

Reforming Health Policy For Universal Health Care

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"Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State." Since Henry Sigerist said this long ago, most of Europe and many other countries have made this a reality. And today when such demands are raised in third world countries, India being one of them, it is claimed that this is no longer possible - the welfare state must wither away and make way for global capital! Europe is also facing pressures to retract the socialist measures which working class struggles had gained since 19th century. However, while this is an era of global capital in endless search of profit, it is also the era when social and economic rights, apart from the political rights, are increasingly on the international agenda and an important cause for advocacy. The Peoples' Health Assembly is one such example of an initiative on this front and this is perhaps for the first time that health care has come up as a common concern for peoples' organisations, NGOs and others from all over the country.

Thus health and health care is now being viewed within the rights perspective and this is reflected in Article 12 "**The right to the highest attainable standard of health**" of the International Covenant on Economic, Social and Cultural Rights. This requires *availability, accessibility, affordability, and quality* with regard to both health care and underlying preconditions of health.

"Availability refers to the existence of health facilities, goods and services to meet the basic health needs of the people, including, *inter alia*, hospitals and clinics, trained medical personnel, essential drugs and so forth. *Accessibility* means that the above must be within physical reach for all parts of the population (*without any discrimination or conditionality*). *Affordability* requires that the above be affordable for all. (*That is there should be no constraints in the form of payments for seeking health care.*) *Quality* means that they must be scientifically and culturally appropriate. This requires, *inter alia*, skilled medical personnel, scientifically approved drugs and hospital equipment, clean water and adequate sanitation, sufficient information on environmental hazards and health risks. Cultural appropriateness signifies that health policies must be at once respectful of the people's culture and aimed at improving people's health status." (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000; *italicised text in parentheses added by author*)

Review of the 1983 National Health Policy

As a consequence of the global debate on alternative strategies during the seventies, the signing of the Alma Ata

Declaration on primary health care and the recommendations of the ICMR-ICSSR Joint Panel, the government felt that a new approach was required. This was the background of the 1983 National Health Policy (NHP) was drafted.

The salient features of the 1983 health policy were:

- (a) It was critical of the curative-oriented western model of health care,
- (b) It emphasised a preventive, promotive and rehabilitative primary health care approach,
- (c) It recommended a decentralised system of health care, the key features of which were low cost, deprofessionalisation (use of volunteers and paramedics), and community participation,
- (d) It called for an expansion of the private curative sector which would help reduce the government's burden,
- (e) It recommended the establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions, and
- (f) It set up targets for achievement that were primarily demographic in nature.

There are three questions that must now be answered. Firstly, have the tasks enlisted in the 1983 NHP been fulfilled as desired? Secondly, were these tasks and the actions that ensued adequate enough to meet the basic goal of the 1983 NHP of providing "**universal, comprehensive primary health care services, relevant to actual needs and priorities of the community**"? (MoHFW, 1983, P 3-4) And thirdly, did the 1983 NHP sufficiently reflect the ground realities in health care provision?

During the decade following the 1983 NHP rural health care received special attention and a massive program of expansion of primary health care facilities was undertaken in the 6th and 7th Five Year Plans to achieve the target of one PHC per 30,000 population and one subcentre per 5000 population. This target has more or less been achieved, though few states still lag behind. However, various studies looking into rural primary health care have observed that, though the infrastructure is in place in most areas, they are grossly underutilized because of poor facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programs and lack of proper monitoring and evaluatory mechanisms. Further, the system being based on the health team concept failed to work because of the mismatch of training and the work allocated to health

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workers, inadequate transport facilities, non-availability of appropriate accommodation for the health team and an unbalanced distribution of work-time for various activities. In fact, all studies have observed that family planning, and more recently immunisation, get a disproportionately large share of the health workers' effective work-time. (NSS,1987, IIM(A),1985, NCAER,1991, NIRD,1989, Ghosh,1991, ICMR,1989, Gupta&Gupta,1986, Duggal & Amin,1989, Jesani et.al,1992, NTI,1988, ICMR,1990)

Among the other tasks listed by the 1983 health policy, decentralisation and deprofessionalisation have taken place in a limited context but there has been no community participation. This is because the model of primary health care being implemented in the rural areas has not been acceptable to the people as evidenced by their health care seeking behaviour. The rural population continues to use private care and whenever they use public facilities for primary care it is the urban hospital they prefer (NSS-1987, Duggal & Amin, 1989, Kannan et.al., 1991, NCAER, 1991, NCAER, 1992, George et.al., 1992). Let alone provision of primary medical care, the rural health care system has not been able to provide for even the epidemiological base that the NHP of 1983 had recommended. Hence, the various national health programs continue in their earlier disparate forms, as was observed in the NHP (MoHFW, 1983, p 6).

