Indian Public Health System Restructuring Short & Medium term Plans

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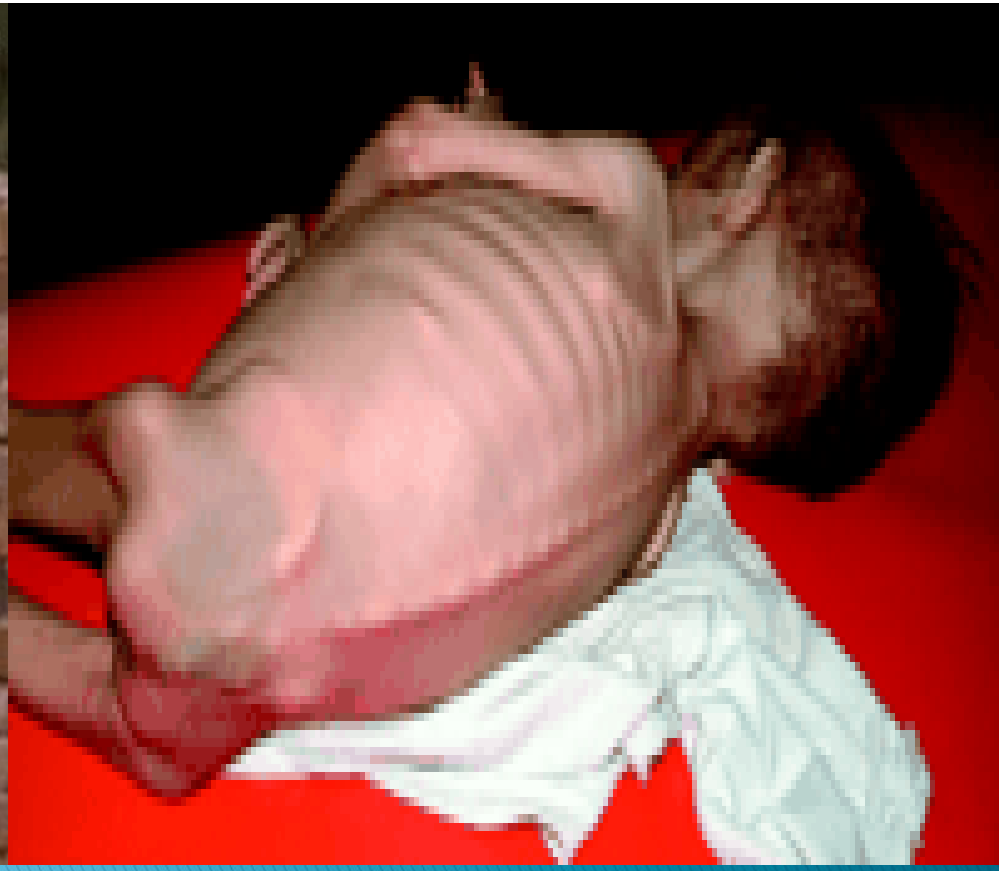
Can we be instrumental in changing for better the lives and health of People?



Whose health care ? the pro-poor people policy -part of the reform agenda

Tragedies of infant deaths in hospitals of Gorakhpur, Farrukabad, Jharkand and even in Raipur shocked us.

Accountability fixed on the political party that rules.

TV channel discussions and press coverage debated

Lack of oxygen?

Lack of energetic medical care ?

Poor resources? Poor governance?

Very few are addressing the health system failure in these states.

Corona Virus taught us many lessons

- Vulnerability and Fragility of the Public Health System
- Cumulative neglect for decades in funding, staffing, infrastructural and technology upgradation
- Resulting in dismembering &annihilation of PH System
- Proved relevance and essentiality of Public Health system.
- The nation needs it with an immediate upgrade
- It is the only option for the poor and marginalized

Cure & Rehabilitation for ailing Health System

- **Health is a basic Human right**
- **Under the Constitutional guarantee of Right to life entitlement**
- **It must be a justiciable Right.**
- **A welfare Nation should not abdicate that responsibility to the Private sector or entrust Insurance sector to manage it.**
- **Private sector is so heterogenous and scattered in its presence and availability.**
- **Private sector displayed its lack of standardization, medical anarchy and uncontrolled exploitative pricing.**

Three questions?

- **1.Whose health care?**
- Health care for All
- with equity more than equality
- So; with a special concern for the poor, neglected, voiceless and marginalized.

