Conceptualising UAHC 'Bottom Up': Implications for Provisioning and Financing

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Health care is a commodity if it is only viewed as something that can be obtained by accessing services that have to be purchased, whether the provider is in the private sector or a public institution. While this external source of health care is a major part of health care, there are others that cannot be thus commodified, and access to those must be ensured as well.

Health care consists of preventive, promotive and illness-management activities, as a continuum from self-care at home to primary, secondary and the highest levels of tertiary care. Self-care is the commonest at the beginning of any illness and in chronic illnesses, consisting of use of home remedies, common medical prescriptions such as pain killers and anti-pyretics, use of formulations of traditional medical systems and, in long-term conditions consists of modulation of regimes that are prescribed for repeated or long-term use. Often, a combination of these is resorted to. (Ref.) Commonly, the second line of action depends on the nature of illness and its severity; based on their collective experience people develop a general pattern of health-seeking behaviour with an understanding of what works best for which health problem in their context. It could be going in for doctor's medicine, or in cases where it is known not to be effective there would be resort to the traditional systems, including in some cases faith-healing as well. This pattern varies across different settings and in groups with diverse ecological, socio-economic and cultural backgrounds.

This experience based behaviour pattern of people has been found to be a good guide to cost-effective solutions in several instances, such as in the case of diarrhoeal diseases and pulmonary tuberculosis, where the 'default' was found to be more on the part of the service providers than on the people's behaviour (Ref.). There is also the spectrum of iatrogenic problems that make people use various options other than those causing side-effects.

TM and CAM are being increasingly adopted world-wide, even where universal access to quality services of modern medicine exists. Ideological reasons such as dissent with the modern development paradigm based on eco-social considerations and against the personal disempowerment due to medical hegemony (women's movement spearheading this since the 1970s and 80s) have led many to 'return' to TM and CAM. However, larger proportions of the population use such means to health by choice based on experiential knowledge, viewing them as cost-effective means of dealing with ill-health and promoting health. Estimates of upto 70% of the world's population using them have been made (Bodeker & Burford, 2005).

This is not to deny that there is much suffering that can be mitigated by a better access to appropriate health care and that people desperately require better access to medical services. The implication is that developing systems to ensure 'Universal access to health care' has to factor in the agency of lay people themselves in action for their own health as well as the

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pluralism in forms of health care. It is necessary to prevent the developing of hegemony or monopolies of any one form, it prevents over-medicalisation, and it allows people to get the benefit of the strengths of each form of health knowledge while allowing others to fill in the gap due to each ones limitations.

Developing systems for universal access with only one form defining the content of health care will result in de-legitimising the other forms and undermining the support structures for them. For instance, in Europe and the US people with medical insurance are spending more out of pocket to get complementary and alternative forms of medicine (CAM) than they are having to on allopathy because CAM is not covered by most insurance packages. (Ref). Once there is insurance, people also tend to go sooner for medical services than they may otherwise, decreasing the use of home remedies and other modes of self-care. Now, in societies where there has been a relative saturation with medical services, there is also an increasing demand for CAM. So we should not let go of our advantage of having live practice of various forms of traditional medicine and discuss a framework that is based almost exclusively on the modern medical/ allopathic doctor. Doing so has brought us to a situation where Illich's analysis of Medical Nemesis seems to be proven true even while large sections are denied access; Medical and 'cultural iatrogenesis' are evident--a truth recognised by 'scientific' medical research as shown by advances in dealing with cases of, eg. diarrhoea, CVDs., diabetes, personalised treatment, over-medicalised deliveries--but still unnecessary interventions are widely accepted and adopted in formal medicine practice.

