TOWARDS A HEALTHY INDIA

A CALL FOR ACTION

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FORUM

OF FREE ENTERPRISE

“Free Enterprise was born with man and shall survive as long as man survives”.

- A. D. Shroff
Founder-President
Forum of Free Enterprise

SHAILESH KAPADIA

(24-12-1949 – 19-10-1988)

Late Mr. Shailesh Kapadia, FCA, was a Chartered Accountant by profession and was a partner of M/s G.M. Kapadia & Co. and M/s Kapadia Associates, Chartered Accountants, Mumbai.

Shailesh qualified as a Chartered Accountant in 1974 after completing his Articles with M/s Dalal & Shah and M/s G.M. Kapadia & Co., Chartered Accountants, Mumbai. Shailesh had done his schooling at Scindia School, Gwalior and he graduated in Commerce from the Sydenham College of Commerce & Economics, Mumbai, in 1970.

Shailesh enjoyed the confidence of clients, colleagues and friends. He had a charming personality and was able to achieve almost every task allotted to him. In his short but dynamic professional career, spanning over fourteen years, Shailesh held important positions in various professional and public institutions.

Shailesh's leadership qualities came to the fore when he was the President of the Bombay Chartered Accountants' Society in the year 1982-83. During his tenure he successfully organized the Third Regional Conference at Mumbai.

Shailesh was member, Institute of Fiscal Studies, U.K.; member of the Law Committee and Vice-Chairman of the Direct Taxation Committee, Indian Merchants' Chamber. He was also a Director of several public companies in India and Trustee of various public Charitable Trusts.

He regularly contributed papers on diverse subjects of professional interest at refresher courses, seminars and conferences organised by professional bodies.

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Editorial Introduction

We, at the Forum of Free Enterprise, are specially privileged to publish and present this comprehensive booklet [indeed, a monograph] on issues and challenges confronting India's health sector. The authors of this booklet are two eminent medical professionals – Dr R Balasubramaniam [popularly known as Balu] and Dr N S Prashanth. Apart from their solid academic and practising backdrop, both of them have vast and enriching experience and expertise – in India and abroad – in the field of public health sector at the grassroots level as well as in the contextual framework of overall socio-economic development strategies.

Development theories, especially of last two or three decades, have come to establish an inextricable relationship between pace of economic growth and quality of human capital – the latter in turn depends, among other things, on levels of education, skill formation and health. It is invariably pointed out that sustainable economic growth depends on levels of human capital whose stocks increase as a result of better education, new learning and training experience and higher levels of health. While high investment rate per se is a desirable determinant of economic growth, it is the productivity of labour force governed by quality of education and health

that enables sustained fuller realization of growth potential in any economy.

That said, this well-structured monograph focuses entirely on the health sector with special emphasis on affordable healthcare. While reflecting holistically on the core theme of striving for healthy India, the authors have scripted a well-meaning design of an action agenda. They put across upfront the critical proposition in precise terms as follows: "...state-led efforts at ensuring equitable healthcare across the country and promoting public health can drive the next decade of socio-economic progress, while ensuring fair sharing of the benefits of this progress across all sections of our society". Given the on-going debate on India's inequitable growth experience of the last couple of decades, we believe that it is most opportune time that our policy makers – both at the Centre and States – pursue the long-pending commitment to reforms of the health sector, more particularly of the public health system.

In their thematic presentation, the authors articulate eleven different cardinal principles, which need to guide our responsive healthcare system. Apart from aspects of equity, social justice, universality, affordability, *et al*, there are crucial other facets such as imperatives of encouraging pluralism and integrative medicine, appropriate technology and public-oriented partnership, *et al*. This monograph is interspersed with very relevant data charts on

several crucial health parameters, be it maternal mortality ratio, death rate due to HIV/AIDS/ Malaria/ TB or risks factors driving the most to death and disability in India.

Authors have been critical about how healthcare financing works in India and point out that “since both government funding and social health insurance contributions are insufficient to meet healthcare needs of households, over three-fourth of all healthcare payments are paid through OOP [out-of-pocket payments] routes at the point of service delivery”. More disturbing is the fact that thanks to such high level of health related expenses a large number of households are estimated to have been pushed into the poverty. It is further observed that “approximately 46 million households may have suffered from catastrophic health expenditure, of which 29 million households incurred catastrophe on account of OOP payments on medicines alone”.

According to authors, much of the challenges of healthcare are on account of [a] India’s low government spending [ranging from 1% to 1.2% of GDP] on healthcare services in international comparison; and [b] fragmented pooling and financing inefficiencies. More distressing is the issue of inequity in financing of healthcare wherein it is found that “the scarce public expenditure is also utilized inequitably; civil servants receive nearly 10 times more for

healthcare from the government than the average citizen".

Against this backdrop, the authors have spelt out a detailed action plan for strengthening the health systems in India, be it secondary, tertiary or "missing" health services. Their most striking conclusion is that "comprehensive primary health care and UHC cannot be achieved by states alone; appropriate financing of health by central governments as well as setting an effective governance of medical and allied education, periodic monitoring, evaluation and research on our policies and programmes and promoting population health through concerted action on social and environmental determinants of health are essential". They have sought to cover practically every single dimension of what needs to be done in the area of governance of the health sector, financing including avenues of resource mobilization, improving efficiency through strategic purchasing of health care services from private facilities, different sources of healthcare services, integrating currently officially propagated AYUSH into mainstream health services, medical education, research and so on.

Surprisingly, however, while setting out the action agenda, authors seem to have not taken into consideration some of the notable national level programmes that are either operational or in the process of implementation. In this context, a specific mention needs to be made of the

PradhanMantriSwasthyaSurakshaYojana that was announced in 2003 with objectives of correcting regional imbalances in the availability of affordable/ reliable tertiary healthcare services and also to augment institutional facilities for quality medical education in the country.

More importantly, the present Union Government has launched a very ambitious Ayushman Bharat - National Health Protection Mission [now popularly known as Modicare scheme], which promises to provide a defined benefit cover of Rs.5 lakh per family per year. This is an entitlement-based scheme with entitlement decided on the basis of deprivation criteria of the intended beneficiaries. They will be allowed to take cashless benefits from any empanelled [either public or private] hospitals across the country. The critical views of the authors on both these schemes would have added considerable value to their proposed well thought out action agenda.

Nevertheless, the scripting of this monograph is the most holistic effort on the part of two eminent authors on this very complex and intricate subject of healthcare in India. Therefore, the FORUM expects that this booklet would be relevant across different layers of opinion makers. It is intended to generate more productive and constructive discussion among researchers, medical practitioners dedicated to the cause of promoting healthcare at the community and

grassroots level, policy makers, our law makers – both in Parliament and State Assemblies – healthcare administrators, *et al*. While releasing this booklet, we congratulate the authors for their sincerity of purpose and genuine commitment to the cause.

Sunil S. Bhandare
Editor

TOWARDS A HEALTHY INDIA : A call for action

Dr. R Balasubramaniam *
Dr. Prashanth N Srinivas**

1 Background

India's overall progress and development rests upon fulfilling our constitutional obligations towards ensuring affordable healthcare and promoting health of the people. Achieving a high standard of healthcare and promoting health is also crucial to the socio-economic aspirations of our country. Arguably, state-led efforts at ensuring equitable healthcare across the country and promoting public health can drive the next decade of socio-economic progress, while ensuring fair sharing of the benefits of this progress across all sections of our society.

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* *The author, Dr. R. Balasubramaniam (Balu) is a medical doctor. He is a widely respected development activist, leadership trainer, thinker and writer.*

** *The co-author, Dr. Prashanth is also a medical doctor and public health researcher.*

1.1 Health as a collective responsibility of state, communities and individuals

Health as defined by the World Health Organization (WHO) is "the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Health is a collective individual and societal responsibility albeit the State having a greater responsibility for ensuring, promoting and sustaining health. There ought to be a clear individual commitment to health by individuals, households and communities. However, ensuring the right environment where such health information, awareness and individual action on health can manifest and thrive is an important obligation of the State. This can be achieved through enacting social policies in wider public interest and effective governance of State institutions. A vision for a healthy India then must be built upon efficient organisation and management and financing of healthcare, as well as laying effective governance to ensure prevention of disease, mitigation of health risks, and promotion of healthy lifestyles.

1.2 Prioritising a systems approach to public health to complement biomedical solutions

A comprehensive healthcare system comprises a range of structures, procedures and programs that cover wellness care and health promotion, preventive care, disease control and treatment interventions. Recognition that medical care is only a subset of health care is the key to a public health approach. Thus, the

tendency to place medical professionals at the centre of health policies and programmes requires change. Health care (not medicine and treatment of diseases alone) is an area which has ample scope and dire need for a range of health professionals with different skills, knowledge and perspectives to participate in and improve. Indeed, a wide range of public health interventions that can save lives need intersectoral action beyond healthcare services. De-medicalization of healthcare by integrating people from various allied health disciplines as well as related sectors into health policy and programme implementation is at the core of the public health and health systems approach to improving health.

