RIGHT TO HEALTH CARE

moving from idea to reality

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Operationalising Right to Healthcare in India

Preamble: 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*

More than half a century's experience of waiting for the policy route to assure respect, protection and fulfillment for healthcare is now behind us. The Bhore Committee recommendations which had the potential for this assurance were assigned to the back-burner due to the failure of the state machinery to commit a mere 2% of the Gross Domestic Product at that point of time for implementation of the Bhore Plan (Bhore, 1946). The experience over the nine plan periods since then in implementing health plans and programs has been that each plan and/or health committee contributed to the dilution of the comprehensive and universal access approach by developing selective schemes or programs, and soon enough the Bhore plan was archived and forgotten about. So our historical experience tells us that we should abandon the policy approach and adopt the human rights route to assuring universal access to all people for healthcare. The State is today talking of health sector reform and hence it is the right time to switch gears and move in the direction of right to health and healthcare.

The right to healthcare is primarily a claim to an entitlement, a positive right, not a protective fence.[1] As entitlements rights are contrasted with privileges, group ideals, societal obligations, or acts of charity, and once legislated they become claims justified by the laws of the state. (Chapman, 1993) The emphasis thus needs to shift from 'respect' and 'protect' to focus more on 'fulfill'. For the right to be effective optimal resources that are needed to fulfill the core obligations have to be made available and utilized effectively.

Further, using a human rights approach also implies that the entitlement is universal. This means there is no exclusion from the provisions made to assure healthcare on any grounds whether purchasing power, employment status, residence, religion, caste, gender, disability, and any other basis of discrimination.[2] But this does not discount the special needs of disadvantaged

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[1] In the 18th century rights were interpreted as fences or protection for the individual from the unfettered authoritarian governments that were considered the greatest threat to human welfare. Today democratic governments do not pose the same kind of problems and there are many new kinds of threats to the right to life and well being. (Chapman, 1993) Hence in today's environment reliance on mechanisms that provide for collective rights is a more appropriate and workable option. Social democrats all over Europe, in Canada, Australia have adequately demonstrated this in the domain of healthcare.

[2] A human rights approach would not necessitate that all healthcare resources be distributed according to strict quantitative equality or that society attempt to provide equality in medical outcomes, neither of which would in any case be feasible. Instead the universality of the right to healthcare requires the definition of a specific entitlement be guaranteed to all members of our society without any discrimination. (Chapman, 1993)

and vulnerable groups who may need special entitlements through affirmative action to rectify historical or other inequities suffered by them.

Thus establishing universal healthcare through the human rights route is the best way to fulfill the obligations mandated by international law and domestic constitutional provisions. International law, specifically ICESCR, the Alma Ata Declaration, among others, provide the basis for the core content of right to health and healthcare. But country situations are very different and hence there should not be a global core content, it needs to be country specific.[3] In India's case a certain trajectory has been followed through the policy route and we have an existing baggage, which we need to sort out and fit into the new strategy.

Specific features of this historical baggage are:

- a very large and unregulated private health sector with an attitude that the existing policy is the best one as it gives space for maximizing their interests, a complete absence of professional ethics and absolute disinterest in organizing around issues of self-regulation, improvement of quality and accountability, and need for an organised health care system
- a declining public health care system which provides selective care through a multiplicity of schemes and programs, and discriminates on the basis of residence (rural-urban) in providing for entitlements for healthcare
- existing inequities in access to healthcare based on employment status and purchasing power
- inadequate development of various pre-conditions of health like water supply and sanitation, environmental health and hygiene and access to food[4]
- very large numbers of unqualified and untrained practitioners
- declining investments and expenditure in public health
- adequate resource availability when we account for out-of-pocket expenses
- humanpower and infrastructure reasonably adequate, though inequitably distributed
- wasteful expenditures due to lack of regulation and standard protocols for treatment

Thus the operationalisation of the right to healthcare will have to be developed keeping in mind what we have and how we need to change it.

Framework for Right to Healthcare

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[3] Country specific thresholds should be developed by indicators measuring nutrition, infant mortality, disease frequency, life expectancy, income, unemployment and underemployment, and by indicators relating to adequate food consumption. States should have an immediate obligation to ensure the fulfillment of this minimum threshold. (Andreassen et.al., 1988 as quoted by Toebes,1998)

[4] Efforts to prevent hunger have been there through the Integrated Child Development Services program and mid-day meals. Analysis of data on malnutrition clearly indicates that where enrollment under ICDS is optimal malnutrition amongst children is absent, but where it is deficient one sees malnutrition. Another issue is that we have overflowing food-stocks in godowns but yet each year there are multiple occasions of mass starvation in various pockets of the country.

The quote used as the Preamble is very relevant to the notion of right to healthcare. Sigerist said this long ago and since then most of Europe and many other countries have made this a reality. And today when such demands are raised in third world countries, India being one of them, it is said that this is no longer possible - the welfare state must wither away and make way for global capital! Europe is also facing pressures to retract the socialist measures, which working class struggles had gained since 19th century. So we are in a hostile era of global capital which wants to make profit out of anything it can lay its hands on. But we are also in an era when social and economic rights, apart from the civil and political rights, are increasingly on the international agenda and an important cause for advocacy.

Thus health and health care is now being viewed very much within the rights perspective and this is reflected in Article 12 **"The right to the highest attainable standard of health"** of the International Covenant on Economic, Social and Cultural Rights to which India has acceded. According to the General Comment 14 the Committee for Economic, Social and Cultural Rights states that the right to health requires *availability*, *accessibility*, *acceptability*, and *quality* with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. This understanding is detailed below:

- The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:
  (a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.
  (b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
  Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
  Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas.

> Accessibility further includes adequate access to buildings for persons with disabilities.
> *Economic accessibility (affordability)*: health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
> *Information accessibility*: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
> (c) *Acceptability*. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
> (d) *Quality*. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000)

Universal access to good quality healthcare equitably is the key element at the core of this understanding of right to health and healthcare. To make this possible the State parties are obligated to *respect, protect and fulfill* the above in a progressive manner:

> The right to health, like all human rights, imposes three types or levels of obligations on State parties: the obligations to *respect*, *protect* and *fulfill*. In turn, the obligation to fulfill contains obligations to facilitate, provide and promote. The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfill* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. (Ibid)

(Further) State parties are referred to the Alma-Ata Declaration, which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. State parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from Article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

> (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) To ensure equitable distribution of all health facilities, goods and services;
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.
The Committee also confirms that the following are obligations of comparable priority:
(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
(b) To provide immunization against the major infectious diseases occurring in the community;
(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(e) To provide appropriate training for health personnel, including education on health and human rights. (Ibid)

The above guidelines from General Comment 14 on Article 12 of ICESCR are critical to the development of the framework for right to health and healthcare. As a reminder it is important to emphasise that in the Bhore Committee report of 1946 we already had these guidelines, though they were not in the 'rights' language. Thus within the country's own policy framework all this has been available as guiding principles for now 56 years.

Before we move on to suggest the framework it is important to review where India stands today vis-à-vis the core principles of availability, accessibility, acceptability and quality in terms of the State's obligation to respect, protect and fulfill.

In Table 1 we see that the availability of healthcare infrastructure, except perhaps availability of doctors and drugs - the two engines of growth of the private health sector, is grossly inadequate. The growth over the years of healthcare services, facilities, humanpower etc.. has been inadequate and the achievements not enough to make any substantive impact on the health of the people. The focus of public investment in the health sector has been on medical education and production of doctors for the private sector, support to the pharmaceutical industry through states own participation in production of bulk drugs at subsidized rates, curative care for urban population and family planning services. The poor health impact we see today has clear linkages with such a pattern of investment:

- the investment in medical education has helped create a mammoth private health sector, not only within India, but in many developed countries through export of over one-fourth of the doctors produced over the years. Even though since mid-eighties private medical colleges have been allowed, still 75-80% of the outturn is from public medical schools. This continued subsidy without any social return[5] is only adding to the burden of inequities and exploitation within the healthcare system in India.
- public sector participation in drug production was a laudable effort but soon it was realized that the focus was on capital goods, that is bulk drug production, and most supplies were directed to private formulation units at subsidized rates. It is true that the government did control drug prices, but post mid-seventies the leash on drug prices was gradually released and by the turn of the nineties controls disappeared. Ironically, at the same time the public pharmaceutical industry has also disappeared – the little of what remains produces a value of drugs lesser than their losses! And with this withering away of public drug production and price control, essential drugs availability has dropped drastically. Another irony in this story is that while today we export 45% of our drug production, we have to import a substantial amount of our essential drug requirements.[6]
- Most public sector hospitals are located in urban areas. In the eighties, post-Alma Ata and India ratifying the ICESCR, efforts were made towards increasing hospitals in rural areas through the Community Health Centres. This was again a good effort but these hospitals are understaffed by over 50% as far as doctors are concerned and hence become ineffective. Today urban areas do have adequate number of beds (including private) at a ratio of one bed per 300 persons but rural areas have 8 times less hospital beds as per required norms (assuming a norm of one bed per 500 persons). So there is gross discrimination based on residence in the way the hospital infrastructure has developed in the country, thereby depriving the rural population access to curative care services.[7] Further, the declining investment in the public health sector since mid-eighties, and the consequent expansion of the private health sector, has further increased inequity in access for people across the country. More recently a facility survey across the country by the Ministry of Health and Family Welfare clearly highlights the inadequacies of the public health infrastructure, especially in the rural areas.[8] This

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[5] Compulsory public medical service for a limited number of years for medical graduates from the public medical schools is a good mechanism to fulfill the needs of the public healthcare system. The Union Ministry of Health is presently seriously considering this option, including allowing post-graduate medical education only to those who have completed the minimum public medical service, including in rural areas.

[6] Data on availability of essential drugs show that in 1982-83 the gap in availability was only 2.7% but by 1991-92 it had walloped to 22.3%. This is precisely the period in which drug price control went out of the window. (Phadke,A, 1998)

[7] NFHS-1998 data shows that in rural areas availability of health services within the village was as follows: 13% of villages had a PHC, 28% villages had a dispensary, 10% had hospitals, 42% had atleast one private doctor (not necessarily qualified), 31% of villages had visiting private doctors, 59% had trained birth attendants, and 33% had village health workers

[8] This first phase of this survey done in 1999, which covered 210 district hospitals, 760 First Referral Units, 886 CHCs and 7959 PHCs, shows the following results: **Percent of Different Units Adequately Equipped**

survey is a major indictment of the underdevelopment of the public healthcare system - even the District Hospitals, which are otherwise well endowed, have a major problem with adequacy of critical supplies needed to run the hospital. The rural health facilities across the board are ill provided. (MOHFW, 2001)

- Family planning services is another area of almost monopolistic public sector involvement. The investment in such services over the years has been very high, to the tune of over 15% of the total public health budget. But over and above this the use of the entire health infrastructure and other government machinery for fulfilling its goals must also be added to these resources expended. This program has also witnessed a lot of coercion[9] and grossly violated human rights. The hard line adopted by the public health system, especially in rural areas, for pushing population control has terribly discredited the public health system and affected adversely utilization of other health programs. The only silver lining within this program is that in the nineties immunisation of children and mothers saw a rapid growth, though as yet it is still quite distant from the universal coverage level.

Then there are the underlying conditions of health and access to factors that determine this, which are equally important in a rights perspective. Given the high level of poverty and even a lesser level of public sector participation in most of these factors the question of respecting, protecting and fulfilling by the state is quite remote. Latest data from NFHS-1998 tells the following story:

- Piped water is available to only 25% of the rural population and 75% of urban population
- Half the urban population and three-fourths of the rural population does not purify/filter the water in any way
- Flush and pit toilets are available to only 19% of the rural population as against 81% of those in towns and cities
- Electricity for domestic use is accessible to 48% rural and 91% urban dwellers
- For cooking fuel 73% of villagers still use wood. LPG and biogas is accessed by 48% urban households but only 6% rural households
- As regards housing 41% village houses are *kachha* whereas only 9% of urban houses are so
- 21% of the population chews *paan masaala* and/or tobacco, 16% smoke and 10% consume alcohol

Units	Infrastructure	Staff	Supply	Equipment	Training
Dist. Hospitals	94	84	28	89	33
FRUs	84	46	26	69	34
CHCs	66	25	10	49	25
PHCs*	36	38	31	56	12

*Only 3% of PHCs had 80% or more of the critical inputs needed to run the PHC, and only 31% had upto 60% of critical inputs (India Facility Survey Phase I, 1999, IIPS, Ministry of Health and Family Welfare, New Delhi, 2001)

[9] It must be noted that coercion was not confined only to the Emergency period in the mid-seventies, but has been part and parcel of the program through a target approach wherein various government officials from the school teacher to the revenue officials were imposed targets for sterilization and IUCDs and were penalized for not fulfilling these targets in different ways, like cuts and/or delays in salaries, punishment postings etc.

Besides this environmental health conditions in both rural and urban areas are quite poor, working conditions in most work situations, including many organized sector units, which are governed by various social security provisions, are unhealthy and unsafe. Infact most of the court cases in India using Article 21 of the Fundamental Rights and relating it to right to health have been cases dealing with working conditions at the workplace, workers rights to healthcare and environmental health related to pollution.

Other concerns in access relate to the question of economic accessibility. It is astounding that large-scale poverty and predominance of private sector in healthcare have to co-exist. It is in a sense a contradiction and reflects the State's failure to respect, protect and fulfill its obligations by letting vast inequities in access to healthcare and vast disparities in health indicators, to continue to persist, and in many situations get worse. Data shows that out of pocket expenses account for over 4% of the GDP as against only 0.9 % of GDP expended by state agencies, and the poorer classes contribute a disproportionately higher amount of their incomes to access health care services both in the private sector and public sector. (Ellis, et.al, 2000; Duggal, 2000; Peters et.al. 2002). Further, the better off classes use public hospitals in much larger numbers with their hospitalization rate being six times higher than the poorest classes[10], and as a consequence consume an estimated over three times more of public hospital resources than the poor. (NSS-1996; Peters et.al. 2002)

Related to the above is another concern vis-à-vis international human rights conventions' stance on matters with regard to provision of services. All conventions talk about *affordability* and never mention 'free of charge'. In the context of poverty this notion is questionable as far as provisions for social security like health, education and housing go. Access to these factors socially has unequivocal consequences for equity, even in the absence of income equity. Free services are viewed negatively in global debate, especially since we have had a unipolar world, because it is deemed to be disrespect to individual responsibility with regard to their healthcare. (Toebes, 1998, p.249) For instance in India there is great pressure on public health systems to introduce or enhance user fees, especially from international donors, because they believe this will enhance responsibility of the public health system and make it more efficient (Peters, et. al.,2002). In many states such a policy has been adopted in India and immediately adverse impacts are seen, the most prominent being decline in utilization of public services by the poorest. It must be kept in mind that India's taxation policy favours the richer classes. Our tax base is largely indirect taxes, which is a regressive form of generating revenues. Direct tax revenues, like income tax is a very small proportion of total tax revenues. Hence the poor end up paying a larger proportion of their income as tax revenues in the form of sales tax, excise duties etc.. on goods and services they consume. Viewed from this perspective the poor have already pre-paid for receiving public goods like health and education from the state free of cost at the point of

[10] The poorer classes have reported such low rates of hospitalization, not because they fall ill less often but because they lack resources to access healthcare, and hence invariably postpone their utilization of hospital services until it is absolutely unavoidable.

provision. So their burden of inequity increases substantially if they have to pay for such services when accessing from the public domain.

The above inequity in access gets reflected in health outcomes, which reflect strong class gradients. Thus infant and child mortality, malnutrition amongst women and children, prevalence of communicable diseases like tuberculosis and malaria, attended childbirth are between 2 to 4 times better amongst the better off groups as compared to the poorest groups. (NFHS-1998) In this quagmire of poverty, the gender disparities also exist but they are significantly smaller than the class inequities. Such disparity, and the consequent failure to protect by the state the health of its population, is a damning statement on the health situation of the country. In India there is an additional dimension to this inequity – differences in health outcomes and access by social groups, specifically the scheduled castes and scheduled tribes. Data shows that these two groups are worse off on all counts when compared to others. Thus in access to hospital care as per NSS-1996 data the STs had 12 times less access in rural areas and 27 times less in urban areas as compared to others; for SCs the disparity was 4 and 9 times, in rural and urban areas, respectively. What is astonishing is that the situation for these groups is worse in urban areas where overall physical access is reasonably good. Their health outcomes are adverse by 1.5 times that of others. (NFHS-1998)

Another stumbling block in meeting state obligations is information access. While data on public health services, with all its limitations, is available, data on the private sector is conspicuous by its absence. The private sector, for instance does not meet its obligations to supply data on notifiable, mostly communicable, diseases, which is mandated by law. This adversely affects the epidemiological database for those diseases and hence affects public health practice and monitoring drastically. Similarly the local authorities have miserably failed to register and record private health institutions and practitioners. This is an extremely important concern because all the data quoted about the private sector is an under-estimate as occasional studies have shown.[11] The situation with regard to practitioners is equally bad. The medical councils of all systems of medicine are statutory bodies but their performance leaves much to be desired. The recording of their own members is not up to the mark, and worse still since they have been unable to regulate medical practice there are a large number of unqualified and untrained persons practicing medicine across the length and breadth of the country. Estimates of this unqualified group vary from 50% to 100% of the proportion of the qualified practitioners. (Duggal, 2000; Rhode et.al.1994) The profession itself is least concerned about the importance of such information and hence does not make any significant efforts to address this issue. This poverty of information is definitely a rights issue even within the current constitutional context as lack of such information could jeopardize right to life.

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[11] A survey in Mumbai in 1994 showed that the official list with the Municipal Corporation accounted for only 64% of private hospitals and nursing homes (Nandraj and Duggal,1997). Similarly, a much larger study in Andhra Pradesh in 1993 revealed extraordinary missing statistics about the private health sector. For that year official records indicated that AP had 266 private hospitals and 11,103 beds, but the survey revealed that the actual strength of the private sector was over ten times more hospitals with a figure of 2802 private hospitals and nearly four times more hospital beds at 42192 private hospital beds. (Mahapatra, P, 1993)

Finally there are issues pertaining to acceptability and quality. Here the Indian state fails totally. There is a clear rural-urban dichotomy in health policy and provision of care; urban areas have been provided comprehensive healthcare services through public hospitals and dispensaries and now even a strengthened preventive input through health posts for those residing in slums. In contrast rural areas have largely been provided preventive and promotive healthcare alone. This violates the principle of non-discrimination and equity and hence is a major ethical concern to be addressed.

Medical practice, especially private, suffers from a complete absence of ethics. The medical associations have as yet not paid heed to this issue at all and over the years malpractices within medical practice have gone from bad to worse. In this malpractice game the pharmaceutical industry is a major contributor as it induces doctors and hospitals to prescribe irrational and/or unnecessary drugs.[12] All this impacts drastically on quality of care. In clinical practice and hospital care in India there exist no standard protocols and hence monitoring quality becomes very difficult. For hospitals the Bureau of Indian Standards have developed guidelines, and often public hospitals do follow these guidelines. (BIS, 1989; Nandraj and Duggal, 1997) But in the case of private hospitals they are generally ignored. Recently efforts at developing accreditation systems has been started in Mumbai (Nandraj, et.al, 2000)[13], and on the basis of that the Central government is considering doing something at the national level on this front so that it can promote quality of care.

