SECTION V

Conclusions and recommendations

Section I

1. Investing in health

EVIDENCE SHOWS THAT INVESTMENT IN HEALTH CAN AND DOES CONTRIBUTE TO economic growth. Healthier persons live longer, are more productive, earn and also save more. Analysis shows disparities in health with an 18-year difference in the life expectancy at birth between 72 years (in Kerala) to 58 (in MP); the probability of the poor falling sick by 2.3 times more than the rich; and a Rs 1000 increase in the per capita income increasing the LEB by 3 years. The challenges for the future are malnutrition, an ageing population, and an increased disease burden on account of new infections and emergence of an epidemic of non-communicable disease, that, in the absence of social security systems, have the potential to impoverish the poor. An estimated 3.3% of the population is estimated to be getting pushed below poverty line on account of medical treatment. Therefore investing in health is investing in economic development and equitable growth.

- Increase investment in a basket of goods consisting of strategies for poverty alleviation, health, nutrition, more particularly micronutrients through production incentives, affordable prices and promoting R&D to produce fortified foods; safe drinking water and sanitation; rural road network; and female education.

II. Disease burden in India

India is reeling under a dual burden of disease with unacceptably high levels of communicable and infectious diseases, diseases/conditions related to reproductive health, and an emergence of chronic and non-communicable diseases. Based on an exhaustive literature review of 17 diseases/conditions, the disease burden projections for 2015 show a grim picture of a large number of persons with cardiovascular diseases, HIV infection, psychiatric illnesses, etc. Projections also show that India will not be able to achieve the MDG goals of IMR, Under-5 MR and MMR and that the non communicable diseases which are also more expensive to treat affect the poor too. An exhaustive causal analysis however clearly demonstrates the efficacy of preventive and low-cost solutions to avert disease and death., making a strong case for shifting priority for public investment to focus on prevention of disease and promoting good health values such as exercise, healthy diet, no smoking or excessive consumption of alcohol, responsible sexual behaviour etc.

- Undertake community-based research to arrive at more credible estimates of disease burden
- Invest on developing public health expertise and the requisite skills to undertake disease estimation studies and projections.
- Increase spending on health promotion-at least 10%-20% of the public sector budget to be earmarked for public health activities such as health information dissemination and education on preventing disease and promoting good health values, allopathy as well as ayush systems such as yoga, ayurveda etc. etc. with the participation of communities, local bodies, NGOs and members of civil society, professional bodies, etc. and by propagating the existing traditional knowledge like yoga that are known to reduce stress, treat chronic ailments like arthritis and improve well being.

Section II

1. Delivery of care in public and private sector

Mismatch in goals and strategies and management failure at various levels of decision making and implementation are reasons for the poor performance of public health systems and India's inability to achieve the goals laid down in the various policy documents. There is an urgent need to shift towards more evidence-based policy-making, decentralization of functions to hospital units and local bodies, shifting the role of States to manage the health system away from the narrow focus on the implementation of budgeted programmes and vertical schemes and develop systems that address the health needs of the poor in particular in a comprehensive manner.

- The growth of the private sector has been phenomenal due largely to the dysfunctional nature of the public health system. But the private sector has by and large failed to provide quality care at a reasonable cost. The qualified provider markets in the private sector are urban-based, technology and specialist driven and consequently expensive and unaffordable to the majority of the people, who take recourse to the local quack-RMP-receiving care of dubious quality.

Besides, to address the failures so characteristic of health markets world over, such as induced demand, there is need to bring in provider regulations to contain costs; incentivise providers to desist from irrational prescription practices etc. which contribute to increasing cost.

