Campaign for ‘Health for All’

Presentation Booklet for PULSE 2017, AIIMS

Dr Srinath Reddy, Chairperson PHFI, addressing the convention on ‘Health for All’ organized at AIIMS on the 26th of August, 2017

Students Union AIIMS, Resident Doctors Association AIIMS, Society for Young Scientists AIIMS and Faculty Members

1. Convention on 'Health for All' – An Introduction

Keeping in mind the mounting challenges in provisioning of health care for all Indian amidst continuing poor health indicators for an overwhelming mass of our countrymen and women, the Resident Doctors Association, the Students Union and the Society for Young Scientists at the All India Institute of Medical Sciences (AIIMS) had organized a convention on 'Health for All' at AIIMS on 26th August 2017. Apart from the representatives of the respective organizations, the convention was addressed by eminent persons in the field of public health in the country. The gathering at the convention included a cross section of medical students, resident doctors, students from Jawaharlal Nehru University (JNU) and faculty members of AIIMS.

The convention began with RDA office bearer Dr Ajay Verma listing out the challenges in achieving the objective of 'Health for All' in the country and how this convention seeks to address these challenges. Thereafter Dr Mohan Rao. Prof at Center for Social Medicine and Community Health at JNU addressed the gathering. He spoke on Primary Health Care and the Road to Alma Ata.

Dr K S Reddy, Chairperson of the High Level Expert Group on 'Universal Health Care' that was constituted and later disowned by the erstwhile UPA government also addressed the convention. Dr Reddy spoke on the 'Universal Health Care' and the 'Recommendations of HLEG'. Dr Punyabrata Gun, well known health activist in West Bengal and formerly associated with the 'Shaheed Hospital' in Chhattisgarh, elaborated on the campaign for 'Universal Health Care' carried out in all the districts of West Bengal. Dr Sujoy Bala, President Shramjibi Swasthya Udyog, West Bengal, spoke on 'Universal Health Care: Experiences of other countries and increasing violence against doctors in public hospitals across India.

Dr Harjeet Bhatti, President of the Resident Doctors Association, AIIMS spoke on the role of young doctors in delivery of health services and the difficulties faced by them in serving the people, especially in the remote and rural areas of the country. Students Union representative Dev Desai dwelt on the dilemmas faced by medical students in making a conscious choice for their career and also emphasized the need for young doctors to serve the underprivileged sections of society. The Chairperson of the Society for Young Scientists, Vishal Sahu spoke on the critical state of research in the country, especially in basic sciences and the lack of jobs for young scientists. He emphasized that the objective of 'Health Care for All' cannot be accomplished if the basic sciences continue to be deprived of funds for research.

Dr Vikas Bajpai, assistant professor at CSMCH, JNU narrated his experiences from the field to highlight the difficulties that need to be overcome in order to make 'Health for

All' a reality. He brought forth the experiences of the past efforts that had been made by progressive doctors, scientists and medical students in opposing various anti-people measures that were sought to be implemented by country's rulers.

Dr Pratap Sharan, professor in the department of psychiatry at AIIMS in his address at the convention marshaled national and international data to show how the policy of levying 'user charges' in health facilities had made health care either inaccessible for overwhelming number of people in the country, or they could access this care only at huge cost which pushed them into poverty. It was regrettable, he said, that the governments in India have persisted with levying user charges despite the fact that the World Bank, which had been instrumental in forcing many countries to implement user charges in the delivery of health services, is itself now opposing this policy.

The meeting ended with the adoption of the resolution (given in this booklet) that was read out by Dr Ashwani who also thanked the students, scientists and faculty members for making this convention a remarkable success.

Even as the AIIMS cultural festival 'Pulse' is going on, as a step to take our campaign for 'Health for All' to various parts of India we are bringing out this booklet for distribution among medical students from throughout India who have gathered for this festival. The booklet presents a synopsis of the presentations that could be made available by some of the speakers at the convention. We hope that this shall arouse your interest and lead you to taking this campaign further among the medical fraternity and people of your respective areas in as many creative ways as possible.

With warm compliments,

Resident Doctors Association, Students Union, Society for Young Scientists and concerned Faculty Members of AIIMS.

2. Universal health coverage: An ethical policy imperative

A background statement in preparation for the convention

Universal health care (UHC) is achieved when all people receive quality and comprehensive health care preventive, promotive, curative and rehabilitative, that meet their needs free of cost without discrimination and reference to their paying capacity. UHC is crucial for sustainable development and for reducing poverty and social inequality. The range of services that can potentially form the package of UHC for LMICs includes services related to preventive, promotive curative and care rehabilitative and services that address social determinants of health. The provision of these services directly falls under the primary responsibility of the state, which has the obligation to improve health of its people.

UHC is not a new concept in India. The Bhore committee (1946) had recommended that India should have a health system that "is designed to provide [a full range of health care] for everyone who wishes to use it. ….everyone who uses the new service is assured of ready access to whichever of its branches he or she needs'. 'Nobody should be denied access to health services for his inability to pay'. This report was accepted by the Government after independence and primary health care centers to provide integrated primitive, preventive curative and rehabilitated services to the entire rural population free of cost as an integral component of wider Community Development Programmed. It also sought to integrate health services approach as a component of intersect oral action to take care of social determinants. This was also the vision articulated by Alma Ata Declaration on Primary Health Care of WHO in 1978. The involvement of community in Health Planning Identification of their needs and priorities as well as implementation and management of health and other related programmes was again emphasized in NHP 1982. But over a period of time from National Health Policy Document (1982) to NHP (2015) this vision of UHC has been diluted variously to limit it to 'essential', 'elementary' 'primary' health care' so as to restrict the range of health services to be provided to cover only immunization, emergency care and top down, cost ineffective, vertical disease central programmes. There was over-reliance on the use of technology; no effort was made to understand community needs and to involve community in Health Planning and Management. This was in tune with the global development policy that was dominated by neo-liberal macroeconomics with its emphasis on cuts in public spending and reduction of fiscal deficits, since the 1980s.

The Government's flagship programme National Rural Health Mission (NRHM), launched in 2005, did include strengthening public health services, but there was neither restoration of Bhore Committees' vision of healthcare any mention of universal provision of health services. It was only in 2011, when the Government of India

commissioned High Level Expert Group (HLEG) that UHC once again entered the lexicon of health policy makers. The HLEG report recommended that India should achieve UHC by 2022 by increasing government finances and by strengthening provision of government administered public health services. This report was not entirely accepted and its diluted vision finds mention in the focus on the health chapter of its12th five-year plan.

India's economy is growing quickly, with more money available for public spending. Its private healthcare industry is expanding rapidly. However, Indians continue to experience the double burden of infectious and non-communicable disease and high out of pocket expenditure on healthcare. India's current health profile reflects the combined effects of multiple transitions (demographic, epidemiological, and nutritional) overlaid by uneven economic development, an under-resourced public health system, and in adequate multi sect oral action on the determinants of health. Striking inequalities in health indicators are present across very diverse states and heterogeneous population groups.