Several committees and Five Year Plans have recommended using the availability of traditional practitioners to advantage as they are providing services in otherwise underserved populations. some states have recruited them to provide allopathic services in PHCs, such as in Maharashtra, J&K and UP. What public health has ignored until now is the inherent worth that is recognised in the 'other systems' by lay people, elements of which are now increasingly being validated even by the frontiers of inter-disciplinary bio-medical research (such as psycho-neuro-immunology, Integrative Medicine etc.). We have also not incorporated the presence of AYUSH facilities in the public system in our analyses of public services, despite the fact that there is a whole parallel structure of dispensaries and hospitals in most states. The number of service delivery institutions, as shown in table 1, is high, with almost as many stand-alone AYUSH dispensaries as there are PHCs in the country, and AYUSH hospitals about one-third the number of allopathic hospitals. The total number of AYUSH colleges is more than of modern medicine and their intake capacity is somewhat less. However, all of this infrastructure is supported by less than 3% of the health budget!

Table 1: Features of AYUSH Services in the Public System

S. No.	AYUSH	Modern Medicine
1.Service Delivery Infrastructure	nil	SC = 1,46,036
	Dispensaries = 22,312	PHC = 23,458
	Hospitals = 3378	RH (including CHC)= 6281 UH = 3115 Total = 11,613
	Beds= 68,155 (AYUSH in India-2007)	Beds (R)= 1,43,069 Beds (U)= 3,69,351 Beds (T)= 5,40,328
2. Colleges	Total AYUSH Colleges= 492 Annual intake capacity= 30,086	Medical Colleges= 300 Annual intake capacity= 34,595
3.Budget Allocation	Dept. of AYUSH= 2.7%	Dept. of H&FW= 90%

Source: National Health Profile 2009, GOI.

With the low funding, quality of infrastructure and functioning of institutions is often weak, and utilisation is reflective of this. This was the finding of a study across 18 states in 2008-09 (Priya & Shwweta, 2010), a comparative analysis showing that the utilisation is high where quality is good. In states such as Tamil Nadu and Kerala, where quality of modern and AYUSH services is very good, utilisation was found to be high of the AYUSH as well (see table 2). This reflects a demand by choice rather than under the constraint of access to modern medicine. Household responses revealed an even higher use of AYUSH and LHT, many going to the private sector.

Responses of doctors of modern medicine in the public system too reflect a high perception of usefulness of the AYUSH and of home remedies by them, reflecting their perceived/observed strengths, especially in case of shortcomings of modern medicine. The practice of combined therapy and cross-referral being practiced informally is indicative of the perception of the complementary role of the various systems.

Table 2: Utilisation of AYUSH Services of the Public System and Use of Home Remedies

	AYUSH & LHT	Modern Medicine
1. Utilisation: OPD attendance (average OPD attendance/ facility /day)	Highly variable across states-- from 8 to 78. In Tamil Nadu: Stand-alone Dispensaries and Co-located PHCs= 50-80	In Tamil Nadu: PHCs = 100-150
2. Utilisation: Households reporting use of AYUSH services in last 3 months.	Households reported use of AYUSH services in the past 3months: 1/3rd states= 0-30% 1/3rd states= 30-60% 1/3rd states= 60-98%	
3. Pattern of Use: Morbidity profile and duration of illness of OPD attendees (exit interviews) [Acute illnesses= less than 1 month Chronic illness= more than 1 month]	Utilised for all kinds of problems--acute and chronic, communicable and non-communicable, except for emergencies and serious conditions, and for preventive-promotive purposes. The proportion of chronic illnesses was higher than among the patients taking treatment of modern medicine. For instance: In Tamil Nadu: Acute illnesses = 40% Chronic illnesses= 60% In Uttarakhand: Acute illnesses = 42% Chronic illnesses= 58%	In Tamil Nadu: Acute illnesses = 100% Chronic illnesses = 0% In Uttarakhand: Acute illnesses = 92% Chronic illnesses= 8%
4. Utilisation of Home Remedies	Variable use of home remedies across states as reported by households: For common illnesses=12-82% For MCH care= 40-98%	Utilisation of home remedies together with doctor's medicine was high at exit interview among patients taking doctor's medicine=
5. Validity of community knowledge against AYUSH principles and texts.	Home remedies for a given list of 21 conditions= more than 75% found valid in all states	
6. Opinion of Medical Officers of modern medicine regarding AYUSH and LHT		70% respondents said AYUSH were of value; 30% thought they were redundant. 55% perceived value in home remedies and also prescribed them to patients, but some were thought to be harmful as well. However, did not write it in the prescription.
7. Combination and Cross-referral	Listed conditions: • in which combined therapy is useful, • for which cross-referral is done to and from providers of modern medicine.	Listed conditions: • in which combined therapy is useful, • for which cross-referral is done to and from AYUSH providers. However, did not write it in the prescription.