To establish right to healthcare with the above scenario certain first essential steps will be compulsory:

- equating directive principles with fundamental rights through a constitutional amendment
- incorporating a National Health Act (similar to Canada Health Act) which will organize the present healthcare system under a common umbrella organization as a public-private mix governed by an autonomous national health authority which will also be responsible for bringing together all resources under a single-payer mechanism
- generating a political commitment through consensus building on right to healthcare in civil society
- development of a strategy for pooling all financial resources deployed in the health sector
- redistribution of existing health resources, public and private, on the basis of standard norms (these would have to be specified) to assure physical (location) equity

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[12] Data of 80 top selling drugs in 1991 showed that 29% of them were irrational and/or hazardous and their value was to the tune of Rs. 2.86 billion. A study of prescription practice in Maharashtra in 1993 revealed that outright irrational drugs constituted 45% of all drugs prescribed and rational prescriptions were only 18%. The proportion of irrationality was higher in private practice by over one-fifth. (Phadke, A, 1998)

[13] In Mumbai CEHAT in collaboration with various medical associations and hospital owner associations have set up a non-profit company called Health Care Accreditation Council. This body hopes to provide the basis for evolving a much larger initiative on this front.

As an immediate step, within its own domain, the State should undertake to accomplish the following:

- Allocation of health budgets as block funding, that is on a per capita basis for each population unit of entitlement as per existing norms. This will create redistribution of current expenditures and reduce substantially inequities based on residence.[14] Local governments should be given the autonomy to use these resources as per local needs but within a broadly defined policy framework of public health goals
- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools, as also make public service of a limited duration mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and will have a dramatic impact on the improvement of the credibility of public health services
- Essential drugs as per the WHO list should be brought back under price control (90% of them are off-patent) and/or volumes needed for domestic consumption must be compulsorily produced so that availability of such drugs is assured at affordable prices and within the public health system
- Local governments must adopt location policies for setting up of hospitals and clinics as per standard acceptable ratios, for instance one hospital bed per 500 population and one general practitioner per 1000 persons. To restrict unnecessary concentration of such resources in areas fiscal measures to discourage such concentration should be instituted.[15]
- The medical councils must be made accountable to assure that only licensed doctors are practicing what they are trained for.[16] Such monitoring is the core responsibility of the council by law which they are not fulfilling, and as a consequence failing to protect the patients who seek care from unqualified and untrained doctors. Further continuing medical education must be implemented strictly by the various medical councils and licenses should not be renewed (as per existing law) if the required hours and certification is not accomplished

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[14]To illustrate this, taking the Community Health Centre (CHC) area of 150,000 population as a "health district" at current budgetary levels under block funding this "health district" would get Rs. 30 million (current resources of state and central govt. combined is over Rs.200 billion, that is Rs. 200 per capita). This could be distributed across this health district as follows : Rs 300,000 per bed for the 30 bedded CHC or Rs. 9 million (Rs.6 million for salaries and Rs. 3 million for consumables, maintenance, POL etc..) and Rs. 4.2 million per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs. 3.2 million as salaries and Rs. 1 million for consumables etc..). This would mean that each PHC would get Rs. 140 per capita as against less than Rs. 50 per capita currently. In contrast a district headquarter town with 300,000 population would get Rs. 60 million, and assuming Rs. 300,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs. 150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would have to contribute 5% of its budget. Ofcourse, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. (Duggal,2002)

[15] Such locational restrictions in setting up practice may be viewed as violation of the fundamental right to practice one's profession anywhere. It must be remembered that this right is not absolute and restrictions can be placed in concern for the public good. The suggestion here is not to have compulsion but to restrict through fiscal measures. In fact in the UK under NHS, the local health authorities have the right to prevent setting up of clinics if their area is saturated.

[16] For instance the Delhi Medical Council has taken first steps in improving the registration and information system within the council and some mechanism of public information has been created.

- Integrate ESIS, CGHS and other such employee based health schemes with the general public health system so that discrimination based on employment status is removed and such integration will help more efficient use of resources. For instance, ESIS is a cash rich organization sitting on funds collected from employees (which are parked in debentures and shares of companies!), and their hospitals and dispensaries are grossly under-utilised. The latter could be made open to the general public
- Strictly regulate the private health sector as per existing laws, but also an effort to make changes in these laws to make them more effective. This will contribute towards improvement of quality of care in the private sector as well as create some accountability
- Strengthen the health information system and database to facilitate better planning as well as audit and accountability.

Carrying out the above immediate steps, for which we need only political commitment and not any radical transformation, will create the basis to move in the direction of first essential steps indicated above. In order to implement the first-steps the essential core contents of healthcare have to be defined and made legally binding through the processes of the first-steps. The literature and debate on the core contents is quite vast and from that we will attempt to draw out the core content of right to health and healthcare keeping the Indian context discussed above in mind.

The Core Content of Right to Healthcare

Audrey Chapman in discussing the minimum core contents summarises this debate, "Operatively, a basic and adequate standard of healthcare is the minimum level of care, the core entitlement, that should be guaranteed to all members of society: it is the floor below which no one will fall.[17] (Chapman, 1993). She further states that the basic package should be fairly generous so that it is widely acceptable by people, it should address special needs of special and vulnerable population groups like under privileged sections (SC and ST in India), women, physically and mentally challenged, elderly etc., it should be based on cost-conscious standards but judge to provide services should not be determined by budgetary constraints[18], and it should be accountable to the community as also demand the latter's participation and involvement in monitoring and supporting it. All this is very familiar terrain, with the Bhore Committee saying precisely the same things way back in 1946.

We would like to put forth the **core content** as under:
Primary care services[19] should include at least the following:

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[17] This implies that the health status of the people should be such that they can atleast work productively and participate actively in the social life of the community in which they live. It also means that essential healthcare sufficient to satisfy basic human needs will be accessible to all, in an acceptable and affordable way, and with their full involvement. (WHO, 1993)

[18] General Comment 3 of ICESCR reiterates this that the minimum core obligations by definition apply irrespective of the availability of resources or any other factors and difficulties. Hence it calls for international cooperation in helping developing countries who lack resources to fulfil obligations under international law.

[19] Most of atleast the curative services will of necessity have to be a public-private mix because of the existing baggage of the health system we have but this has to be under an organized and accountable health care system.

- General practitioner/family physician services for personal health care.
- First level referral hospital care and basic specialty services (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic), including dental and ophthalmic services.
- Immunisation services against all vaccine preventable diseases.
- Maternity and reproductive health services for safe pregnancy, safe abortion, delivery and postnatal care and safe contraception.
- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Health education.
- Rehabilitation services for the physically and mentally challenged and the elderly and other vulnerable groups
- Occupational health services with a clear liability on the employer
- Safe and assured drinking water and sanitation facilities, minimum standards in environmental health and protection from hunger to fulfill obligations of underlying preconditions of health[20]

The above listed components of primary care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. And these have to be within the context of first-steps and not to wait for progressive realisation – these cannot be broken up into stages, as they are the core minimum. The key to equity is the existence of a minimum decent level of provision, a floor that has to be firmly established. However, if this floor has to be stable certain ceilings will have to be maintained toughly, especially on urban health care budgets and hospital use (Abel-Smith,1977). This is important because human needs and demands can be excessive and irrational. Those wanting services beyond the established floor levels will have to seek it outside the system and/or at their own cost.

Therefore it is essential to specify adequate minimum standards of health care facilities, which should be made available to all people irrespective of their social, geographical and financial position. There has been some amount of debate on standards of personnel requirements [doctor: population ratio, doctor: nurse ratio] and of facility levels [bed: population ratio, PHC: population ratio] but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, 3 nurses per doctor, health expenditure to the tune of 5% of GDP etc.. Another way of viewing standards is to look at the levels of countries that already have universal systems in place. In such countries one finds that on an average per 1000 population there are 2 doctors, 5 nurses and as many as 10 hospital beds (OECD, 1990, WHO, 1961). The moot point here is that these ratios have remained more or less constant over the last 30 years indicating that some sort of an optimum level has been reached. In India with regard to

[20] These services need not be part of the health department or the national health authority that may be created and may continue to be part of the urban and rural development departments as of present.

hospital care the Bureau of Indian Standards (BIS) has worked out minimum requirements for personnel, equipment, space, amenities etc.. For doctors they have recommended a ratio of one per 3.3 beds and for nurses one per 2.7 beds for three shifts. (BIS 1989, and 1992). Again way back in 1946 the Bhore Committee had recommended reasonable levels (which at that time were about half that of the levels in developed countries) to be achieved for a national health service, which are as follows:

- one doctor per 1600 persons
- one nurse per 600 persons
- one health visitor per 5000 persons
- one midwife per 100 births
- one pharmacist per 3 doctors
- one dentist per 4000 persons
- one hospital bed per 175 persons
- one PHC per 10 to 20 thousand population depending on population density and geographical area covered
- 15% of total government expenditure to be committed to health care, which at that time was about 2% of GDP (Bhore, 1946)

The first response from the government and policy makers to the question of using the above norms in India is that they are excessive for a poor country and we do not have the resources to create such a level of health care provision. Such a reaction is invariably not a studied one and needs to be corrected. Let us construct a selected epidemiological profile of the country based on whatever proximate data is available through official statistics and research studies. We have obtained the following profile after reviewing available information:

- Daily morbidity = 2% to 3% of population, that is about 20-30 million patients to be handled everyday (7 - 10 billion per year)
- Hospitalisation Rate 20 per 1000 population per year with 12 days average stay per case, that is a requirement of 228 million bed-days (that is 20 million hospitalisations as per NSS -1987 survey, an underestimate because smaller studies give estimates of 50/1000/year or 50 million hospitalisations)
- Prevalence of Tuberculosis 11.4 per 1000 population or a caseload of over 11 million patients
- Prevalence of Leprosy 4.5 per 1000 population or a caseload of over 4 million patients
- Incidence of Malaria 2.6 per 1000 population yearly or 2.6 million new cases each year
- Diarrhoeal diseases (under 5) = 7.5% (2-week incidence) or 1.8 episodes/child/year or about 250 million cases annually
- ARI (under 5) = 18.4% (2-week incidence) or 3.5 episodes per child per year or nearly 500 million cases per year
- Cancers = 1.5 per 1000 population per year (incidence) or 1.5 million new cases every year
- Blindness =1.4% of population or 14 million blind persons
- Pregnancies = 21.4% of childbearing age-group women at any point of time or over 40 million pregnant women

- Deliveries/Births = 25 per 1000 population per year or about 68,500 births every day

(Estimated from CBHI, WHO, 1988, ICMR, 1990<a>, NICD, 1988, Gupta et.al.,1992, NSS,1987)

The above is a very select profile, which reflects what is expected out of a health care delivery system. Let us take handling of daily morbidity alone, that is, outpatient care. There are 30 million cases to be tackled every day. Assuming that all will seek care (this usually happens when health care is universally available, in fact the latter increases perception of morbidity) and that each GP can handle about 60 patients in a days work, we would need over 500,000 GPs equitably distributed across the country. This is only an average; the actual requirement will depend on spatial factors (density and distance). This means one GP per about 2500 population, this ratio being three times less favourable than what prevails presently in the developed capitalist and the socialist countries. Today we already have over 1,300,000 doctors of all systems (550,000 allopathic) and if we can integrate all the systems through a CME program and redistribute doctors as per standard requirements we can provide GP services in the ratio of one GP per 700-1000 population.

Organising the Universal Healthcare System[21]

The conversion of the existing system into an organised system to meet the requirements of universality and equity and the rights based approach will require certain hard decisions by policy-makers and planners. We first need to spell out the structural requirements or the outline of the model, which will need the support of legislation. More than the model suggested hereunder it is the expose of the idea that is important and needs to be debated for evolving a definitive model.

The most important lesson to learn from the existing model is how not to provide curative services. We have seen above that curative care is provided mostly by the private sector, uncontrolled and unregulated. The system operates more on the principles of irrationality than medical science. The pharmaceutical industry is in a large measure responsible for this irrationality in medical care. Twenty thousand drug companies and over 60,000 formulations characterise the over Rs. 260 billion drug industry in India.[22] The WHO recommends less than 300 drugs as essential for provision of any decent level of health care. If good health care at a reasonable cost has to be provided then a mechanism of assuring rationality must be built into the system. Family medical practice, which is adequately regulated, along with referral support, is the best and the most economic means for providing good health care. What follows is an illustration of a mechanism to operationalise the right to healthcare, it should not be seen as a well defined model but only as an example to facilitate a debate on creating a healthcare system based on a right to healthcare approach. This is based on learnings from experiences in other

[21] The following discussion is an updated version based on work done by the author earlier at the Ministry of Health New Delhi as a fulltime WHO National Consultant in the Planning Division of the Ministry. An earlier version was published as "The Private Health Sector in India – Nature, Trends and a Critique" by VHAI, New Delhi, 2000

[22] In addition to this there is a fairly large and expanding ayurvedic and homoeopathy drug industry estimated to be over one-third of mainstream pharmaceuticals

countries which have organized healthcare systems which provide near universal health care coverage to its citizens.

Family Practice

Each family medical practitioner (FMP) will on an average enroll 400 to 500 families; in highly dense areas this number may go upto 800 to 1000 families and in very sparse areas it may be as less as 100 to 200 families. For each family/person enrolled the FMP will get a fixed amount from the local health authority, irrespective of whether care was sought or no. He/she will examine patients, make diagnosis, give advise, prescribe drugs, provide contraceptive services, make referrals, make home-visits when necessary and give specific services within his/her framework of skills. Apart from the capitation amount, he/she will be paid separately for specific services (like minor surgeries, deliveries, home-visits, pathology tests etc..) he /she renders, and also for administrative costs and overheads. The FMP can have the choice of either being a salaried employee of the health services (in which case he/she gets a salary and other benefits) or an independent practitioner receiving a capitation fee and other service charges.

Epidemiological Services

The FMP will receive support and work in close collaboration with the epidemiological station (ES) of his/her area. The present PHC setup will be converted into an epidemiological station. This ES will have one doctor who has some training in public health (one FMP, preferably salaried, of the ES area can occupy this post) and a health team comprising of a public health nurse and health workers and supervisors will assist him. Each ES would cover a population between 10,000 to 50,000 in rural areas depending on density and distance factors and even upto 100,000 population in urban areas. On an average for every 2000 population there will be a health worker and for every four health workers there will be a supervisor. Epidemiological surveillance, monitoring, taking public health measures, laboratory services, and information management will be the main tasks of the ES. The health workers will form the survey team and also carry out tasks related to all the preventive and promotive programs (disease programs, MCH, immunisation etc..) They will work in close collaboration with the FMP and each health worker's family list will coincide with the concerned FMPs list. The health team, including FMPs, will also be responsible for maintaining a minimum information system, which will be necessary for planning, research, monitoring, and auditing. They will also facilitate health education. Ofcourse, there will be other supportive staff to facilitate the work of the health team.

First Level Referral

The FMP and ES will be backed by referral support from a basic hospital at the 50,000 population level. This hospital will provide basic specialist consultation and inpatient care purely on referral from the FMP or ES, except of course in case of emergencies. General medicine, general surgery, paediatrics, obstetrics and gynaecology, orthopaedics, ophthalmology, dental services, radiological and other basic diagnostic services and ambulance services should be available at this basic hospital. This hospital will have 50 beds, the above mentioned specialists, 6 general duty doctors and 18 nurses (for 3 shifts) and other

requisite technical (pharmacists, radiographers, laboratory technicians etc..) and support (administrative, statistical etc..) staff, equipment, supplies etc. as per recommended standards. There should be two ambulances available at each such hospital. The hospital too will maintain a minimum information system and a standard set of records.

Pharmaceutical Services

Under the recommended health care system only the essential drugs required for basic care as mentioned in standard textbooks and/or the WHO essential drug list should be made available through pharmacies contracted by the local health authority. Where pharmacy stores are not available within a 2 km. radial distance from the health facility the FMP should have the assistance of a pharmacist with stocks of all required medicines. Drugs should be dispensed strictly against prescriptions only.

Rehabilitation and Occupational Health Services

Every health district must have a centre for rehabilitation services for the physically and mentally challenged and also services for treating occupational diseases, including occupational and physical therapy

Managing the Health Care System[23]

For every 3 to 5 units of 50,000 population, that is 150,000 to 250,000 population, a health district will be constituted (Taluka or Block level). This will be under a local health authority that will comprise of a committee including political leaders, health bureaucracy, and representatives of consumer/social action groups, ordinary citizens and providers. The health authority will have its secretariat whose job will be to administer the health care system of its area under the supervision of the committee. It will monitor the general working of the system, disburse funds, generate local fund commitments, attend to grievances, provide licensing and registration services to doctors and other health workers, implement CME programs in collaboration with professional associations, assure that minimum standards of medical practice and hospital services are maintained, facilitate regulation and social audit etc... The health authority will be an autonomous body under the control of the State Health Department. The FMP appointments and their family lists will be the responsibility of the local health authority. The FMPs may either be employed on a salary or be contracted on a capitation fee basis to provide specified services to the persons on their list. Similarly, the first level hospitals, either state owned or contracted private hospitals, will function under the supervision of the local health authority with global budgets. The overall coordination, monitoring and canalisation of funds will be vested in a National Health Authority. The NHA will function in effect as a monopoly buyer of health services and a national regulation coordination agency. It will negotiate fee schedules with doctors' associations, determine standards and norms for medical practice and hospital care, and maintain and supervise an audit and monitoring system. It will also have the responsibility and authority to pool

[23] The discussion in this paper is restricted to primary care services but they are not the only component of the core content; higher levels of care are needed as support and these already exist to a fair extent though they need to be reorganized. Thus district level hospitals and metropolitan and teaching hospitals are also part of the core content.

resources for the organized healthcare system using various mechanisms of tax revenues, social and national insurance funds, health cess etc..

Licensing, Registration and CME

The local health authority will have the power to issue licenses to open a medical practice or a hospital. Any doctor wanting to set up a medical practice or anybody wishing to set up a hospital, whether within the universal health care system or outside it will have to seek the permission of the health authority. The licenses will be issued as per norms that will be laid down for geographical distribution of doctors. The local health authority will also register the doctors on behalf of the medical council. Renewal of registration will be linked with continuing medical education (CME) programs which doctors will have to undertake periodically in order to update their medical knowledge and skills. It will be the responsibility of the local health authority, through a mandate form the medical councils, to assure that nobody without a license and a valid registration practices medicine and that minimum standards laid down are strictly maintained.

