UHC
UNIVERSAL HEALTH CARE
सर्वांसाठी आरोग्य सेवा

To find a way out of the deepening health care crisis in Maharashtra –

We need a system for Universal Health Care!

- Have you ever experienced that admission of a family member or acquaintance in a private hospital led to massive, unexpectedly high expenses? Did you notice that a large part of healthcare expenses are consumed by costly branded medicines?
- Did you get a sense that you or your patient had undergone unnecessary lab tests or procedures? Did you feel that sometimes unnecessary medicines were prescribed?
- Have you experienced that often public health facilities are short of doctors and are not sufficiently sensitive to needs of ordinary patients? Did you ever experience that district hospitals and government medical college hospitals are overcrowded beyond capacity?

Well, if you do... do not get surprised and don't think you are alone! Millions of people in Maharashtra suffer a similar ordeal! Take a look at the facts and figures ...

- Only 20% of total healthcare expenditure is Government funded, while 80% expenditure is made by patients themselves, including poor people who can barely afford this.
- Over 70% of people resort to private healthcare which is characterised by large scale irrationalities, unnecessary procedures and investigations, costlier branded medicines, often substandard care and cut practice which makes private healthcare costlier and exploitative. This massive private sector operates without any standards of care or regulation of rates.
- A family of five in Maharashtra today spends an average of Rs. 11,225 every year on Health care, out of this 75- 80% is spent on medicines. Healthcare expenditure has risen faster than inflation in the last decade and it hits hard not only the poor but the middle class also. Annually 30 lakh people in Maharashtra are pushed below poverty line owing to healthcare expenditure.
- Many reports on farmer's suicides in Maharashtra have mentioned catastrophic healthcare expenditure as one of the main reason for rural indebtedness, stress leading to suicides.
- There is practically no expansion in number of public hospitals and health centres in rural areas in last decade despite growing population, leading to stagnation in rural health care.
- Maharashtra does not have an organised public healthcare system in urban areas where 45% people live! Even basic health posts are not in place in all urban areas.

Our state's healthcare system is in crisis - making it difficult for ordinary people to access care!

Minor reforms in the public health system and privatisation oriented schemes can't solve this crisis!

But, Maharashtra is a 'developed' state... isn't it? Then, why is its healthcare system in crisis?

1. Maharashtra is the richest state economy in the country (15% of national GDP) but its *Public Health Expenditure is very low* (less than 0.5% of SDP), indicating lack of political will and resulting in weak public health services.
2. Public health services remain inadequate and insufficiently responsive: National Rural Health Mission (NRHM) has led to some strengthening of Public health services in rural areas. However, compared to the scale and range of services required at various levels, the Public health system in rural and urban areas needs much further upgradation and expansion. This system is today also not sufficiently accountable and responsive to people's health needs, decision making is over-centralised, and resources are focussed more on tertiary care compared to primary care.
3. Insurance calling... Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY)- This scheme hands over large scale public funds to an insurance company, corporate and large private hospitals but effectively caters to very small section of the population (barely 1%), as the scheme is designed only for rare, high tech, high cost medical conditions. This leads to prioritising focus of health systems on rare and complicated medical procedures compared to common conditions and basic health services.
4. Inability to look critically at private sector- Despite worldwide evidence suggesting that healthcare is prone for market failure, the state has witnessed privatisation of public hospitals (often at municipal level), handing over of public land and resources for business interests (including “charitable trust hospitals”), lack of political will to effectively regulate the private medical sector through proposed Maharashtra Clinical Establishment Bill. Key provisions such as regulation of rates have not been included in the bill, reducing its effectiveness.

An answer to this crisis is- A system for Universal Health Care (UHC) Restructuring our government and private health services into a publicly managed system delivering free, quality health care to all!

UHC is a new system that builds on existing resources, but integrates these under public management, links them with a rights-based framework of accountability and takes the entire system to a higher level of functionality. It has revolutionary potential to rejuvenate the debilitated public health system and transform currently unregulated, often irrational, fragmented private healthcare, in tune with the logic and goal of public health. UHC is the globally acknowledged most credible systemic alternative to the modern healthcare crisis. The High level expert group on UHC for the 12th Five year plan has also given recommendations in this direction.

UHC means not just providing health care to those who need it, but also reducing the need for care by promoting good health!

UHC involves providing cashless quality healthcare for every person requiring it, irrespective of economic status and capacity to pay, urban/rural or geographic residency, caste, religion, social status, gender, social or personal background by including government and private providers in a publicly managed single payer system. As part of UHC the public health system will be substantially strengthened, its regulatory capacity enhanced, the private sector will be regulated, and significant sections of private providers who agree with broader 'public logic' will be progressively 'socialised' to conform with the UHC system.

