum value, a Rawlsian position.

Equity in the Health Domain – Specific Egalitarianism

Sudhir Anand further goes on to state that one should be more averse to inequities in health – because health is not only an intrinsic aspect of human development but it can also be instrumental in furthering other intrinsic aspects. It is true that inequalities in health can be derived from income inequalities. There is a strong case for health and basic necessities of life to be distributed less unequally than people's ability to pay. In short, we are more offended by inequalities in health, nutrition and health care than by inequalities in clothes, furniture or motorcars.

NRHM's Action Plan

Briefly, let me point out NRHM's action plan. They are – increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, operationalizing community health centers into functional hospitals, and meeting Indian Public Health Standards in each Block of the Country. It would have been worthwhile if Dr. Ashtekar's presentation identified some of the loopholes in the design, but could elaborate on the implementation also.

Access and Utilization

Diseases - or disability-wise specificity in states or even districts/blocks with emphasis on seasonal and subgroup (age, caste, gender or income) differences will help attune public policy to improve access and utilisation. The question of access to and utilisation of care also needs to address the availability of caregivers. The outflow of trained caregivers (referred to as brain drain) and the growing private corporate sector will reduce their availability in the public sector.

Issues with Private Caregivers

In India a major part of the expenses is out-of-pocket. Almost 4% of the Gross Domestic Product (GDP) or 80% of the total health expenditure is out of pocket. In the US, you have a large section of it coming from insurance providers. Despite that, 17% of the population in the US cannot seek care because they do not have proper insurance. The US model has its serious drawbacks.

Coming back to India, according to the latest NSS (January-June 2004) about 80% of outpatients, and around 60% of inpatient care are going to private caregivers. We cannot go in for a burgeoning growth when it is unregulated. It should be regulated. That also holds good for the insurance market and other kinds of caregivers. Another problem with the insurance market is that they will try to weed out the high-risk segment population – the poor will be taken out of the insurance coverage, the sick will be taken out of the insurance coverage, and then, only those people who can pay will remain.

Among the private caregivers, I would like to share with you the successful initiative of "Aravind Eye". It is a very good initiative in the sense that the care given is not differentiated, whether you are poor or rich. The rich may take a better ward to stay in, but the doctors who operate on them give the same kind of treatment and care, irrespective of your financial status. They have done some innovations – like the time spent on say each cataract operation is about 5 to 7 minutes, and the paramedics assist in a big way. Another public sector initiative I can mention is the "Jaipur Foot". There are other initiatives like home-based neo-natal care which has given good results in, not only the tribal parts of Gadchiroli, Maharashtra, but also taken up by multilateral organizations for replication not only in some other parts of the states/country, but also in Sub-Saharan Africa.

Efficiency, Inequity and Quality

Four-fifths of health care expenses are out of pocket. There

is increasing usage of private unregulated care and this can lead to supplier-induced demand. For example, you go to a doctor and the doctor may ask you to do several tests that may not be required. This is owing to the nature of the structure – the suggestion that the payment is elsewhere, the care is elsewhere and the doctor does not have to bother about the administrative work and the cost of collecting payment. This will also reduce in some sense. This, on the one hand, increases cost, leads to misallocation of scarce resources and, medically speaking, it compromises on an important aspect, i.e. quality of health care.

Effective Regulation – A Prerequisite

Whether we accept it or not, large sections of health care today are in the hands of the private sector, unfortunately, and India is in the league, and is the worst of the countries in this, along with Burma and Chad where democracies do not exist. And, if private sector has to be successful there has to be effective regulation.

When you talk of 5% expenditure, and say it is very close to China, I will beg to differ. Government expenditure on health is 1%, and the total health expenditure is 5% because, 4% is by private out-of-pocket expenses. The point is, this public expenditure has been ineffective because a large amount of what you consider as public expenditure is actually salaries. So all the problems that have been pointed out, existed prior to ASHA and they still perhaps continue to exist. We are three years into the Common Minimum Programme of the UPA Government and we are coming on to the next election and we are nowhere near that. This means you have just repackaged a thing and put it because your expenses don't seem to increase. What has happened is that we are more bundled with the private sector caregivers and India is among the worst of the countries when it comes to this.

