

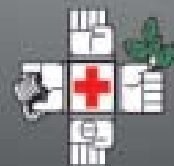
A Report of
**National Seminar on
Health Equity In India**



Organized by
SATHI

(Support for *Advocacy and Training to Health Initiatives*)

2-3 October, 2008



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2nd and 3rd October, 2008

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Preface

As part of 'Maharashtra Health Equity and Rights Watch' project, SATHI - CEHAT had organised a two-day national seminar on the issue of 'Health Equity in India' on 2nd and 3rd of October 2008.

During the seminar, there were presentations and discussions on key issues related to health equity in India like the context of overall growing socioeconomic inequities, equity issues related to social determinants of health like nutrition, inequities in access to health care and specific dimensions like gender inequities in health. Key objectives of this seminar were to dissect out the factors responsible for inequities in accessing healthcare within public health system as well as in the healthcare system as a whole and to analyse how overall intensification of inequities impact upon vulnerable groups and reflect in intra-household and intra-community inequities.

The important topics covered in the seminar were: Overall socioeconomic inequities and issues of food security, Agrarian Crisis in India, Perspectives on health equity, Analysis of Health Equity as reflected in the WHO CSDH report, Health Inequality in India: Evidence from NFHS-III, Health policies and inequities, Gender and Health Inequities: Key issues for Research and Advocacy, Gender inequality as reflected in health research, Regulation and harnessing private sector resources towards a system for Universal access to health care, Modes of interaction between public and private health sectors towards universal

access, Options for a universal access system in India and Health equity issues in NRHM: Evidence from People's Rural Health Watch (PRHW) report.

In these two days, the presentations made by the experts were very informative and they were followed by rich intense discussions among the participants. This report is the documentation of the proceedings of the seminar. SATHI is thankful to all the presenters and the participants for making this event so productive.

In future, we hope to continue the discourse on health equity in India with contributions from the experts in this field.

Dr. Abhay Shukla
Co-ordinator,
SATHI

September, 2009

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Unani, Siddha, & Homeopathy
BEMOC	Basic Emergency Obstetric Care
CBHI	Central Bureau of Health Intelligence
CC	Concentration Curve
CEHAT	Centre for Enquiry into Health and Allied Themes
CEMOC	Comprehensive Emergency Obstetric Care
CGHS	Central Government Health Scheme
CHC	Community Health Center
CSDH	Commission on Social Determinants of Health
EMRI	Electron Magnetic Resonance Imaging
ESIS	Employees State Insurance Scheme
FRUs	First referral units
GDP	Gross Domestic Product
ICDS	Integrated Child Development Scheme
IFA	Iron Folic Acid
IGIDR	Indira Gandhi Institute of Development Research
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
JSY	Janani Suraksha Yojana
MDGs	Millennium Development Goals

MP	Madhya Pradesh
MPCE	Monthly Per capita Consumer Expenditure
NCEUS	National Commission for Enterprises in Unorganised Sector
NFHS	National Family Health Survey
NGO	Non Governmental Organisation
NRHM	National Rural Health Mission
NSS	National Sample Survey
OECD	Organisation for Economic Co-operation and Development
ORS	Oral Rehydration Solution
PDS	Public Distribution System
PHC	Primary Health Care approach
PHC	Primary Health Centre
PHS	Private Health System
PPP	Public Private Partnership
PRHW	People's Rural Health Watch
RCH	Reproductive and Child Health
SATHI	Support for Advocacy and Training to Health Initiatives
SHS	Supplementary Health System
SMR	Suicide Mortality Rate
TISS	Tata Institute of Social Sciences
TN	Tamilnadu
TNMSC	Tamilnadu Medical Service Corporation
WB	World bank
WHO	World Health Organisation

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About the Maharashtra Health Equity & Rights Watch

SATHI is the action-centre of Anusandhan Trust evolved from CEHAT. The SATHI team which has been working since a decade now, originated in 1998 as part of CEHAT, Pune. After working for more than seven years as an action-team in CEHAT, from 1st April 2005, SATHI has developed into the full-fledged action-centre of Anusandhan Trust with headquarters in Pune. SATHI has been working on the issue of health equity since 2005 in the form of its project 'Maharashtra Health Equity and Rights Watch'. The aim of the project is to monitor gaps in access to health care (particularly with a focus on women's access to health care) in Maharashtra to support equity-oriented health sector reform and advocacy for health rights.

Specific objectives of the project

In context of Maharashtra are:

- To document existing inequities in access to health care with special focus on caste, class, gender, rural-urban and regional disparities
- To monitor trends regarding key process indicators responsible for such inequities and to widely disseminate the findings
- To support state-level advocacy for reduction of inequities in health care and to strengthen initiatives to establish the Right to health and health care

At an all India level, the objectives are:

- To share the key learnings of this project with the decision makers and health advocacy groups in other Indian states
- To explore the possibility and lay the groundwork for an all India Health Equity and Rights Watch.

Key activities of the project

This project entails primary research activities as well as research based on secondary data. In addition, advocacy for policy changes directed towards reduction in health care access inequities and partnerships with grass-root level organisations for effective advocacy are also important activities of the project, though the focus of the project is more on research.

Primary research activities of this project are as follows:

- A Household survey in 10 districts of Maharashtra covering 1650 households to document existing inequities in access to health care, in utilisation of health services, expenditure on health care across class, caste, gender and geographical location
- A Facility survey to find out the status of provisioning of services in the facilities accessed by the respondents of the household survey
- A study of migrant workers (sugarcane cutters) in Kolhapur district of Maharashtra to gain knowledge about the vulnerabilities faced by the sugarcane cutters which impinge on their health status and to study the access to health care for them

Secondary data based research activities

- 'Report on health inequities in Maharashtra' - This report, published in Feb. 2008, consists of papers which analyse the variety of existing data from an equity lens, to explore various dimensions of health inequity in the state.
- A report on nutritional crisis in Maharashtra -
- Analysis of state & district health budgets has been undertaken to assess budgetary gaps and disparities in the healthcare provisioning and to capture the effective usage of the budget, linking the budget/expenditure with the utilization data.

This national seminar on health equity in India was organized as a part of this initiative of SATHI.

About the Seminar

One of the key objectives of the project has been to bring together public health experts, social scientists, health sector NGOs and health activists on the issue of 'Health Equity' to develop a discourse on this emerging area of concern in health sector. Similarly the project also aims at exploring possibilities of developing Health Equity research and advocacy by interaction with similar groups across the country. This seminar intended to fulfil both these objectives.

Specific objectives of the seminar were to

- Locate health inequity in the context of socio-economic inequities in India
- Discuss some basic concepts and various perspectives related to the Health equity approach
- Discuss equity analysis as a tool to analyse the health sector; to take an overview of inequities in health status and inequities in access to healthcare
- Analyse how overall intensification of inequities impact upon women; understanding gender related health inequities
- Deliberate upon options towards a system for Universal access to healthcare as an approach to reduce health inequities
- Explore the possibility of further collaborations on health equity research and advocacy

In this seminar, the following sessions were designed to cover various aspects related to the issue of Health Equity in India.

- Socioeconomic inequities in India: Context of Health inequity
- Perspectives on health equity
- Applying the equity approach to Health systems research
- Overview of health status and health care access inequities at national level
- Gender dimension of Health Inequity
- Moving towards a system for Universal Access to health care
- Health Equity issues related to NRHM
- Broadening Health Equity activities in India

One session for each of these themes was planned in the two day seminar. The seminar was attended by health researchers, economists and social scientists, NGO representatives and students from prominent institutes like TISS, IGIDR & IIPS. The seminar was successful in initiating a discourse on the issue of health equity in India. The presentations by the speakers and the discussions that took place in these two days brought out various dimensions of health equity in India.

This report gives a gist of the discussions that took place in this seminar.

Inaugural Session

“In operational terms, pursuing equity in health can be defined as striving to eliminate disparities in health between more and less advantaged social groups i.e. groups that occupy different positions in a social hierarchy. Health inequities are disparities in health or its social determinants that favor the social groups that were already more advantaged. Inequity does not refer generically to just any inequalities between population groups, but very specifically to disparities between groups of people categorized a priori according to some important feature of their underlying social positions.”

- **Paula A Braveman**

Dr. Anant Phadke, coordinator of SATHI, first explained the broad perspective and development process of SATHI in his introductory speech. He said this seminar would attempt to bring experts from various backgrounds to discuss the different aspects of health equity, to understand the nuances of the issue. Dr. Phadke said that ‘Universal Access to Health Care’ is an emerging phenomenon in India. The discourse has not yet developed in India as it has worldwide. Therefore SATHI decided to initiate a discussion with the stalwarts around the table. He said that with this intervention, SATHI expects to understand how it can broaden and strengthen this enquiry into Health Equity in India and address it at the advocacy level.

Dr. Phadke then gave a brief introduction of the chief guest; Prof. Amit Bhaduri. He expressed thanks to all the participants for making their presence in this seminar and invited Prof. Amit Bhaduri to give the inaugural speech.

Inaugural Address by Prof. Amit Bhaduri

Prof Amit Bhaduri initiated his inaugural address by talking about two kinds of displacements viz. displacement from land and ideological displacement. He said that displacement from land is caused mostly due to acquisitions by the Government and large corporate sector. Both these actors are on a spree of acquiring land, water and other resources. As a result of this we have experienced anti-acquisition campaigns in places like Nandigram, Singur, Chingada and Raigad.

Prof Bhaduri noted that the anti-acquisition campaigns, demonstrate people's resistance to land displacement and destruction of livelihood, some of which have shown violent outbursts while some have remained peaceful, nevertheless have given a general feeling of dissatisfaction among people regarding the land acquisition processes.

He then revealed that the second type of displacement which he calls 'ideological displacement' is more crucial and is invisible. He further elucidated this concept. He said that ideological displacement began with neo-liberalism which has prevailed since last twenty years. He further added that the leading elements in the ruling coalition such as the Finance Minister, his allies and the members of the Planning Commission are active proponents of this kind of displacement.

Prof. Bhaduri added that many economists believe that everybody in the market is more or less equal. He said that this theory actually helps to give a strong ideological justification to prove certain mathematical results e.g. in a perfect competitive market all demand and supply would be equal. In common language,

one would say, when demand and supply are equal, there is a self regulating market. If supply is high, prices go down and if supply is low prices go up. This is called the first theorem of Welfare Economics. Professor Bhaduri explained that it is commonly believed that when development occurs, some people must sacrifice and the economy remains in the state of stagnation in case this doesn't happen. As a result, in a stationary market, development is not possible.

He further explained that the theorem of Welfare Economics does not work for two reasons:

- First, in best of circumstances, the income distribution of the optimum is under perfect competition which means that those who have enough money are the ones who have choice over resources. Those who do not have money can not choose between resources, and the resources are limited e.g. on one hand, in many tribal parts of the country, hundreds of children living in the villages die due to water borne diseases every year and on the other hand, there are state of the art hospitals and cancer hospitals in some big cities. It manifests the fact that if one has unequal distribution of power and resources, the market will produce what the rich want.
- Second, in the situation of perfect competition, market is supposed to decide and allocate efficiently. In reality the market does not do so, as the income distribution is unfair.
- Similarly, there is no theory in economics that can tell us how long it would take to reach the equilibrium and how quickly one can convert the market.

Prof. Bhaduri further expressed that in real life, the market is quite different from the ideal in two fundamental senses. In the market, firstly there are players who act differently, either due

to their purchasing power or their voting practice; secondly market functions on the basis of specific rules, primarily formed by social norms, but largely enforced by the Government. Therefore, it is essential to understand that an important aspect of the market is the rules; they are changed when important people in the market, i.e. those who have higher purchasing power in terms of money, insist on change. This preferential change is made out as a natural state of things. It is the biggest invisibility regarding the modern market in India for about twenty-five years. The social ethics have changed and this is the biggest ideological victory, the conception that the market can be a guide for social ethics.

Prof Amit Bhaduri added that ideological displacement leads to the following consequences:

- Unequal growth of resources among the masses that causes disparity.
- Creative destruction: Direct assault on the resources of the poor where their livelihoods are systematically grabbed and are used for development projects, which support extravagant needs of some people.
- Government professes inability to spend on social welfare programmes such as health, education and other programmes. It follows a tight budget.

Prof Amit Bhaduri concluded his speech by saying that India's health situation would improve if definite social and health related interventions are conducted, and the inter connection between health and income is strongly established.

