Long on Aspiration, Short on Detail

Report on Universal Health Coverage

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The recommendations of the Planning Commission's High Level Expert Group on Access to Universal Healthcare are significant because they make explicit the need to contextualise health within the rights. However, the problem with the report is that it does not ask why many of the same recommendations that were made by previous committees have not been implemented. The HLEG neither recognises the problems, constraints and compulsions at the national, state and district levels nor offers any solutions on how to deal with them.

The author is grateful to Sunil Nandraj for his insightful comments and suggestions which helped in writing this article.

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In October 2010 the Planning Commission constituted the High Level Expert Group (HLEG) on Universal Health Coverage (UHC). The group in its report submitted in late 2011 made several recommendations pertaining to human resources for health, access to drugs, social determinants of health, governance, financing, and people's participation. A majority of the recommendations find resonance in earlier expert committee reports.

The recommendations made in earlier reports include universal health coverage as a right of every citizen (Bhore, 1946; constantly raised by civil society); increasing public health spending to 3% of GDP (National Commission on Macroeconomics and Health – NCMH – 2005, Common Minimum Programme of United Progressive Alliance (UPA) I, 2004); the concept of having a benefit package that is universally available as an entitlement (NCMH 2005); increasing the overall size of the health workforce to achieve the World Health Organisation (WHO) global norm of 2.3 workers for every 1,000 population (NCMH 2005); expanding the essential drug list and capping prices (judgment of the Supreme Court); assuring access to water, sanitation and nutrition (National Health Policy – NHP – of 1984 and 2002); improving health governance through decentralisation and making the district the unit for administration (NHP 2002 and NCMH 2005); establishing autonomous regulatory bodies for drugs, accreditation for quality; dissemination of information, etc (NCMH 2005); and community participation (Shrivastava Committee Report 1975; NHP 1984 and 2002; NCMH 2005).

The HLEG is, however, significant for two reasons: One, it has explicitly brought to the fore the need to contextualise health within the rights framework and, following, from that, to entitle every citizen of India equal access to publicly funded primary, secondary, tertiary, preventive and curative services, which will be provided free and will be cashless at the point of service. Hitherto, on grounds of financial constraints, the focus of public spending has been on a select set of services that largely concern the poor. The implementation of universal access to services over the next 10 years is expected to effectively bring down household expenditures that account for 72% of total health spending to 33%; and also increase public spending from the current level of 1.2% of GDP to 3%. While the emphasis on the rights framework is unexceptionable, there is, however, a lack of clarity on the second aspect as explained below.

Health Financing

The report has suggested that a National Health Package be defined by an expert group and be made accessible to all citizens irrespective of their ability to pay. The funding of the package is to be by the government on a capitation basis of Rs 1,500,[1] of which 70% is to be earmarked for primary care. The package would be administered by and provided in government-owned facilities. However, to expand supply-side shortages, private facilities could be contracted subject to two conditions: One, that such "contracted-in" facilities would either have to agree to provide only the package and/or provide 75% of outpatient (OP) treatment and 50% of inpatient (IP) treatment with the freedom to charge for the remaining. Two, that negotiation of prices, contracting and its administration is to be done directly by the government or an owned subsidiary and not by a private or commercial insurance agency or third party administrator.

The first set of issues is that the report is silent on the implications that such a policy may have on prices, availability and the response of the private sector which commands the market with its deep penetration in the villages of India, providing over 70% of OP, 60% of IP and commanding more than 75% of human resources and technology. More significantly, the private sector is not a

homogeneous entity, it is subject to no laws, and it has varied revenue streams and price structures. What if the private sector refuses to accept the package, reduces prices to stay competitive resulting in patients preferring the private sector to facing long queues, rude behaviour or corruption that are often associated with government-run programmes? International experience and the voucher scheme in Gujarat show clearly that in such dual systems, the private sector resorts to skimming and dumping high risks on to the government. In other words, the report does not spell out the programmatic implications of how the government might control, contain, engage or utilise the private sector to achieve public health goals. Or is it suggesting the winding up of the private sector in health except those enterprises which provide the National Health Package? If so, how?

Second, the feasibility of such a model where the government is the single payer rests on the government beating the private sector on price and quality – giving it no choice except to conform or perish. But even if the price is low or subsidised, in the absence of good quality, beneficiaries, particularly those with the ability to pay, will prefer to go for private care, forgoing if necessary the subsidy. This we see happening under the Central Government Health Scheme (CGHS), where for all its low cost care, beneficiaries resort to the private sector rather than go through the hassles of prior permission from the CGHS or standing in long queues. Quality and people's perception of this quality then becomes the critical variable and the report does not get into that issue.

Third, assessing with any seriousness, the financial feasibility of the HLEG recommendation is quite impossible in the absence of any clarity on what the content of the benefit package will be and at what cost will it be provided. India spends a mere 3% of its total public spending on health – both Canada and the UK, which have assured systems of healthcare, spend about 20% of the total budget. It is important to note that almost all countries – Brazil, UK, Canada, Thailand – got into the UHC debate only after addressing the basic health determinants of water supply, sanitation and nutrition and after having the public health infrastructure built on strong foundations. It is not clear if the HLEG has examined the feasibility of the government's ability to increase the share of health in total public spending by six times. It is also necessary to know the complementary increase on the social determinants of health, without which the realisation of health and well-being will not be possible.