- **2. Who will do it** in a democratic, socialist republic ?
- Of course –The government in a welfare state. For the people and by the people.
- Cannot expect the private sector to do it.

- **3.Who should bear the cost?**
- The government of the people from the taxes paid by them, not insurance agency

Universal health coverage (UHC) is a critical component for

- sustainable development,
- reduction of poverty
- reducing social inequities

- India also striving for all these –Is it not?
- **Universal Health Coverage cannot be achieved by relying on the Insurance package and roping in private sector**
- **Ayushman Bharat PMJAY or PPP ???**

Universal Health Coverage

- Improving **Access to people**–Wider coverage of beneficiaries and frequency of services
- Improving the **range of services**–Expanding package of services and choice
- Improving **quality of services**–standards and technological advancement
- Improving **Client satisfaction**– Participation and empowerment.

Universal health Care or Universal health Coverage?

- UH Care includes various social determinants of health like safe water, sanitation, nutrition, food security, primary education, livelihood and poverty aversion, community empowerment, gender and social equity etc

- Then the health ministry has to be serious for convergence with allied sectors and need to build up its capacity for inter-sectoral coordination.

Cost of healthcare

- UHC requires a **financing system**
  protect people from financial hardship and being pushed into poverty from health care costs.
- Health expenditure by government is very low thereby shifting it to personal out of pocket expenditure.
- In a democratic country financing health care must be from a “pooled resource”
  mainly **tax funds**
- Cannot be left to the vagaries of market forces
  or to **insurance sector**– poorly enrolled whether mandatory or voluntary, poorly reimbursed.

Cost of healthcare

- Per capita health expenditure varies in states.
- UP is only Rs 790/- per annum whereas the National level is Rs.1538/- (almost double the amount)
- Low investment in business cannot have big turnover and good profits. Poor spending gives poor returns.

- We must allocate around Rs.80,000/- Crore for Health. Out of this chunk 55-60,000/- Crore can be allocated for National Health Mission.

- Globally the proportion of GDP for Health expenditure is 5.99%
- ***Immediate allocation of 3 per cent of GDP for health sector in India and thereafter incremental increase to reach 6%.***

Health expenditure by government is very low

Financial Year	Proportion of GDP for Health Budget %
2009-10	1.4
2013-14	1.2
2015-16	1.15
2016-17	1.18
2018-19	1.3

Poverty burden and Out of Pocket expenses

- India was moving towards a middle income country status like Brazil, Mexico and South Africa.
- Gap between the rich and poor within the country is widening
- Still a huge poverty burden of 22% of world population living in India
- Challenging burden of communicable as well as non-communicable diseases
- 20 per cent of all ailments go untreated (NSSO estimates)
- ***Unless debilitating, most tend to self treat, ignore and delay availing of treatment or resort to the locally available cheaper rural medical practitioners and quacks.***

Health expenditure-Govt & OOP

- Wide interstate variation in 2004-05
  Bihar was Rs.93 compared to Rs.630 in Himachal Pradesh
  (Y.Balarajan et al Health care and equity in India-India towards UHC, The Lancet series, January12,2011.
- Out of pocket expenditure per person- increased 60 times over 25 years, from Rs.88 in 1984 to 5,679 in 2011,mainly because of price rise of medicines- Kerala Science and Literature Society(KSSP) study.
- "Out of pocket expenditure of more than 15-20% can lead to impoverishment" -WHO guidelines
- India's OOP is 61% (Annual report to the people on health 2010 Ministry of Health, India)
- 4.4% of total government spending on health by India1999-2009 183rd rank out of 191-WHO

NRHM– Vision

- Decentralization for district management of health.
- Participatory bottom-up planning
- Quality assurance in services& client satisfaction
- Inter-sectoral convergence
- Define time-bound goals and report publicly on their progress.
- Improving access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

NRHM – The Key Principles

- Distrust to trust
- Inflexibility to flexibility
- Centralized to decentralized action
- Funds, functions, functionaries for service
- Building capacities at all levels

Efficient State and District level Health System to manage

- Centre must assist technically States in improving Public health systems
- A two prong strategy of
  management efficiency
  transparency in transactions.

National level management experts (not political appointment of advisors) can be deployed for capacity building in States.

Constitute National cadre of Public Health like IAS may be constituted.