Massive challenges exist to UHC in India. People living in rural areas, belonging to lower caste households, and having a low economic status use the services much less compared to other groups. The gap between the rich and poor is widening. Apart from providing access to health services, UHC needs a financing system to protect people from financial hardship caused by healthcare costs. Government spending on health is low. The costs of healthcare are, therefore, shifted directly to patients. The World Health Organization estimates that out of pocket expenditure of more than 15-20%of a household's income which can lead to impoverishment in case of lower income brackets. To provide universal health coverage, around 3% of GDP must be allocated to the health sector, with incremental increases reaching 6%. In a democratic country, the healthcare of citizens must be financed from a "pooled resource" of mainly tax funds. It cannot be left to the patient's capacity to pay or the contributions of mandatory or voluntary insurance schemes, which have a low level of coverage so far. The 2015 draft health policy's continued support for such public insurance schemes for poor people to protect them from impoverishing effects of catastrophic illness is a matter of concern because these have substantial administrative costs, cover only hospital care, and do not tackle health inequities or out of pocket expenditure. Increasing public expenditure on healthcare is crucial given the detrimental effect of out of pocket expenditure on access to health care and consequently on health outcomes. International evidence also corroborates that increasing public expenditure on healthcare improves population health outcomes. Increasing the role of Governments healthcare provider will also provide leverage to improve governance of health systems, including in the private sector, where overuse of technology is endemic. It is unfortunate that public financing

for healthcare (as a percentage of GDP) from the central government has remained a little over 1%.

The recent scandal on sterilization related deaths has highlighted concerns about the poor quality of healthcare in some states. It is therefore important that future investments provide increased resources for strengthening public sector health services and for improving regulation and monitoring of the private sector to improve quality, equity, and affordability throughout the Indian health system. India's current trend of abdicating public responsibility for providing healthcare and relying on the uncontrolled, profit oriented private sector is unfortunate. The solution to an "inefficient poorly performing public health system" is not the much touted public-private partnership but a restructured, revived and strengthened public system. This would be cost effective and would have beneficial outcomes on health of the people and therefore would serve the interests of the poor. Partnership business models are likely to benefit the private sector while weakening, and even destroying, the public health system. The media's focus on corruption and inefficiency of the public health system is fuelling support for the privatization of health services rather than leading to efforts to salvage public health services. Yet, private health care too has problems of inefficiency, compromises with quality and resorts to exploitation of the gullible. There is lack of transparency while there is no accountability to tax payers. There is a need for a strong and independent regulatory system to check this with empowered patients, advocacy groups, and efforts aimed at expanded available services with quality, as well as to retain health personnel in the public sector.

There is a strong need for reiteration of national vision of Bhore Committee Report with an emphasis on the removal of interstate differentials on health spending and governance due to deficient human and financial resources. The Planning and Implementation of health services should be decentralized. Communities must be empowered to take responsibility for identification of their needs, assist in health care planning and participate actively in healthcare implementation including monitoring with social audits.

UHC should include health promotion (including immunization), disease prevention, primary and secondary level curative care, rehabilitative, palliative care, and cost effective tertiary care. Currently, secondary and tertiary level care is delivered mainly by the private sector. Community health centers and district hospitals administered by the government need to be strengthened substantially in respect of specialist care. Over the past few decades, staffing has emerged as a huge problem, with shortages of medical and paramedical staff, as well as a lack of diagnostic services, drugs, and equipments. Currently, India has 6.5 doctors per 10 000 people, less than half the global average of 14.2 per 10 000. These numbers vary widely between states, with Karnataka, Delhi, and

Goa having much higher proportion of doctors than Haryana, Bihar, and Uttar Pradesh. There are high vacancy rates for specialist's in4535 community health centres. Despite India's 355 medical colleges, there is a move to allow the private sector to open more medical and nursing colleges to reduce the shortfall in skilled staff. But increasing the number of private medical collages won't improve the inequality in distribution of healthcare staff, many of whom will migrate to urban areas or overseas. Medical education should be restructured to suit the needs of rural health care. This would require redesigning of curricula, efforts it inducting candidates from rural areas for training. About two thirds of doctors already work in urban areas, whereas two thirds of the population lives in rural areas. Doctors should be incentivized variously to serve in the rural areas.

There is a need to endorse a radical new system of health-care delivery for the rural masses. Every village should have at least one 'village doctor' e.g. whether AYUSH or registered medical practitioner (RMP); who is trained in both Indian and western medical knowledge (with appropriate syllabus, textbooks and examinations) and is committed to practicing medicine in villages. Efforts could be made to develop a system of accountability of health care delivery. This would provide a low-cost solution built around easily available indigenous resources. Such practitioners could combine Indian and western medicine in their medical practice; with the expectation that the program would slowly but effectively establish modern methods and forms of care in rural India.

There is a need to expand access to medicines, vaccines and laboratory services through a comprehensive healthcare supply chain management in the country. One of the measures that the Government could take to improve coverage would be to provide access to free essential medicines for all individuals seeking care, which would reduce out-of-pocket payments considerably. The cost of other drugs could also be reduced. This would require a national procurement programme and the supply of generic drugs, consumables, and diagnostics through a corruption-free, transparent, process. Indian medicines should also receive official legitimacy and judiciously promoted because of their relative affordability. However, there may be a need for standardization of its pharmacopeia. To address the growing demand and expectations of the public and the limited outlets for medicines and supplies for non–prioritized interventions, the state could roll out community pharmacies similar to health facility–embedded pharmacies.

If we fail to deliver universal healthcare, it will be due to lack of political will, system inefficiencies, and poor fund allocation, rather than a lack of creative ideas and plans. Academics, researchers, health providers and peoples should come together to ensure that UHC remains high on the economic, social, and political agenda in India.

3. Roadblocks to UHC and HLEG Recommendations

Dr K Srinath Reddy
Chairperson, HLEG &
President Public Health Foundation of India

- Over the past two decades, despite solemn promises made by successive governments to substantially raise India's public health expenditure, it continues to hover around 1.4% of the GDP. The share of the states in this expenditure is to the extent of 0.9% of the GDP while the Centre accounts for the rest of 0.5% of the GDP. India's new National Health Policy, 2017 once again emphasizes health systems strengthening by increasing public health expenditure to the tune of 2.5% of the GDP by 2025, and to increase the spending on health by the states to more than 8% of their budget by 2020. However, if the present expenditure of less than 5% of their budget on health amidst declining trend in health expenditure by some states is any indicator, all the solemn promises made in the new health policy are also headed to become missed targets as in the past.

- Low levels of public spending on health along with an overall expenditure on health in India to the tune of 4.7% of the GDP implies that out-of-pocket spending accounts for around 63% of this expenditure. This pushes 63 million people - close to the population of the United Kingdom - into poverty each year because of catastrophic health expenditure. Given the poor state of public protection from ill-health people are forced to abandon jobs and sell their land and other assets to pay for health care costs.

- With more than 9 in 10 people being self-employed, the private and employer-provided health insurance covers only a fraction of the population. This notwithstanding, the government is not coming clear on the National Health Protection Scheme, which is expected to replace the Rashtriya Swasthya Bima Yojana. At the same time there are new concerns on the anvil. Will the advocacy of a Universal Basic Income (UBI), made in the Economic Survey, lead to abandonment of Universal Health Coverage (UHC) as a government-led initiative? The government should clearly affirm its commitment to UHC, especially as it is now a defining feature of the Sustainable Development Goal on health. UBI should be an additional entitlement, not an alternative to UHC.

- Given the outrageously high out-of-pocket expenditure on health providing essential drugs free of cost at public facilities and making the inexpensive generic drugs widely available in the market has become an imperative. However, provision of free essential drugs and diagnostics by itself will not be enough, as India would need the infrastructure, manpower and resources to support delivery, and clear targets and data for course correction.

- The most recent tragedy that took the lives of a large number of newborns and small children at the BRD Medical College in Gorakhpur has become the symbol of the collapse of the primary health care system in India. There ought not to be a need for the people to go to medical colleges as treatment of fever, provisioning of anticonvulsant medication, basic oxygenation and monitoring of fluid balance, as had been the requirement in case of these children who died, should be available at the primary health centres. Strengthening rural health systems is still not getting the priority it needs if improving the quality of health services in the country is any concern at all.