Session I

Socio economic Inequities in India: Context of Health Inequity

Background

In the last two decades, India, termed the biggest democracy in the world, is going through economic turmoil. Economists and politicians are going gaga over the high growth rate, which had reached above 9 per cent in the year 2006-07; however the fact that this growth is highly skewed in nature is being completely disregarded or is deliberately pushed under the carpet.

The worrisome facts - that there are still over 300 million people below the official poverty line (which is considered a gross underestimate of the large population deprived of basic necessities of life), about one third of the adult population is below the BMI of 18.5, and more than half of the children below age of five years are anthropometrical failures i.e. they are either stunted, wasted or underweight - seldom get any prominence in official documents or media.

The fruits of the global economy are enjoyed by a small section of the society whereas large sections are bearing the brunt of this morbid model of development. As noted by the Research Unit for Political Economy¹ -

“ ... as the NCEUS has pointed out, consumption by the top four per cent of the population recorded in the

¹India's Runaway 'Growth', Aspects of India's Economy no. 45, Research Unit of Political Economy, Mumbai, 2008

NSS grew at more than six times the rate as consumption by the bottom 36 per cent of the population.”

“A recent study based on income tax returns calculates that the share of the top 1 per cent of Indian households in national income doubled between 1981-82 and 1999-2000 ...”

“This picture of a much skewed distribution of income or expenditure fits in with press reports of an even more skewed distribution of assets: namely, lists compiled by Forbes and Business Standard of the number of billionaires in this poverty-stricken country. ...In all there are 53 Indians on the list, with a combined net worth of \$334.6 billion (about Rs 13.38 trillion). Their combined wealth increased by 75 per cent over the previous year. ... Another way to get a sense of the size of the wealth of the billionaires’ wealth is by comparing it to India’s GDP. The wealth of the Forbes 53 would be around 28.5 per cent of India’s 2007-08 GDP; that of the Business Standard 533 would be around 29.3 per cent of India’s 2006-07 GDP.”

Even today more than half of the country’s population is dependent on agriculture and allied industries for survival. But the share of agriculture in growth of GDP is showing consistent decline over the past decade. (4.72 per cent during 1992-96, compared to 2.30 per cent during 2002-2006). The crisis situation in the agrarian sector has resulted in growing income inequities, since incomes of large sections are stagnant or declining whereas a small subset of the population is enjoying very high and growing incomes. This income inequity clubbed with weakening of State intervention in social sectors such as education, health care and public distribution of food grains has resulted in a disastrous situation for the poor, especially those who reside in rural areas.

Access to determinants of health like safe drinking water, hygienic living conditions and food security is directly correlated with socioeconomic conditions. As per NFHS-III² survey findings, 48 percent of the population in urban areas is in the highest wealth quintile; in contrast only seven percent of the rural population being in the highest wealth quintile. Similarly, half of the persons in scheduled-tribe households and about one in four (27 percent) households in scheduled-caste households are in the lowest wealth quintile.

It is essential to examine the inequities in access to determinants of health along with the discussion on inequities in health status and health care access across various groups. (Since each of these determinants requires in depth attention, in its current activity in Maharashtra, the SATHI team has decided to focus attention on one important determinant i.e. nutrition. As a linked activity, we are in the process of bringing out a report on the nutritional crisis in the state). Food security being vital for maintaining nutritional status and health was touched upon in this seminar.

Availability, access, utilisation and stability of food sources which constitutes food security have a direct impact on nutritional status and health. The 61st round of National Sample Survey (2004-05) shows that the daily average per capita intake of food grains and consumption of calories has reduced in successive NSS rounds from 2266 kcal in the 27th round (1972-73) to 2047 kcal in the latest round (2004-05) in rural areas. All these figures are lower than the recommended daily intake of 2400 kcal. Similarly the decrease in urban areas in the same period is from 2107 to 2020 kcal, the latter figure being below the recommended of 2100 kcal for urban areas.

²International Institute For Population Sciences (2005-2006): National Family Health Survey (NFHS-III)

Another key presentation in this session particularly focused on the agrarian crisis in India as it is critical to understand both declining food security and the widening socioeconomic disparities.

This session was intended to outline the broader picture of socioeconomic inequities, so that the discussion on health inequities can be located in the context of our inequitable socioeconomic system and the current model of 'predatory growth', which has been well analysed by Prof. Amit Bhaduri³-

“As the privileged thin layer of the society distances themselves from the poor, the speed at which the secession takes place comes to be celebrated as a measure of the rapid growth of the country. Thus, India is said to be poised to become a global power in the twenty first century, with the largest number of homeless, undernourished, illiterate children coexisting with the billionaires created by this rapid growth. An unbridled market whose rules are fixed by the corporations aided by state power shapes this process. ...

No society, not even our malfunctioning democratic system, can withstand beyond a point the increasing inequality that nurtures this high growth. The rising dissent of the poor must either be suppressed with increasing state violence flouting every norm of democracy, and violence will be met with counter-violence to engulf the whole society. Or, an alternative path to development that depends on deepening our democracy with popular participation has to be found. Neither the rulers nor the ruled can escape for long this challenge thrown up by the recent high growth of India.”

³Predatory Growth, Amit Bhaduri, Economic and Political Weekly, VOL 43
No. 16, April 19 - April 25, 2008

1.1 Overall Socio Economic Inequities and Issues of Food Security- Dr. Jaya Mehta

Dr. Jaya Mehta commenced her presentation by giving an example of Khandwa district of Madhya Pradesh where 137 children died of malnourishment. This incidence was followed by reviewing the implementation of various schemes like PDS, ICDS, and mid-day meal scheme in the district.

Dr. Mehta presented the definition of Poverty given by a taskforce in 1978. This definition stated the essential rural per capita per day intake as 2400 kcal and urban per capita per day intake as 2100 kcal and those who are not able to consume the said amount of food grain were termed as poor.

She stressed that the limitation of this definition is that it fails to cover the expenditure one needs to make on health, nutrition, dwelling and clothing etc. Similarly, no norm on specific nutrient intake such as protein intake etc was taken into consideration while designing this definition. Dr. Mehta further pointed out that planning commission estimates show an alarming gap between these norms and actual consumption. The planning commission estimates would show 1800 kcal as the rural consumption level at the poverty line.

A report by the committee led by Shri. Arjun Sengupta on unorganised sector and vulnerable groups shows 77 percent Indians live on less than Rs. 20 per day which means that very large section of Indians is poor.

Based on the figures in Table no.1 and 2, Dr. Mehta explained that it is seen that there is considerable gap in intake of rural and urban population and there is a difference in current official poverty line and the norm set for both Rural and Urban areas. Thus the issue concerning food security becomes extremely important. She justified her statement arguing that 90 percent people are deprived of adequate food, as ICDS and other

Table 1: Poverty Ratio and Nutritional Intakes- Urban

States	Official Poverty Line (Rs.)	Official Poverty Ratio (%)	Calorie Intake at official Poverty Line (Kcal)	Poverty Line at 2100 Kcal (Rs.)	Poverty Ratio at 2100 Kcal (%)
Andhra Pradesh	542.89	28.0	1733	860	59.1
Assam	378.84	3.3	1582	860	47.7
Bihar	435.00	34.6	2018	485	42.7
Chhattisgarh	560.00	41.2	2012	730	54.4
Gujarat	541.16	13.0	1694	1015	56.9
Haryana	504.49	15.1	1770	1015	59.7
Himachal Pradesh	504.49	3.4	2116	505	3.9
Jharkhand	451.24	20.2	1928	630	36.8
Karnataka	599.66	32.6	1772	1240	74.0
Kerala	559.39	20.2	1488	1100	60.8
Madhya Pradesh	570.15	42.1	1802	860	66.0
Maharashtra	665.90	32.2	1694	1380	76.7
Orissa	528.49	44.3	2080	535	44.7
Punjab	466.16	7.1	1547	930	50.0
Rajasthan	559.63	32.9	1894	730	52.3
Tamilnadu	447.42	22.2	1533	1015	72.6
Uttar Pradesh	483.26	30.6	1793	730	58.0
Uttarakhand	637.67	36.5	1998	730	45.4
West Bengal	449.32	14.8	1729	1190	70.8
All States	538.60	25.7	1833	1015	65.1

Table 2: Poverty Ratio and Nutritional Intakes- Rural

States	Official Poverty Line (Rs.)	Official Poverty Ratio (%)	Calorie Intake at official Poverty Line (Kcal)	Poverty Line at 2400 Kcal (Rs.)	Poverty Ratio at 2400 Kcal (%)
Andhra Pradesh	292.95	11.2	1608	890	88.9
Assam	387.64	22.3	1805	800	88.9
Bihar	354.36	42.1	1912	545	83.8
Chhattisgarh	322.41	40.8	1844	635	89.5
Gujarat	353.93	19.1	1624	890	86.9
Haryana	414.76	13.6	1750	800	62.5
Himachal Pradesh	394.28	10.7	1848	800	66.6
Jharkhand	366.56	46.3	2016	635	89.3
Karnataka	324.17	20.8	1654	890	94.3
Kerala	430.12	13.2	1496	890	62.5
Madhya Pradesh	327.78	36.9	1830	790	92.3
Maharashtra	362.25	29.6	1634	890	88.7
Orissa	325.79	46.8	2059	545	83.3
Punjab	410.38	9.1	1772	890	68.1
Rajasthan	374.57	18.7	1871	690	78.3
Tamilnadu	351.86	22.8	1532	890	89.2
Uttar Pradesh	365.84	33.4	2009	580	73.8
Uttarakhand	478.02	40.8	2066	790	72.8
West Bengal	382.82	28.6	1881	690	81.8
All States	356.3	28.3	1800	790	85.9

Government schemes are incapable of providing two meals a day.

Dr. Mehta drew attention towards the declining employment in agriculture during 1983 to 2004-05. The employment in agriculture and allied industries has reduced by ten per cent in these years, almost all the new employment being in the unorganised sector. She said that agricultural labour has shifted to construction, trade, hotel, financial institutions and services.

To substantiate this point, following statistics were presented by Dr. Jaya Mehta.

Industry	1983	1993-94	1999-2000	2004-05
Agriculture and Allied	68.29	63.89	60.28	58.17
Mining and Quarrying	0.61	0.72	0.57	0.55
Manufacturing	10.76	10.65	10.99	11.81
Electricity, Gas and Water Supply	0.28	0.37	0.26	0.25
Construction	2.25	3.24	4.40	5.57
Trade, Hotels and Restaurant	6.38	7.60	10.26	10.32
Transport, Storage and Communications	2.52	2.88	3.68	3.87
Finance, Insurance, Real Estate and Business Services and Community, Social and Personal Services	8.91	10.65	9.56	9.47
TOTAL	100.00	100.00	100.00	100.00

Analysis of percentage of workers with average daily earning below national minimum wage in NCEUS in 2007 (given in Table no. 5) showed that about 90 percent of the labour force do not earn enough income to fend for themselves.

While explaining the concept of differentiation in Peasantry, she said that one can neither consider market nor peasantry as homogenous entities. Similarly, with the advent of corporate

market in rural areas, for the corporate class the need to develop allies in the rural market economy has emerged. This has certainly affected different sections of the peasantry in multiple ways.

Industry	1981	1991	2001
Agriculture and Allied	99.15	99.24	99.18
Mining and Quarrying	34.44	37.24	49.95
Manufacturing	75.83	76.43	84.51
Electricity, Gas and Water Supply	29.40	23.23	34.77
Construction	72.17	77.95	90.09
Trade, Hotels and Restaurant	96.82	97.77	98.28
Transport, Storage and Communications	55.20	61.60	74.96
Finance, Insurance, Real Estate and Business Services	47.44	52.38	72.87
Community, Social and Personal Services	53.46	59.97	61.81

She further gave an account of the land distribution pattern in the rural economy. She said, about 80 per cent of rural households own less than 1 hectare of land, and including landless and near landless households these contribute to 62 percent of the rural community.

In the new corporate market, the marginal farmers have no scope to get integrated. On this backdrop she argued that, the Government has implemented ITC norm for food grain trade, under which ITC started market houses and opened trading markets. These markets have effectively excluded small farmers.

Dr. Mehta concluded by stressing the need to reinstate cooperatives for the marginal and small farmers although they have had problems in the past which need to be addressed.