State level Public Health Cadre building a must

Challenge for the fund absorptive capacity of NHM

- Needs stronger professional Project Management team in every state
- Currently around 275,000 Contractual workers, Consultants and Technical hands
- Essential to run the project activities adding value to the program implementation.
- Corner stone for transforming Health services as a Mission instead of a departmental activity.
- That quality improvement led to client satisfaction and increased utilization of services by Public Health system.
- If they are inevitable to run the health program, make them regular employees and pay them just.
- Consume required funds from the increased allocation.

ASHAs of Murigiri CHC, Upper Subanshiri district, Arunachal Pradesh meeting Primary healthcare

Photocredit – Antony

Improving fund absorptive capacity of NHM

- **A huge army of around 900,000 women, part time "voluntary" workers named ASHAs**

"Voluntary" *is a highly exploitative arrangement to overcome requirements under the prevailing Labor laws.*

- **Back bone of entire surveillance activity in the community, contact tracing, getting suspects tested, quarantine of the family members and isolation of clinically asymptomatic positives and reverse quarantine of the vulnerable and elderly during the Pandemic.**
- **If ASHAs are inevitable as intermediary between the health officials and Community, accept it and pay them right wages.**
- **Charge it to the increased NHM allocation.**

Mitanin learning skill of mucus extraction for neonatal Asphyxia management

Mitanin learning skill of bag and mask ventilation for neonatal Asphyxia management

Increased budgetary allocation for allied sectors- determinants of health outcomes

- Invest more in determinants of health like, Nutrition, Water, Sanitation and Education
- There must be a concomitant increase in the allocation for Education, ICDS, Food Security and livelihood.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INTO A DEEP
DRY SPELL
Villagers gathered to draw water from a massive well in Natwarghad in the Indian state of Gujarat in June. During the region's worst drought in more than a decade, the temperature rose as high as 111°
Photograph by Amit Dave—Reuters
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Children in and out of school a tragedy in many villages

Adolescent Girls on cycles to school–a sign of future empowerment and better survival of children and mothers

Photocredit –Antony

Make State Planning cycle for 5 years not annual

- The whole process of reworking on annual planning and budgeting from December, submission of the draft plan in January laborious and time taking task.
- An annual budget allocation is made by April
- But whole administrative machinery is busy closing annual account by end March.
- Initial tranche of funds reach by June, insufficient to embark upon big budget activities like construction.
- So a small implementation window of 6-8 months, from September to February only after release of major funds.

5 year versus Annual cycle

- Rigorous work planning will be undertaken only once in 5 years.
- Broad strategies to achieve general objectives and goals are agreed upon
- Phasing of annual financial allocation of the project cycle spelled out with specific tasks, quantified out puts and results.
- This gives flexibility of continuing long term activities and carryover of funds at State and district level.
- Submission of expenditure statements and settling accounts with Utilization Certificates must become an ongoing process or quarterly affair till end of project cycle
- Funds must be earmarked from the beginning of the accounting year for payment of salaries, electricity, water supply, waste disposal, telephones and communication, regular consumables and supplies like oxygen, essential maintenance etc.

Application of information technology and –e governance

- To eliminate massive corruption in Health department and prevent diversion of NHM funds
- will make the whole governance fair and transparent to public. It strikes at the root of corruption

- **Web based-**
- advertisement of vacant and new posts,
- recruitment including test and selection interview,
- appointment and transfer of health staff
- for award of contracts for civil works and intake of human resource.
- Electronic payment of bills and invoices – helps tracking of undue delay in payment of cheques with provision for satisfactory reasons for rejection or modification of claim bills

ANM in Tamia block of Madhya Pradesh –climbing down and up for 5 hours to reach children of Pathalkot hamlet.

Photocredit –Antony

A tribal girl of Ganiari in Bilaspur district

Tenth class passed Echo technician trained by Cardiologists of AIIMS New Delhi

Lack of fair Non-discriminatory transfer and promotion policy.