- To reduce government expenditures by atleast 30%, an exercise for rationalizing and restructuring the Public Health Delivery System at the primary health care level should be taken up. By aligning the finances, functions and functionaries with the services to be provided at each of the facilities, efficiencies can be improved. For this, mapping of all facilities should be undertaken, and facilities relocated based on workload norms, community preferences, and distance norms, for example access to the first contact for care within 30 minutes; inpatient care within 60 minutes; an EmOC facility within 2 hours; and a specialist in 2-4 hours, etc.
- Improve efficiencies of public facilities by having utilization norms such as 40 OP per doctor in a PHC/CHC and 75% occupancy rate for IP care, etc. Integrate CHC as the health administrative unit and gatekeeper for referrals to higher facilities and have the PHC focus on health promotion, emergency care and women's health; and professionalize the management of public facilites by having trained hospital managers. This will also relieve the clinicians to attend to work s/he are trained for : patient care.
- Formulate Public Health Laws for the range of issues in the health sector- legislation for location, establishment and conducting of health care provisioning; on medical ethics and professional qualifications, prescription practices, drug pricing, quality, availability and pricing of services, use of technology, and advertising / the consumption of products that adversely affect health such as tobacco, alcohol, fast foods, unhealthy products through the media and against increasing vehicular pollution, etc.
- Professionalize health management and administration: Currently, both at the Central and State levels, institutional mechanisms to keep pace with new demands generated by a rapidly changed circumstance-dominant presence of private players in all aspects of health; new financing systems; more aware and demanding consumers, technological advances and information explosion, etc.-require the health management and administration to be suitably upgraded and professionalized. Appropriate institutions need to be established to cope with these new demands and better skilled and informed managers are required at all levels. For this, it is recommended that by an Act of Parliament or whatever considered adequate/appropriate to assure the required level of autonomy and stature, the following institutions be established:

1) Federal Drug Authority; 2) Indian Medical Devices and Technology Authority; 3) National Commission for Quality Assurance; 4) National Commission for Medical and Health Education; and 5) Hospital Financing Corporation.

- Strengthen the mechanisms for enforcement of laws related to quality assurance, disease surveillance and public health measures, quality of education, and drug and food safety.

2. Three drivers of the health system costs — Human Resources, Drugs and Medicines, and Technology

Human resources

The biggest impediment in India's ability to achieve health goals will be human resources, both in terms of availability as well as expertise. There are a few health economists and a grossly inadequate number of biostatisticians for a country of this size. Besides even the current availability of human resources (doctors, nurses, midwives) fall short of the international norm of 2.5 per 1000 population. There is a shortage of doctors in specialties that are required for addressing our disease burden viz. anaesthetists, opthalmologists, gynecologists, etc. and in disciplines such as Anatomy, Physiology, etc.-basic disciplines that are needed in medical colleges. Lack of teaching faculty will be the main impediment in expanding and opening more colleges. There is an increasing shortage of well-trained skilled nurses and other paramedical resources such as pharmacists, laboratory technicians, etc. There is concern of the low quality of instruction and skill acquisition, more particularly in private medical colleges, and neglect of community medicine. Equal attention also needs to be paid to involve the community and train a community based cadre of health providers. Training the existing rural medical practitioners who enjoy a measure of social consent over three years, could have the twin benefits of addressing over 80% of health care needs within the village habitation itself and also at the same time relieve the pressure on the production of trained medical doctors who, by virtue of their training and professional aspirations are reluctant to serve rural villages. These RMP's can be trained in district hospitals having more than 100 beds and having a good occupancy rate.