On the NRHM, it is perhaps a bit premature to gauge as to what could be the impact because it is a 12-year-period mission. There are several positive things with NRHM particularly with the

kind of information they are providing, information is updated in the website more regularly, they are taking some positive steps overall like on smoking, though not part of NRHM, and then they have come in with Arogya – a health site which is, in some sense, positive. I need to point out that they are talking of some diseases which are more for certain kinds of groups of diseases, not the preventive kind of diseases or infectious or communicable diseases.

Evidence Based Public Policy

Be it regulation or monitoring of cost and quality, access to or utilization of healthcare, or analysis of epidemiological patterns – public health has to get out of anecdotal evidence and increasingly rely on scrutiny of 'hard facts'. This requires the availability of real-time data in the public domain. Its analysis will help design locally relevant public policy.

Specific comments on presentations – NRHM

To sum up, I would state that Dr. Ashtekar misses the aspect that at least some data with regard to NRHM are very well maintained. I agree that some outcome parameters like IMR/MMR cannot be evaluated at this stage with the available data. Nevertheless, the decline in IMR from 58 in 2005 to 55 in 2007 is too slow to help in attaining the goal of 30 by 2012. A matter of concern is that even after the mission of NRHM, public expenditure on health continues to remain around 1%.

Specific comments on presentations – Arogyabank

The presentation by Dr. Mankad is a good initiative and needs encouragement. One feels that Arogyabank needs to be experimented and evaluated in different conditions. One can appreciate its flexibility, but at the same time, put a note of caution that the project may be a bit too ambitious. A question that begs me is whether there is the possibility of integrating the positive aspects of NRHM with that of Arogyabank.

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Summary of Discussions

Dr. Srijit Mishra's intervention was followed by a discussion. It has been summarized below for ease of reading.

Ashish Deshpande: It was said that the US model is fragmented or it is not good. I would like to know something more about this. Regarding insurance, I would certainly say that the insurance sector is much more flexible, yes, it's costly, but by American standards it is affordable, as compared to India, and available to all age groups and for a variety of diseases or diseases which have been prevalent but which are not available for insurance in most countries of the world.

Insurance, as a commodity, hasn't reached the populace, but certainly it is a commodity, and probably, to my mind, it's a commodity which has probably made the Hippocratic Oath more meaningful. Because, if you translate the Hippocratic Oath, it says that "Do as much good to the patient", now "…as much good…" that when it is being translated from Latin, sometimes it misses the issue. Because when I know that there is a CT scan facility available and I have a doubt in my mind, whether doing a CT scan or an MRI is going to, maybe, help the client then the Hippocratic Oath says – yes. The essence is that the insurance sector or privatized medical care, all these things, contributes to progress.

More than 90% of medical research happens in America, so most of the drugs that we get, maybe, even for malaria, were discovered in that kind of a system. So we cannot really target that system and say that it is not good and it is not worth following.

Shyam Ashtekar: I will just briefly say that, in this system today, the doctors, the patients, the insurance companies, all of them are unhappy, even the political parties. So, this can't be a very good system where everybody is unhappy, except the insurance companies.

Dhruv Mankad: The fact is that even the insurance companies are not very happy about it, because if you look at the recession, the number of claimants has drastically come down. If you look at 2002 to 2004 to till now, what has happened with Lehman is a recent phenomenon. There are at least 7 million Americans who are losing on insurance. The market is going down. And, new companies are coming up to compete with them. Secondly, about health economics: I am not an economist, but all economists agree on one point that health cannot be a free market, so there cannot be a commodity in health market. The information level should be a symmetric level in any good market. I should know what is best for me. In insurance, a third party decides. You don't do that for any other commodity. We decide, as buyers, whether we want to go in for a Suzuki or a Honda, and the company sells it to us. In health, that is not the case.