Table 5 : Percentage of Workers with Average Daily Earning below National Minimum Wage by Industry and Status

Industry	Rural		Urban		Industry	Rural Casual Workers	Urban Casual Workers
	Regular worker in Unorganised	Regular unorganized worker in Organised	Regular worker in Unorganised	Regular unorganized worker in Organised			
Manufacturing	58.21	57.65	39.20	36.08			
Construction	-	62.23	32.33	24.42	Agriculture	90.46	86.13
Trade, hotels and restaurants	64.06	46.76	45.93	29.12	Manufacturing	71.37	60.68
Transport, storage and communications	36.45	24.94	28.79	24.73	Construction	61.91	40.94
Finance, Insurance, Real Estate and Business Services and	49.65	-	41.35	18.24	Trade, Hotels and Restaurants	65.05	68.22
Public administrations	70.28	72.31	38.64	38.34	Transport, Storage and Communication	59.03	39.49
Education, health and other services	60.88	61.98	57.69	42.35	Education, Health and other services	70.51	73.10
Domestic services	88.21	-	72.66	-	Non Agricultural	64.70	51.94
All Non Agricultural	57.27	56.80	47.20	34.35	All Casual Workers	83.72	57.20

Source: NCEUS (2007)

1.2 Agrarian Crisis in India (Two Dimensions of Crisis) - Dr. Srijit Mishra

Dr. Srijit Mishra began his presentation by stating that the agrarian crisis in India is two dimensional, one is the livelihood crisis and other is the developmental crisis. He primarily discussed issues related to agrarian crisis and agricultural (developmental) crisis and presented following features of the crisis.

- Deceleration in production and productivity.
- Waning profitability and poor returns.
- High dependence of population on agriculture (64% rural persons in 2004-05) - limited non-farm opportunities.
- Low size-class of holdings (63% marginal, 2000-01).
- Decline of public investment in irrigation and other infrastructure.
- Inadequate supply of credit from formal sources.
- Failure of research and extension (rainfed / dry land).
- Changing technology and market conditions have increased uncertainties in product & factor markets.

To support this, Dr. Mishra further presented various findings of the study on farmer's suicides conducted in 2003. The following table was presented to stress the deceleration in Production and Yield over the period.

The study threw light on deceleration in production and yield of various crops in recent years, per capita per day returns of farmers vs. other groups and monthly Per Capita Income/Consumption by Size-Class of Holding of land. The study showed that in 70- 80 per cent of cases, consumption is higher than income. Only medium and large farm owners have more income than consumption. However, the income of the large farm owners is also not substantially high.

Table 6: Trend in Production & Yield of Foodgrains, Oilseeds, Sugarcane & Cotton				
Crops	Production		Yield	
	TE 81-82 to TE 92-93	TE 93-94 to TE 04-05	TE 81-82 to TE 92-93	TE 93-94 to TE 04-05
Total Food grains	3.0	1.0	3.3	1.3
Cereals	3.2	1.2	3.5	1.4
Pulses	1.5	-0.5	1.6	0.1
Total Oilseeds	6.6	0.0	3.0	0.9
Sugarcane	3.9	1.4	1.8	-0.2
Cotton (Lint)	4.2	0.3	4.0	-1.0

TE- Triennium Ending

The study illustrated that Suicide Mortality Rate (SMR) for Male Farmers has been gradually increasing since 1995, it has surpassed the SMR among non farmers way back in 1997 and the difference between the two groups is increasing till 2006. Also, SMR among Male farmers is higher in the state of Maharashtra as compared to many other states with the exception of Kerala.

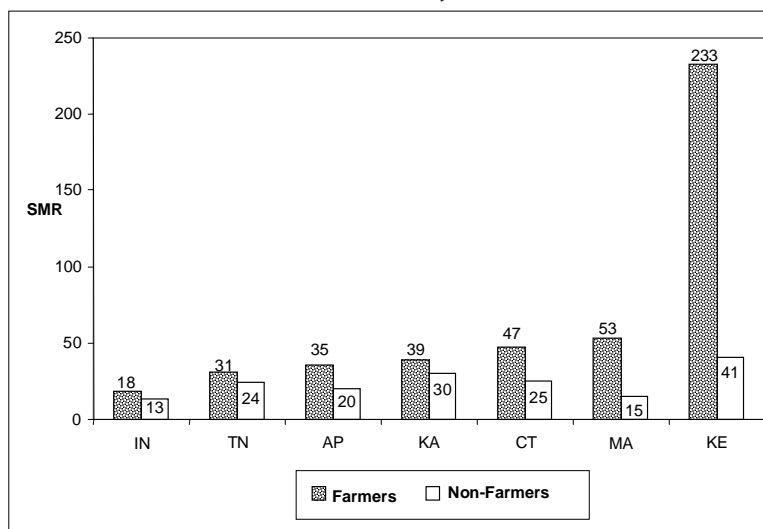
Dr. Mishra cited the following learnings of this study:

- Interventions that are thought to address a part of the risk will also have a cost dimension and instead of reducing the risk it sometimes ends up in adding to it.
- With poor returns, there is a need for an intervention or a mix of products where costs should reduce and returns should increase.

Dr. Mishra concluded the session making following remarks

- There is a challenge of producing innovative products that reduce costs while increasing returns.

**Figure 1 : SMR for Male Farmers and Non-Farmers,
Selected States, 2001-06**



- We have to address larger crisis of low returns and declining profitability (not a piecemeal approach).
- Risk management should address yield, price, credit, income, weather and other uncertainties.
- Water availability should be increased.
- Diversification in farm and non-farm opportunities should also increase.
- Research and extension, rural credit should increase and private providers of input and credit should be regulated.

Concluding remarks by the Chair

Prof. Amit Bhaduri who chaired the session said that urbanization today is a black hole, if we do not improve agriculture and increase job opportunities in general, in

metropolitan cities any amount of urban planning will be wiped out by the migrating population within few years, as in case of Mumbai which has grown immensely in ten years.

He explained that currently there are economic mechanisms by which creation of such black holes is accentuated rather than reduced. This has happened in many countries such as Latin America with large numbers of urban poor. However, one need not conclude that industries should not be encouraged; rather an alternative kind of industrialisation is required.

All these farmers' suicides, agricultural distress, hundreds of protests are symptoms which are correlated to the larger development model, which requires to be changed.

He further opined that it has become extremely important to shift towards strengthening the economy and suggested that the only way towards it is to give Panchayats the power. Nevertheless, Prof. Bhaduri said that it is extremely important to know what instrument one has to create for strengthening livelihoods in rural areas. He further noted that, PRIs need to be given powers of authorization and to encourage associations that need to percolate down with successive Panchayats, so that co-operative ventures could be established. He expressed that today the social situation has become extremely complex. Therefore Panchayats may be more instrumental in effectively addressing people's issues. It is a historical process, and once people recognize their rights they would begin to demand them collectively which he said would definitely make the difference.

Glimpses of the Seminar



Inaugural Session - Welcome by Dr. Anant Phadke



Session on Socioeconomic Inequities in India
L to R - Dr. Srijit Mishra, Dr. Jaya Mehta, Prof. Amit Bhaduri

Glimpses of the Seminar



Session on Perspectives on Health Equity
L to R - Dr. Amit Sengupta, Ravi Duggal, Dr. Abhay Shukla



Session on Gender Dimension of Health Inequity
L to R - Dr. Laxmi Lingam, Ms. Neha Madhiwala, Ms. Renu Khanna

Glimpses of the Seminar



Session on Moving towards a System for Universal Access to Health Care

L to R - Ravi Duggal, Dr. Abhay Shukla, Dr. Muraleedharan, Dr. Sundaraman, Dr. Amar Jesani, Dr. Vandana Prasad



Presentation by Dr. Laxmi Lingam during the Session on Gender Dimension of Health Inequity

Glimpses of the Seminar



Participants of the Seminar



Participants of the Seminar

Session II

Perspectives on Health Equity

Background

The concept of Health equity is a rich and evolving concept, which is not devoid of debates and contention. While the value of applying a health equity approach might be broadly accepted by most researchers and even policy makers, there are differing opinions about the kind of policy options which should be adopted in order to achieve greater health equity. Keeping this in mind, during this session the following areas were dealt with –

- Discussing some key definitions of health equity in order to more clearly delineate what we understand by the health equity approach; distinguishing between horizontal equity (equal resources for equal need) and vertical equity (greater resources for greater need)
- Contextualising health equity, by clarifying that this approach is not a ‘stand alone’ viewpoint, but rather it complements and reinforces the following existing perspectives and approaches relevant to the health sector –
 - Social justice principles
 - Structural analysis of exploitation as the basis for socio-economic inequity; critiquing and posing alternatives to neo-liberal globalization
 - The Right to Health approach
 - Comprehensive PHC approach, integrated health system approaches

- Intersectoral action to strengthen Social determinants of health
 - Community empowerment and community based action for health
- Recognising that a wide spectrum of policy implications can be derived, drawing justification from the Health equity approach. These vary in the degree to which they are focused on certain social sections or take up a comprehensive, society-wide agenda, and the degree to which they take the form of ‘system adjustment’ or ‘system change’. Some measures that may be adopted to strengthen health equity, ranging from ‘sectional’ to ‘comprehensive’ include –
 - Narrowly designed targeting of health benefits to especially deprived sections (often parallel to the ‘poverty reduction’ approach). (targeting in the Indian situation has generally been adopted in the absence of a more comprehensive system to ensure universal access to health care)
 - Sectional programmes, special programmes or schemes for deprived sections (which may be launched in the context of overall inadequate health systems or may be integrated with comprehensive health system strengthening)
 - Developing equitable health care systems / Universal access to health care (which might be in the context of continuing, significant socioeconomic inequities or may be part of a wider social change agenda as in the following point)
 - Developing equitable health care systems linked with processes for basic social change, moving towards a much more equitable socio-economic system

It is obvious that these approaches are not mutually exclusive and there is considerable overlap between them. Nevertheless it is considered useful to understand the serious limitations of targeting, to understand the advantages of comprehensive approaches and to differentiate between various approaches while deciding about which combination may be adopted.

- Identification of the specific value that is added by incorporating a Health equity approach in our work. As mentioned above, the Health equity approach is neither something fundamentally new, nor a ‘stand alone’ panacea for the health sector. It needs to be adopted and developed in conjunction with various complementary pro-people perspectives and approaches within and beyond the health sector. Having said this, there are certain definite advantages that may flow from adopting a Health equity approach –
 - Examining those social sections with best health status, and comparing them with less advantaged sections having worse health status gives us a definite benchmark of what levels of health are definitely and realistically possible within our own society; this can emphasise the need to ‘close the gap’ so that all achieve levels of health status close to that which are today available only to the privileged
 - Especially in societies like India where despite clear increase in overall health care resources, inequities are growing, focusing on health inequities may be a powerful argument for greater redistribution in the health sector
 - The health equity approach powerfully deconstructs ‘averages’ and points out areas and sections of the population which are the most

disadvantaged and require attention. Monitoring of health inequities may be a useful tool to examine how far nominally 'universal' systems are actually reaching the most needy

- The health equity approach draws upon values of social solidarity and compassion, prompting action towards redistributive and universal health systems
- Analysis of continuing, even growing health inequities despite high growth rates of GDP can more fundamentally critique the type of 'growth' model being followed, and can create grounds for championing alternative models of development

In this session, there was also an analysis of the manner in which the recent report of the WHO Commission on Social Determinants of Health deals with Health Equity issues. Concerning the WHO-CSDH report, positive equity-oriented analyses may be drawn upon to strengthen further health equity work, while limitations especially in recommendations need to be critiqued along with a discussion of alternative recommendations.

2.1 Perspectives on Health Equity – Dr. Abhay Shukla

Dr. Abhay Shukla's presentation was based on the basic concepts on Health Equity and it spelled how SATHI looks at the health equity approach.

Dr. Shukla said that there are multiple definitions of health equity. Some definitions are:

- "Inequities are differences in health that are unnecessary, avoidable, unfair and unjust." – Whitehead

- “Equity is the absence of systematic disparities in health between groups with different levels of underlying social advantage or disadvantage.” - Braveman and Gruskin
- Health inequities are “systematic differences in the health of groups and communities occupying unequal positions in society” - Graham
- “Equal opportunity of use of health services for equal need” – Newbrander and Collins

Dr. Shukla advanced his session giving details on different aspects of health equity, and attempted to put the theory in the context. In the beginning he explained the difference between the concepts of ‘Equality and Equity’ and defined two terms- Horizontal Equity and Vertical Equity. He added that, equality (same share for all) can be referred as horizontal equity with assumption of same need for all. In situations like health care, where needs may be widely different, the term equity is more appropriate than equality.

