HEALTH FINANCING FOR PRIMARY HEALTHCARE IN RURAL INDIA: PROSPECTS AND OPTIONS

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ABSTRACT

Primary healthcare in rural India is provided on the basis of a system of entitlements – a sub-centre with two health workers for 2500-5000 population, a 4-10 bedded primary health center with one doctor and various paramedic staff for 10,000-30,000 population, and a 30 bedded Community Health Centre with six doctors including basic specialists for every 5 PHCs. Apart from this there are sub-district and district hospitals for secondary level referral. While this is the stated norm not all states have as yet achieved these levels. These are reasonable levels (though not adequate or optimal) of provision provided all expected facilities in terms of staff, medicines, diagnostics, maintenance, transportation etc are adequately provided for. That is adequate resources are made available for these services to function optimally. In reality this does not happen even in a developed state like Maharashtra. This paper addresses issues related to resource mobilization and resource use in rural health services and develops a framework that can be used to improve allocative efficiency of existing resources as well as tapping additional resources. The paper begins with a review of rural health services, utilization and expenditure patterns, both in the public and private sector. It highlights the various dichotomies existing in the healthcare system vis-à-vis rural health services. It next looks at how resources are presently being used in the public health system and provides a critical and analytic assessment using data from Finance Accounts of various state governments, and uses an illustration from Maharashtra to highlight resource related concerns, constraints and opportunities within the state. After presenting the above analysis the paper goes on to develop a framework for a universal access healthcare system based on equity. It not only discusses the possibilities within the public system but goes beyond to present a comprehensive framework of a public-private mix which works on the principle of universal access and equity, debunking the iniquitous system of user-charges. The paper concludes with how the framework can be made workable, including a profile of financial requirements for the reorganized healthcare system.

Rural Healthcare

With some roots embedded in the Bhore Committee Report[1] the health policy process in India mandated specific entitlements for public healthcare services in India, especially for rural areas. Of course, the entitlements which the Bhore Committee had recommended, and that too within a rights framework, are far away in the State's governance strategy. What we have is a much diluted version which got consolidated under the Minimum Needs Program started in the seventies. The infrastructural entitlements are very minimal, a sub-centre with two health workers for 2500-5000 population, a 4-10 bedded primary health center with one doctor and various paramedic staff for 10,000-30,000 population, and a 30 bedded Community Health Centre with six doctors including basic specialists for every 5 PHCs. Apart from this there are sub-district and district hospitals for secondary level referral. At the PHC and sub-centre level the focus is preventive and

[1] GOI, 1946: Health Survey and Development Committee, GOI, New Delhi

promotive services like disease surveillance, family planning, immunisation for children and ante-natal care for pregnant women. Data shows that even this minimal provision is grossly underprovided. The MoHFW's own RCH-RHS facility survey[2] indicts severely the inadequacies within the public health system, especially primary healthcare. This state of affairs is largely due to poor investments being committed to primary healthcare over the years. And what is worse, new investments have virtually stopped, expenditures are declining, especially so since India committed to the Structural Adjustment Program under World Bank dictat. In the nineties public health expenditures have declined rapidly both in terms of proportion to government spending as well as a ratio to GDP. In contrast private health investments and expenditures have grown rapidly. This scenario of healthcare is not very encouraging for a country like India which suffers widespread poverty and under-nourishment, especially in rural areas as evidenced by highly adverse health outcomes.

Rural-Urban Differentials in Healthcare Investment and Health Outcomes

RURAL (per 1000 population)	**URBAN (per 1000 population)**
■ Hospital Beds = 0.2	■ Hospital Beds = 3.0
■ Doctors = 0.6	■ Doctors = 3.4
■ Public Expenditures = Rs.80,000	■ Public Expenditures = Rs.560,000
■ Out of pocket = Rs.750,000	■ Out of Pocket = Rs.1,150,000
■ IMR = 74/1000 LB	■ IMR = 44/1000 LB
■ U5MR = 133/1000 LB	■ U5MR = 87/1000 LB
■ Births Attended = 33.5%	■ Births Attended = 73.3%
■ Full Immunization =37%	■ Full Immunization = 61%
■ Median ANCs =2.5	■ Median ANCs =4.2