UHC In India : Not A Straight Path

2005 – 2007	NRHM + RSBY Provide Platform (Improved MCH Services + Partial Financial Protection)
2010 – 2011	HLEG On UHC (Planning Commission)
2012	UHC In 12th Five Year Plan
2012-2014	Economic Slowdown & Food Security Act Push UHC off Radar
2014	Government Change : Promise Of 'National Health Assurance'
2015-16	Responsibility shifts to states; SDGs to guide action over 15 years
2017	New National Health Policy 2017; NITI Aayog Releases 3 Year Action Plan

Notes for the slide above: UHC - Universal Health Coverage; NRHM - National Rural Health Mission; RSBY - Rashtriya Swasthya Bima Yojana; MCH - Maternal & Child Health; HLEG - High Level Expert Group; SDGs - Sustainable Developmental Goals

NRHM ⟹ NHM

Gains

- Improved MCH Services
  ⇩
  RMNCH + A
- Improved Control of TB, Malaria
- Improved Emergency Services
- Infrastructure Strengthening
- Attention to HMIS

Shortcomings

- NCDs, Mental Health etc. excluded
- Shortages of Human Resources: Limit Access, Quality and Affordability
- Marked Inter-State Differences in Performance And Governance
- Urban Component Yet To Take Off

RSBY

Gains

- Large Scale Enrolment
- Increased Access to 2º Care
- Private Sector Engagement
- IT Platforms Established

Shortcomings

- Confined to Hospital Care
- Limited / No Impact On OOPS
- Regulatory Challenges + Fraud
- Competition With State Programmes

Health Financing : Inadequate So Far

- **Low Level of Public Financing:** 30.5% of health expenditure.
- **High OOP & Catastrophic Health Expenditures**: push 60-80 million Indians into poverty each year.
- **Health Insurance Programmes:** mostly Government funded; total coverage ~370 million (enrolled); cover partial cost of hospitalisation for secondary or tertiary care; OPD care and drugs not covered, though they account for 70% of OOP.

OOP: Out of Pocket Expenditure

Health Care Related Impoverishment
(NSSO: 2004-2014)

- Impoverishment caused due to poor health has remained unchanged over the ten years. Overall the percentage of Indian households that fell below the poverty line due to OOP health expenditures has remained unchanged at approximately 7 per cent of the population.
- Overall, the different regression analyses show that having public health insurance coverage in India has not been associated with lower health burden as measured by (i) total real OOP expenditure, (ii) probability of catastrophic health expenditures or (iii) impoverishment caused by health expenditures.

Ravi S et al; Brookings India, 2016

HLEG's Recommendations (2011)

- **Scale up public expenditure on Health**
- **Lay emphasis on Primary Healthcare**
- **Strengthen and upgrade District Hospitals**
- **Ensure access to free generic medicines in Government Health Facilities**
- **Expand Human Resources in Health**
- **Emphasize Public Health and its management**
- **Strengthen regulatory systems**

Envisioning UHC in 2017

India needs to evolve a UHC framework which features:

- Mandatory coverage for all population groups.
- Free primary care and emergency care.
- Contributions from those who can afford them, with subsidization for those who cannot (for secondary and tertiary care).
- Decrease in the number of pools and schemes in the country to increase efficiency.
- Concentration on comprehensive benefit package for all people and in all services.
- Reliance on strategic purchasing, including purchasing from empanelled private sector providers.
- Supplementary role of open market private health insurance.
- Provide portability across the country.

4. Campaign for Universal Health Care in West Bengal

Dr Punyabrat Gun
Noted health activist, West Bengal

The following is a small brief regarding the campaign for Universal Health Care taken up by Shramajibi Swasthya Udyog and All West Bengal "Health for All" Campaign Committee.

Shramajibi Swasthya Udyog is an organisation of doctors and health workers, which opposes commercialisation of health. It runs eight Model Rational Therapy Clinics to prove that modern medical care can be provided at low-cost. It attempts to educate people on socio-economic causes of ill-health. It attempts to empower people with

knowledge of disease prevention and treatment. It attempts to integrate health movement with people's movements. It opposes external funding of health programs.

All West Bengal 'Health for All' Campaign Committee is a conglomeration of more than 33 people's health organisations, people's science organisations, cultural organisations, students and youth organisations, trade unions and peasant organisations, campaigning for Universal Health Care.

During our days as medical students, we learned of socialised medicine from the renowned public health physician, a great teacher and a revolutionary Dr. Norman Bethune. Dr Bethune was a Canadian citizen but organized health care efforts wherever the workers struggles were going on in the world. He went to provide medical care at the front in Spanish Civil War against the Fascist dictator General Franco and later participated in providing and organizing medical services during China's revolutionary was led by Com Mao Zedong. Thus spoke Dr. Bethune:

> Socialized medicine means that health protection becomes public property, like the post office, the army, the navy, the judiciary and the school; 2nd: supported by public funds; 3rd: with services available to all, not according to income but according to need. Charity must be abolished and justice substituted. Charity bebases the donor and debauches he recipient; 4th: its workers to be paid by the State, with assured salaries and pensions; 5th: with democratic self government by the health workers themselves.

WHO defines Universal Health Coverage in this way: 'All people and communities receive quality health services they need, and are protected from health threats, without suffering financial hardship.'

On 6—12 September, 1978 at Alma Ata, Kazakh Soviet Socialist Republic an International Conference on Primary Health Care was held. It was declared that there will be 'HEALTH FOR ALL BY 2000 AD.' India was a signatory to this Alma Ata Declaration; however the Indian rulers failed to live up to their commitment to the people of the country. Today Universal Health Care seems like a dream, but it is an AFFORDABLE DREAM which though belated can still be fulfilled.

In 2010, the Planning Commission constituted a High Level Expert Group (HLEG) under the chairmanship of Dr. K. Srinath Reddy to make recommendations for Universal Health Care. The HLEG on UHC placed its report in 2011. It was in mid-2011 that we learned of the HLEG on UHC from a radio talk by Dr. Binayak Sen, the renowned public health physician and human rights activist of India. Dr. Sen was appointed as an adviser to the HELG after his release from Jail on bail. Unfortunately

the Planning Commission did not take on board HLEG's recommendations in its 12th Plan Document.

Some individuals and organizations in West Bengal started discussing among themselves the recommendations made by the HLEG report and the Plan Document. On February 17, 2013 at the Academy of Fine Arts Kolkata conference hall, a discussion on the report of HLEG on UHC and the Plan Document was organized. A network 'People for Health Care' was formed to campaign for universal health care .

At first we campaigned in South Bengal—Santipur, Fuleshwar, Bongaon, Kulpi, Sandeshkhali, Kolkata, Halisahar, Naihati, Beliatore, Patharpratima and Chakdah.

Our campaign materials were:

- Power point presentation and booklet: UHC is not a mirage
- Power point presentation and folder : Demanding Essential Medicines for All
- Power point presentation and booklet: RSBY—what we should get and what is the reality.

In March, 2014, the constituents of 'People for Health Care' met in a large meeting. Discussions were held on Universal Health Care, What are the government health care facilities one should get free of cost, RSBY, Essential medicines which should be available free of cost in West Bengal. However, the 'People for Health Care' disintegrated after this meeting, when we pressed for more commitment from other constituents in the campaign.

Then onwards, the campaign continued mainly on the initiative of Shramajibi Swasthya Udyog. We added a new campaign topic: West Bengal Government Health Care Facilities One Should Get Free of Cost. Power point presentation and a booklet were prepared.