- To meet the growing demand for physicians, both within and outside the country, it is necessary, to increase the number of medical colleges and nursing schools. However, priority should be given to reducing the existing inequity by establishing 60 medical colleges in the deficit states of UP, MP, Bihar, etc.
- Establish 6 Schools of Public Health are also required besides upgrading those in the country – public or private.
- Likewise an additional estimated 3.25 lakh nurses would be required by 2015, excluding the demand from the western countries : USA alone is reportedly in need of an estimated 10 lakh nurses from abroad over the next decade. For this, it is necessary to establish an additional 225 nursing colleges and upgrade the existing ones to become benchmarks of excellence.
- The Medical Council of India and State Medical Councils as also the Nursing Council of India have failed to carry out the mandate provided to them for regulating the profession and raising the standards of medical education and enforcing them; it is essential that the MCI/NCI Act be amended to allow for civil society representation in the Council. Besides, the MCI should restrict itself to regulating undergraduate education with the postgraduate education being monitored separately by another body. Similar are the concerns regarding the functioning of the professional councils of the department of AYUSH as well.
- The standards of training in medical colleges, nursing schools and colleges, and in those institutions that impart training to paramedical personnel have to be improved. There is an urgent need to establish a Commission for Human Resource Development and Medical and Health Education for promoting excellence in health care and human resources for health. This Commission should be empowered to set standards of training, design courses relevant for the health needs, standardize and upgrade the curriculum and undertake the integrated planning and development of human resources in health-doctors, nurses and other paramedical personnel and a system of accreditation of training institutions. This Commission should also have a financial corpus to provide as grants/loans to institutions for helping them reach the laid down standards.
- A live register and database needs to be maintained for all categories of medical and paramedical personnel and regularly updated by the respective professional councils. A system of re-registration of doctors and nurses once every five years and linking re-registration with minimum number of hours of continuing medical education (CME) should be introduced.
- To encourage young persons to take up public health, it is recommended that an All India Cadre of Public Health be established on the lines of the IAS/IPS.
- Sufficient incentives, financial and non-financial, should be given for attracting medical teachers to join and continue in pre- and paraclinical specialties in medical colleges. In addition, non-MBBS postgraduate seats may be increased in these specialties. Teachers in medical and nursing training institutions should be provided fellowships for undertaking higher studies and provided incentives for undertaking research.
- The number of seats in specialties such as Anaesthesiology, Paediatrics, Obstetrics/Gynaecology, Psychiatry and Community Medicine should be increased. Multiskilling of MBBS doctors with 9 months post graduate certificate training at the district hospitals in the scarce speciality would enahance availability of the required skills at the community health centers and help bridge the existing void in specialist care in rural areas.
- Every state should focus on nursing for better management and development of this critical human resource for health. There is a need to formulate and implement a national strategic plan for nursing and midwifery development, as done in Bangladesh, Thailand, Indonesia, Myanmar and Sri Lanka, etc. For developing leadership skills among nurses, the government should invest in multidisciplinary leadership and management development programmes for nurses and midwives. The bottom line is to create conditions that will enable us to retain our best and most qualified nurses to serve the health needs of the country.
- Institute atleast 1000 fellowships for research and higher education in various fields of public health, nursing, medical management etc. for faculty positions in the various schools and autonomous bodies proposed. 25% of these should be earmarked for PhD and post graduate studies and be open to all – government employees, universities, research institutions etc. alike.

Integrating the AYUSH system

- Constitute an independent regulation to assess and monitor quality aspects of AYUSH practice.
- Amend the Act that defines 'medical practitioner' in the Indian Medical Council Act to the MBBS degree holders, disqualifying the 5 lakh degree holders of AYUSH systems registered under the Indian Medicine Central Council Act, 1970 and Central Council of Homeopathy Act of 1972 of the Govt. of India. Suitable changes in the IMC Act will help in expanded use of this resource.
- A coordinated programme of participatory clinical research should be launched by the ICMR, CSIR to validate the best practices in traditional systems of health care. Likewise, a coordinated approach to the documentation of ecosystem-specific remedies, of traditional foods and related knowledge, epidemiological studies on the linkages between traditional food practices and health status of selected communities, etc. needs to be put into motion quickly.
- Functional collaboration of ISM with modern medicine may be facilitated at the PHC level. To begin with in a few places pilot projects with the integrated model be implemented. Based on this experience, the model can be upscaled to cover all the PHC's. To steer the development of integrative medicine, a Central Directorate of Integrative Medicine may be instituted.
- Formulation of an integrated national approach for the

management of HIV/AIDS similar to the model in China and undertaking a systematic research on specific aspects related to HIV and the role of ISM are required.

- The promotion of ISM herbal gardens under the Gram Aushadhi Udyan Cooperative farms and Gram Aushadhi Nirman programmes must be developed in at least 10,000 villages; the village healers identified, skills assessed, enhanced and utilized in the integrative model.
- Establish a coordinating body for a single window approach to undertake clinical trials under all systems of medicine.

Access to affordable drugs

It is difficult to predict the impact of the Patent Act on the access to drugs, both in terms of price as well as availability. At the time of the writing of this report, there are various scenarios emerging, ranging from cautious optimism to downright pessimism. Given the agreed position on the necessity to ensure that we safeguard this basic and fundamental right to access to essential medicines, there is need to carefully study experiences of other countries and coping strategies from the patients' and not only the commercial point of view. We see the Government's role to be very critical in being able to exploit the strengths and minimize the threats that are inherent in this Act.

