



municipalservicesproject

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# Universal health care in India

*Making it public, making it a reality*

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*\*This monograph is an abridged and adapted version of a booklet by the Jan Swasthya Abhiyan (People's Health Movement, India chapter) titled Universalising Health Care for All.*

### ABOUT THE PROJECT

The Municipal Services Project (MSP) is a research project that explores alternatives to the privatization and commercialization of service provision in electricity, health, water and sanitation in Africa, Asia and Latin America. It is composed of academics, labour unions, non-governmental organizations, social movements and activists from around the globe who are committed to analyzing successful alternative service delivery models to understand the conditions required for their sustainability and reproducibility.

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## EXECUTIVE SUMMARY

The seemingly impressive growth of the Indian economy hides many social ills, one of which is the failure to provide health care for all. The 2012 release of the Planning Commission's draft strategy for universal health coverage (UHC) was seen as an attempt to address the situation and it attracted considerable attention, and criticism. At the heart of the debate is the proposal that UHC could be best achieved through greater participation of the already dominant private sector, and by scaling up health insurance schemes.

This paper argues for a fundamentally different vision of UHC policy, premised on creating an integrated and comprehensive public health system that prioritizes people's needs, and on reversing the drift toward increasingly private healthcare delivery. It examines key facets of India's healthcare sector, analyzes the reasons underlying its inability to meet UHC goals at present, and proposes public solutions to fill health delivery gaps in a more efficient, transparent, equitable and sustainable way.

### Public health gaps

The public health sector in India is in a state of neglect and large sections of the population depend on a poorly regulated private sector increasingly dominated by big hospitals, which have an infamous track record of unethical practices. In fact, with private health care accounting for 80% of outpatient and 60% of in-patient care, India is one of the most privatized systems in the world.

Public health services are marked by poor access, low quality and limited choice. Inefficiency and deficiencies abound. Labour shortages can be partly explained by two decades of declining investment in medical education, improper training and flawed deployment mechanisms. Programs such as the National Rural Health Mission (2005) have made some inroads by improving access to health workers in under-served areas, but much remains to be done. Overall, poor management results in mismatches between demand and supply of services, with facilities not being distributed optimally, and with equipment and funds not meeting needed requirements and not flowing efficiently. Rampant corruption linked to appointments and procurement only makes matters worse. The problem is largely one of unresponsiveness to needs articulated by citizens but also one of unreliable technical estimates of disease burden and of costs of health care, leading to ill-informed prioritization of health care needs in the public system.

Out-of-pocket expenditure on health care continues to contribute to widespread poverty in India. In an attempt to protect patients from 'catastrophic' health expenses, publicly funded health insurance schemes have been rolled out. But they exclusively cover in-patient care in the secondary and tertiary sector – leaving out most infectious and chronic diseases – and end up distorting an already weak public health system by neglecting primary care and giving private providers the higher hand. Indeed, the private sector is growing rapidly and developing into a corporate hospital-based system

of care. This sector is largely unregulated, expensive, often provides care of dubious quality, and is plagued by complaints of unethical behaviour.

A large part of out-of-pocket payments are made on medicines, and public procurement and distribution of medicines constitute a very small fraction of drug consumption. Hence, paradoxically, India is both the largest producer of medicines in the developing world and home to the largest number of people who do not have access to essential medicines. The health insurance schemes in place do not address this problem. Due to poor or non-existent regulations, it has been estimated that at least 50% of the average family spending on medicines in the country is incurred on irrational or unnecessary drugs and diagnostic tests. In addition, since the protection of the long-standing 1970 Patent Act was lifted in 2005, generic pharmaceutical companies are unable to produce cheaper versions of new drugs, and most new drugs are now sold by multinational corporations at prices well beyond the reach of most Indian patients.

## Alternative visions of universal health care

For these reasons it is necessary to recast the debate on UHC. First, the bulk of efforts need to be geared toward significantly strengthening and reorienting the public health system to offer integrated and comprehensive services, with built-in mechanisms of accountability, as follows:

- Earmark adequate financing for the public system that should aim to reach 5% of GDP in the medium term
- Streamline structures and human resources in facilities to improve efficiency, as well as rationalize costs of care in public facilities based on actual needs
- Provide more equitable access across rural and urban areas
- Set standard treatment protocols to ensure quality of care
- Establish mechanisms to empower communities to hold health authorities accountable

Instead of indirectly financing the growth of the private sector via insurance schemes, in the short term private resources could be in-sourced via a strengthened public system, provided they are bound by a 'public' logic and operate under clear terms and conditions. Some not-for-profit healthcare facilities working in less developed parts of the country could also, with a certain level of public funds, complement the public system.