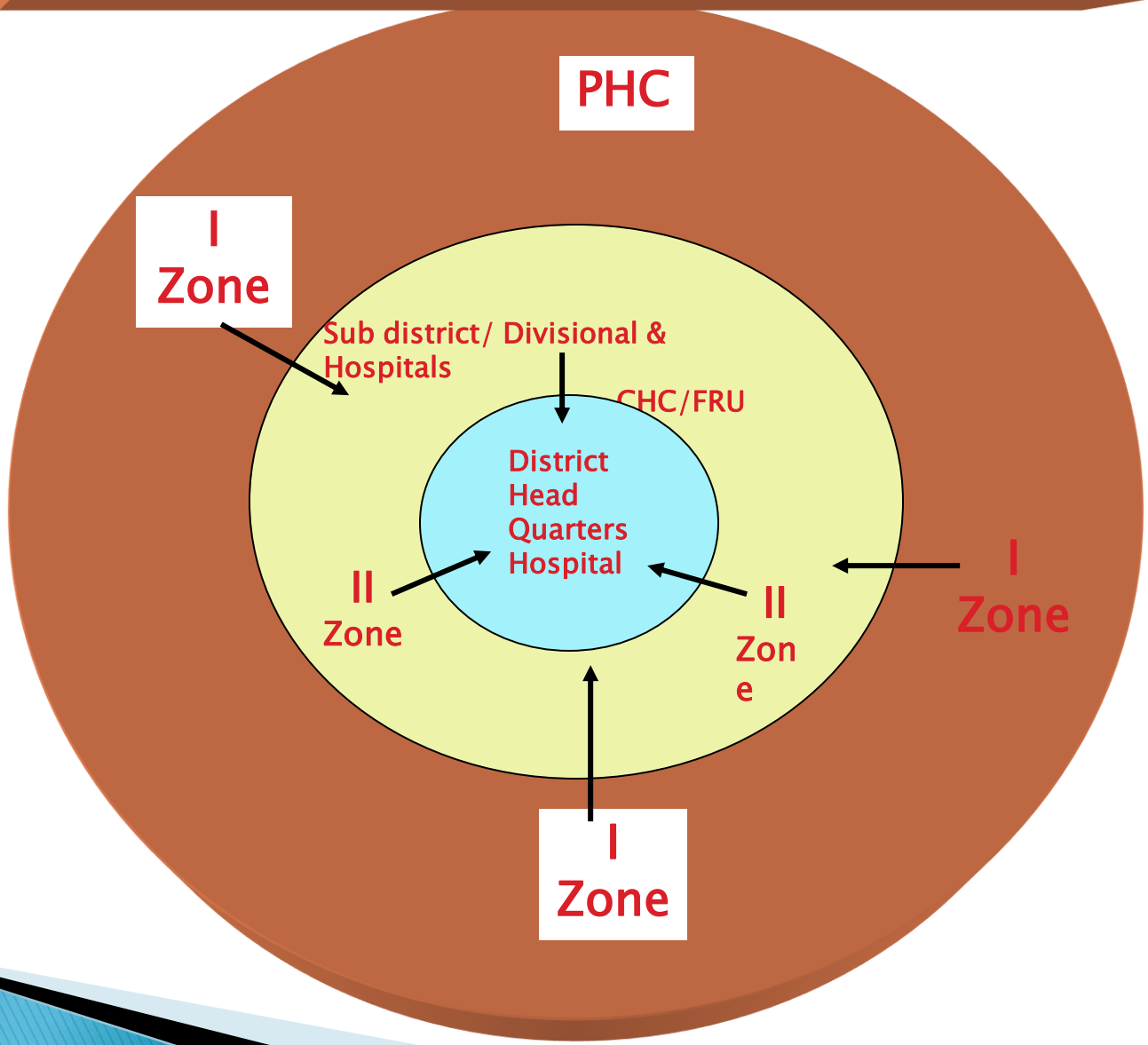
- *Whimsical transfers and postings by different committees/authorities at different times.*
- *Lack of motivation of staff already completed dedicated service in the periphery.*
- *How to prevent this?*

Solution: There could be a three layer of placement circles

- *The outer most layer is for postings in PHCs and rural dispensaries which may be made compulsory for all new graduates entering government service*

- *Once they finish a minimum of five years in the outer most layer, they must be shifted to the middle layer which is for posting in the sub district towns with CHC and FRU hospitals.*

Movement only to the Centre, Not to the periphery.



- *Once they finish 5-10 years of service they should be brought to the inner most circle of postings in district headquarters and major urban areas.*

- *Once a candidate finished the minimum requirement in a circle, she/he should move to the next layer towards the centre and not to be shunted back to the periphery again.*

PRINCIPLES OF POSTING

- Fix Minimum Numbers of Years Required to move to the next Circle.
- Circle I - Minimum 5 years ?
- Circle II – Minimum 7-10 Years?