As regards the demographic and other targets set in the NHP, only crude death rate and life expectancy have been on schedule. The others, especially fertility and immunisation related targets are much below expectation (despite special initiatives and resources for these programs over the last two decades), and those related to national disease programs are also much below the expected level of achievement. In fact, we are seeing a resurgence of communicable diseases.

However, where the expansion of the private health sector is concerned, the growth has been phenomenal thanks to state subsidies in the form of medical education, soft loans to set up medical practice etc ... The private health sector's mainstay is curative care and this is growing over the years (especially during the eighties and nineties) at a rapid pace largely due to a lack of interest of the state sector in non-hospital medical care services, especially in rural areas (Jesani & Ananthram, 1993). Various studies show that the private health sector accounts for over 70% of all primary care treatment sought and over 40% of all hospital care (NSS-1987, Duggal & Amin, 1989, Kannan et.al., 1991, NCAER, 1991, George et.al., 1992). This is not a very healthy sign for a country where over three-fourths of the population lives at or below subsistence levels.

The above analysis clearly indicates that the 1983 NHP did not reflect the ground realities adequately. The tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially those residing in rural areas. The present paradigm of health care development has in fact raised inequities, and in the current scenario of structural adjustment the present strategy is only making things worse. The current policy of selective health care and a selected target population has got even more focused since the 1993 World Development Report: *Investing in Health*.

In this report the World Bank has not only argued in favour of selective primary health care but has also introduced the concept of DALY's (Disability Adjusted Life Year's) and recommends that investments should be made in directions where the resources can maximise gains in DALY's. That is, committing increasing resources in favour of health priorities where gains in terms of efficiency override the severity of the health care problems and questions of equity and social justice. So powerful has been the World Bank's influence, that the WHO too has taken an about turn on its Alma Ata Declaration. WHO in its "Health for All in the 21st Century" agenda too is talking about selective health care, by supporting selected disease control programs and pushing under the carpet commitments to equity and social justice. India's health policy too has been moving increasingly in the direction of selective health care - from a commitment of comprehensive health care on the eve of Independence, and its reiteration in the 1983 health policy, to a narrowing down of concern only for family planning, immunisation and control of selected diseases. Hence, one has to view with seriousness the continuance of the current paradigm and make policy changes which would make primary health care as per the needs of the population a reality and accessible to all without any social, geographical and financial inequities.

Section I

Rationale For A New Health Policy

Universal coverage and equity for primary health care are accepted and oft repeated goals. The experience of all countries having near-universal health care systems is that with increased coverage of health care services, inequities in health status decline rapidly.

To assure equity and universal coverage the present health care system needs modifications. The health sector in India is a mix of public and private health care services. To compound this duality there are multiple systems - allopathy, ayurveda, homoeopathy, Unani, Siddha etc ... Studies have shown that the multiplicity of systems is confined to training alone because in actual practice an overwhelming number of practitioners of all systems practice modern medicine (NSS-1987, Duggal & Amin, 1989, Kannan et.al., 1991, NCAER, 1991, NCAER, 1992, George et al., 1992, FRCH, 1993, Nandraj & Duggal, 1996).

The general practitioners together handle over three-fourths of all outpatient cases in both rural and urban areas. These practitioners qualified in various systems of medicine, practice modern medicine - a whopping 96% of them according to the 1987 National Sample Survey on morbidity and utilisation of health services. Thus, private medical practitioners operate under conditions of complete absence of any control, monitoring and regulation by either the government or professional bodies. In fact, there are a large, unknown number of unqualified practitioners, especially in areas where qualified doctors are difficult to find. The role of the private sector in hospital care is comparatively limited

but expanding at a fast rate. The private sector, though owning 68% of the hospitals accounts for only 36% of the hospital beds and 54% of all hospital cases (NSS-1997). However, with the availability of a new generation of health care technologies and the consequent entry of the corporate sector in a large way, the private hospital sector is all set for an unprecedented growth (Jesani, 1993).