Fourth, the distribution of the per capita amount of Rs 1,500 among the different facilities has not been provided to assess the soundness of the proposal. More importantly, it is not clear whether this per capita figure is inclusive of the massive capital expenditures required for upgrading and strengthening public health infrastructure, particularly at the secondary and tertiary care level.

Fifth, with no mention of the private practice by government providers, issues related to the conflicts of interest among government care providers when they do private practice as consultants or owners have not been discussed or even acknowledged. This will be a major issue as in most cases government doctors double up owning or working for private clinics. In fact, the main reason for the continued underperformance of public sector facilities is this duality.

Finally, the government's ability to discharge a wide array of crucial tasks such as developing standards, accrediting hospitals based on quality benchmarks, designing the benefit packages, pricing, negotiating and contracting providers, minimising fraud, containing cost, redressing grievances, regulating provider behaviour, ensuring patient satisfaction, etc, is contingent on it having the requisite skills, capability, flexibility and governance mechanisms and institutional structures. Such capabilities and competencies cannot be just piled on top of existing structures by recruiting consultants on contracts. It requires implanting a new culture of governance. The critical issue then is to align the existing governance and financing structures which are today incapable of synchronising even their limited responsibilities. The report is silent on how this can be achieved in all 600 districts within the next 10 years.

Human Resources for Health

Operationalising the UHC would require a similar review of the recommendations pertaining to human resources and drugs. How to motivate a doctor who has paid Rs 2-3 crore as capitation fee for his MD to work in a government hospital at government salaries in rural or semi-urban areas; or providing generic drugs only while ensuring their quality are issues that have plagued policymakers for long. Naturally then, it follows that all medical education needs to be in the public sector, payment systems unlinked from civil service salary structures to better reflect market prices, drug regulation scaled up expeditiously so as to ensure availability of high quality generic drugs accompanied with a massive advocacy campaign among patients and doctors, etc. The report is silent on all these important issues. Instead it has spent considerable energy on calculating the number of personnel required to achieve the WHO norm of 23/10,000 population, on the urgent need to scale up the availability of human resources from the current level of about 2 million to 4.9 million; and on the need to establish 189 medical colleges, 234 nursing schools and 600 District Knowledge Centres to train and retrain a wide variety of human personnel, etc.

Sadly enough, the fundamental questions related to public employment in health have not been addressed. First, the reason for the acute shortage of human personnel in public hospitals is partly a lack of availability and partly poor payment systems, weak incentive structures and poor governance. Benchmarked with the salary structure of civil servants, few want to join government, particularly specialists. Even as there is a clamour for more medical colleges and an increase in the MBBS seats, against the sanctioned 35,000 capacity hardly 25,000 join. Why? Second, there is an urgent need for public health reform in terms of human resource (HR) policies related to recruitment, training, retention, and development of avenues for specialisation and creation of the correct

balance of skills and competencies in keeping with our disease burden. Most states are yet to create posts and are carrying on with staff contracted on an annual basis, contributing to attrition and interruptions in the delivery of services and hindering efforts to improve skills through training and team building. Health is not a sector like accounting where rapid attrition will have no adverse impact.

The third key burning issue is the poor quality of the personnel. The lack of dedicated teachers and faculty is a matter of grave concern. There is enough evidence to show the poor quality of training of our doctors, nurses and lab technicians. No cognisance of how training is being imparted to ensure excellence in other countries or the private sector has been taken note of. Instead reviving the relatively dead and long forgotten Rural Health and Family Welfare (RHFW) centres and the dysfunctional State Institutes of Health and Family Welfare (SIHFWs) have been proposed. There is no harm doing so but can they be made to deliver the expected level of quality and speed or are there other options that can help expand the base of the training infrastructure, for example, by the use of institutions run by NGOs, faith-based organisations or private foundations? Besides, somewhere we are missing the role of values and inspirational training as opposed to a mechanical one-week, three-month, one-year type of knowledge-based courses.

Finally, governance, particularly related to the power of transfer, needs to be squarely addressed, as repeatedly professionals trained at considerable cost are invariably posted to facilities where the skills cannot be utilised. Besides, it is not just a body of doctors or nurses that is required – instead, what is desperately needed is a host of skills – biostatisticians, virologists, epidemiologists, entomologists, health economists, specialists in cardiology, neurosurgery, oncology, medicine, paediatrics, clinical psychology, nurse practitioners, public health nurses, etc. How do we get them? Where can they be trained? Where is the faculty? Should we allow, in the short run, scarce skills to be imported like what other countries in west Asia and Africa are doing?

