

WHERE ARE WE TODAY : HEALTH POLICIES, PROGRAMS.....?

We are into year 2000 but where is “Health For All” as vowed by WHO member nations at Alma Ata in 1978? Year 2000 was selected to be that magical year by when all people of this world were projected to have access to primary health care. Since then the situation has barely changed. The countries that could not provide basic health care to its people then, continue to be unable to do so even today. It is not as if there is a lack of resources – more drugs are produced, the private health sector has grown geometrically, people are spending much more out of pocket, newer technologies are available etc – but those not having access to primary health care have increased in numbers.

Where Did We Start?

In 1946 we had a very well worked out plan and strategy for health for all, the Health Survey and Development Committee Report (popularly called the Bhore Committee Report). It was a comprehensive plan that guaranteed universal access to health care 15 years down the line. But the first Health Ministers Conference in 1947 scuttled it saying that it was unaffordable. The Bhore plan demanded only about 1.33% of GNP, including capital expenditures (or Rs.2.98 per capita at 1945 prices). This wasn't a very difficult thing to achieve considering that it would be a very fruitful investment in people who would then be able to contribute fully to the new emerging and growing economy.

We opted instead for a selective program-based approach, perhaps an influence of the American community development model which had become the cornerstone of our development policy in the early years of planning. Many of these were vertical programs that had their own bureaucracy and which over time developed into “empires”. No doubt this approach had some well known successes like the eradication of small pox by 1976, good control over malaria by mid-sixties (but this was messed up due to complacency, and malaria since then continues to be a menace), reasonable control over leprosy by mid-eighties and more recently the pulse polio program. However, basic health care and access to it, especially in the rural areas, is still unavailable to a large majority. This despite a large expansion of rural health infrastructure in the seventies and eighties under the Minimum Needs Program. While this infrastructure is in place in many states it does not meet the health care needs of the people. People need basic curative and preventive care but the existing system is obsessed with providing family planning and related services. From the 3rd Five Year Plan onwards family planning has remained the main concern of the Ministry of Health and Family Welfare. Since then nomenclatures may have changed from maternal and child health to child survival and safe-motherhood and presently reproductive and child health under international patronage, but the underlying emphasis of the health program is family planning or population control. As a consequence even the poor have to seek primary care from the private health providers, often from those not qualified in any system of medicine and/or from non-allopaths who practice allopathy.

Despite this we do see improvement in measurable indicators like longevity, infant mortality, crude death rates etc. over the years. But these figures reflect more the improvement in the quality of life of the top 20% and/or the concerted efforts in health care in states like Kerala and Tamil Nadu. Overall the miseries of the bottom 50-60% continue and this is adequately reflected in disaggregated figures of these same indicators in the BIMARU states.

Where Are We Today?

Health care access and availability in India has a peculiar public-private mix that generates a political economy, which makes the health sector purchasing-power-dependant. This is a contradiction given the fact that the larger majority does not have purchasing power even to sustain adequate nutritional requirements. In a country where nearly half the population struggles under severe poverty conditions and another one-half of the remaining manages at the subsistence level it is a sad state of affairs that social needs like health and education have to be more often than not bought in the market place.

Today there are over 15,000 hospitals (68% private) with about 900,000 hospital beds (45% private) and about 25,000 Primary Health Centres in the country, and a total of over 1,200,000 qualified practitioners (89% private) of all systems of medicine. The skewed rural/urban availability of public health services is well known - 70% hospitals and 85% of hospital beds under public domain are located in urban/metropolitan areas when 70% of the population lives in the rural and backward areas of the country. The pattern of distribution of the private health sector is not very different, they too tending to concentrate in urban/metropolitan areas - 60% hospitals, 75% of hospital beds and 70% of allopathic doctors are found in urban areas. However, the private health sector is not confined to just the allopathic qualified practitioners. There are nearly twice as many practitioners qualified in various Indian systems of medicine and homoeopathy, and a larger proportion of them (60%) are located in the rural and backward areas, 90% of them also practicing modern medicine.

Hence, the private sector definitely has a better penetration in areas where the majority live. Further, because of a complete lack of regulation and control there is another large chunk of practitioners, estimated at about half as many as the qualified, who practice modern medicine without having any qualifications in any system of medicine - again a larger majority of them are in rural and backward areas. This entire private health sector operates on a for-profit basis within the context of a supply-induced-demand economy. And estimates based on various studies show that the private health sector is as much as 4 to 6% of the GDP, in sharp contrast to less than one percent of the GDP which the governments spend.

In the new scenario of liberalisation and globalisation the pressures for reduced State participation in the health sector is going to be difficult to fight. Hence, the fight has to be at another level, both to strengthen the State's role in the health sector as well as to make the private sector more accountable. Over the last nine plan periods the Planning Commission or for that matter the Ministries of Health have not paid much heed to the way in which the private health sector has grown or operated. Infact, the State has subsidised the growth of the private health sector by various means - subsidised medical education even for those who ultimately go into private practice or worse still migrate abroad; concessions, subsidies and tax reliefs to private practitioners and hospitals - infact many private hospitals function as trust hospitals whose incomes are exempt from tax; public sector units have supplied bulk drugs and raw materials at subsidised prices to the private pharmaceutical industry and in the process have earned the label of "being in the red" and "inefficient"; import duty concessions for importing the expensive new medical technology which largely benefits the richer sections; etc..