In contrast, the public health sector presents a vastly different picture. In urban areas the public health sector has hospitals and dispensaries which provide both outpatient and inpatient care. These hospitals are generally overcrowded; firstly, because their number is inadequate and they are insufficiently staffed, and secondly, populations from peripheral rural areas also utilise urban hospitals for both outpatient and inpatient care because rural areas lack these services. Further, increased migration and expansion of the urban population adds to the pressure on the urban system. In the 1983 NHP it was recommended that hospitals should become only referral centres but no effort is in evidence for evolving such a system. In the rural areas the state has set up a network of primary health centres through which various national health programs are integrated. We have discussed in a preceding section the observations of various studies on the performance and utilisation of PHCs. The weakest component of PHC services is curative care and this is the main reason why PHCs are so grossly underutilized - less than 8% of all illness care (NSS-1987, NCAER, 1991, Jesani, 1992) - and have so little credibility. The PHCs and sub centres, in public opinion, are basically family planning centres. The effort at setting up rural hospitals to fill this demand gap for curative care is woefully slow, and is further made more difficult with the no availability of medical personnel. Observations show that where rural hospitals are well staffed and equipped they are as crowded as the district hospitals. Thus, in comparative terms the public sector serves the urban areas better than it does the rural areas but in absolute terms even the urban population is under-served as far as public health services are concerned.

Apart from the above noted scenario of health care services in the country a further rationale for change in the health policy is provided by global experience in evolving universal health care systems. There is a general tendency to move towards more organised national health systems and an increased share of public finance for health care (Roemer, 1985, OECD, 1990). Almost all developed capitalist (exception USA) and socialist countries have universal health care systems where the share of the fiscal burden by the public sector is between 60% and 100% (ibid.). This trend is the consequence of the pursuit for equity and universal coverage. Countries that have not set up universal systems for health care continue to experience high inequities. In spite of being economically most developed, the USA is an outstanding example where still over 30 million persons don't have access to a reasonable level of health care (President Clinton in his campaigns had promised to wipe out this lack of health care through Federal intervention). The fate of most Asian and African countries is miserable - low public sector investment, large private sector, and wide-ranging inequities in access to basic health care. In the case of most Latin

American countries a significantly large proportion of population is covered for primary health care, though coverage is still not universal. A large country like India cannot wait for economic development as a precondition for health care development. Intervention in social sectors like health, education and housing can be independent of economic development as demonstrated by most socialist countries. These in turn create social conditions for a more rapid economic development.

Framework for a New Health Policy

Before we set out to outline the framework for a new health policy and identify the main issues to be tackled, it is important to define the frame of reference of the health sector. As pointed out earlier, for all practical purposes the health sector may be divided into the private sector and public sector, each with its specific features. To re-emphasise, we had identified two sets of dichotomies in the health sector, the curative (private sector) - preventive (public sector) dichotomy, and the rural (preventive) - urban (curative) dichotomy. It is extremely important to remove these dichotomies for universal coverage and equity considerations. Therefore the first step is to recognise the health sector as a single sector of a public - private mix with a social goal, and the second step is to consider health care as comprehensive without any social and geographical discrimination. Hence there is a need for organising the existing health care system under a universal umbrella for the delivery of primary care as per the rational needs of the people. Further it is important in this context to define the minimum which should be included under primary care.

Primary care services should include at least the following:

- (a) General practitioner/family physician services for personal health care.
- (b) First level referral hospital care and basic speciality (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic) services, including dental and ophthalmic services.
- (c) Immunisation services against vaccine preventable diseases.
- (d) Maternity services for safe pregnancy (or safe abortion), delivery and postnatal care.
- (e) Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
- (f) Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- (g) Ambulance services.
- (h) Contraceptive services.
- (i) Health education.

The above listed components of primary care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. The key to equity is the existence of a minimum decent level of provision, a floor that has to be firmly established. However, if this floor has to be stable certain ceilings will have to be maintained

toughly, especially on urban health care budgets and hospital use (Abel-Smith, 1977). Those wanting services beyond the established floor levels will have to seek it outside the system and/or at their own cost.