Need for Prioritisation

The report is well intentioned as it is based on the foundational principles of democratic governance, namely, the right to health and people's participation. Unlike the report of the National Commission on Macroeconomics and Health which too advocated making available a benefit package to all citizens (though albeit only covering primary care and secondary care to be delivered through district hospitals and contracted-in private sector administered by the district health authorities through social health insurance with the government subsidising the premium up to 30%), the HLEG severely falls short in providing a blueprint on what, how, at what cost, and with what trade-offs, making it difficult to translate the ideas into operational strategies and make the 12th Plan the game changer it was hoped to be. It would have been advisable if ground realities had been taken into consideration, available evidence studied, and stakeholder consultations held. It would have perhaps enabled the HLEG to come up with a different approach that would have reflected the wide diversity in the health status, health infrastructure and health-seeking behaviour. After all, money is a limited commodity and any planning of systems has to be cost-effective, avoiding duplication of service delivery and the unhealthy competition between the public and private sector.

It follows then that targeting and prioritisation of public investment in areas of need – for both patients and facilities – is inevitable in, for example, the delivery of basic healthcare in tribal areas through doctors and well-trained paramedics. The recent incident of the suspension of a gynaecologist in a tribal district of West Bengal for having cut and stitched up the womb of a tribal woman after not finding the baby, which resulted in the woman delivering a dead baby was a terrible event. But what was worse was the fact that the suspension had to be revoked following a demand by people's representatives on the ground that the adivasis were now denied even the little they were getting.[2] Likewise, to achieve a reduction in maternal mortality, the evidence shows that instead of equipping all the 1.75 lakh public health facilities for deliveries, no more than 20-30,000 facilities are adequate for the purpose. These need to be provided with infrastructure, skilled human resources, drugs, transport and phone facilities on a differential basis. Finally, almost 30% of the existing facilities are located in inaccessible areas. These have to be closed down.

The burden of these examples is that the first step is to undertake a mapping of health facilities and develop different financing models to achieve the goal of universalising access to the benefit package of services. This is because, studies and programme data clearly show that while distance (location) is a big barrier to consumption of services, the mere physical location of a facility is also no guarantee of access. The need of the hour is for critical concepts such as differential planning, results-based financing, performance-based incentives, upgradation of educational qualifications, training duration, skills and competencies through sustained concurrent and frequent training of paramedics, etc, to enter the policy dialogue.

Similarly, ensuring availability of all inputs in a synchronised manner and the timely release of funds, bookkeeping, account maintenance, and auditing and management of contracts require changes in the financial rules of government that are more oriented to accounting than financing. The HLEG should have studied the financing of the public system at the district level which is still struggling to effectively and satisfactorily implement the relatively simple cash transfer scheme under the Janani Suraksha Yojana or ensure that every pregnant woman, irrespective of place of delivery, gets Rs 500 as mandated by the Supreme Court. The financial mismanagement as found in Uttar Pradesh could be a great starting point of analysis.

Finally, the HLEG report does not ask how one can resolve the complex tension between the vertical and the horizontal approach to managing important disease control programmes. In thinking about benefit packages, how do we ensure that infectious disease control programmes

do not get neglected the way they did under National Rural Health Mission with very serious consequences for disease control in India?

Conclusions

Basically, if the HLEG had undertaken a literature review as a starting point, the time it had could have been utilised in examining the reasons why many of the recommendations made by previous committees (such as of the NCMH) did not get implemented. The HLEG report neither recognises the problems, constraints and compulsions of the departments of health at the national, state and district levels, nor offers any solutions on how to deal with them. Nationwide discussions and consultations were also not held with all stakeholders from the Accredited Social Health Activists (ASHAs) to the specialists, communities and providers, rural and urban, rich and poor, health administrators and civil society groups, etc. Such a process would have provided the reform agenda and an operational plan that could have been sustained over time.

The need now is to have a vision and the strategy based on a national dialogue. Models of different financial options also need to be tested – some are useful in some settings, others are not. We need to have a strong empirical basis to assess their suitability or otherwise. It is for this reason that the NCMH had given 20 years to achieve the goal of health security for all. That time frame still stands. Rhetoric cannot substitute for hard work, the type that was put in to formulate the National Education Policy in the early 1980s. The national strategy needs the endorsement of all the people engaged in the health sector on a day-to-day basis. Such a process alone will enable the crafting of a sustainable policy framework, preparation of a road map, and have the capacity to overcome the opposition of several vested interests that are deeply entrenched in this sector.

NOTES

1 This, however, is not clear as in the chapter on norms, the estimated need for the essential health package (at 2011 prices) is Rs 133 for OP cost at the PHC; Rs 490 at CHC level and Rs 1,104 for tertiary care as compared to NCMH estimations (2005 prices) of Rs 90 for a core package at PHC; Rs 320 for basic package at CHC; and Rs 699 at district hospitals but only for secondary care. But due to variations in HR needs, the input prices of HLEG will be higher than the estimates. Second with HLEG treating CHC as secondary care, the basis for spending 70% of Rs 1,500 on primary care is not clear.

2 Personal communication from Secretary, department of health, Government of West Bengal.

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