1.3 Guiding principles for a responsive health system

This call for action to strengthen the Indian health system is guided by the following cardinal principles. These principles provide a framework upon which to make choices for policies, programmes or interventions. They are drawn from foundational principles that have guided our Constitution and other public policy frameworks. In addition, we have also chosen some specific principles that are of particular importance for a health service (as opposed to any other public service).

1) **Equity and social justice**[1] **:** State investments on people's health should

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1 *The WHO Commission on Social Determinants of Health (2007) has marshalled a large body of knowledge to highlight the social*

choose to make higher investments wherever there are health gaps/needs of individuals and communities. Financial, human and policy investments in health must be informed by, as well as influence overall equity, and become instruments to ensure social justice. In line with this, this document prioritises policy and programme components that are known to advance equity and social justice. Embracing this principle implies higher spending and policy focus on improving access and financial protection measures across health inequity axes including socio-economic, caste, gender, geography, disability and other known vulnerabilities.

2) **Universality :** While maintaining a special focus to advance equity, the overall implementation of health policies, programmes and systems should strive to achieve universality. In terms of healthcare, this means that our health services and wider health policies shall achieve universality in terms of population coverage (*who all are covered*), service coverage (*what are the services that are covered*), and financial

origins of disease and ill-health. In their view, a health system that does not address the "causes of the causes" of disease and ill-health (underlying social drivers of health inequity) cannot ever achieve an acceptable level of human development

coverage or financial protection (*how much of the cost of the needed services are covered*). This is in line with the World Health Organisation's (WHO) focus on universal health coverage (UHC). Universality should not come in the way of prioritising and modifying care wherever needed to advance equity and social justice and prevent any form of social or cultural exclusion.

3) **Social accountability and people-centred services:** Healthcare institutions shall be designed, managed and monitored keeping the aspirations of patients and communities. They shall promote accountability mechanisms to communities and local bodies including Panchayats, village health, sanitation and nutrition committees and other community engagement platforms. Health systems should ensure that healthcare is effective, provided with safety and dignity and involves individuals and communities in its management and monitoring. In a people-centred health system, patients and people participate in decision-making on their treatment options and healthcare interventions resulting in an empowering healthcare interaction, rather than as passive recipients of expert-determined care. A people-centred health system puts the voices and needs of people at the centre.

It respects and empowers community's aspirations to shape systems and services. It also acknowledges healthcare institutions as social institutions (as opposed to being merely technical institutions) which operate through building trust and relationships with patients and society through respectful dialogue, reciprocity and valuing human relationships within these institutions and with the communities.

4) **Affordability :** Financial protection from healthcare costs is a foundational function of a country's health system and is at the heart of achieving universality, equity and social justice. Costs of healthcare continue to rise and hence health policies and programmes should ensure that people do not suffer financial consequences in addition to the suffering from the illness. Healthcare costs of a household exceeding 10% of its total monthly consumption expenditures or 40% of its non-food consumption expenditure is designated as catastrophic health expenditure and is declared as an unacceptable level of healthcare cost.

5) **Resilience and responsiveness** : Health systems should strive for the capacity to survive sudden and often unpredictable events such as outbreak of diseases and epidemics. They should also be adaptable

enough to accommodate changes in aspirations and expectations of patients, providers and communities. Policies, programmes and reforms need to contribute towards responsive and resilient health system built upon sound knowledge and evidence base. At the same time, there should be an environment for critical and reflective practice, learning from the wisdom of implementers and communities.

6) **Professionalism, Integrity and Ethics :** Health policies, programmes and systems shall strive for attaining the highest levels of professionalism and integrity through implementing workplace rules and environments that foster ethical practice, respect and dignity for patients and providers.

7) **Pluralism and integrative medicine:** Patients should be able to choose health providers and healthcare options most suited to their expectations including access to other systems of medicine, especially traditional and Indian systems.[2] These

2 *Diverse systems of medicine are often bunched together under an umbrella term, AYUSH. This includes Ayurveda, Yoga, Unani, Siddha and Homeopathy. Various local health traditions practiced within households and communities and oral health traditions handed down across generations of traditional healers are now being documented, studied and validated creating an evidence-base for some local health traditions. These too*

systems of medicine should be provided with adequate support and supervision to contribute to the overall goal of meeting the national health goals and objectives. Eventually, healthcare institutions need to be oriented towards practicing integrative medicine that bring together good practices and evidence-base from these different systems of medicine, offered through a team of health providers within an environment of mutual respect and exchange.

8) **Integration of services and systems:** According to the WHO, integration means the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money. Such an integration of services can be achieved only through a well-functioning primary health centre network that is publicly financed, and supplemented by health and wellness centres at village level. These primary and sub-primary units should be supported by a referral system of secondary and tertiary care hospitals in towns and cities to ensure

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ought to be integrated into health systems in order to decrease overdependence and medicalisation of primary care ailments that can be handled within households and communities.

smooth navigation of patients through the health services.

9) **Appropriate technology**: While emerging technologies including advances in diagnostics, eHealth, mHealth and molecular biology offer enormous potential for improving treatment outcomes, country health systems should make choices of technology based on a strong evidence-base for its use, cost-effectiveness and its utility to the widest possible section of society. Technologies need to be embraced in so far as they are enabling, improving autonomy and empowering patients, communities and health workers, and not creating a dependence. Choice of technologies should also be guided by relevance to context, geographical location, user needs, system capability and should include using it for community monitoring and improving social accountability.

10) **Public-oriented partnerships:** The task of providing healthcare is a complex task in a country as diverse as India. Health policies and programmes need the support of a variety of stakeholders including academic institutions and universities, patient groups, community-based organisations and civil society groups, industry groups, professional associations and others. However, these

partnerships should be in the spirit of strengthening overall health system with well-articulated and monitored roles and responsibilities, and clearly guided by a vision of improving public health.

11) **Life-course approach:** Health policies and programmes should respect all age groups while identifying and catering to the differential needs across a lifetime as well as accounting for the special needs at specific life events including infancy, childhood, adolescence, pregnancy and the elderly.

2. The Indian health system: a brief situation analysis

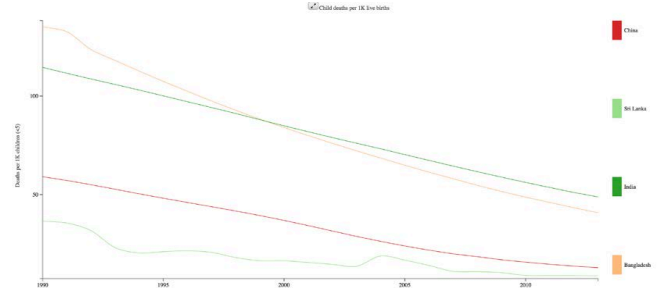
2.1 Quick overview of health progress and gaps[3]

India has done well in terms of improving various population level health outcomes. The high rates of economic growth in the past two decades are an opportunity to achieve human development gains. However, the achievements in health have not kept

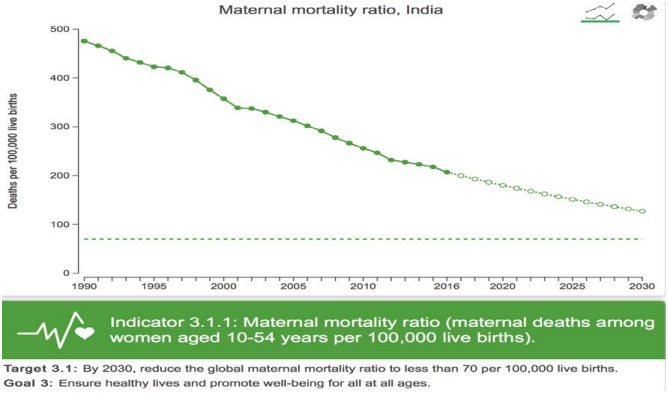
3 *Data from the following sources are used in this section: World Bank 2017. World Development Indicators 2017, The India State-Level Disease Burden Initiative. New Delhi & Niti Aayog Healthy States Progressive India Report. All visualisations generated online from the Institute of Health Metrics & Evaluation data visualisation dashboard at healthdata.org that uses various in-country data sources including large-scale national household surveys, other population-level surveys and cohort studies, disease surveillance data, disease programme-level data, administrative records of health services, disease registries, and a wide range of other studies conducted across India.*

pace with the economic development. For instance, while life expectancy at birth has increased by nearly 10 years from 1991 to 2015; yet at 67 years, we are trailing 9 years behind China and Sri Lanka, and 3 years behind Bangladesh.

The United Nations' Sustainable Development Goals (SDG) are a global commitment by member nations including India towards investing in various aspects of overall human development and planetary health in a sustainable manner. By formulating a clear strategy for achieving UHC and investing and strengthening comprehensive primary health care, India can quicken its gains in SDG 3. In addition, improved health and well-being of populations has enormous cross-sectoral benefits in terms of economic development and overall improvements in human development.