There has been some amount of debate on standards of personnel requirements [doctor: population ratio, doctor: nurse ratio] and of facility levels [bed: population ratio, PHC: population ratio] but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, 3 nurses per doctor, health expenditure of approx 5% of GNP etc. Another way of viewing standards is to look at the levels of countries that already have universal systems in place. In such countries one finds that on an average per 1000 population there are 2 doctors, 5 nurses and as many as 10 hospital beds (OECD,1990, WHO,1961) The moot point here is that these ratios have remained more or less constant over the last 30 years indicating that some sort of an optimum level has been reached. In India with regard to hospital care the Bureau of Indian Standards (BIS) has worked out minimum requirements for personnel, equipment, space, amenities etc. For doctors they have recommended a ratio of one per 3.3 beds and for nurses one per 2.7 beds for three shifts. (BIS 1989, and 1992). Again way back in 1946 the Bhore Committee had recommended reasonable levels (which at that time were about half that of the levels in developed countries) to be achieved for a national health service which are as follows:

- one doctor per 1600 persons
- one nurse per 600 persons
- one health visitor per 5000 persons
- one midwife per 100 births
- one pharmacist per 3 doctors
- one dentist per 4000 persons
- one hospital bed per 175 persons
- one PHC per 10 to 20 thousand populations depending on population density and geographical area covered
- 15% of total government expenditure to be committed to health care, which at that time was less than 2% of GNP

The above requirements were worked out, after a thorough study of the health situation in the country, by the Committee members. This exercise is lost to history because of inadequate efforts on part of the planners and policy makers to implement fully the recommendations of the Bhore Committee. The first response from the government and policy makers is that they are excessive for a poor country and we do not have the resources to create such a level of health care provision. Such a reaction is invariably not a studied one and needs to be corrected. We have obtained the following profile after reviewing available information:

(i) Daily morbidity = 1 % to 2% of population, that is about 10 - 20 million patients to be handled everyday (4 - 7 billion per year)

(ii) Hospitalisation Rate = 20 per 1000 population per year with 12 days average stay per case, that is a requirement of 228 million bed-days (that is 20 million hospitalisations as per NSS - 1987 survey, an underestimate because smaller studies give estimates of 50/1000/year or 50 million hospitalisations)

(iii) Prevalence of Tuberculosis = 11.4 per 1000 population or a caseload of over 11 million patients

(iv) Prevalence of Leprosy = 4.5 per 1000 population or a caseload of over 4 million patients

(v) Incidence of Malaria = 2.6 per 1000 population yearly or 2.6 million new cases each year

(vi) Diarrhoeal diseases = (under 5) = 7.5% (2-week incidence) or 1.8 episodes/child/year or about 250 million cases annually

(vii) Acute Respiratory Infections (under 5) = 18.4% (2-week incidence) or 3.5 episodes per child per year or nearly 500 million cases per year

(viii) Cancers = 1.5 per 1000 population per year (incidence) or 1.5 million new cases every year

(ix) Blindness = 1.4% of population or 14 million blind persons

(x) Pregnancies = 21.4% of childbearing age-group women at any point of time or over 40 million pregnant women

(xi) Deliveries/Births = 25 per 1000 population per year or about 68,500 births every day

(Estimated from CBHI, WHO, 1988, ICMR, 1990<a>, NICD, 1988, Gupta et.al.,1992, NSS,1987)

The above is a very select profile which reflects what is expected out of a health care delivery system. Let us take handling of daily morbidity alone, that is, outpatient care. There are between 10- 20 million cases to be tackled every day. Assuming that all will seek care (this usually happens when health care is universally available) and that each GP can handle about 60 patients in a days work, we would need about 350,000 GPs equitably distributed across the country. The actual requirement will depend on spatial factors (density and distance). This means one GP per about 500 families, this ratio being three times less favourable than what prevails presently in the developed capitalist and the socialist countries: Today we already have over 1,300,000 doctors of all systems (550,000 allopathic) and we can integrate all the systems through a continuing medical education (CME) program and redistribute doctors as per standard requirements.