We campaigned in Bansberia, Baharampur, Radhanagar of Bankura, Fuleshwar, Kolkata, Kalyani, and Jhargram.

Shramik Krishak Maitri Swasthya Kendra, a people's health program, initiated by Kanoria Jute Sangrami Shramik Union and run by Shramajibi Swasthya Udyog, completed 20 years of its existence on March 21, 2015. From March 21 to April 7, the World Health Day, we intensified our campaign. Posteres, Badges, Campaign Folders in Bengali & Hindi were prepared. We campaigned in Chengail, Medical College Kolkata, Sarberia, Panchla, Beliatore, Halisahar, Santipur, Fuleshwar Cotton Labour Lines, Diknagar, Kandi, Sivnath Sastri College Kolkata and Naihati.

On August 16, 2015 'All West Bengal Health for All Campaign Committee' was formed. AWBSRU, IFTU,APDR, MCDSA, Canning Juktibadi Sanskritik Sanstha , Calcutta Ahead, Kanchrapara Bijnan Darbar, KNS, Jansanskrit i, TUCI, Tapshili Unnayan Samiti Pandaveshwar , Dishari Jansanskritik Sanstha, Naihati Institute of Science & Culture, PYL, Pandaveshwar Chhatra Samiti, PDSF, Foundation for Health Action, FAMA, Barasat Citizens' Forum, Bansberia Sunday Sitting, Bijnan o Sanskritik Sanstha Chakdah , Bijnan Mansikata Vikash Kendra, Bibartan Bijana Sanstha , Bharatiya Bijnan o Yuktibadi Samiti , Dr. Bhaskar Rao Janaswasthya Committee, Madan Mukherjee Smriti Janswasthya Kendra, Belur Sramajibi Swasthya Prakalpa, Ragini Santipur, Santipur Marami, Sivnath Sastri Ganaswasthya Udyog, Shramajibi Swasthya Udyog, Sundarban Sramajibi Hospital and Halisahar Bijnan Parishad were initial constituents of this committee.

We intensified the campaign on September 28, 2015 the 24th Martyrdom Day of Com Shankar Guha Niyogi. Com. Niyogi in eighties led the contractual iron ore-miners of Chhattishgarh in an unique health movement.

Our campaign continued in Barasat, Ultadanga, Kolkata, Uttarpara, Beliatore and Naihati.

On November 8, 2015 an organisers' meet was organized.

During November 19-21, 2015 we took part in Science Expedition of Bharatiya Bijnan o Yuktibadi Samiti to bring the messages to North Bengal. We continued our campaign in South Bengal also—Siakhala, Naihati, Uttarpara, Chinsurah, Mankar, Sivnath Sastri College, Medical College, Galsi, in the villages around Sarberia, Nonadanga Kolkata, Pandaveshwar, Srirampur and Behala.

We planned to hold a Public Convention on Health for All on January 24, 2016 at Kolkata. Six Jathas were organized. One campaigned in four North Bengal districts during January 17-20, 2016. Five other Jathas campaigned in rural Howrah & adjoining Hooghly, South 24 Parganas, Bankura & Burdwan, Hooghly industrial areas and Nadia & North 24 Parganas.

The Public Convention on UHC was held with Dr. K. Srinath Reddy, Dr. Binayak Sen, Dr. Arun Singh, Dr. Rahul Mukherjee, Satya Sivaraman, Bankim Datta and Alakesh Mondal as speakers.

April 7, 2016, the World Health Day was observed as Demand Day demanding that Government must take the responsibility of the citizens' health.

Dr. K. Srinath Reddy's lecture in the convention, which was video recorded, was used as campaign material.

In later part of 2016, we campaigned in Siliguri, Tindharia tea garden, Margaret's Hope tea garden, Jalpaiguri and in a route of Science Expedition of Bharatiya Bijnan o Yuktibadi Samiti along four districts of North Bengal. In South Bengal, we campaigned in Santipur and Kandi

To form a Campaign Committee in North Bengal, meetings were held on February 19, 2017 at Jalpaiguri and on March 19, 2017 at Siliguri

To spread the campaign all over India, an All India Delegates Meet on Campaign for UHC was held at Kolkata on the World Health Day, April 7, 2017. Apart from delegates from the constituent organizations of West Bengal, delegates from Tripura, Uttar Pradesh, New Delhi, Maharashtra and Tamil Nadu participated. A book containing the translation of the lectures delivered in January 24, 2016 public convention was released in this occasion.

A provisional National Campaign Committee was formed. It was decided to hold its 1st public meeting at AIIMS . 5 zonal campaign committees were planned dividing the Indian states—East, West, North, South and Central. W B districts were divided into six zones for campaign purpose. A bulletin on Universal Health Care has been planned.

The Campaign in West Bengal used various forms and mediums such as leaflets, pamphlets, folders, booklets, books, magazine and newspaper articles, U-tube documentaries, Facebook, WhatsApp, workshops, seminars, conventions, street corner meetings, public meetings, rallies and jatthas. We utilised different opportunities at State and National level to convince the people of the necessity of Universal Health Care.

Some of the things that were emphasized in the state of West Bengal by the campaigh included:

- Direction to government doctors to write generic prescriptions,
- Opening of Fair Price Medicine Shops,
- Opening of Fair Price Diagnostics,
- Declaration of free medicines in government hospitals,
- Declaration of supplying full course of medicines in government health care facilities,
- Declaration of free treatment in government facilities,
- Promulgation of new Clinical Establishments act and increasing violence on doctors.

In 1936, after a visit to the Soviet Union Dr. Norman Bethune stated:

> The best form of providing health protection would be to change the economic system which produces ill-health, liquidate ignorance, poverty and unemployment. The practice of each individual purchasing his own medical care does not work. It is unjust, inefficient, wasteful and completely out-moded …… In our highly-geared, modern industrial society there is no such thing as private health—all health is public. The illness and mal-adjustments of one unit of the mass affects all other members. The protection of the people's health should be recognised by the Government as its primary obligation and duty to its citizens.

स्वास्थ्य के लिए संगर्ष करो (struggle to ensure everyone's health) — Struggle is the only way to force the government to materialise Universal Health Care for all sections of society in India. Let us carry the message of 'Health for All' to all corners of our vast country.

Dr. Punyabrata Gun

The Journey from User Fee to Universal Health Care

Dr Pratap Sharan
Professor in Department of Psychiatry, AIIMS

***"The history of user fees imposed on the poor is a history of the poor being excluded from basic services."* –** Jeffrey Sachs, Director, Earth Institute, *End of Poverty* (2005; pp 275).

***"User Fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen. Instead, user fees punished the poor."* -**Dr. Margaret Chan, Director-General, WHO (2009).

An evidence-based approach to secure efficient, equity oriented health care suggests that need to review policy changes on health and social wellbeing for their impact on poorer, more vulnerable sections of society (Whitehead et al, 2001).

User fees refer to the official fees collected by public health facilities. They are a subset of out-of-pocket expenditure. Out-of-pocket payments are defined in the World Health

Report 2010 as “charges or fees levied for consultations with health professionals, medical or investigative procedures, medicines and other supplies, and for laboratory tests levied by government, non-governmental organizations, faith-based and private health facilities. Coming under its purview are coinsurance, co-payment and deductibles paid by the insured.