Financing the Health Care System

We again reemphasise that if a universal health care system has to assure equity in access and quality then there should be no direct payment by the patient to the provider for services availed. This means that the provider must be paid for by an indirect method so that he/she cannot take undue advantage of the vulnerability of the patient. An indirect monopoly payment mechanism has numerous advantages, the main being keeping costs down and facilitating regulation, control and audit of services.

Tax revenues will continue to remain a major source of finance for the universal health care system. In fact, efforts will be needed to push for a larger share of funds for health care from the state exchequer. However, in addition alternative sources will have to be tapped to generate more resources. Employers and employees of the organised sector will be another major source (ESIS, CGHS and other such health schemes should be merged with general health services) for payroll deductions. The agricultural sector is the largest sector in terms of employment and population and at least one-fourth to one-third of this population has the means to contribute to a health scheme. Some mechanism, either linked to land revenue or land ownership, will have to be evolved to facilitate receiving their contributions. Similarly self-employed persons like professionals, traders, shopkeepers, etc. who can afford to contribute can pay out in a similar manner to the payment of profession tax in some states. Further, resources could be generated through other innovative methods - health cess collected by local governments as part of the municipal/house taxes, proportion of sales turnover and/or excise duties of health degrading products like alcohol, cigarettes, paan-masalas, guthkas etc.. should be earmarked for the health sector, voluntary collection through collection boxes at hospitals or health centres or through community collections by panchayats , municipalities etc... All these methods are used in different countries to enhance health sector finances. Many more methods appropriate to the local situation can be evolved for raising resources. The effort should be directed at assuring that at least 50% of the families are covered under some statutory

contribution scheme. Since there will be no user-charges people will be willing to contribute as per their capacity to social security funding pools.

All these resources would be pooled under a single body, the national health authority, and payments to providers of services would also be made by this body. In order to do this standardized protocols of treatment and charges will have to be evolved and this itself will have a major impact on both quality of care as well as on efficient use of resources.

Projection Of Resource Requirements

The projections we are making are for the fiscal year 2000-2001. The population base is one billion. There are over 1.3 million doctors (of which allopathic are 550,000, including over 180,000 specialists), 600,000 nurses, 950,000 hospital beds, 400,000 health workers and 25,000 PHCs with government and municipal health care spending at about Rs.250 billion (excluding water supply).

An Estimate of Providers and Facilities

What will be the requirements as per the suggested framework for a universal health care system?

- Family medical practitioners = 500,000
- Epidemiological stations = 35,000
- Health workers = 500,000
- Health supervisors = 125,000
- Public health nurses = 35,000
- Basic hospitals = 20,000
- Basic hospital beds = 1 million
- Basic hospital staff :
  - general duty doctor = 120,000
  - specialists = 100,000
  - dentists = 20,000
  - nurses = 360,000
- Other technical and non-technical support staff as per requirements (Please note that the basic hospital would address to about 75% of the inpatient and specialist care needs, the remaining will be catered to at the secondary/district level and teaching/tertiary hospitals)

One can see from the above that except for the hospitals and hospital beds the other requirements are not very difficult to achieve. Training of nurses, dentists, public health nurses would need additional investments. We have more than an adequate number of doctors, even after assuming that 80% of the registered doctors are active (as per census estimates). What will be needed are crash CME programs to facilitate integration of systems and reorganisation of medical education to produce a single cadre of basic doctors. The PHC health workers will have to be reoriented to fit into the epidemiological framework. And construction of hospitals in underserved areas either by the government or by the private sector (but only under the universal system) will have to be undertaken on a rapid scale to meet the requirements of such an organised system.

An Estimate of the Cost

The costing worked out hereunder is based on known costs of public sector and NGO facilities. The FMP costs are projected on the basis of employed professional incomes. The actual figures are on the higher side to make the acceptance of the universal system attractive. Please note that the costs and payments are averages, the actuals will vary a lot depending on numerous factors.

Projected Universal Health Care Costs (2000-2001 Rs. in millions)

Type of Costs		
➢ Capitation/salaries to FMPs (@ Rs.300 per family per year x 200 mi families) 50% of FMP services	60,000	
➢ Overheads 30% of FMP services	36,000	
➢ Fees for specific services 20% of FMP services	24,000	
➢ Total FMP Services	120,000	
➢ Pharmaceutical Services (10% of FMP services)	12,000	
➢ **Total FMP Costs**		**132,000**
➢ **Epidemiological Stations** (@ Rs.3 mi per ES x 35,000)		**105,000**
➢ **Basic Hospitals** (@ Rs.10 mi per hospital x 20,000, including drugs, i.e.Rs.200,000 per bed)		**200,000**
➢ **Total Primary Care Cost**		**437,000**
➢ **Per capita = Rs. 437; 2.18% of GDP**		
➢ **Secondary and Teaching Hospitals**, including medical education and training of doctors/nurses/paramedics (@ Rs.2.5 lakh per bed x 3 lakh beds)		**75,000**
➢ **Total health services costs**		**512,000**
➢ **Medical Research (2%)**		**10,240**
➢ **Audit/Info.Mgt/Social Res. (2%)**		**10,240**
➢ **Administrative costs (2%)**		**10,240**
➢ **TOTAL RECURRING COST**		**542,720**
➢ **Add capital Costs (10% of recurring)**		**54,272**
➢ **ALL HEALTH CARE COSTS**		**596,992**
➢ **Per Capita = Rs. 596.99; 2.98% of GDP**		

(Calculations done on population base of 1 billion and GDP of Rs. 20,000 billion; $1 = Rs.45, that is $13.24 billion)

Distribution of Costs

The above costs from the point of view of the public exchequer might seem excessive to commit to the health sector given current level of public health spending. But this is less than 3% of GDP at Rs.597 per capita annually, including capital costs. The public exchequer's share, that is from tax and related revenues, would be about Rs.400 billion or two-thirds of the cost. This is well within the current resources of the governments and local governments

put together. The remaining would come from the other sources discussed earlier, mostly from employers and employees in the organised sector, and other innovative mechanisms of financing. As things progress the share of the state should stabilise at 50% and the balance half coming from other sources. Raising further resources will not be too difficult. Part of the organized sector today contributes to the ESIS 6.75% of the salary/wage bill. If the entire organized sector contributes even 5% of the employee compensation (2% by employee and 3% by employer) then that itself will raise close to Rs.250 billion. Infact the employer share could be higher at 5%. Further resources through other mechanisms suggested above will add substantially to this, which infact may actually reduce the burden on the state exchequer and increase contributory share from those who can afford to pay. Given below is a rough projection of the share of burden by different sources:

Projected Sharing of Health Care Costs (2000-2001 Rs. in millions)

	Type of Source			
	Central Govt.	State/ Muncp.	Organised Sector	Other Sources
1. Epidemiological services	70,000	25,000	7,000	3,000
2. FMP Services	5,000	65,000	45,000	5,000
3. Drugs (FMP)	--	5,500	5,500	1,000
4. Basic Hospitals	--	100,000	85,000	15,000
5. Secondary/Teaching Hospitals	20,000	30,000	20,000	5,000
6. Medical Research	8,000	1,000	1,000	240
7. Audit/ Info. Mgt./ Soc.Research	5,000	5,000	240	--
8. Administrative Costs	3,000	7,000	240	--
9. Capital Costs	25,000	25,000	4,000	272
ALL COSTS	**136,000**	**263,500**	**167,980**	**29,512**
		Rs.596,992 million		
Percentages	**23**	**44**	**28**	**5**

Creating a consensus on the right to health care

We are at a stage in history where political will to do something progressive is conspicuous by its absence. We may have constitutional commitments and backing of international law but without political will nothing will happen. To reach the goals of right to health and healthcare discussed above civil society will have to be involved in a very large way and in different ways.

The initiative to bring healthcare on the political agenda will have to be a multi-pronged one and fought on different levels. The idea here is not to develop a plan of action but to indicate the various steps and involvements which will be needed to build a consensus and struggle for right to healthcare. We make the following suggestions:

- Policy level advocacy for creation of an organized system for universal healthcare
- Research to develop the detailed framework of the organized system

- Lobbying with the medical profession to build support for universal healthcare and regulation of medical practice
- Filing a public interest litigation on right to healthcare to create a basis for constitutional amendment
- Lobbying with parliamentarians to demand justiciability of directive principles
- Holding national and regional consultations on right to healthcare with involvement of a wide array of civil society groups
- Running campaigns on right to healthcare with networks of peoples organizations at the national and regional level
- Bringing right to healthcare on the agenda of political parties to incorporate it in their manifestoes
- Pressurizing international bodies like WHO, Committee of ESCR, UNCHR, as well as national bodies like NHRC, NCW to do effective monitoring of India's state obligations and demand accountability
- Preparing and circulating widely shadow reports on right to healthcare to create international pressure

The above is not an exhaustive list. The basic idea is that there should be widespread dialogue, awareness raising, research, documentation and legal/constitutional discourse.

To conclude, it is evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. There are a lot of small efforts towards this end all over the country. Synergies have to be created for these efforts to multiply so that people of India can enjoy right to healthcare

Table 1: HEALTHCARE DEVELOPMENT IN INDIA 1951-2000

			1951	1961	1971	1981	1991	1995	1996	1997	1998	2000
1	Hospitals	Total	2694	3054	3862	6805	11174	15097	15170	15188		17,000
		% Rural	39	34	32	27		31	34	34		
		%Private				43	57	68	68	68		
2	Hospital & dispensary beds	Total	117000	229634	348655	504538	806409	849431	892738	896767		1,000000
		% Rural	23	22	21	17		20	23	23		
		%Private				28	32	36	37	37		
3	Dispensaries		6600	9406	12180	16745	27431	28225	25653	25670		
		% Rural	79	80	78	69		43	41	40		
		% Private				13	60	61	57	56		

4	PHCs		725	2695	5131	5568	22243	21693	21917	22446	23179	24,000
5	Sub-centres				27929	51192	131098	131900	134931	136379	137006	140,000
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	492634	503947	550,000
		All Systems	156000	184606	450000	665340	920000			1080173	1133470	1,250000
7	Nurses		16550	35584	80620	150399	311235	562966	565700	607376		700,000
8	Medical colleges	Allopathy	30	60	98	111	128		165	165	165	170
9	Out turn	Grads	1600	3400	10400	12170	13934	*	*	*	*	20,000
		P. Grads		397	1396	3833	3139			3656		5,000
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	79.4	91.3	104.9	120.7	165.0
11	Health outcomes	IMR/000	134	146	138	110	80	74/69	72	71	72	70
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	27	27	27	26
		CDR/000	22.8	19	15	12.5	9.8	10	9	8.9	9	8.7
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62	62.4	63.5	64	65
	Births attended by trained practitioners	Percent				18.5	21.9		28.5		42.3	
12	Health Expenditure Rs. Billion	Public	0.22	1.08	3.35	12.86	50.78	82.17	101.65	113.13	126.27	178.00
		Private@	1.05	3.04	8.15	43.82	173.60	233.47		399.84		
		CSO estimate pvt.		2.05	6.18	29.70	82.61	279.00	329.00	373.00	459.00	833.00
	Health Expenditure as percent of GDP	Public	0.25	0.71	0.84	1.05	0.92	0.95	0.91	0.88	0.81	0.87
		Private CSO		1.34	1.56	2.43	1.73	3.25	2.95	2.94	2.98	4.07
	Health Expenditure as % to Govt. Total	Public	2.69	5.13	3.84	3.29	2.88	2.13	2.98	2.94	2.7	2.9

@ Data from - 1951:NSS 1st Round 1949-50; 1961: SC Seals All India District Surveys,1958; 1971: NSS 28th Round 1973-74; 1981: NSS 42nd Round 1987; 1991 and 1995: NCAER – 1990; 1995: NSS 52nd Round 1995-96; 1997: CEHAT 1996-97

*Data available is grossly under-reported, hence not included

Notes: The data on hospitals, dispensaries and beds are underestimates, especially for the private sector because of under-reporting. Rounded figures for year 2000 are rough estimates.

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South African Health Care
A System in Transition

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Since the overthrow of Apartheid in 1994, the health care system in South Africa has been under an ongoing revolution to erase inequities in service and access, and to fund a higher level of health care. Their approach is to decentralize the health care system into a District Health System, and to assure that a standard Primary Health Care package is available to all. This system in transition has made commendable achievements, but there are still plenty of improvements to be made before South Africa attains the system it has envisioned. The most formidable adversary to their health care reform is the HIV/AIDS epidemic. The successes and shortcomings of this middle-income developing country's approach to improving health care provide valuable lessons to other countries that face similar challenges to improving their health care systems.

The South African Health Care System

South Africa, a middle income nation with a GDP per capita of USD$7,555, and a population of 43,791,000, is a nation in transition.[24] After four decades of minority apartheid rule, a democratic government was established in 1994.[25] This radical change in identity has called for a great deal of policy adjustment. This change, coupled with the emergence of the HIV/AIDS epidemic has cornered South Africa into a national crisis; a crisis that is centered on health care. The keystone of any government is tending to the well being of its people. The well being of South Africans is teetering on the edge, and the people are depending on the government to respond by putting the majority of its efforts into improving national health.

Currently, the total health expenditure per capita in South Africa is USD$530.00, and the total health expenditure as a percentage of the GDP is 8.8%. These expenditures stand beside marginal quality health indicators such as the life expectancy at birth of 47.7 years for men, and 50.3 years for women. Child mortality rates are 103 deaths per 1000 births for males, and 90 deaths per 1000 births for females.[26] Unfortunately, these figures are worsening in a landslide caused by

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[24] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en
[25] McIntyre, D. and Gilson, L. "Putting Equity in Health Back onto the Social Policy Agenda: Experience from South Africa." Soc Sci Med 2002 Jun; 54(11): 1637-56.
[26] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

HIV/AIDS. But the government's formidable approach to reforming health care, by starting anew with a vision of health care equity, is on the right track.

South Africa's vision for health care is a decentralized system that offers an equally accessible and free basic package of primary health care to all of its citizens.[27] These goals are presented in the National Health Bill of 2001, which establishes the structure for the implementation of a national health care system based on Primary Health Care (PHC), and operated by District Health Systems (DHS). For a description of the government-funded services covered by the Primary Health Care package in South Africa, visit this website (http://www.doh.gov.za/docs/reports-f.html). The national Department of Health, headed by Minister Mantombazana Edmie Tshabalala-Msimang, oversees the system of nine provincial health departments. Municipal boundaries for local governments were demarcated in 2000. Each provincial health department has its own ministers and leaders. However, the youth of this decentralized system is resulting in predictable management issues.

The impetus behind creating a decentralized health care delivery system was that provincial governments would have the ability to customize the health systems to their unique cultural groups, while the national department of health would balance out inequities to assure that all districts conform to the national health policy. In such a culturally diverse nation, the state would be mistaken to mandate a one-size-fits-all national health care policy. Meanwhile, the districts are presumably small enough, and carry enough social solidarity that the District Health Systems are centralized into one department. Eric Buch of the School of Public Health of the University of Pretoria praises the model of decentralization:

> "Establishment of a District Health System with provinces and local authorities starting to pool their resources and integrate care, [offers] a more comprehensive service under one roof. This not only improves economies of scale and efficiency, but means that parents do not have to go to two or more venues and face duplicate queues and examinations to get care for themselves and their families."[28]

He also explains that in order to meet the goals for elevating clinics to fully functional levels, all clinics must have infrastructural services, such

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[27] Sait, Lynette. "Health Legislation: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter1.htm

[28] Buch, Eric. "SAHR 2000: The Health Sector Strategic Framework: A Review." *The Health Systems Trust.* http://www.healthlink.org.za/sahr/2000/chapter2.htm.

as electricity, refrigeration, potable water, sanitation, and roads by 2004.[29] Not only are clinics to be improved, but more clinics are to be built. The goal is to provide equal accessibility to health care for all South Africans. This primary objective of the South African health care system is to ensure that all South Sfrican citizens are able to realize their fundamental rights to health care as enshrined in Section 27 of the Constitution. However, Dr. David McCoy, the Director of Research at the Health Systems Trust in South Africa, explains why the South African system is not yet a "universal" health care system:

> "In order to define the nature of people's rights to health care, the national DoH has defined 'package of Primary Health Care' that is expected to be available through the public sector. It lists the scope of services to be provided in clinics and district hospitals. In addition, we have a variety of clinical policies that define national policy on standards of treatment and care in the country. For example, we have official national HIV treatment guidelines. However, while everyone essentially has unimpeded access to PHC, in practice, many people have physical and financial barriers to getting to health facilities, and when they do attend a health facility, there is a significant gap between what is set out in the policies with what is actually being delivered."[30]

The definition of "universal" health care that is generally subscribed to is a system in which the government covers the costs and administration of the entire health sector, such as in the Canadian Health Care system. But this kind of system is highly unlikely to be instituted in South Africa. The obstacles are that the health system is already saturated with issues demanding attention, there is an entrenched private health sector, HIV/AIDS is churning up any continuity in health system development, it is not an upper wealth nation, and there is not enough social solidarity.

Dr. McCoy explains the funding mechanisms of the South African health system:

> "We don't have a dedicated health insurance system. The public sector is mainly funded from the general tax base and to a much lesser degree from user fees. There are proposals for social health insurance for the poor but employed, [leaving the poor and unemployed unattended], which may segment the health care

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[29] Buch, Eric. "SAHR 2000: The Health Sector Strategic Framework: A Review." *The Health Systems Trust.* http://www.healthlink.org.za/sahr/2000/chapter2.htm.

[30] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 25, 2002."

> system between the unemployed and the employed, as happens in South America. While this offers opportunities for more people to access the private sector, it could entrench a weak health care system for the poor who are excluded from social health insurance. Outside of the public sector, is a large private health care sector which outstrips public health expenditure."[31]

In the private sector, prepaid health plans accounted for 76.6% of the private expenditure on health in 2000.[32] Medical Schemes are the dominant third-party intermediary with 73% of the private expenditure.[33] And out-of-pocket expenditure on health as a percentage of the total expenditure on health in 2000 was 12.6%.[34] Antoinette Ntuli of the Health Systems Trust proclaims: "The greatest health sector inequity continues to be the imbalance of resources available to the public and private sectors."[35] Such inequities are inherent in a young system that is developing rapidly on a macro scale. Eric Buch explains the development pattern in South Africa:

> "In other middle income countries the issues are more around constant improvement off the baseline. In South Africa they are around providing services for all that were previously available to a few."[36]

This approach has been necessary given South Africa's impending health crisis, yet it has left much room for improvement. The mission statement of the Department of Health's "1999-2004 Health Sector Strategic Framework" is:

> "While the first five years focussed on increasing access to health care, especially for those who did not have access, ... the next five years will focus on accelerating quality health service delivery."[37]

This optimistic outlook passes over the need to improve on areas missed in the initial surge of health sector reform. It inappropriately implies that an end has been reached for achieving equal access to health care. Let us now look at the issues that have challenged health sector reform, address suggested improvements, and present the direction in which

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[31] Dr. David McCoy. Director of Research for the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[32] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

[33] Goudge, Jane, et Al. "Private Sector Funding: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter4.htm

[34] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

[35] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

[36] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[37] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

South Africa is moving toward achieving its envisioned socialized health care system.