Section II

Making Structural Changes - A New Approach

The conversion of the existing system into an organised system to meet the requirements of universality and equity

will require certain hard decisions by policy-makers and planners. Before we discuss the issues involved for a new health policy we first need to spell out the structural requirements or the outline of the model which will need the support of a policy. More than the model suggested hereunder it is the expose of the idea that is important and needs to be debated for evolving a definitive model. The most important lesson to learn from the existing model is how not to provide curative services. Curative care is provided mostly by the private sector, uncontrolled and unregulated. The system operates more on the principles of irrationality than medical science. The pharmaceutical industry is in a large measure responsible for this irrationality in medical care. Twenty thousand drug companies and over 60,000 formulations characterise the over Rs. 160 billion drug industry in India. (In addition to this there is a fairly large and expanding ayurvedic and homoeopathy drug industry estimated to be atleast one-third of mainstream pharmaceuticals) The WHO recommends 306 drugs as essential for provision of any decent level of health care. If good health care at a reasonable cost has to be provided then a mechanism of assuring rationality must be built into the system. Family medical practice that is adequately regulated is the best and the most economic means for providing good primary health care.

Family Practice

Each family medical practitioner (FMP) will on an average enroll 400 to 500 families; in highly dense areas this number may go upto 800 to 1000 families and in very sparse areas it may be as less as 100 to 200 families. For each family/person enrolled the FMP will get a fixed amount from the local health authority, irrespective of whether care was sought or no (of course, those in remote and sparsely populated areas will get a higher per family compensation because their client strength would be lower). He/she will examine patients, make diagnosis, give advice, prescribe drugs, provide contraceptive services, make referrals, make home-visits when necessary and give specific services within his/her framework of skills. Apart from the capitation amount, he/she will be paid separately for specific services (like minor surgeries, deliveries, home-visits, pathology tests etc.) he /she renders, and also for administrative costs and overheads. The FMP can have the choice of either being a salaried employee of the health services (in which case he/she gets a salary and other benefits) or an independent practitioner receiving a capitation fee and other service charges.

Epidemiological Services

The FMP will receive support and work in close collaboration with the epidemiological station (ES) of his/her area. The present PHC setup will be converted into an epidemiological station. This ES will have one doctor who has some training in public health (one FMP, preferably salaried, of the ES area can occupy this post) and he/she will be assisted by a health team comprising of a public health nurse and health workers and supervisors. Each ES would

cover a population between 10,000 to 50,000 in rural areas depending on density and distance factors and even upto 100,000 population in urban areas. On an average for every 2000 population there will be a health worker and for every four health workers there will be a supervisor.' Epidemiological surveillance, monitoring, taking public health measures, laboratory services, and information management will be the main tasks of the ES. The health workers will form the survey team and also carry out tasks related to all the preventive and promotive programs (disease programs, MCH, immunisation etc...) They will work in close collaboration with the FMP and each health worker's family list will coincide with the concerned FMPs list. The health team, including FMPs, will also be responsible for maintaining a minimum information system, which will be necessary for planning, research, monitoring, and auditing. They will also facilitate health education. Of course, there will be other supportive staff to facilitate the work of the health team.

First Level Referral

The FMP and ES will be backed by referral support from a basic hospital at the 50,000 population level. This hospital will provide basic specialist consultation' and inpatient care purely on referral from the FMP or ES, except of course in case of emergencies. General medicine, general surgery, paediatrics, obstetrics and gynaecology, orthopaedics, ophthalmology, dental services, radiological and other basic diagnostic services and ambulance services should be available at this basic hospital. This hospital will have 50 beds, the above mentioned specialists, 6 general duty doctors and 18 nurses (for 3 shifts) and other requisite technical (pharmacists, radiographers, laboratory technicians etc ..) and support (administrative, statistical etc ..) staff, equipment, supplies etc. as per recommended standards. There should be two ambulances available at each such hospital. The hospital too will maintain a minimum information system and a standard set of records.

Pharmaceutical Services

Under the recommended health care system only the essential drugs required for basic care as mentioned in standard textbooks and/or the WHO essential drug list should be made available through pharmacies contracted by the local health authority. Where pharmacy stores are not available within a 2 km. radial distance from the health facility the FMP should have the assistance of a pharmacist with stocks of all required medicines. Drugs should be dispensed strictly against prescriptions only.

