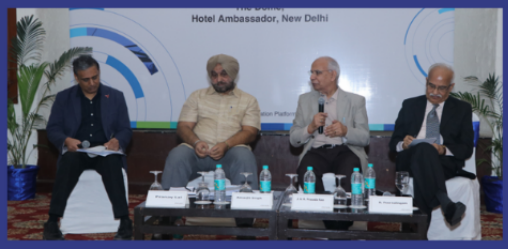
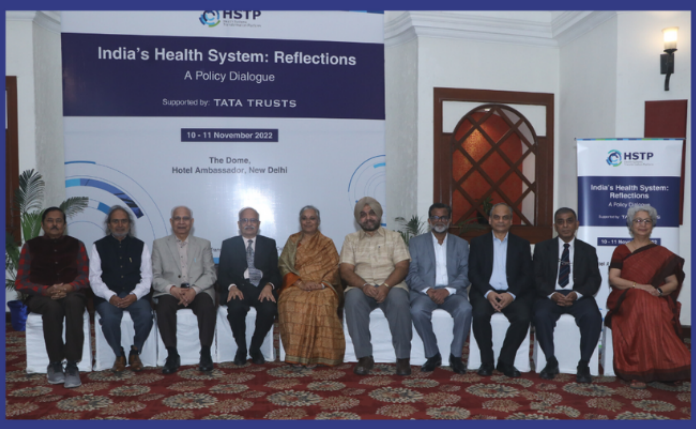
India's Health System: Reflections

A Policy Dialogue with former Union and State Health Secretaries





10th - 11th November 2022
New Delhi

HSTP
Health Systems Transformation Platform

Foreword

Currently, the healthcare system in India presents a mixed picture. The governments at the Union and State levels have undertaken several policy initiatives, schemes, and programmes in the past. These have led to positive outcomes, though perhaps not matching the expectations given our development in other sectors. Access, affordability, and quality of care remain major challenges in the Indian healthcare system. The COVID-19 pandemic highlighted India's health system's resilience and capacity to recently endure one of humanity's most challenging crises. This highlights the need to reflect on possible opportunities and strategies which can optimise the health of the population of India.

Health Systems Transformation Platform (HSTP) is recognised as an organisation that brings together key stakeholders, including policymakers, researchers, academicians, and public health experts, to generate ideas to strengthen the health system. We have been organising consultations, training programmes and fellowship programmes for senior policymakers, practitioners, and researchers in the health system as part of HSTP's commitment to encouraging the development and use of evidence for policymaking to achieve Universal Health Coverage.

The health secretaries at the Union and State government levels have been crucial in taking major decisions and efforts of reform in the health sector at various points in time. HSTP organised a two-day policy dialogue in New Delhi on the 10th and 11th of November 2022, with former health secretaries and other stakeholders in India's health system to share their experience and expertise. The discussion led to an insightful analysis of the sector and generated many ideas, as will be seen in this document.

I would like to take this opportunity to express my deepest appreciation to all those who made this onerous undertaking a reality. Special gratitude to the panellists Dr Amarjit Singh, Mr C. K. Mishra, Mr J. V. R. Prasada Rao, Ms K. Sujatha Rao, Mr M. Madan Gopal, Mr Prasanna Kumar Hota, Dr Prasanta Mahapatra, Mr R. Poornalingam, Ms Rita Teaotia, and Ms S. Jalaja for taking out time from their busy schedules and joining us for the course of the policy dialogue.

The panel discussions wouldn't have been thought-provoking if it weren't for the moderators, Mr Pranay Lal, and Mr Rathish Balakrishnan, they facilitated the panel discussions in a very engaging manner and kept not just the panellists but also the participants involved. The whole audience was essentially a part of the panel.

This policy dialogue wouldn't have been possible without Mr Sunil Nandraj, whose contribution in coming up with this idea, stimulating suggestions and encouragement, made this possible. I would also like to express my appreciation to Ms Pallavi Gupta, Ms Sakshi Khemani, and Dr Sonali Randhawa as this initiative was steered by them and Dr Pratheeba J and Dr Veenapani Verma for their contribution to the planning process.

Furthermore, I would like to acknowledge with much appreciation the crucial role of the HSTP Team, especially Mr Sridhar Guduthur, Mr Diwakar Gautam, Mr Peter Parekattil and Ms Rugma M for providing administrative and logistical support.

I would also like to express my gratitude to Ms Anagha Khot for documenting the policy dialogue in this report, which we will foster in the coming period.

We hope this document will help identify potential areas for research, policy, and programme intervention to strengthen the country's health system.

Rajeev Sadanandan
Chief Executive Officer
Health Systems Transformation Platform

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Acronyms

AB-PMJAY	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
AIIMS	All India Institute of Medical Science
ANM	Auxiliary Nurse and Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
CCHFW	Central Council of Health and Family Welfare
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CSO	Civil Society Organization
COVID-19	novel Coronavirus SARS-CoV2
DGHS	Directorate General of Health Services
DHS	Directorate of Health Services
ESIC	Employee's State Insurance Corporation
ESIS	Employees' State Insurance Scheme
GDP	Gross Domestic Product
HIV/AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HMIS	Health Management Information System
HSTP	Health Systems Transformation Platform
ICMR	Indian Council of Medical Research
IDSP	Integrated Disease Surveillance Project
MOHFW	Ministry of Health and Family Welfare
NCDC	National Centre for Disease Control
NHM	National Health Mission
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organization
OOPE	Out of Pocket Expenditure
PHC	Primary Health Centre
PPP	Public Private Partnerships
RSBY	Rashtriya Swasthya Bima Yojana
UT	Union Territory

Key Takeaways

The Health Systems Transformation Platform (HSTP) in partnership with the Tata Trusts, organized a policy dialogue on 10-11 November 2022, in New Delhi. This policy dialogue was unique in that it brought together ten former Health Secretaries and other stakeholders, including the government and associated institutions, the private sector, academicians, public health practitioners, researchers, and partners to reflect on key issues of India's health system.

The genesis of the policy dialogue can be traced to acknowledging the pivotal role played by Health Secretaries – at the Central and State level - in shaping health policy and programmes. The policy dialogue sought to engage with former policymakers; facilitate sharing of insights based on their rich and varied experience; provide a platform for the exchange of views; generate alternate and novel ideas to strengthen the health system of the country and, identify areas for future health systems research and practice

The dialogue was designed in the form of moderated panel discussions with the former Health Secretaries on five inter-linked health systems themes, namely:

- Centre State Relations in Health
- Leveraging the Private Health Sector Towards Universal Health Coverage
- Is Health Insurance the Way Forward for India to achieve Universal Health Coverage?
- Aligning Human Resources with Universal Health Coverage
- Importance of data, the role of technology in healthcare delivery

The panellists and participants shared wide-ranging insights and reflections which are captured in this report. This documentation is expected to contribute towards identifying potential areas for research, policy, and programme intervention to strengthen the country's health system. In keeping with Chatham House Rule, neither the identity nor the affiliation of the speaker(s), nor that of any other participant, is revealed.

Key takeaways from the Policy Dialogue:

- **Steering role of the Ministry of Health and Family Welfare.** The Union government should focus on its stewardship role and ensure the separation of health sector activities between the Centre and states, which has become blurred, given its direct management of programs, of institutions under this ambit.

- **Strengthen accountability and regulatory controls.** An effective system of accountability is fundamental for achieving successful public health outcomes. Accountability needs to be fixed amongst the health workforce, starting from the highest level of the Health Secretary, Government of India to the peripheral staff. Empowerment of the Central Council of Health and Family Welfare is crucial for building accountability between the Centre and the states. There is also a need to re-examine the content and relevance of areas under the Concurrent List (e.g., pharmaceutical regulation namely the Drugs and Cosmetics Act) and food safety regulations to make them responsive to existing realities). Also, community-level structures such as Village Health and Sanitation Committee, Rogi Kalyan Samitis, and Food Safety Committees may be provided with more teeth and regulatory authority for greater impact.

- **Re-imagine India's health system - re-design, re-configure.** Healthcare is provided by myriad organisations, institutions, and arrangements leading to fragmentation, which is compounded by market failures and governance challenges. All of this contributes to an underperforming health system. There is an urgent requirement to undertake organized and comprehensive reforms in the health sector in India. A new health system design responsive to community needs, and disease burden and in line with emerging service delivery models is required. The continued relevance and functioning of prevalent institutional mechanisms (e.g., Central Council of Health and Family Welfare)

as well as organizational structures (e.g., Directorate of Health Services) and service delivery arrangements (e.g., configuration of the primary health care system) needs to be reviewed and re-structured to enable transformational change for India to truly realize the vision of Universal Health Coverage.

- **Public health systems are conceptually distinct from medical services.** The COVID-19 pandemic highlighted the importance of essential public health functions and the need for a dedicated Public Health Department. A Department of Public Health headed by a full-time Secretary at the national and state level needs to be established on a priority basis.