Source: Priya Ritu & A.S. Shweta, 2010 (preliminary figures pending final check)

Some Key Contemporary Global Issues in Organising Health Care

There are various streams of thought developing within health services development in the world at this point of time, all charged with some commonly recognised problems with the existing systems. One strand attempts to reform the financing and provisioning without questioning the knowledge content while the other challenges the prevailing dominant knowledge base and provides openings for a different direction for development of health care in the future. In fact there is much frontier research that is changing the state-of-the-art practice of medicine from a high technology to a lower and more appropriate technology use, often drawing from other systems of knowledge. The findings of a rich body of analytical studies can be summarised as follows:

Consequences of Bio-medical Dominance

- Over-medicalisation, specialist services further increase unnecessary interventions and costs
- Iatrogenesis
- Commodification of health
- Unaffordable and Escalating Costs
- Pharmaceutical and insurance industry attempting to generate higher markets for fewer technological advances; pressure for higher public funding of medical services and for absorbing the costs of R&D in curative and preventive medical technologies.

Challenges to the Bio-medical Dominance

- High and increasing NCD load even while Communicable Diseases remain high; an aging population
- Widening recognition of significance of the Social determinants of health
- Increasing use of Traditional Medicine (TM) and Complementary & Alternative Medicine (CAM)
- Questioning of development models that ignore natural environments and processes
- Demands around 'right to quality health care', 'rights of patients' especially in terms of information and role in decision making, 'rights of providers'; involvement of communities in decision making.

In this Context, Optional Paradigms for Solutions to the lack of access to health care

A. To make the bio-medical dominance 'affordable' through social insurance/tax based financing.

B. To break the dominance by supporting and legitimising the cost-effective pluralistic forms, ensuring universal access to all the forms through making knowledge and material requirements of all forms accessible to all.

Health Services: The Indian Context

In addition to the issues faced by health systems globally, some specific issues are relevant for consideration for UAHC in India (as well as other low and middle income countries):

- Large infrastructure of public services of modern medicine and AYUSH, but still inadequate coverage
- Larger private sector, formal and informal, single dr. to polyclinics and nursing home to corporate hospitals and their franchisee outlets
- Large paramedical cadre along with community level 'volunteer workers'
- Large pharmaceutical industry of modern medicine and traditional medical systems
- Yet, access poor due to concentration of services in some parts and sparse in others and due to costs
- High unethical and irrational practice, lack of trustworthy and quality services; completely unregulated
- Pervasive nexus of vested interests, normalisation of unethical practices
- High availability of health human resources, yet shortages due to lack of/distorted policies of production and deployment
- High 'untreated' illness episodes on one hand, and high unnecessary use of medical technologies and specialist care on the other
- Triple burden of disease with continuing CDs., increasing NCDs and Injuries
- High resort to the private sector (formal and informal), and to Traditional Medicine (TM) and the use of Local Health Traditions (LHT)--pluralist health seeking behaviours widely pervasive in all communities
- Large no. of civil society experiments and formally trained doctors of modern medicine are combining TM interventions and modern medicine for maximum benefit to patient

- NRHM is the ongoing country-wide initiative by the state for strengthening the health service system and any future efforts at health systems development must examine and build upon its achievements/ potential/ negative possibilities--(i) setting into motion mechanisms for revival and internal strengthening of the public system and its sub-systems on one hand and involvement of the private sector on the other; which have been multiple and diverse across the states, and can provide positive lessons, (ii) strengthening of structures for community level action and involvement on one hand and institutional strengthening on the other, again multiple and varied implementation with lessons, but generally weak on people's role in governance processes; (iii) commercialisation, contractualisation, and/or monetary incentivisation of activities, which may be counter-productive to strengthening of the public system and community processes.