Organising the Health Care System

For every 3 to 5 units of 50,000 populations, that is 150,000 to 250,000 populations, a health district will be constituted (Taluka or Block level). This will be under a local health authority that will comprise of a committee including political leaders, health bureaucracy, and representatives of

consumer/social action groups, ordinary citizens and providers. The health authority will have its secretariat whose job will be to administer the health care system of its area under the supervision of the committee. It will monitor the general working of the system, disburse funds, generate local fund commitments, attend to grievances, provide licensing and registration services to doctors and other health workers, implement CME programs in collaboration with professional associations, assure that minimum standards of medical practice and hospital services are maintained, facilitate regulation and social audit etc... The health authority will be an autonomous body under the control of an autonomous State Health Authority. The FMP appointments and their family lists will be the responsibility of the local health authority. The FMPs may either be employed on a salary or be contracted on a capitation fee basis to provide specified services to the persons on their list. Similarly, the first level hospitals, either state owned or contracted private hospitals, will function under the supervision of the local health authority with global-budgets. The overall coordination, monitoring and canalisation of funds will be vested in a National Health Authority. The NHA will function in effect as a monopoly buyer of health services and a national regulation coordination agency. It will negotiate fee schedules with doctors' associations, determine standards and norms for medical practice and hospital care, and maintain and supervise an audit and monitoring system.

Licensing, Registration and CME

The local health authority will have the power to issue licenses to open a medical practice or a hospital. Any doctor wanting to set up a medical practice or anybody wishing to set up a hospital, whether within the universal health care system or outside it will have to seek the permission of the health authority. The licenses will be issued as per norms that will be laid down for geographical distribution of doctors. The local health authority will also register the doctors on behalf of the medical council. Renewal of registration will be linked with continuing medical education (CME) programs which doctors will have to undertake periodically in order to update their medical knowledge and skills. It will be the responsibility of the local health authority to assure that nobody without a license and a valid registration practices medicine and that minimum standards laid down are strictly maintained.

Financing the Health Care System

We again reemphasise that if a universal health care system has to assure equity in access and quality then there should be no direct payment by the patient to the provider for services availed. This means that the provider must be paid for by an indirect method so that he/she cannot take undue advantage of the vulnerability of the patient. An indirect monopoly payment mechanism has numerous advantages, the main being keeping costs down and facilitating regulation, control and audit of services.

Tax revenues will continue to remain a major source of

finance for the universal health care system. In fact, efforts will be needed to push for a larger share of funds for health care from the state exchequer. However, in addition alternative sources will have to be tapped to generate more resources. Employers and employees of the organised sector will be another major source (ESIS, CGHS and other such health schemes should be merged with general health services). The agricultural sector is the largest sector in terms of employment and population and at least one-fourth to one-third of this population has the means to contribute to a health scheme. Some mechanism, either linked to land revenue or land ownership, will have to be evolved to facilitate receiving their contributions. Similarly self-employed persons like professionals, traders, shopkeepers, etc. who can afford to contribute can payout in a similar manner to the payment of profession tax in some states. Further, resources could be generated through other innovative methods - health cess collected by local governments as part of the municipal/house taxes, taxes on ownership of various assets like property, vehicles etc., proportion of sales turnover and/or excise duties of health degrading products like alcohol, cigarettes, paan-masalas, guthkas etc... should be earmarked for the health sector, voluntary collection through collection boxes at hospitals or health centres or through community collections by Panchayats, municipalities etc ... All these methods are used in different countries to enhance health sector finances. Many more methods appropriate to the local situation can be evolved for raising resources. The effort should be directed at assuring that at least 50% of the families are covered under some statutory contribution scheme.

Section III

Projection of Resource Requirements

The projections we are making is for the fiscal year 2000 - 2001. The population base is one billion. There are over 1.3 million doctors (of which allopathic are 550,000, including over 200,000 specialists), 600,000 nurses, 950,000 hospital beds, 400,000 health workers and 25,000 PHCs with government and municipal health care spending at about Rs.250 billion (excluding water supply).

An Estimate of Providers and Facilities

What will be the requirements as per the suggested framework for a universal health care system?

- Family medical practitioners = 400,000
- Epidemiological stations = 35,000
- Health workers = 500,000
- Health supervisors = 125,000
- Public health nurses = 35,000
- Basic hospitals = 20,000
- Basic hospital beds = 1 million

Basic hospital staff:

- General duty doctor = 120,000
- Specialists = 120,000
- Dentists = 20,000

- Nurses = 360,000

Other technical and non-technical support staff as per requirements (Please note that the basic hospital would address to about 75% of the inpatient and specialist care needs, the remaining will be catered to at the secondary/district level and teaching/tertiary hospitals)

Except for the hospitals and hospital beds the other requirements are not very difficult to achieve. Training of nurses, dentists, and public health nurses would need additional investments. We have more than an adequate number of doctors, even after assuming that 80% of the registered doctors are active (as per census estimates). Crash CME programs to facilitate integration of systems to produce a single cadre of doctors. The PRC health workers will have to be reoriented to fit into the epidemiological framework. And construction of hospitals in under-served areas either by the government or by the private sector (but only under the universal system) will have to be undertaken on a rapid scale to meet the requirements of such an organised system.