Second, effective regulations are required to contain private healthcare costs, ensure quality and prevent unethical practices. State authorities need to create an adequate and just grievance redressal system at the local level, and raise public awareness of patients' rights. The pharmaceutical sector should be reigned in as well to ensure that drug prices are affordable and that medicines are rational and of good quality. All essential drugs need to be made available, free of cost, at all public facilities. Health safeguards in the country's Patent Act have to be used liberally to make new drugs accessible.

## Introduction

While India is recognized as one of the fastest growing economies in the developing world, this growth has done little to improve the lives of large segments of the population. The health sector has performed particularly poorly, with public health expenditures at 1.04% of GDP in 2012,<sup>3</sup> far below the average of low and middle income countries and the WHO's recommended minimum of 5%.

Overall, the public health sector is in a state of neglect, while the private sector accounts for 80% of outpatient and 60% of in-patient care, making India one of the most privatized systems in the world.<sup>4</sup> Publicly financed health insurance schemes have been rolled out to mitigate the burden of out-of-pocket expenses on health care, but these programs have left care provision open to private companies. Private hospitals benefit most from these publicly funded schemes, distorting the very structure of the health system by starving primary care facilities to the benefit of private secondary and tertiary care. And while health insurance has the explicit purpose of protecting patients from 'catastrophic' healthcare expenses, the actual depth of coverage under these schemes is poor.<sup>5</sup>

The July 2012 release of the Indian government's draft strategy for universal health coverage (UHC)<sup>6</sup> has generated intense debate, with civil society and even the Ministry of Health expressing their opposition to its main thrust. Subsequent versions have responded to some of this criticism, but the underlying themes of commercialization remain untouched or only superficially changed. Given that India has been enforcing neoliberal economic reforms for over 20 years, it comes as no surprise that the strategy being proposed adopts a market-friendly framework placing growth of the corporate private sector – including the hospital, pharmaceutical and insurance industries – above the real health needs of people. This approach is in line with the UHC discourse promoted by mainstream international development agencies in a framework that uncritically endorses and promotes the existing private medical sector, including its high costs and irrationality.<sup>7</sup>

What India needs is a radical transformation of the health system that puts people front and centre. For this to happen, the entire health system needs to be recast along the lines of the Primary Health Care approach proposed in the 1978 Alma-Ata declaration.<sup>8</sup> The stated intent of the government to introduce UHC is welcome, but it must be built around a strengthened public system that prioritizes the primary health needs of the majority. The only guarantor of secure access to quality health care is a well-resourced and accountable public health system. Only services with a strong public ethos can prioritize the needs of populations that are vulnerable or marginalized. Women, children and elderly people suffer disproportionately from denial of health rights due to a combination of special health needs and oppressive social hierarchies and power relationships. Persons living with HIV-AIDS and people with mental health problems today suffer serious discrimination



Jan Swasthya Abhiyan protest calling for a strengthened public system to achieve health for all, New Delhi, 2012.

Photo: Rajeev Chaudhury

in India, which compounds their health problems. Dalit and Adivasi communities have historically been denied health rights. Migrants, unorganized workers, displaced persons and LGBTI are often placed in situations of extreme marginalization and require special measures to ensure protection of their health rights. Movements defending health for all need to place these populations at the centre of programs to universalize access to good quality, comprehensive health care.

In this paper, we present the current state of the public health system in India and describe the dominance of the private sector, which has left millions without access to the services they need. We then analyze the ongoing debate on UHC that was supposed to address health gaps but has instead limited itself to corporate-friendly solutions. The paper also focuses on how the current emphasis on health insurance schemes can do little to improve health outcomes; worse, in their present form they serve to further weaken the public sector. We also discuss strategies to enhance access to medicines as part of the overall goal of universalizing health care access. Finally, the paper proposes alternative ways forward and makes the case for a significantly expanded, publicly financed and publicly provisioned system.

## Current state of India's public health system

Public health care in India is marked by poor access to services, which are often low quality and limited in range. Management of the services is influenced by powerful corporate interests (international and national) and bureaucracy-driven policy reforms that deny any meaningful popular participation in the planning, implementation and monitoring of healthcare services.