Challenges to the South African Health Care System

If the vitality of the health care services were related to water supply, then the health care system would be the dam, and the reservoir would be the resources that power the system. In South Africa, the reservoir is running dry. There is inadequate funding, poor access to information, a outward migration of medical professionals, and insufficient leadership to sustain the system.

The most basic resource that the health care system relies on is funding. In light of the HIV/AIDS crisis, it is promising that the government spends 11.2% of its budget on public health.[38] However, this will need to increase. In the medical sector, it appears that even if all efficiency measures are achieved, current public sector funding will not satisfy the costs of providing the care desired.[39] Eric Buch suggests:

> "There are two places that significant additional funds could come from. The first is a budget that grows significantly in real terms, and the second through raising more funds from users."[40]

These are not dynamic solutions. But perhaps what is most needed is more resources from the conduits built into the system. However, the funding mechanisms built into the system are also problematic. Antoinette Ntuli outlines the funding paradox:

> "Current mechanisms for funding local government health services are problematic. From the provincial perspective they do not allow for adequate monitoring, while local governments are concerned about the cash flow problems resulting from payments that are paid quarterly in arrears."[41]

In parallel, the private sector is also experiencing funding problems. Eric Buch reports:

> "The private sector model of guaranteed fee-for-service payment to providers through for-profit medical administration companies, together with other factors, kept private health inflation well above that prevailing in the economy."[42]

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[38] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

[39] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[40] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[41] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

[42] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

The above passage may imply that excessive expenditures are the results of overproviding by health care professionals, however Buch clarifies that this is not the primary cause of expense:

> "Excessive expenditure on health care is not only driven by the lack of constraints on members due to third party payer insurance, but more importantly due to an asymmetry of information between provider and patient on what interventions are required and suitable."[43]

Effective information dissemination is crucial to operating an efficient health care system. In South Africa, information is in short supply. Ninety-seven percent of provincial expenditures on health information goes to hospitals, with the districts getting only three percent.[44] In order for inequities of access to be neutralized, this ratio must be reduced so that rural clinics are given, and return enough information to enable them to deliver care of acceptable quality. When asked if South Africa is doing a good job of information dissemination, Dr. David McCoy responded:

> "I guess it's all relative. The Department of Health does take the need to disseminate information seriously. The Health Systems Trust is one of the main sources of information [in South Africa] to health care workers, and they are partially funded by the DoH. "[45]

The other side of information dissemination is information gathering. Dr. McCoy elaborates on this theme:

> "Research is very important, but it can also be very distracting. What is important is relevant research and research that targets policy makers and managers as the consumers (not academic journal editors). South Africa also needs to invest time in face-to-face communication of research findings, and not rely on passive paper-based dissemination. The bureaucracy is reasonably receptive to constructive criticism, but this culture needs to be carefully nurtured and protected."[46]

One way any government bureaucracy can be culturally sensitive and open to civil input is to empower nongovernmental organizations (NGO's)

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[43] Buch, Eric. "SAHR 2000: The Health Sector Strategic Framework: A Review." *The Health Systems Trust.* http://www.healthlink.org.za/sahr/2000/chapter2.htm.

[44] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

[45] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[46] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

to perform some of the work on the ground. Eric Buch makes a case for NGO support in this passage:

> "It is generally agreed that NGO's working in, and with, communities and those focussing on a health problem e.g. cancer, tuberculosis, or a disability, have the ability to achieve results and mobilize energy and volunteerism in a manner that is difficult for formal health services to match. This energy seems to be dissipating in our society, with people waiting for government to do things for them. The Health Department needs to intervene to create an enabling environment for NGO's, facilitate the emergence of local NGO's and provide seed funding in hitherto unserved areas."[47]

NGO's tend to have an ability to feel the pulse of the people. They also tend to access areas that would normally be overlooked by government. One of the major challenges to the South African health care system is bringing health care to rural underserved populations. These people often forego health services that would be deemed necessary by health professionals because they don't have access to services, or because they lack the funds for services. There are also many traditional healers throughout South Africa, who should not be dismissed in the new health care system, but should be allowed their niche alongside modern health care services. NGO's are crucial to mediating sensitive issues like traditional healing, and helping to facilitate new measures in underserved areas.

Extending service to underserved areas is one of the most significant challenges to the health care system. Not only must new clinics be built, and basic utilities and resources provided, but also there need to be health professionals to work in underserved areas. Doctors will need to commit to working regularly in clinics. Moreover, supporting health services staff such as nurses and assistants will need to be enticed into working in underserved areas, and will require specific training for working in these new environments. This will be a costly and demanding measure. Eric Buch offers one suggestion for alleviating the financial burden and pressing demand for sending health professionals to work in underserved areas:

> "Large numbers of rehabilitation, pharmacy, environmental and other assistant categories (mid-level health workers), with one to two years of tertiary education, need to be rapidly but effectively trained and deployed...One conclusion drawn by the Human

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[47] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

> Resources planning process is that the current staffing model, based on professionals alone, is unaffordable, and that extensive use should be made of mid-level health workers."[48]

This advice, while sensible, may sound grating to many South African health analysts who are pressing for a more professional work force. Amid the rapid, but necessary changes to the health sector, the health work force is overburdened by changing values in the jobs, and unreasonable work loads.[49] Dr. Graham Bresick comments:

> "Urgent attention needs to be paid to the low morale, disillusionment, and high levels of stress and burnout among health service staff. We can't hope to build a reformed and improved health sector on a spent work force."[50]

Difficult working conditions, few incentives, and low morale are causing health professionals to leave their jobs or seek work in other countries. South Africa has an enormous problem with the colloquially termed phenomenon of "Brain-Drain." Many health care professionals, who have received their training in South Africa, emigrate to countries with more inviting health care systems. South African Department of Health Minister Manto Tshabalala-Msimang states in her speech, "Health Department's Multi-Pronged Health Staffing Strategy":

> "We believe that if there is a major – and insidious – threat to our overall health effort, it is the continued outward migration of key health professionals, particularly professional nurses, with a consequent de-skilling of the professional base in both the public and private sector."[51]

Antoinette Ntuli illustrates the magnitude of this threat with the following statistics:

> "In 2001 there were 19.8 medical practitioners per 100,000 population as compared with 21.9 in 2000. For professional nurses the ratio reduced from 120.3 in 2000 to 111.9 in 2001."[52]

The Department of Health has taken a few measures to combat this readily apparent threat. It developed a Code of Conduct for other Commonwealth Nations in their recruitment of South African professionals. It created a new "Community Service" program to

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[48] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[49] Bresick, Graham. "Email to Greg Connolly – Dec. 13, 2002."

[50] Bresick, Graham. "Email to Greg Connolly – Dec. 13, 2002"

[51] Minister Manto Tshabalala-Msimang. "Health Department's Multi-Pronged Health Staffing Strategy." http://www.doh.gov.za/docs/pr/2002/pr1023.html

[52] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

encourage professionals to work in underserved areas. And it sent 254 students to Cuba to train to become physicians. These students have committed to return to South Africa to offer four years of service to underserved areas.[53]

Dr. David McCoy comments on these incentive programs:

> "This is a major priority of the health system and we have been talking about incentive schemes for the last six years. There has been a recent resurgence of interest in policy-making circles, but we await some positive outcomes. The only program that has been put in place is a compulsory community service program for medical graduates of one year, and a program to place Cuban doctors in rural areas. Both initiatives have been partially successful, but are insufficient to address the "brain drain" and the inadequate levels of staffing in the rural areas."[54]

It is not only the doctors and nurses who are strained by the needs of the health care systems; it is also the administrators. In the early stages of the new decentralized health care system, leadership was given to those who may not have had proper training, avenues of decision making were unclear, and the responsibilities of the leaders were too burdensome. Antoinette Ntuli elaborates on these problems:

> "Worryingly, many health services managers have a low sense of personal accomplishment. Huge demands, difficulties in prioritizing, inadequate management skills, lack of rewards for competence or sanctions for incompetence, and hierarchies that are too rigid all impact upon their ability to deliver quality health care. Other difficulties include inappropriate organograms, lack of financial delegation, unsatisfactory communication between provinces and districts and inconclusive appointments of staff, (especially to strategic positions) many of whom are in acting positions."[55]

Dr. David McCoy echoes her concerns:

> "There are inadequate management skills amongst managers and policy makers who set the operational priorities for transforming

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[53] Minister Manto Tshabalala-Msimang. "Health Department's Multi-Pronged Health Staffing Strategy." http://www.doh.gov.za/docs/pr/2002/pr1023.html

[54] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 25, 2002."

[55] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

> the health care system in a rational sequence of steps. One cannot put the roof on before building the walls. This is technical work."[56]

Building a national health system is not easy, and South Africa has only had eight years in which to do it. The nation has certainly made a commendable effort at health care reform. The problems that arose are all problems that can be solved, and were virtually inherent in developing a new health care system. South Africa provides an example of a nation doing fairly well in transforming their health care system under pressure.

However, that pressure is immense and must be confronted. When asked if South Africa was doing a good job with its health care reform, David McCoy gave this response:

> "Is the glass half empty or half full? Relative to many developing countries we are doing okay. Given the history of the country and the relative inexperience of the government, we are also doing okay. However, relative to our health needs and the emergency that is AIDS, we are doing poorly. AIDS threatens to wipe out all gains made since 1994. We have to run fast to keep still."[57]

The HIV/AIDS Crisis

"South Africa has more HIV positive people than any other country in the world."[58] Two years ago the South African government reported that 4.7 million, which is one in nine, South Africans was HIV positive. Today that number is expected to be far higher. The South African government is starting to acknowledge its massive HIV/AIDS crisis. "This year the government almost tripled its anti-AIDS budget to USD$108 million, and plans to up to $194 million in the next financial year."[59] "Tony Leon, leader of the main opposition Democratic Alliance said, 'South Africa's fight against AIDS has been massively hampered and harmed by government's dithering, denial and dissent from the orthodoxies associated with the disease." He also pointed out that women's life

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[56] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[57] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[58] Cohen, Mike. "World AIDS Day rallies focus on global awareness." *Associated Press*. The Burlington Free Press. December 2, 2002.

[59] Cohen, Mike. "World AIDS Day rallies focus on global awareness." *Associated Press*. The Burlington Free Press. December 2, 2002.

expectancy will fall from 54 to 38 in the next decade, and more than 2 million children will be orphaned by AIDS in this time.[60]

Not only are children being orphaned, but also:

> "Each year, more than 600,000 infants [worldwide] become infected with HIV, mainly through mother-to-child transmission. WHO and the UNAIDS Secretariat recommend that the prevention of mother-to-child transmission of HIV, including antiretroviral regimens such as nevirapine, should be included in the minimum standard package of care for HIV-positive women and their children."[61]

The article by WHO and UNAIDS also explains: "The simplest regimen [of PMTCT drug therapy] requires a single dose of nevirapine to the mother at delivery and a single dose to the newborn within 72 hours of birth."[62]

Yet despite the World Health Organization and UNAIDS endorsements of nevirapine therapy, the South African government was reluctant to distribute the drug to health providers. Instead the Department of Health set up an eighteen-site test of the effectiveness and risks of Intrapartum Nevirapine treatment, because as Minister Manto Tshabalala-Msimang explained:

> "The public sector cannot afford to provide the drugs, while nevirapine did not guarantee the virus could not be passed from mother to child."[63]

This is a clear example of the Department of Health's reluctance to give HIV/AIDS the attention it has warranted. It is this kind of negligence that prompted Dr. Peter Berman of the Harvard School of Public Health to say; "South Africa could be an example of what to avoid in AIDS policy."[64]

Dr. David McCoy issued the following statement on what other countries can learn from South Africa's HIV/AIDS policy:

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[60] Cohen, Mike. "World AIDS Day rallies focus on global awareness." *Associated Press*. The Burlington Free Press. December 2, 2002.

[61] "WHO and UNAIDS continue to support use of nevirapine for prevention of mother-to-child HIV transmission." http://www.who.int/mediacentre/statements/unaids/en/print.html

[62] "WHO and UNAIDS continue to support use of nevirapine for prevention of mother-to-child HIV transmission." http://www.who.int/mediacentre/statements/unaids/en/print.html

[63] Sait, Lynette. "Health Legislation: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter1.htm

[64] Berman, Peter and Bossert, Tom. "Interview with the Global Health Council." *Harvard School of Public Health.*

> "Political leadership is critical [to an effective HIV/AIDS policy]. Openness is critical, as is making the problem a national priority at the early stages of the epidemic.
>
> Ensuring that the basic primary health care infrastructure is capable of providing correct treatment of sexually transmitted infections (STI's), condoms, family planning, and TB control...in other words, getting the basics in place. This then provides a foundation for the implementation of more complex treatment programs.
>
> Human resource training is critical – especially of community lay workers who can act as agents of community mobilization. Prevention intervention is not just a health care system responsibility, but needs to be planned and implemented from a broad base of government and non-governmental institutions.
>
> Understanding local culture and beliefs is very important. Social science research must be employed from the beginning to inform prevention interventions in particular. The western model of individual-based counseling is inappropriate and has been a millstone around our neck."[65]

These words of advice are poignant especially to countries that are now just starting to be infiltrated by HIV/AIDS. India, China and other countries in Asia, where the virus is spreading most rapidly should learn from South Africa's shortcomings in HIV/AIDS policy.

Implications

The South African health care system has many implications for developing countries. The model of social equity in health care that South Africa envisions is appropriate to the needs of its people, and can be achieved given the nation's wealth, infrastructure, and relative social solidarity. Decentralization beneath a governing body seems to be the most effective design in a socialized health care system. Public provision of primary health care services without interfering with privatized secondary and tertiary health care services achieves a balance of government control while allowing for the private market to drive progress. South Africa's approach to reform was on the macro scale. This may not be possible for more diverse and impoverished nations, and

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[65] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 25, 2002."

as seen here, can leave holes, which require repairing. Perhaps a more thorough approach to health care reform would be to start small in a pilot program format, and through the work of both government and non-governmental organizations, build up to a national system while attending to the complications that arrive along the way. Most significantly, developing countries should learn from South Africa's HIV/AIDS policy. As South Africa is learning, while it is important to develop a strong national health care system, the effort may be futile if the country doesn't also address the HIV/AIDS pandemic.

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Canadian Health Care

The Universal Model Evolving

Greg Connolly 11/18/02

Global Health Council

For over thirty years Canada has taken pride in its universal health care program, Medicare. This experiment in health care systems is founded on the principal that every citizen should have equal access to high quality health care. But what was the nation's pride has become nation's most controversial program. Skyrocketing costs and plummeting satisfaction levels forecast a dire future for Canadian Medicare. Public consensus calls for fundamental changes to the system. An eighteen-month study ending in Roy Romanow's report, *Building on Values: The Future of Health Care in Canada,* attempts to answer the calls for reform by making a comprehensive series of suggestions for the renewal of the Medicare system. A group of medical economists are advising that Canada should introduce a Catastrophe Insurance/Medical Savings Account model into the health care system. This dynamic time in the Canadian health care system is yielding important lessons for the other nations of the world, who for many years have looked to the Canadian model for health care.

The Canadian Medicare System

"Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed."

--Canadian Justice Emmett Hall

In Canada, health is viewed as a human right. Using this philosophy as their guide, the Canadian government has developed a socialized health care system that evolved from a small experiment in Saskatchewan in the 30's and 40's, to the current Medicare system.[66] This system provides almost 32 million people spread out over 10 million square kilometers with equal access to government-funded health services.[67]

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[66] Blouin, Chantal. "Canadians' Health Care Concerns Cannot Stop at Our Borders." The North-South Institute. http://www.straightgoods.ca/ViewFeature.cfm?REF=724. Nov. 10, 02.

[67] IDB Summary Demographic Data for Canada. http://devdata.worldbank.org/external/dgprofile.asp?RMDK=82656&SMDK=1&W=0.

The policy of a universal health care system was solidified in the 1960's with the passage of two key acts. "The Hospital Insurance and Diagnostic Services Act (1957)" and the "Medical Care Act (1968)" dictated the terms for the Medicare system. However, due to low compensation and a lack of incentives, medical service providers, such as doctors and nurses, manipulated loopholes in the legislation to increase their salaries. Some providers introduced extra-billing, which was the direct charging of extra fees to patients for insured services. User charges were another exploitation of the system. These were fees charged to the patients, which were not covered by insurance. For example, a patient could have been charged a user fee before being given access to care by a doctor. The problems of extra-billing and user charges were addressed by the "Canada Health Act (1984)." This legislation penalized such behaviors by allowing the national government to withhold payments to provincial health departments equal to the amounts predicted that were charged in extra billing and user charges. Once the providers paid the provincial health ministers back the extra charges, then the Government would release the withheld funds. This alleviated the problems of extra-billing and user-fees.

The hierarchy of the Canadian Medicare System cascades as such: House and Senate, Governor in Council, Minister of Health, Provincial Health Ministers, Provincial Health Insurance Nonprofit, Provider, Consumer. As a means of understanding this mechanism, consider the following profile:

> Philip Brodeur, of Quebec, breaks his arm. He reports to the ER, which, unfortunately is crowded. Eventually he is treated, his paperwork is filed, and he goes home. His paperwork is then processed by the hospital, and sent to the public provincial nonprofit health insurance agency, called the Ministere de la Sante et des Services Sociaux (Ministry of Health and Social Services). The insurance agency then sends a payment to the doctor, and a payment to the hospital. The amount payable to the doctor is based on the service provided, and the hospital is reimbursed for the materials used. At the end of the year, the public insurance agency reports the annual provincial health costs to the national Ministry of Health. The Ministry of Health then sponsors an audit of the provincial health insurance nonprofit. If all information reported is accurate, then the Minister of Health, under the authority of the Governor in Council, reimburses the provincial health nonprofit for all of the publicly insured health care expenses incurred in the province that year. The Governor in Council then reports the national annual

spending on health care to the House of Parliament and the Senate, which determines the national budget for the Medicare system and the tax rate for health care. The system's greatest achievement is that Philip LaFayette would have ideally received the same high level of medical care if he were a businessman in Toronto, or a commercial fisherman in British Columbia.

The treatment of health care as a basic right is responsible for the high standard of health in Canada, as shown by the following indicators from 1999: The life expectancy at birth was 78.2 years; the fertility rate was 1.6 births per woman, the infant mortality rate was 6.1 per 1,000 live births, and there was negligible malnutrition for children under 5 years.[68] But despite these signs of a healthy population, the health care system is ailing.

Challenges to the Medicare System

"The fundamental flaw of the [Canadian] Medicare system is that patients bear no direct costs for the medical services they receive."

--David Gratzer

The state of the Canadian Medicare system has become the nation's foremost political issue. Despite the successes of the system complaints, flaws, and suggestions are procuring the most attention. The system is founded on humanistic principals, but is plagued by a flaw of human nature: in a free-care system, there is virtually no personal accountability.