Thirdly, the data is very clear. The total state expenditure is very high in USA compared to any European or any developed country. Even Scandinavia uses about 13% for salaries, roughly, and it is entirely covered – it's a universal health insurance company. Data also shows that in the USA about 20% are not covered by any insurance.

Srijit Mishra: When we talk about "Equity in Health Domain : Specific Egalitarianism", we are talking about inequities and we all know about income inequities. Even if I give you some allowance that inequities can be allowed in income because of effort, because of various kinds of things, we should be more averse to inequities in health, because health is intrinsic and instrumental to the life of human beings. We should get out of anecdotal evidences. We should be more macro based. You think that because of some doubt, a person needs a scan and you recommend it, fine. But let's have evidence, we have thousands of people who don't have access to care, even ORT (Oral Redehydration Therapy) when they require it. Where should we put our money, where should we put our research, where should it go? Where more people should benefit, where the more vulnerable should benefit.

Now why is the American system wrong? You look at the sickness based structures. That's one thing. The other thing I was trying to tell you is that if you take only health rank, it's the economy which is doing its best; on a zero to one scale, it will get one, whereas Scandinavian countries do much better than USA in the health sector because income does not translate into health automatically. That is where I say that the health system that they (US) have put up is not appropriately getting translated into better lives, longer lives, even if you consider it in terms of life expectancy. It is much lower than many other countries that have much lower incomes.

The US health care system therefore has its drawbacks. If you try to put it in India, it can get translated to further inequalities in health. So we should be much more careful than the West.

Sudhakar Malpe: The 16-point programme is an excellent document. It has a very descriptive opening. Do you interact with the Planning Commission or the Minister of Health? If it can be sent to them then somebody there may help. How do you bridge the gap with the paramedics? What is your suggestion, if at all there is a gap and if at all it is possible.

Nikhil Datar: It is of course possible. I would say that there has to be a great amount of concentric effort because it's apparent that most of us are aware of what is needed, but nobody is able to achieve one. This particular kind of issue has to be taken up at different levels. There are organizations/institutes which are willing to train people as paramedics, as nurses. But there is a problem. We approached the Nursing Council saying "well, you require a Nursing College to be opened which has got so much of requirement, which is very typical for a big tertiary care. But, we are not talking of tertiary care, we are talking of a primary or a secondary care where that kind of an infrastructure may not be needed and an ample number of nursing opportunities can be created. The Nursing Council replied that we don't want our registration to be downgraded, so I said that we could have a different cadre called as "Nursing Assistants". They

said we don't know and that's not under our purview, anyway.

The trouble in the health sector is this that those who are so-called regulatory bodies like the Medical Council of India or the Maharashtra Medical Council or the Nursing Council have probably no connection with the whole health care scenario. For example, the Medical Council can generate action against me, but it cannot be generated against the hospital, because the hospital is not a member of the Medical Council. Today, if at all the Medical Council wants to take action against the Hinduja Hospital, it cannot, because the Hinduja Hospital is not a member of the Medical Council. That is the problem.

Srijit and Ashish were talking about issues – over-exploitation of the system on one side and under-dogging of the system on the other, the trouble is with this kind of standardization of medical care in terms of medical practice, what is just and fair and what is economically feasible. Unless and until you have two strata – one a minimum standard which can be funded by any insurance company, available across the board, irrespective of payment directly, and the other for those who are affluent and willing to pay an additional amount of premium, and can be offered certain kinds of additional screenings or whatever. For example, Ashish talked of extra investigations, I would say, today if I am working in Bombay, the amount of sonographies done of patients in a municipal hospital where the care is free, relatively speaking, are more than the number of sonographies done by a hospital in the private sector. You will be surprised to know that. It's a fact. It can be proved. There is a disparity in the number of sonographies done by the J.J. Hospital or the K.E.M. Hospital of each patient versus number of sonographies done of pregnant patients in a nursing home by a private practitioner/ obstetrician.