However we envisage that UHC must be accompanied by comprehensive action to tackle the causes of ill-health, so that illness will be minimised. This will be based on community based integration mechanisms and implementation of Essential Public Health Functions, such as effective oversight and monitoring of drinking water and sanitation, nutrition, environmental conditions, addictions etc. by the Public health system working in coordination with other departments.

UHC is possible in Maharashtra!

Maharashtra has three major prerequisites for moving towards UHC system namely- economic resources, healthcare resources and vibrant social movements! It has highest the GSDP in the country (Rs. 13 trillion= 15% of national GDP) which is growing at a rapid pace over the last few years, and about 2 % of GSDP will be sufficient for setting up a decent UHC system in the state. Maharashtra has one of the highest numbers of medical colleges and AYUSH colleges in the country. The doctor-population ratio for the state (Allopathic + AYUSH) is 1:585 as against norm of 1:1000., thus we have adequate number of doctors. 25 % of the total medicines in the country are manufactured here. Large number of beds for poor patients in Charitable Trust Hospitals across the state can be brought under UHC system. ESIS in Maharashtra has substantial resources locked within it, which can be utilised much better under UHC system. The state has a legacy of progressive social movements and civil society initiatives, including pioneering work in community health. If properly mobilised, these can be a basis for developing the requisite socio-political will for UHC in Maharashtra. We should keep in mind that health is a state subject in the Indian constitution, hence political will at state level can be the basis for making UHC a reality.

UHC is possible!

Other developing countries like Thailand, Brazil, Sri Lanka have achieved UHC....

Key features of a Universal Health Care (UHC) system

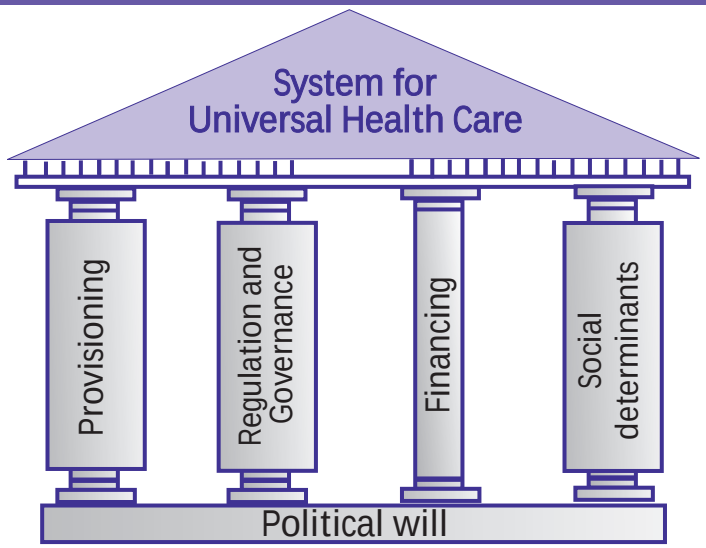
- Right to Comprehensive Health Care for all! No exclusions! No targeting!
- No payment at point of service! No user fees! No role for commercial insurance!
- Special efforts and programmes for marginalised groups!
- Elimination of unnecessary medicines, investigations, procedures – reducing wastage of resources and avoiding health impacts of over-medicalisation!
- Uniform norms for urban and rural areas and integrated care from primary to tertiary levels!
- Reducing ill-health through integrated action on factors related to health!
- Accountable, participatory governance at all levels with observance of Patient's rights!

What Universal Health Care is NOT ...

Universal Health Care (UHC) does not mean Universal Health Insurance. Universal Insurance and Universal Coverage are problematic concepts, which today often mean providing state subsidised insurance 'cover' only for hospital care, which does not strengthen public health systems or genuinely regulate the private medical sector, which leads to major cost inflation and does not ensure comprehensive healthcare including primary care.

Political will is the single most important requirement for UHC in Maharashtra!
Is Maharashtra's political leadership ready to take up this challenge?
Are the people of Maharashtra willing to mobilise and demand this strongly?

Developing a system for UHC is naturally a large, complex and multi-dimensional process. We will very briefly outline here four major components required for an effective UHC system – provisioning of care, regulation and governance, financing, and tackling social determinants of health. These would be the basis of a comprehensive UHC system.