Dr. Shukla added that the ‘Health Equity’ concept is not a stand alone concept. Rather it complements and reinforces other current approaches such as the social justice approach, structural analysis of exploitation, right to health care approach, comprehensive PHC approach and community empowerment.

Dr. Shukla then discussed about different approaches to deal with inequities such as Targeting approach, Programmes for sections with special needs and Universal access to health care. He said that even Universal access to health care would not be enough for countries like India where there are very high socio-economic inequities. We may need some focused schemes for some excluded groups of the population, programmes for sections with special health needs but these must be in the

overriding context of an equitable health care system, and all this in the setting of an equitable socio economic system. Without moving towards such equitable health care and socio-economic systems, targeted special programmes become stop-gap solutions, even substitutes for broader change.

Dr. Shukla then put forth a concept of convergence of inequities across different stratifiers such as caste, class and gender. He gave some illustrations in Maharashtra to emphasize this point. He further said that there is a notion that inequity is a problem only within developing countries and they will deal with it. But in reality it is not so. The inequities between developing and developed countries also need be seen in the context of analysis of global inequities.

Dr. Shukla concluded his presentation by making following points.

- The health equity approach is a powerful tool to challenge unjust differences within and beyond the health sector
- It should be applied in the context of and in conjunction with allied pro-people approaches relevant to health
- It can be used both as a tool for analyzing and monitoring specific health inequities, as well as a method to critique the larger inequitable socio-economic system
- An attempt should be made to take a comprehensive approach rather than a targeted approach. Health equity is not about ‘adjustments’ within the existing health system but about changing the overall health system as well as the larger socio-economic system.

2.2 Analysis of Health Equity as Reflected in the WHO-Commission on Social Determinants of Health (CSDH) Report- Dr. Amit Sengupta

Dr. Sengupta clarified in the beginning that his presentation would not be an adulation of the 'Report of the Commission on Social Determinants of Health' but that it would be an attempt to present the report in the context of equity.

He began by saying that there was a sense of discontent among the WHO and other experts that the Commission on Macroeconomics and Health has reviewed and equated the health aspects merely in terms of economic statistics and outcomes, and have completely ignored social aspects of health. Therefore the need to incorporate the social perspective on health in the report was spelt out. Thus this particular commission was formed. The final report thus talks about closing the gap i.e. eliminating inequities.

Dr. Sengupta expressed that one of the concerns of the commission was the social gradient in health within and across countries which is caused by unequal distribution of power, income, services and goods globally and nationally. The reasons for this unequal distribution are poor social policies and programmes, unfair economic arrangements and bad politics.

Broad recommendations of the commission are structured around 3 points-

- Improvement of circumstances
- To tackle the inequitable distribution of power, money and resources
- Measuring the inequity, evaluating action and expanding knowledge of social determinants

Dr. Sengupta gave a detailed description of the recommendations made by the commission to reduce the inequities as depicted in the report. Then he explained the roles of different social actors in minimizing inequities. These are as follows:

- Multilateral agencies can take up health equity as a fundamental shared goal, ensure that increases in aid and debt relief support coherent social determinants of health policy-making and action and improve participation in global governance.
- The role of National and Local Government is envisaged in placing action on health and health equity at the highest level, streamlining incoming international finance (aid, debt relief) through a framework for social determinants of health, strengthening revenue through improved progressive domestic taxation and measurement and evaluation of the programmes.
- Civil society, Private Health Care Sector and Research Organizations were also seen to have a role in changing the overall picture. Civil society can monitor the performance of the health systems as well as have participation in policy making and planning. The private sector can help by increasing their accountability, commit to research on neglected diseases and sharing of their knowledge for the benefit of the people. The research institutions can participate by generating and disseminating knowledge regarding social determinants of health.

Tracing developments prior to finalisation of the report, Dr. Sengupta then shared some of the core issues mentioned in the Civil Society report submitted to the Commission before the commission came out with this report. In this Civil Society report following suggestions were made-

... ‘The commission needs to look at the existing analysis given by the Primary health care approach and the

negative role of neo-liberal policies in delegitimizing the PHC approach. It was believed that if the commission is looking at the social determinants of health, it is essential for the commission to look back and consider why the Alma Ata declaration in 1978 was not followed by fundamental changes in health and health equity.’

Addressing mere inequality is not enough. The extent of inequality can not give adequate information to assess health equity. Dr. Sengupta mentioned that the commission has considered this suggestion and has put together evidence on inequities within the country with respect to excluded groups, gender etc.

The ultimate goal is not to look for health policies that favour the poor by targeting, but policies should directly address the social determinants responsible for inequitable distribution of resources. There is need to broaden and deepen the understanding about right to health care and to formulate indicators that chart the progress of Governments in safeguarding the right to health.

People’s Health can be ensured in the long term only if people have control over their lives. Empowerment should be seen as a concept that challenges established hegemonies and bases itself in a discourse that recognizes basic rights. It is people who wrest power and thereby empower themselves.

He said that the health sector has created two problems. One is to consider health as health care and another is considering health care as medical care. So often we talk about medical care and not health. Also, historically we look at health as an input to development. But we should look at health as an output of development. If people are healthy it means that development is taking place.

He commented that, the approach taken by the commission is an advance although not a revolutionary step. The report illustrates a powerful analysis and equity diagnosis, both in India and across other countries.

The problem regarding the commission's report is that the report is ahistorical because it looked at the causes of the causes (i.e. social and economic conditions that are responsible for getting disease) and not the causes of the cause of the causes (i.e. the global and national socio-economic structures which are responsible for the socio economic conditions). However this itself is an advance from simply taking into account the causes.

In his concluding remarks Dr. Sengupta commented that it would be strategic for the people working in the health movement to look at the diagnosis given by the commission and to press for focused action at country level, because this opens an opportunity at the country level to put pressure on the Government and other multilateral agencies for demands concerning equity in health.

Session III

Overview of Health Status and Health Care Access Inequities at National Level

Background

After deliberating upon the application of the equity approach in health systems research, it is worthwhile to actually look at the data regarding health status and health care inequities in India. Hence this session brought to light the important statistics as revealed from various rounds of the National Family Health Survey and NSSO surveys. This session also deliberated upon underlying policy related issues such as inequities in health care infrastructure in rural and urban areas.

For example, the World Health Survey India⁴ (2003) report reveals that the availability of health professionals per 100,000 population is greater among urban population compared to rural, among higher income quintile compared to lower income quintile. Physicians are three times higher in urban areas compared to rural areas. The primary work location of the health professionals indicates that almost four-fifth of the physicians (79 percent) are working in private health facilities, whose services are available only to those who can afford their fees.

This inequitable distribution of human resources is one of the examples of the underlying processes which result in health

⁴Health System Performance Assessment, World Health Survey, India, 2003, IIPS, WHO

status and health care access inequities. Similar inequities can be shown in budgetary allocation for public health in urban and rural areas.

The report of Commission on Macroeconomic and Health indicates⁵,

“In India, as in most countries, there is a clear urban-rural, rich-poor divide. Affluent sections, urban populations and those working in the organized sector covered under some form of social security such as theESIS or CGHS, have unlimited access to medical services. The rural population and those working in the unorganized sector have only the tax-based public facilities to depend on for free or subsidized care, and private facilities depending on their ability to pay. The impact on equity then gets determined on whether the tax-based public facilities are able to provide a similar quality of care as provided under the Social Health Insurance Scheme. Because, if funding is low and the quality of care falls below expectation, is inaccessible, entails informal payments, etc. then the benefit of free care at the public facility gets neutralized with the second option of paying out-of-pocket to a relatively hassle free private provider available close by, making the system of financing inequitable as well as inefficient.”

This session threw light on the extent of inequities in health status and health care access, while elaborating on some of the processes which are the cause of these inequities.

⁵Background Papers of the National Commission on Macroeconomics and Health, Ministry Of Health And Family Welfare, Government Of India, 2005

3.1 Health Inequality in India: Evidence from NFHS-III - Dr. U S Mishra

Dr. Mishra made a presentation based on a paper regarding the health inequities that emerged from analysis of data from NFHS-III. The presentation gave an interesting exposition of how to relate income inequality to health inequality.

Dr. Mishra informed that the purpose of this paper is to use secondary level data on the basis of which inequity can be computed, and the analysis can also be used for adjustments of aggregate indicators.

In his presentation, Dr. Mishra explained fundamental aspects of measuring health inequities in the Indian context. He vividly explained relevance and motivation, methods, data and indicators, results, income-related inequalities. His exposition focussed on the relationship between income and health inequality. Dr. Mishra underlined the importance of studying both the actual income levels and the income inequalities together while studying health inequalities.

While talking about methods, he spoke about use of Concentration Curve and Concentration index. His presentation was mainly based on the data from NFHS-III. The analysis was done on the following indicators:

- Survival indicator- Under-five mortality
- Health Promotion indicators- Undernutrition (Stunting, Underweight, Wasting and Anaemia)
- Prevention indicators - Immunization Status, Diarrhoea

The conclusions of this exercise of studying health inequalities and income inequalities were:

- There is a need to contemplate over measurement of health deprivations
- Distribution-sensitized measures offer better policy inference
- Some States need a much more focused policy approach
- There is a need to think about how to reduce health inequalities when income and income inequalities are higher
- Inclusion of non-income domain is important
- Need to learn from the better performing States

3.2 Health Policies and Inequities- Ravi Duggal

Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade – it becomes a public function of the State.

- Henry Sigerist

Mr. Duggal gave this quotation as a preamble and said that it is essential to look at constant development in India as health policies play a larger role in the development paradigm and quoted Rupert Gustov “There is a direct connection between the social and economic conditions and health.”

On speaking of the Development Paradigm, he said India’s constitution mentions “Socialist” pattern of development in preamble. However in the limited entitlements approach, there is no legal mandate for right to healthcare. He remarked that on

the contrary, support to private capital growth has been the larger economic paradigm. The planned development actually facilitated the growth of private capital which has become the basis of rural-urban planning divide.

He pointed out that there are two different development strategies applied for rural and urban development- Community Development Plan (CDP) in rural areas and Industrial and economy development in urban areas. Therefore, the programmes that these policies design, suit this framework, continuing the rural-urban gaps regarding the health outcome indicators or indicators of education or poverty.

The Bhore committee report stressed the need for a national health care system which would make private sector redundant; however it was never adopted and the colonial continuum was continued in new form. It focused on a programmatic approach that promoted an 'enclave pattern of development'.

Mr. Duggal explained that health and medical care is a state subject, whereas public health measures, communicable diseases, family planning all come under the Central government. He added that since the beginning, India has developed vertical programmes (e.g. - malaria control programme and small pox eradication programme etc) which has compounded rural-urban dichotomy. Medical care is neglected especially in rural areas. The dichotomy has continued and is not addressed by the major policies.

Mr. Duggal said that until 1990s, the private sector could not compete with the kind of public medical services and medical care provided in public hospitals in metros like Mumbai and Delhi. He further added that it is important to understand that Private sector has built on the weaknesses of public sector in many places.

Mr. Duggal said that until 1983, India did not have separate health policy which could bring in all the issues related to health. It came into being after the Alma Ata declaration that stated that the Government should develop a health policy. The first National Health Policy of 1983 was comprehensive, however the broader socio-economic policy trend was not favourable since subsequently larger neo-liberal economic reforms were carried out.

Mr. Duggal expressed that under the recent Common Minimum Program, the National Rural Health Mission (NRHM) tried to bring all the vertical programmes under common umbrella, but structurally it failed. He said that NRHM has succeeded in politically giving priority to the public health system, but there were no major structural changes and therefore it could not make adequate impact.

He further analysed disparities in availability and utilization of health facilities across rural- urban areas, gender, class and caste dimensions in India.

Mr. Duggal concluded his presentation by talking about the following changes that are needed so that equity in health can be achieved.

- Restructuring and reorganising of the health care system with a mix of Public and regulated Private health care systems.
- Single payer financing strategy – need for multi-stakeholder public agency
- National Health Legislation and constitutional mandate – universal social security

- Reining in the private sector – regulation and control under public domain
- Changes in governance and management of the health system – decentralization and autonomy
- Community and local government oversight and monitoring/audit
- Raising public spending to at least 3% of GDP for Health and Healthcare
- Ensuring universal access to Health care.