- **Public Health Cadre is an absolute necessity.** The current policy level efforts to establish a public health cadre are noteworthy. At the same time, there is a need to ensure that the public health cadre and health management cadre are not restricted to clinicians/medical professionals alone but also include non-medical professionals with multi-disciplinary skill sets.

- **Move away from primary reliance on a doctor-centric system.** Community Health Officers need to be given prescription rights and nurse practitioners should also be encouraged at clinical facilities.

- **Health workforce planning should be based on the burden of disease and epidemiology.** There is a need to establish institutional arrangements that ensure the production of human resources keeps up with the need – in terms of numbers, geographical availability as well as competencies and skill sets.

- **Standardize curricula and ensure uniform quality of public health education and training.** Given the plethora of organizations offering training in public health, the curricula and the quality of training must be standardized. A self-regulatory body of Schools of Public Health must be established to maintain standards.

- **State and central governments should employ a 'whole-systems approach' - Private Health Sector is the Elephant in the room, we choose to ignore.** There is a lack of clarity on what is the role of the private health sector in India today. This fundamental question needs thought and clarity at the policy level before action can be taken. Policy frameworks need to be improved upon and the strengths of the private sector should be utilized by the government. As health is an imperfect market, the government is required to play all three roles – provider, financer as well as a regulator. The government has a role in regulating the private sector, including in price-setting. Alongside this, there is a need for an independent body or agency to regulate the sector and ensure that it operates independently without bias.

- **Insurance is a double-edged sword – it can help as well as hurt.** Existing insurance schemes, by and large, are not aiding in reducing out-of-pocket expenditure (OOPE) as they do not provide outpatient care, including drugs. Government must intervene to ensure that essential drugs are provided to people free of cost to reduce out of pocket expenditure. In case this cannot be guaranteed as part of insurance, there should be a direct provision of services, including drugs.

- **Unlock existing functional schemes, expand their scope and coverage, and move towards universalization.** Given India's pluralistic system, the possibility of creating one national risk pool is unfeasible. Globally, India ranks highest in terms of labour workforce informality, thereby posing considerable constraints to options for growing and improving the risk pool in the country. As a first step, after evaluation of the performance of ESIS in states and at the national level, one may explore the possibility of expanding the scope of the Employees State Insurance Scheme to provide cover to the informal sector. Based on these analyses, the ESIS could perhaps be re-configured to serve as a universal program for those not covered under AB PM-JAY.

- **Data and evidence, and not individual perceptions should form the basis for policymaking and programme**

implementation. An independent mechanism for data collection, analysis and evaluation, which is separate from the implementing agency should be established. This will bring in data discipline, autonomy and process data professionally to generate evidence which can be used by policymakers.

About the Policy Dialogue

Today, the healthcare system in India presents a mixed picture. Over the last several years, the government at the Union and State level have undertaken several policy and programmatic initiatives. While these have led to positive outcomes, the pace and extent are not commensurate with progress seen in other sectors. The impact of these initiatives on the health of the most vulnerable sections of the population has been limited. Access, affordability, and quality of care continue to remain major challenges in the Indian healthcare system. The COVID-19 pandemic underscored India's health system's resilience and capacity to endure one of the most challenging crises faced. This highlights the need to reflect on possible opportunities and strategies which can optimise the health of the population of India.

The Health Systems Transformation Platform (HSTP) in partnership with the Tata Trusts, organized a two-day policy dialogue on 10-11 November 2022 in New Delhi. **This policy dialogue was unique in that it brought together ten former Health Secretaries and other stakeholders, including the government and associated institutions, the private sector, practitioners, researchers, and partners to reflect on India's health system.**

The genesis of the policy dialogue can be traced to acknowledging the pivotal role played by Health Secretaries – at the Central and State level - in shaping health policy and programmes. In this context, former Health Secretaries are a storehouse of knowledge, information, and history. Each of them has been closely involved in key reforms that have shaped the course of India's health sector. Several of them continue to be involved in the health sector, in varying capacities even after retiring from active service. However, there has been an absence of any systematic platform to engage with and tap into their collective wisdom. Further, there has been a lack of adequate opportunities to enable sharing of views and insights with present policymakers, practitioners, and researchers.

Acknowledging this vast, rich knowledge and experience, HSTP sought to provide a platform to build a linkage between the past and the present to shape the tomorrow of India's health system. Hence, a two-day policy dialogue was conceived with the former Health Secretaries.

The policy dialogue sought to:

- facilitate sharing of insights based on the rich and varied experience of former policymakers
- provide a platform to current policymakers, researchers, health managers, academicians, and public health practitioners to engage with former policymakers
- generate alternate and novel ideas to strengthen the health system of the country
- identify areas for future health systems research and practice

The dialogue was designed in the form of moderated panel discussions with the former Health Secretaries on five inter-linked health systems themes, namely:

- Centre State Relations in Health
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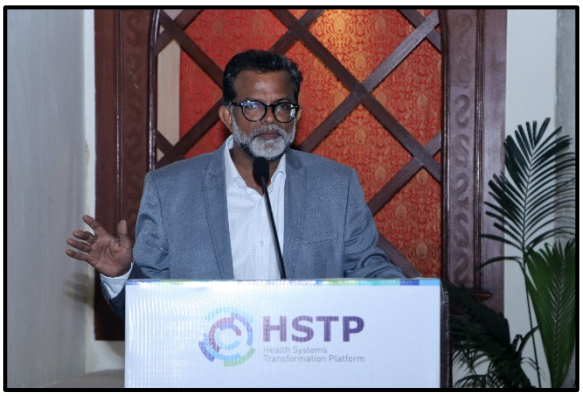
- Aligning Human Resources with Universal Health Coverage

- Importance of data, the role of technology in healthcare delivery

The structure and content of the policy dialogue were designed by the HSTP team in consultation with the moderators. The choice of themes was driven by the topicality of the issue. To dive deeper rather than exploring a wide range of issues, the choice was limited to four themes. An open session was included in the agenda to enable panellists as well as participants to raise any other issues of concern.

The key discussion points and insights that emerged during the two-day Policy Dialogue on India's Health System are documented in this report. **The report is structured around the five core themes** mentioned above. A brief context of the issue is presented at the start of each theme. Thereafter, discussion points that emerged during conversations between the moderators and panellists and those raised by the participants are collated and presented around key sub-themes. Given the inter-linkages between the themes, at times, varied aspects of the same theme flowed into different sessions.



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Meeting agenda, list of panellists and participants are provided in Annexe 1, Annexe 2 and Annexe 3 respectively.

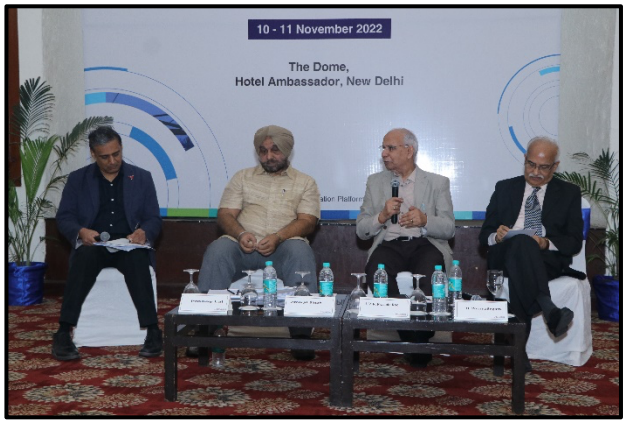
1. Centre and State Relations in Health

The Context

India has a federal structure of governance with defined jurisdictions for the Central (Union) and state governments. In the health sector, it means that decision-making, planning and health delivery systems are influenced by the Union and state governments. Given its mixed systems, health services are delivered by a diverse set of public, for-profit and not-for-profit private providers. These providers vary by patterns of ownership and organization. The management of government facilities at different levels is also divided across different administrative bodies. Moreover, roles and responsibilities for financing, provision and regulation are split across the central, state, and local governments, complicating the governance of the system. In addition to the Department /Ministry of Health and Family Welfare, a plethora of agencies outside its direct purview are also involved in India's health sector. Over time, parallel organizational systems have emerged: old organizational forms (e.g., Directorate of Health Services) co-exist alongside the new organizational arrangements (e.g., National Health Mission; National/State Health Authority). There is considerable heterogeneity across state healthcare systems in terms of their organizational arrangements, public-private makeup, appetite for change, and, ultimately, their health outcomes. The presence of disaggregated and fragmented service delivery system results in huge gaps and variations in access, quality, and affordability both across and within states.

Within this broad context, the conversation in this theme focused on:

- Role of the centre and state in the health sector. Views on how state and central government can work together while leveraging each other's strengths?
- Relevance of existing organizational structures in light of new organizational arrangements and introduction of multiple autonomous organizations.
- Deeper dive and reflections on collaboration/coordination between the National Health Mission and Directorate of Health Services. The relevance and role of the Directorate of health services at the state level especially after the introduction of the NHM.