The increasing level of national dissatisfaction in the Canadian Medicare system is alarming to health care professionals and policy makers. In 2001, only one in five Canadians thought the Medicare system was working well. In 1998, 80% of Canadians thought the system needed at least fundamental changes; and three years later, 18% believed the system required complete rebuilding. Also in 2001, 26% of Canadians claimed that their access to health care had deteriorated over the previous two years.[69]

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[68] IDB Summary Demographic Data for Canada. http://devdata.worldbank.org/external/dgprofile.asp?RMDK=82656&SMDK=1&W=0.

[69] Blendon, Robert, et. Al. "Canadian Adults' Health Care System Views and Experiences, 2001." http://www.cmwf.org/programs/international/can_sb_552.pdf. The Commonwealth Fund. New York, NY: 2001.

The primary cause for dissatisfaction is the pattern of extensive queuing in the health care system. Long waits for medical attention result from overuse of the health care system. Consider the following queuing estimates to see the source of dissatisfaction:

> "It takes nearly 25 weeks to get an appointment with an ophthalmologist in Canada, almost 21 weeks to receive orthopedic care, more than 18 weeks to get a heart by-pass, over 16 weeks to see a neurosurgeon, and nearly 12 weeks for a gynecological exam."[70]

Another source of dissatisfaction is the apparent breach of one of the Canada Health Act's five principals; universality. Studies have shown the existence of class disparities in the provision of health care in Canada. One study, conducted by the Commonwealth Foundation in 2001, found that 23% of Canadians with below national average income thought the health care system needed to be rebuilt, whereas only 13% of those with above national average income thought the system needed to be rebuilt.[71] Likewise, 47% of those earning under $25,000 wanted a private health insurance option for Medicare, whereas only 39% of those earning over $75,000 wanted such an option.[72] These results show that the lower socioeconomic groups are not as satisfied with their access to services as are the upper socioeconomic groups. The lower classes reported more difficulty accessing insured care; especially off-hours and specialty care. This could possibly be attributed to the upper class members' greater abilities to advocate for themselves.[73] The lower classes also had trouble obtaining uninsured elective health services, such as dental, optometry, medical equipment, and prescription drug services because they would have to pay for these services from their own funds. Many in the upper classes now have private insurance to cover these expenses, but the poor usually cannot afford supplemental insurance.[74]

The cost of health care is climbing rapidly, not only for consumers, but also for the entire system. The national cost of health care in 1998 was 55.6 billion dollars, which is 6.32% of the Gross

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[70] Weber, Joseph. "Canada's Health Care System Isn't a Model Anymore." *Business Week*. August 31, 1998.

[71] Blendon, Robert, et. Al. "Canadian Adults' Health Care System Views and Experiences, 2001." http://www.cmwf.org/programs/international/can_sb_552.pdf. The Commonwealth Fund. New York, NY: 2001.

[72] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies*.

[73] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies*.

[74] Blendon, Robert, et. Al. "Canadian Adults' Health Care System Views and Experiences, 2001." http://www.cmwf.org/programs/international/can_sb_552.pdf. The Commonwealth Fund. New York, NY: 2001.

Domestic Product.[75] This is a smaller fraction of the GDP than the US system spends on their health care system; however, the Canadian system has hidden costs, such as the loss of productivity due to queuing.[76] A study by Foot and Stoffman found that, "Canada's health spending nearly doubled between the mid-1980's and mid-1990's, but there was no evidence that people were healthier as a result."[77] These findings imply that the extra spending has gone to ineffective administration of the system. In individual provinces, where most of the administering is done, 30% of the annual provincial budgets are portioned to health care. Unfortunately, these discouraging figures are on the early slope of a gathering wave.

Canada's birth rate is low, and its mortality rate is also low. This recipe will yield a glut of seniors when the baby-boomers reach those years, accompanied by a small work force to support them. By 2030 the population of seniors will be equivalent to 40% of the working population, which must cover their health costs. Canadians over 65 currently use about half of all health care expenditures.[78] Foot and Stoffman observe:

> "By the time you are in your late 70s, you will use hospitals five times more than your life-time average rate of use. If you survive until your late 80's, you will use hospitals 12 times more than your lifetime average."[79]

The amount of usage of the health care system is exactly the problem. There is not one group in the system to blame; they all contribute to its inefficiency. Beginning with the first-tier of the system, we can see that consumers are overconsuming. In a free-care system, expense is not a consideration; only convenience matters. For example, when given the option to receive immediate attention in the ER, or wait for a less expensive appointment with a physician, the tendency is to choose the ER because it is more convenient. "In 1997, the Regina Health District found that from 43-49% of the ER patients in its three hospitals were nonurgent cases."[80] In the 1973 *New England Journal of Medicine* article, "Distribution," by Enterline et al., it was found

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[75] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies.*

[76] Danzon, Patricia, M. "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs.* Spring 1992.

[77] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[78] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies.*

[79] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[80] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

that before Medicare, patients called their doctors for free consultation on minor problems, but immediately after Medicare was introduced, phone calls dropped, and personal free visits increased by the same percentage. In another *New England Journal of Medicine* article titled, "Effects," also by Enterline, et al., it was found that physicians in Quebec believed that since the introduction of Medicare, frivolous patient complaints rose by 75%.[81] Also in Quebec, in the first two years after Medicare was introduced, the amount of time physicians spent with each patient dropped by 16%, and the number of patients seen per day increased by 32%.[82] This shows that the number of patients increased dramatically, but also, doctors' behaviors changed.

In the Medicare system, doctors are paid on a fee-for-service basis. Due to the high national cost of health care, each service is assigned a relatively low rate of compensation. Low compensation, and overwhelming demand for services, are disincentives for providers. As a result, there are few Canadian medical students; and of the ones who become doctors, many leave Canada for the greener pastures of the American health care system. Canadian doctors have one primary way to raise their incomes; raise the number of patients they see.

A major trend in physician overprovision is requiring multiple patient visits, when fewer visits would suffice. Not only is the doctor/patient relationship strained by the shorter, incomplete visits, but also the patient is removed from the work force and made to suffer from his or her ailments longer by having to make multiple visits. Here is an example of overprovision:

> "In Ontario, it was reported that over 200 family physicians had billed the government for more than $400,000 each in 1994-95 (Bohuslawsky, "Patient Overdose"). These high-billing doctors had pushed through an average of 67 patients a day, or one every eight minutes."[83]

The RAND Health Insurance Experiment, conducted on 2,000 families in the U.S., between 1974-1982 tested for overprovision as a result of health systems. One group of patients with free-care coverage paid on a fee-for-service basis, like the Canadian model. The other group of patients with free-care coverage had HMO plans, in which the providers got paid a capitated (flat)

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[81] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.
[82] Danzon, Patricia, M. "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs*. Spring 1992.
[83] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

fee. Expenditures in the fee-for-service group were 28% higher, and hospital admissions and days spent in the hospital were 40% higher than for the HMO coverage group.[84] The only difference was that doctors had an incentive to overprovide for the fee-for-service group. A more disquieting version of this experiment was conducted by Blomqvist. He found that in California, when surgeons were paid on a fee-for-service basis, the number of hysterectomies (removal of the uterus) was five times higher than when surgeons were paid a flat salary.[85] Although these experiments were conducted outside of Canada, and now have some years behind them, they still reveal the negative trends of overprovision, which are applicable to the Canadian system.

Overprovision and overconsumption are manifestations of a system that needs fixing. Hospital administrators, and politicians are also responsible for the problems in Canadian health care. Hospital expenses account for 40% of provincial health costs. For this reason, hospital reform has been the focus of health officials for almost a decade.[86] Other attempted repairs such as reducing medical payments, and limiting the time doctors can spend performing surgery, have come up short.[87] Politicians tend to point out obvious faults, and pour money into fixing them. This looks good to the public, whereas addressing the messy roots of problems looks bad. Perhaps this is partly responsible for why attempted solutions are treating the symptoms, and not the system.

Reform

In April 2001, the Canadian Prime Minister appointed former Saskatchewan Premier Roy Romanow to head a Commission on the Future of Health Care in Canada. The ensuing 18 month, $10 million investigation, which gathered information and public input from tens of thousands of Canadians, culminated on November 28, 2002 with the release of Romanow's final report, *Building on Values: The Future of Health Care in Canada.*

The question addressed was the almost frantic question reverberating throughout Canada, "What shall we do to sustain our health care system?" The most striking recommendation that Romanow made was a drastic input of national funds into the Canadian Medicare system. The

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[84] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.
[85] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.
[86] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.
[87] Weber, Joseph. "Canada's Health Care System Isn't a Model Anymore." *Business Week.* August 31, 1998.

report was a profound message that Canada should not regress from the accomplishments of the Medicare system toward a hybrid privatized system; Canada should commit to restoring its national health care system to meet the ideals that it set out to achieve many years ago.

Romanow's report makes the recommendations that he feels Canadians would agree with for restoring the medicare system.[88] Each recommendation is thoroughly explained, given a timeline, and given an estimated cost. But it is the cost that has alarmed Canadians. Romanow recommends that the government cover a minimum of 25% of the cost of insured health services by 2005/2006 and it should sustain this funding floor in the future. In addition to this, Romanow has called for an initial surge of funds to get Canada back on a track for sustainability. The additional funding should be above forecasted federal funding by $3.5 billion in 2003/2004, $5 billion in 2004/2005, and $6.5 billion in 2005/2006, which is a surge of $15 billion.[89] In his statement to the nation about his final report, he emphasizes this passage:

> "But I want to make one thing absolutely clear. The new money that I propose investing in health care is to stabilize the system over the short-term, and to buy enduring change over the long-term. I cannot say often enough: that the status quo IS NOT AN OPTION! If the only result of these past 18 months of collective effort by Canadians is simply more dollars for health care, our time will have been wasted."[90]

These renewal funds will go to the following five new programs to regenerate the sustainability of the Medicare system:

- *A Rural and Remote Access Fund ($1.5B total over 2 years):* to improve timely access to care in rural and remote areas.
- *A Diagnostic Services Fund ($1.5B total over 2 years):* to improve wait times for diagnostic services.
- *A Primary Health Care Transfer ($2.5B over 2 years):* to support efforts to remove obstacles to renewing primary care delivery.

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[88] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.
[89] "Romanow Report Proposes Sweeping Changes to Medicare." Commission on the Future of Health Care in Canada. http://finalreport.healthcarecommission.ca.
[90] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

- *A Home Care Transfer ($2B over 2 years): to provide a foundation for an eventual national homecare strategy.*
- *A Catastrophic Drug Transfer ($1B beginning in FY 2004/5):* to protect Canadians in instances where they require expensive drug therapies to remain healthy.[91]

Romanow expands on some of these recommendations in his speech. He makes several recommendations for improving access and quality of care. One suggestion is an improved data collection system to help provinces collect health outcomes information, and to report regularly to other provinces so that the nation acts together to improve. A national personal electronic health record will improve efficiency, accuracy, and security in keeping patient records. A coordinated wait list management system between health care centers will provide more reliable wait time estimates and reduce wait times. Attention to long-term human resources strategies will attune administrators to the evolving needs of supply and demand in the health sector.[92]

To address the challenges posed by the rapidly advancing pharmaceutical industry and rising drug costs, Romanow makes three suggestions: There should be a catastrophic drug transfer to help provinces provide funding for prescriptions in cases where drugs become crucial to a consumer's health. Currently many Canadians have no drug coverage, and the majority of those without coverage are poor. The establishment of a national drug agency could monitor the pharmaceutical industry to improve costs, safety, and knowledge about drugs. And the drug patent legislation should be refined to allow for purchasing of generic versions of drugs immediately after new drug patents run out.[93]

One of the thematic grievances about modernized health systems is the loss of home care services. In Canada, where doctors are paid on a fee-for-service basis, home care is especially neglected. But research has found the obvious, that home care is very valuable to improving health for many people. In particular, home mental health care, post-acute home care, and

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[91] "Romanow Report Proposes Sweeping Changes to Medicare." Commission on the Future of Health Care in Canada. http://finalreport.healthcarecommission.ca.
[92] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.
[93] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

palliative home care demand attention. Romanow suggests the establishment of a national home care system.[94] This will become increasingly important as the population ages.

Romanow makes many smaller recommendations; forty-seven of them in total. In addition to recommendations, he issues observations, warnings and requests, which make his final report an approachable, sensible, and sensitive document. He warns politicians that inter-provincial bickering over health care is deleterious and he requests cooperation. This request has already been denied, especially by Quebec. Quebec traditionally prefers to be more autonomous than other provinces, and is upset by the centrality of Romanow's recommendations. The province would very much like the extra funding Romanow proposes, but would like it with no strings attached so that it can use the funds in its own way. Alberta is also unhappy with Romanow's request that all provinces report the precise usage of its federal funds.[95] These provinces feel that they can better attend to its peoples' health care needs with less patriarchal central monitoring.

Another warning that Romanow issues is that if Canada does not renew the sustainability of Medicare, then the system will succumb to the privatized sector. He states:

> "The grave risk we will face is pressure for access to private, parallel services – one set of services for the well off, another for those who are not. Canadians do not want this."[96]

Romanow holds strongly to the ideals of the Canadian system; universality, equity, and quality. His commission's nationally engaging, comprehensive, transparently presented investigation, and its clearly written, persuasive final report present to Canadians what is nearly the most accessible evaluation of the medicare system possible. While there have been many other suggestions for improving the Canadian health care system, Romanow's recommendations seem to construct a track toward sustainability.

Implications

At the end of his statement to the nation, Roy Romanow issues this pointed counsel:

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[94] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.
[95] "Health minister promises help on national reform." The Burlington Free Press. Wire Reports. Dec. 8, 2002. Pg. 4B.
[96] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

> "Many of the so-called "new solutions" being proposed for health care – pay-as-you-go, user and facility fees, fast-track treatment for the lucky few, and wait-lists for everyone else – are not new at all. We've been there. They are old solutions that didn't work then, and were discarded for that reason. And the preponderance of evidence is that they will not work today."[97]

Romanow clearly has his biases. Although his recommendations are supported by evidence, it would be unfortunate to dismiss other "new solutions." One new solution that is gradually garnering support from medical economists, is what Romanow would perhaps refer to as a pay-as-you-go model. A new Catastrophe Insurance/Medical Savings Account model of health care coverage could have profound implications for Canada. And even if this model is not eventually utilized to rebuild Canada's health care system, exploring it will surely hold lessons. The Catastrophe/MSA model has also been looked at in the US as a way to reduce health care costs in a completely privatized system. For this reason, it will be valuable for other countries, such as India, which has a highly privatized system, to consider the Catastrophe/MSA model.

The Catastrophe Insurance/Medical Savings Account Model

"We generally rely on insurance to protect us against events that are highly unlikely to occur but involve large losses if they do occur—major catastrophes, not minor regularly occurring expenses. We insure our houses against loss from fire, not against the cost of having to cut the lawn."[98]

--Milton Friedman

Health insurance around the world has become an integral part of health care systems. Yet, it has evolved its own definition of insurance. Health insurance policies that cover everything from family planning to geriatrics are costly, and may not be the best means to paying for health care. From the U.S.'s privatized health care system, to Canada's universal health care system, to

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[97] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

[98] Friedman, Milton. "How to Cure Health Care." *The Public Interest*. Winter 2001. http://www.thepublicinterest.com/archives/2001winter/article1.html.

systems in developing nations, a new model is emerging to challenge the current health insurance paradigm.

Many health economists are recommending a restoration of health insurance to its original purpose. It is far more cost-effective for an employer, or country, to purchase a high-deductible catastrophe medical plan for its dependents, rather than purchasing a comprehensive plan, which covers a lot of services not used. The money saved from switching to a catastrophe medical plan, would be deposited into a Medical Savings Account (MSA). An MSA is a tax-exempt account that can be used to pay for approved medical services of the holder's choice. The result is, instead of putting money into a comprehensive insurance plan, where unused money goes to the insurance company, the account holder pays for his own services and keeps the unused money. This new catastrophe insurance/MSA model has promising implications backed by empirical evidence.

The previously mentioned RAND Health Insurance Experiment also tested consumer paying models. One group received free care, like in the Canadian system. The other group was given money, and had to pay for their medical services (user fee group). It was found that the free care group was 28% more likely to use medical services, 67% more likely to see a doctor, and 30% more likely to be admitted to the hospital, with 20% more days per year of restricted activity than those who were in the user fee group. It costs 45% more to have a free care system. *And there was no difference found in the overall health of either group.*[99]

Similarly, Lohr et al. (1996) found that a cost-sharing scheme, like the catastrophe/MSA model, reduced the use of both necessary and unnecessary medical services. Yet there was no decrease in the health of the individuals surveyed. Their hypothesis is that unnecessary medical visits can be adverse to your health, resulting in necessary visits. When you eliminate both, there is no net change in health.[100]

The natural conclusion to draw from these studies is that when consumers must spend their own money on health care, they spend it more prudently than when they are spending the government's or insurance company's money.

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[99] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[100] Ramsay, Cynthia. "Medical Savings Accounts: Universal, Accessible, Portable, and Comprehensive Health Care for Canadians." *The Frasier Institute – Critical Issues Bulletin.* May 1998.

The Canadian government could introduce a catastrophe insurance/MSA health care system, in which it pays for catastrophe insurance for each citizen, and gives each citizen an MSA stipend based on his or her health, age, and socio-economic class. The catastrophe insurance would relieve the anxiety-producing risk of major medical expenses. And the MSA's would reintroduce a competitive market to the health care system.

A competitive market drives progress through efficiency and incentives. Consumers would benefit most because the affects of change are amplified most at the end of a cascade. They would likely spend less on health care because they would be accountable for their own expenses. These expenses could include currently uninsured services, such as dental, home care, and medical supplies. This freedom would be beneficial to the sick and the poor who currently have trouble paying for prescriptions and other uninsured services.[101] Fewer visits to the doctor would allow consumers more time to participate in the work force. At the end of each year they could withdraw the money in their MSA's as taxable income, or they could roll it over into their accounts for the next year. Less spending would mean lower national health costs, leading to lower taxes for consumers. Less consumption would resolve the queuing problem and raise consumer satisfaction by giving them faster access to medical services. They would also likely be more discerning over who provides their medical services.

The catastrophe insurance/MSA model would restore doctor/patient relationships. Patients would choose their providers carefully and know about their doctors before they went in for appointments. Lower demand on services would give doctors more time to spend with their patients. This would give them time to develop relationships with their patients, educate their patients, and address medical complaints that in the current system would require multiple patient visits. Increased patient selectivity would bolster competition between physicians to provide better care to attract more patients. This incentive would raise provider salaries, which in turn would make medicine a more attractive career field. Medical school admissions would likely rise, and the resultant doctor to patient ratio would improve, thus potentially leading to better national health.

