

potential to save costs and improve health. Such measures may be possible only while constructing new buildings, but measures such as increasing energy efficiency, video-conferencing to avoid travelling to meetings and replacing paper-based with electronic records can be implemented in most organizations.

Lastly, doctors need to be at the forefront of planning to help their communities adapt to climate change. Climate change is increasing health hazards ranging from more frequent heat waves, severe floods and drought to increasing intensity of transmission of vector-borne diseases. Doctors are well placed to enhance and lead the surveillance and monitoring of the health impact of climate change, to help develop preparedness and response plans to extreme weather events and changes in the distribution and patterns of disease, and to help increase cross-sectoral collaboration and the resilience of communities. Let us seize this opportunity to spread the message that 'what's good for climate is good for health'¹² and help ensure that 'lower carbon saves lives'.

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Does India need NICE healthcare?

Despite a thriving economy, almost three-quarters of the Indian population lives on less than US\$ 2 per day, which in a healthcare economy dominated by the private sector, with out-of-pocket expenditure or distress financing commonplace for the majority, breeds health inequalities. With a 4.9% GDP (~US\$ 39 per head) expenditure on healthcare (of which approximately 20% is government funding), India's investment in healthcare exceeds that of its neighbours (Pakistan, Nepal and Sri Lanka each spend <1% of GDP on healthcare) and is close to that of several European countries.¹ Why then, are there still so many challenges to delivering equitable healthcare in India?

At the outset, let me dispel the notion that increasing investment results in proportional health gains. The USA spends 17% of its GDP (US\$ 2.4 trillion) on healthcare, yet 47 million people remain uninsured and health inequalities are striking.² Investment alone is, therefore, not the sole marker of the efficacy of healthcare systems. It is the way in which resources are derived and allocated which determines the efficacy of investment.

Developing socialized healthcare systems in India demands financial affordability, political acceptability and change, which must be sustainable and scaleable. A core difference between England (a socialized healthcare system) and India is the relative imbalance of the private and public healthcare sectors. In India while the public sector dominates provision of public health services such as immunization, the private sector dominates provision of profiteering, specialty services, e.g. over 80% of outpatient activity is in the private sector. In contrast, the taxpayer-funded National Health Service (NHS) dominates in England. The principles of universal coverage and equity of access to healthcare, free at the point of entry, regardless of ability to pay, underpin the NHS. Is it conceivable that India might also be able to provide universal health coverage? Before we answer that, one must ask if it is desirable for India to do so.

Ethical arguments aside, universal health coverage is essential to a developing economy such as India, since poor population health contributes to socioeconomic instability and undermines development efforts. Strengthening healthcare systems is vitally important to India if it is to avoid the economic consequences of failing to do so. Put into perspective, if risk factor trends for cardiovascular disease go unchecked over the next 5 years, India will see more myocardial infarctions than the UK has ever seen, with an economic impact of US\$ 54 billion predicted by 2015. The economic argument is compelling.

In England, a nation boasting of predominantly socialized healthcare, the National Institute of Health and Clinical Excellence (NICE) has played a major role in allocative decision-making over the past decade, contributing to a reduction in health inequalities by balancing expenditure on healthcare across and along clinical pathways, with investment in both upstream and downstream interventions. What is NICE and would India benefit from a NICE approach to healthcare to assist development of a universal healthcare system free of inequity?

Resource allocation in taxpayer-funded healthcare systems is inherently controversial as financial constraints challenge public and professional expectation that healthcare should be universally and comprehensively available to all. All healthcare systems require an allocative decision-maker, particularly when confronted by an ageing population, rising healthcare costs³ and increasing public expectation. In private healthcare systems, the consumer essentially pays for what he receives, often oblivious to alternatives or cost-effectiveness. India therefore is likely to derive limited benefit from a NICE in terms of ameliorating health inequalities, since the dominant private sector will continue to provide a wider range of services and interventions than the public sector will be able to afford. Additionally, the private sector is unlikely to provide public health interventions such as immunization or health promotion. A NICE approach would benefit the public sector in ensuring optimal resource utilization, commencing mainly with highly cost-effective public health-level interventions, but reducing health inequalities will be challenged by the presence of a dominant private sector.