- Expand price control of all drugs and mandate use of only generic drugs in all publicly funded programmes. Such price caps will help contain costs.
- Weed out irrational drugs and irrational combination drugs to substantially reduce household drug expenditures.
- A minimum VAT of 1% as against the proposed 4% should be levied for essential drugs
- Fix ceilings on trade margins as suggested by the interim report of the Sandhu Committee.
- Centralized pooled procurement reduce government expenditure by over 30%-50%. For this, we recommend adoption of the TNMSC model throughout the country.
- The recommendations of the Mashelkar Committee regarding setting-up of the National Drug Authority (NDA) with an autonomous status to take up the functions of drug pricing, quality, clinical trials, etc. need to be implemented without delay. Consequently, the present National Pharmaceutical Pricing Authority (NPPA) could be merged with the proposed NDA and Central Government provide assistance to states for strengthening the drug regulatory system.
- The Patent Act passed recently needs to clarify the scope of patentability; 'reasonableness' of royalty to be paid on the issuance of compulsory licensing; definition of 'significant' for the Indian companies manufacturing these drugs, mechanisms for automatic compulsory licensing and strengthening of the regulatory bodies to ensure that drug security is assured.

Access to modern technology

Modern technology has immense potential to save lives ad improve the quality of life if used wisely. Due to tax exemptions for import of technology and intense competition in private health markets, there is a rapid proliferation of technology, which is not regulated for quality or use. This is driving up costs of health care without any concrete evidence of good health outcomes. The public sector for various reasons is also costly and inefficient in the procurement and management of technology. Finally, information technology also needs to be more intensively used for patient care as well as health management.

- Regulate the proliferation of technology and reduce the clustering, particularly of high end technology by establishing norms and requirements of certificate of need by the public health authority, as done in most countries.
- Public sector should shift to contracting the private sector more for diagnostic services as it is more cost effective;
- Establish the Indian Medical Devices Authority and implement the recommendations of the High Level Committee constituted for the purpose by the ICMR and INSA. This committee should be outside the Ministry of Health as it requires skills that the Ministry does not have, being an end user of such technology. Necessarily the membership should consist of representation from DST, CSIR, INSA, DRDO, IT etc. .
- Introduce and intensively promote use of IT in health care for patient care in 3 areas : 1) Telemedicine, 2) computerized data management and record keeping; 3) training through the Edusat facility. For facilitating this recommendation, constitute a Working Group with representation from NASSCOM and IT department to formulate a policy for upscaling the use of IT in health. Similarly, there should be an increased use of the Geographic Information System (GIS) for facility mapping, areas of disease burden, etc. and its use as a decision-making tool for deployment of resources by expanding this expertise in the NIC which has the institutional capacity to service the requirements of health planners at the district level.

3. Financing of health

In the absence of a national health accounts system in the country, we have no idea of how much is being spent by whom and on what. Such information provides trends and enables policy action to contain costs and plan for addressing the shifts in health-seeking behavior. Second, public spending is also driven more by historical precedent rather than evidence or need. Third, in the absence of a system of research, cost effectiveness of interventions does not become a factor while deciding on strategies, which may often entail substantial budgetary implications. Fourth, the system of fund releases is fraught with great uncertainties and often budget cuts imposed are arbitrary, entailing the unintended risks, such as for example, drug resistance as a consequence of the sudden stoppage of drug supply. Fifth, the present system of budgeting is good for accounting and ensuring expenditure controls but not useful for policy shifts. Finally, the administrative capacity to maintain accounts and monitor utilization is woeful at all levels -from the PHC to the Central Min-

istry, giving scope for misuse. In other words, the systems of health financing in India are archaic and need overhauling.

- Constitute an Expert Group to evaluate the current system of budgeting and harmonize the accounting needs of the Finance Department and the operational requirements of the implementing agencies at all levels.
- All spending departments must have a budget line with major and minor heads on the nature of health spending. This should be uniform for all departments throughout the country and compiled systematically on an annual basis.
- Standardization of treatment protocols and unit cost estimations should be taken up and a schedule of benefits published. This then could be the basis for public funding of health in both public and private facilities. This will also enable people to get an idea of how much a service ought to cost and protect them from being exploited.

Section III — Way Forward

1.Organizational and financial restructuring

The existing system of delivery and financing will neither protect cost inflation and consequent impoverishment of the people nor help achieve health outcomes. The system has the worst features of health financing: unregulated, fee for service, technology and provider-driven, private insurance-led systems of risk protection, non-incentivized payment systems, etc. with the insurance function of public spending being limited in its impact as it is underfunded, dysfunctional and too narrowly focused on specific disease conditions.