The reason is this – we do not know which standard we are referring to, because a patient may say I want sonography done every month, I am willing to pay or my insurer is willing to pay. If I don't

do it, there is a problem, if I do it, there is a problem. Unless and until there is evidence-based economic planning and health care planning that say, in the pregnancy, the standard of care as well as economic surveillance allows you one sonography, anything more than that either has to be co-payment from your side or by any extra premium or whichever way, only then can the system survive to provide a solution to the problem that we are talking of.

G. S. Panikar: The common man seems to be between the devil and the deep sea where public sector medical care is very bad, and at the same time, private sector is very unaffordable and sometimes all kinds of problems arise. So, as Dr. Datar said there are regulatory bodies for doctors or professionals, but not for hospitals. We have been talking about regulations. In a liberalized scenario, we need some sort of a regulatory body where the number of hospitals coming up, where 70% of the medical care is given by private sector and super-specialty hospitals. Can somebody enlighten on the setting up of regulatory bodies for hospitals?

Ashish Deshpande: You made a statement where you said that public sector hospitals are doing a bad job. I work in the field of geriatrics and one of the repeated reports I read is "…due to the improvements in the health sector, life spans are improving…" and when I attend seminars on infant mortality rate, "…the dismal and marginal functioning of the health sector…" So where exactly are we – are we dismal, marginal or is it health sector improvement?

Srijit Mishra: That's a good observation, but the point is that the first observation is from an old study from the US. There are many good studies that have come from the US. I once read a famous Paper "The Failure of Successes". It said: As you live longer, one reason is because of your increasing health care, you become more vulnerable to disease. The number of days that you become morbid increases! But having said that, the other thing is that in India, we have so much of variation, for example, the kind of care available in Kerala, despite the recent kinds of setbacks, both in the public

as well as in the private sector, is way above of what is available in Bihar. Or, for that matter, even in Mumbai, those who have access to certain kinds of hospitals and those who are staying in slums with much lower incomes. So, when we talk of malnourishment and those kind of things there are different groups or subgroups of population who are staying in the same city like Mumbai. As Dr. Datar pointed out there are people who go to municipal hospitals and sharing beds while another group of people go to Nanavati Hospital and don't want to stay even in the general ward. So, we need to be very specific which group one is referring to and the kind of problem that one is referring to.

My question to Dr. Ashtekar and Dr. Mankad: One problem in India, not only in health, but in social service in Maharashtra is the problem of scaling it up. They may experiment in Nashik or your University may do it in Nashik, and there will be good successes. But when you want to scale it up for the whole of Maharashtra or the whole of India, we won't have another Ashtekar or Mankad there when it goes to another locality. How do we address that problem?

Shyam Ashtekar: You have models and models, but you have to build models or design models to a scale of operation rather than just building one model. We are actually building a scale into this model; it is built for numbers. The pilot is going to be of a hundred sizes.

Dhruv Mankad: This is a scaffold and you can put up whatever you want around it, concretize it according to the need. The key to its success is drawn on certain basic principles. Firstly, keep the cost as low as possible, because it is the people who are actually suffering and I know that it's not only the poor who are accessing it, it is the not-so-poor as well who are accessing the same hospitals. And the kind of facilities you are giving – you are dealing with two things – the cost part of it, *where* it will be generated is a different issue and *how much* one can pay is a different issue. This is a key economic point that you can't pay more than a thousand rupees per

day, this is the maximum they are probably charging, even for a heart operation. This is the ceiling they have kept on that and the rest of the cost we will see how to generate. Delinking the payment part and the quality of service delivery part are the two key success points.

Lalit Deshpande: A question to the Group – What do we plan to do? We have had excellent presentations and they threw up number of points. Now as a Liberal Group, what is it that we are interested in doing. Once we are clear about it – I take the Liberal Group as championing some of the individual's rights as well as social rights. How do you tie them together or what should you give precedence and so on. Dr. Srijit Mishra made theoretical presentations of instrumental value and intrinsic value and so on. Now there are a number of groups that are intrinsically important and also instrumentally important – education is one mode and you will have the same problems – is it information, asymmetry of information, it is not only in health that there is asymmetry of information. There are a number of goods. In the light of that, how do you propose to, or, what is the purpose in having this kind of discussion on health where a number of points of view have been expressed, but what is the operational significance of all this, that we want to follow up. How we should go ahead with preparing whatever our final objective or aim is.