Several nations are already using catastrophe insurance/MSA options to optimize their national health. The private sector in the U.S. is gradually implementing such plans, to high reported

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[101] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

levels of success. Singapore and China have catastrophe insurance/MSA options. Shaunn Matisonn of the National Center for Policy Analysis discusses South Africa's experience with such plans:

> "For most of the last decade [the nineties]...South Africa enjoyed what was probably the freest market for health insurance anywhere in the world...In just five years, MSA plans captured half the [private insurance] market...attract[ing] individuals of all different ages and different degrees of health."[102]

Success in other nations, empirical evidence, and advising from medical economists strongly support the new health care systems model of catastrophe insurance with MSA's. The dust storm of politics over the current state of Medicare, makes such a change difficult to see in the near future for Canada. However, this model could emerge as a solution for other countries.

Conclusion

The Canadian Medicare system has been a grand experiment in health care systems. It has succeeded for many years, and it has set an example for the rest of the world, both in its successes and its failings. Current trends allude to its eventual collapse. In order for Canada to regain the sustainability of its touted health care system, there will need to be fundamental changes to its structure. Roy Romanow's very thorough report, *Building on Values: The Future of Health Care in Canada,* makes a complete collection of recommendations for refurbishing the health care system that was once Canada's jewel. If the recommendations are followed closely with minimal political interruption, then it seems that they could lead Canada back onto the track for sustainability in its health care system. The forthcoming, honest, comprehensive methodology used by the Commission on the Future of Health Care in Canada during its study should provide a model to other countries for how to properly evaluate and confront national health care issues. Meanwhile, a growing group of health economists are adhering to the catastrophe insurance/MSA model. Other nations can learn a great deal from the ideas and methodologies that are emerging in this period of transition for the Canadian health care system.

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Costa Rican Health Care

A Maturing Comprehensive System

Greg Connolly 12/8/02
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A history of commitment to health and social reform has yielded for Costa Rica the best health outcomes of any country in Latin America. These outcomes are the result of a well-developed publicly funded comprehensive health care system built on the principals of universal coverage and equity. While the fundamentals of this system were becoming entrenched, several predictable challenges arose. Costa Rica is confronting those problems with outside aid in a period of reform, which began in 1994. Now, the World Bank has decided to support Costa Rica with its Second Health Sector Strengthening and Modernization Project, which will build off of existing initiatives and trends toward improvement of the health care system. While Costa Rica occupies a tight niche as a small country of middle wealth and high social solidarity, the development of its health care system still holds lessons for some of the most complex nations of the world.

The Costa Rican Health Care System

Framed by Nicaragua to the north, Panama to the south, and the Pacific Ocean and Caribbean Sea, the small country of Costa Rica (area 51,100 sq. km)[103] stands out from its neighbors with a deep history of commitment to social reform and a thriving economy. With a population of only 3,810,179, 59% of which live in urban areas,[104] the nation is not only small, but also it has been able to hold social solidarity. This solidarity arose from the nation's agricultural history in which the upper and lower classes were dependent upon each other.[105] In the past decade the ratio between the income of the upper 20% and the lower 20% held stable.[106] The democratic government composed of executive, legislative, and judicial branches, and a four-year rotating presidency, has also shown remarkable stability. Sustained economic growth has built a GDP per capita of USD$8,500 in 2001 with the primary industries being services, industry, and agriculture. The development model, "Based on promoting exports and tourism and modernizing state

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[103] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 1.
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CONTENTS

The Right to Health Care – moving from idea to reality

"Should medicine ever fulfil its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life cycle and remove them. Should it ever come to pass, Medicine, whatever it may then be, will become the common good of all." - *Rudolf Virchow, c.1850*

Background: Inequity in health and access to health care

India is known to have poor health indicators in the global context, even in comparison with many other developing countries. However, we also bear the dubious distinction of being among the more inequitous countries of the world, as far as health status of the poor compared to the rich is concerned. This underscores the fact that there is a tremendous burden of unnecessary morbidity and mortality, which is borne almost entirely by the poor. Some striking facts in this regard are -

- Infant mortality among the economically lowest 20% of the population is 109, which is ***2.5 times*** the IMR among the top 20% population of the country.
- Under-five mortality among the economic bottom 20% of the population (bottom quintile) is 155, which is not only unacceptably high but is also ***2.8 times*** the U5MR of the top 20% (top quintile).
- Child mortality (1-5yrs age) among children from the 'Low standard of living index' group is ***3.9 times*** that for those from the 'High standard of living index' group according to recent NFHS data (IIPS, 2002). Every year, 2 million children under the age of five years die in India, of largely preventable causes and mostly among the poor. If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala, then 16 lakh deaths of under-five children would be avoided every year. This amounts to ***4380 avoidable deaths every day,*** which translates into ***three avoidable child deaths every minute.***
- Tribals, who account for only 8% of India's population, bear the burden of ***60% of malarial deaths*** in the country.

Such gross inequalities are of course morally unacceptable and are a serious social and economic issue. In addition, such a situation may also be considered a *gross violation of the rights of the deprived sections of society.* This becomes even more serious when viewed in the context of ***gross disparities in access to health care*** -

- The richest quintile of the population, despite overall better health status, is *six times more likely* to access hospitalisation than the poorest quintile. This actually means that the poor are unable to afford and access hospitalisation in a large proportion of illness episodes, even when it is required
- The richest quintile have *three times higher level* of coverage for measles immunization compared to the poorest quintile. Similarly, a mother from the richest 20% of the population is *3.6 times more likely* to receive antenatal care from a medically trained person, compared to a mother from the poorest 20%. The delivery of the richer mother is *over six times more likely* to be attended by a medically trained person than the delivery of the poor mother.
- As high of 82% of outpatient care is accessed from the private sector, met almost entirely by out-of-pocket expenses, which is again often unaffordable for the poor.
- About three-fourths of spending on health is made by households and only one-fourth by the government. This often pushes the already vulnerable poor into indebtedness, and in

over 40% of hospitalisation episodes, the costs are met by either sale of assets or taking loans.

- The per capita public health expenditure in India is abysmally low at Rs. 21 per person, among the lowest in the world. India has one of the most privatized health systems in the world (only five countries on the globe are worse off in this respect), effectively denying the poor access to even basic health care.

The gist of these sample facts is that the existing system of 'leave it to the market' effectively means ***'leave health care for the rich and leave the poor to fend for themselves'***.

One implication that emerges from the above discussion is that the problem of large-scale ill health in India should not be seen as primarily a technical-medical issue. The key requirement is not newer medical technologies, more sophisticated vaccines or diagnostic techniques. The fact that the prosperous sections of the population enjoy a reasonably good health status implies that *the technical means to achieve good health do broadly exist in our country today* (though there is definitely a need to better adapt these to our country's conditions and traditions, and certain improved techniques might help in specific contexts). *In fact, for the vast majority, the key barriers to good health are not the lack of technology but poverty and health system inequity.* Poverty, a manifestation of social inequity, leads to large sections of the population being denied adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and a healthy local environment, which are all prerequisites for health. At the same time, we have a ***highly inequitable health system*** which denies quality health care to all those who cannot afford it (the fact that even those who **can** afford it do not always get rational care is another important, but somewhat separate issue!). In this paper, which is primarily addressed to those working in the health sector, we will focus on the critical *health system* issues, with a rights-based approach. Let us see how we can view this entire situation from a rights based perspective.

The Right to Health Care as a component of the Right to Health

Looking at the issue of health under the equity lens, it becomes obvious that the massive burden of morbidity and mortality suffered by the deprived majority is not just an unfortunate accident. It constitutes *the daily denial of a healthy life, to crores of people, because of deep structural injustice, within and beyond the health sector.* This denial needs to be addressed in a rights based framework, by systematically establishing the right of every citizen of this country, to a healthy life. More specifically, health care can no longer be viewed as just a technical issue to be left to the experts and bureaucrats, an issue of charity to be dealt with by benevolent service delivering institutions, or a commodity to be sold by private doctors and hospitals. The role of all these actors needs to be redefined and recast in a framework where every person, including the most marginalized, is assured of basic health care and *can demand and access this as a right.*

It is clear that achieving a decent standard of health for all requires a range of far reaching social, economic, environmental and health system changes. There is a need to bring about broad transformations both within and beyond the health care sector, which would ensure an adequate standard of health for all. To promote the **Right to Health** requires action on two related fronts (WHO, 2002):

Similarly in the cases *Bandhua Mukti Morcha v. Union of India and others, 1982* concerning bonded workers, the Supreme Court gave orders interpreting Article 21 as mandating the right to medical facilities for the workers.

Basic social services are now being recognised as fundamental rights with the 93rd amendment in the constitution accepting Education as a fundamental right. Despite the controversy and problems regarding the actual provisions of the Bill, it is now being accepted that essential social services like education can be enshrined in the fundamental rights of the Constitution. This forms an appropriate context to establish the right to health care as a constitutionally recognised fundamental right.

The social and economic justification

It is now widely recognised that besides being a basic human right, provision of adequate health care to a population is one of the essential preconditions for sustained and equitable economic growth. The proponents of 'economic growth above all' may do well to heed the words of the Nobel Laureate economist Amartya Sen:

> 'Among the different forms of intervention that can contribute to the provision of social security, the role of health care deserves forceful emphasis ... A well developed system of public health is an essential contribution to the fulfilment of social security objectives.
> ...we have every reason to pay full attention to the importance of human capabilities *also as instruments* for economic and social performance. ... Basic education, good health and other human attainments are not only directly valuable ... these capabilities can also help in generating economic success of a more standard kind ... *(from India: Economic Development and Social Opportunity by Jean Dreze and Amartya Sen)*

The human rights justification

The right to basic health care is recognised internationally as a human right and India is a signatory to the International Covenant on Economic, Social and Cultural Rights which states in its Article 12 -

> The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health... The steps to be taken...shall include those necessary for ...The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Reference can be made to other similar international conventions, wherein the Government of India has committed itself to providing various services and conditions related to the right to health, e.g. the Alma Ata declaration of 'Health for all by 2000'. The National Human Rights Commission has also concerned itself with the issue of 'Public health and human rights' with one of the areas of discussion being 'Access to health care'. The time has come to begin asking as to how these human rights related commitments and concerns will be translated into action in a realistic, time-bound and accountable framework.

The core content of the Right to Health Care in the first phase

Moving towards establishing the Right to Health Care is likely to be a process with various phases. First let us see what could be the *core content* of this right in the first phase, which could be achieved in the short to medium term.

Promoting the Right to underlying determinants of health

This involves working for the right to 'the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health' (WHO, 2002). Agencies engaged in the health sector cannot deal with most of these issues on their own, though they need to highlight the need for better services and conditions, and can advocate for improvements in these areas in a rights based framework. Organisations working in the health sector can support other agencies working directly in these areas, to help bring about relevant improvements.

Promoting the Right to Health Care

Given the gross inequities in access to health care and inadequate state of health services today, one important component of promoting the Right to Health would be to ensure access to appropriate and good quality ***health care*** for all. This would involve reorganisation, reorientation and redistribution of health care resources on a societal scale. The responsibility of taking forward this issue lies primarily with agencies working in the health sector, though efforts in this direction would surely be supported by a broad spectrum of society.

In the remaining portion of this paper, we will focus on the process of establishing ***the Right to health care*** as a imminent task, to be taken up by organisations in the health sector in the broader context of Right to Health outlined above.

The justification for establishing the Right to Health Care

We may view the justification for this right at three levels - constitutional-legal, social-economic and as a human right issue.

The constitutional and legal justification

The right to life is recognised as a fundamental right in the constitution (Article 21) and this right has been quoted in various judgements as a basis for preventing avoidable disease producing conditions and to protect health and life. The ***directive principles of the Indian constitution*** include article 47, which specifies the duty of the state in this regard:

> 47. Duty of the state to raise the level of nutrition and the standard of living and to improve health:- The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties …

In an important judgement (*Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996)*, the Supreme Court of India ruled that -

> In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. … Article 21 imposes an obligation on the State to safeguard the right to life of every person. … The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. *Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21.* (emphasis added)

Right to a set of basic public health services

In the context of the goal of 'Health for All' and various Health Policy documents, an entire range of health care services are supposed to be provided to all from village level to tertiary hospital level. As of today these services are hardly being provided adequately, regularly or of the required quality. Components of the public health system to be ensured in a rights based framework include:

1. Adequate physical infrastructure at various levels
2. Adequate skilled humanpower in all health care facilities
3. Availability of the complete range of specific services appropriate to the level
4. Availability of all basic medications (also see below)

The expected infrastructure and services need to be clearly identified and displayed at various levels and converted into an enforceable right, with appropriate mechanisms to functionalise this. For example, in a justiciable framework, basic medical services especially at Primary and Secondary levels cannot be refused to anyone – for example a PHC cannot express inability to perform a normal delivery or a Rural hospital cannot refuse to perform an emergency caesarean section. *In case the requisite service is not provided by the facility when required, the patient would be entitled to approach a private hospital and receive care, for which the hospital would receive time-bound reimbursement of costs incurred, at standard rates.* This would firstly constitute a strong pressure on the public health system to perform and deliver all services, and secondly, would ensure that the patient receives the requisite care when required, without incurring personal expenses. This forms the one of the first steps towards accessing the right to health care.

Similarly the state has an explicit obligation to maintain public health through a set of preventive and promotive services and measures. These of course include coverage by immunisation, antenatal care, and prevention, detection and treatment of various communicable diseases. However, it should also encompass the operation of epidemiological stations for each defined population unit (say a block), organizing multi-level surveillance and providing a set of integrated preventive services to all communities and individuals.

Right to emergency medical care and care based on minimum standards from private medical services

Although the right to health care is not a fundamental right in India today, the right to life is. In keeping with this 'Emergency Medical Care' in situations where it is lifesaving, is the right of every citizen. No doctor or hospital, *including those in the private sector*, can refuse minimum essential first aid and medical care to a citizen in times of emergency, irrespective of the person's ability to pay for it. The Supreme Court judgement quoted above (*Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996)*, directly relates to this right and clear norms for emergency care need to be laid down if this right is to be effectively implemented. As a parallel, we can look at the constitutional amendments enacted in South Africa, wherein the Right to Emergency Medical care has been made a fundamental right.

At the same time there is an urgent need for a comprehensive legislation to regulate qualification of doctors, required infrastructure, investigation and treatment procedures especially in the private medical sector. Standard guidelines for investigations, therapy and surgical decision making need to be adopted and followed, combined with legal restrictions on common medical malpractices. Maintaining complete patient records, notification of specific diseases and observing a ceiling on fees also needs to be observed by the private medical sector. The Govt. of Maharashtra is in the process of enacting a modified act to

address many of these issues, and the National Health Policy 2002 stipulates the enactment of suitable regulations for regulation of minimum standards in the private medical sector in the entire country by the year 2003. This would include statutory guidelines for the conduct of clinical practice and delivery of medical services. There is a need to shape such social regulation of this large medical sector within the larger, integrated framework of Right to health care.

Right to essential drugs at affordable cost

Attaining this right would consist of two components:

1. Availability of certain basic medications free of cost through the public health system
2. A National Essential Drug Policy ensuring the production and availability of an entire range of essential drugs at affordable prices

The Union as well as state Governments need to publish comprehensive lists of essential drugs for their areas. A ceiling on the prices of these drugs must be decided and scrupulously adhered to, with production quotas and a strict ban on irrational combinations and unnecessary additives to these drugs.

Right to patient information and redressal

The entire range of treatment and diagnosis related information should be made available to every patient in either private or public medical facility. Every patient has a right to information regarding staff qualifications, fees and facilities for any medical centre even before they decide to take treatment from the centre. Information about the likely risks and side effects of all major procedures can be made available in a standard format to patients. Information regarding various public health services which people have a right to demand at all levels should be displayed and disseminated. This should include information about complaint mechanisms and for redressal of illegal charging by public health personnel.

Superseding the CPA, a much more patient-friendly grievance redressal mechanism needs to be made functional, with technical guidance and legal support being made available to all those who approach this system. This would provide an effective check on various forms of malpractice. In case the services mandated under this right are not given by a particular facility, the complainant need not take recourse to lengthy legal procedures. Rather, the grievance redressal mechanism with participation of consumer and community representatives should be empowered to take prompt, effective and exemplary action.

Right to monitoring and accountability mechanisms

Keeping in mind the devolution of powers to the Panchayati Raj system, we need to propose an effective system of people's monitoring of public health services which would be organised at the village, block and district levels. Community monitoring of health services would significantly increase the accountability of these services and will lead to greater people's involvement in the process of implementing them. The Union Ministry of Health and Family Welfare, with support from WHO, has been successfully implementing an innovative pilot project for 'Empowering the rural poor for better health' in six talukas of the country. Taking this and various other experiments into account, a basic framework for such monitoring needs to be developed.

The broader objective - a system for universal health care and basic health care as a fundamental constitutional right

While trying to achieve these specific rights in the first phase, our overall goal should be to move towards a system where every citizen has assured access to basic health care,

irrespective of capacity to pay. A number of countries in the world have made provisions in this direction, ranging from the Canadian system of Universal health care and NHS in Britain to the Cuban system of health care for every citizen. In the Indian context, the right to health care needs to be enshrined in the Constitution as a fundamental right. One conception of the minimum content of the fundamental right to health care is outlined in the accompanying box.

Proposed minimum content of the fundamental right to health care

1. *Making the right to health care a legally enforceable entitlement by legal enactment*
2. *A national health policy with a detailed plan and timetable for realization of the core right to health care*
3. *Developing essential public health infrastructure required for health care; investing sufficient resources in health and allocating these funds in a cost-effective and fair manner*
4. *Providing basic health services to all communities and persons; focusing on equity so as to improve the health status of poor and neglected communities and regions*
5. *Adopting a comprehensive strategy based on a gender perspective so as to overcome inequalities in women's access to health facilities*
6. *Adopting measures to identify, monitor, control and prevent the transmission of major epidemic and endemic diseases*
7. *Making reproductive health and family planning information and services available to all persons and couples without any form of coercion*
8. *Implementing an essential drug policy*

(Adapted from Audrey R. Chapman, The Minimum Core Content of the Right to Health)

One realistic scenario to make this right functional could be a system of universal social health insurance. The services could be given by a combination of a strengthened and community-monitored public health system along with publicly regulated and financed private providers, under a single umbrella. The entire system would be based on public subsidisation and cross-subsidy, with free services to the majority population of rural and urban working people including vulnerable sections, and affordable premium amounts (which could be integrated with the taxation system) for higher income groups. One key aspect would be that this should be a *Universal system* (not targeted), which would ensure coverage of the entire population and also retain a strong internal demand for good quality services. (Of course, certain very affluent sections may choose to pay their share of taxation / premium and yet opt out and access private providers.) Another issue is that there would be *no fees or nominal fees at the time of actual giving of services*. Finally, the patient would be assured of a range of services with minimum standards, whether given from the public health system or publicly financed and regulated private providers. The entire system could be managed in a decentralised manner, with consumer's monitoring of quality and accessibility of services.