Centre and State Government in India's health care system

> ***"Equity is where the government has failed"***

As per the Constitution of India, health is a state subject, and implementation of health programmes is left to state governments. The Central Government plays an overall stewardship role, providing vision and funds to policies and programmes. State governments play a larger role in combining the role of vision, leadership, funding, regulation, and delivery of health care. "Public Health, Sanitation, Hospitals and Dispensaries" are designated as a state subject, while "Population Control and Family Planning", "adulteration of foodstuff", "control of infectious and contagious diseases across state boundaries" and "issues governing the medical profession" are placed under the Concurrent List. "Surveillance of infection at the port of entry" and "prevention of infection between states" is on the union list.

The panellists opined that the subjects under the purview of the Union, State and Concurrent list are defined. However, with the introduction of new organizational arrangements as well as actors, and direct engagement

of the central government with institutions under its ambit or in areas like medical training, and pharmaceutical regulations, the activities between the Centre and states have become blurred and this needs to be examined and addressed.

In this context of the role of centre vs state, one of the participants raised the question of what such division of powers would mean in terms of pharmaceutical regulation which is on the Concurrent List. And what would be an appropriate regulatory model for India? In response, it was mentioned that drug regulation is an area where we see a lot of overlap and confusion. The biggest challenge is that we continue to be governed by a Drugs and Cosmetics Act, first enacted in 1940. Periodically attempts have been made to amend the Act and make it responsive to the present. Although bound by a single policy regarding the manufacture and sale of drugs, its implementation varies across state governments. Human resource challenges, especially the low number of drug inspectors are one of the contributory factors affecting implementation. The situation of dual licensing authorities, for instance, in terms of control over the quality of imported drugs leads to more confusion. It was felt that **there is a need to re-examine the pharmaceutical legislation considering the current climate and requirements.** A similar case in point, albeit less outdated, is the case of the Food Safety Act.

> ***"Health sector is littered with unfinished agendas."***

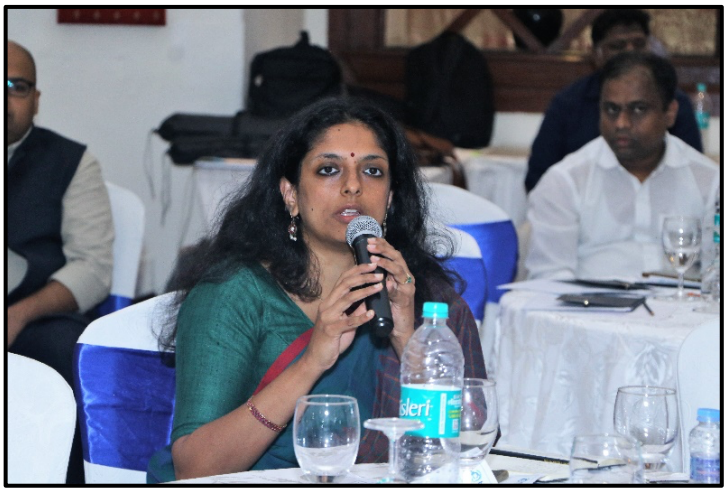
Trust between the national and state government, coupled with a common goal and shared vision were seen as key to successful planning and implementation. Also, political will is very important and it is important to make health a part of the political agenda. For instance, the introduction of a new category of health worker - Accredited Social Health Activist (ASHA) - was made possible due to political support. Almost a million ASHAs were inducted into the health system - this positively illustrates the scale and impact of government involvement. Today, ASHAs are an integral part of the health system.

Relevance and role of existing organizational structures in helping India move towards Universal Health Coverage

> ***"There have been no organized and comprehensive reforms undertaken in the health sector…… There is a requirement for transformational change in the health sector"***
>
> ***"We are in desperate need of reforms when it comes to public health in India"***

The organizational structure of the Ministry of Health and Family Welfare itself has evolved in response to time and changes in the health sector. **Over a period, different structures and organizational arrangements have evolved for different diseases/programmes but there's resistance towards the integration of different programmes. Primary health centre needs to be made into a truly integrated facility. While there have been some sporadic efforts to reform the health sector, these have largely been confined to certain programmes (e.g., Health and Wellness Centres) or the creation of new structures (e.g., National Health Mission, National Health Authority).**

The focus must be on the health of people and not only on healthcare. Despite evidence on the impact of social determinants on health, there is a lack of an institutional mechanism for coordination between health and other sectors. The only available institutional mechanism namely, the Central Council of Health and Family Welfare (CCHFW) does not have any enforcement powers. **The CCHFW needs to be empowered, possibly akin to the Goods and Services Tax (GST) Council.** A collaborative effort is needed from the Government of India and the states towards comprehensive health sector reforms. Further, the government needs to engage and harness civil society organizations (CSO). A case in point that was mentioned was a pivotal contribution of CSO to HIV/AIDS.



Citing the example of COVID-19, one of the panellists opined that at a time when disease surveillance was critical, the weekly Integrated Disease Surveillance Programme (IDSP) updates were suspended during the pandemic. Also, **the fact that the National Disaster Management Act was invoked to deal with a health emergency, meant that India primarily dealt with the COVID-19 pandemic through the police department and the magistracy. This begets the question of whether a different organizational structure or arrangement is needed.**

There was a consensus that the Government of India and state governments need to systematically re-organize and restructure themselves in response to emerging health trends.

One of the panellists mentioned that **instead of the Department of Medical Education a separate Department of Public Health should be constituted in its place.** While another opined that **COVID-19 demonstrates the need for a dedicated focus on public health, only then will institutions like National Centre for Disease Control (NCDC) get a higher profile and autonomy to realise its full potential.**

Organizational arrangements: Urgent Policy Actions Needed

- ***The Primary Health Care model is 75 years old, and it needs to be revamped, reconfigured, and restructured given the changing environment and realities.***
- ***There is an urgent need to set up a separate Department of Public Health, both at the national level and in states/UTs.***
- ***A full-time Secretary dedicated to Public Health is the need of the hour.***

Considering how service delivery looks today, especially post-COVID and with technological innovations enabling last-mile reach, there is a need to rethink the three-tier system to redefine what constitutes primary, secondary, and tertiary care. There is a need to consider a new health system design along with new approaches to organizing human resources. Lessons from alternate models such as Mohalla Clinics in Delhi and Family Health Centres in Kerala could be considered for such reconfiguration and ensuring that the health system is responsive to community needs. It was mentioned that the case of the state of Tamil Nadu is often cited as a good example, especially the priority given to Public Health. However, it is important to bear in mind that until recently the Directorate of Public Health in Tamil Nadu primarily only focused on Reproductive and Child Health and Family Planning. It is only in recent years, that Non-Communicable Diseases came to be seen as a public health issue (even in states having a long-standing focus on Public Health).

Capacities, Collaboration and Co-ordination between the National Health Mission (NHM) and Directorate of Health Services (DHS)

> ***"There is an urgent need to undertake a functional review of the Directorate of Health Services….many states continue to have cadres that are redundant today. However, the re-organizing, rationalization of such cadres and re-vamping of the DGHS has not been undertaken."***

Proper division of functions within the health department and ministries needs to be demarcated. There was a consensus that there is a lack of synergy between the NHM and the DHS, and that **there are serious capacity constraints which affect the role and functioning of the Directorate of Health Services. The introduction of NHM and the creation of parallel systems have contributed to this constraint**. One of the participants highlighted the need to undertake a functional review of the Directorate of Health Services on priority. This becomes all the more pertinent when it is seen that even smaller states in the Northeast have as many as 800 cadres and larger states have up to 1,700 cadres, several of which are redundant today. However, the re-organizing, rationalization of such cadres and re-vamping of the DGHS has not been undertaken.

Two points of view emerged regarding capacities, collaboration and coordination between the National Health Mission and Directorate of Health Services, especially at the state level:

- The first view was that **programs like NRHM/NHM which are being run in a Mission mode should have a finite existence. And Missions should be phased off once the objectives are achieved.** NHM should primarily continue as a source of funding/funding agency. NHM should be handed over to the states. Health care should be the state's responsibility while the Government of India should focus on setting policy framework, supplementing financial and technical resources, monitoring and overall accountability and regulation.

> ***"The National Health Mission, which was built to improve the system, has become the system."***
>
> ***"NHM did a good job in the beginning and gave the system the kickstart it needed, but subsequently, we ended up having two different bodies (at the state level) - NHM and DHS. After establishing a system of evaluation, surveillance, monitoring and quality, NHM should have passed on the baton to the DHS."***

- The second view was that health and education are not a priority for many (state) governments. Programmes like NHM brought in flexible funding, a community driven approach and a level of innovativeness. Hence, NHM has been able to bring a lot of changes. Also, the state's capacity is varied, and this too needs to be considered. And thus, the **Mission should not be completely phased off**. It was proposed that Village Health and Sanitation Committee, Rogi Kalyan Samitis, Arogya Raksha Simitis and Food Safety Committees under NHM should be converted into statutory bodies (similar to School Development and Management Committees in the field of Education) as this would lead to an impact on the ground.