Challenges for building an alternative paradigm with UAHC in the 21st century:

In the context of both the global and India specific sets of issues related to a health system that is sustainable and cost-effective in improving people's health and wellbeing, some challenges are highlighted below for evolving any meaningful system of UAHC:

- Hegemony of the provider and medical technology needs to be broken--demystifying the information gap and role of technology--while simultaneously empowering the doctors/providers to practice ethically and with dignity

- Nexus of provider-prescriber and pharmaceuticals is to be broken.

- Nexus of provider-prescriber and commercial diagnostics is to be broken.

- Levels of appropriate care that can be provided to all must be publically funded. this has largely to be by the state, but also by facilitating workers' cooperatives, civil society organisations organisations, philanthropic bodies etc. to the task of providing rational health care universally, as distinct from the commercial for-profit private sector.

- Limiting the escalation in demand for newer technologies as access to services improves. Escalation in available technologies and their marketing strategies change people's perceptions, especially of those who are already advantaged in terms of achieving access. Thereby there is a distorting the rationality of 'need' such that the system cannot gear up to reach those who do not have access to even the basic services.

- A wide diversity of context requires that priorities be decided based on context specific problems and ways of handling them

- Centralised, capital intensive structures can only be at centres of concentration in order to allow access to the maximum number and to ensure all required inputs--eg. hospitals have largely to be located in urban areas (and wherever a successful rural hospital is set up, the area tends to get urbanised), therefore outreach services and referral systems are more necessary for the rural areas. Even in a setting such as of Canada, it has been found that universal access resulted in overcoming the disparity in mortality rates as well as in inequity of access for primary level and generalist services but not for specialist services which continued to be disproportionately utilised by the better-off (Veugelers & Yip, 2003). This also implies that, by norms of equity, developing services other than hospital based and specialist dependent care should be prioritised for all settings--rural and urban.

- The GP, paramedic, providers of AYUSH services and self-care must form a larger part of the formal health service delivery system everywhere, both for cost-effective rational care for a majority of health problems, and for the widest possible coverage and access. This is as necessary for the middle-class and urban as it is for the poor and rural.

- PG education must be oriented towards producing specialists who should not only be able to use more and higher level technology but even more so, be more knowledgeable and skilled in assessing which patient management approach will be most suited to a patient with least intervention, and refer the patient appropriately to the GP / paramedic / providers of TM services as well as inculcate capability for self-care.

  Thus, in addition to the norms for coverage of institutions and health human resources, a model for the structure of health services will have to take into consideration: (i) the content of services to be provided since optional methods and technologies have their own imperatives for levels and forms of service delivery; their inherent rationality varies in diverse contexts; comparative cost-effectiveness analyses may imply huge financial differentials; (ii) people's health seeking behaviours since they may provide indicators of the most cost-effective ways of dealing with problems within their context, as well as an understanding of rationality of people's expectations from a health service; and (iii) the work culture of health care providers since that would determine the rationality, quality and outcomes of care. In fact, the norms may have to be re-considered in light of these factors. Diversity of context in terms of the level of health services development would have to be factored in. An incremental process of strengthening universal access may be envisaged for realistic planning and implementation.

The Framework for UAHC

There are two clear trends in health care--a medical technology, doctor and institution-centred approach and a social determinants and people-centred, pluralistic approach--and the model for UAHC would have to adopt one of the frameworks, incorporating within it elements of the other as required. The former can only be developed as a top down process since it inherently relies on the medical expert. The latter can be developed as either a top down process or a bottom up process.