## Efficiency

Different levels of inefficiency are built into the current public health system. First, the lack of appropriate and skilled human resources plagues health services, especially in rural and remote areas. India is bearing the brunt of choices made years ago to significantly reduce government investment in public sector medical colleges and to encourage private medical and nursing institutions.<sup>9</sup> Fewer doctors are willing to work in the public sector after private training and even students from the best public medical colleges largely prefer to seek opportunities in the growing private medical sector that offers better pay and working conditions.<sup>10</sup>

More importantly, the medical education system has historically focused on training doctors and neglected other essential actors in a health workforce: nurses, midwives, etc. A focus on these sectors could have the additional benefit of increasing recruitment from rural communities, versus urban areas where most doctors come from. The large effort by the government to deploy over 700,000 Accredited Social Health Activists (called ASHAs), in 2005, has had some positive impact in rural areas, but the program is under-resourced and these health assistants are paid a pittance, which is not commensurate with their heavy workloads.<sup>11</sup> Further, sporadic attempts to put together a cadre of health workers with three-year training to address the most common problems at primary levels of care has not taken off (except to a limited extent in a few states); this is largely a consequence of opposition from the medical fraternity.<sup>12</sup> A required corrective is to identify skill requirements at different levels of care and to deploy health personnel based on such requirements. Primary healthcare doctors, nurses or paramedics should have skills that are comprehensive and appropriate to the needs, but different from specialist skills required at a secondary level care facility, which are in turn very different from what is needed in tertiary care hospitals. The existing curriculum should reflect this reality and this may require bridge courses, specially designed supplementary packages and the creation of new categories of health workers.<sup>13</sup>

Second, this situation is compounded by a severe mismatch between demand and supply of services: many facilities are overcrowded while others are under-utilized. Similarly equipment and funds do not match requirements or flow inefficiently; facilities with high patient loads run out of funds in weeks while those with lower loads cannot spend their money. Consequently, substantial funds are locked in the pipeline and the quality of care in high volume facilities remains very poor.<sup>14</sup>

More fundamentally, services offered are often disconnected from the needs of communities. The problem is largely one of unresponsiveness to demands articulated by citizens but also one of unreliable technical estimates of disease burden and of costs of health care, leading to ill-informed prioritization of healthcare needs in the public system.

## Access and quality

An estimated 40% of Indians still rely on the public sector for in-patient care,<sup>15</sup> but many communities either lack facilities altogether or have dysfunctional ones due to shortages of doctors and health workers, and they are left with insufficient supplies of medicines and other consumables. The introduction of user fees and major cuts in public health expenditure forced public hospitals to recover the costs of services. As a consequence, public facilities stopped supplying free medicines and diagnostics. Today, drug supplies in public facilities do not cover all requirements and are often interrupted, making outside drug prescriptions with out-of-pocket expenditures common. Diagnostics is the main source of user fee collection across the nation, and hospitals are loathe to let this avenue go.

Due to unfilled vacancies, absenteeism, or a lack of medicines and equipment, even services that are supposedly assured in the public system are not always available in practice. At the same time, the experience that many patients have with the public health system is dismal because access to quality care is not seen as a 'right', and the system is often considered as a mere safety net for those who cannot afford the private system.

Unfortunately, an erroneous understanding has been promoted that if people want quality care they should go to a private facility. A very large number go to the private sector to access care because public facilities cannot offer the services they need, and are then required to pay the entire cost of care. Without a doubt, this situation has had disastrous consequences for the poorest segments of society, including historically marginalized groups, who cannot afford private care that is not covered.

Given the shortage of medical professionals in rural areas described earlier, for some patients travel to the closest facility can represent a huge cost, although a number of assured patient transport services have somewhat reduced the financial burden. The National Rural Health Mission (NRHM), launched in 2005, marked an attempt to improve health services in more remote regions. Quality has started to improve in some places, though the changes have been uneven.<sup>16</sup> What is significant nonetheless is that we now have fresh evidence in India that good quality care, as certified by external assessors, can be provided by public hospitals.<sup>17</sup> Quality health care, available through public facilities, should be the norm, not the exception.

## Accountability and transparency

Corruption is not an aberration in the public health system; it is a key dimension of power relationships that promotes rent-seeking at all levels. In many states, the single biggest source of corruption is the appointment of the chief medical officers, district medical officers and directors of health services. In states most notorious for corruption, almost all chief medical and health officers get and keep their posts by paying 'rent', which they can finance by demanding the same from junior officers and vendors.<sup>18</sup>

Other major sources of corruption are in procurement of consumables and equipment, as well as infrastructure creation, leading to poor performance, slow utilization of resources and a failure to meet targets. Transfers and postings are another problem. In many states once transfer season comes, a large number of providers have to pay to keep their positions. An emerging avenue of corruption is kickbacks in public-private partnerships and in contracting out programs to non-governmental agencies.<sup>19</sup>

## Corporate takeover of health care

The declining state of India's public system is undeniably linked to the ascent of a private sector that now has a majority share in various components of health care, as illustrated in Table 1. The last 20 years have witnessed a proliferation of private medical colleges that have created human resource shortages in the public system, the growth of an unregulated medical equipment industry contributing to booming costs of care, and of a powerful pharmaceutical industry that manufactures and sells overpriced, irrational medicines and drug combinations.