2. Human Resources for Health

The Context

Health systems can only function with health workers. Healthcare (curative and preventive) services in India are delivered by a wide range of professionals. These include doctors (allopathy and AYUSH, generalist, and specialist), dentists, nurses and midwives, pharmacists, allied professionals such as physiotherapists, psychologists, paramedics, and support service providers among others. Additionally, there are community-level functionaries known as Accredited Social Health Activists (ASHAs) who assist in health service delivery.

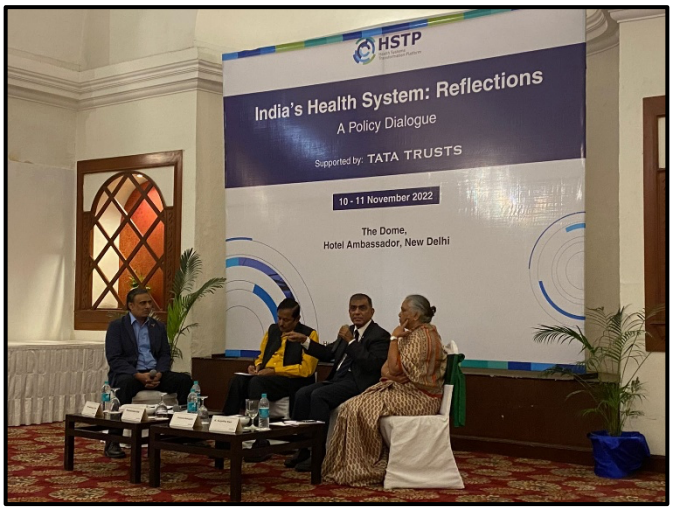
India continues to grapple with workforce challenges such as shortages, recruitment, deployment, unequal distribution across geographies, difficulty in retention, adapting health workers' education to fit rapidly changing needs, continuing education, ensuring standards of quality education, concurrent monitoring and improving health worker performance. Large scale disparities across and within states in these areas further affect health workforce planning and management. A 2020 WHO mid-term review of progress on the decade for health workforce strengthening in Southeast Asia Region 2015-2024, mentions that India needs at least 1.8 million doctors, nurses, and midwives to achieve the minimum threshold of 44.5 professional health workers per 10,000 population.

At the same time, India produces among the largest numbers of doctors in the developing world. The widespread expansion of medical education and the provision of skilled/qualified healthcare staff were aided by the private sector. However, there are several concerns, including the uneven distribution of colleges across the states and in rural-urban areas, ambiguous oversight of the quality of education, lack of infrastructure, and high tuition rates in private colleges. More disturbing is the fact that about 30% of those who report themselves as doctors in the census and NSSO do not have any formal medical qualification and these untrained self-appointed providers are the first resort for a large section of the poor.

A health workforce policy is required to continually balance the need for functional health teams at primary, secondary and tertiary levels of healthcare and facilitate a judicious mix of public health practitioners, clinical practitioners, and specialists.

Within this broad context, the conversation on the human resources for health theme focused on:

- Reflections on Human Resource Planning, Capacity Building and Management – Where did we go wrong? What do we need to do so that India's health workforce is responsive to the needs of the population?
- Is having a public health cadre the solution? Is it feasible? What lessons can we learn from the past? And from states having such cadres?
- Views on content, quality of education and training.



Human Resource Planning, Capacity Building and Management

> *"Various Committee reports from 1959 to 2022, keep saying the same thing (about reforming the health workforce system), yet nothing is done. Everything is a knee-jerk reaction. We need to swim against the tide and bring reform."*

Human Resources are one of the key drivers of the health system. From the point of view of delivery and cost of health services, it is critical to have people who have been trained to deliver healthcare efficiently. **There have been large scale investments and efforts underway in building the capacity of the health workforce at various levels. Yet, there is a disconnect between the nature of health services that are required and the training that is provided to individuals.** This issue was first highlighted way back in the Mudaliar Committee Report of 1959. However, this disconnect continues even to date and could be one of the contributory reasons for the primary health care centres not functioning as desired as there is a disconnect between the nature of the training provided to MBBS doctors and the needs of the community. There is a lack of skill balance in the health sector.

> *"Based on the burden of disease (and epidemiology), we need to link the production of doctors and nurses to demand (and needs of the population)…. This is unaddressed in the Indian context….. we don't use disease burden data for human resource planning and management."*

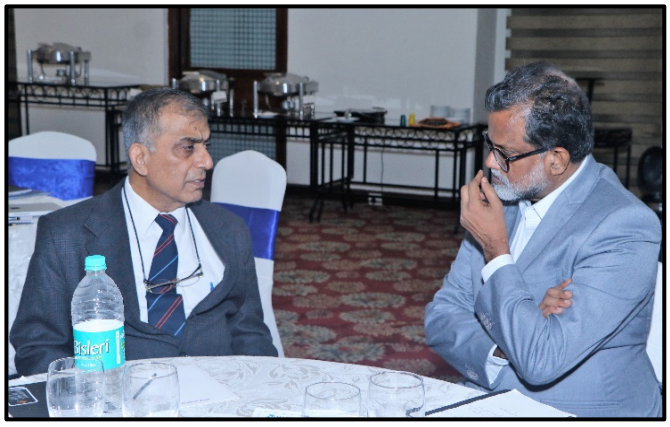
In India, there has been no assessment of emerging demand for doctors, nurses, and allied staff on account of shifts in disease burden and epidemiology. It was shared that in the United Kingdom, for instance, the government provides direction to the British Medical Council on the annual speciality specific requirements of health personnel. Based on this, the exact number of seats across these specializations are approved. Whereas in India there is no linkage between the Medical Council of India (now, National Medical Commission) and the government (on such matters). **There is a need to establish institutional arrangements that ensure that the production of human resources keeps up with the need – in terms of numbers, geographical availability as well as competencies and skill sets.**

One of the panellists highlighted how despite such large-scale investments in capacity building, we continue to see scenarios where an auxiliary nurse midwife (ANM) in our country does not know how to insert IUDs or deliver a baby. **There is an urgent need to review whether the huge investments in capacity building and skill development of the health workforce have truly translated into the transfer of requisite skills – both technical and managerial - especially in rural and remote areas.**

Another panellist brought up the issue of where and how should centre and state invest their resources in terms of human resources and related infrastructure. The panellist was of the view that the present emphasis by the Union government on setting up central medical colleges like AIIMS in states should not be the Union government's priority. The states need to take up the responsibility to set up large medical colleges and prioritise funding for the same. Prioritising local teaching hospitals and colleges can also ensure that locally trained doctors are able to fill up vacancies in PHCs/CHCs in the district, instead of posting trained staff from outside the district. **Infrastructure and human resources for healthcare need to be a high-priority investment for states.**

Presently, there is poor accountability among the health workforce. They are not clear about their functions and do not know what they are accountable for. The proactiveness of the primary healthcare system right from the top leadership to the field level is missing. The services that the government promises must be accompanied by adequate human resources and should be delivered on time. One of the participants mentioned that the Government of India is nudging states to spend 8% of their budget on health. With a view, to encourage states to invest in their health workforce, going forward, the Government of India's

support for contractual staff will likely be on a decline. For instance, states have been asked to make the Community Health Officer a permanent cadre. In this context, it was mentioned that **given the large number of contractual staff under various programmes, the GOI needs to work out a transition/exit policy for the same.**



One of the participants highlighted that for decades, the discussion has focused on shortages of human resources and there is a need to unshackle the supply side to meet the demand. The Ministry of Health and Family Welfare missed the opportunity to leverage the initiative by the Ministry of Skill Development and Entrepreneurship for the development of a national skill framework to its advantage. Another participant observed that there is also a need to pay attention to the salaries of health personnel in the private and public health systems. Corruption and transfers are other factors that need to be looked at when discussing human resources in health.

Public Health Cadre – A Necessity

Historically, post-Independence, the country carried on with the erstwhile Indian Medical Council, a legacy oriented towards a medical approach driven by allopathic doctors rather than focusing on having a public health cadre suited to addressing country requirements. **The health sector has continued to have a predominantly clinical and doctor-centric approach, with public health being relegated to the background.** Past effort in 2014, albeit an unsuccessful one for the introduction of a 3-year basic rural doctor course was also shared, thereby illustrating the resistance from the medical profession against any reforms and innovations.