In the 1980’s, the World Bank was becoming influential in the health sector, transforming power relations on the international health scene. It pursued structural adjustment programs in developing countries that aimed to reduce public spending in the social sectors including health. Through its financial strength and technical expertise, the World Bank became the leader on the global health scene (Robert & Ridde, 2013), defining new norms and rules for international cooperation organizations, academic institutions and policy makers of LMICs who were dependent on international aid. Many African (e.g. Burkina Faso, Niger, Senegal, South Africa, Uganda), Asian (e.g. Burma, Vietnam, Cambodia) and Latin America (e.g. Peru, Honduras) countries reformed their health system based on these principles (Robert & Ridde, 2013). The Government of India introduced user charges in public sector hospitals and health centres on a pilot basis as part of its health sector reforms in late 1990s and early 2000 (MOHFW, 2000). The National Rural Health Mission has also endorsed this strategy to create local resources which would then be utilized locally (MOHFW, 2005). However, realizing the problems with the user fees at point of care, India have introduced policies which aim at reducing the extent of out-of-pocket payment in the last decade (HLEG, 2011; MOHFW, 2017).

The issue of user fees has been fiercely debated since the publication of the De Ferranti report (De Ferranti, 1985), and the Agenda for Reform by the World Bank (Akin et al, 1987), and the implementation of the Bamako Initiative of UNICEF and WHO in the late 1980s. Even in the early years of implementing the Bamako Initiative in Africa and Asia, voices were raised to denounce the potential risks of such an approach for the most disadvantaged populations (Canadian Public Health Association, 1990).

Evidence

Since the 1990s, the evidence-based approach has gained interest, particularly in the area of political decision-making (Niessen et al, 2000). This approach aims to encourage policy-makers to take scientific evidence into consideration when developing new policies.

Given the considerable challenge of health care financing reforms, and in order to inform policy makers and the public about the effects of these reforms, many researchers have focused on the impact of user fees on utilization of health services by

populations. Despite the methodological limitations of these studies, the results mostly demonstrated a negative impact of user fees on access to health care for the poor.

Inefficiency

User fees eventually leads to higher expenditure because large number of people neglect seeking care at the earliest, making it highly inefficient way of raising revenue. Poor people delay seeking care until an emergency situation arises, because of financial constraints (Tipping 2000). This delay often forces them eventually to seek care at a more expensive level, typically at a hospital, rather than at a health centre. The negative effects of user fees are therefore two-fold: poorer health and increased medical expenditure (Whitehead et al, 2001). High user fees are thus inefficient and inequitable. Advocates of private finance have argued that efficient and fair systems for waiving user fees could be established, and thereby secure access to public health-care services for those not able to pay. In practice, establishment of well functioning systems for waiving fees has proved very difficult (Russel & Gilson, 1997). In the study conducted in Haryana, Prinja et al (2012) found that only about 5.3% patients had been given exemption from user charges for out-patient care in the past three months; whereas nearly 30% of the population is below poverty line.

Gilson et al (1995) had cautioned against the limited success of targeting mechanisms in user fees. Experiences of waiver in public sector hospitals have raised the issue of actual beneficiary identification, information dissemination and monitoring of this process. A major difficulty is to identify very poor people in a population in which poverty is rife. Evidences show that exemption scheme at the secondary level care in Punjab (GOI, 2005), West Bengal (Roy & Gupta 2011) and Uttar Pradesh (Shariff and Mondal 2006) did not work as envisaged. In Tanzania, despite the exemption policy, only 20% of children below five years of age could avail of the waiver (Save the Children, 2005). Many patients did not know the process of obtaining exemption certificates and found it cumbersome. The political interference and corruption in issuing those waiver certificates by the rural administrative authorities are also counterproductive. There is no system to appraise the stakeholders about the provisions of exemptions and waivers. In West Bengal, 45% of the BPL families could not access OPD services due to economic barriers (Sen & Gupta, 2011).

Public health-care providers, who depend on revenue from fees, are likely to start to give priority to patients who can pay. In such a financial climate, public hospitals tend to favour rich people, who generally gain greater shares of public funds than poor people. A study by National Council of Applied Economic Research revealed that the share of public subsidy for health enjoyed by the richest 20% is 3 times that enjoyed by the poorest quintile (NSSO, 1996). Prinja et al (2015) found that public sector hospital

utilization for inpatient services had a pro-rich distribution in the three districts of Haryana with user charges and pro-poor in the 17 districts without user charges.

User fees are designed to generate additional revenue for recurrent cost and ensure financial sustainability with minimum external inputs. However, the amount and sustainability of revenue generated from user fees has mixed evidence. Cost recovery ratios in 16 African countries averaged only 5%, against the envisaged revenue generation of 15%-20%. In fact, the costs of administering collection outweighed the actual collection per se (Creese 1997; Yates, 2009). A study in Kenya found that nearly 40% of the revenue generated wasn't utilized (Mwabu et el 1995). The all India figures for total receipts from revenue generated through user charges were in the range of 2.5% to 6.5% of the total health expenditure over the period of 1980-2000 (Bajpai & Saraya, 2010). In a district hospital of West Bengal (2002 – 2006 period), the share of user charges to the total expenditure showed a decline from 2.1% to 1.8% (Roy & Gupta, 2011). A study from Maharashtra also indicated that user fees remained largely un-utilized even when retained by hospital committees at district level (Mahal & Veerabharaiah, 2015). There are no indications yet that Indian states which levied user charges have achieved better healthcare indicators (Bajpai & Saraya, 2010).

Poverty

The World Health Organization estimates that out of pocket expenditure of more than 15-20% can lead to impoverishment; India's proportion is 61%. High disease burden, soaring financial costs, and lack of protective mechanisms often lead to worsening of existing poverty (Sen et al, 1998). Rise in out-of-pocket costs for public and private health-care services may also drive many families into a medical poverty trap. A study by National Council of Applied Economic Research revealed that over 20 million Indians are pushed below the poverty line each year because of out of pocket spending on health care [NCAER, 2002]. In 1999-2000, around 32.5 million persons in India fell below the poverty line (BPL) due to out-of-pocket expenditure with greater and deeper impact in poorer states and rural areas (Garg and Karan 2008).

In traditional economic analyses, poorer groups' payment for health care is typically used as evidence of willingness to pay. However, it is increasingly clear that payment is not the same as ability to pay. Many poor people cannot afford to pay, but still do so, at great long-term cost to themselves and their families. People buy health care even if it costs them their long-term livelihood, because medical expenses are often forced payments. The negative social effects of direct user fees for health care are also greater than most other fees, because these expenses are unexpected and total cost is often not known until after treatment. Loans and debt are common consequences of such expenses. Many families cut down on food to offset the cost of borrowing. Families raise

money for health-care bills not only by borrowing, but also by working for others, or selling off assets such as land or cattle. Withdrawal of children from school is another common coping strategy - to save on school fees and so that children can help out to pay off loans for hospital bills.

Burundi introduced user fees in 2002. Two years later, four out of five patients were either in debt or had sold assets (WHO, 2010). A recent USAID report found that hospitalizations in Haryana state led to nearly 30% households incurring catastrophic health expenditures (USAID, 2015). Another study from Haryana reported significantly higher prevalence of catastrophic health expenditure in public sector institutions with user charges (48%) compared to those without user charges (35.4%) (Prinja et al, 2012). Balasubramaniam et al (2015) found that catastrophic expenditure on surgeries affected the poor more than the rich. While 13.9% incurred catastrophic expenditure in poorest quintile, none from the richest quintile experienced catastrophic outcomes of out-of-pocket expenditure incurred on surgical care. Catastrophic health expenditure was defined in Prinja et al's (2012) and Balasubramaniam et al's (2015) studies as households spending more than 10% of the total household expenditure as out-of-pocket expenditure on healthcare as suggested by Pradhan and Prescott (2002). This definition was followed, as their data did not permit differentiation between food and non-food consumption expenditure. This definition has been endorsed for application in the Indian context by the draft National Health Policy 2015 of India. A higher proportion among the poorest 20% population coped through borrowing money (47.2%), while majority (86.1%) of those belonging to richest quintile paid from their monthly income or savings, or had insurance.