The underlying remit of NICE in England, to address challenging issues and justify often difficult 'rationing' decisions, requires an organization with a high degree of transparency and robust processes able to withstand challenge from stakeholders, patients and politicians. NICE meets each of these requirements and was complimented by the WHO in a review of its methods and processes.⁴ Since inception in 1999, NICE has developed over 300 guidelines for the NHS. Upon identification of pertinent health issues, the Government requests of NICE, and NICE independently formulates guidance, underpinned by evidence and cost effectiveness.⁵

India's healthcare needs, dominated at present by communicable diseases, differ from those of the UK and question whether India currently needs NICE at all. The

Millennium Development Goals (MDGs) from the WHO, covering communicable diseases, maternal and child health and other important areas, are conspicuous however by the absence of a focus on non-communicable disease (NCD). NCDs are the unseen tsunami of emerging epidemics in India, with cardiovascular disease and diabetes drawing clear parallels with developed nations in terms of healthcare challenges. The emergence of NCDs, in a population still confronting communicable diseases, provides a firm rationale for a NICE approach to healthcare in India. Neglecting the full portfolio of healthcare needs will cost India dearly.

India first requires a framework for prioritizing health needs. The Public Health Foundation of India has made a commendable start. Clearly defining healthcare challenges will provide a platform for prioritizing and defining optimal utilization of finite healthcare resources.

Second, India must take its fiscal resource and begin to allocate it wisely. Just as NICE defines that below £30 000 per QALY (quality-adjusted life year), an intervention is affordable to the NHS, India must decide what is acceptable as an affordability threshold for use of its scarce resources. India must then define and prioritize the range of interventions and procedures which are acceptable to be funded by the public purse. Adopting the robust, transparent approach of NICE would provide a tried and trusted mechanism for such allocative decision-making across the health economy, not allocation according to strength of representation⁶ or political influence. Inappropriate influences guiding healthcare expenditure must be curtailed in a country of over a billion people, a lucrative market to healthcare industries.

Third, India must empower its NICE and in doing so, appropriate the responsibility for guideline development for the public sector away from the array of bodies and organizations which currently develop guidelines (usually without reference to cost-effectiveness or incremental cost-effectiveness), to avoid the risks of diverting resources away from more pressing areas. India will only then begin to move away from an era where clinical care has traditionally been guided by professional groups poorly integrated into the public sector, taking little account of the consequences of their recommendations beyond a single specialty focus. Single specialty panels are also more likely to demonstrate a pro-intervention ('optimism') bias when asked to appraise the same evidence as a multidisciplinary panel.⁷ While 'expert' opinion does deserve a place within an evidence pyramid, it is 'part' of the evidence rather than 'the' evidence. At NICE, individuals participating in guideline development make clear declarations of any real or perceived conflicts of interest. Stakeholders (from a variety of backgrounds, e.g. pharmaceutical and non-pharmaceutical industry, healthcare and voluntary sector organizations) are given an equitable opportunity to comment on guideline development from early scoping through to final iterations of a guideline. India must therefore use NICE as a means to maintain freedom from overt or covert conflicts of interest driving inappropriate resource utilization.

Fourth, India would benefit from using the NICE focus on evidence-based medicine to guide disinvestment opportunities in a country with a thriving, unregulated alternative medicine industry. Highlighting this to the public may prove unpopular and attract opposition from self-interest groups, but for a nation, it may be an appropriate mechanism to generate opportunity cost and improve population health.

Fifth, India must ensure it meets the needs of both individual and public health. Health outcomes are not solely determined by healthcare provision, but are influenced by social determinants of health, the environment, etc. Healthcare economies need to resource healthcare both for individuals and for populations. Just as NICE in England develops guidelines for interventions and technology appraisals in parallel with public health-level guidance, a similar approach for India would ensure a balanced focus on prevention as well as cure.

Finally, the nation will require an independent organization to monitor implementation of guidance, assess health outcomes and set standards of care. In England, NICE is shortly to embark upon being responsible for the establishment and definition of quality standards, an exercise which other healthcare economies the

world over will watch with interest to see if these are a foundation for clinical quality improvement and reduction of health inequalities.⁸

On balance, a NICE approach to healthcare resource utilization appears justifiable in India. In England, there is clear support for NICE's role by politicians, professionals⁹ and the public, all of whom have endorsed the rigour of NICE's methodology and called for a public debate around rationing. The challenges faced by NICE in its first decade should not be forgotten or underestimated.¹⁰ It was established on a national fault line where societal, political, fiscal, professional and commercial tectonic plates abut. Following the turbulence created by the tensions of these plates, its greatest achievement is that it is respected and still exists in England. Of equal flattery, other healthcare economies are looking to adopt its approaches. Whether India either needs or is ready for NICE is an issue one might continue to debate. While we pontificate on whether a NICE approach to Indian healthcare is appealing, one must be cognizant of the reality that with each passing second of time in a country without universal healthcare or allocative decision-making, those not fortunate enough to have access to basic healthcare shockingly die from inexpensively preventable or treatable conditions.

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