**TABLE 1:**  
Share of the private sector in India's health system

Category	Share of the private sector
<b>Medical graduates and post-graduates</b>	90-95% <sup>20</sup>
<b>Outpatient care</b>	80% <sup>21</sup>
<b>Indoor patients</b>	60% <sup>22</sup>
<b>Undergraduate seats in medical colleges</b>	45% <sup>23</sup>
<b>Manufacture of medicines</b>	99.5 % <sup>24</sup>
<b>Manufacture of medical devices</b>	100% <sup>25</sup>

One very visible manifestation of the private takeover of health services is the mushrooming of corporate hospitals. Hospital chains' revenues have grown exponentially in recent years. For example, the total nationwide revenue of Apollo Hospital, the largest corporate chain in India, rose from Rs 16.1 billion in 2009 to Rs 31.5 billion in 2012 (roughly US\$295 to 580 millions).<sup>26</sup>

The rules of the game have shifted from promoting public health to mere profiteering as made possible by corporate-friendly regulations. There is also a large body of evidence – anecdotal and scientifically recorded – that shows how private providers entice patients with false claims and promises, fleece poor patients, and provide inadequate care.<sup>27</sup> Regulatory agencies such as the Central Drugs Standards Control Organisation (CDSCO) and the Medical Council of India (MCI) have been largely ineffective in controlling this.

## Medicines for the few

There is perhaps no more powerful illustration of the mismatch between rational treatment goals and commercial goals than what is happening in the pharmaceutical sector. The WHO says: "rational use of medicines requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community."<sup>28</sup> Prescription practices in India stand in clear violation of such norms. Drug manufacturers are driven by the need to maximize profits, not to optimize therapeutic goals. It has been estimated that at least 50% of the average family spending on medicines in the country is incurred on irrational or unnecessary drugs and diagnostic tests.<sup>29</sup>

Despite the recent explosion in the number of drugs available, only a small portion offers an advantage over existing drugs. There are 60,000-80,000 estimated brands of various drugs available on the market nationally, while the essential drug list in India contains just 348. In this situation of extreme anarchy the task of an already overstretched Drug Control Authority becomes almost impossible. A significant number of products in the market are either hazardous or irrational and useless.<sup>30</sup>

Pharmaceutical companies and the government regulatory bodies share the blame for allowing such a situation to develop. The 59th Report of the Parliamentary Standing Committee of Health and Family Welfare has extensively documented the fraudulent role of the CDSCO in particular; for example, it examined approval of 42 new medicines and found that in the case of 33 of these medicines there existed no scientific evidence to show that they are effective and safe for patients, and no trials were conducted for 11 of them.<sup>31</sup>

All this would not be possible without the active involvement of the medical profession, which contributes by prescribing irrational and useless drugs. A contributory factor is the absence of unbiased and reliable information on drugs in the country. Most medical practitioners depend on promotional materials supplied by pharmaceutical companies that often make false or exaggerated claims, using incomplete or misleading evidence to promote medicines. There is no effective law that prevents drug companies from bribing doctors to prescribe their medicines either. The government came out with a draft voluntary code of ethics for marketing of medicines in June 2011 but it is clearly not enough.

The most common problem is the unnecessary use of drugs: we see expensive antibiotics being used for trivial infections, or a large number of drugs prescribed for a simple ailment, when cheaper or fewer drugs would have sufficed. Such prescription practices increase the cost to the patient, risk exposing them to side effects, and in the case of antibiotics can lead to drug resistance, which is becoming a major problem in India. In the case tuberculosis and malaria, older and cheaper drugs are no longer effective in a significant number of patients.<sup>32</sup> As a result, the country now has the largest number of multi-drug resistant TB cases in the world, which require treatment with second-line drugs that can be 10 times more expensive than first-line ones. At the heart of the problem is the license provided by drug regulatory agencies to produce combination products (two or more drugs), an overwhelming majority of which are irrational and need to be banned.<sup>33</sup>

This situation is all the more worrying considering that households spend significant amounts on drugs. Indeed, a prominent feature of the medicines market in India is that a large proportion of drugs consumed are procured through retail sales – an estimated 80-85% – compared to the dominant pattern of institutional sales in developed countries.<sup>34</sup> The National Sample Survey Organisation's report on morbidity for 2004 showed that medicines account for 81% of private health care expenditure in rural areas and 75% in urban areas.<sup>35</sup> Worryingly, it has been estimated that 50% to 65% of the Indian population are not able to access all the medicines they need.<sup>36</sup> Given that India is the world's third largest producer of drugs (by volume) and exports medicines to over 200 countries, this is an unacceptable situation.