The critical need for having a public health cadre was brought up by each of the panellists as well as several participants. The recent policy emphasis and support for the creation of public health cadre was appreciated by the panellists. At the same time, there were two main cautionary notes:

- The first being that **merely instituting a public health cadre (and related to that, the creation of a department of public health) is not sufficient.** An example was cited as to how despite having a public health cadre (and department of public health), the Directorate of Public Health in the state of Tamil Nadu focused primarily on reproductive child health and family planning. And it can be noted that only in recent years non-communicable diseases have been added to its area of work.

> ***"All in all, we need a public health cadre, we need to understand disease burden and train human resources in the sector adequately."***

- The second, being that **we need to ensure that the public health cadre is not restricted to clinicians/medical professionals alone. The importance of bringing in non-medical professionals and building multi-disciplinary skills was highlighted** by panellists as well as participants. Participants involved in these reforms provided clarification that the focus is on building public health and management cadres (including 4 sub-cadres: viz., teaching cadre, specialist cadre, public health cadre and health management cadre) and providing assured career progression for the health workforce.

It was remarked that public health and health management are two different concepts. The system currently lacks an adequate number of public health experts as well as health managers, as seen during the COVID-19 pandemic. The importance of acknowledging the important role of pharmacists, laboratory technicians and auxiliary nurse midwives (and not merely doctors) was reiterated by one of the panellists. Another panellist

remarked that the health sector does not have adequate human resource experts (i.e., those who are trained in health workforce planning and management) as well as those with auxiliary skills like infrastructure maintenance etc. One of the participants opined that the consultants who are an integral part of the Ministry of Health workforce should also be considered when one looks at issues of the health workforce.

Competencies, Standardization and Quality of Education and Training

> ***"We need to view human resources with a 360-degree approach and not as numbers alone."***

Competencies that are needed to deliver healthcare are lacking amongst most of the present health workforce. It was felt that we need to focus on what competencies are needed to deliver a service, rather than focusing on the 'cadre'. In the Indian context, one has refrained from introducing nurse practitioners. Lessons from Europe show that it was the midwives and not gynaecologists who were responsible for the reduction in the maternal mortality rate. It was suggested that the Community Health Officer (CHO) (under Ayushman Bharat) should be given prescription rights and be used as nurse practitioners.

While the number of public health courses has increased over the years, the **lack of uniformity and standardization in public health education was highlighted as an area of concern.** It was mentioned that around 80 institutions offer a master's degree in public health. However, the course content is not standardized. One of the panellists proposed that the government needs to intervene in this area and try to establish a self-regulatory body for Schools of Public Health, to maintain standards and uniformity.

Similar remarks and concerns about the standard and quality of medical education were raised by another panellist as well as a participant. Medical education continues to be plagued by inadequate numbers being insufficiently trained, use of outdated curricula and pedagogy, deterioration in the quality of hands-on training, and inequitable availability of colleges and trained faculty among others. It was illustrated that for example, the United Kingdom has a standard concept of (what constitutes) a British doctor. There is an assurance that each doctor, irrespective of where they have been trained would have a similar standard of training and skill set. Such uniformity, it was opined, is lacking in the Indian context.

> ***Quality of Education and Training: Urgent Policy Actions Needed***
>
> - ***Government needs to intervene and ensure standardization of course content in public health education and training.***
> - ***A self-regulatory body such as the Association of Schools of Public Health should be established to maintain standards and ensure uniformity.***

The issue of regional disparity in terms of distribution of the medical colleges (e.g., an abundance of medical colleges in UT of Puducherry versus other states) was highlighted as an area requiring the attention of decision-makers. Another participant reiterated that while there is a standard council for doctors, nurses and pharmacists, there is a lack of uniformity in terms of education and training not just in public health but also in areas such as health insurance, health informatics, and health management to name a few. Yet another suggested that we need to introduce foundational courses on public health administration for medical officers and hospital administrators.

3. Private Health Sector: The Elephant in the room we choose to ignore….

The Context

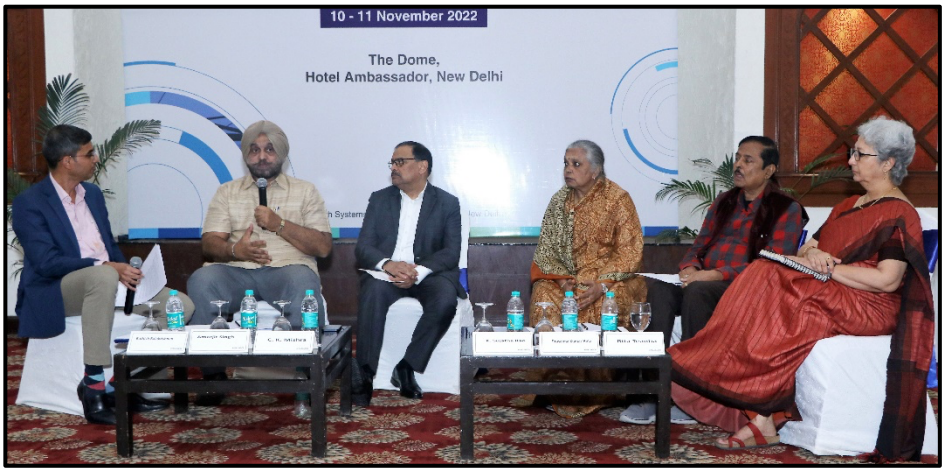
The private health sector is vast, varied, and fragmented. There is limited information available about the size, structure, distribution, capabilities, and costs of private facilities. Primarily, government engagement with the private sector has focused on large, highly visible private hospitals and corporate chains that comprise just a sliver of the private sector market. Further, there is a considerable trust deficit between the two sectors. Varied opinions and/or disagreements over the expected roles of and the relationship between the two sectors, coupled with a lack of clear policy have resulted in sporadic engagements. The lack of a comprehensive vision has led to a disorganized healthcare delivery landscape that fails to achieve public goals.

Several factors, including the nature of health financing and payment systems, type of technology, cost of initial medical education and training, public expectations, regulatory frameworks, etc. impact the functioning of the private health sector. Despite the phenomenal rise of the private sector in health, particularly over the last two decades, its relationship to health outcomes at the population level has not been demonstrated. This is because the market-driven growth of this sector has been lopsided. The penetration of the private sector into the rural sector has been extremely weak and whatever growth it does have in rural areas usually follows the establishment of public healthcare facilities.

The quality of private health services is a mixed bag with reports of irrational treatment and unethical practices. The COVID-19 pandemic exposed the exorbitant and inconsistent charging practices of the private sector, even though several state governments announced that care for COVID-19 patients should be free or subsidized in private facilities. The availability of accurate data on the number and quality of private healthcare providers/facilities is further constrained due to limited provider/facility registration. The Clinical Establishments Act, (CEA) 2010 and Rules enacted in 2012, is a key legislation of the Central Government that relates to the private health sector. Efforts to strengthen the regulatory environment have yielded limited success. This is partly due to political interference and regulatory capture by the medical fraternity and partly due to insufficient capacity at the state level.

Within this broad context, the conversation on the theme of the private health sector focused on:

- Reflections on what constitutes the private health sector in today's context. What is the role of the private sector in health care delivery in India today? How one can better engage and involve the private sector to meet health system goals.
- Rationale and potential approaches for effectively regulating the private health sector.
- Thoughts on public private partnerships.



Leveraging the Private Health Sector towards Universal Health Coverage

> ***"The question is not whether we want the private sector to be involved or not. The private sector is here to stay."***

The contours of what constitutes the private health sector have been evolving over the years. **The private health sector is not a monolithic entity – it is heterogenous and fragmented** and includes for-profit as well as not-for-profit institutions. The private health sector comprises solo practitioners (belonging to AYUSH or allopathy), small hospitals and nursing homes, as well as large hospital chains, laboratories, diagnostic centres, dental clinics, retail pharmacies, and emergency transport, amongst others. Recent years have also witnessed a proliferation of private medical, nursing, and allied health educational institutions, and the entry of med-tech and technology-led start-ups in the health sector. The COVID-19 pandemic has accelerated the adoption of home healthcare services, telemedicine, and advanced healthcare delivery models.

There has been exponential growth in the private health sector in India. At the time of India's Independence, the private health sector provided only about 8% of total patient care. Today, it accounts for about 80% of outpatient visits and 60% of inpatient care, thereby making it a major stakeholder in the healthcare system. At the same time, there is a skewed distribution of the private sector across urban and rural areas. Solo practitioners, often AYUSH doctors or small nursing homes, continue to be the first point of contact for a person seeking care in a rural area, while large hospital chains tend to be concentrated in urban areas.