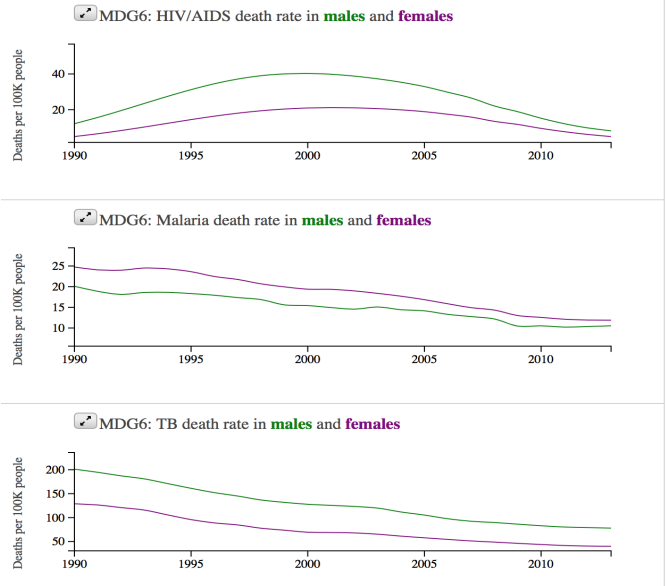
Decline in child mortality (1-5 y) in terms of number of child deaths per 1000 live births from 1990 to 2015 in India and select neighbours



Decline in maternal mortality in terms of number of maternal deaths per 100,000 live births from 1990 showing the downward trend; the trend is not the same in all states and districts with several EAG states & Schedule V & VI areas needing special focus.

Infant Mortality Rate (IMR) has more than halved in the last two decades whereas Total Fertility Rate (TFR) dropped to near replacement level. Maternal

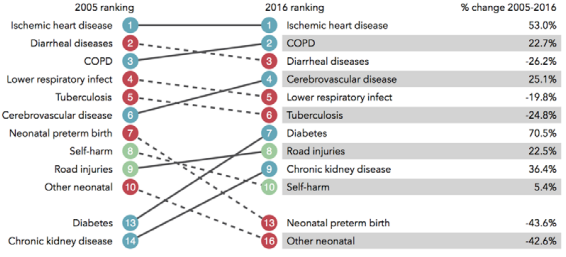
Mortality Ratio (MMR) declined by more than 60 percent. However, the rate of decline is not uniform across the country with several states (designated empowered action group states) recording a much slower decline than others. Overall, India continues to record unacceptably high maternal mortality in many states while demonstrating steady decline in some southern states like Kerala and Tamil Nadu.



Favourable declines in deaths due to HIV/AIDS, Malaria and Tuberculosis nationwide; however several hotspots of high mortality and morbidity due to communicable diseases persist especially in EAG states and Schedule V & VI areas (with high Adivasi populations)

At the same time, non-communicable diseases (NCDs) remain a growing challenge and continue to account for some of the highest number of deaths. Since 2005, ischaemic heart disease has overtaken diarrhoeal disease and lower respiratory tract infections as the leading cause of premature deaths. This is in line with the global trend of the increasing contribution of NCDs to premature deaths and disability. Iron deficiency anaemia (especially among children, adolescents and mothers), a condition easily treatable with low-cost medicines as well as easily preventable through good nutrition and health promotion continues as the highest cause of disability in the country.

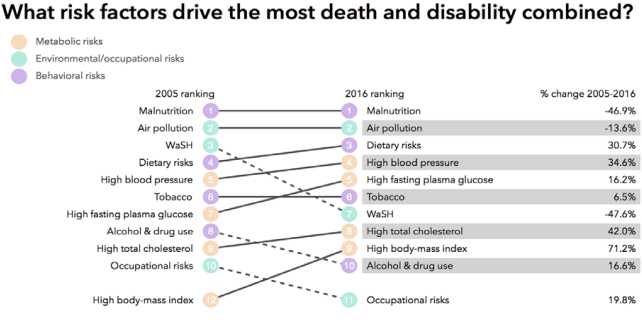
What causes the most deaths?



Top 10 causes of death in 2016 and percent change, 2005-2016, all ages, number

Childhood malnutrition continues to be a huge problem. As a risk factor for death and disability, malnutrition ranks highest in India. New and emerging health risks include environmental threats which pose a health risk, particularly air pollution. Air pollution along with access to water, hygiene and sanitation is

the second and third largest risk factor that contributes to death and disability (combined) in India. Tobacco, alcohol and food together represent population level risk factors that account for multiple population health risks. Effective health governance and regulation in the interest of health promotion could easily limit the deaths and disability.



Top 10 risks contributing to DALYs in 2016 and percent change, 2005-2016, all ages, number

2.2 Nations within a nation

There is large variation in terms of health outcomes and health systems across states. The India State-Level Disease Burden Initiative has studied epidemiological transition i.e, to what extent burden of diseases in the state is due to communicable, maternal, neonatal, and nutritional diseases versus the emerging burden due to NCDs. In an analysis describing India's diverse disease burden levels across states as *nations within a nation*, the assessment is the need for a decentralised and locally adapted state and district-level strategies as opposed to a one-size fits all national level plan.

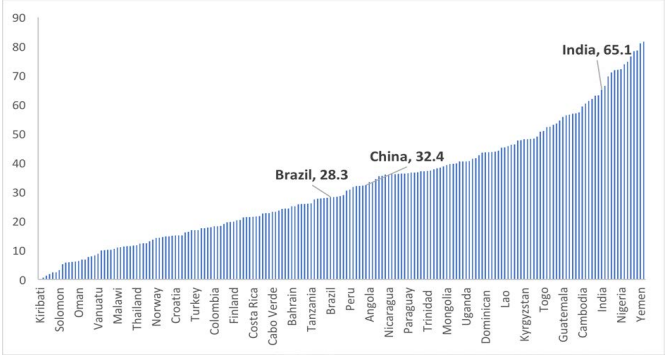
While several EAG states are grappling with a double burden of communicable, maternal, neonatal, and nutritional diseases and NCDs, some states including Himachal Pradesh and Punjab in the north and Kerala and Tamil Nadu in the south have achieved significant reduction in these diseases, but struggling to ensure NCD care. The mounting NCD burden highlights the need for India to accord importance to NCDs in line with the United Nations General Assembly resolution on NCDs as well as explore strengthening compliance with our commitment to improved tobacco control frameworks such as the Framework Convention on Tobacco Control, already endorsed by India.

2.3 High out-of-pocket payments especially on medicines[4]

Globally, healthcare is financed either through pre-payment mechanisms (recommended) or through direct payment mechanisms. Out-of-pocket payments (OOP) at the point of care have two main problems; they form a barrier to accessing healthcare services more so for the poor and disadvantaged people, and secondly, those who do use the services face catastrophic health expenditure and even impoverishment. Indeed, several households in India are falling into poverty and remain there due to

4 This section on health financing situation analysis as well as subsequent sections on health financing are based on inputs from N Devadasan through sharing of unpublished note on health financing situation analysis and recommendations for India. Figures adapted from the WHO Global Health Observatory were also provided and are hereby acknowledged.

healthcare related expenses. Since both government funding and social health insurance contributions are insufficient to meet healthcare needs of households, over three-fourth of all healthcare payments are paid through OOP routes at the point of service delivery.



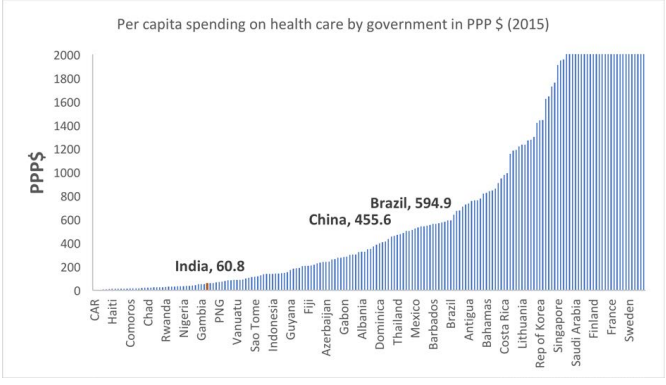
OOP as a proportion of GDP (2015) from the WHO Global Health Observatory

OOP on medicines is as high as 63% and accounts for the single largest component of OOP payments. Estimates of households falling into poverty due to health related expenses are disturbing; approximately 46 million households may have suffered from catastrophic health expenditure, of which 29 million households incurred catastrophe on account of OOP payments on medicines alone.[5] In terms of people that

5 *These estimates are from NSSO data. See Selvaraj S, Farooqui HH, Karan A Quantifying the financial burden of households' out-of-pocket payments on medicines in India: a repeated cross-sectional analysis of National Sample Survey data, 1994–2014 BMJ Open 2018;8:e018020.*

fell under the poverty line on account of healthcare expenses, estimates are as high as 8% of the country (over 80 million people).[6] Compared globally, Indian government expenditure on health as a proportion of our GDP is comparable to countries with much lesser degree of socio-economic and governance, with OOP expenses in India being higher than in several other countries such as Uganda and Cambodia.