- It is recommended that public spending be increased from the current level of 1.2% to 3% of GDP. The investment plan provides the suggested areas for such increases in funding, with priority focus to three areas : improving, upgrading and strengthening the battered health infrastructure in the country to conform to minimum standards, increasing the regulatory and information dissemination capacity of the government and R&D.It is believed that investment along these lines over the next ten years in a strategic way, will enable India achieve the MDGs' as well as the targets laid down in the NHP, 2002.
- Increase public investment to primary health care for providing universal access to a basic package of services at CHCs and facilities below it, alongside reorganizing the structure for enhancing accountability and increased sharing of oversight functions by the communities and local bodies. This will address about 90% of the health needs of the community and reduce household spending on these services.
- Rather than funding specific line programmes, restructure the financing system to fund packages of health care: core packages, basic health packages and packages for secondary care. Such packages enable the inclusion of preventive, promotive and curative service provisioning. To arrive at the cost of the package, unit cost estimations need to be taken up based on agreed treatment protocols that have the consent of professional bodies and therefore be enforceable.
- Upscale the investment on public health education and information from the current abysmal levels to reach 20% of the total government health spending. To start with, allocate at least Rs 50 per capita per year or 5% of the budget, whichever is more on prevention of disease and promotion of health values. Of this we recommend a ratio of 2:2:1 to be spent by local bodies and Village Health Committees on mass media campaigns against tobacco, risky sexual behaviour and promotion of health values such as yoga, etc. and on the establishment of the Epidemiological and Health Information and Disease Surveillance Units at CHCs, and at the district, state and central levels.
- Experiment with alternate financing models in a few districts for one year to obtain insights for designing new financing systems that would help contain cost. The shift should be towards the state becoming a financier and purchaser of care, alongside own provisioning to ensure that the patient gets the care as per his choice and also of good quality.
- Gradually shift towards a mandatory Universal Health Insurance System for secondary and tertiary care. There is also a need to carefully examine the substantial evidence available globally on the extensive market failures of private health insurance, particularly in the context of future risk to government finances and accordingly design the model that would be suitable and sustainable for India, that has a huge population with limited capacity to pay. Besides, for deepening the Health Insurance markets, action should be initiated to put in place the appropriate regulatory and institutional mechanisms, for example, the necessary health laws to govern health insurance business and a health regulator to oversee the enforcement of such regulations.
- Merge CGHS and ESIS, expand membership to others and reconstitute it as a Social Health Insurance Corporation of India. A new management culture and professional skills will need to be injected for managing such a Corporation. The SHIC may act as a re-insurer like NABARD to refinance other Health Insurance companies or entities. Without such a mechanism, financial risk protection for the poor will be impossible unless the Government chooses to fund the entire expenditure that may then require a five fold increase in the current level of health budgets.
- Given the limitations of our ability to have a single payer model and the diversity and complexity of India, the need for plurality will need to be recognized. Hospitals that have more than 500 beds and five superspecialties; NGOs, cooperative societies, PSUs or District Health Authorities having a minimum of 10-15,000 members and own hospitals networks; TPAs having a similar membership and provider networks, etc. should be permitted to provide insurance policies as a competitive environment can theoretically ensure efficiencies. But international evidence needs to be kept in mind. It is recommended therefore that assistance of external experts be availed of for designing the UHIS for India.
- To keep premiums low and promote large risk pools, insurance should be made mandatory for all. This should be implemented in phases starting with all employees in the public or private sector. They can be given the choice of enrolling with a Social Health Insurance Company. In the subse-

quent phases, community groups should be enrolled. While premiums will need to be community-rated but income-related, even the poor must pay some amount. For this, loans can be made available to be repaid over the year. In the case of no claim, after five years, the money should be refunded to the poor with interest.

- Government subsidy for rural communities and urban poor should be 30% of the premium be provided as an incentive to those having 70% enrolment. This will be only fair and on par with the employed who get 30% tax exemption for insurance. This will also act as an incentive and stimulate solidarity for formation of risk pools.
- The design features of the insurance programme needs to be carefully thought, particularly in the absence of any expertise, research or experience on provider and consumer behaviour in such circumstances in India to guide us. It would be useful to have on a long-term basis (not as short-term consultants) experts from the more mature market economies to assist us in the process.

Increasing accountability and focusing on monitoring

- Increase performance -based accountability by improving monitoring through concurrent sample surveys, social audit and institutionalizing community management at all levels through elected management committees in the village, at the PHC and the CHC.
- After building appropriate capacity, gradually shift to giving greater managerial and financial autonomy to provider units which could be formed into Public Trust Hospitals with their own board of Directors consisting of experts and representatives of civil society / local residents.