> ***"At the national level, amongst the highest decision-makers, there is a lack of clarity on what is the role of the private (health) sector in India today. This fundamental question needs thought and clarity at the policy level before action can be taken…… Given the trajectory and diversity of private health sector growth in India, much of the policy initiatives are like fixing a leaking bucket rather than developing a clear policy."***

It is evident that while the government may have the primary responsibility to ensure health care to all its citizens, it does not have the capacity to deliver the same. The private sector is already a key stakeholder – while its strengths can't be overlooked, there needs to be clarity in terms of what is expected from them. **The government's role is not just to facilitate, but to also recognize the areas where help is needed and let the private sector get involved there – with appropriate oversight and regulation. Policy frameworks need to be improved upon and the strengths of the private sector should be utilized by the government.** At the state level too, the health system needs to be looked at. What are the facilities available in the state and how best can they be mobilized? Government officials are not just there for public enterprises but also private establishments and should find ways of involving them in improving public health in the state.

Private Sector Regulation

Good governance is critical for a well-performing service delivery system as it establishes rules as well as the roles and responsibilities of different stakeholders in the system. **The government is required to play all three roles – provider, financer as well as the regulator.**

Based on its health system, various regulatory approaches are adopted by countries for regulating their private health sector. Country experiences (e.g., the United Kingdom) have shown the importance of a strong and effective regulatory framework within which the private sector should be allowed to function.

> ***"Health is an imperfect market, and the government has a role in regulating the private health sector, including price-setting."***

The government must invest in health. Regulation needs to cover both the public and the private health sector. Being accountable to the public, and overseeing the private sector is the responsibility of the government. While private sector participation is important, it needs to be regulated, otherwise, it is a big mess. A big forest full of weeds is what India's health sector is nowadays. The variety of care providers that are there in the private sector makes it impossible for the government to bring in regulations. Most importantly, **regulation must be complemented with incentives to bring in appropriate behaviour amongst care providers and those seeking care.** The COVID-19 pandemic has brought to light the exorbitant pricing practices of the private sector. At the same time, it has also highlighted how the government can regulate prices.

Another view from the panellists is that **the government alone cannot regulate the private sector. There is a need for an independent body or agency to regulate the sector and for efforts to be put in place to ensure that this body continues to operate independently without bias.**

There was a comment that an alternative forum for redressal that is accessible to citizens (apart from legal redressal) has not been adequately examined.

Public Private Partnerships

> ***"PPP has been primarily confined to contracting out of services, where the government's role has been largely limited to being a purchaser of care."***

Public Private Partnerships (PPPs) became a buzzword and gained prominence in the health policy space in the early 2000s. The adoption of PPPs in health care has been nominal. It is important to differentiate between PPP, contracting and strategic purchasing from the private sector. Experience has shown that PPP has not worked and has been primarily confined to contracting out services, where the government's role has been largely limited to being a purchaser of care. Mostly, the services provided under PPPs range from diagnostic services, to dialysis, and supportive services. **The third P of PPP – 'Partnerships – has been missing.** A significant lack of trust between the public and private sector is one of the stumbling blocks to effective partnerships. **There is a need to understand what it truly takes to get the public and private sectors to collaborate.**

The government's capacity to engage with and manage private sector partnerships is limited. Examples shared from the states of Gujarat and Andhra Pradesh show that the **state's capacity to design and execute partnerships with the private sector has been varied, thereby yielding mixed results**. Successful PPP initiatives across states are largely characterised by:

- Government operating from a position of strength with continued investments in and strengthening of the public sector
- Role clarity and articulation of expected outcomes from both government and private sector partner

- Flexibility to use government resources for innovative projects
- Availability of credible partners, including technical intermediaries/academia/civil society organizations
- Trust between the partners
- Clear and specific payment modalities
- Government ensuring timely payment
- Provision of indemnity as may be relevant/appropriate to the objective of the partnership (as was done in the state of Gujarat)
- Clear and specific contract agreements with the private sector
- Monitoring and oversight by the government

One of the participants highlighted the heterogeneity of the private sector and the need to segment the private sector itself when formulating policy and designing any programme. The need for long term and responsible capital was highlighted as one of the requirements of a 'quality-conscious part of the private sector', which is unable to grow due to lack of funding.

Standards, Quality, and Eco-system level interventions that can help improve the overall effectiveness of the private sector

Several initiatives and efforts have been made to standardize and improve the quality of care in medical facilities. This includes the creation of the National Accreditation Board for Hospitals and Healthcare Providers (NABH) and the National Accreditation Board for Laboratories (NABL), as a national-level accreditation system. Despite ongoing efforts, recent years have seen inconsistent outcomes emerge from some of the accredited facilities/laboratories. A possible reason may be the lack of capacity in NABH to follow up on the accreditation at regular intervals.

The importance of making 'quality' transparent to every citizen was stressed by one of the panellists. **The idea of creating a citizen centric information facilitation App, to bring together all information about various aspects of health and healthcare delivery was proposed.**

From the overall lens of private sector engagement, the following issues and suggestions emerged:

- Need to institutionalize minimum quality standards, track outcomes and monitor adherence to agreed outcomes.
- Ensure greater focus and transparency in the pricing of services
- Institutionalize mechanisms for data sharing by the private sector
- Introduce and demonstrate a new service delivery model – a chain of hospitals that provides standard care at standard cost. The improved services in the Hospital Corporation of India were cited as a model that could be followed.

4. Is health insurance the panacea for achieving Universal Health Coverage?

The Context

India's current health financing scenario is characterized by a high level of fragmentation, and low levels of risk pooling and payment at the point of consumption. High OOPE on health is impoverishing some 55 million Indians annually, with over 17 per cent of households incurring catastrophic levels of health expenditures every year (WHO, 2022)[1]. Limited access, insufficient availability, sub-optimal or unknown quality of health services, and high out-of-pocket expenditure (OOPE) are among some of the key health challenges.

Several tax-funded health insurance programmes have been initiated in India since the mid-2000s. The population and service coverage of such programmes has expanded significantly over time. A new scheme - Pradhan Mantri Jan Aarogya Yojana (PM-JAY replaced the earlier Rashtriya Swasthya Bima Yojana and integrated health insurance schemes of several state governments under one umbrella) was launched in 2018. The PM-JAY seeks to cover 500 million people with a benefit package entitlement of Rs. 500, 000 annually to a household, involving over 1500 packages provided free to patients from poor, economically and socially disadvantaged groups.

Serving or retired employees of the Central Government can access outpatient and inpatient care, drugs and diagnostic services from government facilities as well as private empanelled facilities under the Central Government Health Scheme (CGHS), in exchange for a nominal contribution of monthly deductions from employees' salary. Other organized sector workers can access health services from hospitals and dispensaries under the Employees' State Insurance Scheme (ESIS) and empanelled facilities.

Within this broad context, the conversation on the theme of health insurance focused on:

- Reflections on the role of the state and the role of the market? How should a state look at financing health care? Is health insurance a solution to bridge the demand-supply gap and financial barriers to access and achieve Universal Health Coverage?
- What would be an appropriate health insurance model for a mixed health system like India? Can existing insurance mechanisms be consolidated to ensure equity in access to healthcare services by all? What would be the best approach to address the needs of the informal sector?
- Going forward, what is the one thing we should do in health insurance in India?

[1] Selvaraj S, Karan K A, Srivastava S, Bhan N, & Mukhopadhyay I. India health system review. New Delhi: World Health Organization, Regional Office for South-East Asia; 2022.

Insurance is a double-edged sword – it can help, it can hurt…

Insurance is a double-edged sword – it can help as well as hurt. Health Insurance protects from financial impoverishment, but it can be used indiscriminately and can distort markets. It should ensure more rational behaviour from both providers and consumers. Insurance influences both provider and consumer behaviour. Different countries have dealt with the problem of impoverishment due to healthcare in different ways. For instance, in Japan, only the state can purchase healthcare from private providers as per a benefit schedule. Every citizen gets equal access and is covered by the government. The budget line is fixed by the government and the patient gets top-quality care at no cost. In the case of the United Kingdom, the funding is tax based, but the general practitioners are private. The private stakeholders are paid by the government, so they control the market. In the United States of America, the system is largely private, but the country spends 18-20% of the Gross Domestic Product (GDP) on health, half of which is government funding.

> **"General insurance principles cannot be applied to health sector…*Insurance is a financing mechanism that we need to use intelligently, while being conscious of the fact that we don't allow a fee for service system which is highly inflationary.*"**

> ***"Data shows that (existing) insurance (schemes) are not helping India to reduce its out-of-pocket expenditure (OOPE) as they do not provide outpatient care."***

We need to understand the system our country needs today (as is) and bring in appropriate reforms. Government Funded **Health insurance in the Indian context has taken the form of schemes like CGHS, ESIS, RSBY and PM-JAY along with state specific schemes.** Current insurance scheme – PM-JAY primarily provides cover for in-patient care. Whereas **NSSO data shows that out-of-pocket expenditure is incurred on account of outpatient care. And, within this, the expenditure is largely on drugs, which are not covered in existing insurance schemes. The government must intervene and make sure that drugs are provided free of cost to people.** Another panellist pointed out the regional disparity in terms of PM-JAY coverage – wherein 72% of the empanelled hospitals were in 7 out of 29 states in the country – thereby being counterproductive to the intent of PM-JAY.