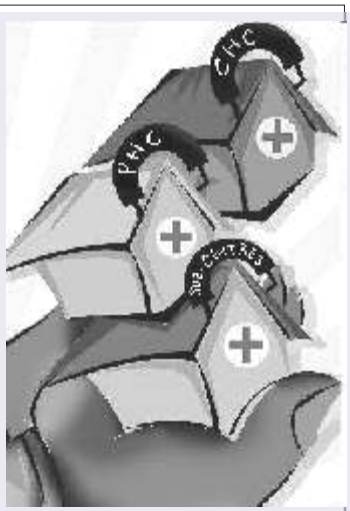
A. Provisioning for UHC

Major changes in the system of provisioning health care would be required for UHC, which would include:

- Integrating existing public providers at various levels; effective integration of various kinds of public providers which are currently compartmentalised - State health department facilities, State medical colleges, Municipal corporation hospitals and dispensaries, ESI hospitals, Railways and PSU hospitals etc. into the UHC system
- Expanding and strengthening public provisioning especially for rural areas and preventive and promotive health functions. To be ensured through recruitment of additional staff and in-sourcing of some human resources such as specialist doctors.
- Involving sections of regulated private providers as per need, especially individual practitioners, small and medium sized providers, genuine not-for- profit hospitals etc. into the proposed UHC system, to fill the gaps in public health care system.
- Integrating providers in rural and urban areas, and at primary, secondary and tertiary levels to become part of a seamless, comprehensive system of UHC.

Expanding and strengthening the public health system, creating new institutions as per need- The focus should be on expansion and strengthening of the public health system (especially on regular recruitment of doctors and paramedical staff, and actual provision of quality healthcare beyond limited focus on infrastructure) across different levels of care in time bound manner, including the following measures for rural areas:

- Upgraded and improved ASHA programme, with one ASHA per 500 population. *ASHAs will be substantially upgraded* in terms of skills, availability of medicines and linkage with health facilities, along with provision of regular honorarium. ASHAs would treat simple outpatient cases and would work as patient counsellors, advocates and public health activists.
- Sub-centres will be upgraded to function as first contact care units, with availability of a basic integrated doctor / nurse practitioner, to ensure symptomatic/curative care for all rural habitations. Integrating the existing Male health workers (MPWs), a cadre of Public Health Workers (either female or male) would be created, with emphasis on monitoring and working with communities to advocate for safe water supply, ICDS services and social determinants of health.
- PHCs would be empowered to perform the full range of essential public health functions to the population covered by it by appointing a Public Health Officer (PHO) responsible for implementing essential public health functions - ensuring social determinants.
- CHCs and SDHs would be strengthened to provide round-the-clock specialist referral care, overcoming the backlog of FRUs in the state. Compulsory posting of fresh PG doctors and short courses for serving MBBS doctors in major specialities would be done to fill the gaps in specialists.



Creating a coordinated Urban health care system-

Differentiated strategies would be adopted to addresses the specific healthcare needs of three distinct categories of urban Maharashtra: (1) Metropolis of Mumbai, (2) Municipal Corporation cities and (3) Council Towns.

A coordinating mechanism would be set up between State health department and various Corporations/ Councils by creating an Urban Health Directorate under Health Ministry.

There would be focus on time bound ensuring of an organised system of urban health care, with a three-tier structure:

1. *Urban PHCs* would be set up in adequate numbers (1 for 50,000 population) and would be upgraded to 10 bedded in-patient facilities with two MOs each. Insourcing of general practitioners, including AYUSH graduates with training as 'Basic integrated doctors' for running these UPHCs. *Mini urban PHCs* would be established for the 427 small towns having population less than 50,000, with delineated referral tie-ups.
2. *Peripheral hospitals* would provide secondary health care for units of 3 lakh population, trust hospitals and small / medium sized private hospitals may be insourced for this where public institutions are not sufficient.
3. Each *District hospital needs to be upgraded to a Medical College* with responsibility to provide tertiary care to both urban and rural populations in the district.

An *organised and integrated referral and transport system with emergency medical service wing* linking CHWs to primary facilities, further enabling patients to access secondary and tertiary facilities would be set up, to ensure rapid and appropriate referrals, and screening of patients requiring various levels of care to ensure optimal use of higher facilities.

Upgraded Health Information Systems, based on diverse sources including community based data such as findings of Community based monitoring, should be used at local and district as well as state levels, to plan health services and take effective actions to prevent illness.

In-sourcing of regulated private providers to complement the public system-

Private clinics and hospitals can be contracted-in with proper regulation to bridge the gap in required services. This in-sourcing should be in a manner that would complement and strengthen public systems rather than replacing them. The manner of in-sourcing and monitoring framework should minimize cost inflation, moral hazards and any siphoning of funds. *Over time such providers would conform more and more to 'public logic' instead of the now dominant 'profit logic', and such ongoing insourcing would lead to their progressive 'socialisation'.* This process would be in complete contrast to current 'PPPs' where unregulated private providers soak up public funds while weakening the role of public systems.