If cost-effectiveness is a major criterion for evaluating a health intervention, then the choice of framework is clearly the second, given the prevailing and emerging morbidity profile and the need for preventive, promotive, curative, palliative and rehabilitative services. However, since it is counter to the prevailing policy environment and the larger political economy framework, the challenge is how to get it accepted and operationalise it. Unfortunately, the imperative of technology development and marketing, as of the commodified mindset, is to make the social determinants and humanist health care approaches seem 'unacceptable' or 'not feasible'. Evidence from experience of countries across the world, at all levels of health service development, tells us otherwise; that the prevailing bio-medical paradigm including its public health dimensions, is not sustainable either in economic terms or in terms of continuing to improve health and wellbeing of all. At one end, the US has faced a recession, partly fuelled by health care costs to the corporates, and a fierce controversy about how to finance health care for all citizens. At the other end is the revelation by an analysis of implications for the poor and marginalised of the most rational and low cost medical care being provided by Jan Swasthya Sahyog-Bilaspur. Presented at the MFC meet at Vellore three years ago, it showed how even the most low cost and rational services of modern medicine remained unaffordable for over one-third (35%) of the community members who died without accessing any care for their terminal illness (JSS, 2006). Countries that have had an ideology-backed adoption of the principle of universal health care and of the principle of people's empowerment together with a perceived resource constraint, have relied on community structures and TM/people's knowledge for primary health care (China, Sri Lanka, East European countries). Even Cuba, with its surplus of doctors, has incorporated TM and is currently teaching children about home herbal remedies through schools. Thailand has, as part of its UHC initiatives promoted the use of home remedies as well as strengthening of institutional structures for Traditional Thai Medicine.

PPPs for UAHC

Given the reality of our existing health service system, PPPs are a necessity. With what purpose and within what kind of framework are the issues to be worked out in congruence with the larger perspective adopted for UAHC. Drawing the private providers into an integrated system of universal provisioning is essential from the PHC/MFC perspective since they can fill gaps of general and specialist doctors in some settings. Engaging them in the UAHC framework is also important if a unified, low cost and appropriate technology service

system is to be generated over time. Without regulation of the private sector is this possible? Strengthening of the public services, with contracting in of private providers as a last resort seems to be the way forward. As the public services incrementally increase coverage and quality, more of the practitioners could come into the public system if regular positions are given or be contracted in when required. Both, the public system and the private providers will have to work towards developing an effective working relationship and a work culture of cooperation that puts the users centre-stage and takes STGs seriously.

I am proposing that we add on three dimensions relevant to provisioning and financing that are missing in the present discussion and need to be incorporated as central to UAHC for the alternative discourse to be meaningful in our real life settings-- self-care, traditional medicine and strengthening of public provisioning.

A Model for Universal Provisioning of Health Care

We began by answering some key questions and making some assumptions based on a large body of available literature:

1. How do people define 'quality' of health care?

- Produces effective results
- Convenience in access
- Reasonable quality of infrastructure
- Knowledgeable personnel
- Personnel pay adequate attention to all
- Tests and medicines available as needed
- Short waiting time

2. What is access most commonly defined by:

- Distance
- Cost
- Trust in providers

3. How to assess comparative advantages of different pathies, self care and professional care?

Cost and effectiveness for all types of optional regimens needs to be analysed rather than base assessments only on RCTs that compare a candidate drug merely with another existing drug. also, the assessment should be conducted for different forms of service delivery--as self care, and by primary/secondary/tertiary level providers. Providers and users are well known

to have other valid considerations in use of each regimen within their context. Thus, eg. evaluations, eg. of pharmaceutical products, should include under diverse conditions:

- Objective evaluation of proposed/practiced regimens vs placebo or symptomatic treatment
- Objective evaluation of proposed/practiced drug regimens vs drugless management
- Provider's assessment of the advantages and disadvantages of the various options
- Users' assessment of the advantages and disadvantages of the various options

Multi-dimensional and innovative mechanisms could be evolved for dealing with each requirement through optimal solutions in light of all the experience of different countries and within India. For instance:

To decrease waiting time:

- decrease unnecessary prescribing/demand for interventions
- increase coverage of population with providers and facilities
- strengthen management to improve functional efficiency

To decrease prescribing/demand for unnecessary interventions:

- by a rational use of interventions,
- using a pluralistic approach to management