Concluding remarks by the Chair

Dr. Narayana said that both the presentations and the discussion that followed were very interesting. He said that Dr. Mishra demystified some of the numbers and added that his presentation helped us to understand the perspective and analysis behind the graphs and tables.

He opined that in the example on Rajasthan and Kerala, the lesson one can learn from comparing Rajasthan and Kerala is that the state needs to allocate more public resources to the poor. Kerala, he said is a celebrated model but when one looks at the CC index, one realizes that the situation is not very equitable therefore something needs to be done. He further added that the message given by Dr. Mishra is very clear, one needs to move away from aggregate measures, as they hide more than what they tell us. Value judgment is behind equity, he said, so what is equitable for one situation is not equitable for the other.

Session IV

Gender Dimension of Health Inequity

Background

The first session on the second day of the seminar was dedicated to understanding the gender dimension of health inequity. Gender inequities often include both types of inequities i.e. vertical inequities as well as horizontal inequities. Moreover, women have to face additional health risks due to the inferior status ascribed to them by society. Gendered division of workload, reproductive responsibilities coupled with inadequate nutrition and violence make women further vulnerable to ill-health. Gender inequities in access to health care and health status are based on gender inequities reflected in the health system, and inequitable distribution of resources within the community as well as within the household. It may also be kept in mind that gender interacts with socio-economic status, and these key stratifiers may interact with each other. As noted by Aditi Iyer⁶ et al –

“Responses to long-term ailments showed elements of class inequalities as well as both types of gender bias-pure and rationing. These class variations can themselves be properly understood only through a gender lens. Apparent class differences in non-treatment, discontinuation, or continuation of treatment were almost entirely due to differences among women rather than men. ...

⁶The dynamics of gender and class in access to health care: evidence from rural Karnataka, India by Aditi Iyer, Gita Sen and Asha George- International Journal of Health Services, 2007;37(3):537-554.

Rationing through discontinuation of treatment was an important phenomenon and was particularly gender-biased among poor households in quintiles 2 and 3. Men in these households seemed to be able to insulate themselves and to pass on the burden to women. However, in the poorest households, where women perhaps could be pushed no lower, men were also forced to curtail treatment. This shows just how acute the problem of health care affordability has become, and how rationing systems at work within households reproduce gender and economic inequalities.”

The Report of the Women and Gender Equity Knowledge Network⁷ (WHO Commission on Social Determinants of Health) highlights the role of gender in strongly interacting with other axes of inequity -

“Gender intersects with economic inequality, racial or ethnic hierarchy, caste domination, differences based on sexual orientation, and a number of other social markers. Only focusing on economic inequalities across households can seriously distort our understanding of how inequality works and who actually bears much of its burdens. Health gradients can be significantly different for men and women; medical poverty may not trap women and men to the same extent or in the same way. The standard work on gradients and gaps tells us easily enough that the poor are worse off in terms of both health access and health outcomes than those who are economically better off. But it does not tell us whether the burden of this inequity is borne equally by different

⁷Unequal, Unfair, Ineffective and Inefficient-Gender Inequity in Health: Why it exists and how we can change it- Final Report to the WHO Commission on Social Determinants of Health, September 2007- Women and Gender Equity Knowledge Network, Submitted by Gita Sen and Pirooska Östlin

caste or racial groups among the poor. However, it does not tell us how the burden of health inequity is shared among different members of poor households. Are women and men, widows and income-earning youths equally trapped by medical poverty? Are they treated alike in the event of catastrophic illness or injury? When health costs go up significantly, as they have in many countries in recent years, do households tighten the belt equally for women and men? And are these patterns similar across different income quintiles? This poses a challenge for policy to ensure not only equity across but also and simultaneously within households.”

These are some of the challenges which necessitate specific attention to gender inequities in the context of other dimensions of health inequity. Thus this session was aimed at taking stock of the situation in India regarding the concerns articulated above.

4.1 Gender and Health Inequities: Key Issues for Research and Advocacy- Dr. Lakshmi Lingam

Dr. Lakshmi Lingam started with mentioning the fact that there are other aspects to women’s health than reproductive health care issues. She added that, we have to look at access to basic health care issues which are missing in the dominant RCH framework. She proposed a term ‘Missing Access’ for these. She said that another term, ‘Misguided Access’ pertains to creation of artificial choice for medical technologies and interventions. She added that, issues to deal with availability of safe drinking water, sanitation facilities and safe fuel and a large number of untreated morbidities are of concern regarding missing access. Over- medicalisation and unethical medical interventions (e.g. increasing number of caesareans and hysterectomies) are issues of concern regarding the misguided access to health care.

Dr. Lingam also pointed at the epidemiological transition the country is experiencing. Obesity among the rich is a well known fact. However with the changing scenario, proportion of obese women among the poor is also increasing and thus there is an increased load of non communicable diseases.

Dr. Lingam gave several examples regarding the problems of over nutrition and undernutrition affecting different sections of women at the same time. These were:

- Under-nutrition and overweight / obesity are both higher for women than men
- Malnutrition levels are higher among young girls. Almost half of the girls in age 15-19 are undernourished. Undernutrition declines and over nutrition increases with age of women
- The prevalence of under-nutrition is nearly two times higher among women with no education than among those with 12 or more years of schooling. The prevalence of overweight and obesity is three times higher among women with 12 or more years of schooling than those with no education.
- More than half of women in the lowest income quintile are underweight. In contrast, almost one-third of women in the highest income quintile are overweight or obese.

Dr. Lingam mentioned that a few areas need to be closely examined. These include:

- Shifts in the diets of poor are linked to shifts in costs and availability of food through PDS. Since the 1980s, Government is supplying rice and wheat across the country which has changed the diet pattern in many parts of the country.
- Increased consumption of carbohydrates and fatty rich oils- Introduction of Palm oil through PDS.

Dr. Lingam emphasized that a process of nutritional transition is taking place in the developing world. As countries are moving from low levels of development to high levels, people are shifting from, unprocessed food to more processed, packaged, easily available food having high levels of sodium and rich in fats.

4.2 Gender Inequality as Reflected in Health Research- Ms. Neha Madhiwala

Ms. Madhiwala presented the various mechanisms by which patriarchy, through the systems like household, markets and the state agencies, perpetuates gender inequities. She drew attention to the fact that gender inequities are not just the gaps between men and women but we need to look at the gap between aspirations of women and opportunities for them, between need (as defined by the state or the health system) and the actual need and access and also between rights, entitlements and provisioning. She emphasized her points through several examples from her research.

She mentioned findings of one of the studies showing that more adolescent girls feel themselves entitled for freedom (regarding going to school, going outside village, working outside village after puberty etc.) than the boys in the same age group. But in reality same girls have less chances of enrolment in schools, more chances of getting engaged with the household chores only. This explains the differences between aspirations and opportunities for them. Also, the gap between aspirations and the opportunities goes on increasing as the girls grow older.

She further added that, for girls, adulthood is attained along with greater integration in the family, through intensification of labour and voluntarily prioritizing family needs over their own.

Thus, autonomy in other spheres of life does not necessarily reflect in greater care for themselves.

Similarly, she gave examples of case studies showing the gaps in need and access, entitlements and provisioning. These examples clearly showed how patriarchy operates differently in different situations.

Concluding remarks by the Chair

The chairperson of the session Ms. Renu Khanna shared her remarks. She said that one needs to look at the conceptual framework in respect to gender disparity, and assess whether it is simply sex differential (men & women), or is it one looking at sex as binaries, or is one considering sexual minorities such as transgender and inter-sexes, this needs to be clarified.

Ms. Khanna mentioned that just as one is looking at disaggregation of wealth quintiles, looking at poor and not so poor, and one is considering rural and urban, one also needs to look at social groups of women such as single women and to understand their issues, and actually capture that with available data. She further suggested that if one is considering gender inequality in health and gender structures in health then studies on these issues are available to explain, nevertheless one needs to capture dynamics, and have quantitative and qualitative tools to explain it.

Ms. Khanna raised an issue regarding engaging in understanding patriarchal framework of delivery systems which are resulting in health inequities as part of outcomes. She further added that advocacy is essential and policy makers' needs to be included in this kind of discussion. She concluded her remarks with an example of number of hysterectomy cases observed in Baroda in younger women between the ages of 24 -27, she stressed that it is not an issue of older women. Therefore it becomes essential to research some of these aspects.

Session V

Moving towards a System for Universal Access to Health Care

Background

While discussing inequities in access to quality health care, in the Indian context we are confronted not only with inequities emanating from the public health system, but more importantly the inequities generated by predominance of the much larger private medical sector. As we know, the private medical sector in India commands nearly 80% of allopathic doctors and provides about 80% of outpatient care and 60% of inpatient care. Due to charging of fee-for-service by almost the entire private medical sector and low insurance coverage, this situation translates into massive class based and urban rural inequities (which overlap with and reinforce each other) in access to health care. For example, according to NSS 60th round⁸ data, in rural areas 24.1% persons in the poorest MPCE class reported non-treatment of ailment spells, compared to only 5.5% in the richest MPCE class in urban areas. In rural areas, financial constraints were cited as reason for non-treatment of illness episode by 28% of those who had not availed of treatment (NSS 60th round, 2004), this proportion having increased from 24% in the previous NSS round⁹ (NSS 52nd round, 1995-96).

⁸National Sample Survey, NSS 60th Round, Consumer Expenditure, Employment- Unemployment, Morbidity, Health Care & Condition Of The Aged, January' 2004-June' 2004, National Sample Survey Organisation, Ministry Of Statistics And Programme Implementation, Government Of India

In this situation, there is a clear need, along with strengthening the public health system, to devise methods of regulating and harnessing the predominant private medical resources in a manner that rational health services become available to all without any constraint of ability to pay. This envisages moving towards a system for universal access to health care which would ensure equity in access to health care.

Keeping this in mind, in this session of the seminar the following aspects were envisaged to be discussed-

- Modes of regulation of the private medical sector, with a view to rationalizing and harnessing private sector resources towards a system for Universal access to health care. Legal regulation to ensure minimum physical and human power standards in private facilities is conceptually relatively straightforward, yet even this long overdue measure is yet to be implemented across the country. Further the more complex yet crucial issue of regulation of rationality of care needs to be tackled urgently and decisively, since curbing of large scale over-medication and irrational medication, over-investigation, unnecessary surgeries etc. would lead to both major reduction in overall health care expenditures as well as better health care outcomes.
- Modes of interaction between the public health system and the private health sector towards universal access. Here in contrast to the dominant form of 'Public Private Partnerships', we may like to explore forms of public control and accessing of private medical resources which expand access to health care in a rational and equitable

⁹National Sample Survey, NSS 52nd round, Consumer Expenditure, Education, Health and Aged in India, July' 1995 -June' 1996, National Sample Survey Organisation, Ministry of Statistics and Programme Implementation, Government of India

manner. Here, for example, the criterion of strengthening Public health facilities (as possible in specific types of in sourcing of skills) instead of weakening the public health system (as seen in most types of outsourcing), may need to be considered.

- Discussing the features of an equitable health care system, such as¹⁰-
 - Adopting a policy goal of universal coverage
 - Ensuring that Public funding plays a central role in the entire system
 - No fees or nominal fees being charged for public / publicly managed services
 - Offering a comprehensive set of health care services, ranging from primary to tertiary services
 - Ensuring that the private sector operates in a framework which is regulated by the public health system, fulfils public health goals and complements the public system rather than weakening or diverting from it
- Looking at some of the issues to be considered while designing a system for universal access to health care, which encompasses the private medical sector:
 - Financing options (such as tax revenues, mandatory health insurance)
 - Options concerning provision of services (arrangements with various public and private providers)

¹⁰Adapted from 'Challenging Inequity through Health Systems', Final Report of Knowledge Network on Health Systems, June 2007, WHO Commission on the Social Determinants of Health

- Pooling of funds and combination of existing schemes (e.g. ESI, CGHS)
- Mechanisms for regulation, for ensuring quality and rationality of care, and participatory, community oriented monitoring
- Some key experiences of processes in other developing countries (e.g. Thailand, Brazil, Costa Rica, Sri Lanka) which have achieved universal access to health care may also be touched upon in the discussion.