It is mandatory for charitable trust hospitals who have received govt aid to use 20% of beds for free/subsidized treatment to poor and economically weaker people. But compliance is low. To ensure full compliance, these beds should be brought under public management for UHC.

Individual practitioners could be completely in-sourced to work in various levels of UHC facilities, with a periodic (say yearly) renewal of contract. *Willing private nursing homes and hospitals may be in-sourced to the UHC system with two options.* One option would be of complete in-sourcing, implying that they would not be allowed to treat any patients outside the UHC system during their period of contract. The second option would be of *'primarily in-sourced' facilities,* which would reserve at least two-thirds of their beds / patient facilities for UHC patients. Such options along with comprehensive regulation of treatment practices, costs and standards would make such facilities work as an extension of the public system, under the publicly organised UHC umbrella.

Role of AYUSH systems of healing in the UHC system-

The UHC system would systematically integrate and promote these systems including Ayurveda and Homeopathy. *The model to begin with could be Medical pluralism, where AYUSH systems will be available to people as a choice at various levels,* and practitioners will be enabled to practice their system along with its theoretical framework, clinical diagnosis, validation methods and research. *AYUSH practitioners would be offered a choice of either exclusively practicing their own system, or working as 'basic integrated doctors'* at primary level, based on a one-year skill and knowledge development course, to provide primary health care with core allopathy skills based on standard guidelines. They

would also run a clinic of their original system in a systematic fashion at least few days in a week. Stand alone dispensaries for Ayurveda / Homeopathy would be set up in each block / ward and would be co-located at district hospitals and CHCs. Research institutions for AYUSH to be started, or strengthened to undertake research and evidence generation required for plural and progressively integrative systems of medicine. The paramedical curriculum would be revised to include AYUSH therapies also.

A Human Resources for Health Policy would be developed for the state, taking various measures for developing a public health workforce consistent with the needs of UHC.

With UHC, there will be significant expansion of the public healthcare system. Hence larger number of ANMs, Public Health Workers, Para medical professionals will be required. Government should open up large number of training institutions linked with public health facilities to fill vacant posts rapidly.

Large numbers of 'Bachelor in Community Health' with a 3-year course would need to be trained in centres attached to District and Sub-district hospitals. The graduates would work entirely in the rural public health system, starting with upgraded SHCs, with avenues for career mobility and upgradation of skills to work at higher levels.

There would be clear career progression paths for general doctors, ANMs and staff nurses, as well as other types of staff. The system of contractual appointments should be done away with, possible exceptions being specialists who may prefer flexible arrangements for association with the UHC system.

A major part of the policy would be a transparent and rational system for recruitments, promotions and transfers based on a legal framework and counselling similar to the Karnataka system, minimising corruption and maximising staff satisfaction.

Efficient recruitment and retention strategies for specialist doctors need to be explored like higher compensation packages and incentives, as well as empowering doctors with more autonomy in running institutions as was successfully done in Haryana. Significant number of specialists in urban areas will need to be contracted-in, in a manner that would strengthen the functionality of public facilities.

Procurement, supply and use of medicines for the UHC System

1 The procurement and distribution mechanism for public health system would be overhauled to ensure that medicines would be purchased at lower costs, and would be more efficiently distributed.

This would include setting up a state level autonomous procurement agency like Tamil Nadu Medical Services Corporation (TNMSC) for efficient procurement and distribution of medicines; allocating adequate budgets for procurement of medicines (starting with Rs. 60 per capita); computerized, interlinked information system from facility to state level, for real time stock monitoring, and demand driven supply to all Health facilities using the 'passbook-system'.

2 Usage of quality and rational generic medicines would be promoted. Prescribing drugs with generic names would be mandatory for all providers in public and private sector. Generic medicine centres would be set up in each block and ward, to make these medicines accessible to patients accessing the UHC system. Standard Treatment Guidelines would be adopted across the UHC system in both public and private facilities to minimise irrational prescribing of medicines.

B. Regulation, Governance and Inclusion for UHC

UHC is a novel system which requires certain new, designated structures with adequate competent staff to do justice to the newer functions of developing and managing the system. Further there is need to develop an overarching legal framework for coordination and assurance of entitlements. Ensuring inclusion of various sections with special health needs is essential to make UHC genuinely 'universal'. Hence we propose the following measures-

Reform existing administrative systems

- Merge Medical Education Ministry into Public Health Ministry, or create mechanisms for regular and effective close coordination between these two Ministries, for integration of tertiary care and to ensure development of various training capacities required for UHC

- Expand and democratise Maharashtra Medical Council (MMC) and other State Councils with civil society participation, make their structures and functioning more accountable and transparent.