One of the participants raised a question about whether despite the inherent limitations, the current government sponsored health insurance model such as AB PM-JAY can be seen as a segue towards universal health coverage. Another participant observed that parallel systems of financing and health care exist within India, such as ESIS, CGHS, PM-JAY, and the Insurance scheme for defence personnel instead of a single system. There was an observation on whether an insurance model is effective in locations with supply side constraints: for instance, in the North Eastern States that have limited private sector. And **whether an insurance focused approach has hindered states from designing their own fit-for-purpose solutions to meet the health needs of their population.**

Trends show that the government is spending around 1.2-1.4% of GDP on health. If this is to be increased to 3.3% of GDP, the state government would have to increase their health spending to 8% and the average is currently at 5%. In the last two years, on average, catastrophic expenditures are at around 16%. Of these, 70-80% is spent on drugs, and some on diagnostics. NSSO data also shows that consumption levels have fallen, and people do not have money to pay out of pocket. **This begets the question of to what extent insurance will be able to achieve its stated objectives and whether there is a need to revisit and correct the imperfections in the design itself.**

What is an appropriate health insurance model for India?

Given the plurality of the Indian health system, one of the panellists' proposed that an appropriate model would be a hybrid model with a capitative form of paying mechanism. Until and unless the government comes up with an interventionalist policy with a low premium program, commercial / private insurance will continue to reign and wreak havoc and increase the cost of care.

Another panellist opined that while the cost is high in the case of catastrophic medical events, the probability of such events is relatively low. Providing cover for catastrophic medical care costs to avail specialist services hinders attempts to achieve universal healthcare. **Evidence suggests that specialist medical care does not promote equity and the scheme primarily ends up expanding the market of specialist services.** We need to introduce insurance in primary medical care and ensure that people in rural areas get access to hospital services that are not in their vicinity.

> ***"While the cost is high in case of catastrophic medical events, the probability of such events is relatively low…. India needs an insurance model which covers ambulatory care."***

Suggested design features for an ambulatory health insurance model: The government should introduce a family health protection plan, including ambulatory care and hospital care services to be provided by primary health centres or private clinics. The scheme should be available to all citizens, the premium should be paid to the clinic on a yearly capitation basis. Every family would be able to choose a clinic (private or public) of their choice with a lock-in period of one year. A graded subsidy for the premium could be suggested for low-income groups. The overall administration of the scheme should be through a mutual health foundation.

> ***"The way forward for India is a hybrid model of assurance and insurance."***

Another alternative view from a panellist was that health is a public good. Health care needs to be universalized. **The focus should be on universal health care and not merely on universal health coverage.** As a model, we need to move away from only insurance models to also looking at assurance models (a case in point mentioned was that of the state of Karnataka). The government should continue to be responsible for improving health care access, and provision of primary, preventive, and secondary care and not support tertiary care. If there is sufficient investment in primary care, the demand for tertiary care will reduce over some time. **Tertiary care can be provided through a hybrid model, along with capping of price as necessary.**

A contrary opinion was that **it would not be possible for the government to provide health care to the entire population and hence, the government should only focus on ensuring care for poor and vulnerable people.**

In this context, examples of Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) and erstwhile Rashtriya Swasthya Bima Yojana (RSBY) were given. In the case of PM-JAY, it was mentioned that **there are implementation challenges, the foremost being the complicated eligibility criteria for the identification of beneficiaries which also contributes to the misuse of the scheme in absence of the principle of universalization.** It was proposed that **India needs to focus on ensuring adequate protection for its informal sector.** As these people are largely migrants, insurance companies are unwilling to cater to the needs of the informal sector. Country-wide health insurance should be introduced, and credible private sector stakeholders could be invited to be part of this initiative. The government should invest its resources in primary health care, and not in secondary and tertiary level facilities. Public campaigns would need to be designed so that the informal sector is aware and well-versed in government initiatives.

Going forward, what is the one thing we should do in health insurance in India?

It was opined that multiple health insurance programs such as CGHS, ESIS, PM-JAY, and state government schemes would continue to co-exist in the Indian context. The question is how we unlock existing functional schemes, expand their scope and coverage and move towards universalization.

> ***"ESIS may be explored as a potential platform that can be expanded to cover informal sector."***

The instance of the Employee State Insurance Scheme (ESIS)[2] was discussed. It was mentioned that the Employee State Insurance Corporation (ESIC) is currently mandated to look after the health of about 400 million Indians who work in the formal sector, has resources to the tune of about Rs. 90,000 crore and spends about 30% of its annual income on their health. Given India's high labour workforce informality, coupled with under-utilisation of the ESIS system, going forward, as the first step after due evaluation of the performance of ESIS in states and at the national level, the possibility of expanding the scope of the Employees' State Insurance Scheme to provide cover to the informal sector may be considered. **Based on these analyses, the ESIS could perhaps, be re-configured to serve as a universal program for those not covered under AB PM-JAY.**

[2] Standard Note on Employees' State Insurance Scheme (As on 01.01.2022). Available at: https://www.esic.nic.in/attachments/publicationfile/9decf733b65a587e3e6201914e54dbaa.pdf (Accessed 20 Nov 2022)

5. Importance and role of data, evidence, and technologies in the health sector

The importance and use of data for policymaking and programme implementation were emphasized across sessions by panellists and participants during the two-day dialogue. Additionally, an open discussion was specifically held on this topic. Relevant points that emerged are consolidated and captured under this theme.

> *"While making policies we need to look at the data instead of our perceptions."*

> *"Government is an organization where inputs are measured, and outputs are not measured... measurement of the outputs is necessary to monitor the system…"*

Ensuring that data infrastructure is available is an investment and investing in a data system is a prerequisite. Moreover, data needs to be captured in an integrated system, consolidated in a timely (preferably in real time) and accurate manner, and made available in the public domain. And technology should be leveraged to automate this process. **Until one invests in a data system, evidence-based decision making is not possible. Moreover, data needs to be converted to information and used so that it can lead to change, action and results.** This would encourage programme managers as well as Health Secretaries to look at data in more serious ways. The private sector would also be able to see opportunities for partnering with the public sector.

In course of the discussion, it was acknowledged that HMIS is an important tool that can be used to study various aspects of the health sector. HMIS, itself per se, needs to be improved, and the data quality needs to be monitored. **Examples of COVID-19 were cited to illustrate the importance of data, and how perhaps it was the first time that the entire country was looking at data (in some form or the other).** It also accelerated the uptake of technology (e.g., telemedicine) while at the same time raising issues around the availability and reliability of government data, and the emergence of alternative datasets.

It was suggested that states need to be encouraged and supported to strengthen their statistical, surveillance and related systems and regularly publish state-level reports. It also suggested that the vital statistics division may be upgraded to the Directorate of Vital Statistics and given autonomy (as done in Canada). The lack of a proper system for the estimation of disease burden was mentioned as another gap along with a suggestion to invest in disease burden estimation process, modelling and forecasting. Instances of how previous data collection systems such as the use of family health registers at the sub-centre level, are no longer used were also shared. The importance of having measurable outcomes/key performance indicators for the public sector, including for the health workforce was emphasized by one of the panellists.

> *"There is a lack of good evidence-based research in our country on public health."*

Alongside investing in data, good research is needed to understand what is going on and what needs to be done. **There was a view that investment in research is inadequate.** One of the areas where there is a lack of adequate research and evidence is Centre State financing. It was also proposed that the government needs to make sure that good practices are collated and disseminated. Another area that needs to be examined closely is that of pharmaceutical research, particularly to understand the extent of private sector engagement and investment in pharma research. And, to explore the possibility of formulating a policy

directive/law (akin to the corporate social responsibility regulation) that mandates pharmaceutical industries to invest in medical research. Given the various models of learning across the country, it was suggested that a dedicated group of people should identify and document innovations across the country and try to take them to scale.

Regarding evaluation, it was mentioned that there is a lack of external evaluation and the creation of feedback loops to drive change. An external organization or setup is necessary to evaluate the processes in place. **Data collection, analysis and evaluation systems should be delinked from the implementing agency. When the implementing agency monitors itself then the data is not reliable. Having an independent mechanism is the way to get data discipline.**

"Can we look at the possibility of harnessing technology – à la Make My Trip for Health? "

On technologies in the health sector, the interface between technology and the health sector – be it in the form of telemedicine or recent initiatives like big data and the digital health mission and the opportunity for health system redesign was mentioned as an area for further deliberation.

Taking Forward the Dialogue ……

Policy dialogue is not a "one-shot event" but a continuous process and the same is true in the case of this Policy Dialogue too.