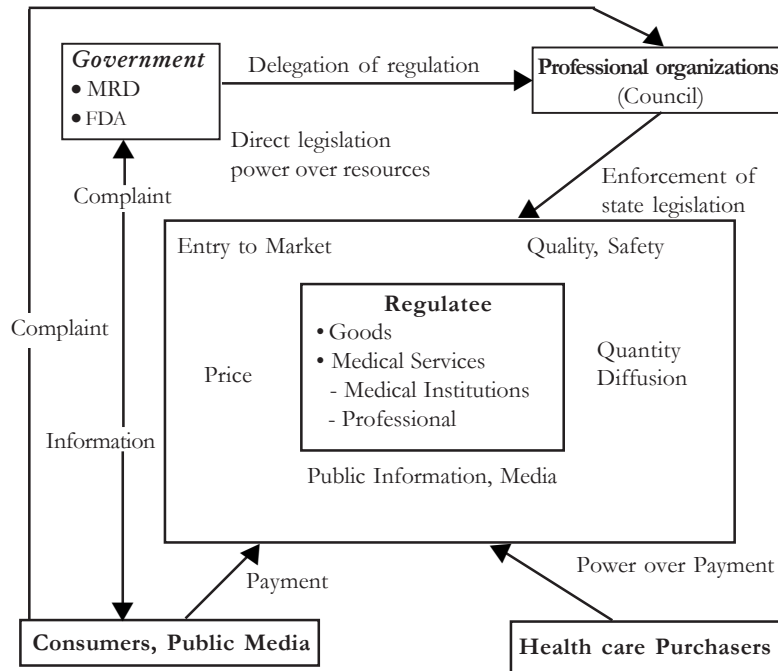
5.1 Regulation and Harnessing Private Sector Resources towards a System for Universal Access to Health Care- Dr. Muraleedharan V. R.

Dr. Muraleedharan clarified in the beginning that his presentation would be more of perspective presentation and would emphasize on empirical content drawn from his work. Dr. Muraleedharan began with putting up six generic questions regarding regulation viz. why Regulate, what to regulate, how much, who regulates, by what process, and has regulation worked.

Dr. Muraleedharan explained the rationale behind demand for regulation. He said that there is rampant commercialization, supplier-induced demand and medical negligence resulting in increasing the gap between public expectations and reality of what the health care system can deliver.

He further explained the Conceptual Framework for Health Sector Regulation prepared for Thailand by Viroj et al in 2003 illustrated in the diagram below and said that we can apply it to a country like India.

Conceptual Framework for Health Sector Regulation (Viroj et al., 2003)



Dr. Muraleedharan then talked about some of the enabling measures such as policies regarding technical support to the Private Sector such as trainings, dissemination of guidelines, providing incentive for improved performance and provision of financial subsidies through low interest loans and tax etc.

Dr. Muraleedharan further said that while addressing the question ‘has the regulation worked?’ we have to look at the content and design of regulation and the enforcement mechanisms. He gave examples of two laws regarding this. First was Transplantation of Human Organs Act 1994. Preamble to this act states that

“...to provide for the regulation of removal, storage, and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs”. He said that this Act can be misused by certain people giving example of Kidney Transplant. He mentioned that there are several ways in which a person can produce evidence that a person is willing to donate his or her kidney because of love or affection.

Another example was of Consumer Protection Act 1986/1995 which says, “...to provide legal protection to patients who suffer from “negligence and deficiency in health services” that they receive.” Dr., Muraleedharan said that the terms ‘negligence’ and ‘deficiency in health services’ need to be given more attention from the regulation point of view.

Dr. Muraleedharan mentioned that there is empirical evidence regarding these two laws which shows that because of the lack of supportive framework, access to legal avenues has been limited. The entire process becomes very costly because of the nature of regulation.

Dr. Muraleedharan concluded by saying that ill-designed regulation can increase the inequities in access to care and sometimes laws or acts which are supposed to be regulatory can actually aggravate the situation looking at it from an equity perspective.

5.2 Modes of Interaction between Public and Private Health Sectors towards Universal Access- Dr. T. Sundararaman

Dr. Sundararaman started his presentation with the definition of ‘Health System’ mentioned in World Health Report, 2000 and the objectives of the health systems. He posed five key points regarding the need to interact with Private sector. He

said that it is important to establish a link with the Private sector because it plays a dominant role in Curative health care and has potential to reach many people. He added that Private sector provides specialized services to people and it could complement the public health system. Furthermore, interaction is also needed because the State has a role in ensuring the quality and reasonable costs and preventing unfair practices. Also, it is the responsibility of the State to protect the poor from high cost of care and from economically catastrophic illness.

Dr. Sundararaman then differentiated highly complex, moderately complex and simple organizations in private health care sector. He further divided each of these organizations into three types viz. for-profit healthcare providers, non-profit healthcare providers and voluntary healthcare providers and showed the characteristics of each of these.

Dr. Sundararaman then described what would be an ideal Public Private Partnership (PPP). He mentioned that for a relationship between government & private sector to be genuinely called a PPP, it must be based on shared objectives, shared risks, shared investments and participatory decision-making. He said that most of the examples of PPP that we are currently seeing in India are nowhere close to this definition.

He mentioned the consensus principles of PPP in health sector that came out of the Peoples Alternate Health Plan. The five consensus principles of PPP in health sector as he mentioned were:

- The PPPs should be Pro-poor:
- Effective monitoring mechanisms should be in place.
- Both quality and costs should be monitored.
- The PPPs should be output based and cost effective – decided by fair process.

- Payment to private provider must be made promptly and with dignity.

Four more perspective based principles were:

- Pro-poor investment and services provided in public health sector should be expanded and public sector should not be substituted by private sector.
- The PPPs should not weaken public health system but should contribute to its strengthening.
- “Efficiency” should not mean disregard for equity – especially as regards labour laws and workers rights within providing institutions.
- The PPPs should differentiate between contractual terms concerning the for-profit and not for profit providers.

Regarding the supply side partnership, Dr. Sundararaman gave several examples of outsourcing ancillary and auxiliary services as a part of PPP. He said that the experience of this outsourcing is mixed. The problem lies in defining and monitoring of services. In places where governance is weak there are experiences of weak contractual arrangements.

Another area where PPPs are done is outsourcing of key supportive functions typically with NGO involvement. E.g. - ASHA programme, Community processes and mobilization etc. the idea behind the partnership is that the local organizations or NGOs would arrange for the logistics of the programme and training whereas the trainers would be from the government. The major problem he stated regarding this issue of outsourcing functions is the poor designing of the programme.

He gave an example of training of ANMs in PPP mode which has strengthened the public health system and contributed in a way in which the investment was most effectively utilized. Based on partnerships with few private nursing homes and establishing

some ANM training centres in the state, the West Bengal government has been able to fill the gap of around 9000 ANMs within a period of three years.

Another variety of PPP as he mentioned was the outsourcing of services in key geographic areas which have suffered because of extremely poor design. The emerging mode of PPP is the facility management contract where a Subcentre, PHC or CHC is outsourced. In some places like Karnataka, this is managed by a local trust. The major problem in this kind of partnership seen in some places is that the salaries that are given to the staff are less than the government salaries. So whenever government posts become available, they tend to leave the job for better salary. This kind of outsourcing also faces problems because of very poor contractual arrangements.

Dr. Sundararaman further discussed examples of Social Franchisee Models such as Janani, Parivar Seva Sansthan, and Marygold chain.

Regarding demand side financing, he mentioned different modes of financing such as accredited centres with patients' reimbursement, accredited centres with direct provider reimbursement which includes Chiranjeevi and EMRI, accredited centres in voucher scheme and accredited centres with insurance provider reimbursement.

He concluded his session saying that overall PPPs in the Health sector in India are not doing well. However there are very few examples which have done well- most of them are related to strengthening public sector. He further added that outsourcing of auxiliary and ancillary services will continue although it needs to improve the terms and outcomes and explore alternatives. Dr. Sundararaman then expressed that there is a need to regulate private sector and considered that a successful insurance programme would change the situation.

5.3 Options for a Universal Access System in India

- Dr. Abhay Shukla

Dr. Abhay Shukla commenced his presentation by discussing the features of equitable healthcare systems. He said that in an equitable health care system, policy goal is of universal coverage, public funding plays a central role, no fees are charged for public services, comprehensive health services are offered and policy and regulatory action ensures that private sector contributes to universal access. He further said that universal access to health care means that everybody in a country can access the same range of services based on their needs, in which beneficiaries contribute to the services based on their income (by taxation) and no one is denied the treatment based on their inability to pay.

Dr. Shukla gave examples of two countries viz. Thailand and Brazil which can be considered while dealing with the peculiar situation in India.

He discussed how Thailand moved from a targeted model towards the universal coverage scheme. The situation in Thailand is different from India in that the proportion of Public hospitals compared to Private is quite high. Another important feature is that they have mandatory rural service for all doctors passing out from the medical colleges for three years. There is a well developed district health service and because of weak presence of private health care in rural areas the public health system is the main provider of health care in rural areas. He added that because of the effective referral system that has been established in Thailand during last few years, there is a marked shift in the utilization of services from regional or general hospitals to the smaller health centres.

Another example was of Brazil, where previously the health system was highly privatized like in case of India and there was

no public control over health policy. The universal system of health care provision was started in 1988. Presently in Brazil three health systems are coexisting.

- The SUS, which provides free care to all residents in the country (covers 75% of population)
- The Supplementary Health System (SHS) run by private healthcare insurance companies or health cooperatives (covering 35 million paying members)
- The Private Health System (PHS), totally private, used only by the highest-income population

The landmark of the Universal system of health care is the community participation. There is decentralization of this system to the municipal level. There is a functioning network of Health Councils at the municipal, state and national level. Most of the decisions on healthcare such as budget, construction of health facilities, implementation of health programs, etc., must be approved by health councils. Two thirds of health care spending is public where as one third is privately funded.

While discussing the options for moving towards a universal access system in India, Dr. Shukla said that a large scale social process combined with proactive political intervention is required. He then spelled out the need for universal access system.

Dr. Shukla said that regarding Health care India has a peculiar situation. There is a very large, predominant, stratified private medical sector. There is a complete lack of regulation of medical practices which has resulted in large scale irrationality in health care. In most urban areas, there is weak public health provision and in rural areas more emphasis is on preventive and promotive services. The middle class has largely opted out of publicly managed health services and vast majority of workers are in

informal sector with relatively small formal sector, leading to low employment linked Health care coverage.

He suggested some financial options for operating the system of Universal access. He said that consolidated pools of financing should be built which should be managed by an overarching publicly managed body. There should be mandatory contribution from all the tax payers. All people working in organized sector should have some mechanism for contribution from employers as well as employees (moving beyond present ESI), and the rural population should be provided for by tax based funding.

He further said that there should be block, district, state and national level health authorities and participatory bodies, and the funds and services at respective levels should be mainly managed at that level itself, based on common principles and norms.

Discussion- Dr. Amar Jesani

Dr. Amar Jesani shared his remarks with the experts and said the paradox of this whole issue is political will, and so without parallel struggle issues related to regulations cannot be discussed. He further said that the issue is how one defines equity. He pointed out that the presentations did not identify issues of BPL etc. and that there is a need to identify equity indicators which have not been spelt out clearly in any of the frameworks such as ICDS etc. He further added that some references have been made to poverty and one needs to define it from geographic, comprehensiveness, application to women and marginalized group's point of view.

He concluded saying that it is believed that people's health is in people's hands. But one needs to understand the construct of concept of the 'people', whether they are public or private or both; this he said is essential in context to people's health movement.

Session VI

Health Equity Issues Related to NRHM

Background

NRHM is a major programme to improve rural public health services, introduced by the UPA government in April 2005. One of the objectives stated in the mission document of National Rural Health Mission is that NRHM seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

The NRHM - 'Framework for Implementation' document mentions that¹¹ -

“Promoting Equity is one of the main challenges under NRHM. Empowering those who are vulnerable through education & health education, giving priority to areas/ hamlets/households inhabited by them, running fully functional facilities, exemption for below poverty line families from all charges, ensuring access, risk pooling, human resource development / capacity building, recruiting volunteers from amongst them are important strategies under the Mission. These are reflected in the planning process at every level. Studies have revealed the unsatisfactory health indicators of socially and

¹¹ NRHM Framework for Implementation, 2005-2012, Ministry of Health and Family Welfare, Government of India

economically deprived groups and NRHM makes conscious efforts to address this inequity. The percentage of vulnerable sections of society using the public health facilities is a benchmark for the performance of these institutions.”