2.4 Low government spending on health care services



Per-capita spending on healthcare by governments upto PPP $ 2000. There are 21 countries with expenditure more than PPP$ 2000. From WHO Global Health Observatory

Governments in India have consistently under-spent on healthcare. It ranges from 1% to 1.2% of the GDP. International comparisons clearly demonstrate that government health expenditure in India is very low

6 *Pandey Anamika,* et al. *Trends in catastrophic health expenditure in India: 1993 to 2014. Bulletin of the WHO 2018*

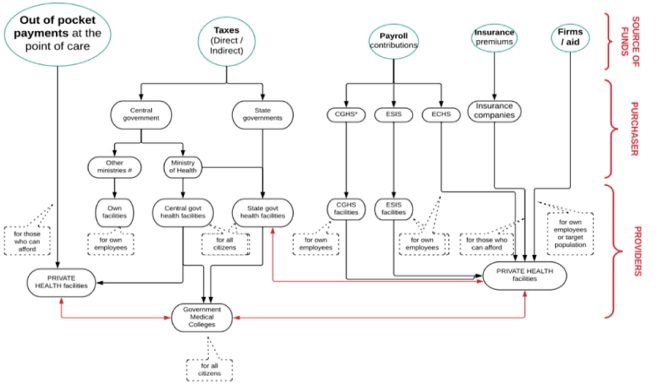
compared to other countries with similar/smaller size or even lower economic development indices. This results in inadequate government healthcare services ranging from low density of government healthcare staff to facilities without medicines or necessary equipment.

Sl. No.	Indicator	NHA 2014-15	NHA 2013-14	NHA 2004-05
1	Total Health Expenditure (THE) as per cent of GDP	3.9	4	4.2
2	Total Health Expenditure (THE) Per capita (Rs.)	3826	3638	1201
3	Current Health Expenditures (CHE) as per cent of THE	93.4	93	98.9
4	Government Health Expenditure (GHE) per cent of THE	29	28.6	22.5
5	Out of Pocket Expenditures (OOPE) as per cent of THE	62.6	64.2	69.4
6	Social Security Expenditure on health as per cent of THE	5.7	6	4.2
7	Private Health Insurance Expenditures as per cent of THE	3.7	3.4	1.6
8	External/ Donor Funding for health as per cent of THE	0.7	0.3	2.3

Indicators of expenditure on health by governments, insurance, donors as per the three National Health Accounts. OOP has been shown an alarming rise instead of a downward trend.

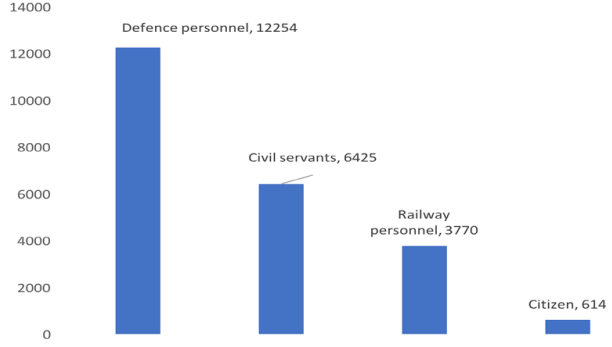
2.5 Fragmented pooling and financing inefficiencies

Not only is the amount of money spent on healthcare low, but it is distributed through multiple channels, each with its own management structure, leading to inefficiency in spending. The distribution to the government health facilities is further fragmented according to individual disease control programs, e.g. Tuberculosis control, Malaria control, etc, further aggravating inefficiencies.



An illustration of the fragmented pooling and purchasing systems in the Indian Health Financing Mechanism by N Devadasan (2018)

2.6 Inequity in financing of care



Per capita government expenditure (INR) by different groups in 2014-15. From National Health Profile & National Health Accounts (2014-15)

The scarce public expenditure is also utilized inequitably; civil servants receive nearly 10 times

more for health care from the government than the average citizen.

2.7 Weak purchasing mechanisms and governance

In a resource-limited setting for health, it is important to achieve an efficient healthcare provision. Currently, government facilities are given an annual budget that is not sufficiently well linked to performance, utilisation and coverage of population. Incentives to perform or accountability mechanisms for poor or non-performance are relatively weak. On the other hand, the individual patient purchases care with very little information and power. This creates a double-edged sword as government facilities tend to underperform and under-provide services, whereas private facilities tend to provide unnecessary and expensive care.

Over the last few years, several state governments have begun using tax funds to purchase healthcare from private hospitals and providers, the Rashtriya Swasthya Bima Yojana (RSBY) or the Vajpayee Arogyashree Scheme (VAS) are examples of this. The hypothesis here is that this improves access to health care for the rural population and is more efficient as it is linked to performance. However, for these schemes to benefit the poor, there are important governance gaps and limited capacity for strategic purchasing, both of which are essential to ensure efficiency as well as an acceptable quality of care.

2.8 Pre-payment for health rather than OOP at point of service delivery

Social protection and UHC requires that India shift away from direct payment mechanisms at the point of service delivery to some form of pre-payment mechanisms to improve access and provide financial protection against medical costs.

3 Strengthening health systems in India: A call for action

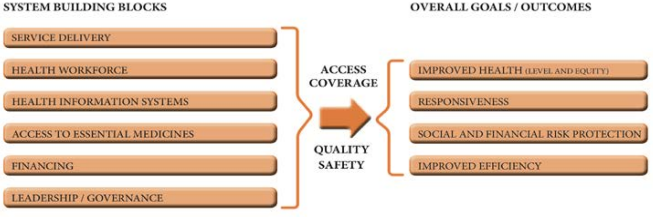
3.1 Health systems in India: origins in primary health care

India has a long history of investing in primary health care and has been a pioneer in advancing the concept of primary health care much before the WHO organised a global consensus on primary health care through the Alma Ata declaration in 1978. India's history with primary health care can be traced back to the recommendations of the *Health Survey and Development Committee,* popularly called Bhore Committee that submitted its report in 1946. The Bhore Committee's recommendation of integrating preventive and curative services at all administrative levels of the health system continues to be the ideal foundational element of all global recommendations for health systems today. The committee suggested centrally implemented vertical programmes only on a short term. This was done to address select healthcare services that were then not widely available. However, today several programmes have continued with a

central orientation rather than achieving integration into the primary health care system.

The Bhore Committee also pushed for a wide network of primary health centres (PHC) to deliver comprehensive primary health care backed up by a multi-tiered health service consisting of secondary and tertiary care centres at towns and cities. They also made important recommendations regarding medical education reforms to ensure that all medical students receive adequate training in preventive and social medicine (today called community medicine) in order to align medical education and training with the needs of the population (what the committee called the *social physician*).

Today, most Indian states have established a vast network of PHCs which implement various curative, preventive and health promotion programmes (rehabilitative care and palliative care have unfortunately not been well integrated into the primary health care system). However, to deliver good quality and comprehensive services, the PHCs need to be supported by a wider health system.



THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

According to the WHO, a good health system delivers quality services to all people, when and where they need them. In India, since health is a state subject, the best way to ensure that these services are delivered and how to organise and manage a health system that delivers these services varies from state to state. However, in all cases, a well-performing health system requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality medicines and technologies.

3.2 Core strategies for a call for action on health systems strengthening in India

The overarching aim should be based on achieving UHC. Progress towards UHC can be systematically assessed and monitored. To achieve it, the pathway should be through publicly provided comprehensive primary health care & strategic purchasing of services for secondary and tertiary care (on the short-term) and long-term investments in public health infrastructure and delivery. Achieving or moving the country towards UHC ensures equitable and just distribution of health benefits to the population. However, achieving UHC requires a careful and coordinated investment in strengthening comprehensive primary health care as well as building a resilient and responsive health system. To achieve and maintain the highest standards of health in the country, three overarching strategies need to be taken up.

The definition of UHC adapted from WHO definition and the erstwhile Planning Commission's High Level Expert Group (HLEG) on UHC can be used to guide this call for action: *to ensure equitable access for all residents in any part of the country, regardless of income and social status, caste, religion or gender orientation, an affordable, accountable and appropriate health service of assured quality (promotive, preventive, curative and rehabilitative/palliative care) as well as moving the country towards a wider policy environment addressing the social determinants of health, with the central government being the guarantor and enabler, while state governments being the pre-dominant provider of comprehensive primary health care and facilitating higher level care through strategic purchasing in the short term and pre-dominant public provisioning in the long term*

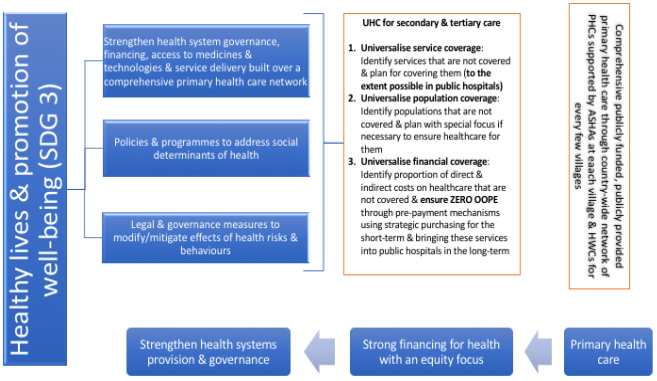
Three core strategies are proposed to help move the country towards UHC

1. **Strengthen health systems through coordinated investments in all the health system building blocks outlined below:** There is a need for healthcare delivery and health service level improvements including comprehensive primary health care, secondary and tertiary care, preventive care and rehabilitation that address curative and preventive aspects of health. In addition, strong health systems require long-term

investments in governance and financing health in the country as well as building a responsive and motivated health workforce, improving access to medicines, vaccines and technologies, as well as laying the foundations for a people-centred health service that is responsive and accountable to populations and communities.