- Option clear to aspirant candidate at entry to the system-Computer locked (System Generated) options, like allocation of Medical College seats
- Choice then yours-Stagnate?
- Or move out ?
- And settle where you clicked well.

Principles of Posting

- No Direct posting of MBBS level to “Specialist Leave Vacancy” at Level – II.
- No “Specialist” first recruited to PHC – Level -I

Universalization of Free Drug & Diagnostics

- Though health is a state subject, there must be full resource allocation for this head from National government, like other National programmes
- Burden of Malaria and Tuberculosis in a few States must be seen as a National direct responsibility to control rather than to leave it to the State to manage it from their share of overall Central funds.

Essential Medicines for Children

- 50 EML surveyed for the first time in the country in Chhattisgarh showed low availability of 17% and a mark up price for retailers more than 376 % !!
- Bulk procurement of generic essential medicine through transparent e-tendering was the answer like the model of TNMSC- Tamil Nadu Medical Services Corporation.
- 6 States of Andhra Pradesh, Bihar, Chhattisgarh, Kerala, Rajasthan and Karnataka have emulated TNMSC.
- Delhi, Gujarat and Himachal Pradesh have a central procurement agency.

Tamil Nadu model of Procurement and Supply of medicines, equipment and consumables must be enforced in all States with poor governance and system failure.

Insurance-based purchase of secondary and tertiary health care from Private sector Can continue with very stringent oversight and guard against misuse and exploitation.

Out sourcing or rate-contract based purchase of diagnostics from private sector should give way for an inhouse provision.

Health and Wellness Centres- newly branded face of National Health Mission

A retrained Nurse, Pharmacist or Sector Supervisor acting as Community Health Officer, ANM & ASHA team

Available 24x7 hours Mini hospital

Medical consultation, investigations and dispense medicines or provide first aid and emergency care

Community participation and ownership

- For rejuvenation of a weakened and corrupt public health system, it must rely on strong ownership by the public, user involvement.
- Rogi Kalyan Samithis and hospital management committees needs expansion with more broadly represented user groups and Community watchdogs rather than just one MLA or MP.
- These user groups and community watchdogs can facilitate social audit of major activities undertaken by health institutions.

Great Asset of Social Capital ready to go an extra mile

- Large army of 26310 ASHA workers, Community based Health Activists connecting Communities with most peripheral health system staff- Junior Public Health Nurse
- 33,115 Anganwadi workers - Honorary workers for Child Care, Development and Preschool education of Under-5 age children
- Kudumbashree workers - a network of 4.54 million neighborhood women entrepreneurs at grass roots in 290,723 NH Groups.
- 48 Transgender Groups too.
- 21,682 Elected Ward members of 978 Village GP and 65 Municipal/Corporation Councils
- 45,000 extra Registered volunteers for Covid-19 Pandemic control activities

Wealthy cities may not be healthy cities

- Mumbai, Delhi, Pune, Hyderabad and Kolkata proved that
- Weak Public Health system can make the life of Urban poor miserable and equally dangerous to others
- Migrant Labourers are builders of economy, but the least enumerated, accounted for and planned for
- Provision of basic services- water, sanitation and clean night shelter or temporary dwellings
- **Multi use community centers:**
- Needed during cyclones, floods, earthquakes and recent Pandemic and Lockdown period
- For relocation, relief camps, isolation or quarantine, Community meetings and social events.

Short term plans for-Every State/district

- Telemedicine as regular modality for Health promotion, follow up of NCD , mental illness, Palliative treatment etc.
-
- Regional Virology research and additional Vaccine production units in every states
- One or two Medical Oxygen Factories in every state with requisite tankers for immediate supply of LMO to hospitals
- Every State to have Centres for Communicable Disease Control
- More allocation to LSGs for planning, delivery and monitoring of Health Services under them, including disease outbreak control
- Enforcement of Clinical Establishment Act, regulation of Pvt.Sector
- Liquid Medical Oxygen generation Plants of 150 tonnes production capacity in every Dist.Hospitals
- Also 50 bed isolation ward out of which at least 10 beds will be ICU beds with minimum 5 Ventilator beds

Social interaction of Young Children

Thank You