The two-day policy dialogue provided a unique opportunity to reflect on select elements of India's health system together with former Health Secretaries and other stakeholders, including the government and associated institutions, the private sector, practitioners, researchers, and partners. As part of this dialogue, the group identified several issues that form part of a health policy and system research and practice agenda.

- Review of governance structures of the Ministry /Department of Health and Family Welfare and creation of a separate department of public health and public health cadre.
- Functional review of the Directorate of Health Services in select states, particularly in the context of the National Health Mission. This would include a situational analysis and mapping of all cadres in the health department to understand their present status and relevance.
- Review Centre-State financing which includes an analysis of budget data, and flexibility in finances at the state level.
- Study to understand factors that lead some states to achieve better outcomes within the same resource and system constraints as compared to others.
- Review the extent to which investments made in the capacity building and skilling of the health workforce (especially in rural and remote areas) have led to their acquiring the requisite technical and managerial skills.
- Review recommendations on key health system issues emerging from various government committees established to date and the extent of their implementation in practice.
- Examine issues in the field of pharmaceutical research, particularly private sector engagement and investment.
- Organization of a Policy Dialogue with Health Ministers on the theme of Human Resources for Health.
- Identify and document innovations in key areas and support implementation. models.

As part of its mandate to encourage the development and use of evidence for policymaking, the Health Systems Transformation Platform continues to remain committed to being a bridge and connector between diverse stakeholders, including undertaking research on potential issues identified as part of the Policy Dialogue. Moreover, HSTP would explore potential interests and opportunities on how best to systematically draw on the rich expertise of the former Health Secretaries to take forward the insights gleaned from this two-day dialogue.


HSTP
India's Health System: Reflections
A Policy Dialogue
Supported by: TATA TRUSTS
10 - 11 November 2022

Annexe 1: Agenda

India's Health System: Reflections
A Policy Dialogue
10-11 November 2022
The Dome, Hotel Ambassador, New Delhi

10 November 2022, Thursday	
9.30 to 9.40 am	Mr Rajeev Sadanandan, CEO, HSTP
9.40 to 10.30 am	Introduction of Participants
10.30 to 11.00 am	Tea Break and Group Photograph
11.00 to 1.00 pm	Technical Session: Centre-State Relations in Health Moderator: Mr Pranay Lal Panellists: Mr JVR Prasada Rao, Mr R Poornalingam, Dr Amarjit Singh
1.00 to 2.00 pm	Lunch
2.00 to 3.30 pm	Technical Session: Leveraging the Private Health Sector Towards UHC Moderator: Mr Rathish Balakrishnan Panellists: Ms K Sujatha Rao, Mr CK Mishra, Dr Amarjit Singh, Ms Rita Teaotia, Mr Prasanna Kumar Hota
3.30 to 4.00 pm	Tea Break
4.00 to 5.30 pm	Technical Session: Is Health Insurance the Way Forward for India to achieve UHC? Moderator: Mr Rathish Balakrishnan Panellists: Ms S Jalaja, Ms K Sujatha Rao, Mr M Madan Gopal, Dr Prasanta Mahapatra
11 November 2022, Friday	
9.45 to 10.00 am	Recap of Day One
10.00 to 10.30 am	Technical Session: Aligning Human Resources with UHC Moderator: Mr Pranay Lal Panelists: Ms K Sujatha Rao, Mr Prasanna Kumar Hota, Dr Prasanta Mahapatra
10.30 to 11.00 am	Tea Break
11.00 to 12.00 noon	Technical Session Continued
12.00 to 12.30 pm	Open Technical Session: Importance and role of data, evidence, and technologies in the health sector Moderator: Mr Rajeev Sadanandan
12.30 to 1.00 pm	Concluding Session: Closing, Vote of thanks
1.00 pm	Lunch

Annexe 2: Panellists

S. No.	Name	Designation
1	Amarjit Singh	Former Secretary, Ministry of Water Resources, River Development & Ganga Rejuvenation, Government of India
2	C. K. Mishra	Former Secretary, Ministry of Environment, Forest & Climate Change, Government of India
3	J. V. R. Prasada Rao	Former Secretary, Ministry of Health and Family Welfare, Government of India
4	K. Sujatha Rao	Former Union Secretary, Ministry of Health and Family Welfare, Government of India
5	M. Madan Gopal	Former Additional Chief Secretary, Government of Karnataka
6	Prasanna Kumar Hota	Former Secretary, Ministry of Health and Family Welfare, Government of India
7	Prasanta Mahapatra	Former Health Secretary, Government of Andhra Pradesh
8	R. Poornalingam	Former Secretary, Government of Tamil Nadu
9	Rita Teaotia	Former Secretary, Ministry of Commerce & Industry, Department of Commerce, Government of India
10	S. Jalaja	Former Secretary, Ministry of Ayush, Government of India

Annexe 3: Participants

S. No.	Name	Designation
Moderators		
1	Pranay Lal	Senior Technical Advisor - International Union Against Tuberculosis and Lung Disease
2	Rathish Balakrishnan	Sattva, Co-founder & Managing Partner
Participants		
3	Aditya Natraj	CEO, Piramal Foundation
4	Aman Kumar Singh	Programme Lead, Tata Trusts
5	Amar Nawkar	Program Officer, Tata Trusts
6	Anagha Khot	Independent Consultant - Health Systems
7	Aravindan Srinivasan	CEO, AVPN India Foundation
8	Arun K Agarwal	Co-Chair, FICCI Swasth Bharat Task Force; Medical Advisor, Apollo Hospitals Group and Former Prof. ENT & Ex-Dean MAMC
9	Atul Kotwal	Executive Director, National Health Systems Resource Centre, Government of India
10	Bathula Amith Nagaraj	Senior Operations Officer, World Bank
11	Burzis S. Taraporevala	Senior Advisor, Tata Trusts
12	Dhvani Mehta	Co-Founder and Lead, Health, Vidhi Centre for Legal Policy
13	Disha Chaudhari	Assistant Director at Centre for Justice, Law and Society
14	Granthika Chatterjee	Senior Consultant, Health Practice - Sattva Knowledge Institute
15	H. S. D. Srinivas	Project Director - Health Systems, Tata Trusts
16	Jay Prakash	Human Resource & Operations Specialist, JVMaRKiS Private Limited
17	K. Madan Gopal	Senior Consultant (Health), Niti Aayog
18	Krishna Reddy Nallamalla	Country Director, Access Health International
19	Lakshmi Sripada	Deputy Country Director, University of Manitoba, Public Health Consultant, World Bank Group
20	Maulik Chokshi	Deputy Country Director - Technical, Director - Health System at ACCESS Health International
21	Mohan H. L.	CEO, Karnataka Health Promotion Trust
22	Nidhi Prabha Tewari	Co-Founder, Facilitator and Coach - Athulya Performance Facilitators
23	Pravin Srivastava	Former Chief Statistician of India and Secretary, Ministry of Statistics & Programme Implementation, Government of India
24	Raghu Sundaraneedi	Director, JVMaRKiS Private Limited
25	Ritu Priya Mehrotra	Professor, Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University
26	Roli Singh	Additional Secretary & Mission Director, National Health Mission
27	Santhosh Mathew	Country Lead, Public Policy and Finance, Bill & Melinda Gates Foundation

28	Siddhartha Bhattacharya	Secretary General, NATHEALTH Healthcare Federation of India
29	Sita Rama Budaraju	Medical Head – Tata Trusts
30	Sudha Chandrasekhar	Executive Director - Health Policy & Hospital Engagement Assurance, National Health Authority
31	Yashasvi Murali	Senior Consultant, Health Practice - Sattva Knowledge Institute
HSTP Team		
1	Rajeev Sadanandan	CEO
2	Sunil Nandraj	Adviser
3	N. Devadasan	Course Director, India Health Policy & Systems Research Fellowships
4	Sridhar Guduthur	Chief Finance Officer
5	Rahul S. Reddy	National Coordinator
6	Pratheeba J	Technical Specialist – Health Financing
7	Arun Tiwari	Specialist – Health Financing
8	Kumaravel Ilangovan	Specialist – Primary healthcare and PMJAY linkages
9	Shilpa John	Specialist – India Health Policy & Systems Research Fellowships
10	Sanjeev Kumar	Specialist – Research
11	Pallavi Gupta	Specialist – Health Systems Governance
12	Veenapani Verma	Junior Specialist
13	Sonali Randhawa	Research Associate – Health Systems Governance
14	Sakshi Khemani	Research Associate – Health Systems Governance
15	Diwakar Gautam	Finance Officer
16	Peter Parekattil	Operations Officer
17	Aaliyah Ali Khan	Program Associate, Program Management Unit
18	Rugma M.	Program Assistant, Program Management Unit

Disclaimer

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We also strive to enable Indian researchers and policymakers to conduct research and translate evidence for achieving Universal Health Coverage. We collaborate with Indian & Global expertise by strengthening stakeholder capabilities for health systems redesign, validating interventions, and fostering policy dialogue.

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