2. **Design and implement policies and programmes to specifically address social determinants of health:** While there are many genetic and bio-medical causes of disease and ill-health, the WHO Commission on Social Determinants of Health (2006) has compiled a wide body of scientific evidence to show that health and healthcare are strongly determined by various social determinants of health including socio-economic status, caste, gender, disability and various other drivers of social disadvantage. While there is an overall architecture of affirmative action across sectors, it is imperative to design specific policies and programmes that address barriers and drivers of social disadvantage.

3. **Effective legal and governance measures that modify/mitigate/protect against population level health risks and behaviours:** While individual behaviour change and health promotion is taken up by comprehensive primary health care system, there are large-scale and powerful population level drivers of disease, ill-health and risks including (but not limited to) tobacco, food



Summary of core strategies for moving India towards UHC based on strengthening publicly provided comprehensive primary health care and short-term strategic purchasing of secondary/tertiary care, with concomitant improvements in health systems governance and health financing (Illustration by authors)

industry, alcohol and road safety. The 'Health in all policies' approach that is widely embraced the world over is useful to guide effective legal and governance measures across sectors that have important gains in health.

4 Towards comprehensive primary health care through PHC

A vision for accessible and people-oriented health system can be realised only through a well-financed and well-performing network of primary health centres (PHCs). Such a network of PHCs is already available in **most** (but not yet all) parts of the country. There is a need for a systematic and coordinated investment

in ensuring good performance and motivated health workforce in all PHCs. Comprehensive Primary Health Care[7] has an important role in the primary and secondary prevention of several disease conditions, including NCDs. Estimates suggest that almost 52% of all conditions can be managed at the primary care level.

4.1 Health and wellness centres:

The announcement of a long-term investment in health and wellness centres (HWCs) below PHC level in the *Ayushman Bharat* is a great opportunity to strengthen comprehensive primary health care through improving its community orientation. However, there is a need for urgently improving the capacity and motivation of the health workforce as well as carefully monitoring their performance, coverage and community orientation.

4.2 Services at PHCs:

In the long-term, the PHC should aim to become the first point of contact for **all** conditions. At the PHC, the team should be able to organise appropriate care that is feasible at that level for primary level conditions. In addition, there should be a clear plan to organise referral to the most appropriate secondary and/or tertiary level along with a health financing pre-payment mechanism

7 *The National Health Systems Resource Centre set up the Task Force on Comprehensive Primary Health Care Rollout (TF-CPHC) which has provided a comprehensive outline and an operational plan for rolling out and strengthening primary health care. The recommendations in this section are adapted from the guidance provided by the Task Force.*

that ensures no OOPE on healthcare, medicines or other ancillary care. However, in the short-term, in order to begin advancing towards comprehensive care, a basic minimum set of conditions for which PHCs should provide care have been outlined by the TF-CPHC:

(i) Care in pregnancy and child-birth

(ii) Neonatal and infant health care services

(iii) Childhood and adolescent health care services, including immunization.

(iv) Family planning, Contraceptive services and Other Reproductive Health Care services

(v) Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments

(vi) Management of Communicable diseases: National Health Programmes

(vii) Prevention, Screening and Management of Non-Communicable diseases

(viii) Screening and Basic management of Mental health ailments

(ix) Care for Common Ophthalmic and ENT problems

(x) Basic oral health care

(xi) Geriatric and palliative health care services

(xii) Trauma Care (that can be managed at this level) and Emergency Medical services

4.3 Strengthen care at family and household level through promoting evidence-based local health

traditions including home-based care for minor illness, herbal medicines and promotion of Yoga, *pranayama* and meditation techniques for improving mindfulness and spiritual health in accordance with people's cultural preferences. The existing network of ASHAs needs to be further strengthened and capacitated to promote this role along with other community-based cadres such as Anganwadi Workers and government school teachers. Empowering patients for home-based monitoring of chronic conditions is the preferred approach in reducing over-dependence on doctors and professionals wherever feasible.

4.4 **Strengthen solidarity and community platforms:**

Integrate roles for Village Health, Sanitation and nutrition Committee (VHSnC) and Panchayath Raj Institutions (PRIs) in various health policies and programmes across all sectors especially women and child development, social welfare schemes and national health programmes

4.5 **Health and wellness centres with physician-assistants:**

Existing sub-centres should be upgraded to health and wellness centres. Given the limited desire among medical professionals to serve at village level and in remote rural/forested regions, a new cadre of middle-level healthcare providers such as physician-assistants needs to be put in place for effective functioning of HWCs.

4.6 Multi-skilled and new cadres for PHCs:

Counsellors for various chronic conditions are an urgent need at PHC level (including TB, HIV/AIDS, Diabetes, mental health conditions and adolescent and sexual health). Either capacitating existing staff such as male health workers or else investing in a new cadre of counsellors is an urgent need to ensure comprehensive primary health care.

4.7 Hospital-held health records:

In order to ensure integrated and good quality healthcare, PHCs need to have health records for all the population in their catchment area. The use of appropriate eHealth technologies can be explored to improve efficient implementation of health records. Such records should be beyond medical care and illness, and should include preventive services such as immunisation history and reproductive health.

4.8 Access to good quality diagnostics improves technical quality of care, enables early detection and timely treatment. Strengthen diagnostics quality and availability at PHC (especially for NCDs which are currently not available) and establish nodal diagnostics facility at taluka/block level to ensure access. In remote rural and tribal areas, improve access by setting up collection centres for blood, urine and other biological material to ensure equitable access to essential diagnostics.

4.9 Benefits of eHealth & mHealth at PHCs: Enable equitable access to benefits of technology

through appropriate use of tablets, handheld devices and other eHealth technologies to improve quality of care at PHCs. These can be useful for setting up health information systems, home-based monitoring, facilitating referral and treatment, health education, grievance redressal and community monitoring of health facilities.

4.10 Standards of care and quality: A concerted action by all state governments is needed to ensure compliance of PHC services availability and quality of care as per pre-defined quality protocols. The standards prescribed under the Indian Public Health Standards and the Quality Council of India is a good starting point.

5 Strengthening health systems in India

Health being a state subject in India, there needs to be a concerted and coordinated action between the central and state governments in strengthening health systems. The central government through its responsibility to play a convening role as the guarantor of health and wellness across the country can play a steering role in guiding states towards stronger health systems. In addition, the central government can supplement and complement state and district level systems (EAG states for example as well as districts with pre-dominant tribal/Adivasi populations, Schedule V and VI states) through financial and technical assistance to achieve the health and wellness goals of the population. The central government also has an important role in monitoring the progress of the

country towards UHC as well as undertaking structural and institutional reforms in medical education, human resources for health, financing and governance of health.

Comprehensive primary health care and UHC cannot be achieved by states alone; appropriate financing of health by central governments as well as setting an effective governance of medical and allied education, periodic monitoring, evaluation and research on our policies and programmes and promoting population health through concerted action on social and environmental determinants of health are essential. A plan of action including both short-term and long-term measures are outlined below.

5.1 Governance

5.1.1 **Enable Health sector regulation by state governments through setting up State Health Regulatory Agencies**

Indian states vary in their technical capacity for regulation of healthcare in government and private facilities. In addition, there is currently no institutional structure or mechanism to organise and manage health governance at the state level. There is an urgent need to ensure a fair regulatory environment wherein both government and private hospitals are provided support and guidance on technical quality and safety, as well as careful monitoring of the quality and

safety standards being maintained in these facilities. While many states have adopted private medical establishment acts to register private facilities, monitoring of their safety and quality of care in these facilities is limited to private accreditation efforts. States need to develop the technical capacity to design, monitor and oversee quality and safety standards. Hence, there is a need to set up a state level regulatory agency with multi-stakeholder involvement including (but not limited to) civil society especially patient groups, professional associations of doctors and allied health professionals, private hospital managements, government health and medical education departments as well as departments of social welfare and women/child development. Such an agency should be technically enabled with public health professionals who can work on setting up standards for quality, treatment protocols, safety as well as monitoring of UHC through sentinel UHC monitoring sites in disadvantaged or remote/rural regions and smaller cities of the state.

5.1.2 Evidence-based decision-making and Management systems

There is a need to provide technical capacity and guidance to state governments to set up robust health informatics enabled

management information systems covering both public and private sector providers across the state. Such data should be made publicly available to enable and encourage public debate and evidence-based decision-making.