To evolve a model for UAHC, make evidence based estimates for common problems, bringing together (i) Epidemiological data on disease profile, (ii) People's health seeking behaviour and perceptions, (iii) Providers' practices, (iv) Learnings from realist evaluations of systems of UAHC in diverse settings. Estimation of need may be based on computations of the following and the service structre and humna resource planning may be done accordingly:

- % of illness episodes not needing allopathic medicines
- % of illness episodes needing primary care or long term support from paramedics + allopathic medicines + AYUSH
- % for GP care (allopathic)
- % for GP care (AYUSH)
- % needing specialist attention
- % using home remedies effectively (with or without other treatment)

Strengthening Public Services

The Planning approach outlined in the accompanying paper "UAHC with 'Community Participation' OR 'People Centre-stage'?: Implications for Governance, Provisioning and Financing" provides a framework within which strengthening of services in the government system can be envisaged. It also provides a rational basis for appropriate 'contracting-in' PPPs.

In addition, if universal access is the goal and the public system is to be strengthened, coverage of services will have to be increased to bring them physically closer to users. a structure for the public system is given below to illustrate the possible integration of AYUSH and parameidcs for preventive and curative services at all levels.

Proposed Structure for Public Services for UAHC

[Village level facilitation by AWW+ASHA+VHSC members]

1. Subcentres for 2-4,000 with 2 ANM + 2 MPW + 1or 2 AYUSH doctor + 1 Social worker
2. PHCs for 15-25,000 population, with 2 AYUSH Drs. of different systems and 2 GPs of modern medicine.
3. CHCs/Sub-district hospitals for 50,000 population with GPs and specialists of AYUSH and modern medicine.
4. General District Hospitals and AYUSH sub-district and district hospitals
5. Medical and AYUSH colleges

Existing functional AYUSH dispensaries can be used to co-locate a sub-centre or a PHC, with the AYUSH doctor retaining charge. Infrastructure could be suitable upgraded. The AYUSH hospitals should be strengthened to function entirely for their respective systems and provide specialised OPD and indoor services.

The AYUSH doctors at the sub-centers and PHCs must provide only services of their own system and promote cultivation of herbal gardens and use of herbal medicines, as well as provide supervisory support to the paramedics for promotion of home remedies and use of AYUSH as well as specified national health programmes. At the CHC and DH, they should exclusively practice their own systems and work with the Allopaths to give patients the

benefit of all health knowledge as well as provide referral support and technical advice to the primary level providers.

The ANM and MPW should be trained in multi-pathy health care along with public health activities so that they provide comprehensive promotive, preventive and curative services as well as promote and supervise self-care. Regular outreach activities and institutional services would constitute their duties. Supervisory staff and other paramedics would be appropriately included at each level.

The doctors of all systems would need to be trained in promotion of self-care as well as sensitised to the strengths of the other systems and oriented to use of STGs.

The social worker will have the responsibility of overseeing community activities, such as the VHSCs activation, inter-sectoral coordination and other local specific needs, eg for palliative terminal care at home, adequate referral linkages and transport etc., as well as ensuring that the most marginalised sections in the villages in her area are not neglected during implementation of various schemes and service delivery.

Thus, by combining all existing infrastructure, the need for capital investments would be reduced while comprehensive and integrated services would become possible and provide greater choice of pathy to the patients. Wherever doctors are not available in the public system they may be contracted in from the private sector. Where the private doctors are also not available, paramedics and referral services need to be strengthened, along with nurses who can be trained for basic care.

To support such a structure, education and training capacities will have to be strengthened at district levels. With a large part of the everyday illnesses being taken care of by self-care, paramedics and AYUSH, the need for setting up more medical colleges will be limited leading to saving on capital investments and the high recurring costs at that level.

Paramedical education and training will have to be strengthened all round. Existing ANM-Training Centres and Health Schools should be upgraded and additional institutions after assessment of need.