An Estimate of the Cost

The costing worked out hereunder is based on known costs of public sector and NGO facilities. The FMP costs are projected on the basis of employed professional incomes. The actual figures are on the higher side to make the acceptance of the universal system attractive. Please note that the costs and payments are averages, the actuals will vary a lot depending on numerous factors.

Table 1. Projected Universal Health Care Costs (2000-2001)

Type of Costs	Rs. in millions
Capitation/salaries to FMPs (@ Rs.300 per family p.a. x 200 mi fam.)50% of FMP services	60,000
Overheads 30% of FMP services	36,000
Fees for specific services 20% of FMP services	<u>24,000</u>
Total FMP Services	120,000
Pharmaceutical Services (20% of FMP services)	<u>24,000</u>
Total FMP Costs	144,000
Epidemiological Stations (@ Rs.3 mi per ES x 35,000)	105,000
Basic Hospitals (@ Rs.6 mi per hospital x 20,000, including drugs, i.e.Rs.120, 000 per bed) Total Primary Care Cost	<u>120,000</u>
	369,000
Per capita = Rs, 369; 1.84 % of GDP	
Secondary and Teaching Hospitals, Incl. med. edu. and trng of doctors/ nurses/ paramed. (@ Rs.2.5lakh per bed x 3 lakh beds)	<u>75,000</u>
Total health services costs	444,000
Medical Research (2 %)	8,880
Audit/Info. Mgt/Social Res. (2%)	8,880
Administrative costs (2 %)	<u>8,880</u>

TOTAL RECURRING COST	470,640
Add capital Costs (10% of recurring)	<u>47,064</u>
ALL HEALTH CARE COSTS	517,704

Per Capita = Rs. 517.70; 2.59% of GDP

(Estimates done on population base of 1 billion and GDP of Rs. 20,000 billion)

Distribution of Costs

The above costs from the point of view of the public exchequer might seem excessive to commit to the health sector. But this is only 2.6% of GDP or Rs.518 per capita annually, including capital costs. The public exchequer's share, that is from tax revenues, would be about Rs.350 billion or two-thirds of the cost. This is well within the current resources of the governments and local governments put together. The remaining would come from the other sources discussed earlier, mostly from employers and employees in the organised sector, and other innovative mechanisms of financing. As things progress the share of the state should stabilise at 50% and the balance half coming from other sources. Given below is a rough projection of the share of burden by different sources:

	Type of Source			
	Central Govt.	State/ Muncp.	Orgns'd. Sector	Other Sources
Enidem. Ser vices	70,000	25,000	7,000	3,000
FMP Services	5,000	65,000	45,000	5,000
Drugs (FMP)	--	11,000	11,000	2,000
Basic Hospitals	--	65,000	45,000	10,000
Secondary/Teach Hospitals	20,000	30,000	20,000	5,000
Medical Research	7,000	1,000	880	--
Audit/ Mgt./ Info. Social Res.	4,000	4,000	880	--
Admin. Costs	2,000	6,000	880	--
Capital Costs	20,000	20,000	5,000	2,064
ALL COSTS	128,000	227,000	135,640	27,064
	Rs.517.704 million			
Percentages	24.7	43.8	26.2	5.3

Section IV

Making the System Work - Policy Issues

To make the above recommended system work a number of policy initiatives and decisions need to be taken. We will not discuss the question of feasibility here because it is a political matter. We will only say this that provision of basic health care will have to be made statutory if the goal is health for all with equity. Thus, the first task on the part of the government would be the proclamation of an organised health care service under which every citizen would be enrolled irrespective of his/her social, geographical or financial status. The structure, the terms and conditions,

administrative measures etc., will have to be spelt out by an Act of Parliament. The Act must take cognisance of existing ground realities and assure that the implementation process addresses these ground realities. For instance, the elimination of rural-urban disparities in health care provision must be the primary task to begin with if such a policy has to be successful.