This entire model would of course imply a significantly higher public expenditure on health services. However, with decentralised management and a focus on rational therapy, it has been estimated that it should be possible to organise the basic elements of such a system by devoting about 3% of the GNP towards public health care to start with. This should then be progressively raised to the level of 5% of GNP to give a full range of services to all. This level of funds could be partly raised by appropriate taxation of unhealthy industries, reallocations within the health sector (including reorganising existing schemes like ESI) and ending all subsidisation of the private medical sector. This of course needs to be combined with changed budgetary priorities and higher overall allocation for the health sector. Incidentally, the new National Health Policy claims on paper the intention to more than double the financial allocation for the public health system and bring it to the level of 2% of

the GDP, and to increase utilisation of public health facilities to above 75% by the end of this decade. This admirable yet vague intention needs to be converted into concrete action by means of strong and sustained pressure from various sections of civil society, coupled with concrete proposals to functionalise universal access to health care.

In this context, ensuring Health care for all is not an unrealistic scenario, but both a practical possibility and an imperative for a nation, which as the 'world's largest democracy' claims to accord certain basic rights to its citizens, including the right to life in its broadest sense.

Ways ahead - creating a consensus on the right to health care

Some of the possible areas of activity of a potential broad coalition which could support a campaign on the issue of Right to Health Care are suggested below.

Involving diverse social sectors in a dialogue on the Right to Health Care

While some health activists and groups have mooted the concept of the Right to Health Care, it is an idea which is yet to be widely discussed and accepted in our country. One of the key tasks in the immediate future is to generate discussion at the broadest possible level about this right. Groups to be involved in such a debate include health policy makers, medical and public health academics, private medical professionals, various segments of the NGO sector including both health related and non-health NGOs, trade unions of health care personnel and people's organisations. It is obvious that the viewpoints of various social groups and actors may be greatly divergent on this issue. However, the very process of discussing and debating the issue gives it a primary legitimacy, which then needs to be built upon. This becomes a basis for generating a continuously widening consensus about the basic justification, content and implementation model for the Right to Health Care.

Collating international experience on the Right to Health Care

There is valuable international experience available about mandating the Right to Health or Health Care. These experiences need to be collated, and analysed with the Indian context in mind. Especially legislation and provisions made in developing countries are of value in this respect.

Twelve different countries of Latin America, which have Civil law provisions, include the right to health or State duties to protect health in their constitutions. While Chile was the first such country to make such a provision, Argentina, Brazil, and Mexico are also included among these. Cuba with a socialist constitution accords the right to health to its citizens, according it a status equivalent to civil and political rights.

South Africa, after the overthrow of apartheid, in Article 27 of its constitution has specified certain provisions relevant to this right. This includes mandating the right to access to health care services, specifying that the state must take reasonable legislative measures to achieve realisation of this right, and declaring that no one may be refused emergency medical treatment. From another end, we have a new system of Universal health care access in Thailand whose features need to be studied and discussed as relevant to the Indian context.

Similarly, there has been an entire process of developing the concept of right to health and health care in the international human rights discourse. Various United Nations health rights instruments refer to health related rights. The UN International Covenant on Economic, Social and Cultural Rights (ICESCR), UN Convention on Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) are some such significant conventions, in which India is a signatory.

Given this background, one of the critical tasks ahead of us is to make an in-depth study of these experiences and utilise this for developing the judicial form and implementation-related content of the Right to Health Care in the Indian situation.

Organizing state and national conventions on the Right to Health Care

One way of developing such a consensus is to organise a series of conventions, on the issue of Right to Health Care, first at state level and ultimately at the national level. Each convention could bring together representatives of key stakeholders outlined above, and could result in a clearer conceptualisation of the core content and processes related to making this right functional. The national convention could also culminate in a dialogue with the Health Minister, promoting the idea of recognising and implementing this right.

Discussing detailed proposals to implement the Right to Health Care

One of the crucial issues in furthering this campaign is the development of a model for implementing this Right. This needs to be done, keeping in mind the specificities of the Indian health care system, judicial framework (including the fact that Health is a state subject), socio-economic situation including major class, caste and gender disparities and recent processes such as the 93rd Constitutional amendment. Considerable groundwork and consultation is required to develop a model, which would take into account the positions of various stakeholders and form the basis for practical implementation of this right.

Forming a multi-sector independent body to monitor implementation of the Right to Health Care

Finally, there is the need for a multi-sectoral body with representation from various social sectors to monitor the processes of establishment and implementation of the Right to Health Care. Such a body would have the social legitimacy, diverse experience and capacity to continuously assess the movement towards realisation of this right, and help usher in a new phase in the development of the health system and establishment of social-economic rights in this country.

(This note has been prepared by Dr. Abhay Shukla of CEHAT, with inputs of various health experts including Dr. Ravi Narayan, of Community Health Cell. Several sections of this article are adapted from Abhay's article 'Right to health care' published in Health Action, May 2001)

institutions in the 1990's,"[107] has landed Costa Rica in 41st position in a 1999 development survey of 162 of the world's wealthiest countries.[108]

A primary contributor to Costa Rica's success has been its focus on the well being of its people. For Costa Rica, health and education are priorities for the success of their nation. The World Bank highlights this priority:

> "The Government of Costa Rica sees the health sector as an essential determinant of the country's economic and social development, giving it a priority that is manifested in sustained high levels of spending and active policy attention at the highest levels."[109]

The attention to health has brought this middle-wealth country's health indicators in line with those of OECD countries.[110] In 2001 the average life expectancy at birth in Costa Rica was 76.6 years.[111] In 2000, 97% of births were attended by skilled professionals, 89% of the pregnant women were given prenatal care, and 93% of children under 1 had health insurance.[112] From 1990 to 2000 life expectancy increased by 0.8 years, the fertility rate dropped, and the population grew due to an influx of Nicaraguan immigrants.[113] In 2000 there were 16 physicians and 3.2 nurses per 10,000 population.[114] In 1999 there were 12,000 people living with HIV/AIDS, giving an adult prevalence rate of 0.54%.[115] However, Costa is the only Central American country to provide antiretroviral treatment to all patients through its social security system.[116] The leading causes of death were cardiovascular disease and neoplasms, which is comparable to many OECD countries.[117] Spending on health care has increased steadily over recent years, and in 2000 it composed 9% of the national GDP.[118]

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[107] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 3.
[108] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 1.
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[110] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 1.
[111] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 1.
[112] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.
[113] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.
[114] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 7.
[115] UNAIDS. "National Response Brief – Costa Rica." http://www.unaids.org/nationalresponse/result.asp
[116] UNAIDS. "National Response Brief – Costa Rica." http://www.unaids.org/nationalresponse/result.asp
[117] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 4.
[118] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 2.

These outcomes are the result of one of the world's most successful "universal" health care systems. "Universality" in the Costa Rican system means that 100% of the population is given equal comprehensive public health insurance with equal access to services. The success of the system is built upon a history of stalwart determination by the national government to ensure high quality health care for its entire people. In 1941 social security legislation was passed in Costa Rica, establishing the Costa Rican Bureau of Social Security (CCSS). This legislation set the provisions for medical insurance that through the gradual expansion of the CCSS would eventually become a universal health insurance system. Costa Rica wrote a new constitution in 1949. The most significant component of the Constitution was the abolishment of a national army. This opened funding and allowed more attention to go toward social programs, such as education and health. Gradual health sector improvement ensued until 1973, when the health sector was given a dramatic boost. The General Health Law of 1973 placed all health treatment services, including all health care areas and hospitals, under the control of the national social security program. In the next decade public health care coverage extended to reach 78% of the population in 1982. By this point, all those employed, regardless of their socioeconomic status, received health care.[119] The Ministry of Health (MOH), which was established in 1907[120], at this time was responsible for public health programs such as prevention and promotion, and provided primary care for the uninsured. The MOH and the CCSS, working together to provide national health care, continued to refine their roles. In the early 1990's the MOH turned over primary health care provision responsibilities to the CCSS.[121] The MOH has since been in charge of all public health programs, and the CCSS has been in charge of all health provision programs.

The public sector is the predominant health care sector in Costa Rica. It is composed of the following branches:

> "The Costa Rican Social Security Fund (CCSS), which provides health insurance, including comprehensive health care and financial and social benefits; the National Insurance Institute (INS), which covers occupational and automobile accidents; the Costa

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[119] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

[120] IHCAI Foundation. "Costa Rican Health Care System Profile." http://www.ihcai.org/Health%20System%20of%20Costa%20Rica_Learn%20Spanish%20in%20tropics%20.htm.

[121] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 1.

> Rican Institute of Water Supply and Sewerage Systems (AyA), which regulates the supply of water for human consumption and wastewater disposal; and the Ministry of Health (MOH), which monitors the performance of essential public health functions and exercises the steering role in the sector." [122]

The CCSS provides universal health care insurance to employed Costa Ricans. Workers contribute 15% of their salaries to health insurance, broken down in this manor: 9.25% from the employers, 0.25% from the total national wages, and 5.5% from actual worker wages.[123] Universal coverage means that even those who are unemployed are able to obtain public funding for all health services, including prescription drugs. By law, the CCSS must cover 100% of the population, and it achieves this with the following strategy:

> "The CCSS is aware that only 80% of the population is insured either through the compulsory or voluntary system, or as pensioners or their dependents. Of the remaining 20%, 10% are insured through state subsidies, given that this population group is under the poverty line. The other 10% can request public services when necessary and pay for them directly."[124]

Not only is the insurance coverage universal, but also the access to comprehensive health care is nearly equal throughout the country:

> "A 1998 study showed that...access was practically the same in rural and urban areas (average distances to the nearest facility of 1.28 km and 1.10 km, respectively)."[125]

A large reason why the quality of coverage and access to care are so strong is that the CCSS employs a large number of mid-level health workers:

> "[There is] a relatively modest supply of doctors, which apparently serves the country's needs quite well because of extensive use of auxiliary nurses and health assistants; these personnel work in the rural health posts, health centers, and hospitals."[126]

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[122] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 5.
[123] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.
[124] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.
[125] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 24.
[126] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

Mid-level health workers with little training are very effective at extending access to rural areas. The relatively small amount of training necessary makes it easier for people from villages to become medically certified and contribute to the health care provision in their villages. The usage of mid-level health workers also reduces the overall cost of the health care system because the government doesn't have to pay for expensive medical educations, and it doesn't have to pay high doctors' salaries. South Africa is looking to use more mid-level health workers for just this reason.

The CCSS has a very innovative way of organizing its health care professionals. It provides five comprehensive care programs for children adolescents, women, adults, and the elderly.[127] It operates through 93 health areas and 783 Basic Comprehensive Health Care Teams (EBAIS).[128] Each EBAIS is composed of a physician, a nurse, and one or more primary care technical assistants (ATAP's). Currently each EBAIS serves an average of 3,500 people.[129] Teamwork is an overarching theme in the health care system. The branches of the centralized public health sector must work together, the states must cooperate with national mandates, and the health care providers work in teams. Working in teams allows each EBAIS to develop comraderie and refine its skills as a unit to provide better health care than if the members were working in inconsistent groups. These teams serve set groups of people. In the Costa Rican system, a person is assigned to providers and a medical center based on place of residence.[130] Lack of choice may be perceived as a problem, but consistency gives each patient the best care he can receive in a centralized publicly funded system. Consistency also nurtures Costa Rica's highly developed information collection system. There is a very extensive amount of information available in the public health sector. However, the private sector lacks an efficient information collection system. This is a significant problem because of the increasing importance of the private sector in health care.[131]

Thirty percent of the population used the private sector in 2001, and 24% of doctors worked at least partly in the private sector.[132] The CCSS does not cover the costs of private sector usage. Mixed Medicine, in which a patient will pay for a private consultation with the physician of his choice, and the CCSS will pay for the diagnostic services and drugs,

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[127] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 12.
[128] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 15.
[129] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.
[130] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 26.
[131] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 3.
[132] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.

is playing an increasing role.[133] Another new trend is the usage of Corporate Medical Officers. In this type of program a company will hire a private physician to care for its workers and their families, and the CCSS pays for diagnostic and drug services.[134] A more direct form of Public-Private Partnership (PPP) arose in 1998 when the CCSS began purchasing services from private providers called health cooperatives. "In 2001, four cooperatives and a foundation at the University of Costa Rica were already contracted, serving a total population of 400,000."[135] 11% of the population now gets coverage from PPP's.[136] Incorporating the private sector has alleviated some of the strain on the public system. The private sector does not threaten the public sector because people are happy with the public insurance they already pay for, the quality of public health care is very high, and publicly employed providers are well compensated.[137] A major problem that is arising with the incorporation of the private sector is the difficulty of regulating it. It has been suggested that:

> "There are opportunities for the CCSS to use its purchasing power to require minimum performance as it contracts more with private providers."[138]

Strengthening the CCSS's central power will make it more effective. In a country where interests are do not deviate far from general consensus, centralizing power is the most effective way to guide social programs to achieve equity and public satisfaction and monitor outcomes. The CCSS has wielded its power throughout its existence to effect change. The CCSS uses its central purchasing power to maximize cost-effectiveness of drug purchases by making mass orders to international pharmaceutical companies for all the nation's pharmaceutical needs. Another example of how the CCSS has been able to affect a positive change is the recent implementation of management contracts.

In 2001, all health areas signed management contracts, which set outcome-based goals for performance to be evaluated at the end of each year.[139] This is a significant step toward giving health sector

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[133] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 20.
[134] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 21.
[135] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.
[136] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.
[137] Bossert, Thomas, PhD. "Phone Interview – December 5, 2002." *Harvard School of Public Health.*
[138] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.
[139] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 2.

administration more of a business-like approach. Hospital and clinic directors are now getting managerial education.[140] This will hopefully increase efficiency in medical facilities. Management contracts are the primary new tool to guide the reallocation of public funds on a performance-based system, where case mix, adjusted production, and quality outcomes will determine hospital revenues.[141] This gives incentives to hospitals and providers to be more efficient and have better patient outcomes. The result is that finally, half of the accountability for health sector performance is now taken off of the CCSS and put onto the hospitals and clinics.[142] The evaluation of management contracts will be aided by a Diagnostic Related Groups (DRG) system, which is set up in Costa Rica but has not yet been used.[143] The DRG system is a way of monitoring the services rendered by each hospital or clinic monthly. It is a helpful guide, but it only gives quantitative measures. Therefore qualitative evaluation will have to be made separately when evaluating each hospital's annual performance. There will need to be a large amount of new support for the CCSS to successfully monitor this program and link pay to performance.[144]

In parallel, the MOH has recently developed a regulation program for the accreditation of hospitals based on quality assurance. The program is currently a pilot project, which requires all maternity hospitals to adhere to standards set by the MOH in order to earn accreditation.[145] However, "The ministry's ability to enforce sector regulation is weak,"[146] and will need support to make this program effective on a national scale.

The Ministry of Health has recently maintained a low profile. With the transfer of many of its programs to the CCSS in the 1990's, the MOH lost power. However, throughout the history of the Costa Rican health care system, the Ministry of Health's public health programs have been crucial to the success of the system. Milton Roemer praises the MOH's prevention programs:

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[140] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 21.
[141] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 5.
[142] Bossert, Thomas, PhD. "Phone Interview – December 5, 2002." *Harvard School of Public Health.*
[143] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 5.
[144] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 2.
[145] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 13
[146] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 3.

> "The benefits of prevention were dramatically demonstrated. Their strength and effectiveness probably contributed to the harmonious relationships that the MOH developed later with the social security program."[147]

Indeed, the MOH's prevention and promotion programs have contributed greatly to Costa Rica's overall health outcomes. The following two departments give examples of what the MOH contributes:

> "Sanitary controls for and registration of drugs, food, and hazardous toxic substances are the responsibility of the Department of Drugs and Narcotics Controls and Registries of the MOH. Health regulation and surveillance, which includes the monitoring of air and soil quality, housing, chemical safety, and hazardous waste are the responsibility of the Environmental Sanitation Division of the MOH."[148]

There are several other programs that contribute to Costa Rica's health sector success. By 1995 the National Institute of Aqueducts and Sewers (AyA), had provided potable drinking water to 99.6% of the population, and had given 95.7% of the population a sewerage system. Electricity was available to 93% of the population at that time.[149] The Costa Rican Demographic Association does extensive work in sex education and family planning.[150] Roemer states, "Health-related research, to produce new knowledge in fields of special importance, is exceptionally well-developed in Costa Rica."[151]

The specialization of duties created by dividing the MOH and the CCSS and their collaboration has lead to a very successful health care system. Milton Roemer says, "According to conventional measurements of health status, the results [of the Costa Rican health care system] have been phenomenal."[152] However, nothing makes a more decisive statement about the success of a health care system than the satisfaction levels of

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[147] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.
[148] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 13.
[149] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 3.
[150] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.
[151] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.
[152] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991. Pg. 420

its users. A 2000 SUGESS survey found that 88% of health system users reported receiving proper medical treatment and 81% said the physicians educated them properly.[153] And a national survey in 2000 showed that over 70% of health system users were satisfied with their care.[154]

Reform

The Costa Rican health care system has matured through several waves of challenge and reform. Despite its impressive health outcomes, Costa Rica is now in a period of reform intended to refine its successful programs, and improve efficiency by building off of trends that have been developing for years. A period of reform starting in 1994 was successful, and now the World Bank will provide an extra surge to finish implementing positive reforms.

The reform period from 1994-2001 was funded by the Inter-American Development Bank (USD$4.3 million), and the World Bank (USD$22 million). Technical support was also given by the Pan-American Health Organization/World Health Organization.[155] This reform had a four part agenda:

> "A steering role for the Ministry of Health and its strengthening; institutional strengthening of the CCSS; a new system for the reallocation of financial resources; and adaptation of the health care model."[156]

The new World Bank reform project is entitled, "Costa Rica – Second Health Sector Strengthening and Modernization Project." This project will allocate nearly USD$33 million to: "Improve health system performance and financial sustainability by supporting the ongoing policy changes in the health sector in Costa Rica."[157] The Costa Rican government's reform priorities are to: "Develop high levels of regulatory capacity and to implement the most important regulations during the next five years."[158]

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[153] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg.27.
[154] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 17.
[155] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.
[156] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.
[157] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 6.
[158] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 6.

Many of the problems with the health care system can be better addressed by first strengthening the centralized power of the MOH and the CCSS. PAHO states:

> "Steering role functions [in the MOH] need to be further strengthened, and it is necessary to improve the performance of certain essential public health functions, the management of services [by the CCSS], the quality of care, and equity in the allocation of resources."[159]

Once the MOH and the CCSS have been strengthened, then the CCSS will be better enabled to fulfill its responsibility of facilitating the reform projects. A major objective is to improve the financial state of the health care system by enacting efficiencies and reallocating funds.