5.1.3 Improve system responsiveness and oversight through a Health Ombudsman

Given the widespread perception that public health services and lack of quality go hand in hand, the end result is that the citizen or the user is left with little choice to complain and seek redressal outside of the consumer protection act that operates largely between individual patients and private providers. Hence an informal channel of engagement with the system where the citizen enjoys the benefit of anonymity and a space to air grievances freely, besides experiencing a sense of fairness, is envisioned as a step towards improving the quality, reliability and accountability of public services in India. The setting up of Ombudsmen at various levels in the system of public service delivery is one of the steps in this direction. The position of the Ombudsman can not only establish the aforementioned channels of engagement for the citizens, but also trigger actions that improve the overall system in terms of being responsive to the very citizens it is supposed

to serve. Importantly, the position of the Ombudsman is expected to complement the existing structures in the system to make it better. In fact, it would be an obligation of the ombudsman to ensure that the existing norms and parameters are respected and a parallel system or a disparate power centre does not develop. The Ombudsman would also play a proactive role in observing and suggesting systemic improvements and because of a direct role of interacting with citizens, would be in a position to provide citizen's perspectives and bring their voice to the table.

In the case of large private health establishments (to be identified based on annual financial turn-over cut-offs or with bed number cut-offs) setting up of independent offices of Ombudsman (Health) on the principles outlined below should be a good practice. Alternatively, district level committees under the state private medical establishment acts can also be strengthened at each District in coordination with the Department of Consumer Affairs / National Consumer Disputes Redressal Commission as well as in collaboration with the state health regulatory agencies (see above).

The objectives of Ombudsman could include:

1. Acting as an independent facilitator for addressing of grievances and resolving conflicts among citizens and the hospital / health system in a fair and neutral manner within the existing systems and structures.
2. Setting up a channel of communication: The foremost gap that the position of the Ombudsman seeks to fill is that of setting up a channel of communication that is simple, informal and handled in confidence with users of health facilities provided by the Government.
3. Provide and promote an environment, that leads to improvement in quality of services rendered by way of greater and effective information dissemination mechanisms, that leads to education of citizens and increased accountability among health functionaries.
4. Promote the awareness of patient rights: The Ombudsman would also particularly take note of cases where patient rights are violated and would also proactively promote the awareness of patient rights among citizens.
5. Encourage fair administrative practices: The Ombudsman would take note of administrative practices that are not in alignment with the intent of providing good quality reliable health care and are deemed to be hindering forces, and work with the

management and the departments to ensure that these practices are based on principles of fairness, equity and transparency.

6. Recommend systemic changes and reforms to the state health regulatory agency (see above) that lead to better delivery of services by proactive observation, documentation and analysis.

5.2 Health financing[8]

Health financing strategies should be closely aligned with ensuring comprehensive primary health care by the state governments on one hand, while facilitating secondary and tertiary care through pre-payment mechanisms on the other, either through government hospitals or from the private sector within an environment of fair dialogue and shared public vision of health. In terms of health financing, this means that the government should shift healthcare expenditure out of households onto pre-payment mechanisms. This **cannot be achieved without an architectural reform** of current health financing arrangements.

Broadly the way of strengthening health financing would range from (1) **increasing revenue allocation for health care**, (2) **pooling the funds to provide financing protection** and (3) **purchasing healthcare strategically** and in public interest.

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8 With the acknowledgement of inputs from N Devadasan through sharing of unpublished note on health financing situation analysis and recommendations for India

5.2.1 Increasing Revenue Collection

One of the main reasons why government health care services are inadequately funded is the low tax to GDP ratio. Efforts like the GST and stricter monitoring of financial deals have increased the tax revenue in the past years. There are few other ways of increasing the revenue for health care.

1. **Increase taxes on alcohol, tobacco and highly processed trans-fat rich food** and use this revenue to specifically finance healthcare. A strong case for individual liberty of using these products has been made and that may still be preserved. However, at a population level and given strong industry promotion of these behaviours and recruitment of younger and new people into these habit-forming substances with high cardiovascular and road safety risk, there is a need for raising revenue for the additional burden of health created by its use and regulate industry impact on people's health.
2. **Expand the Employees State Insurance Scheme (ESIS)** to cover larger population groups in the formal sector. Currently, only those who earn less than INR 21,000 per month are eligible for joining the ESIS. If the government increases this cap to INR 100,000 pm, then most of the formal sector (7.5 crores) would come under the ambit

of the ESIS and health care protection. It of course will increase the cost of labour in India, as the employer has to provide 4.5% of the contribution, but this would be a fairer and equitable costing of labour than current costs which do not reflect the costs of social protection of the poorer sections. The ESIC has today accumulated more than INR 73,000 crores and this money along with the proposed increase in cap can be used to strengthen the government health care services, especially in the urban areas, so that those enrolled can use the services without having to make out of pocket payments.

3. **Reduce excessive tax rebates to industry** and use this for healthcare provision. As per the 2015-16 budget figures, INR 4,82,489 crores were provided as subsidy to the industry, while the government allocates only INR 1,40,054 crores for health care services. The pool of funds that is accounted under the head of 'Foregone revenues' under the union budget can be mobilized and redeployed for the health sector.

5.2.2 Pooling funds and improving financial protection for health

Reducing out-of-pocket expenses: Large proportions of OOP by households is on medicines, more so for NCDs that require

long-term medications such as Diabetes, Hypertension, Epilepsy, Mental health conditions and HIV/AIDS. **Widespread availability of low-cost good quality generic versions of these medicines** in all taluka hospitals and PHCs (as per the essential drugs list) will significantly bring down overall OOP. The recently introduced 'Jan Aushad Kendras' is a step in the right direction and this initiative needs to be scaled up across the country to make a real impact.

Yet another cause of OOP is the financial shock due to hospitalisation. The soon-to-be-launched **National Health Protection Scheme** will protect a sizable proportion of the poor from hospitalisation expenses. However, NHPS needs to be expanded to the near-poor and slowly to even the non-salaried socio-economic groups which are a sizeable number.

2. **Improving efficiency through optimising health fund flows:** Due to multiple types of health providers, the meagre tax allocation is split between central government, state governments, defence medical services, railway medical services, and several overlapping national health programs. This does not include the usual leakages at each of these levels. This can be avoided

if the government **reduced the number of channels for financing health care and streamline them in public interest**. A simple way could be to allocate a specific untied amount to each state government every year with the caveat that this money should be used for providing or purchasing health care services and that at the end of three years, the governments should have met the **performance targets that could be mutually set up.** The Niti Aayog's Healthy States Performance Index is a useful step in advancing this preferential and need-based health-specific allocation to states in the spirit of cooperative federalism. Wherever underperformance at state/district level is due to lack of technical capacity, the central government could allocate special financing mechanism to these states/ districts to assist them in implementation (eg. in districts with high Adivasi populations or remote rural districts or tier II/III cities with weak urban governance systems). The performance indicators can be measured by allocating a monitoring system to the large network of government medical colleges and their community medicine departments, thus improving the involvement of these departments in public health monitoring and action.

5.2.3 Improving efficiency through strategic purchasing in public interest

Yet another way of improving efficiency is by purchasing health care services strategically from the private facilities. India has a very large number of formal private health care facilities that provide mostly curative care ranging from ambulatory care to complex speciality care. The government can purchase care from these services, thereby improving the access to effective and quality health care services. The caveat here is that the government should have the capacity to purchase health care strategically. The government has already started implementing such strategic purchasing schemes, e.g. the RSBY, the Rajiv Arogya Shree and the Vajpayee Arogyashree Schemes. This is a beginning and can be expanded in a phased manner to include ambulatory care as well.

While strategic purchasing from private sector is a short-term and immediate measure to ensure care, the only long-term and cost-effective solution for UHC can be decentralised care through well performing publicly funded secondary and tertiary care hospital network with a robust backward follow-up linkage to primary health centres closer to people's homes.

5.3 Secondary & tertiary care and strengthening "missing" health services

1. Strengthen secondary care at all taluka/ block level government hospitals

A coordinated effort is needed to improve the performance of the secondary care hospitals of the government and to ensure good quality secondary care services in all talukas/block levels of the country in line with the Indian Public Health Standards. There is an urgent need to ensure that all taluka/ block hospitals are able to function as first referral units for emergency obstetric care and hence should have the infrastructure, equipment and human resources for providing surgical obstetric interventions for safe delivery and new-born care for high-risk pregnancies.

2. Expand government-provided tertiary care to compulsorily include ICUs, transplant and dialysis centres in all district level hospitals

Tertiary care institutions, specialized and super-specialty hospitals should be established keeping in mind equity considerations and need rather than in large capital cities only. New medical colleges should be preferentially attached to district and government hospitals. As a part of super-specialty care strengthening, organ

transplant facilities should be scaled up in all the district hospitals that have been upgraded to provide super-specialty care. All district hospitals should be upgraded to have intensive care units with ventilator facilities and dialysis centers.