Untreated morbidity

In health terms, the most severe effects of out-of-pocket payments are felt by those who are denied services because they cannot afford them and whose sickness goes untreated. Such people are at risk of further suffering and deterioration in health. In some Indian rural areas, 17% of people who reported illness did not seek care, of whom more than a quarter cited financial reasons (Iyer & Sen, 2000). In household surveys in rural China, more than one-third of people who reported that they had had an illness did not seek health care, with financial difficulties cited by poor people as the main reason (Fu, 1999). Additionally, 60% of those referred to hospital by a doctor never contacted the hospital because they knew they could not afford to pay the high user charges (Fu, 1999). This finding is supported by high unmet need on account of lack of financial resources according to NSS data in India (NSSO, 2006). Costs to individuals and society from untreated morbidity are potentially devastating.

Reduction in access to care

Introduction of high user fees has typically caused an indiscriminate reduction in access to care. The United Nations Research Institute for Social Development recently stated that user fees is probably the most ill advised measure for raising revenue from people. One study of 39 developing countries found that the introduction of user fees had increased revenues only slightly, while significantly reducing the access of low-income people to basic social services. Other studies have shown that fees reinforce gender inequality (UNIRSD, 2000).

In a Cochrane review, Lagarde & Palmer (2011) assessed the effectiveness of introducing, removing or changing user fees to improve access to care in low-and middle-income countries through literature search of 25 international databases (16 studies). They found the use of health services decreased significantly in most studies when fees were introduced or increased. Hone et al (2017) conducted a systematic review (8 studies) to assess the impact of differential user charges between primary and secondary care on utilisation of primary health care in health systems with limited gate keeping. Overall, there was little evidence that differential user charges can actually shift utilisation from secondary health care to primary health care.

In health systems such as in India which are primarily driven by out-of-pocket payment, opportunity to access health care is severely constrained by ability to pay. In India, evidence from the NSSO survey shows that about 20% and 30% of urban and rural households respectively who reported unmet need for curative care, cited financial constraint and high out-of-pocket payment as the reason for the same (NSSO, 2004). In Andhra Pradesh (2001 – 2004 period) the proportion of the poor utilising hospital services showed a marked decline, particularly for hospitalisation, outpatient services, surgeries, deliveries, and laboratory and diagnostic services after the introduction of user charges. In particular there was low utilisation by the scheduled caste and tribe (SC/ST) population (Mahal & Veerabharaiah, 2015). A study in Maharashtra also indicated a decline in both OPD and indoor admissions after introduction of user charges, both at overall level and specifically for the poor (Mahal & Veerabharaiah, 2015).

Prinja et al (2012) assessed the effect of user charges on inpatient hospitalizations in public sector facilities Haryana (2000 – 2006 period) based on National Sample Survey data. The median out-of-pocket inpatient expenditure in public sector hospitals was almost two times in the three districts with user charges (Rs. 9,170) as compared to the rest of the state (Rs. 4,700). Overall, households in districts with and without user charges spent 48% and 17% of their consumption expenditure on meeting curative care needs. Hospital admissions declined by 23.8% in a district with user charges compared

to an almost static hospitalization rate in a district without user charges. Admissions at rural health centres declined by 57.2% in a district with user charges compared to an increase of 40.2% in a district without user charges. The decline in in-patient admissions in district with user charges was significantly higher among females as compared to males. Households from the poorest quintile did not utilize of inpatient care. Balasubramanian et al (2015) assessed the impact of user charges in the form of Surgical Package Program (SPP) in district hospitals of Haryana (2006 – 2013 period). User charges had a negative effect on the number of surgeries in public sector district hospitals.

In Ghana, a fee exemption policy for deliveries implemented in 2005 and its subsequent incorporation into the national health insurance contributed greatly to the increase in facility-based deliveries with qualified personnel. By the end of 2009, more than 70% of deliveries occurred in maternity units. This exemption policy also reduced inequalities in utilization, as it was women from the poorest households who benefited most. The gap in assisted delivery rates between the least poor and the poorest went from 65% in 2004, before the first policy, to 54% in 2009 (Dzakpasu et al, 2012). Similarly, in Burkina Faso, a fee exemption policy for deliveries has ensured that nearly 90% of women today deliver in the maternity unit of a health centre with qualified personnel (Ridde, 2015)

Emerging consensus

The evidence suggests that user charges have a negative influence on health care utilization, especially among the poor; and for a significant proportion of the population leads to catatstrophic expenditure. Currently there are few supporters of user fees. Indeed, in a context where the objectives of the Millennium Development Goals are still far from being achieved, user fees are seen as major barriers to access to care for vulnerable populations (McIntyre et al, 2006). South Africa has decided to make health care free for a certain part of its population in 1994. Many other low-and-middle income countries, supported by several international donors, have followed the example of South Africa (Robert & Ridde, 2013). Between 2008 and 2010 many influential stakeholders such as the WHO, the European Commission, the G8 and several working groups and transnational networks started taking a stand against user fees (Robert & Ridde, 2013). A consensus is emerging that user fees are not an appropriate financing mechanism for health services in developing countries" (Yates, 2009).

The recent speech by ***the president of World Bank, Jim Yong Kim*** at the World Health Assembly in May 2013 gives effect to this change. He claimed there: ***"Anyone who has provided health care to poor people knows that even tiny out-of-***

pocket charges can drastically reduce their use of needed services. This is both unjust and unnecessary." (Kim, 2013)

Robert and Ridde (2013) conducted a study on 140 public documents officially attributed to global health actors consisting of intergovernmental organizations, international non-governmental organizations, government agencies, and working groups and networks over the period 2005 to 2011. Of the 56 global health actors, 55% were in favour of the abolition of user fees or in favour of free care at the point of delivery. None of the global health actors stated that they were in favour of user fees. Intergovernmental organizations like the African Union, Council of the European Union, Danish cooperation, and WHO stated that user fees should be avoided, and other financing mechanisms like social protection or pre-payment mechanisms should be explored.

Solutions

A change from direct payments to social health insurance or tax based systems is needed, in which healthy, high-income groups subsidise care for low-income groups. Most of the low and middle income countries, including India have introduced policies which aim at reducing the extent of out-of-pocket expenditure, and thus progressing towards universal health care. Broadly, two forms of routes have been taken. In the first, it is through a risk pooling mechanism where Government pays for the community-rated premium of the poor through tax-funding and the population gets coverage for a defined benefit package. Care is cashless at point of use through a network of empanelled hospitals. In this, the rich may want to opt in the insurance scheme with payment of a pre-determined premium which is usually not risk rated. The Rashtriya Swasthya Bima Yojana (RSBY) in India is an example of this model (Palacios, 2010). Again, numerous other State funded health insurance schemes in India also tend to take this model (PHFI, 2011). Other countries like Thailand, Ghana, Rwanda and others also have similar models (Odeyemi , 2014; Saksena et al, 2011; Wagstaff & Manachotphong, 2012). In the second model, the Government invests adequate resources though tax-money into the public sector and provides health care services. This is a model which is publicly financed and publicly provided health care services. This model is being promoted by Sri Lanka. Some Indian states, such as Haryana, are also now attempting to emulate this model Balasubramanian et al, 2015). The overall aim of each of these strategies is to improve financial risk protection.