We have already reviewed the reform mechanisms for reallocating funds; namely, using management contracts to create performance-based allocation of funds. Another movement to save money is to reduce the amount of inpatient care by transferring more patients to ambulatory care. Inpatient care is far more expensive than ambulatory care. But ambulatory care requires higher quality health service initially, and better mechanisms for providing home care. The World Bank makes this statement about increasing ambulatory care:

> "In 1999, fewer than 5 percent of all hospital discharges were resolved in an ambulatory setting. With minor investments in training, equipment and infrastructure (remodeling), the CCSS could increase ambulatory interventions to nearly 20 percent of all discharges. Benefits would include cost savings of more than USD$12 million per year, improved quality, and greater patient satisfaction."[160]

Another area where financial improvements can be made is in purchasing pharmaceuticals. "Pharmaceuticals represent 12% of CCSS health expenditure (nearly 1% of the GDP)."[161] There needs to be improved monitoring of drug usage through improved communication between health centers and the central purchasing power of the CCSS, so that the correct amounts and types of drugs are purchased.

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[159] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.
[160] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.
[161] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

The need for better communication calls for an improvement in health care information systems. For reasons referred to above:

> "Implementation of an integrated [information] management system for health care providers, hospitals and health areas is a continuing obstacle to improved efficiency."[162]

Better access to information will be needed to monitor health outcomes, which is especially important to the new performance-based funding allocation system. The natural counterpart to improving communication is improving technology. In the past ten years technology has made astronomical advances. However:

> "The CCSS has not built a new hospital in the past 30 years, and during the 1990's investment [in hospital infrastructure] was reduced to less than 3 percent of total expenditure."[163]

More money will clearly have to be invested into hospitals and technology if Costa Rica is to achieve the high potential for health care that its excellent system has set it up for. While Costa Rica has impressive outcomes for its region and its economy, it still lags behind the best systems in the world in terms of performance. But it may work its way up in the pattern of gradual improvement that it has traditionally followed.

A major problem with health care access is that there are long waiting lines for specialty care such as orthopedics, surgery, and gynecology. PAHO reports:

> "[At the start of 2001 the waiting list for surgical hospitalization numbered nearly 14,000 patients][164]...75% of hospitals have one or more specialties with...waiting lists longer than three months."[165]

Another area where access can be improved is in rural areas. Although Costa Rica does an excellent job of extending services to all, there is still room for improvement toward equity.[166] As the demographics change, approaches toward equity will have to follow suit. There is an increasing elderly population, which will benefit from establishing better home care

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[162] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.
[163] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.
[164] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.
[165] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 26.
[166] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

and hospice care mechanisms.[167] Likewise, the leading causes of death have changed in Costa Rica, and the MOH needs to adjust its prevention and promotion programs to address non-communicable diseases and healthy lifestyles.[168]

Medical education also needs to adjust to the changes of the times. In particular the medical education curriculum needs to better address the most advanced technologies, pharmaceutical advances, and the new primary health care model. At the same time, continuing medical education needs to be enforced and the same topics need to be taught to keep the current physicians up to date.[169]

These reforms are being made to Costa Rica's strong comprehensive health care system to help it achieve its potential for reaching and sustaining goals of universality, quality, and affordability.

Implications

One of the World Bank's statements of purpose for funding the second health sector reform in Costa Rica is:

> "Provision of assistance to expand knowledge of international experiences in similar topics, emphasizing and facilitating the dissemination of the Costa Rican experience to other countries."[170]

Costa Rica's health care system will serve as an example to other countries. There are very few countries that match Costa Rica's profile of small size, small population, social and political solidarity, and gradually growing middle-wealth economy. But it was not these factors that led to Costa Rica's excellent health care system. It was how Costa Rica used these factors that has aligned it for success. When one looks at Costa Rica in the Latin American context, the nation's achievements become very impressive. The factors listed above did not come with the land, but were arrived at through social development. It becomes apparent that steadfast commitment to social reform with priorities on education and health may lead a nation to social success.

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[167] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.
[168] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 5.
[169] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.
[170] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 7.

Costa Rica can be looked at as a pilot project for Latin America. This is analogous to looking at the health care system in one state of India as compared to the entire nation. When segmented down to a manageable region, a centralized health care system works best if one agrees with the Costa Rican model. Centralization allows for decisive management, and power to effect the changes necessary to building a successful health care system. However, when dealing with a larger region, the South African and Canadian systems point to centralization within states, and a decentralized national approach under the control of a central authority.

There are several components of the Costa Rican health care system, which should be of special notice to India. Primarily, management contracts are an excellent way to share accountability, promote the monitoring of information and health outcomes, promote improved quality of care through incentives, and reduce costs by leading to more efficiency. Mid-level health workers are very valuable for extending care to underserved regions and for reducing overall medical costs. Costa Rica's use of Public-Private Partnerships may carry some lessons about how to better incorporate India's 80% private sector into a national health care system. And Costa Rica's ability to harness and utilize external aid could be a good example to India, which will rely heavily on external funding to alleviate its problems with HIV/AIDS, and to build its national health care system.

Draft Note

LEGAL POSITION PAPER ON RIGHT TO HEALTH

It is a well-accepted fact that majority of the people in the world today are living at appallingly low levels of nutrition and health. Health and nutrition are becoming issues that non-governmental agencies are increasingly being asked to tackle during the course of their work. Governmental agencies are spending lesser amounts on public health care, leading to a situation where the populations are accessing private health care services, which can be unaffordable.

A person's health is related to several other aspects of her/ his life, and good health becomes a pre condition to the enjoyment of other rights as well as the individual participation in social, political, economic life. A World Health Organization Report on Health and Economics from 1989, states that, globally government spending on health averaged less than 10 dollars per person per year. Most developing countries have large populations that live in endemic poverty. Health care systems in these countries do not serve these populations. Infrastructure investment in health is not a priority spending area for governments.

There are many factors that influence health and are integral to it. These include access to nutritious food, clean environments- air and water, source of livelihood that is constant, etc.

In this context it becomes imperative to closely examine what the burden of the State in providing health is care and will making right of health care a fundamental right act as a pressure on the State to provide quality health care services.

The concept of the State being responsible to provide health care facilities, has its origins in the Charter of the United Nations and has been held in several individual constitutions.

United Nations Charter hold that "...the United Nations shall promote
a. higher standards of living, full employment, and conditions of economic and social progress and development; and
b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; ..."[1]

Article 25 further outlines the protection of health and also details the protection of health of vulnerable populations, such as women and children should be specially protected.

Article 25.
(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

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[1] Universal Declaration of Human Rights Articles 23 (1)

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection"[2]
The World Health Organisation, in its Constitution, states clearly, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[3]
However it is only in the International Covenant on Economic, Social and Cultural Rights that one explicitly sees that health is recognized as a fundamental right of every human being.

International Covenant on Economic, Social and Cultural Rights:[4]
Article 7 (b)
" Safe and healthy working conditions;"
Article 10 (2)
" Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits."

Article 11 (1)
"...recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions..."

Article 12
"1. ...recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a)The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

This is the most comprehensive and direct statement on the right to health at the international level. Article 12 (2) outlines the specific goals that must be attained with regard to the enforcement of this right.

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[2] ibid, Article 25
[3] Constitution of the World Health Organization, opened for signature July 22, 1946
[4] International Covenant on Economic, Social and Cultural Rights
Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966; entry into force3 January 1976, in accordance with article 27

Several countries, in their constitutions, have held the right to health in varying degrees. Perhaps the most comprehensive of these is the South African Constitution that takes into account several rights that are necessary for healthy living apart from access to health care services. It also clearly states the right to access reproductive health care.
Chapter 2, The Bill of Rights in the South African Constitution states as follows-

"Section 24 Environment
Everyone has the right -
(a) to an environment that is not harmful to their health or well-being; and…
Section 27 Health care, food, water and social security
(1) Everyone has the right to have access to -
(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
(3) No one may be refused emergency medical treatment"[5]

Similarly, the Constitution of Uzbekistan, holds the right of citizens to skilled medical care, social security in the case of old age and disability. It also guarantees the access to skilled medical care.

Constitution of the Socialist Republic of Vietnam:

Chapter V: Fundamental Rights and Duties of the Citizen

Article 61

"The citizen is entitled to a regime of health protection.

The State shall establish a system of hospital fees, together with one of exemption from and reduction of such fees.

The citizen has the duty to observe all regulations on disease prevention and public hygiene…"

Constitution of Mongolia

Chapter Two: Human Rights and Freedoms Article 16 "2) The right to healthy and safe environment, and to be protected against environmental pollution and ecological imbalance….

5) The right to material and financial assistance in old age, disability, childbirth and childcare and in other cases as provided by law.

6) The right to the protection of health and medical care. The procedure and conditions of free medical aid shall be determined by law."[1]

[5] Constitution of the Republic of South Africa Adopted on: 8 May 1996}{Amended on: 11 Oct 1996} {In Force since: 7 Feb 1997}

The Constitution of India also has provisions regarding the right to health. They are outlined the Directive Principles of State Policy- Articles 42 and 47, outlined in Chapter IV, and are therefore non-justiciable.

Article 42
"**Provision for just and humane conditions of work and maternity relief**- The State shall make provision for securing just and humane conditions of work and for maternity relief"

Article 47
"**Duty of the State to raise the level of nutrition and the standard of living and to improve public health**- The State shall regard the raising of he level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health"[1]

The above articles act as guidelines that the State must pursue towards achieving certain standards of living for its citizens'. It also shows clearly the understanding of the State that nutrition, conditions of work and maternity benefit as being integral to health.

Although the DPSP quoted above are a compelling argument for the right to health, this alone is not a guarantee. There must be a clearly defined right to health so that individuals can have this right enforced and violations can be redressed.

The Indian judiciary has interpreted the right to health in many ways. Through public interest litigation as well as litigation arising out of claims that individuals have made on the State, with respect to health services etc. As a result there is substantial case law in India, which shows the gamut of issues that are related to health.

The Fundamental Right to Life, as stated in Article 21 of the Indian Constitution, guaranties to the individual her/his life which or personal liberty except by a procedure established by law. The Supreme Court has widely interpreted this fundamental right and has included in Article 21 the right to live with dignity and "all the necessities of life such as adequate nutrition, clothing....". It has also held that act which affects the dignity of an individual will also violate her/his right to life.[2]. Similarly in Bandhua Mukti Morcha Vs Union of India, the Supreme Court has held that the Right to life includes the right to live with dignity.

The recognition that the right to health is essential for human existence and is, therefore, an integral part of the Right to Life, is laid out clearly in Consumer Education and Resource Centre Vs Union of India[3]. It also held in the same judgment that humane

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[1] Part IV, Constitution of India adopted on 26th November 1949
[2] Mullin Vs Union Teritory of Delhi
[3] AIR 1995 SC 636

working conditions and health services and medical care are an essential part of Article 21.
Further in, State of Punjab and Others v. Mohinder Singh[4] **"It is now a settled law that right to health is integral to right to life. Government has a constitutional obligation to provide health facilities."**

Apart from recognizing the fundamental right to health as an integral part of the Right to Life, there is sufficient case law both from the Supreme and High Courts that lays down the obligation of the State to provide medical health services.
This has been explicitly held with regard to the provision of emergency medical treatment in Parmanand Katara Vs Union of India [5]. It was held that **"Every doctor whether at a government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life".**

The issue of adequacy of medical helath services was also addressed in Paschim Baga Khet Mazoor Samiti Vs State of West Bengal.[6] The question before the court was whether the non-availability of services in the government health centres amount to a violation of Article 21? It was held that that Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. **The government hospitals run by the State and the medical officers employed therein are duty-bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.** Therefore, the failure of a government run health centre to provide timely treatment, is violative of a person's right to life. Further, the Court ordered that Primary health care centres be equipped to deal with medical emergencies. It has also been held in this judgement that the lack of financial resources cannot be a reason for the State to shy away from its constitutional obligation.

In Mahendra Pratap Singh v. State of Orissa[7], a case pertaining to the failure of the govrnment in opening a primary health care centre ina village, the court had held "In a country like ours, it may not be possible to have sophisticated hospitals but definitely villagers within their limitations can aspire to have a Primary Health Centre. The government is required to assist people get treatment and lead a healthy life. Healthy society is a collective gain and no Government should make any effort to smother it. Primary concern should be the primary health centre and technical fetters cannot be introduced as subterfuges to cause hindrances in the establishment of health centre." It also stated that, " great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life". **Thereby, there is an implication that the enforcing of the right to life is a duty of the state and that this duty covers the providing of right to primary health care.** This would then imply that the right to life includes the right to primary health care.

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[4] AIR 1997 SC 1225
[5] AIR 1989 SC 2039
[6] AIR 1996 SC 2426
[7] AIR 1997 Ori 37

The instrument of Public Interest Litigation used by Common Cause,[8] addresses the issue of the working of commercial blood banks. The court while recognizing that blood donation is considered as a great life saving service to humanity, it must be ensured that the blood that is available with the blood banks for use is healthy and free from infection. The Supreme Court in this case laid down a system of licensing of blood banks. **It may be inferred from the above reasoning that the State is entrusted with the responsibility in matters of health, to ensure efficient functioning all centres relating to health care.**

More recently the Supreme Court has addressed the epidemic of HIV/ AIDS. In a case where the court had to decide whether an HIV positive man should disclose his condition to the woman he was to marry, the court has held that "the woman's right to good health to precedence over the man's right to privacy".[9] It found that the hospital did not error in disclosing his status to his fiancé. In MX VS ZY[10], the Bombay High Court found that if a person were fired from his employment solely because of his HIV positive condition, it would be condemning a person to "certain economic death".

While the provision of health services is essential to ensure good health, there are several others factors that influence a person's health. The Supreme Court has recognized this in a number of ways. This was first addressed in Bandhua Mukti Morcha V Union of India,[11] a case concerning the living and working conditions of stone quarry workers and whether these conditions deprived them of their right to life. The court held that humane working conditions are essential to the pursuit of the right life. It laid down that workers should be provided with medical facilities, clean drinking water and sanitation facilities so that they may live with human dignity.

In Citizens and Inhabitants of Municipal Ward v. Municipal Corporation, Gwalior the court deliberated on the question- Is the State machinery bound to assure adequate conditions necessary for health? The case involved the maintaining of sanitation and drainage facilities by municipal corporartions. It was held that **the State and its machineries (in the instant case, the Muncipal Corporation) are bound to assure hygienic conditions of living and therefore, health.**

The Karnataka High Court has deliberated on the right of an individual to have access to drinking water. In Puttappa Honnappa Talavar v. Deputy Commissioner, Dharwad [12], the High Court has held that the right to dig bore wells therefore can be restricted or regulated only by an Act of legislature and that the right to life includes the right to have access to clean drinking water.

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[8] AIR 1996 SC 83
[9] AIR 1999 SC 495
[10] MX v. ZY, A.I.R. 1997 Bom. 406
[11] A.I.R. 1984 S.C. 802, 808
[12] AIR 1998 Kar 10

The High Court of Rajasthan has held that stray animals in urban areas pose a danger to people and also cause nuisance to the public.[13] The question before the court was, does the negligence of restraining the number of these animals violate Art 21 of the public at large? The court found that stray animals on the road interfere with transportation, polluted the city and therefore posed a health risk to people. It was held that **public nuisance caused by these stray animals was a violation of Art. 21,**of the public at large.

With regard to maintaining a clean environment, which is critical to a person's health, there are many questions that Courts have deliberated on. For example in Municipal Council, Ratnam v Shri Vardichan [14], where the Court had been called upon to decide whether municipalities are obligated to maintain certain conditions to ensure public health. It was held by the court that a public body constituted for the principal statutory duty of ensuring sanitation and health is not entitled to an immunity on breach of this duty. Further, "pollutants being discharged by big factories... are a challenge to the social justice component of the rule of law".

Also in Santosh Kumar Gupta v Secretary, Ministry of Environment, New Delhi[15], contended that the policy, controls/regulations and their implementations are inadequate thereby causing health hazards. In its judgements, the High Court of Madhya Pradesh has laid down that pollution from cars poses a helath hazard to people and that the State must ensure that emission standards are implemented maintained.

In the land mark MC Mehta v Union of India[16], the Supreme Court has held that environmental pollution causes several health hazards, and therefore violates right to life. Specifically, the case dealt with the pollution discharged by industries into the Ganges. It was held that victims, affected by the pollution caused, were liable to be compensated.

There is sufficient case law on the issue of health in State run institutions such as remand homes for children and "care homes". In Sheela Barse v Union of India and Another [17], a case pertaining to the admitting of non-criminal mentally ill persons to prisons in West Bengal, the Supreme Court has held that "(1) Admission of non-criminal mentally ill persons to jails is illegal and unconstitutional.... The Judicial Magistrate will, upon a mentally ill person being produced, have him or her examined by a Mental Helath Professional/Psychiatrist and if advised by such MHP/Psychiatrist send the mentally ill person to the nearest place of treatment and care." It has further directed the state to improve mental health institutions and integrate mental health into primary health care, among others.

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[13] Sanjay Phophaliya v. State of Rajasthan, AIR 1998 Raj 96
[14] 1980 (4) SCC 162
[15] AIR 1998 MP 43
[16] A.I.R. 1987 S.C. 1086
[17] 1993-(004)-SCC -0204 -SC

Further in Sheela Barse v Union of India and others[18], the Supreme Court has entrusted to High Courts the duty to monitor the conditions of "mentally ill and insane" women and children in prisons and pass appropriate orders from time to time.

In the most recent case involving the death of 25 inmates of a mental helath institution in Erawadi, Ramnathapuram District[19] as they were chained to poles or beds and could not escape from a fire that broke out, the Supreme Court has directed the state to implement the provisions of the mental health act as well s undertake a survey of all institutions that provide mental health facilities and ensure that they are maintaining standards of care.

From the above discussion of cases it is evident that the judiciary has clearly read into Article 21, Right to Life, the right to health. It in fact has gone deepr into the meaning of health and has substantiated the meaning of the the right to life.

The question that must be discussued more thoroughly is whether an amendment to the Constitution, which will state the fundamental right to helath, is desirable. Enumerated rights have an edge over wider interpretations of existing rights, as States can be held accountable for violations. However, with the extensive case law that is available is it not possible to use what is available to ensure that health care, facilities and condition ensuring health are fundamental rights of every citizen? If the case law reflects the ability of the courts to read the meaning of 'health' in very wide sense (everything from the responsibility of the municipal corporation to provide sanitation facilities down to access to emergency medical treatment has been interpreted in the right to health) then why not use the instrument of case law to confer rights? It is this question that must be examine in the light of the recent amendment guaranteeing primary education for all. Th process that led upto the amendment must be looked at crtically as well as how the implementation of it is currently taking place.

Also, closely associated with helath are the issues of nutrition and clean drinking water, which must be available through out the year. The judiciary has read into Article21, the right to food. These are complementary rights, the guaranteeing of the right to health, will have no meaning without the others.

Any amendment guaranteeing the right to health should have a focus on primary health care, which is preventive and curative. It should also have specific focus on the health of women- more specifically reproductive health, children, and the disabled- both physically and mentally.

Keeping this in mind there must be more detailed examination of an amendment to the Constitution, guaranteeing the right to helath.

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[18] 1995-(005)-SCC -0654 -SC
[19] 2002-(003)-SCC -0031 -SC