3. **Strengthen Emergency services and trauma care**

   There is a need to strengthen both emergency transport as well as emergency care services in an accessible and timely manner. Financing of action plans by states to identify and upgrade existing district hospitals along national highways as well as identify points of care close to hotspots of road injuries should be undertaken. Similarly upgrading nodal hospitals in under-served areas as well as forested/Adivasi areas for providing trauma care and other emergency services shall advance equity and UHC. A professionally managed emergency care system to be run by an autonomous government entity in close coordination with medical colleges, private and government hospitals should be encouraged at state and district levels.

4. **Linking curative care for NCDs and their complications with community-based care at PHCs and HWCs**

   Given the increasing burden of NCDs including diabetes, hypertension, stroke, cardiovascular diseases, mental health and injuries/snakebites, hospitals need to be upgraded to provide curative care for these as well as invest in counselling, health promotion and behavioural change. On one hand this includes induction of new cadres of health workers including counsellors. On the other, strengthening backward referral linkages to ASHAs, ANMs, HWCs and PHCs after diagnosis of NCDs is needed. This will enable home-based monitoring and patient empowerment and ensure care within less expensive and more enabling community settings rather than expensive care at higher settings.

5. **Palliative care and pain management**[9]

   In addition to pain management, palliative care involves management of various conditions including breathlessness, nausea and vomiting, paralysis of limbs, fungating ulcers and many other symptoms that can cause and aggravate suffering. Prolonged disease, the bed-ridden state,

9 *Some states like Karnataka*

and various disabilities, all can cause intense psychological distress in addition to physical pain, anxiety and depression. The distress is not only for the patient but the entire household suffers. While some states have evolved a palliative care policy, there is a need for a national level action plan along with state-level action plans for organising palliative care through district hospital networks as well as integrating this in community settings with HWCs and PHCs. Current recommendation of shared financing of palliative care by central and state governments as per the National Program for Palliative Care needs to be strengthened due to its poor update by district hospitals and state governments to ensure widespread availability of palliative care.

6. **Integrate AYUSH into mainstream health care services**

Various international resolutions passed by WHO member states urge National (and State) Governments to respect, preserve and widely communicate traditional medicine knowledge while formulating national policies and regulations to promote appropriate, safe, and effective use; to further develop traditional medicine based on research and innovation, and to consider

the inclusion of traditional medicine into their national health systems. Government health services should provide care under all systems of medicine currently under AYUSH in an integrated manner and not separately as currently being provided to improve efficiency and optimal use of resources. Operational guidelines for co-location and integrated provision of AYUSH care within the formal health system should be prepared and implemented. Adequate and fair financial allocations for AYUSH should be integrated into the health budget and protocols. Guidelines for treatment under AYUSH, similar to standard treatment guidelines in modern medicine should be prepared. Accreditation and certification system for local health practitioners should be taken up.

The Government should also provide a regulatory framework for AYUSH medical practice and create an enabling environment for effective involvement of traditional practitioners as well as exploring traditional medicinal plants and encouraging bio-prospecting.

5.4. Access to medicines, vaccines, diagnostics and health technologies

Access to medicines, vaccines, diagnostics and health technologies has to be mainstreamed into the

health system through appropriate procurement and efficient supply chains. Since this is largely a state-level function, there needs to be a national framework and monitoring across states to incentivise states to invest in efficient and equitable supply chains rather than leaving it entirely to states.

1. **Essential diagnostics list and investing in affordable point-of-care testing:** In 2018, the WHO has begun to lay the ground for the preparation of an essential diagnostics list. India has swiftly announced its intent to have such a list in the same year. Such an essential diagnostics list should enable widespread assessment and provisioning of these diagnostics at the most appropriate level including the provisioning of point-of-care testing faciliteis at homes and households through ASHAs and HWCs, at PHCs and at higher centres.
2. **Strengthen district laboratories to become ONEHEALTH centres:** There is a need to systematically invest in a centrally networked and well provisioned district laboratories that are linked closely to outbreak investigation and response. The current system of IDSP-run laboratories need to be upgraded as per the essential diagnostics list for district hospitals. With the rise of zoonoses and re-emergence of infectious diseases in the form of sudden

and often unpredictable outbreaks (Nipah, Kyasanur Forest Disease, Ebola, Japanese Encephalitis to name a few), there is a need to set up periodic surveillance and referral laboratories using the ONEHEALTH approach. The OneHealth approach integrates surveillance of pathogens across human, veterinary and wildlife systems and enables sharing of information and action across these sectors. In order to improve India's disaster preparedness and response, such an integrated OneHealth approach is imperative at the district level.

3. **Health Technology assessment** is required to ensure that technology choice is participatory and is guided by considerations of scientific evidence, safety, consideration on cost effectiveness and social values. In line with the NHP 2017, there needs to be a coordinated action towards setting up and managing Health technology assessment boards at national and state levels. The recent efforts by the Indian Council of Medical Research in this direction needs to be expanded to all states.

4. **Strengthening mortuary facilities and medical jurisprudence:** India lags behind in terms of building a scientific and technical infrastructure for forensic medicine and medical jurisprudence. There needs to be

a national effort at building up facilities and infrastructure in all medical colleges and district and taluka/secondary hospitals for mortuary and forensic medicine facilities.

5. **Antimicrobial stewardship**

   Despite being among the world's largest consumer of antibiotics, antimicrobial resistance patterns in India and our response to the rising problem of antimicrobial resistance is insufficient. Antimicrobial resistance has been compared to climate change in its global and local effects. There is a need for a national level action plan on antimicrobial resistance coupled with incentivising state-level hospitals to implement antimicrobial stewardship practices and plan locally.

5.5 Human resources (HR) for health

An effective human resource for health strategy ensures an appropriately skilled, motivated, well distributed and productive workforce for the provision of quality health services effectively and efficiently. The health workforce constitutes those persons recruited primarily for health and related service provision and management who have undergone a defined, formally recognized training programme.

Since most of the healthcare provision is organised and managed by states, there is a need to help

state governments establish HR cells for the health workforce.

States that have prioritised good public health practices along with clinical care have ensured better health outcomes. There is a need to facilitate administrative reforms at state level to set up public health cadres, a separate management cadre of doctors/nurses that are trained and oriented in public health management (as opposed to clinical care).

Compulsory rural medical services rules that make serving in rural areas for one year after undergraduate and postgraduate medical education is an important policy option to correct urban-rural distributional disparities in health workforce.

5.6 Medical education[10]

Professional education has not kept pace with the growing needs and challenges in public health, largely because of fragmented, outdated, and static curricula that produce ill-equipped graduates. A global assessment of the problems of medical education has found that the problems are systemic and many of these apply to India, where medical colleges and education followed a somewhat post-colonial model resulting in a mismatch of competencies to patient and population needs; poor teamwork; persistent gender stratification of professional status; narrow technical focus without broader contextual understanding;

10 *This section is adapted from the Independent Commission on education of health professionals for the 21st century. See Frenk* et. al. *(2010) in the Lancet*

episodic encounters rather than continuous care; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labour market; and weak leadership to improve health system performance. Laudable efforts to address these deficiencies have mostly floundered, partly because of the so-called tribalism of the professions—ie, the tendency of the various professions to act in isolation from or even in competition with each other rather than in coordination. It becomes imperative for the central government to then play a stewardship role in ensuring greater coordination between population needs and the aspirations of individual professionals or professional associations. In line with this, important reforms in medical education are needed including:

1. Improving the relevance and community orientation medical and allied health disciplines
2. Encourage inter-professional movement between health professions through bridge courses and career development opportunities
3. Establish new cadres including physician-assistants and/or nurse-practitioners
4. Establish Public health complements of clinical professions and improve their representation within the health system such as public health nurses, public health pharmacists
5. Improve relevance and role for medical colleges to participate in public health research, UHC

monitoring, implementation research and policy evaluations.

6. Consider cross system training, eg: Students of Allopathy get a basic course in AYUSH and vice versa.
7. Strengthen existing reform processes to make the National Medical Council accountable and accessible to patients, professionals and governments

5.7 Health Information systems

A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status. Current information systems capture incomplete data (as they exclude private sector). The staff in the public health sector is often overburdened with maintenance of multiple registers and many forms that need to be filled each day. There is a need to leverage technological achievements in eHealth and mHealth in upgrading information systems in hospitals, health centres and patient records into digital format. In some states, there may be up to 34 registers maintained at each sub-centre. From these registers, a single programme, Reproductive and Child Health (RCH) programme produces more than 30 reports monthly. Currently only NRHM-HMIS, MCTS (Mother to Child Tracking System) and NACP-SIMS (Strategic Information Management System) have the provision for internet based reporting, which involves

real time data entry and feedback from the level of PHC. For the rest it is paper-based and is largely vertical and time consuming. Mechanism to ensure that the generator of data also has use for the data in terms of analysis, monitoring and future planning is to be built into the system.

5.8 Health policy evaluations, health systems research and implementation research

All policies and programmes in health should be subject to the highest quality of monitoring, evaluation and research. Research and evidence are important inputs into policy, programmes and practice. While cutting-edge biomedical research is important on one hand, there is also a need for socially relevant health policy and systems research. At least 1% of the budget of major policies and programmes should be allocated as a norm for monitoring, evaluation and research of the respective health policies and programmes.