Source: 1. Health Information India, MoHFW, GOI, 2000, New Delhi
2. Finance Accounts, various states, MoF, GOI, 2001, New Delhi
3. NFHS, IIPS, 1998, Mumbai
4. National Accounts, GOI, 2001, New Delhi

Disaggregated data reveals very severe disparities in distribution of healthcare resources as well as health outcomes across rural and urban areas. The situation in urban India is closer to developed country averages, whereas the rural scenario in India is one of the worst in the world. The disparity in infrastructure is indeed very severe with difference in availability of hospital beds being as much as 15 times less in rural areas and public expenditures 7 times less. In case of health outcomes the urban areas do nearly twice better than rural areas.

The critical factor here is the investment of resources in rural and urban areas. Urban areas have received relatively adequate resources over the years and hence its infrastructure and facilities are reasonable both in numbers and qualitative terms. Rural areas have been neglected historically and the main inputs have been only for preventive

[2] IIPS, 2001: RCH Facilty Survey, GOI, Mumbai

and promotive services, especially family planning and more recently immunisation services. The rural infrastructure had got a boost during the 5th and 6th Five Year Plans under the Minimum Needs program. But since then there has been a declining trend in new investments and slowing down of growth in expenditures, infact decline as a percent to both total govt. expenditures and as a proportion of GDP. The only way to remedy this gross disparity is more resources for the health sector at one level and greater equity in distribution of resources between rural and urban areas at another level.

Utilisation data gives us a clear indication where public resources are being committed. Immunisation and contraception overwhelmingly, and hospital care, institutional deliveries and ante-natal care to a fair extent are in the public domain. But things are changing rapidly in many of these services in favour of the private health sector. It is evident that curative care is dominated by the private sector. If we view this in the context of poverty then such dominance by the private sector (as out of pocket costs to people) cannot produce good health outcomes.

Rural-urban differentials in Utilisation of Various Health Services across Public and Private sectors (percentages)

	Rural Areas		Urban Areas	
Type of Care	Private	Public	Private	Public
Hospital care (1)	55 / 37	45 / 63	57 / 40	43 / 60
Outpatient care (1)	81 / 74	19 / 26	80 / 73	20 / 27
Institutional births (2)	49	51	55	45
Child illnesses (2)	55	45*	66	34*
RTI treatment (2)	77	33	80	20
Child Immunization (2)	15	85	28	72
Contraception (2)	17	83	40	60
Antenatal care (2)	42	58	55	45

Note: For hospital and OPD care 1st figure is for year 1996 and 2nd 1986
* Includes Home remedies
Source: (1) NSSO 42nd (1986) and 52nd (1996) Rounds, GOI, New Delhi
(2) NFHS - India, IIPS, 1998, Mumbai

Rural Health Expenditures

This changing pattern of utilisation is again linked to declining investments and expenditures in the public health sector. That immunisation and contraception are still largely in the public domain is because investment and expenditures in health budgets are increasingly being concentrated for these services selectively. The situation is similar in

rural and urban areas with rural population showing higher rates for public services, especially preventive. Reviewing various utilisation surveys shows that people favour using public services across the board if they were accessible to them equitably and were well provided.

In the late seventies and the first half of the eighties the Central government supported a massive expansion of the rural health infrastructure through the Minimum Needs Program. This helped states mainstream modern health care in the rural areas. Since then the Central government has abdicated its responsibility. Their only interest remains supporting medical care in Delhi and some union territories and promoting aggressively family planning in the rest of the country, especially the villages. The little support it gives for public health programs like tuberculosis, AIDS, leprosy, blindness control etc. are increasingly coming from international borrowings and serving the agenda of international agencies like World Bank and the USAID. Capital expenditures have disappeared and grant in aid to states, which largely supports preventive care programs like the National Disease Control Programs, is also declining as a ratio within the Central health budget. This is clearly an indication that the Central government is cutting back expenditures in the health sector.