Vivek Damle: What is the thinking on population control in terms of resource capacity meaning, resources are limited, people are more, in India or globally, the factor of climate change, we can relate all these things together. What is the status on that in terms of thought process, whether population control is required, not required. I think we have reached a stage where it is beyond control, not manageable.

Sudha Deshpande: If you look at the data on population, the rates of growth of population have come down substantially, so we have succeeded on that front. Now the question is once the children are born are we providing them enough health support and health care? I remember, long time back, Shyam Ashtekar wrote an article in

Loksatta where he had described the kind of medical aid available in villages when most of the doctors are flocking to urban areas. Fewer children are born and there is tremendous awareness to limit the size of the family, irrespective of religion or income. Now that's something that is very important. And, on that score, I think, all demographers are happy, so am I.

K. S. Varadhachary: I have spent 35 years in K.E.M., Nair, J.J. Group, another 20 years in Hinduja Hospital and about 10-15 years with an NGO group. My personal experience of health workers who were selected from the community, from the slums – we had about 60 health workers in our NGO – was that they did a splendid job at a very, very low cost and I think all of us should look into that. They are very good people who go into the community, do checking, take blood pressure, do anemia testing, etc. and it is easily producable. I am sorry about one aspect of government apathy. Dr. Rajnikant Arole of Jamkhed, he is the President of SOSVA (Society for Service to Voluntary Agencies). He selected a couple who was willing to go and work in the tribal areas for a period of ten years. But the government was unable to sanction even one public health unit for three years! The government had the temerity to ask me what is the value addition you are giving. I replied that here is a dead person I am making alive, what do you mean by value addition? By that time, the Health Secretary changed and we got nowhere. Even a person of the stature of Dr. Arole could not get it done, I don't know who can do it, and he himself is on the Committee of the Rural Health Mission!

I am happy with public-private ownership. Glaxo is very active and have given us about Rs.20-30 lacs and we are running two dispensaries in the Nashik tribal districts where there is not even a proper road. It is possible, with good leadership, to have lot of public-private partnerships. It is not a thing that should be scoffed at.

About project cost, my wife and I recently visited Tamil Nadu and went to some public health units. I also visited my own village

with a population of 3000. It has a public health unit covering five villages with a total population of 15,000. There are a hundred patients attending the health unit every day. It has got every health care facility, every medicine possible, two obstetric beds and it has a tie-up with a nearby district hospital. The cost per head, per month is only Rs.10. You will be surprised they are not only giving pregnant ladies health care, but in the last trimester of pregnancy and after three months of delivery, they are paid Rs.1000 per month for nutrition. If the Tamil Nadu government can do it, why can't Maharashtra or other states do it?

Denny John

- To look at the impact of ill-health and poverty as a part of this exercise, because as we know, 80% of the sector is privatized and many people have to resort to loans, and if we go into the figures, health insurance (even including the private or defence or railways) is just about 10% of the total population. A huge chunk of the population are getting impoverished due to ill-health and I work in the area of poverty, ill-health and health insurance, especially in the poorer sections and somehow insurance coverage tends to look at the direct expenses only, whereas social security tries to look into the indirect expenses also – loss of income, long-term care, benefits of the family, loss of employment.

- Dr. Ashtekar rightly pointed out that the design of the health policy is a little bit faulty as no effort is being made to create an evidence-based health policy. There is need to gather information of the kind of disease priorities we have in the community and then building it up to design an evidence-based policy which we don't see in the current NRHM.

- The entire financing of health care has somehow shifted from a typical vertical financing approach a few decades back where each programme was specifically financed and then propagated, to a horizontal financing approach where you have NRHM coming under one umbrella. But now what we see (and this is

so even in European countries) is a diagonal kind of financing approach of how to look at the entire problem as a whole. You want to decrease IMR from 5 points. So what do you actually do right from budgeting, infrastructure support, manpower and how to increase efficiency?