1. Develop and implement a comprehensive research agenda for health incorporating epidemiological, clinical and health systems research together with sociological, ethnographic and other multi-disciplinary methods, with recognition of the role of diverse disciplines and methodologies including participatory research methods.
2. Commit equitable funds for promoting health research, with a target consistent with the burden of health problems in the state.

3. Invest in building research capacity in health and research both through existing institutions and developing new institutions focused on niche areas
4. Foster partnerships between Public health institutions, Medical College Departments of community medicine with the District Health officer and state officers, and with appropriate non-governmental research institutions to implement priority health research.
5. Develop learning sites in different regions of the states, around such partnerships, which can monitor population health through long-term cohort studies, panel surveys and evaluate health programs.
6. Develop and facilitate mechanisms for dissemination of research findings and for translating research findings into action at the service delivery level.

6 Policies and programmes for mitigating health risks and addressing social determinants

6.1 Strengthen tobacco control and reduce industry interference

Nearly one in two men and one in five women in India consume tobacco in one form or another. Directly or indirectly, tobacco kills one million adult Indians every year. At the family level, expenditure on tobacco crowds out spending on education and essential

items such as food. At the societal level, we are yet to come to terms with the ecological impact, through deforestation and environmental degradation, of large-scale tobacco farming and manufacturing processes. India should continue to ensure that new and young population shall be offered healthy choices through school and society-based programmes and limit recruitment of new smokers through advertisement and endorsement of tobacco products. There is also a need for a progressive system of increasing tobacco taxation in line with international commitments made by the Indian government, as well as the health burden imposed by tobacco consumption in various forms. Along with this, there is a need to invest in a 'tobacco cessation' infrastructure at district levels in order to help people seeking help with addiction to tobacco use.

6.2 Reduction of alcohol consumption regulation

Alcohol dependence and related psychological and social impact is a complex medical and social problem, affecting several sections of the society, and especially having indirect ill-effects on children, women and poor households. Irresponsible and harmful alcohol use is also closely linked to road traffic injuries and violence. The state shall ensure sufficient geographical spread of alcohol de-addiction infrastructure in its district hospitals, as well as invest in a primary health care and school based programme to promote healthy choices among adolescents. Existing regulations and

taxation shall be used to limit harmful consumption of alcohol.

6.3 Reduction of risky sexual behaviour

Appropriate investments in adolescent reproductive and sexual health programmes and school health will help mitigate effects of risky sexual behaviour and concomitant increase in sexually transmitted infections.

6.4 Reduction of unhealthy food and promotion of balanced diet

In line with the need for improved nutrition and health, there should be a policy focus on improving nutritional food intake, locally available traditional foods as opposed to highly processed trans-fat rich and pre-packaged junk food. Encouraging healthy food practices in Anganwadis, schools and regulating adverse nutritional impacts through industry-based advertising is an important component of health and well-being.

6.5 Promotion of physical activity, Yoga and meditation

Physical activity, Yoga and meditation are important drivers of healthy lifestyle and well-being. However, access to parks and open spaces are not well distributed in cities and in rural areas. There has to be a coordinated action between health departments, panchayats/urban local bodies in ensuring equitable access to parks and open areas in all neighbourhoods.

6.6 Community empowerment for self-reliance of households in improving and promoting health

Traditional health culture of Indian households includes hundreds of eco-system specific practices for management of common ailments, nutrition, prevention, safe drinking water, ethnic diets and so on. These need to be documented, studied, validated and disseminated through health education building upon these practices.

6.7 Monitoring and mitigating effects of air, water and noise pollution

Health is intricately linked to the environment within which people live, both within households, as well as with respect to the air, water, noise and the larger climatic variations. Unplanned industrialization, inadequate monitoring and control and excessive use of chemical pesticides, can and do have serious health effects on people. Air pollution through vehicle and factory emissions, as well as water pollution through untreated sewage are important problems in our cities. Various international bodies have also urged to consider the problems imposed by climate change, especially on vulnerable communities and geographies. While pollution control boards function independently, there is a need to integrate monitoring of the quality of air, water and noise levels with promoting healthy living environments for the population.

Action plans for inter-sectoral action on health: State-level action plans are needed to identify linkages

and coordinate with pollution control boards, transport departments and city planning authorities to ensure mitigation of health impacts of environmental factors.

Responsible management of medical waste: Adequate healthcare waste management infrastructure is needed to ensure proper treatment of biomedical waste not only in large cities, but also in all districts and select talukas, either through partnerships, or with the assistance of Pollution Control Boards.

6.8 School health

Schools are an important arena for promoting health and improving health literacy. Stressing on healthy behaviours including water sanitation and hygiene, creating an environment for healthy discussions on adolescent sexual and reproductive health, early introduction of Yoga and breathing exercises and promoting menstrual hygiene and building resilience of young people through life skills education builds an important foundation for a healthy future citizenry.

6.9 Food safety and adulteration

Ensuring quality and safety of food in canteens, hotels and private enterprises is an important health and safety measure. There is a need to build capacity of state and district health departments in being able to play this role. Current health departments although vested with this role are unable to fulfil this. Structural reforms to create new administrative cadres to fulfil this important public health function are needed.

6.10 Gender, caste and socio-economic groups[11]

All policies, programmes and schemes should take into consideration gender, caste and socio-economic status as important social barriers preventing universal and equitable access to healthcare. While universality and inclusiveness is an important guiding principle for health rather than charity-based approaches, there should be a strong focus on equity in all health and related policies, programmes and schemes to ensure that societal barriers in the form of caste, socio-economic groups, gender and other social vulnerabilities do not hinder access to these schemes, services and programmes. In order to ensure equitable allocation of resources, the regional and inter-state/district disparities should be factored into the mechanisms of allocation of resources among the states and districts. Doing this through an equity score/index is one mechanism of integrating equity principles in allocation of funds.

Disadvantaged groups: The Scheduled Castes and Scheduled Tribes as well as other population groups that face social disadvantage ought to receive priority attention. For indigenous/Adivasi people, a package commensurate to their needs and in line with their social, cultural and geographical setting has to be developed and implemented.

Gender: The poor status of women's health, the declining gender ratio and poor coverage and quality of

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11 Based on input by authors to the Karnataka Knowledge Commission drafting committee

mother and child health services (including instances of disrespect and abuse during delivery) are areas of concern.

1. Measures to improve women's health status and access to care should be implemented and closely monitored.
2. Efforts should be made to increase the number of women doctors, senior and junior health assistants, male / female (Lady Health Visitors and Auxiliary Nursing and Midwifery) by providing adequate reservation for women in the health educational institutions and appointments and providing better residential facilities and personal security.
3. Health conditions specific to women but relatively neglected, such as anemia, low backache, gestational diabetes, cancer of the cervix, uterine prolapse and osteoporosis should be prioritised.
4. Psychosocial support systems for women facing physical, emotional or mental trauma within households have to be strengthened.
5. Priority efforts for capacitating women to manage and monitor their own health at household level is also needed.

Other disadvantaged groups: Innovative, flexible and collaborative approaches would be adopted for meeting the health needs of neglected and/or disadvantaged groups including, but not limited to:

1. Street children,

2. Out of school and working children,
3. Persons with disability,
4. Homeless people with or without mental health problems,
5. People dependent on or victims of harmful use of alcohol and narcotics.

References

1. Niti Aayog: On the implementation of the Sustainable Development Goals http://niti.gov.in/writereaddata/files/India%20VNR_Final.pdf
2. Report Of Task Force On Comprehensive PHC Rollout (2016) National Health Systems Resource Centre, New Delhi
3. Operational guidelines for screening and early detection for major Noncommunicable Diseases (NCDs) (2016) National Health Systems Resource Centre, New Delhi
4. NHSRC. National Health Accounts Estimates for India 2013-14: Ministry of Health and Family Welfare (MoHFW) - Government of India. 2014
5. Ministry of Health and Family Welfare (MoHFW) GoI. National Health Policy, 2017. 2017. https://www.nhp.gov.in//NHPfiles/national_health_policy_2017.pdf
6. N Devadasan. Health financing in India: The way forward (2018) *Unpublished*
7. Devadasan N, Ghosh S, Nandraj S, Sundararaman T. Monitoring and Evaluating Progress towards Universal Health Coverage in India. PLoS Medicine 2014 Sep 22;11(9):e1001697.
8. Grassroots Research And Advocacy Movement (2014) Draft concept note on The Ombudsman (Public Health) by Rohit Shetti & R Balasubramaniam, Mysore

9. Planning Commission of India. High Level Expert Group Report on Universal Health Coverage for India. Group. New Delhi; 2011.
10. WHO. The World Health Report 2008 : Primary health care now more than ever. Geneva; 2008.
11. WHO Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva, Switzerland; 2008. Available from: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf
12. Gaitonde R & Ravindran S *Eds* (2018) Health inequities in India: A synthesis of Evidence. Springer Publications

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