- Start new courses like Bachelor in Community Health (to work at Sub-centre and PHC levels), Public Health Officer (to deal with social determinants and inter-sectoral coordination) and diploma courses for

skill upgradation of MBBS doctors in major specialities.

- Improve inter-departmental coordination for public health goals by making public health department as the nodal agency with powers to activate other departments.

Enact new comprehensive legislations

- Enact Maharashtra Right to Healthcare Act to provide entitlements and redressal mechanisms regarding right to healthcare for patients, while providing a framework for UHC providers and administrators. This will also define standards, structures and community oriented monitoring mechanisms for UHC.

- Enact Maharashtra Public Health Act to deal with health determinants and public health functions. This will bring together the existing frameworks on social determinants of health in a cohesive fashion, so that effective inter-departmental coordination can be achieved while carrying out essential public health functions.

- Enact Maharashtra Clinical Establishment (Registration and Regulation) Act to standardise quality of care, costs and human resources in all clinical establishments, whether involved or outside of UHC. It will also provide a Charter of patient's rights and responsibilities, provisions for regulation of rates and grievance redressal.

Create new institutions for UHC

- *State Health Regulatory and Development Authority* (and similarly district level authorities), to co-ordinate and integrate all public providers, in-source certain private health care providers and ensure rational referral chains, while dovetailing all of these into the UHC system.

- *State Health System Evaluation Unit* under the SHRDA to evaluate the performance of both public and private health facilities at all levels, with a view to ensuring standards, appropriate costs and rationality of care.

- Director for Clinical Establishments, Local Regulatory Authorities and appellate bodies, for regulation of clinical establishments and ensuring Patients rights in context of CEA.

Regulation of Medical and Para-Medical Education

Medical and para-medical education in Maharashtra has become a highly commercialised industry with exorbitant costs but poor quality of education, the 'donation' system having disastrous effects on healthcare costs. Hence medical and para-medical education in Maharashtra needs major overhaul and effective regulation. *All private medical colleges should be strictly monitored to function within the fee structure defined for state medical colleges without charging any donations, otherwise these should be taken over by the state government. No new private medical colleges should be allowed in the state.*

Governance and accountability for UHC

Health policies, budgets, plans, programmes are launched, decisions are taken by Ministers and senior officials in highly centralised way in the name of 'people'

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But in reality, the Public Health System remains alienated from ordinary people!

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It's time to bring people to the centre of the health system...Time to go beyond limited 'representation' and bureaucratic control, and usher in an era of participatory health governance!

Without democratic transformation of governance of the Health system, achieving a genuinely people-oriented system for UHC will remain a dream.

This will require:

- Generalization of Community based monitoring and planning (CBMP) in Maharashtra, moving from 'Project' to 'system wide process'. *Ensuring regular forums for direct democracy* including Jan Sunwais at PHC, block and district levels and Arogya Gram sabhas at village level, actively involving people in monitoring and supporting health services.

- Creation of multi-stakeholder *Health and social services councils* at Block and District levels, drawing on the model of Brazilian health councils and the Monitoring and Planning committees created through the CBMP process. These would involve expansion, reorganisation and activation of present Panchayat health committees with significant civil society participation. Councils would facilitate convergence and coordination of various social services, and would be involved in formulating block and district health plans.

- *Major decentralisation of decision making* – empowering such Health and social service councils at block and district levels, with genuine powers and finances to manage the health system locally. *District health planning to become the hub of responsive planning, not just in nominal but real terms, with only broad themes and norms for UHC being defined from the state level.*

- Formation of State level multi-stakeholder Health council, through expansion of State monitoring and planning committee, for participatory planning and review at state level. Organisation of annual multi-stakeholder *State Health Assembly* to review functioning of the UHC system (similar to Thai Health assemblies) and to plan overall priorities.

- *Ensuring social accountability of private medical services* through participatory regulation. All publicly funded, privately provided services should be held accountable in manner similar to public services.

- *Measures for transparency* with public display and availability of information about services, rights and financial dealings. *Protection of whistleblowers* who complain about corruption in public or private health sector.

- *Internal democratisation of Health system* with involvement of Health sector employees. Consultative mechanisms for quality improvement and planning of services to involve frontline employees such as ANMs, nurses, support staff, service doctors, paramedical staff etc.