It is evident that there is a need to increase public financing for curative services and it should be based on the needs of population. Despite high economic growth in India, more than three-fourths of Indians are poor (below poverty line; about 22%) or marginal/vulnerable (level of consumption less than twice the official Indian poverty

line and below the international definition of poverty line; they are considered vulnerable because one exogenous shock or death or accident or major hospitalization or even a temporary loss of job or earnings can drive them to destitution; about 55%). This proportion of the population is much higher among certain social groups, especially for scheduled castes and tribes, and Muslims. There is also evidence that inequality is widening between the common people and the better-off sections of the society (Sengupta et al, 2008). In India, the growth of Indian economy at the rate of about 8% should provide enough resources for investing in the healthcare of the underprivileged people, who have unfortunately, not benefited proportionately from India's economic growth. Cross subsidization from the vulnerable to the poor is thus not a good idea. To provide universal health coverage, around 3% of GDP must be allocated to the health sector.

Other weaknesses in public health services also need to be acknowledged and tackled. Cultural access is a special problem that encompasses lack of responsiveness; disrespect shown towards disadvantaged groups of people; and widespread use of informal so-called under-the-table payments. Other barriers are the indirect costs of service use, such as transport and loss of income (Action for Global Health, 2012). Efforts should be intensified to reduce, and even eliminate, informal payments for public health services.

UHC... An Affordable Dream

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Universal health care (UHC), in broad terms refers to a health care system where all people receive quality and comprehensive health care preventive, promotive, curative and rehabilitative, at free of cost without discrimination and irrespective of their paying capacity. At present, all developed nations (except US) have UHC. On the other hand, with notable exceptions of China, Sri Lanka, Peru, Thailand, and Cuba, almost no other developing country provides UHC.

A Brief History

It all started in 1912 when Norway became the first country to provide UHC to its citizens. But it was the October Revolution in 1917 which changed the world dynamics of health care delivery as the Soviet Union established a fully public and centralized health care system in 1920. Lenin stated, “Socialized medicine is the keystone to the Arch of the Socialist State”. Later World War-II (1941-45) and Stalin's Red Army defeating Hitler resulted in serious socio-political implications. Soviets were by then occupying much of

Eastern Europe and membership of Communist parties soared across Western Europe. Resultantly, concept of welfare state was brought in to ward off the threat of socialist revolutions and UHC became an integral part of Western Europe in years to come.

A model for UHC emerged from the United Kingdom with the launch of 'National Health Service' (NHS) on July 5, 1948. Other countries followed soon thereafter to implement UHC like Sweden (1955), Norway (1956), Denmark (1961), Finland (1964), Austria (1967), Slovenia (1972), France (1974), Italy (1978), Ireland (1977), Portugal (1978), Cyprus (1980), Greece (1983), and Spain (1986). Iceland (1990) and Switzerland (1994) were the last European countries to implement UHC. Universal health insurance started in Japan (1961), Canada (1968-72), and Australia (1975). Meanwhile, communist countries like China (1951) and Cuba (1961) established UHC right in the beginning. Later, many Asian countries like South Korea (1989), Hong Kong & Singapore (1993), Israel (1995), Taiwan (1995), Thailand (2001) and Peru (2009) introduced UHC. Even Sri Lanka, our neighboring war ravaged country, against all odds introduced UHC in 2000.

Comparing Global Healthcare Access and Quality

Recently, Lancet Journal in its 'Global Disease Burden Study 2015' published its much anticipated Healthcare Access Quality (HAQ) Index which compared healthcare access and quality amongst 195 nations from 1990 to 2015. It was based on death rates for 32 diseases that can be avoided or effectively treated with proper medical care. Switzerland topped the health index, followed by Sweden and Norway. Canada, Australia, Japan and much of Europe are right at the top of the table. Collected data indicates that per capita GDP dictates government health spending, which in turn determines nation's healthcare access and quality. But, a closer scrutiny reveals that healthcare is not always an inevitable product of increased development. US, with highest per capita healthcare expenditure is the worst offender, finishing dismal 35th, while Britain ranked 30, a direct reflection of ongoing dilution of NHS policy. This clearly indicates that healthcare access and quality depends not only on the economic health of the country, but also on social indicators signifying class equality.

India, on the other hand stands at dismal 154 (out of 195 counties) with a score of 44.8, just better of Afghanistan and Pakistan. This 'paid media' created economic powerhouse shamefully lags behind countries like Sri Lanka which is ranked as high as 73, followed by China (Ranked 82), Bangladesh, Bhutan, and Nepal. The criticism goes beyond numbers as the Lancet goes on to comment that 'Newborn in war ravaged Somalia and Afghanistan has a better chance of survival than in India'. Currently Government health expenditure contributes only 31.3% of total health expenditure. 'Out of Pocket' expenditure remains the major contributor with a share of 65.6%. Due to this 'Out of Pocket' expenditure, 63 million people go below the poverty line every year. To make

matters worse, every third malnourished child in the world comes from India. This provides the perfect milieu for the communicable diseases like tuberculosis to flourish.

Bourgeois 'intellectuals' have always come with a lame excuse for such dismal state of affairs citing 'huge population burden' and 'world economic crises'. To counter such political helplessness, the study also published frontier HAQ index which calculates the 'potential' health care access and quality based on the Social Development Index (SDI). SDI is a measure of overall development consisting of income per capita, average years of education, and total fertility rates. Thus frontier HAQ index allows us to quantify the maximum levels of health-care access and quality which can be achieved across the development spectrum of that particular country, and pinpoint geographies where gaps between observed and potential levels have narrowed or widened over time. Several countries, particularly in eastern and western sub-Saharan Africa, reached HAQ Index values similar to or beyond their development levels, whereas others, namely in southern sub-Saharan Africa, the Middle East, and south Asia, lagged behind what geographies of similar development attained between 1990 and 2015. In fact India is amongst the worst offenders, falling behind the expected health standards miserably. India today is home to 21% of world's disease burden, world's highest number of women dying in childbirth, and world's highest number of deaths under the age of five. This comes with no surprise considering that we have the world's tiniest health budget of less than 1% of GDP.

Indian Health Policy... Past and Present

UHC is not a new concept in India. The Bhore committee (1946) had recommended that India should have a health system that "is designed to provide [a full range of health care] for everyone who wishes to use it. ....everyone who uses the new service is assured of ready access to whichever of its branches he or she needs'. 'Nobody should be denied access to health services for his inability to pay'. This report was accepted by the Government after independence and primary health care centers to provide integrated primitive, preventive curative and rehabilitated services to the entire rural population free of cost as an integral component of wider community Development Programme. It also sought to integrate health services approach as a component of intersect oral action to take care of social determinants. This was also the vision articulated by Alma Ata Declaration on Primary Health Care of WHO in 1978. The involvement of community in Health Planning Identification of their needs and priorities as well as implementation and management of health and other related programmes was again emphasized in NHP 1982.

But over a period of time from National Health Policy Document (1982) to NHP (2015) this vision of UHC has been diluted variously to limit it to 'essential', 'elementary' 'primary' health care' so as to restrict the range of health services to be provided to cover

only immunization, emergency care and top down, cost ineffective, vertical disease central programmes. There was over-reliance on the use of technology; no effort was made to understand community needs and to involve community in Health Planning and Management. This was in tune with the global development policy that was dominated by neo-liberal macroeconomics with its emphasis on cuts in public spending and reduction of fiscal deficits, since the 1980s. The Government's flagship programme National Rural Health Mission (NRHM), launched in 2005, did include strengthening public health services, but there was neither restoration of Bhore Committees' vision of healthcare any mention of universal provision of health services.