Another priority policy initiative needed for implementing a universal health care system would be related to tackling the medical profession. A small, established section of the medical profession would oppose any organised system of health care because it would threaten their position in the health care market. In sharp contrast, the younger professionals (the majority) would welcome such a step because it would not only give them an assured market/clientele but it also would provide for relative equality within the profession. This is precisely what happened when Britain introduced the NHS system or Canada implemented its health sector reforms. Thus one of the prime foci of such a policy should be regulating provider behaviour. This would include issues of licensing, registration, CME, compulsory public service, especially in rural areas, strict controls over out migration of doctors, integration of various systems of medicine, standards of medical practice and hospital care etc...

Hitherto the health sector has operated without any restrictions and regulations. This has to be changed to assure better distribution of health human power. Thus licensing in setting up medical practice will have to be resorted to. Strong restrictions and disincentives in over served areas and incentives in underserved areas will be necessary to ensure equitable access to all. This would mean setting up of norms for access and availability, for instance, minimum and maximum number of doctors in a given radial distance or population in dense and sparse areas. Under the FMP system discussed above the remuneration or capitation amounts should be significantly higher in underserved or remote areas, both because of fewer families as well as to encourage the setting up of medical practice in these areas. Further to enhance the number of doctors under the public health sector compulsory public health service must be legislated. No medical graduate must be given a registration until he/she has served a minimum of 5 years in public health services, of which at least 3 years should be in rural areas. Similarly, until the 3 years of rural service is completed postgraduate course registration too should not be allowed. This is the minimum return that must accrue to society for its contribution to the social production of doctors. Also doctors working in the health bureaucracy (directorates, district administration etc...) must by rotation do clinical work so that their skills are not wasted. Further, doctors trained in the country should not be allowed to migrate abroad. In specialties where training is not available within the country only government service doctors should be allowed to go abroad for obtaining those skills and must return and develop that speciality with public sector support.

A major policy issue would be with regard to medical education. In practice the multiple-system doesn't work because people overwhelmingly demand modern medicine, and non-allopathic doctors too practice modern medicine.

Hence there is a need to bring drastic changes in medical education. Whether MCI or the other Councils like it or not, the only solution is to have a single cadre of basic doctors. Those who want to study alternative systems can do it as a basic specialisation. This restructuring is a must to prevent the gross medical cross-practice and malpractice, which at times is dangerous. Thus there is an urgent need to restructure medical education to produce a cadre of basic doctors who would provide compulsory service in the public health sector for a specified period. The integration of existing doctors of different systems of medicine can be done through a crash CME program so that their knowledge and skills are rationalised and updated. Further, doctors should not get permanent registration but periodic with renewal being linked to completion of relevant CME programs as is done in many countries.

Another area of policy action would be setting up standard norms for medical practice and hospital care. The Bureau of Indian Standards has begun this process but more concerted efforts are needed to finalise norms and assure their implementation. This is very important for the universal health care system because the entire monitoring and auditing of the system will depend on having such norms. Social audit and information management can only be facilitated if standards of practice and care are well established.

Issues related to pharmaceutical production and pricing should be a major concern of a national health policy. Unfortunately as of now the health ministry's role is limited to monitoring drug quality standards. The health ministry is presently in no position to assure the production of essential drugs or even drugs required for the various national programs. The health ministry must make efforts at vesting control of the pharmaceutical industry in order to assure the production of rational and essential drugs. For a universal health care system to function unimpaired essential drugs must be available in the required quantities whenever and wherever needed. This will be possible only if the health ministry has complete control of the pharmaceutical industry under its wings.

Finally, the most important area for policy initiative would be the efforts needed to generate resources through various alternative modes of financing. The thumb-rule for a policy on health financing should be that no direct payments are made by patients to providers because a direct payment system increases both costs and inequalities, as well as leaves ample room for irrational medical practice. The health ministry has to pressurise the government to commit a much larger quantum of funds to the health sector. This need not be only through the 'existing mechanism of financing (tax revenues) but also through other public and private sources as discussed in a preceding section. The universal health care system will mean the existence of monopoly buyer/s of health care services. This will necessitate the creation of a National Health Authority that will receive contributions from all specified sources and will disburse funds to all agencies under the organised health care system.

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