Inclusion is essential to make the UHC system genuinely universal!

Today discrimination or differential quality of care on the basis of gender, caste, ethnicity and other forms of vulnerability is evident in health care settings. The State has an obligation to ensure the human rights of all, and it is inclusion that would make the UHC system genuinely universal. In this context, given below are some dimensions of exclusion, and possible measures to address the multiple discriminations faced by excluded groups and sections with special health needs. These need to be integrated in the design of a UHC system in Maharashtra.

We need to overcome various forms of marginalisation based on:

- Stage in life cycle (children, pregnant and lactating women, elderly persons etc.)
- Social position (Women, Dalits, Adivasis, Muslims etc.)
- Health status or bodily capacities (persons with mental health problems, people living with HIV-AIDS, differently abled persons etc.)
- Occupation (sex workers, sanitation workers, wastepickers etc.)
- Sexual orientation (transgender people and persons with various kinds of sexual orientation)
- Social context (situations of displacement, migration, conflict etc.)

These forms of exclusion are often overlapping, the same group may face multiple barriers to access quality care.

Some measures proposed to ensure inclusion:

- Placement of Health care delivery units in areas where the most marginalised sections live, making physical and social access to health services universal
- Appointing service providers from socially excluded groups, reversing social hierarchy
- Regularly sensitising all healthcare providers regarding gender, sexuality, addressing violence, upholding disability rights and ending discrimination
- Ensuring confidentiality and adequate physical and emotional space in health care settings
- Democratisation of health systems and involving organisations, groups of marginalised people in planning and monitoring, so that denial, violation or neglect of rights is eliminated.

C. Financing for UHC

Maharashtra is one of the most developed states in India, with a per capita income of Rs. 130,000, however the State government spends only Rs. 630 per capita on public health services. On the other hand, expenditures made by ordinary people on health care are very high; estimated annual out of pocket expenditure on health care in Maharashtra today is over Rs. 2245 per person, which is nearly four times compared to public spending. In this scenario, *major increase in public health financing is both necessary and possible,* given the scale of Maharashtra's economy. The level of public health spending made in neighbouring Goa at Rs. 2200 per capita (1.7% of current SDP in Maharashtra) needs to be reached as quickly as possible.

It may be kept in mind that the UPA government had pledged almost a decade back to raise public health spending to the level of 2-3% of the GDP. The scale of funds required for UHC today is well within this range, which is below what governments in many developing countries currently spend on Health care. The resources are not difficult to raise, because nearly half of Maharashtra is urban, it has a large organized sector population, and has a huge potential for generating larger tax revenues by improved tax collection, taxing financial transactions, and reducing unnecessary subsidies given to the corporate sector. Along with adopting the policy goal of UHC in Maharashtra, a roadmap for raising finances needs to be chalked out over the coming decade, which would include the following:

How can resources be ensured for the proposed UHC system?

1. The resources for UHC would come mainly from general tax revenues of the Central and State Governments. The state government will need to negotiate and demand with central government to make much larger scale of resources available for the UHC system; with political will, this is possible. If existing tax exemptions to corporate sector and business class are reduced substantially, there is potential for doubling the tax-revenue: GDP ratio and ensuring adequate resources for UHC as well as other social services. Comprehensive Financial Transaction Tax (on FDI investments, Currency exchange, stock-market transactions etc.) can be another major source for raising public revenues. Like in many other countries, Indian government should levy tax on inherited property, whichwould generate substantial revenues.
2. Measures to raise additional tax based resources by state government for UHC- A state health tax may be introduced on lines of professional tax, so that those who are in regular employment or business (and not covered by any social insurance) can contribute to the health budget directly. Health cess could be charged from owners of personal four-wheelers, on sale of health degrading products like alcohol, tobacco etc. Further judicious use of various resources that are presently being offered to the corporate sector at discounted prices, offers major potential for generating finances for social sector spending.
3. Hospital beds under Charitable Trust ownership are estimated to be at least 50,000 across Maharashtra, and 20% of these are mandated as social benefit amounting to 10,000 beds. These health care resources in form of social obligation of Trust hospitals is worth Rs. 1000 crores annually, which could boost the UHC system in Maharashtra. Public allocation of patients to all these beds and participatory monitoring mechanisms would ensure effective use of this large resource for UHC.
4. Termination of various commercial insurance-based health schemes would make available several hundred crores annually, which could be invested in strengthening public health services and operationalising the UHC system.
5. Tax based financing would be the main basis for UHC, but this could be complemented by existing Social health insurance resources like ESIS, CGHS, Railways health funds, health funds for construction workers etc. which could be pooled into the UHC Health Fund. In parallel, comprehensive and rational health care would be ensured for all these groups of workers, which would generally be an improvement over their existing health entitlements.
6. Using UHC funds in an effective and accountable manner- resources from taxes, social insurance, cesses etc. would be pooled and transferred to the State Health Authority, who would further send appropriate amounts (based on per capita norms) to each district / municipal health authority as per their requirements. Multi-stakeholder health authorities would function as the planning and budgeting unit, with complete transparency of decision making. Regular Social audit and Community based monitoring processes would be organised to ensure accountability of these public management institutions.