It was only in 2011, when the Government of India commissioned High Level Expert Group (HLEG) under Dr. K. Srinath Reddy that UHC once again entered the lexicon of health policy makers. The HLEG report recommended that India should achieve UHC by 2022 by increasing government public expenditures on health from 1.4% of GDP to at least 2.5% by 2017, and to at least 3% of GDP by 2022. This was to support free of cost primary, secondary, and tertiary healthcare delivery through strengthened public health services. When required, Government would purchase private services (through agencies). Availability of free essential medicines would be ensured by increasing public spending on drug procurement. These facilities will be provided cashless to all citizens of India through a pan India Health card. General taxation will be the principal source of health care financing, complemented by additional mandatory deductions from salaried individuals & tax payers. The 12th five-year plan was tabled soon thereafter by the Manmohan Singh government, which as expected shamelessly defaulted on the recommendations. On the contrary to what was expected, the government decided to give up all its responsibilities to private health services and health insurance. It was to act from sidelines as a manager. The idea was to promote corporate hospitals by giving tax concessions and subsidies, so they can continue providing profitable tertiary care services. In short, government decided to continue with the failed 'Out of Pocket' health policy of US and Mexico.

Modi-Healthcare or Nightmare

Modi came to power in 2014 with lot of promises, and many of us were naïve enough to believe him. Branding Manmohan Singh a failure, he promised UHC to all citizens of India in his pre-poll campaign. But with time, his UHC promises have quietly been replaced with assurances. Somewhere in between he even managed to bring in a new National Health Policy 2017, but forgot to allocate money in the health budget to execute the plan. So the proposed health budget of 2.5% of GDP remains on papers, and as the government goes on collecting Swachh Bharat Cess (0.5%), the health budget has gone down quietly from 1.04% to <1% of GDP in the last 3 years. On the other hand, the NITI Ayog wants the health budget to remain <1% of GDP. It is not only against any increase in public health sector investment, including free drugs or diagnostics, but has

even floated an insurance based model of privatizing the existing district and other government hospitals. Two set of contrasting policies coming from the same government seems to a ploy to create confusion till the next election.

Now let's compare our helplessness with Thailand which began implementing UHC only in 2002. Backed by enormous political will, pressure from people and civil society groups, it had covered 98% of the population in a decade. It's completely financed by the government, through general tax, and covers nearly 80% of the healthcare needs of people compared to India's 30%. Obviously, the risk of health catastrophes has dramatically fallen and people feel safe and secure. The per capita expenditure on health in Thailand is nearly four times than that of India, but it spends only 4.1% of GDP (compared to India's 3.9%). The crucial difference lies in the fact that 80% of this 4.1% is government spending (and not private). This optimizes the cost as the government "purchases" quality services from 'state of the art' public hospitals at a very low price. In reality, it is the priority what matters. Today, Indian ruling class is busy appeasing the big corporate who have funded their election campaign (300 crores spent on Modi campaign in the last election), and it's payback time. Meanwhile the interest of 'common man' goes for a ride, who is left confused with false assurances and no alternatives. And if all of these fail, then right-wing extremism generated hatred in the name of caste, creed or religion comes to their rescue.

So we can safely conclude by saying that **"Healthcare is a human right"** and denying it is a crime in itself. Even then, if we fail to deliver UHC, it will be due to lack of political will, and nothing else. Academics, researchers, health providers and most importantly 'the common man' should come together to ensure that UHC remains high on the economic, social, and political agenda in India, so that we can force our policy makers to re-think their priorities.

Epilogue: Violence against Doctors

Doctors are the most recent victims of this fallacious 'Out of Pocket' Healthcare system. Earlier, the common man who could not afford quality treatment would just curse his fate. But with time, this frustration and anger had started to pile up. The ruling class was quick to intervene. Rationally speaking, implementing UHC so the common man gets access to quality healthcare without bearing financial strain would have solved the problem. But instead, colluding with the media, they start malicious propaganda against doctors to cover up their fallacies. In this whole system, doctors are most vulnerable entity as they stand between life and death. So they become easy victim of all these frustration and anger. On the other hand, some doctors have over the years have given into unethical practice, coaxed by easy money promoted by private business interests. This exploitation of ignorance of a common man is now highlighted by the ruling class to divert the attention from them. The private healthcare system which promotes such

unethical practice is equally to be blamed. But it remains unscathed, thanks to the business interests of the ruling class. In reality, commodification of health care and subsequent deterioration of people's health is intricately related to violence against doctors and until and unless this is addressed, violence against doctors will not stop.

Resolution Passed at the Convention on 'Health for All' Organized by Medical Students, Resident Doctors and Faculty Members of AIIMS on the 26 August 2017.

This Convention held on 26th August 2017 at All India Institute of Medical Sciences, New Delhi, resolves to build a powerful movement for "Health for All" as laid down in the Note which was circulated earlier and in speeches made in the Convention. "Health for All" is a wide concept having socio-economic, preventive and curative aspects. Adequate nutrition, safe drinking water and healthy habitat are integral to achieving Health for All. The recently stated concept of Universal health coverage (UHC) says that it is achieved when 'all people receive quality health services that meet their needs without exposing them to financial hardship in paying for them.'

This Convention strongly condemns the total apathy and inhuman callousness displayed by successive govts. towards improving health care delivery system. In the period before new economic policy, some noises were made in favour of moving towards improving Govt. health care delivery system though these were hardly translated into practice. Since the advent of new economic policy, even this pretence has been given up with Govt. abandoning the very goal as well. Being convinced that the present powers do not want to and cannot move in the direction of UHC with the framework proposed by them. This Convention calls for building a strong movement of the people including the personnel engaged in health care delivery system.

This Convention resolves to develop a people's movement to demand higher Budget allocation for health, more and better equipped hospitals in all the areas including remote areas, availability of health personnel including doctors, nurses, technicians and other paramedical staff, availability of medicines and necessary investigations, adequate and fully functional set-up for preventing diseases and strengthening primary health care delivery system. The convention resolves to oppose privatisation and commercialization of medical education and health care.

This Convention resolves to undertake and support initiatives to educate the people on the health needs of society, both curative and preventive. The Convention also supports developing a more equitable distribution of health care personnel in the villages , slums

and remote areas by increasing the skills of those already working there, giving them adequate training and making them part of health care system with defined roles.

This Convention calls upon all doctors, particularly young doctors and medical students and other health personnel to know the health needs of the people particularly in villages and slums areas by undertaking regular interaction and study of their problems. The Convention appreciates the role played by medical personnel who have taken up the task of providing health care in remote areas and also training personnel for the same in different parts of the country.

This Convention calls upon doctors and other health personnel to study the conditions in different regions where thousands are dying for sheer apathy and callousness shown by the rulers due to diseases which are both preventable and treatable. We also note that millions are debilitated and die due to malnutrition and waterborne and vector-borne diseases and unhealthy conditions. The convention expresses its concern on the recent death of children at BRD medical college hospital, Gorakhpur and condemns the callous attitude of government both central as well as state for not taking any action to prevent such deaths occurring for more than two decades in the region.

This Convention resolves to cooperate with all those engaged in building people's campaign in favour of Health for All in different states in order to build a country wide movement. We resolve to undertake regular activities in this direction and we will support such campaigns in other states as well.

Realizing that health of the people is linked to their socio-economic status as well. This Convention supports and considers itself a part of people's struggles against economic and social inequities and for an egalitarian society where health is a realized right.

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