Keeping this context in mind, this session aimed at discussing the strategies enunciated in NRHM to address health inequities in India, and examining the specific strategies and extent to which NRHM is addressing the massive challenge of reducing inequities in health status and access to health care in India.

To emphasise a community-oriented perspective, this session also took into account the findings of the People’s Rural Health Watch report, which is a Jan Swasthya Abhiyan initiative to audit the performance of health services in rural areas, with a focus on NRHM.

Dr. Raman Kutty opened the session saying that it is appropriate to have a seminar on health equity on the 30th anniversary of Alma Ata and primary health care observed last month. Primary Health Care is about equity. It is one of the major concerns, primary consensus and policy statements that have emerged at international levels on universal access to equity. NRHM is one of those policy measures which has been designed to address inequity at a very basic dimension to address issues of inequity at rural levels. If one looks at the statistics whether it is investment in health, outcome as indicator or output in health the rural urban divide is getting more and more evident. NRHM is focusing on it. It is the most important recent policy decision of the government concerning health.

6.1 Health Equity Issues in NRHM: Evidence from People's Rural Health Watch (PRHW) Report- Indira Chakravarty

Ms. Chakravarty presented issues concerning health equity in NRHM. She gave the definition of equity as given by International Society for Equity in Health which states that health equity is 'the absence of systematic and potentially remediable differences in one or more aspects of health across populations or groups of populations defined socially, economically, demographically or geographically'.

Ms. Chakravarty said that NRHM-

- Acknowledges existence of disparities in health status and access to health services
- States access to integrated comprehensive primary health care as one of its goals
- Seeks to provide universal access to equitable, affordable and quality health care, which is accountable, responsive and deals with access to primary health and
- Promotes equity and takes it up as a challenge of the Mission

She explained that NRHM has succeeded in attracting attention and has roused people's aspirations. It is a health program that is implemented after over a decade of 'Health sector reforms'. She said that NRHM has constituent like universal access to health care and primary healthcare which has received mass appeal.

Ms. Chakravarty said that NRHM has laid down specific goals, outcomes and strategies and prepared detailed operational

framework for its implementation. The measures that are taken in this programme are as follows:

- The statement of intention to provide universal access to rural people to effective, equitable, affordable, and accountable primary health care.
- The commitment to increase central budgetary allocation for health.
- The acceptance at the policy level of having a community health worker at the village level, and the appointment of ASHAs, despite the limited conceptualization.
- The formulation of Indian Public Health Standards (IPHS), despite the limitations.
- Increasing number of nursing staff; move towards having 24X7 PHCs.
- Untied funds and maintenance grants for health facilities.
- Mainstreaming of AYUSH into the rural health system.
- District has been given a predominant position, as the center of decentralized planning and action.
- Inclusion of accountability and monitoring mechanisms

With this background Ms. Chakravarty presented some findings from field Survey and Policy Analysis that was undertaken as Jan Swasthya Abhiyan's PRHW activity to review the performance of health services in rural areas, with a focus on NRHM as well as discussed different facets that would help strengthening the Mission. Some of the observations were as follows:

- Continued provision of a limited package of services, periodic health melas or visits by mobile units, rather than equipping for comprehensive services.

- Availability of increased funds has had a mixed effect - enabled improvements in some facilities by innovative Medical Officers. However, such changes are not generalized.
- Not very effective in addressing the basic problems that persist – lack of essential medicines, doctors and support staff and transport.
- NRHM considered by field level health functionaries to be synonymous with ASHA and JSY.
- ASHA role restricted to mobilizing women for institutional delivery and family planning operations and as assistant to ANM for immunization and ANC.
- Inadequate/lack of training, not much infrastructural and back-up support, to ASHA to function as health worker (such as no drug-kit).
- JSY – incentive-driven – poor quality of care and lack of transport for pregnant woman, defeating the very purpose of institutional delivery.
- Measures such as ASHA, upgrading to FRUs- BEMOC-CEMOC-24x7 units, all geared only for delivery and services for pregnant women – not equipping for comprehensive health services – emphasis only on selected RCH services continues.
- Human resources: focus only on increasing nursing personnel. Same formula of ad-hoc, contractual appointments-redeployment-multi-skilling, despite problems (TN, and MP-Gujarat: CBHI report 2007). Attrition of contractual staff quite high.
- Access to essential drugs – simplest of medicines- chloroquine, IFA, antibiotics, not available regularly; patients having to buy medicines (despite parallel procurement mechanisms).

- Rate of budgetary increase has slowed down after the initial 30% increase.
- The increase in finances for health still is largely going for family welfare - RCH, pulse polio and AIDS control programme get the bulk of the allocations

NRHM needs to be analysed in the context of several reform measures that have been going on since the past decade with WB and donor assistance—privatization, contracting, outsourcing, hiring consultants, etc. All these have been critically analyzed by public health experts for their impact on equity in health.

Ms. Chakravarty added that it is important to observe how NRHM contributes in addressing inequity and suggested that it may contribute in implementing ASHA program properly. She opined that in the long run one needs to ponder upon the process of the activities undertaken under public health system strengthening since privatization options have also been listed in priority list. Therefore, she said that NRHM needs to deal with such contradictions, and ensure clarity on ideas about programs such as individual insurance, privatization etc. which run counter to the comprehensive health care objective of NRHM.

6.2 Equity Concerns as addressed in NRHM – Dr. T. Sundararaman

Dr. T. Sundararaman questioned the boundaries of NRHM and when one does attribute a thing to NRHM and when one does not. It is a Central programme which actually got modified at the State level because some States had serious problems with its implementation process, he informed. He further informed that Part A & B & D of NRHM program is largely donor funded

and that the financial agreements, milestones written down, are largely fixed and these predate NRHM conceptualization. Therefore he said that there are variations in programs such as HIV/AIDS control program, TB control programme, etc. and also state bilateral programmes are segregated out from NRHM.

Dr. T. Sundararaman further added that the state requested the center to fund implementation of certain programmes which NRHM rejected as they did not fall under the construct of NRHM.

He then raised the issues related to medical supply which he said, is a central issue. One of the benchmarks, Dr. T. Sundararaman said is that one needs a responsive drug supply system which is provided within the essential drug list and its procurement system needs to be responsive.

He added that, India has a global benchmark in this respect and gave example of Tamil Nadu Medical Service Corporation (TNMSC). He said TNMSC is able to provide good supply of medicines. The NSS figures of Tamil Nadu's per capita public health expenditure on drugs are highest. It is Rs.100/- per capita, none other state has as much as this.

He further drew participants attention to NSSO figures in which the out pocket expenditure in a public hospital of Tamil Nadu is at the bottom at Rs. 250. But if the same figures are compared with national average of 1400, in Uttaranchal it is 5000/- and Bihar it is 4000/- one hardly sees any difference between the public and the private sector expenditures in the latter states.

The supply of drugs kits in the PHCs, he said contains ORS, iron folic acid and de-worming tablets in a fixed proportion. Therefore the places where ANMs are functional the demand for drugs is expected to grow and in the places where ANMs

are not active or not recruited the kit would be wasted. He further expressed that in most cases the medicines are out of stock. However, a procurement audit is being undertaken in six states to check how the mismanagement of procurement. TNMSC, he said, has recruited as special consultant to conduct the audit.

Dr. Sundararaman said that one option is that one can give money to the state, but actually the Centre decided to give states certain medicines since their procurement systems needed improvement. He further added that aspects of procurement conducted at Center is also problematic, despite promoting improved procurement for several years. Therefore, enormous pressure is being put back and forth to get procurement in place.

Dr. Sundararaman then asked whether NRHM is part of political apparatus? And answered that, it is very much so, and explained that, if central government procurement system is well placed then the state would also follow the system and would get better results and may be substantially benefited. However he said, it is appearing difficult to pursue Health as a political agenda in a serious way.

Concluding Session

Broadening Health Equity Activities in India

The concluding session of the seminar was in a form of a group discussion, which was moderated by Dr. Anant Phadke.

Dr. Anant invited participants to share their views and suggestions on conceptual framework and empirical aspects, and advocacy issues. The discussion on exploring further areas in health equity research and advocacy was focused on three areas of work.

- Future directions in health equity research
- Gender equity- Issues for research and advocacy
- Emerging advocacy issues to address health inequities

Dr. Phadke suggested that the seminar needs to culminate into some constructive outcomes, therefore there is a need to take concrete steps ahead such as forming a network or continuing conceptual dialogue. He urged the participants to think of their role in advocacy on various issues, and to consider preparing advocacy material to take issues forward such as policy briefs, policy critiques, and other such activities which are not basically research activity but help advocacy groups to take issues forward.

Various specific suggestions came up during the discussions:

- Dr. Narayana expressed willingness to host a seminar on research and health equity to conduct further detailed discussions.
- Universal access to health care is one important policy measure which can help to enhance health equity.

Similarly there is a need to consider specific equity related strategies to strengthen ground work for advocacy.

- Three key dimensions of Health have been identified: outcome, access, and process. Now there is a need to cover these three key areas in a health equity research framework.
- In equity research, there is a measurement component. Regarding access and processes where measurements cannot be direct indicators, how does one make assessment? These are important aspects which need to be worked on.
- There is a need to consider our role in taking up the issues related to nutritional transition, by looking at NHFS data.
- Need for further work on qualitative research, field based understanding, in which the issues of equity take lead and complement the macro level data. How micro level questions can throw light on macro level issues.

Equity Status Assessment

Monitoring process: there are MDGs where all types of monitoring of progress is going on, such as achievement and progress in indicators which are based on simplistic aggregates. So if equity component is included in this then perhaps the monitoring aspects would become more relevant and so the accounting for equity can be claimed.

A second research domain would be whether two kinds of parallel work could be developed at macro level. One can assess equity which is dependent on data availability. In research the characteristic base or identity base are two different things and have two different methodologies.

Source of equity: technical methods and applications to identify sources of equity, and to measure equity, by considering potential variations. To observe and undertake de-composition to find the source from which is inequity generated.

There is a lack of clarity regarding the equity measurement tools. Another issue is insufficient data. Therefore there is a need to collate information related to the available tools.

There is a need to examine PPPs. Once the data is ready, groups could be identified which would help to understand and analyze the data from equity point of view.

Gender Issues- Gender Inequity Analysis

If one wants to understand the inequity analysis on gender, there is a need to look at gender constructs although there may not be sufficient data available.

One of the participants raised concern about moving from equality to equity perspective. Methodology of research tends to miss out certain sections of the community (e.g. migrants, sex workers) as there are constraints about the sample household survey. Therefore there is a need to include all the sections of the society within the purview of the research.

The term Health Equity is new in the Indian context. There is a need to understand the strengths and the weaknesses of both equality and equity. We already have epidemiology as a resource. The challenge is how is it actually used? Historically the concept of social justice has been a part of public health. It will be a challenge to broaden the concept of Health equity.

Advocacy

The government has some times used our research in adverse ways. There is a need to take the issue of universalisation of Health care with the state, based on evidence and positive models. There is a need to put together policy analyses for advocacy. □

Some Actions Suggested -

- SATHI would take the initiative to discuss the issues over email and share notes.
- Notes on developing methodology in research on Health Equity would be worked out and circulated.
- Search references and researches done previously with equity perspective may be shared.
- Unpublished researches, articles concerning health equity can also be shared and they could be published.
- Understand PPP with more focussed data and from health equity lens.
- Generate models for universal access to healthcare and exchange it. More in-depth sessions on the issue of equity and universal access to healthcare, may be organised after some preparatory papers have been circulated.
- Organise a specific seminar on Health Equity research.
- Nutrition and Health equity can be taken up as a specific issue.

Dr. Phadke concluded the session mentioning that this seminar was an introduction to Health Equity, and much more intellectual work needs to be done to understand nuances of the issue, which would help in contextualizing the work. It would primarily focus on research as well as conducting evidence based advocacy on universal access to health care.

Dr. Nilangi concluded the seminar. She said that SATHI has attempted to initiate a national discourse on the issue of Health equity. She also mentioned about SATHI's objective to initiate a network of academicians and activists around Health equity and hoped that it would concretise eventually.