The situation of the state governments is not very different from that of the central government. One sees the same declining trends. The state government's expenditures too are mostly on urban health care – teaching hospitals, district hospitals and health administration – and on family planning in the rural areas. One sees a drastic decline of expenditures by state governments on medical care, part of which is absorbed by family planning. Capital expenditures, which were low in the seventies and eighties when the big rural infrastructure expansion took place under the Minimum Needs Program (largely supported by the Centre), also show a declining trend. The fifth pay commission has put a further strain on resources and further worsened allocative efficiencies. All this puts a great burden on out-of-pocket expenses on households, especially the poor and the rural population because it is in the latter that public investment and expenditures have suffered the most.

In the public domain bulk of resources allocated in rural areas are for preventive and promotive care like disease surveillance, family planning, immunisation and ante-natal care. Eighty percent of the curative care budget, especially hospital care is spent in urban areas. As a consequence of this the out-of-pocket burden on the rural population is tremendous. National data reveals that in urban areas out-of-pocket expenditures are twice that of public spending but in rural areas people spend a whopping ten times more than what the state spends on healthcare in rural areas. This adequately demonstrates the gross inequities of our healthcare system and when we correlate this information with the large-scale prevalence of rural poverty the severe handicap in accessing healthcare faced by rural India becomes very evident.

Another issue in public finance is that rural health budgets largely come from plan expenditures, usually as part of vertical programs sponsored by the Centre. Unlike non-

plan funds, plan funds are not internalised expenditures and hence may not have long term commitment. This makes rural public funding highly precarious. Further urban areas also have municipal finances, a substantial chunk of which goes for public health expenditures. Rural local bodies have negligible commitments for public health, despite decentralisation of primary healthcare under Panchayat Raj.

The private domain is totally curative oriented and is strongly driven by the pharmaceutical industry which is responsible for a large volume of irrational and unnecessary expenditures. The penetration of modern drugs is seen in the remotest of areas, and national survey data has adequately revealed that it is a myth that a large part of rural and tribal areas are still dependent on traditional and/or herbal remedies!

Another concern is allocative efficiencies within the public health system. After SAP and the Fifth Pay Commission, the already adverse allocations became more precarious. Since budgets have not expanded in the nineties, and coupled with major increases in salaries, the public health delivery system has been affected adversely. This we have already seen in declining utilisation rates of public provision. The public health system's credibility is at stake.

Rural-urban desegregation of expenditures is not done completely in the accounts. While some expenditures are directly available as rural and urban like rural allopathy and urban allopathy, rural FP and urban FP, capital expenses, etc., others have to be estimated on basis of judgment and experience as to where the expenditure is incurred. Since this requires extensive knowledge of how the state's healthcare system operates it is difficult to estimate for the entire country. Hence we have done this exercise for Maharashtra state alone. In 2000-2001 Maharashtra government spent Rs.15,953.43 million on healthcare under the revenue account and Rs.389.45 million on the capital account. Capital expenditure was only 2.4% of total expenditure on health. This shows that new investments are not being made adequately to upgrade and expand the public health system. Further the total health expenditure (Rs.16.34 billion) is a mere 0.58% of GSDP and 4.2% of total government expenditure. The revenue expenditure on health is only Rs.165 per capita, which is much less than the national average of Rs.220 per capita for the same year. Further the rural-urban gap in percapita spending is more than twice. Urban areas get Rs.236.29 per capita and rural areas get only Rs.112.34 per capita. This is a clear indication of neglect of rural areas by the state in healthcare investment and expenditures. Also the curative – preventive dichotomy across urban and rural areas comes out very clearly in public spending patterns.