Estimated scale of finances required to operationalise a UHC system in Maharashtra	
Primary care	15,363 crores (including first referral hospitals)
Secondary and Tertiary care	4,275 crores (including medical and health education)
Administration, health authorities and UHC agencies, medical research, accounting & audit, information management	1,768 crores
Capital investment for expanding public health services, maintenance and renewal of assets and contingencies	6,428 crores
Total cost of UHC: Rs. 27,834 crores (Rs. 2,442 per capita or 1.99% of State Domestic Product)	

If the government uses existing resources efficiently along with generating some additional funds, and if there is substantial improvement in quality and access to health care in the coming few years, then a better environment would be created for levying additional taxes by the State Government as suggested above.

Moving from publicly funded Health Insurance schemes to a UHC system

While the government has been pumping hundreds of crores of rupees into Rashtriya Swasthya Bima Yojana (RSBY) and Rajiv Gandhi Jeevandayi Arogya Yojana (RGJAY) schemes every year, there are fundamental problems in design of these schemes, apart from their problematic implementation.

There is no country in the world where commercial insurance has been able to ensure comprehensive health care for all. Involvement of insurance companies fragments the nature of care being provided, and leads to high health care cost inflation with lower levels of wellness. Given negative experiences in many other countries and failures in the Indian context, including the serious problems with RSBY in Maharashtra (which has now been shut down by the state government), commercial insurance companies should not be used to purchase health care services on behalf of the government. RGJAY and other such schemes need to be transformed and reshaped, and along with elimination of the role of insurance companies, they should be merged with the public-centred UHC System in Maharashtra.

The Employees' State Insurance Corporation (ESIC) is today the largest social health insurance programme for organized sector workers, which has substantial health care and financial resources but low utilisation and performance. This can be changed if ESI is reclaimed by workers, and ESI healthcare facilities are brought into the broader UHC framework. While maintaining all social security benefits, ESIC hospitals (actually run by State Public Health Department) need to be integrated with the UHC system. Salary ceilings for ESI should be removed and care should be provided to unorganised sector workers also, to fully use the capacity of ESIC health facilities.

D. Addressing social determinants of health and essential public health functions

The UHC system which ensures health care for all must be accompanied by a framework to minimise ill health and promote health, thus reducing the numbers of people needing health care. In other words, social determinants of health, which are various social factors responsible for the health of a population, must be addressed effectively. Services like water supply, nutrition and sanitation, and measures to check unhealthy influences like addiction to tobacco, alcohol etc., need to be integrated with the UHC system. In this context, two kinds of measures would be necessary.

1. Addressing social determinants of health through coordination mechanisms from below-

Strong convergent governance and accountability mechanisms will need to be operationalised to ensure that various departments coordinate their efforts and close various gaps in provisioning, so that social determinants are addressed in keeping with health needs of each population. Here Taluka / Ward and District / City level 'Health and Social service councils' with involvement of elected representatives, officials of various departments and broad range of civil society and community representatives are envisaged as forums to ensure effective convergence in a rights based framework. Naturally this convergence from below would need to be supported by political endorsement from the highest levels and administratively mandating such coordination forums.

2. Performing Essential public health functions-

It is necessary that the health system has a dedicated cadre and mandate to monitor and strongly advocate for redressal of determinants of health problems in each locality, starting from the Block or Ward level onwards. These would include promoting clean drinking water, nutrition, environmental conditions and checking negative factors like addictions. Health personnel would need to be trained in basic epidemiological skills, enabling them to develop an epidemiological profile and locally relevant strategies for health promotion and disease control in each area. A step towards the building of public health cadre would be *upgrading the old multipurpose workers (MPWs) as public health workers (PHWs) at the sub centre level, with expansion these could be either male or female. Similarly, appointing a Public Health Officer (PHO) at each Primary health centre (PHC), block and district* who will be responsible for ensuring essential public health functions within the covered population area. Such Health officials could play the role of convenors of Health and social service councils at various levels, ensuring that such councils meet regularly, take cognisance of critical issues and decide on necessary actions effectively. They would thus perform an advocacy function to ensure that various social determinants are addressed in an ongoing and effective manner, as part of an accountable, rights based framework.