What Can Be Done?

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 have. 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 !

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 overserved 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 : nonsalary spending and setting up a referral system for secondary and tertiary care. These are only some examples of what can be done through macro policy initiatives.

Specific Actions for Strengthening Public Health Care - A few Suggestions

The urgent need to strengthen, restructure and reorient public health services: The urban bias in medical care provision by the State needs to be removed. The Primary Health Centres (PHCs) and Subcentres (SCs) need to be thoroughly reoriented to meet peoples' needs of medical care and not be obsessed with family planning alone. Facilities for medical care need to be substantially enhanced at the PHCs both in terms of personnel and supplies. While supplies can be increased through larger budgetary allocations the difficulty would be in getting personnel to work in the public system. Since private individual practice is the norm it becomes necessary to involve such practitioners to join a public sponsored health care program on a pre-defined payment system, for instance, a fixed capitation fee per family registered with the practitioner. Such a system needs to be evolved both in the rural and urban areas. This would mean a five-fold increase in primary care costs which would be partly financed from within the existing resources and the remaining from the organised sectors of the economy, including insurance, and special health related taxes. Ofcourse, this would mean a lot of restructuring, including stronger regulations and control and a mechanism for regular audit of the system's functioning. This is the only way of guaranteeing universal access to health care and achieving 'health for all'. The bottom line would be no direct payments by patients at the time of receiving care. All payments would be made through a statutory authority which would be the monopoly buyer. People having the capacity to pay should be charged indirectly through taxes, insurance premia, levies etc.. Such restructuring would not disturb the autonomy of the individual practitioner or the private hospitals except that it would strive to eliminate irrational and unnecessary practices, demand some amount of relocation of practitioners, standardise and rationalise costs and incomes, eliminate quackery and demand accountability from the providers. The Ministry of Health at the Centre has shown some interest in these areas and is promoting processes geared in this direction.

Making the public health sector efficient, cost-effective and socially accountable: The response to the malaise of the public health services should not be 'privatisation'. We already have a large, exploitative and unsustainable private health sector. What makes the private health sector 'popular' in usage is its better access (irrespective of quality), a personalised interface, availability at convenience, and its non-bureaucratic nature. The public health services by contrast are bureaucratic, having poor access - especially in rural areas, have often inconvenient timings, are generally impersonal, often don't have requisite supplies like drugs etc.. and are plagued by nepotism and corruption. There is a lot of scope for improvement of public health services with better planning, reallocation of existing resources as well as pumping in additional resources - especially for non-salary expenditures, reducing wastage and improving efficiency by better management practices and separation of primary, secondary and tertiary care through setting up of referral systems, improving working conditions of employees etc.. One good example of enhancing the value, efficiency and effectiveness of the existing system using available resources is to assure that all medical graduates who pass out of public medical schools

(80% of all graduates every year) serve in the public system for say at least five years without which they should be denied the licence to practice as well as admission for postgraduate studies. After all the State is spending about Rs.1,000,000 per medical graduate ! This measure if enacted by law will itself make available 14,000 doctors of modern medicine alone every year for the public health care system. There can be many such macro decisions which can help in making the existing resources more effective and useful. Further, public health services must be made accountable to local communities they serve and the latter must perform both the role of social audit as well as take responsibility of seeing that the system works properly for the benefit of patients. As regards the private health sector, as mentioned above, there is an urgent need to regulate it, implement minimum standards of care, standardise charges, have policies for location and distribution etc.. All these are feasible possibilities which can be undertaken irrespective of the structural changes suggested in the preceding paragraph.

Modes of Financing, Payments etc.. : While the public sector is funded through tax revenues the private sector relies mostly on fee-for-services. There is a growing trend of thought favouring at least partial user-charges or fee-for-services for public health services. This trend must be countered since in the given socio-economic conditions such a policy would hit the majority very hard. WHO has been firm about nations spending 5% of GDP on health care. In India the State doesn't even spend one percent. So the first effort must be at getting the State to commit a much larger share for the health sector from existing resources. Additional revenues specifically for health budgets may be collected on the lines of profession tax in some states which funds employment programs, levies and cesses for health could be collected by local bodies, employers in the organised sector must be made to contribute for health care services, those with capacity to pay like organised sector employees, the middle and rich peasantry (so far completely untaxed), and other self-employed, must do so through insurance and other pre-payment programs. In a vast and varied country like India no single system can work. What we would need is a combination of social insurance for the poor (premia paid by the state), employment related insurance for the organised sector employees, voluntary insurance for other categories who can afford to pay and ofcourse tax and related revenues. Further, payments of any kind at the point of provision of care must not exist as they usually are unfavourable to patients. Payments must be made to providers by a monopoly buyer/s of health services who can also command certain standard practices and maintain a minimum quality of care - payments could be made in a variety of ways such as capitation or fixed charges for a standard regimen of services, fee-for-service as per standardised rates, etc.. The move towards monopoly purchase of health services through insurance or other means and payment to providers through this single channel is a logical and growing global trend. To achieve universal access to health care and relative equity this is perhaps the only alternative available at present, but this of necessity implies the setting up of an organised system and for this the State has to play the lead role and involve the large private sector within this universal health care paradigm if it must be successful.