- Looking at the urban poor as a component, many of the indicators in NRHM history point out that the urban poor health indicator is more backward as compared to the rural poor. This point could also be focussed in the document to be produced.

V. S. Palekar:

- What is our objective? Are we talking about equity in health care or in the distribution of intrinsic health. For example, a rich man suffering from cancer is in intrinsically as much suffering pain as a poor man suffering from cancer. Both should be treated equally. So what is the public policy you want to address?
- We have forgotten the crucial role of technology in today's discussion, though there were some references. Modern information technology will go a long way to make for a less expensive health care system.
- Also, the role the chemist plays for the poor in urban areas. When a person visits a chemist shop and narrates a simple illness, say headache, the chemist gives him the medicine. If you are incorporating quacks, you also need to incorporate chemists.
- Some legal issues like a quack treats a patient and he dies. Is the quack free of the kind of immunities that a doctor in a consulting practice is subject to?

The presentations, discussions and questions-answers have brought all of us together to understand that this is not one problem. It is a cluster of problems that really starts with the theoretical one for which we had excellent presentations and the 16-point programme. Then we had practical answers of what actually happens in the

medical profession or what happens to the young medicos.

We should coordinate this effort and present the suggestions to the authorities concerned.

Nikhil Datar: On behalf of the doctors' group, the Association of Medical Consultants, we are absolutely open and free for any kind of discussion and the practicalities of the preparation of the draft, organization-based system of working may be helpful in bringing up certain issues.

Conclusion

Arising from the above discussions, Mr. Bhandare suggested the following plan of action:

a) Preparation of a draft document that will also have the benefit of the deliberations of the two-day seminar we had in Hyderabad in November 2006.

b) Have one more round of discussion on the draft document, as a large number of issues did not find a full-fledged debate during the day's discussion.

c) Bring out a final document that will be presented to the Government.

d) Network with like-minded institutes.

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Appendix

PARTICIPANTS

Dr. R. K. Anand	Pediatrician and social activist
Ms. Aruna B. H.	Paramedic
Dr. Ratna Ashtekar	Pediatrician
Mr. Vivek Damle	Managing Director, Skillnet Solutions (I) Pvt. Ltd.
Dr. Ashish Deshpande	Psychiatrist
Dr. C. S. Deshpande	Economist; Executive Director, Maharashtra Economic Development Council (MEDC)
Prof. Lalit Deshpande	Research Consultant; retired Professor of Economics and Director of Economics, Bombay University
Prof. Sudha Deshpande	Demographer and Economist
Dr. Shekhar Galinde	Occupational Health Consultant
Dr. Mukesh Ghuge	General Physician
Mrs. Kalpana Iyer	Proprietor of a photo studio
Dr. Denny John	Faculty, Institute of Public Health, Thane
Mr. Sudhakar Malpe	Global Centre for Prevention of Diseases

Mr. Varun Miglani	Economist, Indian Merchants' Chamber
Prof. G. S. Panikar	Professor of Economics
Mr. S. V. Raju	Director, Project for Economic Education
Mrs. Kashmira Rao	Director, Project for Economic Education
Mr. Satish Sahney	Formerly Commissioner of Police; currently, Chief Executive, Nehru Centre
Ms. Pushpa Soneji	Executive Secretary, Chartered Accountant's firm
Mrs. Jamna Varadhachary	Joint Secretary, Consumer Guidance Society of India
Dr. K. S. Varadhachary	Physician and social activist

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PROJECT FOR ECONOMIC EDUCATION is a non-party organisation founded in 1985 by Mr. Minoo Masani. On October 4, 2005, the PROJECT was registered as a company under Section 25 of the Companies Act 1956.

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The PROJECT stands for a free economy in a free and liberal society. Its primary objective is to offer critical support to the process of economic liberalisation and to make it both understood by and acceptable to the people. Towards this end, the PROJECT has held a large number of seminars and workshops and sponsored numerous publications on subjects relating to the economy, economic reforms and the importance of a secular and liberal environment based on the Rule of Law.

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