Technical Support will need to be made part of the organisational structure for setting of technical guidelines for clinical practice as well as programme design and their implementation. This should include the following:

Institutionalising mechanisms for technology assessment and choices would require a national level body to work out the modalities and principles on which health technology use should be undertaken in the country. The NICE that has been doing this task for the NHS of the UK provides a structure to start our thinking on this. However, we would require expertise to assess old and new allopathic medicines and other interventions as well as AYUSH regimens, especially for continuing and emerging epidemiological priorities, including communicable diseases, NCDs, MCH and mental illness.

Creation and updating of RDU guidelines, EDLs and STGs with the spectrum from home remedies to optional or combined AYUSH and allopathic regimens at primary, secondary,

and tertiary levels, conducting studies to monitor prescribing practices and identify context specific adaptation needs, would all be supportive tasks for improving the quality of clinical practice.

The State Health System Resource Centres should have an AYUSH unit to contribute to innovation and change in the health system. At the district level, a ***District Interdisciplinary Resource Centre for People's Health Knowledge*** could perform multiple functions, including documenting and validating LHTs, health education for promoting the useful and weeding out the harmful traditional practices, sensitising medical and AYUSH practitioners and other health workers to the local health traditions and the significance of people's health knowledge as well as self-care.

The accreditation system for all service delivery institutions should include criteria for 'promotion of health and self-care' as an important element. Thailand accredits those hospitals as '***health promotion hospitals***' that promote self-care, produce traditional herbal medicines and use them for their patients. Referral audits could help in restricting referrals to higher levels to only the essential, and provide pointers to the kind of support required by doctors within the system to perform at their optimal.

Promoting Innovative High Quality Low Cost Solutions in clinical and surgical care: Several innovations are made every day by doctors, surgeons and health workers in order to provide optimal care to their patients and these largely remain restricted to individual use or within their hospital. A number of such innovations and experiments related to screening and diagnostic tests (Phadke A.), surgery (Thomas G), trauma services (John J), deliveries (Bhattacharji S.), leukemia (Chandy, M) were shared and discussed at the MFC Annual Meet at Vellore in January 2006, and are available in the bulletin. Several AYUSH medical regimens have been evaluated by RCTs and found to be effective. Integrative medicine combining the principles of allopathy and TM has produced good results in serious dermatological conditions such as the 'elephant foot' of filariasis (Ryan T, 2010). Wound healing in intractable chronic ulcers, and chemical fistulectomy by ksharsutra (Shukla et al, 1994) are well acknowledged as more effective than modern surgical methods. A Golden Triangle initiative is underway as a collaborative effort of the AYUSH Dept., ICMR and CSIR for evaluating Ayurvedic regimens for 28 conditions and standardising the effective ones (GOI, 2010). Facilitating systematic work on such innovations, with sharing of the experience and dissemination of findings would be inimical to critical interest and excitement of the providers in working with marginalised communities as it provides a professional challenge. It would also be useful for all practitioners including those in the private sector which can use these in a win-win situation for their patients as well as profit margins. Institutionalising this through organisations such as the Association of Rural Surgeons of India is important but the resources of time and finances remain stretched so that systematic dissemination is difficult and does not impact the mainstream of the profession. The ICMR/Department of Health Research could develop a special unit for the purpose, bring together such clinicians, publish and publicise their innovations and also feed them into in-service orientations and CMEs.

Conclusion: Many more organisational and clinical ideas for ensuring and facilitating universal access must be in the minds of a large number like us, some based on evidence from literature and some also working it out on the ground. The basic issue is the framework for attempting such a challenging task. The building blocks are all there. How do we put them together to move towards an optimal, long-term, sustainable system of universal access? A

major barrier is the readiness to think 'with the people'. Whatever model we adopt, if it does not deal with the divide between the health provider system and the people, it cannot create the sense of solidarity required to ensure universal access. Then UAHC may only become another source of greater profits for the health industry with little addition to the health and wellbeing of India's marginalised, and in fact, even as it provides some relief, it may act as a source of additional suffering for a vast majority.

Annexures:

1. Costing of the proposed service delivery structure
2. Some rough costing exercises for the alternative approaches, as applied to a few disease conditions

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