Schedule of the Seminar

DAY I - 2nd October

Time	Session
9.30-10.00	Registration
10.00-10.15	Welcome and Introduction - Dr. Anant Phadke (Coordinator SATHI)
10.15-10.45	Inaugural address by Chief guest- Prof. Amit Bhaduri
10.45-11.00	Tea break
<i>Session I- Socioeconomic Inequities in India: Context of Health inequity</i> Chairperson - Prof. Amit Bhaduri	
11.00-11.20	Overall socio economic inequities and issues of food security- Dr. Jaya Mehta
11.20-11.40	Agrarian Crisis in India - Dr. Srijit Mishra
11.40-12.00	Discussion
12.00-12.15	Remarks by chair
<i>Session II- Perspectives on Health Equity</i> Chair person- Ravi Duggal	
12.20-12.40	Perspectives on health equity - Dr. Abhay Shukla
12.40-1.00	Analysis of Health Equity as reflected in the WHO CSDH report - Dr. Amit Sengupta
1.00-1.20	Discussion
1.20-1.35	Remarks by chair
1.35-2.50	Lunch break
<i>Session III- Overview of Health Status and Health Care Access Inequities at National Level</i> Chairperson- D. Narayana	
4.20-4.40	Health Inequality in India: Evidence from NFHS-III Dr. Udaya Mishra
4.40-5.00	Health policies and inequities - Ravi Duggal
5.00-5.20	Discussion
5.20-5.35	Remarks by chair

DAY II - 3rd October

Session IV - Gender Dimension of Health Inequity Chairperson- Ms. Renu Khanna	
9.30-9.50	Gender and Health Inequities: Key issues for Research and Advocacy - Dr. Lakshmi Lingam
9.50-10.10	Gender inequality as reflected in health research -by Ms. Neha Madhiwala
10.10-10.30	Discussion
10.30-10.45	Remarks by chair
10.45-11.00	Tea Break
Session V- Moving towards a System for Universal Access to Health Care Chairperson- Dr. Vandana Prasad	
11.00-11.20	Regulation and harnessing private sector resources towards a system for Universal access to health care-Dr. Muraleedharan V.R.
11.20-11.40	Modes of interaction between public and private health sectors towards universal access- Dr. T. Sundararaman
11.40-12.00	Options for a universal access system in India - Dr. Abhay Shukla
12.00-12.15	Discussant - Dr. Amar Jesani
12.15-12.35	Discussion
12.35-12.50	Remarks by chair -Dr. Vandana Prasad
12.50-2.00	Lunch Break
Session VI - Health Equity Issues Related to NRHM Chairperson - Dr. Raman Kutty	
2.00-2.20	Equity concerns as addressed in NRHM-Dr. T. Sundararaman
2.20-2.40	Health equity issues in NRHM: Evidence from People's Rural Health Watch (PRHW) report - Dr. Indira Chakravarty
2.40-3.00	Discussion
3.00-3.15	Remarks by chair Dr. Raman Kutty
Session VII - Concluding Session - Broadening Health Equity Activities in India- Chair person - Dr. Anant Phadke	

Brief Profile of the Presenters & Chairpersons

Profile of the Chairpersons

Dr. Abhay Shukla

Coordinator, SATHI, Pune

Dr. Shukla is a medical graduate with a postgraduate degree in Community Medicine from the All India Institute of Medical Sciences, New Delhi. Since one and half decades, he has been based in Maharashtra, working on health issues in association with people's organisations. Presently Coordinator of SATHI-CEHAT, he has been involved in training health workers, developing health training material and advocacy on Health rights and Primary Health care issues in Maharashtra and West M.P. He is one of the National Joint Convenors of Jan Swasthya Abhiyan (JSA).

Dr. Amit Sen Gupta

Delhi Science Forum, Delhi

Dr. Amit Sen Gupta is a medical doctor, and works on issues related to public health, pharmaceuticals policy, Intellectual Property Rights and other Science and Technology issues. He is associated with Delhi Science Forum, which is a public interest organisation working on Science and Technology policy issues.

Ms. Indira Chakravarty

Research Scholar at Centre for social medicine and community health in Jawaharlal Nehru University, Delhi

Ms. Chakravarty coordinated the People's rural Health Watch activity of Jan Swasthya Abhiyan during 2007-08. Currently, she is working on Public Report on Health.

Dr. Jaya Mehta

Sandarbh Kendra, Indore

Jaya Mehta is a prominent economist and activist. She was reader in Gokhale Institute of Politics and Economics, Pune. She is the founder member of Sandarbh Kendra, Indore. Sandarbh Kendra works for championing the rights of the underprivileged and striving for a more equitable society.

Dr. Lakshmi Lingam

Tata Institute of Social Sciences, Mumbai

Lakshmi Lingam is a Professor and Chairperson of the Centre for Women's Studies at the Tata Institute of Social Sciences, Mumbai. Her research interests range from exploring the social and gender specific implications of health sector reforms and other macro economic policies; studying women's and other social movements in the period of globalization; understanding women's health and reproductive rights; and exploring issues of culture, women's identity and agency.

Ms. Neha Madhiwala

**Coordinator, Centre for Studies in Ethics and Rights (CSER),
Mumbai**

Ms. Madhiwala has done her masters in social work. She has worked on various research projects concerning women and health. She is also engaged in teaching at various institutions.

Mr. Ravi Duggal

Independent Consultant

Ravi Duggal is a Sociologist by academic training and also holds a professional diploma in Business Management. For nearly three decades he has contributed to the areas of political economy of health and health financing through institutions like CEHAT and FRCH. He now works as an undertaking research, advocacy

and trainings on issues like health systems and health sector reforms, health financing and budgets, health and human rights, reproductive health, governance and accountability mechanisms.

Dr. Srijit Mishra

Associate Professor, Indira Gandhi Institute for Developmental Research, Mumbai

Dr. Mishra has done his Ph.D. in Economics. He works on health and other development related issues. He also has research interest in measurement related issues and is currently working on a refinement of the Human Development Index.

Dr. U S Mishra

Associate professor, Centre for Development Studies, Trivandrum, Kerala

Dr. Mishra is currently involved in two research projects relating to the issue of declining child sex ratio in India and the role of decentralized governance in managing the grass-root health system.

Dr. T Sundararaman

Executive Director of National Health Systems Resource Centre (NHSRC), New Delhi

Dr. T Sundararaman is a postgraduate in general medicine. He has been actively involved in both the People's Science and Literacy Movements and Health Movements in the country. He is a founder member of the All India People's Science Network (AIPSN) and the Bharat Gyan Vigyan Samiti (BGVS).

Dr. V R Muraleedharan

Professor & Head of Department of Humanities and Social Sciences, IIT, Chennai

His research interests are healthcare economics, history of health care in south India and environment economics.

Profile of the Chairpersons

Prof. Amit Bhaduri

Amit Bhaduri obtained a doctorate at the University of Cambridge (UK). He has been Professor Emeritus at Jawaharlal Nehru University, Delhi. He was Visiting Professor at various academic institutions. His research work initially dealt with the economic structure of backward agriculture. Subsequently he became interested in the treatment of macroeconomic themes in a multi-sectoral framework. In recent years, he has devoted attention to theoretical and policy issues associated with processes of economic transition and globalisation.

Mr. Ravi Duggal

Independent Consultant

Ravi Duggal is a Sociologist by academic training and also holds a professional diploma in Business Management. For nearly three decades he has contributed to the areas of political economy of health and health financing through institutions like CEHAT and FRCH. He now works as an undertaking research, advocacy and trainings on issues like health systems and health sector reforms, health financing and budgets, health and human rights, reproductive health, governance and accountability mechanisms.

Dr. D Narayana

Professor, Centre for Development Studies, Trivendrum, Kerala

At present, he is coordinating the research project Macroeconomic Adjustment Policies, Health Sector Reform and Access to Health Care in India. He has been a Visiting Professor at the University of Montreal's Department of International Health and a Mac Arthur Foundation Fellow at the Harvard Centre for population and development studies.

Ms. Renu Khanna

Founder member and Trustee of 'Sahaj- towards alternatives in health, education and development', Vadodara

Her areas of interest are women's health rights, gender and health, healthcare management and organisational development.

Dr. Vandana Prasad

Dr. Vandana Prasad is a Paediatrician and has been a Consultant with the 'Mobile Creches' Centres, and the Forum for Creches and Childcare Services. She has worked as a trainer for women and child health issues for almost a decade with groups working in urban slums and rural areas.

Dr. V Ramankutti

Professor at Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, Kerala

Dr. V Ramankutti has done M D (Pediatrics), M Phil and M P H (Harvard). Most of his research and consultancies are regarding health sector reform, non-communicable diseases and governance issues.

Dr. Anant Phadke

Senior Advisor, SATHI, Pune

Dr. Anant Phadke is a Medical graduate (M.B.B.S.), currently working as senior advisor for SATHI since April 2009. Before that he was coordinator of SATHI from April 05 to March 09. Since 2000, he is Co-convenor of the Jan Aarogya Abhiyan, the State wide coalition of Health NGOs in Maharashtra. He is active member of Medico-Friend Circle and a founder member of the All India Drug Action Network (AIDAN) and Lok Vidyan Sanghatana. He is on the trust board of LOCOST, Baroda. He has contributed about 75 and 150 articles respectively in English and Marathi, to various health magazines and lay-press on different topics related to the People's Science and Health Movement, especially on the Drug Policy in India

Dr. Amar Jesani

Amar Jesani is a medical graduate and has been doing health research since 1979. He has been involved in research and teaching/training in health and development, bio-ethics, ethics in social sciences, Health and human rights, health policies in India and gender and medical education.

About SATHI

(Support for Advocacy and Training to Health Initiatives)

SATHI is the action-centre of Anusadhan Trust with headquarters in Pune. The SATHI team initiated its work in 1998 as an action team in CEHAT and has now evolved into an autonomous centre. The core principles of SATHI's functioning are social relevance, democratic mode of functioning, ethical conduct and social accountability.

SATHI dreams of a society,

- which has realized its right to health and health care; a society which has eliminated health inequities, by removing the structural barriers which today prevent the majority from accessing healthy living conditions and quality health care;
- which instead of the current pathological model of development, has adopted a developmental path which fosters health of both the people and their environment;
- where people are not appendages of the health care system; are its prime movers and have universal access to appropriate health care as a human right.

To move towards this dream, SATHI's mission is to contribute to the building of the movement for 'Health For All' through collective action and research.

In collaboration with like minded organizations, SATHI has set the goal of achieving the Right to Health Care for all Indians; as a big step towards achieving 'Health For All'

SATHI's strategy is to contribute, as a team of pro-people health professionals, to the health movement and to various initiatives which foster health rights.

Presently SATHI's core activities are-

- a. Collaborative health initiatives with like minded NGOs and People's organisations in Maharashtra and Madhya Pradesh.
- b. Training related to community health worker programmes and health rights initiatives.
- c. Research on inequities in access to health care, availability of essential medicines.
- d. Action research on specific issues related to health advocacy.
- e. Advocacy at broader level for Primary Health Care and Health Rights.
- f. Publication of relevant training and advocacy material on health issues.
- g. Library and information services.

Further information about SATHI may be accessed at – www.sathicehat.org

About the Report...

As part of the project, Maharashtra Health Equity and Rights Watch, SATHI had organised the 'National Seminar on Health Equity in India' on 2nd and 3rd October 2008 in Mumbai. The seminar was attended by almost 55 to 60 participants, which included health researchers, economists, NGO representatives and students from prominent institutes like TISS, IGIDR & IIPS.

One of the key objectives of the seminar was to bring together public health experts, social scientists, health sector NGOs and health activists on the issue of 'Health Equity' to develop a discourse on this emerging area of concern in health sector. In addition, SATHI wanted to explore the possibilities of developing Health Equity research and advocacy initiatives by interaction with similar groups across the country. Specific objectives of the seminar were

1. To locate health inequity in the context of socio-economic inequities in India
2. To discuss some basic concepts and various perspectives related to the Health equity approach
3. To discuss equity analysis as a tool to analyse the health sector; to take an overview of inequities in health status and inequities in access to healthcare
4. To analyse how overall intensification of inequities impact upon women; understanding gender related health inequities
5. To deliberate upon options towards a system for Universal access to healthcare as an approach to reduce health inequities
6. To explore the possibility of further collaborations on health equity research and advocacy

Overall, the seminar was successful in initiating a discourse on the issue of health equity in India. The presentations by the speakers and the discussions that took place in these two days brought out various dimensions of health equity in India.

This report is a summary documentation of the proceedings of the seminar.