Overall, addressing social determinants of health through empowered, community oriented governance mechanisms and performance of Essential public health functions would be complementary to each other.

Some immediate steps for moving towards UHC in Maharashtra

While achieving a UHC system in comprehensive form would be a process that would develop over several years, certain steps can be taken within a year or two, which could form the basis for moving towards a complete UHC system. These include the following:

A. Adopt and declare a policy of moving towards a system for UHC in Maharashtra, accompanied by a roadmap to mobilise adequate financial resources for the same.

B. Steps in near future for expansion and improvement in Public Health System-

- Launch 'Free medicines scheme' in all public health centres across the state and set up an autonomous procurement agency similar to Tamil Nadu Medical Services Corporation (TNMSC) for efficient public procurement and distribution of medicines.
- Widely publicise 'Guaranteed free health services' in public health system to attract people to public health facilities.
- Maharashtra needs to draw lessons from other states like Haryana to fill up vacant posts of specialist doctors and complete the backlog. For this diploma courses in basic medical specialities can be started. Start course for Bachelor in Community Health, and a course on Public Health to create cadre of rural public healthcare practitioners and public health officers respectively.
- Launch a 'Human Resources in Health Policy' for the state which will be consistent with the needs of UHC, gender sensitive, focused on improving working conditions, opening up promotional and welfare avenues for the staff etc. Adopt Karnataka model of recruitment, transfer and postings of healthcare staff. Conduct orientation programmes for all healthcare staff for gender sensitivity and inclusive healthcare. The system of contractual appointments in health services should be eliminated as far as possible.
- Generalise 'Community Based Monitoring and Planning of Health Services' across the state, so that people in the state will be empowered to monitor public health facilities, Anganwadis and drinking water services. Institutionally involve groups of marginalised populations and sections with special health needs in monitoring and planning health services.
- Make 'Taluka' / Ward as a node for participatory health monitoring, planning and evaluation. Set up multi-stakeholder Taluka/Ward, district, state level 'Health and Social services councils' to ensure accountability of health services, ICDS, ration, drinking water, sanitation etc. while ensuring their effective convergence to promote public health.

Define role and powers of Public health department in activating other departments such as water supply and ICDS to ensure effective action on these social determinants of health.

- Prepare 'Maharashtra Urban Health Plan' to set up a uniform urban public health system structure across the state and start creating new public healthcare institutions as proposed above in time bound manner. Set up Urban Health Directorate or equivalent structure within Directorate of Health Services to coordinate, between State Government and Municipal Corporations/Councils, and for execution of 'Maharashtra Urban Health Plan'.
- Open up availability of medical services in ESI hospitals to unorganised sector workers, with a caveat that 50% of such beds should be reserved for existing ESIS card holder workers and their families.
- Take a step to integrate AYUSH systems (including Ayurved, Homeopathy) by starting a bridge course for basic integrated doctors. Create separate wards for AYUSH treatment in all block and district hospitals.

C. Steps in near future for regulation and socialisation of private medical sector

- Enact 'Maharashtra Clinical Establishment (Registration and Regulation) Act to regulate private clinical establishments and protect patient's rights therein. Standardise range, maximum rates to be charged for various services in different categories of private facilities.
- Ban any new private medical colleges in the state and strictly enforce standardised fee structure with no capitation fees in these colleges.
- Establish a Publicly managed admission system, and regular referral between government hospitals and charitable trust hospitals, to effectively utilise 20% beds in trust hospitals for poor patients under the scheme. Ensure that availability of free/concessional beds in each such hospital is transparently displayed through a Website on a Real Time Basis. Government should launch a free 'Helpline' for patients to avail benefits of these free beds.
- Take steps towards expanding and making Maharashtra Medical Council and other such State Councils of healthcare professional more effective, democratic, and transparent.
- Initiate a chain of low cost generic medicine centres across the state, along with enforcing statutory guidelines of Medical Council of India requiring doctors to prescribe generic medicines only.

Given the worsening health care crisis, where most sections of society – cultivators and farm labourers in rural areas, unorganised sector workers, organised sector working class, middle class -are unable to access affordable, quality health care, do we have any option except moving towards a UHC system?

Political will is the key ingredient and driving force to develop UHC.

Those who will benefit by a UHC system are the vast majority of people, while those who will oppose it due to vested interests are a small handful.

Can we work together and build a powerful movement for UHC, to generate such political will in Maharashtra?

Would you like to be part of this change?

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