## Recasting the debate on UHC

Few issues have generated more criticism on UHC in India than the health insurance schemes which uncritically promote the private medical sector, putting public resources in private hands, without any comprehensive plan for the achievement of public health goals. As it stands, the flagship national insurance scheme would only serve to reinforce the status quo. We need to turn this roadmap around and sketch one that is predicated on public funding and provisioning of a public healthcare system that is comprehensive, integrated and accessible to all. Improving access to medicines must also be a priority.

### Debunking health insurance

In 2009 the Indian Government launched a nationwide health insurance scheme called the Rashtriya Swasthya Bima Yojana (RSBY) designed to protect patients from the 'catastrophic' impact of out-of-pocket expenses incurred on hospital care – as modelled on the state of Andhra Pradesh's Rajiv Arogyasri scheme. The RSBY has been held out as a major achievement by the government and in the current Twelfth Five-Year Plan, similar insurance schemes have received even greater attention and support.

There are state-level health insurance schemes that have been launched or are in the pipeline in Kerala (Comprehensive Health Insurance Scheme), Tamil Nadu (originally called the Kalaigarn scheme), Delhi (Apka Swasthya Bima Yojana), Karnataka (Yeshasvini Health Insurance Scheme) and Maharashtra (Rajiv Gandhi Jeevandayee Arogya Yojana). Implementation timelines for these schemes have been impressive: by the end of 2010 an estimated 247 million people – a quarter of the population – were covered by one or more of these schemes, and coverage has since expanded.<sup>37</sup> This is a significant departure from the pre-2007 situation when the only two social health insurance schemes were the Employees State Insurance Scheme (ESIS) launched in 1952 and the Central Government Health Scheme (CGHS) launched in 1954. The former covers employees in the organized sector (formal sector that covers roughly 7% of the country's workforce, including

government-run enterprises not benefiting from CGHS) while the latter covers central government employees; both are funded through co-payments made by employees and employer.

Unlike the earlier CGHS and ESIS, new schemes are meant for hospital care only and cover a specific list of procedures. Patients are provided a choice of accredited institutions where they can receive treatment and be reimbursed for costs not surpassing a set ceiling. This type of health insurance is publicly funded; in the case of the RSBY the cost of the premiums is shared by central government (75%) and state governments (25%).

Two fundamental pillars support these kinds of health insurance schemes. First, they operate on the logic of what is called a 'split between financing and provisioning', that is, a clear separation between the financing of the services provided and the facilities where these services are available. While financing comes from public resources (central or state government funds), treatment can be provided by any accredited facility, public or private. In practice, when it comes to provisioning a large majority of accredited institutions are in the private sector. For example, in the case of the Arogyasri scheme in Andhra Pradesh,<sup>38</sup> the total payments to facilities accredited under the scheme from 2007 to 2013 amounted to Rs 47.23 billion, of which Rs 10.71 billion was paid to public facilities and Rs 36.52 billion went to private facilities.<sup>39</sup>

The second pillar of these schemes is that beneficiaries are insured against a set of ailments that require hospitalization at secondary and tertiary levels of care. They do not provide comprehensive health care, and are limited only to a pre-defined package of procedures. Excluded are almost all infectious diseases that are treated in out-patient settings, such as tuberculosis that requires prolonged treatment, most chronic diseases (diabetes, hypertension and heart diseases), or cancer treatments that do not call for hospitalization. To take the Arogyasri example again, the scheme draws 25% of the state's health budget while covering only 2% of the burden of disease.<sup>40</sup>

Such skewed priorities end up distorting the entire structure of the health system and public money is squandered to strengthen the already dominant corporate health sector.<sup>41</sup> In theory, good health systems are like pyramids: the largest numbers can be treated at the primary level where people live and work, some would need to be referred to a secondary level such as a community health centre, and few would require specialized care in tertiary hospitals. Better primary and secondary level care ensures that fewer patients end up in more expensive specialty hospitals to undergo major procedures.

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**“Such skewed priorities end up distorting the entire structure of the health system and public money is squandered to strengthen the already dominant corporate health sector.”**

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The health insurance system in India inverts this pyramid and starves primary care facilities. In 2009-2010, direct government expenditure on tertiary care was slightly over 20% of total health expenditure but if one adds spending on the insurance schemes that focus entirely on hospital-based care, total public expenditure on tertiary care would be closer to 37%.<sup>42</sup> In Andhra Pradesh, following the implementation of the Arogyasri scheme the proportion of funds allocated for primary care fell by 14%.<sup>43</sup>

The High Level Expert Group set up by the Planning Commission in preparation for the Twelfth Five-Year Plan clearly stated that the use of independent private sector agencies and insurance companies under schemes such as RSBY:

“fragments the nature of care being provided, and over time leads to high health care cost inflation and lower levels of wellness...since there is virtually no focus on primary level curative, preventive, and promotive services and on long-term wellness outcomes, these traditional insurance schemes often lead to inferior health outcomes and high healthcare cost inflation.”<sup>44</sup>

## Securing access to medicines

Decades ago India set in motion the first major initiative in a developing country to achieve self-reliance in the area of medicines manufacturing. The Patent Act of 1970 allowed Indian companies to produce drugs patented by foreign companies. Indian public sector companies started manufacturing drugs, such as Hindustan Antibiotics Limited and Indian Drugs and Pharmaceuticals Limited that began operations in the late 1950s and early 1960s. The implementation of the recommendations of the Parliamentary Committee on Drugs and Pharmaceuticals (known as the Hathi Committee) through the Drug Policy of 1978 imposed several restrictions on the operations of foreign companies and provided preferential treatment to Indian companies – both in the public and private sectors.

Unfortunately, all these initiatives have been reversed in the last 20 years. The Patent Act of 2005 changed the rules of the game, and Indian generic companies have been forced onto the defensive. Restrictions imposed by the WTO have resulted in the rise of imports of active pharmaceutical ingredients (APIs), leading to de-industrialization in the sector. Many national companies are now dependent on imported APIs for production of generic medicines. There is also a clear move toward acquisition of major Indian companies by foreign multinationals.<sup>45</sup> Denied the protection of the 1970 Patent Act, generic drug companies are unable to produce cheaper versions of new drugs, and most new drugs marketed after 2005 are being sold by multinational corporations at exorbitant prices that are well beyond the reach of most Indian patients.<sup>46</sup>

While formulating the amended Patent Act of 2005 the Indian parliament had incorporated several health safeguards,<sup>47</sup> in order to mitigate the impact of patent protection and ensure production of

generic drugs. However, the government is at times reluctant to make full use of these safeguards, or to defend its own law when its provisions are challenged by foreign drug companies in Indian courts. The government needs to defend its own patent law and resolutely fight the legal challenges being mounted. A much-publicized legal battle against the Patent Act was that led over seven years by the Swiss company Novartis on patenting a cancer drug. In a recent judgment the Supreme Court ruled against Novartis and upheld the Indian law.<sup>48</sup> There is also the key issue of compulsory licensing, “a legal mechanism sanctioned by international trade law that allows governments to authorize production of a medicine by a company other than its patent holder, in the interest of public health.”<sup>49</sup> The German company Bayer is currently fighting a March 2012 decision by the Indian Patent Controller to issue the first compulsory license to an Indian generic manufacturer, NATCO, to produce a kidney and liver cancer drug called Sorafenib that was out of reach for most all citizens; the drug is now available for 97% less thanks to the compulsory license.<sup>50</sup> Public health safeguards should be used liberally instead of being considered as the last resort. The government should establish an institutional mechanism to monitor the impact of patents on access to medicines and recommend suitable measures to ensure such access.



Novartis' legal challenge of India's Patent Act met with strong popular opposition, New Delhi, 2012.

Photo: Rajeev Chaudhury

Drug policies in India have historically been formulated by the Ministry of Chemicals and Fertilizers, who monitors and regulates drug prices, manufacturing, sale and distribution of drugs, while the Ministry of Health and Family Welfare looks into issues of quality and rational use. The two ministries work in silos and there is minimal coordination. In the absence of a coherent link between the health needs as identified by the Ministry of Health and the policies on drug pricing, manufacture and distribution, issues of access and equity have generally been ignored.

It is only recently that India has tried to implement a national essential drugs policy that would aim to achieve better access, as part of the NRHM goal to make all essential drugs available at appropriate levels of the public health system. However progress has been slow in ensuring access and in many states medicines cannot be obtained through the public health system when required. There are several reasons for this, including a lack of adequate supplies due to funding constraints and

procurement policies, and the poor functioning and outreach of public facilities.

More recently, Prime Minister Manmohan Singh announced a “free medicines” scheme, under which all essential medicines would be available at no cost in all public facilities.<sup>51</sup> Unfortunately, there have been mixed signals from government since then. While initially proposed as a scheme that would be financed by the central government, the responsibility is now passed on to state governments. ‘Free medicines for all’ programs in public facilities have been operational in some states for a long time, most notably through the Tamilnadu Medical Services Corporation (TNMSC) in the state of Tamilnadu and more recently in Rajasthan. These experiences need to be replicated in other states; in addition to improving access to medicines, they have helped develop transparent norms for drug procurement and distribution for public sector facilities.<sup>52</sup>