Ministry Of Health And Family Welfare Expenditures 1991-2000 – All India

		1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99 RE	1999-00 BE
All India Health expenditure at current prices in Rs. crores	**Total**	5078	5639	6464	7518	8217	10165	11313	12627	16303	17854
	Central	493	558	705	744	1068	1210	1346	1354	1907	2309
	State	4585	5081	5759	6774	7149	8955	9967	11273	14396	15545
Health expenditure at 1981-82 prices in Rs. crores		2775	2711	2822	3031	2988	3434	3591	3826	4631	4891
Real Growth Rate of health Expenditure %			-2.3	4.1	7.4	-1.4	14.9	4.6	6.5	21	5.6
Share of state govt. in total Health expenditure %		90.3	90.1	89.1	90.1	87.0	88.1	88.1	89.3	88.3	87.1
Grant in Aid component from Centre in state Health expenditure %		17.0	16.2	18.9	20.7	18.8	14.8	14.1	15.6	16.1	
Health expenditure to total govt. expenditure %		2.88	3.11	2.88	2.91	2.13	2.98	2.94	2.7	2.9	3.0
Health expenditure as % of GDP		0.94	0.91	0.91	0.93	0.85	0.91	0.88	0.81	0.86	0.87
Percapita health expenditure in Rs./year		60.02	65.34	73.45	83.90	89.9	109.07	119.08	130.3	165.0	177.3

Source: Budget Papers of the Union Government; The RBI Bulletin for state expenditures; (various years)

Differentials in Health Expenditures: Maharashtra 2000-01

(Rs. Million)

Type of Expenditure	Rural	Urban	Total
Medical care	259.55	7457.24	7716.79
Public Health	4514.34	1947.33	6461.67
Family Planning	677.57	61.70	739.27
MCH	136.91	58.68	195.59
Other FW	672.34	167.77	840.11
Capital	84.41	305.04	389.45
All Categories	**6345.12**	**9997.76**	**16342.88**

Source: Budget 2002-03, GOM, 2003, Mumbai

Bringing Basic Health Care Back On Agenda

Post Independence the Indian State had committed itself to comprehensive health care for all irrespective of the capacity to pay. We even had an elaborate national health plan in the form of the Bhore Committee Report. But as we have seen earlier over the years there has been a clear process of dilution of the basic health care package. Basic health care has to be viewed as a right. Today the world has moved beyond only political rights being fundamental, and increasingly social and economic rights are acquiring such recognition. Thus we would like to view health care in a rights perspective and frame priorities accordingly.

Basic health care, or primary health care as it is referred to today, must begin with family physician services and have adequate support of referral services for specialty and hospital care, including special services for the large disabled population. We have to go much beyond the preventive-promotive package we have as primary healthcare in rural areas today. Curative and preventive services have to be integrated so that existing dichotomies are removed. Pharmaceutical services also need to be regulated and organised, especially given the WTO's anticipated impact. With drug price control virtually out of the window, the rising prices are already creating a crisis in healthcare treatment both in public and private domain.

A system based on a public-private mix would be most suitable for the reality in India. The State has to play a central role in helping develop an organised system of health care as against the prevailing laissez-faire approach. The existing health care services will have to be restructured under a defined system and its financing organised and controlled by an autonomous body. To facilitate such restructuring a well defined system of rules and regulations will have to be put in place so that minimum standards and quality care are assured under such a system.

There will be a lot of resistance to implementing such a system but it is here that the State will have to demonstrate its guts. Experience across the world shows that wherever near

universal access exists, the system is a public-private mix organised under a single umbrella, well regulated and with fiscal control with a monopolistic and autonomous agency or group of agencies. The best examples are Canada, Britain, Sweden, Germany, Costa Rica and South Korea, among others.

Public spending on health care is barely 1% of GDP as it stands today. This infact is a decline over earlier years, especially the mid-eighties when it was 1.3% of GDP. Nearly 70% of state spending goes to urban areas, mostly for hospitals. The balance 30% in rural areas is spent mostly on family planning services. Private out-of-pocket expenditures on health care are not available in any organised way. At best estimates can be made based on sample surveys of household expenditures and indirectly by extrapolating on the basis of the strength of the private health sector. It is today estimated to be over 5% of GDP, more than double that of estimates available for the sixties and seventies.