Section IV

Investing in health: Financing the way forward

The amount required for implementing the Way Forward is estimated to be about Rs.74,000 crores of which about Rs. 33,000 crores is for capital investment – Subcenters, primary health centers, CHC, and upgradation of district hospitals etc. About Rs. 9,000 crores is the estimated amount that may be required to be spent towards premium subsidy for the poor when and if the social health insurance policy gets universalised over the years.

Since health outcomes are the result of other health related activities such as water, sanitation, nutrition, primary schooling and road connectivity, an analysis was undertaken to estimate for 15 major states of India, the order of funds required additionally to achieve the national norms under these sectors set by the GOI. Analysis showed that these states needed an amount of Rs. 3 lakh crores. These estimations were based on very bare and minimal norms such as Rs. 3 per capita for nutrition or just the cost of constructing the minimum facilities and positioning manpower in the CHC's, PHC's and Subcenters. To bridge this resource gap an analysis was also undertaken to assess the amounts that the states can themselves mobilize and the additional amounts that would be required from the central government. Analysis showed a "taxable capacity" of Rs.2.40 lakh crores of which 255 can easily be allocated to health. Analysis also showed that 6 states had the potential to shore up the required level of revenues, while the remaining 9 required an additional support of Rs. 20,800 crores. These are also the worst performing states having the highest disease burden. Finally, there is a need to formulate a comprehensive approach to raising resources for increasing the spending on health and the related sectors of water, sanitation, nutrition and primary schooling, from the current level of 2.7% of GSDP to 9.7% – an increase by 7% of GSDP over the next few years if we are intent on achieving the targets agreed to under the various national policy documents and MDG.

- It is recommended that given the historical neglect of health and health related sectors and the worrying decline in social sector spending in the post 1990 period, amounts equivalent to 2% GDP be mobilized by means of general taxation. Given the current financial problems, an Expert Group may be constituted to work out the modalities of how to mobilize this additional resource through taxation and within what time period.
- Through a combined approach consisting of broadening the tax base and improving tax administration mobilize further amounts. Other measures could range from increasing medical tuition fees, imposing taxes on tobacco and alcohol, levying a "health tax" on corporate hospitals and hospitals that have foreign patients; making contributions and donations to medical colleges corpus/ public hospitals etc. income tax free etc.
- Review the various schemes being implemented by various ministeries to reduce duplication and ensure greater synergy for optimizing returns. Such measures will generate further revenues;
- Review the donor funded projects in the health sector to ensure that such assistance is aimed towards 1) the poorer states for rebuilding their health system by addressing their needs for capital investment; 2) building institutional capabilities; and 3) improving the capacity to deliver services in a comprehensive manner and in accordance with the guidelines laid down in this Report;
- Donor funded projects tend to be expensive and unsustainable in a deteriorating fiscal environment. Therefore, there is a need to more carefully evaluate the long-term financial implications at the design stage itself;
- Donor funding agencies have also multiplied manifold, with each having their own project requirements and monitoring formats. Preparation of projects for donor funding are highly time intensive and often disrupt routine work by diverting key professionals to project preparation. Thought needs to be given on building a more systematic and simplified approach;
- Disparities in health justify according higher priority to poor performing states. However, it is essential to ensure that better performing states, where health gains have been achieved, are not allowed to be eroded or slide back. In other words, sufficient investment and policy attention must con-

tinue to be provided to the better performing states to ensure that the skills acquired and efforts are not lost and due vigilance is maintained.

- Develop supportive policies that will enable the poorer states to mobilize such donor funding;
- Implement the concept of equalization to guide releases of central grants so as to aim at the gaol of having such investments enable all states, regions within states and populations within such regions to come up to a measurable national average bar of healthy well being within a time frame.

Way forward: The next steps to obtain social consent

Health affects all citizens. It is therefore essential that the system be designed to reflect the aspirations, needs and requirements of the people as well as those who provide them the services. Building a social consent through a consultative process will provide greater sustainability to the reforms proposed in this report. Accordingly, it is recommended that

- Task Forces consisting of knowledgeable and eminent people and representing all stakeholder groups be constituted to detail out the issues, the operational plans and financial implications;
- On issues requiring an intersectoral perspective a Group of Ministers may be constituted to deliberate the various policy issues.

The key issue is having a vision, defining it in clear terms and formulating the steps ahead in the knowledge that the realization of this strategy will take more than a decade and that action taken now will help the future generations.