Since 1970, the government has endeavoured to regulate the prices of some drugs through successive Drug Price Control Orders (DPCOs) but the number of drugs covered has come down from 342 in 1979 to 74 in the latest DPCO of 1995. After a Public Interest Litigation was filed by the All India Drug Action Network (AIDAN), highlighting that high drug prices were a major cause for catastrophic medical expenses in the country, the Supreme Court issued a directive to expeditiously put in place a mechanism to control essential drug prices to affordable levels. But recent recommendations by the Group of Ministers tasked to decide on modalities for price control push for a ‘market-based’ mechanism that goes entirely against the grain of the Supreme Court order.<sup>53</sup>

In response to the Supreme Court directive, the government is now set to introduce price control on 348 drugs listed as essential. However, marginal benefits (if any) are likely to accrue because the new DPCO fixes ceiling prices based on an average of existing prices in the market (a departure from the earlier practice of fixing based on manufacturing cost). This methodology would largely reflect the price of the brand leaders, serving to legitimize the rampant overpricing of drugs today. Since the prices of medicines in the bulk market and the costs for manufacturing formulations are widely known, there is no difficulty in fixing prices on a cost-based formula that looks at raw materials and manufacturing costs, after allowing for a fair profit margin.

## Alternative ways forward

Universal health care today means very different things to different people. The dominant neoliberal argument equates ‘coverage’ with minimal, insurance-based packages. In contrast, a public health logic requires that health systems be publicly provisioned and publicly financed, as well as comprehensive, integrated and accountable to the needs of communities.

The enhancement of capacity in the public health system will require tackling deep-rooted corruption, engaging in systematic participatory accountability processes to ensure appropriate provision

of services to communities, and developing pro-people, rational technical norms, guidelines and protocols to operationalize any new regulation. The overall objective of such a regulatory system would be to move toward more equitable, accessible and quality health care under participatory governance.

Some key changes necessary to allow the public sector to regain its primacy in the country's health-care system include:

- Earmarking adequate financing for the public system that should aim to reach 5% of GDP in the medium term
- Streamlining structures and human resources in facilities to improve efficiency, as well as rationalizing costs of care in public facilities based on actual needs
- Providing more equitable access across rural and urban areas
- Setting standard treatment protocols to ensure quality of care
- Establishing mechanisms to empower communities to hold health authorities accountable

Additional ideas around improving efficiency, access and quality, as well as accountability and participation are provided below.

## **Harnessing the private sector for short and medium term goals**

Given the sheer size of the private sector, it is not possible to entirely ignore it while planning for equitable access to services. However, instead of financing the growth of the private sector (as is happening with the current insurance schemes), alternate ways of harnessing private resources for public health goals need to be explored. Over the short term, this could involve in-sourcing some private providers to strengthen and complement the public health system, using them where and if necessary and under clear terms and conditions, all the while working to strengthen and expand the public system. Such in-sourcing should pursue public health goals and there should be no transfer of assets and resources into private hands. Importantly, kickback statutes should be put in place to ensure there are no referrals with conflict of interests, especially where the same providers are working in both public and private facilities.

The private healthcare sector is not a monolithic entity; some segments such as charitable, faith-based and other not-for-profit healthcare facilities that work in less developed parts of the country could, with a certain level of public funds, fill certain critical gaps in the public system.<sup>54</sup> Small and medium-sized private hospitals that fear being pushed out of the market by large corporate hospital chains could also potentially be contracted in to offer a specific package of services not available in public facilities as long as they agree to adhere to a public health logic, and proper regulatory and monitoring systems are in place. Finally, there is also a large majority of general practitioners who run

their small individual clinics. Their practices will need to be regulated to ensure quality of care and fair pricing. Some of these doctors could also serve in the public system, under strict guidelines.

At the same time it is necessary to strictly regulate the private sector in terms of quality, cost of care and ethics. There are large numbers of hospitals that have been registered as trusts to gain public subsidies (including cheap land in prime urban areas) and tax breaks, but which often do not provide the mandatory free care to poor patients – an ongoing social demand supported by court orders.<sup>55</sup> They should be held accountable to their declared trust objectives, including through participatory monitoring and effective redressal mechanisms.

All the possible mechanisms for harnessing private facilities and practitioners should be seen as supplementary (and often interim) measures, and not as a substitute for very significant scaling up and strengthening of the public system both in terms of quality and accessibility.

### **Improving access through better planning**

Another corrective needed is to close human resources gaps and build a public ethos by investing in medical, nursing and paramedical educational institutions that are primarily located in regions where needs are more pressing. It is also important to clearly identify skill requirements at different levels of care and to deploy health personnel based on these criteria. Effecting such a change requires alterations in existing curricula and calls for the creation of new professional categories. This should be supplemented with a package of financial and non-financial incentives to work in the public sector and with sustained efforts to build a positive workforce environment that would retain the employees. It is not enough to berate doctors by saying that they are unwilling to serve in rural areas, for instance. Conditions of work need to be vastly improved to entice and retain them in such areas. Minimum working conditions in terms of salaries, housing, rotational postings and secure conditions of employment are all necessary incentives.