A restructured public-private mix would need much less resources. Estimates calculated for the basic health care package, including existing public secondary and tertiary services would cost around 3% of the GDP. This would mean a whopping saving of 50% of what is spent overall now and coupled with much better quality and more effective services.

In terms of sharing costs the public share would definitely need to go up and private resources would be channelised through employers, employees and insurance funds. The State would have to raise additional resources through earmarked taxes and cesses for the health sector. This would mean a greater burden on those with capacity to pay but there would be an overall saving of out-of-pocket expenses for all but especially for the poor.

Thus the new strategy should focus both on strengthening the state-sector and at the same time also plan for a regulated growth and involvement of the private health sector. There is a need to recognise that the private health sector is huge and has cast its nets, irrespective of quality, far wider than the state-sector health services. Through regulation and involvement of the private health sector an organised public-private mix could be set up which can be used to provide universal and comprehensive care to all. What we are trying to say is that the need of the hour is to look at the entire health care system in unison to evolve some sort of a national system. The private and public health care services need to be organised under a common umbrella to serve one and all. A framework for basic minimum level of care needs to be spelt out in clear terms and this should be accessible to all without direct cost to the patient at the time of receiving care.

Today we are at the threshold of another transition which will probably bring about some of the changes like regulation, price control, quality assurance, rationality in practice etc.. This is the coming of private health insurance that will lay rules of the game for providers to suit its own for-profit motives. While this may improve quality and accountability to some extent it will be of very little help to the poor and the underserved who will anyway not have access to this kind of a system. Worldwide experience shows that private insurance only pushes up costs and serves the interests of the haves. If equity in access to basic health care must remain the goal then the State cannot abdicate its responsibility in the social sectors. The state need not become the primary provider of health care services but this does not mean that it has no stake in the health sector. As long as there are poor the state will have to remain a significant

player, and interestingly enough, as the experience of most developed countries show, the state becomes an even stronger player when the number of poor becomes very small![3]

While reorganisation of the health sector will take its own time, certain positive changes are possible within the existing setup through macro policy initiatives - the medical councils should be directed at putting their house in order by being strict and vigilant about assuring that only those qualified and registered should practice medicine, continuing medical education (CME) should be compulsory and renewal of registration must be linked to it, medical graduates passing out of public medical schools must put in compulsory public service of atleast five years of which three years must be at PHCs and rural hospitals (this should be assured not through bonds or payments but by providing only a provisional license to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies only to those who have completed their three years of rural medical service), regulating the spread of private clinics and hospitals through a strict locational policy whereby the local authority should be given the right to determine how many doctors or how many hospital beds they need in their area (norms for family practice, practitioner : population and bed : population ratios, fiscal incentives for remote and underserved areas and strong disincentives and higher taxes for urban and over-served areas etc.. can be used), regulating the quality of care provided by hospitals and practitioners by setting up minimum standards to be followed, putting in place compulsory health insurance for the organised sector employees (restructuring the existing ESIS and merging it with the common national health care system where each employee has equal rights and cover but contributes as per earning capacity, for example if each employee contributes 2% of their earnings and the employer adds another 3% then nearly Rs.100 billion could be raised through this alone), special taxes and cesses for health can be charged to generate additional resources (alcohol, cigarettes, property owners, vehicle owners etc.. are well known targets and something like one percent of sales turnover for the products and a value tax on the asset could bring in substantial resources), allocation of existing resources can be rationalised better through preserving acceptable ratios of salary : non-salary spending and setting up a referral system for secondary and tertiary care. These are only some examples of setting priorities within the existing system for its improvement.

Priorities For Making It Work

To re-organise the healthcare system we need a policy statement to begin with, that is there has to be a political will to carry out such restructuring and reorganisation as well as the strength to fight resistance from vested interests of the existing system.