Importantly, the challenge is to make district-level plans that are responsive to the needs of the community, as measured by technical estimates of disease burden and costs of health care, and as reflected in current patterns of service utilization. Another related challenge is to build the skills and the systems needed to gather robust epidemiological information, to measure health outcomes and to promote decentralized functioning of the entire health system, so that health care priorities and outcomes are identified in consultation with the community.

### **Regulation for quality care**

Quality assurance systems should be put in place in all public facilities to ensure optimal use of resources and to achieve the desired health outcomes. It is important to raise awareness about the importance of quality care among key players, train them for sound management

to close quality gaps, notably by reordering workflows where needed. Invariably some gaps require more investments but typically about 70% of the gaps in quality of care can be closed with existing resources.<sup>56</sup>

Until the public system has regained strength, it will be important to follow the work of private providers closely to make sure they respect and observe patients' human rights. It is also key to create an adequate and just grievance redressal system at the local level and to conduct a public awareness campaign on patient rights. The 2010 Clinical Establishments Act lays down guidelines in this regard, albeit not with a rights language, but it has only been adopted by a few states so far;<sup>57</sup> it needs to be made universally applicable in all states. The Act was meant to regulate private health providers, but it will have no teeth unless an effective, adequate regulatory authority is put in place to enforce it.

The Act's scope also needs to be broadened since it does not include the principles of patient rights or the obligation for private providers to work for public health. Such reformulation should be based on a consultative process to take into account the concerns of various stakeholders including health rights organizations and patients' groups, so that no serious lacunae remain.

## Accountability and participation

Transparent norms of accountability need to be established as regards appointment of district chief medical officers and state-level directors as well as postings and transfers. More robust and accountable institutional mechanisms are necessary for infrastructure development projects and procurement involving commercial service providers, including transparent grant-in-aid mechanisms for NGOs. Also necessary are fresh procurement rules for academic and not-for-profit partnerships. Evidence from the work done by the Tamilnadu Medical Services Corporation (TNMSC) shows how a public system can conduct procurements with the highest standards of transparency, quality and efficiency, and with equal efficiency allocate resources across facilities in a way that is responsive to people's needs. Simply by removing drug procurement from the functions of the directorate, TNMSC reduced the pressures for corrupt appointments of directors of health services. TNMSC developed transparent norms for procurement of essential generic drugs and a computerized distribution network for public sector facilities. This practice has limited the waste of resources on procurement of costly branded drugs and on irrational formulations. TNMSC has also developed a mechanism for quality testing and reports are made publicly available on its website.<sup>58</sup> Such measures can be replicated country-wide.

Combined with solid monitoring by relevant authorities, there is a need for participatory monitoring by multi-stakeholder bodies. Any program for universal health care must aim to involve

communities as active participants rather than as passive beneficiaries. Community-based monitoring processes – as integrated in the NRHM – have proven to be capable of improving performances of public facilities when there is a direct dialogue with the community.<sup>59</sup> Those processes can be mediated largely through organizations such as elected local bodies, self-help groups and other community-based organizations, and official committees set up by the health department where public participation is provided for.

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**“Any program for universal health care must aim to involve communities as active participants rather than as passive beneficiaries.”**

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## Conclusion

Defending and promoting a ‘social logic’ as we roll back the ‘profit logic’ in the health sector will require building broad-based alliances, not only between health activists and health professionals, but also with trade unions, political parties and various progressive forces. Moving toward ‘health for all’ requires major transformations not only in the area of health care, but also in a wide range of social determinants of health – food security and nutrition, water supply, sanitation, working conditions, housing, environment, education and other sectors. Working on all these fronts requires joining forces with like-minded campaigns, such as those on the right to food or water, to create a broad people’s movement in the social sector that will challenge privatization and corporate-friendly public-private partnerships.

There is a need to reclaim public systems, to strengthen and expand them. There is a growing recognition that public services need to be made accountable through active involvement of citizens at various levels. Initiatives ranging from demanding the right to information, denouncing corruption, conducting social audits, to community-based monitoring exemplify the social churning that is underway to redefine the relationship between public systems and the public at large.

Health care is only one determinant of health outcomes; good health is also a result of better nutrition, safe drinking water and sanitation, universal access to education, gainful employment, better working and living conditions, control over addictions as well as environmental pollution (both material and cultural), the elimination of various forms of discrimination, and equitable and inclusive development.

Fair, accessible, affordable and public universal health care will not happen overnight in India, but it is possible and it is worth fighting for.

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