While the ideal would be to see an organised system in place with an Act of Parliament, the reality is that the political will is missing. The latter is due to health care as a right not being a priority issue in civil society as yet. However, there is adequate interest and concern to take up piecemeal reforms and here the priorities are clear. Improvements and accountability of the existing system, both in public and private, needs immediate attention. People are demanding quality care and with the consumer courts on their side are increasingly

[3] Data from OECD countries clearly shows that the State is a major player in health financing and over three-fourths of the resources for the health sector in these countries, except USA, comes from the public exchequer; even in the USA it is over 40% but in India the State contributes less than one-fifth, the balance coming out of pocket of households. (OECD, 1990: Health Systems in Transition, Organisation for Economic Cooperation and Development, Paris)

confronting bad medical practice. The medical profession has also awakened to the existing mess and is organising to put its house in order - minimum standards, continuing medical education, accreditation are clearly an emerging agenda with them.

In the public domain there is pressure for privatisation via introduction of user charges. Civil society groups in a number of places are fiercely resisting this. This battle has the potential of taking health care into the arena of a rights perspective and expedite the process towards an organised system of health care.

To establish right to health and healthcare with the above scenario certain first essential steps will be necessary:

- equating directive principles with fundamental rights through a constitutional amendment
- incorporating a National Health Act (similar to Canada Health Act) which will organize the present healthcare system under a common umbrella organization as a public-private mix governed by an autonomous national health authority which will also be responsible for bringing together all resources under a single-payer mechanism
- generating a political commitment through consensus building on right to healthcare in civil society
- development of a strategy for pooling all financial resources deployed in the health sector
- redistribution of existing health resources, public and private, on the basis of standard norms (these would have to be specified) to assure physical (location) equity

As an immediate step, within its own domain, the State should undertake to accomplish the following:

- Allocation of health budgets as block funding, that is on a per capita basis for each population unit of entitlement as per existing norms. This will create redistribution of current expenditures and reduce substantially inequities based on residence.[4] Local governments should be given the autonomy to use these resources as per local needs but within a broadly defined policy framework of public health goals
- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools, as also make public service of a limited duration mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and will have a dramatic impact on the improvement of the credibility of public health services
- Essential drugs as per the WHO list should be brought back under price control (90% of them are off-patent) and/or volumes needed for domestic consumption must be

[4]To illustrate this, taking the Community Health Centre (CHC) area of 150,000 population as a "health district" at current budgetary levels under block funding this "health district" would get Rs. 30 million (current resources of state and central govt. combined is over Rs.200 billion, that is Rs. 200 per capita). This could be distributed across this health district as follows : Rs 300,000 per bed for the 30 bedded CHC or Rs. 9 million (Rs.6 million for salaries and Rs. 3 million for consumables, maintenance, POL etc..) and Rs. 4.2 million per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs. 3.2 million as salaries and Rs. 1 million for consumables etc..). This would mean that each PHC would get Rs. 140 per capita as against less than Rs. 50 per capita currently. In contrast a district headquarter town with 300,000 population would get Rs. 60 million, and assuming Rs. 300,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs. 150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would contribute 5% of its budget. Ofcourse, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. (Duggal, Ravi 2002: Resource Generation Without Planned Allocation, Economic and Political Weekly, Jan 5, 2002)

compulsorily produced so that availability of such drugs is assured at affordable prices and within the public health system

- Local governments must adopt location policies for setting up of hospitals and clinics as per standard acceptable ratios, for instance one hospital bed per 500 population and one general practitioner per 1000 persons. To restrict unnecessary concentration of such resources in well provided areas fiscal measures to discourage such concentration should be instituted.[5]
- The medical councils must be made accountable to assure that only licensed doctors are practicing what they are trained for.[6] Such monitoring is the core responsibility of the medical council by law which they are not fulfilling, and as a consequence failing to protect the patients who seek care from unqualified and untrained doctors. Further continuing medical education must be implemented strictly by the various medical councils and licenses should not be renewed (as per existing law) if the required hours and certification is not accomplished
- Integrate ESIS, CGHS and other such employee based health schemes with the general public health system so that discrimination based on employment status is removed and such integration will help more efficient use of resources. For instance, ESIS is a cash rich organization sitting on funds collected from employees (which are parked in debentures and shares of companies!), and their hospitals and dispensaries are grossly under-utilised. The latter could be made open to the general public
- Strictly regulate the private health sector as per existing laws, but also an effort to make changes in these laws to make them more effective. This will contribute towards improvement of quality of care in the private sector as well as create some accountability
- Strengthen the health information system and database to facilitate better planning as well as audit and accountability.

Strategies and Approaches

An organised and universal healthcare system is possible only under a rights perspective. Right to health and healthcare is a fundamental social and economic right recognised by the International Covenant. But such a demand is not on the political agenda in India. The Peoples' Health Assembly initiative (called Jan Swasthya Abhiyan in India)[7] has voiced such a demand but this requires a widespread awareness campaign and participation of many more civil society groups.

On the other end of the spectrum the medical profession needs to be educated not only about self-regulation and the need to organise for minimum standards for quality healthcare but also about the benefits of an organised public-private mix healthcare system.

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[5] Such locational restrictions in setting up practice may be viewed as violation of the fundamental right to practice one's profession anywhere. It must be remembered that this right is not absolute and restrictions can be placed in concern for the public good. The suggestion here is not to have compulsion but to restrict through fiscal measures. In fact in the UK under NHS, the local health authorities have the right to prevent setting up of clinics if their area is saturated.

[6] For instance the Delhi Medical Council has taken first steps in improving the registration and information sysetm within the council and some mechanism of public information has been created.

[7] *The People's Health Campaign* is a unique grassroots-to-global movement for *'Health for All'*, a campaign for better health. This innovative campaign has been active since July 99, to enquire into the current state of health services and to demand better health care The background to this campaign is a global wake-up call being given to governments around the world, reminding them of their promise and pledge made in 1978 to provide 'Health for All by 2000 AD'. India took the lead in this campaign and over 2000 health, science, womens' and other organisations and NGOs, including 19 national networks, in 20 states are involved in the Peoples Health Assembly (PHA) process.

Only such an approach can lead us closer towards a system that guarantees universal access. Healthcare will have to be viewed in the context of social security. The latter becomes even more urgent under the changing political economy. To support this new public management systems and innovations in health financing to raise additional resources will be needed.

We are at a stage in history where political will to do something progressive is conspicuous by its absence. We may have constitutional commitments and backing of international law but without political will nothing will happen. To reach the goals of right to health and healthcare discussed above civil society will have to be involved in a very large way and in different ways.

The initiative to bring healthcare on the political agenda will have to be a multi-pronged one and fought on different levels. The idea here is not to develop a plan of action but to indicate the various steps and involvements which will be needed to build a consensus and struggle for right to healthcare. We make the following suggestions:

- Policy level advocacy for creation of an organized system for universal healthcare
- Research to develop the detailed framework of the organized system
- Lobbying with the medical profession to build support for universal healthcare and regulation of medical practice
- Filing a public interest litigation on right to healthcare to create a basis for constitutional amendment
- Lobbying with parliamentarians to demand justiciability of directive principles
- Holding national and regional consultations on right to healthcare with involvement of a wide array of civil society groups
- Running campaigns on right to healthcare with networks of peoples organizations at the national and regional level
- Bringing right to healthcare on the agenda of political parties to incorporate it in their manifestoes
- Pressurizing international bodies like WHO, Committee of ESCR, UNCHR, as well as national bodies like NHRC, NCW to do effective monitoring of India's state obligations and demand accountability
- Preparing and circulating widely shadow reports on right to healthcare to create international pressure

The above is not an exhaustive list. The basic idea is that there should be widespread dialogue, awareness raising, research, documentation and legal/constitutional discourse.

To conclude, it is evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-

political consensus on right to healthcare. There are a lot of small efforts towards this end all over the country. Synergies have to be created for these efforts to multiply so that people of India can enjoy right to health and healthcare.[8]

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[8] Duggal, Ravi: Health and Development in India – Moving Towards Right to Healthcare, Draft paper for Harvard School of Public Health initiative on Right to Development, 2002